Presentation of Thesis for Examination

Exploring parents' experience of child health reviews with health visitors using video consultations: a Hermeneutic Phenomenological Approach.

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Seuil-réflexion - By Jean Arp 1960/1982

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Abstract

Title: *Exploring Parents' experience of child health reviews with health visitors using video consultations: a Hermeneutic Phenomenological Approach.*

Background

Health visitors deliver the Healthy Child Programme to children under five, involving five reviews: antenatal, birth, six-to-eight weeks, one and two years.

During COVID-19, health visitors engaged with parents using video for the first time as lockdowns forced professionals to alter their working to keep safe. Little is known about this way of engaging for health visitors and families.

Method

A Heideggerian interpretative hermeneutic phenomenological study using unstructured interviews and in-depth data analysis using guidance by Dibley et al and the Diekelmann et al framework.

Ten parents in England who had experience of video consultations with a health visitor, were recruited using social media and snowballing.

Findings

Ten themes, three were constitutive patterns, present in all interviews, five relational themes, prominent in most interviews.

The key finding was parents felt that health visitors were unable to assess their child over the screen so the burden of responsibility was on their shoulders, and they worried their reporting might be inaccurate, or something might get missed.

Technical issues, logistics and being a tick box exercise were also patterns.

The patterns were considered using Heideggerian concepts which helped reveal the phenomenon and meaning the parents had attributed to their experience with '*technology*' and '*presence*' being the prescient philosophical notions.

Conclusion

The experience of video consultations was different for each parent, but all felt the burden of responsibility to report to the health visitor. Recommendations for practice include adopting a conversational style.

Key words

Health visitor, Video consultation, Parents, Hermeneutic Phenomenology, England, Experience, Qualitative Research, Technology, Presence, Lived Experience.

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Glossary

Term	Definition
Being	Term used by Heidegger referring to the ways in which humans reveal themselves to themselves to gain understanding.
Being–with	Term used by Heidegger referring to being with others and how they interact and communicate with each other.
Constitutive patterns	Present in all narratives and indicate there is something meaningful present which warrants attention.
Dasein	Term used by Heidegger, where humans were concerned with their own existence but also understand that other things exist in the world.
Fusion of horizons	Term used by Gadamer, where the researcher and participants combine their understanding and meaning to achieve an interpretation of common meanings and shared practices.
Health Visitor	Health Visitors are specialist community public health nurses, (SCPHN) registered midwives or nurses. They specialise in working with families with a child aged birth to five to identify health needs as early as possible and improve health and wellbeing by promoting health, preventing ill health and reducing inequalities.
Hermeneutic Circle	The back and forth in questioning of our prior knowledge to think about the parts and the whole.
Interpretative hermeneutic phenomenological approach	To uncover the meanings of phenomenon that occur in the world as understood through the interpretation of lived experiences.
Literature scoping review	A systematic method for mapping out the existing literature on a topic. It helps to identify gaps in knowledge and clarify theories.
Nearness	A time-spatial remoteness that cannot be set aside by any overcoming of distances.
Parents' perceptions	The way in which something is regarded, understood, or interpreted.

Parents' views	A particular way of considering or regarding something for example an attitude or opinion.
Phenomenological nod	Term used by Gadamer referring to the way humans indicate through the gesture of a nod, that they agree with something.
Presence	Term used by Heidegger referring to the accessibility of someone here and now.
Reflexivity	An active process of dynamic self-awareness taking place as an event is happening.
Relational themes	Appear across some transcripts.
Video Consultation	Is an appointment that takes place between a patient/service user and a healthcare professional over video, as opposed to face-to-face or over the telephone.

Chapter 1 - Introduction and Background to the Study

1.1. Introduction

This research study explores the experience of parents having video consultations with the health visiting service in England using an interpretative hermeneutic phenomenological approach. Healthcare organisations rapidly introduced video consultations into practice during the Coronavirus pandemic. This study seeks to explore what that experience was like for parents to help to inform future health visiting practice and service delivery models.

This chapter will examine the national context pertaining to the Healthy Child Programme (HCP, Gov.UK 2023), set the context for the study in relation to the use of technology for delivering the health services, explain the role and context for the health visiting service and introduce the choice of methodology. It will set out the purpose of the study proposing the research question and objectives and finally introduce the need for and significance of the research.

1.2. National context and the Healthy Child Programme

The Healthy Child Programme 0 - 5 (Gov.UK, 2023) is an early intervention and prevention Public Health programme, which lies at the heart of the universal service for children and families at a crucial stage of life. Its universal reach provides an invaluable opportunity for health visitors to identify families and children who need additional support and to improve outcomes for children by reducing inequalities. It offers every family screening tests, immunisations, developmental reviews, information, and guidance to support parenting and healthy choices, these are all services that children and families need to receive if they are to achieve their optimum health and wellbeing.

Health visitors are nurses with degrees in specialist community public health nursing, and they lead and deliver the Healthy Child Programme; they have a fundamental role to play in establishing good working relationships with all parents (Burrows and Cowie 2022). Aligning with wider prevention and community-based programmes and services, e.g., health promotion, contraception, sexual health, reducing obesity, smoking cessation, and breastfeeding, health visitors provide a whole system approach to prevention and support the provision of early universal access to information regarding health issues to parents and families.

Health visiting teams offer five mandated child health and development reviews under the Healthy Child Programme (Gov.UK 2023):

- Antenatal from thirty-two weeks,
- New birth visits from eight to fourteen days,
- Six-to-eight-week review,
- Nine to twelve months, and
- Two to two and a half year, development reviews.

Traditionally, prior to the coronavirus pandemic, these reviews were offered face-to-face either in the home or at a community venue, for example, a health clinic or Children's Centre.

1.3. The rise of video consultations

On 23 March 2020, due to the Coronavirus pandemic, the Government introduced the first lockdown (Cabinet Office 2020), which forced new service delivery approaches and health professionals had to reorder their practices to avoid spreading the COVID-19 virus. This change in service delivery needed to be implemented rapidly into the health sector and

professionals found their working methods changed. Health visitors in England engaged with parents, predominantly via online video, for their child's health reviews for the first time. This involved the parent being sent an online link for a consultation; the health visitor and parents would log on at the same time, with cameras switched on thus allowing for synchronous communication. This online method allowed the health visitor, parent, and child to convey ideas, express emotions, and exchange information (Burrows and Cowie 2022).

People in the literature are unanimous in agreeing that, during the coronavirus pandemic, virtual communication was vital for families and health professionals to carry on delivering and receiving the service they required (Burrows and Cowie 2022; Institute of Health Visiting 2021; Parent- Infant Foundation et al 2021; Parent – Infant Foundation 2022; Conti and Dow 2020). Due to the need for a health visitor to complete a professional assessment of the child and family, the Government is now clear that the Healthy Child Programme health reviews should be conducted face-to-face (Gov.UK 2021) and the Institute of Health Visiting (2021) agrees. Despite this, the return to in person child health reviews has been slow and inconsistent across England, perhaps, because online has become a normal experience and people are comfortable with it, but possibly due to workforce reluctance, fear of a return of COVID-19 and / or staff capacity issues as well as policy drivers (NHS 2019). The Parent-Infant Foundation et al (2021) found in their research published in 2021 that 11% of parents with a child under two-years-old had seen a health visitor face-to-face, and 28% stated they were still only being offered an online health review after the pandemic (The Parent-Infant Foundation et al 2021). This was against the backdrop of professional concern about the use of video consultations being continued post pandemic and how they could ensure children were safeguarded appropriately (iHV 2021).

In addition, in a survey of health visitors, 89% disagreed or strongly disagreed, that video contacts were as effective as face-to-face (Boddy 2021), it was felt that video consultations did not offer the same opportunities to explore or identify concerns especially with vulnerable parents (Newham, Fallon, and Darwin 2021). The Professional Records Standard Bureau (2020) in their 'Digital health and Covid-19' report, identified challenges around quality, safety and accessibility issues in online parent and clinician interactions. However, Feger (2021) felt there were perceived positives in continuing with video consultations, as some parents would prefer it, especially if convenient for busy parents with babies. It also meant that, at times, the whole family could participate, as well as saving unnecessary travel to appointments. A review of the literature for this study demonstrates little research has been done to seek parents' views of a video consultation with a health visitor to inform this debate about future service delivery.

1.4. Situating within the literature

Prior to 2020, progress in digitalising health services was patchy (Feger 2021), but the Coronavirus pandemic mainstreamed this way of working and services that were traditionally face-to-face, like health visiting, became virtual for parents and families (Conti and Dow 2020; Parent- Infant Foundation et al 2021). In 2014, only 2% of the population reported digital interaction with the NHS (National Information Board UK 2014), despite 84% using the internet (NHSE 2019). Figures relating to virtual technology usage in health settings are not available, although evidence suggests that health services in 2020 relied heavily on virtual solutions for example video consultations, email or telephone (NHS&I 2020). The Government published a policy statement in June 2022 setting out the vision and expectations of health and social care organisations by 2028 to become digitally

mature and coordinated in their technology leading to faster, more effective, and personalised care for everyone in the UK (Department of Health and Social Care 2022).

There is a plethora of published guidance from organisations for practitioners to help safe and effective online working practices (iHV 2020; NHS a,b,c 2020; NHSE&I 2020; RCPsych 2020; RCGP 2020), they give practitioners detailed guidance on presenting, gaining consent for treatment and recordkeeping. They help practitioners make sense of and stay within professional guidelines to ensure the safety of themselves and their patients.

1.5. Digital health

Nurses and midwives have been key drivers of digital health due to their knowledge of the workflows and decision-making capabilities (NHSE 2022), and their role is becoming more important post pandemic as this progresses (Mitchell 2022). The Royal College of Nursing defines digital health or e-health as being concerned with promoting, empowering, and facilitating individual's health and wellbeing using technology (Royal College of Nursing (RCN) 2022). Nurses' and Midwives' use of digital technologies needs to become "business as usual" (Burrows and Cowie 2022; Cronin 2024) and it is believed it might also help to reduce the burnout effects of the pandemic by reducing paperwork (Mitchell 2022). In 2020, a Chief Nursing Information Officer for England was appointed to NHS Digital to lead on both the digital transformation of nursing and midwifery and a strategy around safe and effective care via information technology to help progress this agenda (NHSE 2022).

Anecdotally, due to the limited research about video consultations, there were questions raised amongst commissioners, clinicians, and managers during professional meetings about whether it was safe to assess families and children online (Parent-Infant Foundation

et al 2021). Additionally, assessing children when conducting a video consultation, to enable families to be helped holistically, is being highlighted by the Institute of Health Visiting (iHV 2021) as an area of concern and they question its safe practice. The iHV are calling for further research to be conducted to establish if this practice should continue. The iHV (2021) acknowledged that current research on video consultations focused on general practice and primary care or hospital services where it was usually introduced as part of a pilot study. They reported that there was a gap in the research that explored the use of video consultations for assessing families in their homes where there might be vulnerabilities, e.g. domestic abuse or developmental concerns about the child (iHV 2021). Barrett (2016) posed that nurses need to use technology as a way of providing high quality care rather than as an end in itself. Technology, by way of video consultation, is embedded in practice but further research is required to establish what parents think about its continued use in their care (Brook 2020). It is therefore timely that this research study seeks to explore and listen to parents' experiences of video consultations so their views may be heard.

1.6. Health visiting and video consultations

Health Visitors play a vital role in the health and development of families with children under the age of five (Conti and Dow 2020). Parents wanted an effective health visiting service that supported them with things that were important to them, they valued being treated as individuals and receiving a responsive service to their family's needs. Dissatisfaction was evident when parents felt rushed and not listened to, especially around the transition to parenthood (Morton 2020).

The research study in this thesis helps to inform practitioners how to work with parents in the post coronavirus pandemic world of blended face-to-face and video consultation reviews and enhances the knowledge of providers and commissioners who must decide what mode of service delivery to use. The Institute of Health Visiting (2021) acknowledged that there was anecdotal evidence that video consultations have a place in a post pandemic world and that some families found online contact extremely helpful during the lockdown periods. The iHV state that video consultation had a role in transactional conversations regarding advice giving e.g., breastfeeding support, but not where assessments of families were required (iHV 2021).

1.7. Hermeneutic Phenomenology

A hermeneutic phenomenological approach was taken based on the work by Martin Heidegger (1889 – 1976). Hermeneutics is the theory of interpretation, and phenomenology is the study of a phenomena, as experienced in the first person (Moran 2000). Hermeneutic Phenomenology recognises that we are all engaged in our lives, that we make decisions and find both meaning and understanding in our actions (Ramsook 2018) and in our interactions with one another and things (Dibley et al 2020). Heidegger's (1962) philosophy is concerned with understanding the meaning of the experience e.g., video consultations; and due to the prevalence of technological mediation, consider what it meant to the participants to experience one. Heidegger proposed that humans are not passive when it concerns technology, that technology is a means to an end and should be manipulated to '*master it'* (Heidegger 1977 p5).

1.8. Purpose of the study

The purpose of this study was to explore the experience of parents who had a child health review with a health visitor by video consultation. The study used social media to recruit participants who lived in England, UK. The study has been undertaken to inform health visiting services and commissioners of the Healthy Child Programme (Gov.UK. 2023) about parents' views because seeking service users' experience is so vital to informing how services should be run in the future (Institute of Public Care 2017).

1.9. Research study questions and objectives.

The research question was to explore parents' experience of child health reviews with health visitors using video consultations.

The **objectives** to answer the research question are:

1. To explore the parents' perceptions of video consultations as it appeared in everyday 'being-in-the-world'.
2. To listen to the parents' views of video consultations and understand their lived experience.
3. To understand parents' experiences and what they say about using technology as a means of communicating with them.

1.10. Need and significance of the research.

The need for this study becomes more urgent as health visitors continue to use video consultations for health reviews, with little evidence base about how best to conduct them, whether they are effective or which families should receive them. Guidance is required nationally, that is realistic, pragmatic, and achievable for services and families and this

research adds to the evidence base of how parents experience video consultations and what their views and perceptions are.

The literature scoping review in Chapter 2 demonstrated that there was little research into parental experience and views and that adult patients data were not comparable with parents of children under 5 as they do not share the same experience or opinions. The findings of this study in Chapter 5 are significant for health visiting services, health visitors and commissioners because it demonstrates in detail the parents' lived experience of video consultations. The parents shared their narratives with openness and generosity, and gave valuable insights into their experience, their '*being-in-the-world*' (Heidegger 1962), and what having a video consultation meant to them. These insights add to the evidence base for health visiting practice and if applied by services could be translated into practice and inform service delivery.

The discussion and recommendations in Chapter 6 and the conclusion in Chapter 7 are drawn from the narratives of the parents' experiences and blended with the researchers' clinical experience as a health visitor and commissioner of the healthy child programme (Gov.UK 2023) in order to draw together the research and literature to make valid recommendations for practice. It is important for the commissioner to give details of the delivery model in a service specification to ensure that it is evidence based and meets the needs of the local community (Institute of Public Care 2017). If this was guided by research and informed by the parents' experience, it would be powerful information to help service delivery and commissioning for the future.

1.11. Summary

This chapter has summarised the national picture both regarding the healthy child programme (Gov.UK 2023) and health visiting, as well as the context around use of digital technology in healthcare. For context, the impact of the coronavirus pandemic on service delivery and in particular video consultations was examined as well as highlighting the professional bodies and Government concerns and recommendations around digital technology and its use. The purpose and objectives have been clearly presented to set out what this research study will achieve. The next chapter, Literature Scoping Review, will describe and examine the literature already published and its relevance to the research question and objectives above.

Chapter 2 - Literature Scoping Review

2.1. Introduction

This chapter provides a summary of the available and pertinent literature to the research question. Literature reviews enhance and support the case for a prospective study as they provide a secondary source of research (Aveyard, Payne and Preston, 2016). A literature review, in its traditional approach as a subjective tool, has the researcher examining research studies in addition to conceptual or theoretical literature to determine importance or collective thinking around the topic (Munn et al 2018).

The main purpose of a scoping review is to demonstrate that the research proposed is necessary (Dibley et al 2020). Deciding whether to complete a literature review or a scoping review for this research involved an examination of both methods, their benefits, and their limitations. The purpose of research is to contribute to the understanding of the world, and this provides the justification for the study (Hart 1998).

The literature will be analysed using a data charting table and categorised into themes using thematic analysis to highlight those that are important in the literature and identify gaps in the papers pertinent to this research question (Appendix 2). This chapter will detail the scoping review undertaken leading to the identification of a gap and rationale for the research project.

2.2. Literature scoping reviews

Scoping reviews offer a panoramic overview and ask, ‘what has been done previously?’ and ‘what does the literature say?’ (Khalil et al 2021). This is especially useful in areas where there is little prior research (Arksey and O’Malley 2005), it allows for a broader approach and a more general research question which encourages a mapping of the body

of literature in an emerging area of research (Munn et al 2018). Due to the lack of published material on parents' experiences of video consultations with a health visitor, it was decided that a scoping review would best meet the question and objectives of this study.

Hermeneutically, the scoping review is a time to engage meaningfully with the literature, to attune to the subject, and layer prior thinking with new knowledge to co-create a new perception of the literature and subject (Dibley et al 2020). As a preliminary activity, a scoping review provides a compelling starting point into an investigation of a specific field and encourages some blue sky thinking as well as demonstrating clear, consistent standards guiding and governing its design (Davis, Drey and Gould 2009). The scoping review approach enabled literature to be presented and merged using analysis to represent the meaning of a body of work as reported in the separate papers (Kemp et al 2022).

The Joanna Briggs Institute published updated guidance in 2020 for conducting and reporting on scoping reviews. The JBI framework is based on the work by Arksey and O'Malley (2005), and Levac, Colquhoun, and O'Brien (2010), who added the seventh step around consultation. This Preferred Reporting Items for Systematic reviews and Meta – Analyses extension for Scoping Reviews or PRISMA-ScR and the JBI guidance helps promote the quality of scoping reviews and their reporting (Aveyard, Payne and Preston 2016) it also guided the reporting of this research. The Joanna Briggs Institute (2020) framework also recommended by Pollock et al (2021), was found to be more complex and less accessible for this study so the Arksey and O'Malley (2005), framework was adopted which gave 5 stages for scoping reviews:

Table 1: Arksey and O'Malley (2005) Framework for Scoping Reviews

Stage 1	Identify the research question
Stage 2	Identify the relevant studies
Stage 3	Study selection
Stage 4	Charting the data
Stage 5	Collating, summarising, and reporting the results.

2.3. Scoping review: Identify the research question (Stage 1)

Research aims and objectives.

All scoping reviews should start with a well-defined topic and carefully articulated research question, which guides the conduct and reporting of the review while also ensuring transparency and minimises reporting bias (Khalil et al 2021). This research study aimed to explore the parents' experience during video consultations with health visitors. The central question the research asked was:

> '*What are parents' experiences of video consultations with their health visitor when undertaking their child's health review?'.*

Objectives to achieve its aim and answer the research question are:

1. To explore the parents' perceptions of video consultations as it appeared in everyday 'being-in-the-world'.
2. To listen to the parents' views of video consultations and understand their lived experience.
3. To understand parents' experiences and what they say about using technology as a means of communicating with them.

2.4. Scoping review: Identify the relevant studies (Stage 2)

2.4.1. Search strategy

Identifying the research question and aims helped to guide the search for relevant literature. It was best to maintain a wide approach to searching the literature to gain the breadth of coverage of studies (Arksey and O'Malley 2005). The key purpose of the literature search for hermeneutic research was to *'provoke thinking'* (Smythe and Spence (2012 p14) and enable the researcher to immerse themselves in the texts to engage in thinking and dwelling to help decide what matters.

The search strategy SPIDER was used to help to clarify and focus on appropriate studies, as demonstrated in Table 2 below. Cooke, Smith, and Booth (2012) devised SPIDER, which is an acronym for Sample, Phenomenon of Interest, Design, Evaluation and Research Type, because they found PICO (Population, Intervention, Comparison and Outcomes) did not suffice for qualitative research. They argue that comparison is more suited to a quantitative study so changed it to 'Design' which they reported influenced the robustness of the study. SPIDER yielded a higher rate of search results than PICO which increased the confidence that all the articles had been identified (Cooke, Smith, and Booth 2012). SPIDER is recommended as the search tool of choice for qualitative approaches such as hermeneutic phenomenological methods and its categories seemed to fit neatly with the research question (Dibley et al 2020),. The cataloguing of research by methodology was widely variable (Cooke, Smith and Booth 2012) and it was felt a better option to retrieve all the results and then hand sift for methodology so the R from SPIDER was not utilised.

Table 2 below details, using SPIDER, the search terms used to gather the relevant research articles for this scoping review. Truncating words using a * allowed for more

variations of the phrase to be searched for, for example parent* could also be parents or parenting (Booth, Sutton and Papaioannou 2016).

Table 2: SPIDER (Cooke, Smith and Booth 2012)

SPIDER element	**Search Terms**
Sample	Health Visit* AND Parent* OR Patient
Phenomenon of Interest	*Experience of video consultation* *OR* Video consultation *OR* Virtual consultation
Design	Health review
Evaluation	*AND* Perce* (perceptions) *OR* Attitud* *OR* View* *OR* Experienc*
Research Type	Qualitative *OR* mixed method

2.4.2. Primary databases

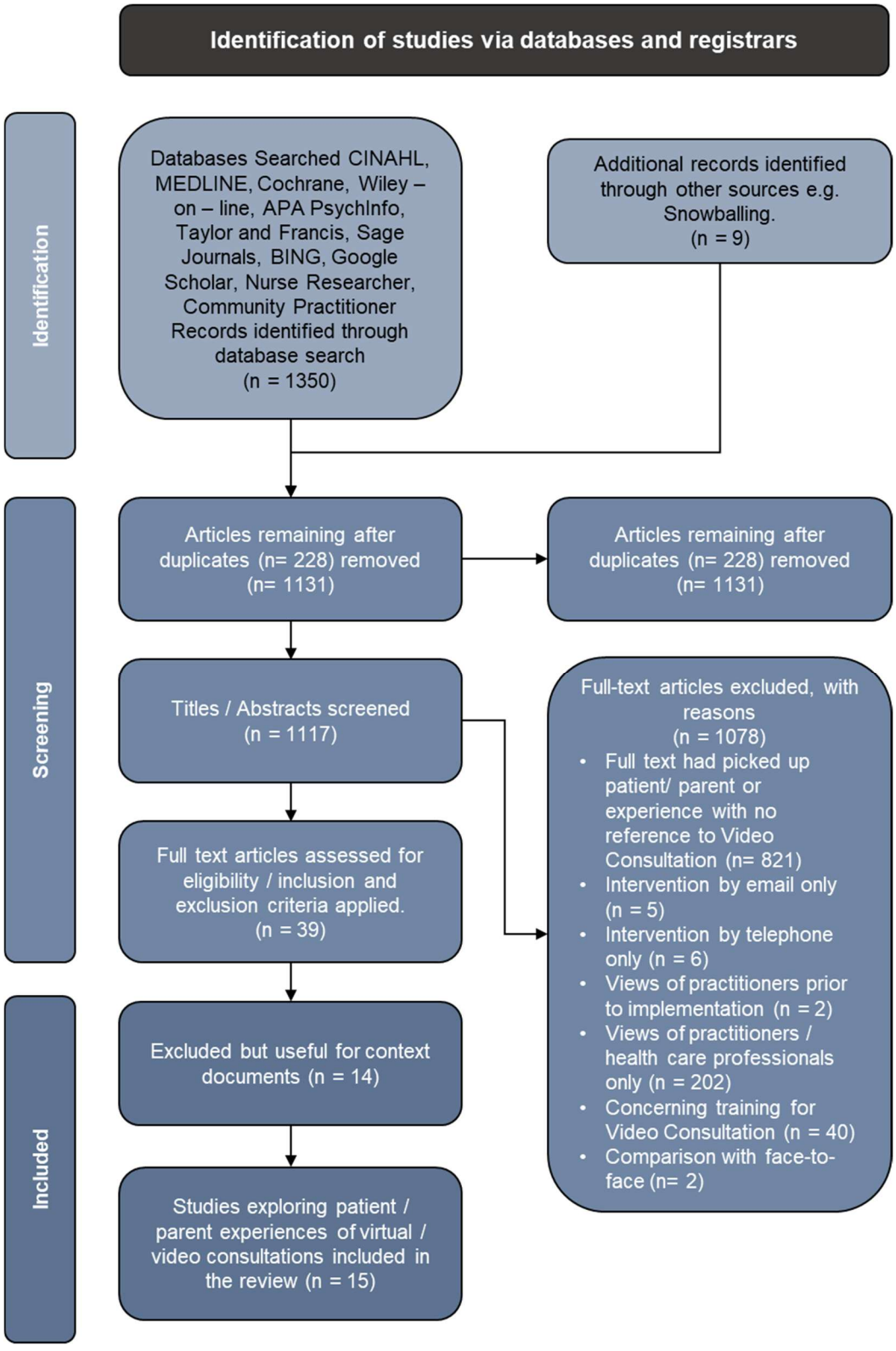
After several attempts at searching the databases, the most effective way was to narrow the search terms, so the number of results returned were more manageable. For example, an early search of MEDLINE and CINAHL, via EBSCOhost, gained 13,650,017 results, mainly due to the use of the word 'Patient'. Searching the abstract not full text reduced this to 1,073,604 but was still unmanageable. The most helpful combination was *'Health Visit* AND Parent OR Patient AND Health review AND Video consultation OR Virtual Consultation'*. The search terms and results table in Appendix 1 give the full detail of the task completed.

Several databases were searched utilising the University of Essex library services to identify potentially relevant articles, and a year 2000-time limiter was applied, allowing identification of recent research which was deemed appropriate, due to the contemporaneous and technological nature of the research question. The researcher started with 2015 but had to broaden the time limiter to 2000 to gain enough articles of interest.

The practical guide by Pollock et al (2021), helped to identify the broad range of databases and grey literature sources available, this included MEDLINE, CINAHL, Cochrane Library, Wiley-on-line, APA PsychInfo, Taylor and Francis, PubMed, and Sage Journals. The electronic database search was supplemented by wider searching using Google Scholar, Google, and BING, for research and grey literature, which is any literature not produced by commercial publishers e.g., thesis, conference papers.

The PRISMA flowchart in Figure 1 was used to demonstrate robustness in retrieval, screening, eligibility assessment and inclusion of studies following the literature search (Liberati et al 2009).

Figure 1: PRISMA Flow diagram detailing study selection (Liberati, Altman, Tetzlaff, Mulrow, Gøtzsche, 2009)



Effective retrieval of research articles depended on clarity of search terms and being included in the title and abstract of the article (Cooke, Smith, and Booth 2012). Boolean operators 'NOT', 'AND' and 'OR' limited, excluded, and combined the search to get the pertinent results for identifying relevant literature (Aveyard 2014). Complementary searching, e.g., hand searching reference lists (snowballing), or searching multiple databases, was necessary to assure the researcher, and subsequent reader, that all available literature had been identified (Aveyard, Payne, and Preston 2016), and was a useful way of gaining quick access to literature because, if like-minded research articles cite it, it was likely to be relevant.

The Community Practitioner and Journal of Health Visiting, as the main sources of health visitor literature, were scanned for the last 10 years of published research. In the third search stage, as suggested by Pollock et al (2021), all identified article titles and abstracts, which totalled 1350, were reviewed both for content and inclusion.

Finally, snowballing was carried out, where the reference list of the included articles was hand searched for relevant research to meet the studies inclusion criteria. On this occasion it was the most effective source and 9 of the final 15 articles were identified this way.

2.4.3. Inclusion and exclusion criteria

The inclusion and exclusion criteria below in Table 3 below, is a required practice to help eliminate studies that do not help address the research question (Arksey and O'Malley 2005). In Hermeneutic Phenomenology the criteria tends to be few and broad to capture the quality and *Daesin* or *being-in-the-world* of the study's participants (Heidegger 1962).

Table 3: Inclusion and Exclusion Criteria

	Example
Inclusion Criteria	Keywords [Health Visit*; Parent*; Patient* AND Health review OR experience; perceptions; attitudes or views AND video consultation OR virtual consultation] appear in title or abstract. Original full text research qualitative or mixed methods design Focuses on experience of video consultation is main or only focus. Year 2000 onwards
Exclusion Criteria	Intervention by email or telephone Focus is on Health Care Practitioners viewpoint/experience. Research is prior to implementation of video consultations. Comparison study with face-to-face

The eligibility criteria, research question and topic were linked (Pollock et al 2021) and there are specific characteristics that a research paper must include for example, focusing on the parent or patient experience. The exclusion criteria were those characteristics deemed inappropriate for inclusion for example, from healthcare practitioners' point of view. To be included in the review, papers needed to focus on the parent or patient perspective expressed by them not a healthcare professional and have had personal experience of video consultations.

In the light of the technological aspect of the research, the papers needed to have been published between 2000 and 2024 to make them relevant to this field of enquiry, this was because, while the majority were recently published, some of the papers were published in the early 2000's (Lindberg, Christensson and Öhrling 2007, and Sevean et al 2008). They were required to be qualitative or mixed methods to capture the depth of a

parent/patients' experience and to be written in English to avoid translation errors. Papers were excluded if they were written from the healthcare professionals' viewpoint and if the virtual consultation was by telephone or email alone.

2.5. Scoping review: Study Selection (Stage 3)

The process for selecting the articles follows the PRISMA decision tree (Liberati et al 2009) and is presented in the PRISMA flow diagram above in Figure 1. It shows the different phases while transparently recording the number of articles identified, included, or excluded at each stage (Booth, Sutton and Papaioannou 2016). After duplicates were removed a total of 1131 citations were identified from the electronic database searches and snowballing, and a review of articles title and abstract was undertaken. Review of the abstract and title for key words is a recognised search strategy and it enabled a comprehensive review of the article in a pragmatic way, because if the key words are not in the title of abstract then the article is unlikely to address the research question (Aveyard, Payne and Preston 2016). Further refinement of this number was attempted, but by excluding key phrases e.g. 'virtual' or 'patient' the search returned zero articles.

Of the 1131 citations, 14 were removed as the keywords were not in the title or abstract, leaving 1117 for screening.

1078 were then excluded for the following reasons:

- the full text had picked up patient or parent or experience but with no reference to virtual or video consultations (821 articles),
- the intervention was by telephone (6) or email (5),
- the research was from the healthcare practitioner's viewpoint (202),

- prior to implementation of video methods (2).
- Finally, exclusion also applied if the article was about training for virtual/ video consultation (40) or comparison with face-to-face (2).

This left 39 full text articles to be retrieved and assessed for eligibility and the inclusion and exclusion criteria was applied. Of these, 14 were excluded as very interesting and useful as context documents but not meeting the inclusion criteria. The remaining 15 studies were considered eligible for this review and are charted in detail in Appendix 2 - Data Charting Form – Summary of Results.

2.6. Scoping review: Charting the data (Stage 4)

The scoping review provided a framework for rigorous and transparent mapping of areas of research (Pollock et al 2021). In a relatively short space of time researchers become familiar with an area of research e.g., volume, nature, and characteristic of experience of interest. It then made it possible to identify gaps in the research area and summarise and disseminate the research findings (Arksey and O'Malley 2005).

A quality assessment of the literature does not take place in a scoping review (Arksey and O'Malley 2005), because the purpose was to establish the information that is already known about the topic (Aveyard, Payne and Preston 2016) with the results being explorative, descriptive and not explanatory or analytical in nature (Khalil et al 2021). The method adopted for a scoping review needed to achieve broad and in-depth results and was aimed at identifying all relevant literature (Arksey and O'Malley 2005).

DeWitt and Pleog (2006) state that hermeneutically, it is important that the scoping review is iterative in nature, where the researcher is '*being-in-the-world'* with the research and applying knowledge to what they are reading and understanding. By doing this the

researcher adds to their body of knowledge about the phenomenon of interest and can interpret the findings and apply them to their own research study.

The data charting process devised by Arksey and O'Malley (2005), Pollock et al (2021) and the JBI guidance (2020) presented in Appendix 2 - Data Charting Form – Summary of Results, gives detailed information about the studies, including key characteristics, aims and research methods, outcomes, ethics approval and evidence of effectiveness. Figure 2 below, gives an example of this table with the Donaghy et al (2019) research article charted:

Figure 2: Example from Charting the Data Table in Appendix 2

	Article title, Author, year of publication and Journal and study location	Intervention type Duration of intervention	Study populations/ participants	Aims of study and research methods (Context and concept)	Methodology Inclusion / Exclusion criteria, Sampling Ethics process	Results / Outcome measures / evidence of effectiveness	Strengths and Limitations	Gaps in research or key findings
1	Donaghy, E. Atherton, H. Hammersley, V. McNeilly, H. Bikker, A. Robbins, L. Campbell, J. McKinstry, B. 2019. Acceptability, benefits and challenges of video consulting: a qualitative study in primary care. UK.	Pre COVID-19 Semi structured Interviews Intervention using 'Attend anywhere'.	21 patients were interviewed. 13 clinicians were interviewed. 6 GP practices in Lothian, Scotland	To explore patients and clinicians experiences of VC. To explore how VC's varied from F-f and T/C in terms of length and contact.	Semi structured telephone interviews within 7 days of VC. Braun and Clarke Thematic analysis. Recruited by clinician and had to be over 16, needing a follow up consultation but not a physical examination. They had to have an email address and internet connected computer. Ethics – obtained from the West of Scotland research ethics committee.	Results – patients reported positive experiences and particularly helpful when working as saved time. Visual aspect of video helpful for picking up cues and also more formal and focused.	Strengths- Experienced team, area of importance and general interest. Limitations – Self selection of participants, access required to expensive technology to take part raising equity issues.	Key findings Generally positive. Participants reported being comfortable with the technology e.g. skype but felt awkard in a virtual waiting room. VC must be more reliable and seamlessly integrated with healthcare systems. For more complex or sensitive problems then face- to-face is preferable and seen as 'gold standard'.

Levac, Colquhoun, and O'Brien (2010) give additional guidance for Stage Five, feeling that otherwise it lacked detail, these were: analysing the data, reporting the results, and including the implications of the findings. The data charting table in Appendix 2 included these additional points to ensure it was comprehensive. Data from the selected papers were extracted based on article characteristics e.g., country of origin, year of publication; engagement characteristics e.g., intervention type and duration, study population, aims of

study, methodology; formal assessment of engagement e.g., outcome measure and evidence of effectiveness, important results, and gaps in research.

Fifteen studies were included in the data charting exercise and further details can be found in Appendix 2:

- Eleven of the studies were qualitative,
- Two mixed-methods, Imlach et al (2020) and Lindberg, Christensson and Öhrling (2007)
- Two were scoping studies, Ewart et al (2022) and Thiyagarajan et al (2020),
- Two of the studies were reports from the same research project, Hvidt et al (2022) and Lüchau et al (2022).
- Three studies were UK based, Donaghy et al (2019), Johns et al (2021) and Trace et al (2020) plus the two scoping reviews and,
- The rest (ten) were international with the most (four) from Denmark (Funderskov et al 2019, Hvidt et al 2022, Christensen and Danbjörg 2018, and Lüchau et al 2022).

2.7. Scoping review: Collating, summarising, and reporting the results (Stage 5)

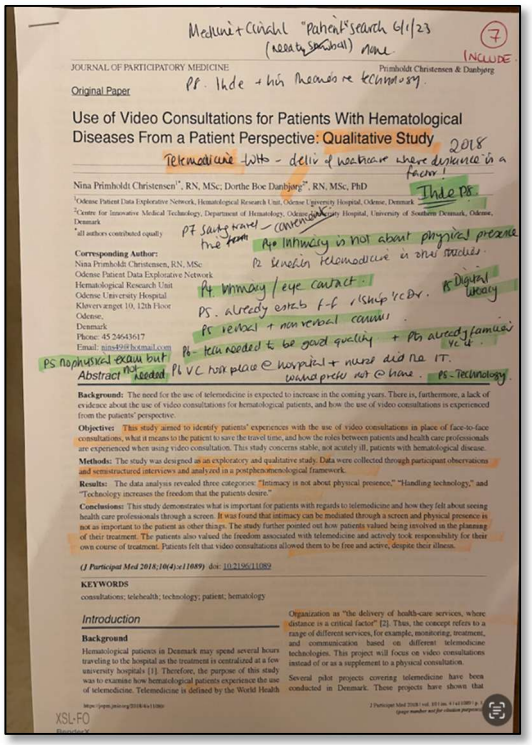
2.7.1. Review of articles

Synthesis and interpretation of the qualitative data by sifting, charting, and sorting the material, according to key issues and themes, was an important part of the scoping review and is detailed in Stage 5 of the framework by Arksey and O'Malley (2005). It was necessary to learn and build on experience, as the data chart in Appendix 2 was completed using knowledge gained by reviewing each article, some were revisited, and the chart amended when it was highlighted that some element was missing or insufficiently recorded.

It was noted that when data was charted from article fourteen, the scoping review by Ewart et al (2022), the summary of key themes chimed with those found in the other research papers in this scoping review. For example, technical issues and digital literacy were factors in people's experience, as was the absence of the ability to conduct a physical examination.

Dibley et al (2020) state the purpose is not just to evidence the knowledge gap but to engage meaningfully with the literature, by bringing our own knowledge and co-creating a new understanding from the literature. Hermeneutically, there is no need to refrain from engaging with the literature to avoid influencing the study, rather to be 'always ready' by being connected with and informed by it. By engaging with the literature, Spence (2017) believed that this helped to inform our preunderstanding or existing knowledge. This was then used to enhance our research as Dibley et al (2020) suggested, in an open and transparent engagement with the literature. This brings together consciousness of our own biases, suppositions and opinions which then help us to adopt an open and accepting attitude towards any possibilities illuminated from the experience.

Figure 3: Example of Annotation of Research Articles


Medline + Cinahl "Patient" search 6/1/23 (research journal) none
INCLUDE
JOURNAL OF PARTICIPATORY MEDICINE
Primholdt Christensen & Danbjørg
Original Paper
PP. Ihde + his theories re technology
Use of Video Consultations for Patients With Hematological Diseases From a Patient Perspective: Qualitative Study
2018
Telemedicine Ihde - delivery of healthcare where distance is a factor!
Nina Primholdt Christensen[1*], RN, MSc; Dorthe Boe Danbjørg[2*], RN, MSc, PhD
Ihde PS
[1]Odense Patient Data Explorative Network, Hematological Research Unit, Odense University Hospital, Odense, Denmark
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Email: nin499@hotmail.com
Ps no physical exam but Abstract not needed
Abstract
Background: The need for the use of telemedicine is expected to increase in the coming years. There is, furthermore, a lack of evidence about the use of video consultations for hematological patients, and how the use of video consultations is experienced from the patients' perspective.
Objectives: This study aimed to identify patients' experiences with the use of video consultations in place of face-to-face consultations, what it means to the patient to save the travel time, and how the roles between patients and health care professionals are experienced when using video consultation. This study concerns stable, not acutely ill, patients with hematological disease.
Methods: The study was designed as an exploratory and qualitative study. Data were collected through participant observations and semistructured interviews and analyzed in a postphenomenological framework.
Results: The data analysis revealed three categories: "Intimacy is not about physical presence," "Handling technology," and "Technology increases the freedom that the patients desire."
Conclusions: This study demonstrates what is important for patients with regards to telemedicine and how they felt about seeing health care professionals through a screen. It was found that intimacy can be mediated through a screen and physical presence is not as important to the patient as other things. The study further pointed out how patients valued being involved in the planning of their treatment. The patients also valued the freedom associated with telemedicine and actively took responsibility for their own course of treatment. Patients felt that video consultations allowed them to be free and active, despite their illness.
(J Participat Med 2018;10(4):e11089) doi: 10.2196/11089
KEYWORDS
consultations; telehealth; technology; patient; hematology
Introduction
Background
Hematological patients in Denmark may spend several hours traveling to the hospital as the treatment is centralized at a few university hospitals [1]. Therefore, the purpose of this study was to examine how hematological patients experience the use of telemedicine. Telemedicine is defined by the World Health Organization as "the delivery of health-care services, where distance is a critical factor" [2]. Thus, the concept refers to a range of different services, for example, monitoring, treatment, and communication based on different telemedicine technologies. This project will focus on video consultations instead of or as a supplement to a physical consultation.
Several pilot projects covering telemedicine have been conducted in Denmark. These projects have shown that
XSL•FO

Figure 3 is an example of the Christensen and Danbjörg 2018 research article, showing the process of hand annotation of the research article to help with the synthesis and meaningful engagement with the literature, each article received the same process of analysis. This figure shows the source of the article from the search activity in this case MEDLINE and CINAHL searching under 'patient' and each theme is page

referenced e.g., eye contact is on page 4. The actual references in the text are also highlighted in orange so was easy to locate. It is included in this thesis to demonstrate the process of analysis in a transparent way.

2.7.2. Synthesis of results and identification of gap

As demonstrated in the data charting form in Appendix 2 and hand annotation above in Figure 3, the drawing together of common themes enabled a summary of the results of the scoping review (Tricco et al 2018). It led to a categorisation of the themes that were most commonly raised and compared similarities between the articles, to see if they answered the research question and objectives. It was established that no studies had been reported regarding parent's experience of child health reviews with a health visitor. Two articles studied parents experience, Trace et al (2020), about chronic kidney disease advice and support, and Lindberg et al (2007) studied parents' experience post childbirth in the community, following an early discharge from hospital. It was helpful to have some parents' perspectives.

It was noticeable from the original literature search, in late 2020, and the subsequent ones in 2023 and 2024, that there was an increase in the amount of literature published on video consultations in primary care and acute settings, like hospitals, but most concerned virtual treatments e.g., Johns et al (2021), Lüchau et al (2021), Imlach et al (2020) and patients' experience during the coronavirus pandemic e.g., Sutarsa et al (2022), Hvidt et al (2022), Christiansen et al (2022) and Ewart et al (2022). While the prevalence of video consultations in health visiting also increased due to COVID-19 (iHV 2021), the research question regarding parent experience was not answered by this scoping review. Table 4 below shows the themes identified from the literature:

Table 4: Themes Within the Scoping Review

Convenience	*Treatment at a distance' including environmental impact*	*Technical Issues*
Pre-existing relationship with practitioner	*No physical examination possible*	*One size doesn't fit all*

2.7.3. Was the video consultation positive?

Overall, participants in fourteen of the fifteen studies' reported positive aspects of video consultations. Sutarsa et al (2022), disagreed as their participants found video consultations were distant and lacking in personal touch or the ability to form a deeper caring relationship between the patient and clinician. They warned that replacing face-to-face with video consultations might lead to a loss of trust and / or continuity of care.

The positive aspects of video consultations were experienced in most studies with participants in Imlach et al's survey of 1010 people yielding a 91% satisfaction rate with video consultations. Other positive aspects included being able to conduct it in the comfort of their own home (Powell et al 2017), feeling the doctor was more focused on the consultation as they made good eye contact and were unrushed (Hvidt et al 2022) and being able to involve relatives in the care discussion (Funderskov et al 2019; Sevean et al 2008).

2.8. Discussion of Themes in the literature (Stage 5 continued)

2.8.1. 'Convenience'

This was the strongest theme, cited by twelve of the fifteen papers in the scoping review as a reason patients liked video consultations (Donaghy et al (2019); Johns et al (2021);

Sevean et al (2008); Hvidt et al (2022; Christensen and Danbjørg (2018); Christiansen et al (2022); Lüchau et al (2021); Powell et al (2017); Imlach et al (2020); Trace et al (2020); Ewart et al (2022); Thiyagarajan et al (2020)). The 21 participants in Donaghy et al (2019) study and Johns et al (2021) mixed methods study of 3561 participants found that video consultations could save time from not missing work and avoided unnecessary travel time. It enabled Sevean et als (2008) 10 patients to have the video consultation in the comfort of their remote rural Canadian homes, which Lüchau et als (2021) 27 patients agreed with and found holding it at home was also pleasingly familiar. Meanwhile, Christensen and Danbjørg's (2018) 12 patients with haematology diagnoses, found it increased their freedom of choice regarding where to see the doctor and decreased their travel time. Funderskov et als (2019) study involving 11 patients reported that it enabled other professionals and absent family members to dial into the consultation which increased their satisfaction with the virtual element.

2.8.2. 'Treatment at a distance' including environmental impact.

This theme focused on treatment at a distance and its effectiveness and tolerance by patients. In Imlach et als (2020) study of 1010 participants, some reported it lessened the burden of the appointment e.g., costs of travel, accommodation, and lost wages or schooling. Sutarsa et al (2022) interviewed 10 patients who found that the treatment at a distance affected their trust in the clinician, whereas the 10 participants in Sevean et als (2008) study found it effective for maintaining healthcare at a distance. The environmental impact of video consultations e.g., reduction in travel, were mentioned as patient considerations in a positive way by ten of the studies (Hvidt et al (2022); Lüchau et al (2021); Trace et al (2020); Lindberg et al (2007); Ewart et al (2020); Powell et al (2017);

Johns et al (2021); Sevean et al (2008); Christensen and Danbjørg (2018; Thiyagarajan et al (2020)). The patients in the Sevean et al (2008) study appreciated the combination of having video consultations as a complementary addition to face-to-face interventions. For Funderskov et als (2019) 11 patients, relatives valued being present on the video consultation to hear the updates and advice.

2.8.3. 'Technical Issues'

Ten papers mentioned technical issues being a concern for patients, Christiansen et al (2022) found that this might be greater for elderly patients, while Trace et al (2020) who studied parent perspectives, found technology to be efficient and trustworthy. However, some of Powell et als (2017) 19 participants raised issues of privacy if the call took place in a workplace and Lindberg et als (2007) study of 9 couples reported concerns if the parent needed privacy to breastfeed during the call. In their scoping review, Ewart et al (2022) found patients expressed dissatisfaction with the technology, for example, experiencing time lags, connection issues and pauses which made it difficult for the conversation to flow. Imlach et als (2020) participants, reported poor sound and visual quality which affected their overall experience, while Donaghy et al (2019) who interviewed 21 patients agreed and found the time lags caused people to talk simultaneously and affected the quality of the consultation. Funderskov et als (2019 p7) participants found the technology '*easy, convenient and recognisable'* which Christensen and Danbjørgs (2018) participants agreed with, although they attended the clinic for their video consultation, with a nurse to oversee the technology for them. Finally, Thiyagarajan et al (2020), reported from their scoping review, that participants experienced issues with passwords and logging into online portals.

Nine of the papers cited digital inequality (not having access to digital devices such as a computer or phone) and digital illiteracy (not being able to understand it), as a consideration for patients (Ewart et al (2022); Donaghy et al (2019); Christiansen et al (2022); Imlach et al (2020); Trace et al (2020); Powell et al (2017); Funderskov et al (2019); Sutarsa et al (2022); Christensen and Danbjørg (2018)). The factors reported above made technology and its issues a strong theme for affecting patients experience of video consultations.

2.8.4. 'Pre-existing relationship with practitioner'

A strong theme in 10 of the 15 studies was that patients preferred to have an existing relationship with their healthcare practitioner before the video consultations commenced. Donaghy et al (2019) and Powell et als (2017), participants felt that it increased rapport, so they felt comfortable with the clinician and Hvidt et al (2022) found this formed a positive experience of video consultations for the patients. Imlach et als (2020), 38 adult participants talked about mutual trust which they felt was better established in person, and in Ewart et als (2022) scoping study, participants reported that creating a virtual relationship was less sociable or friendly and impacted on what they felt they would share. Christiansen et al (2022), Sutarsa et al (2022) and Christensen and Danbjørg's (2018) participants agreed that the face-to-face meeting before a video consultation was important and helped to build a therapeutic relationship. Some of Lindberg et als (2007) 9 participants felt the video consultation was equal to having a physical meeting. Trace et als (2020 p886) 12 families had high satisfaction rates with video consultations and discussed having a 'virtual rapport' that was felt to be essential for establishing good

therapeutic trust as part of the supplement for face-to-face care, however, the families were divided about the need to meet their practitioner before the video consultation.

Face-to-face was considered the preferred method of communication by eight of the studies and Donaghy (2019 p1) designated this the '*gold standard'* because it was regarded as the best way of establishing a relationship between clinician and patients for finding out what the concerns were, as well as performing a physical examination. Imlach et al (2020), Ewart et al (2022), Donaghy et al (2019), Thiyagarajan et al (2020) and Sutarsa et al's (2022) participants all preferred face-to-face to get to know the healthcare professional with Hvidt et al (2022), Christiansen et al (2022) and Lindberg et al (2007) participants deeming it enhanced the therapeutic relationship.

2.8.5. 'No physical examination possible'

Five studies found that not being able to undertake a physical examination was problematic, Imlach et al (2020) in their mixed methods study found participants raised concerns that some procedures were not able to be completed online e.g., removal of a coil (IUD). Ewart et al (2022), in their scoping review, commented on the increased possibility of a missed diagnosis and having extra reassurance when the practitioner performed the examination rather than a patient's self-examination. Sutarsa et al (2022) and Christiansen et als (2022) participants felt that a face-to-face physical observation was essential. Lindberg et als (2007) participants agreed and felt that even a diagnosis of neonatal jaundice, would be difficult to assess across a screen due to the difference in colour perception on a computer monitor.

2.8.6. ‘One size does not fit all’.

Six of the papers felt that one size does not fit all and that individual circumstances and preferences would play a part in whether a video consultation was experienced positively or negatively by a patient. Christiansen et als (2022) participants felt video consultations should be implemented with caution and favoured individual solutions for patients. That was agreed with by Imlach et als (2020) 38 interviewed participants who had concerns around privacy and establishing a trusting relationship with the healthcare practitioner. Christensen and Danbjørg (2018) participants had a high satisfaction rate, although, they all saved over 8 hours of travelling by having it as a video consultation. Trace et als (2020) participants felt it did not work with preschool children who were unable to engage with the video consultation and Ewart et al (2022) scoping review themes included the point that participants considered there was a loss of interpersonal communication. Finally, Thiyagarajan et als (2020) participants felt they could build a rapport but would have preferred face-to-face.

Each study’s participants had individual circumstances that affected how they perceived and received video consultations. It was noticeable from the COVID-19 studies and in particular Johns et al (2021), Hvidt et al (2022) and Lüchau et al (2021) that COVID-19 impacted on participants’ perceptions of the use of video consultations. For example, when the ‘stay at home’ guidance (Cabinet Office 2020) was in place, the online calls were better tolerated as it was perceived to be necessary to keep safe and avoid COVID-19 infections.

Familiarity with the technology impacted on the patient experience of a video consultation, with those who were comfortable with using it reporting increased satisfaction (Ewart et al 2022). Johns et al (2021) found an interesting correlation between patient preference and

perceived value of the video consultation suggesting that, if the patient chose and preferred it, then it was more valued and successful.

2.9. Researchers' Position

During the scoping review, Smythe and Spence (2012) described the researchers' own prejudices being revealed in how the language of the review is crafted and what meaning was being sought. Prejudices have been kept to a minimum in this research by presenting the findings in an objective way using the framework by Arksey and O'Malley (2005) but as Dibley et al (2020) acknowledge as the articles are read and understood, the mind scans for *'ah ha'* phrases and correlations with one's own experience. Keeping personal prejudices in mind assisted the researcher on the thinking journey, enabling fresh thinking around the topic and to extend horizons (Gadamer 2003). It was a journey that helped open new territory as each new piece of research was read, thought about, synthesised, and new knowledge was gained and acknowledged (Smythe and Spence 2012). For example, the subject of privacy as an issue in the patient's home, especially in Lüchau et al (2021) study regarding who else might be listening, was of particular concern to parents in the Trace et al (2020) research and would be interesting to explore to see if it is a theme in the findings of this study.

In hermeneutic research there was a requirement to read on a broad range of topics, to have an open mind to what might be relevant and where the *'ah ha'* factor highlighted it (Smythe et al 2007 p1392). It was a constant dwelling in the data, a journey towards something with no end even though at some point there would be a need to stop and write (Smythe and Spence 2012). Dibley et al (2020) provided a framework of questions to help the researcher's reflexive stance, an example is presented below in Figure 4 which shows

being situated in the literature during the process of reviewing the evidence-base. The full reflexive piece is included in Appendix 12.

Figure 4: Excerpt from Reflexive Journal (13 February 2023)

> ***Am I only choosing it [this topic] because it supports my original view?***
>
> - *I think there was a risk of this as I read the title and abstracts but I was conscious that it was important to find articles of all viewpoints so my search words were broad …rather than anything that might be considered leading.*
> - *I'm not sure I have preconceived ideas of the findings of the research study as it may be that it's such an individual experience based on personal history, bias, and preference.*
>
> ***Am I holding myself open to the 'other' and considering alternatives?***
>
> - *I was mindful that this was important which was why I conducted a scoping review rather than a literature review as I wanted to gather everything available on video consultations.*
> - *Reading the articles, especially as they were predominantly concerned with adult patients' views and experiences, I was mindful that this may not be the whole story and that a parent's experience could be very different or quite similar.*

2.10. Summary and rationale for current study

This scoping review has described and charted research studies to provide both an overall picture of the current evidence in the field of video consultations and it has identified knowledge gaps in the literature including the views of parents' experiencing video consultations for their children's health reviews. Dibley et al (2020) advised that the main purpose of a scoping review was to demonstrate that the research proposed was

necessary. The optimal scoping review is one which demonstrates procedural rigour, ensuring that its findings are useful and add value, as well as being able to be appropriately interpreted by others (Davis, Drey and Gould 2009), this chapter has achieved this. As discussed above there are similar themes in the literature to those found in this research project, and these will be discussed in Chapter 6. The key difference was that most of these research studies report on the experience of adult patients rather than parents of young children.

While the scoping review is situated here in this thesis, it informs the data analysis phase and only when read with the findings and discussion, does it achieve the congruence between the research and the literature for the researcher and reader (Smythe and Spence 2012). Chapter 3 discusses several potential methodologies that were considered before a Heideggerian interpretative hermeneutic phenomenology approach was decided as the most appropriate and how it was applied to this research study.

Chapter 3 - Methodology

Note. All reference to participants' names in this thesis are the pseudonym and not their real names (NMC 2018).

3.1. Introduction and overview

This chapter discusses the chosen methodology, Hermeneutic Phenomenology, and details the methods for the study for example, participant selection, inclusion and exclusion criteria and sample size. A clear rationale is articulated for the research design including the data collection, analysis method and the process followed, to demonstrate rigour and trustworthiness. It was important to plan and execute a sound methodological research project that addressed the objectives of the study and, when challenged by the research community, demonstrated rigorous and ethical principles of practice. Presenting a synergy between the research question and the methodological design mean that the first section of this chapter will address the theoretical basis for the study including the epistemological stance of the researcher and the rationale for deciding to adopt a qualitative methodology.

Reflexivity was threaded throughout the study as a natural tool for keeping in touch with feelings, perceptions, and ideas, as well as acknowledging the researchers' impact on research design and findings (O'Connor 2011). Finally ethical considerations, including safeguarding participants, are discussed to help demonstrate the credibility of the research study.

3.2. Epistemology and methodology

The purpose of this research was *to explore parents' experience of video consultations during a health visitor led child health review, using an interpretivist hermeneutic phenomenological approach*. This included what parents, who had experienced a child

health review with a health visitor, felt about it, what their experience was, and if there were any insights they wished to share.

Methodologies reflect the knowledge and beliefs that arise from the different values of the philosophical perspectives (Caelli, Ray and Mill 2003, Bryman 2004, Bowling 2014). These fall broadly into two areas, positivist (quantitative) and interpretivist (qualitative). The positivist approach is underpinned by scientific truths and laws and this truth is disclosed from what can be observed and measured (Gerrish and Lacey 2015). Whereas the interpretative approach assumes that to make sense of the world, human behaviour should be understood by looking at interactions between people (Bowling 2014).

A third approach, pragmatist, which combines the interpretative and positivist paradigms, was developed by John Dewey in 1933 and allows for a more flexible philosophy, he described it as a ‘back-and-forth’ of reflecting on actions and beliefs.

The question to be answered determines which methodology and then methods should be used (Gerrish and Lacey 2015), which is known as praxis: how theory turned into the method. The research question in this study necessitated a qualitative approach so the parent’s experience could be listened to, heard, and understood in-depth.

3.2.1. Researchers' Epistemological and Ontological stance

Groenewald (2004) encouraged researchers to make a thorough study of available methodologies, and to exercise well informed choices to demonstrate rigorous research practice. The philosophical stance of the researcher, including their ontological and epistemological viewpoint, influences the way their world is viewed, the questions asked and therefore the research they undertake. Each aspect is interconnected and informs the resulting study.

My personal philosophy, which informs the things I am interested in, includes curiosity about people's lives, their modes and styles of communication and how it's received and experienced. Epistemologically, I am drawn to the personal, experiential knowledge that we use to interpret the world and make sense of our experiences (Bryman 2004). I acknowledge that each person's experience of the world is unique and that there can be many different realities amongst people having the same experience e.g., video, or face-to-face consultations. I need to maintain an openness to the experience to enable the topic to be broken open allowing for the truth or phenomenon to be revealed (Gadamer 2003).

An essential component of being a researcher and using this method is recognising that we are a research tool, and that our ontological and epistemological positions affect the research design and outcome (Al-Saadi 2014). It is essential for a researcher, especially a novice one, to reflect on their own values, axiology, and beliefs to recognise how these inform and affect the study (Mockler 2011). My ontological perspective is interpretivist and constructionist; I believe that our knowledge of the world is based on our understanding, which arises from our lived experiences and reflections on them. Knowledge is generated by exploring and understanding our social world and is focused on interpretation and meaning (Dibley et al 2020).

3.3. Consideration of other methodologies

Once the methodology was matched with the researcher's ontological perspective and belief systems, the next question was which one could best help answer the research question and aims. There were many different qualitative methods that could be embraced and followed for this research question e.g., ethnography, grounded theory, case study, phenomenology. However, only one method helps towards achieving the research aims while matching the ontological position of the researcher, the alternatives are considered below. It was necessary to understand each of these before choosing one which best suited the research question.

Ethnography, with its origins in social anthropology, is understanding a particular culture or social setting, it seeks to describe specific patterns and cultures in a specific setting or individual to inform social change or social phenomena (Fetterman 1989). It often involves interaction or immersion and observation of real-life environments over a long period of time. This method is used to understand culture or the social setting (O'Reilly 2005) and would not be appropriate for exploring parents' experiences of video consultations.

Grounded Theory is a methodology concerned with gathering and analysing data to generate a theory (Glaser and Strauss 1967) and is often used when there are no preconceived theories (Robson 2011). This method is used to understand a question and to generate a theory which then emerges from the data (Creswell and Creswell 2018). It would not be an appropriate methodology as the research question for this study is to explore parents' experience not to generate theories.

Case Study research is a commonly utilised research method (Priya 2021) and is a detailed study of a phenomena within its real-life setting. Creswell and Creswell (2018) define it as a qualitative design which explores in depth an event, activity or individual(s),

whereby detailed information is collected and analysed over a prolonged period. It allows flexibility for different data collection and analysis methods and can be descriptive, exploratory, or explanatory in its design (Yin 2017). An important element of case study research is using existing literature or prior understanding of existing theories or settings to formulate the research question (Cronin et al 2024). It explores and understands 'how', 'what' and 'why' things happen in the phenomena of the case under investigation (Yin 2017) which would not be appropriate for exploring parents' experiences of video consultations.

Phenomenology, as originally determined by Husserl, is the essence of how something is described and functions in the lived experience (Lewis and Staehler 2010). It is concerned with peoples' perceptions, meanings, attitudes, and beliefs, going beyond the taken-for-granted. It is the study of conscious human experience in everyday life (Bowling 2014). Husserl sought to suspend judgements and 'bracket' or put aside previous knowledge so that other peoples' experiences were not filtered through their own cultural lens (Dibley et al 2020). This philosophical approach and methodology seem especially difficult to adopt considering the researchers' clinical background and knowledge of the subject. 'Bracketing' or looking at the situation with no preconceived ideas would not allow the researcher to utilise previous knowledge which they considered desirable for this research.

Hermeneutic Phenomenology is a branch of phenomenology and the key philosopher on interpretive phenomenology was Martin Heidegger (1889-1976). Heidegger was a student of Edmund Husserl's but departed from Husserl on the importance of 'context'. Hermeneutics means 'interpret' or 'understand' (McManus Holroyd 2007) and is founded within the phenomenological movement. Hermeneutics is characterised by a search for understanding of natural phenomena and includes uncovering essential insights into individuals' perspectives (Dibley et al 2020). In Heidegger's book, *Sein und Zeit* (Being

and Time 1962), he argued against the mind and body split and claimed that the time and place in which we live was the influence on understanding and experience; nothing can be seen as removed from this (Mulhall 1996). He developed a further philosophy which focused on a human beings existence in their world and social context to expose the everyday meaning of their ordinary human existence. Heidegger proposed that who we are and how we experience '*being-in-the-world'* is necessarily influenced by contextual factors and that researchers embrace these factors and engage with them in research.

The philosophy that guides the methodology for hermeneutic phenomenology is situated in an interpretivist paradigm. Hermeneutic phenomenology offers a reflexive and analytical underpinning philosophy, and this will help inform the research as it moves beyond descriptive to uncover the meaning of experiences (Crowther and Thomson 2020).

The chosen methodology, following consideration of the possible theories and philosophies, is that a hermeneutic phenomenological approach would best answer the research question especially when considering the technological mediation of the consultation and its possible effect on the intervention (Heidegger 1977). Interpretative hermeneutic phenomenology resonated with the researcher's ontological position and enabled their clinical background to be used to understand the parents experience of video consultations.

3.4. Underpinning Philosophy of Hermeneutic Phenomenology

Heidegger (1962) and his student, Gadamer (1960) formulated and articulated a philosophical worldview, which encouraged researchers to ask questions about the meaning of '*being*' within their lives rather than a methodology (Crowther and Thomson 2020). They defined hermeneutics as *"the theory and practice of interpretation and*

understanding in different kinds of human contexts" (Odman, 1988 p63). Humans' viewpoints are influenced, amongst other things, by their cultural backgrounds and values which may be discovered by probing and interpreting dialogue rather than just describing it (Smythe and Spence 2020). They felt that it is through speech and language that our '*being-in-the-world'* is understood (Maggs-Rapport 2001).

The purpose is not to generate theories or generalise, but to make sense of and understand the different ways a human can '*be–there'* (Crowther and Thomson 2022 p8). Heidegger (1962) referred to this as '*Dasein*' where humans were concerned with their own existence but also understood that other things exist in the world. The world of '*Dasein*' is a shared world and Heidegger also articulated '*being–with'* in terms of being with others and how they interact and communicate with each other (Dahlstrom 2013). This is especially relevant to this research project as the participants' '*being -with'* a health visitor was disrupted by the medium of the video consultation with interesting repercussions.

Heidegger's (1962) ontology is that our understanding of '*being*', which is the way humans understand themselves, is informed by temporality (non-chronological time) and historicity (past history and experience). These elements are core to conducting hermeneutic phenomenology research and how we experience and understand our world (Dibley et al 2020). Experiences are personal, often taken for granted and pre–reflexive, not dwelled upon, and are routine parts of everyday life. The focus is on the experience as lived, not how it was perceived, interpreted, or understood during or afterwards (Crowther and Thomson 2022).

Part of hermeneutic phenomenological research is the search and illumination of the phenomenon, described by Heidegger (1962), as the experience that is hidden, forgotten, or disguised, an often taken for granted and unnoticed element of '*being-in-the-world'*.

While the phenomenon can never be fully revealed it can be illuminated by adopting a hermeneutic phenomenological attitude and articulated in a way which has not been focused on before. This was done by immersion within the verbal and written interview transcripts to highlight and interpret themes, which foregrounded the phenomenon of interest and gave it articulation (Dibley et al 2020) as described in detail in Chapter 5.

As Smythe and Spence (2020) concluded in their article, by embracing a hermeneutic phenomenological approach, the researcher recognised the insights that were hidden in the story telling of the experience and the interpretation of this meaning. Using these philosophical approaches helped to understand parents' lived experiences of health reviews using video consultation. Heidegger and Gadamer's philosophies are invaluable for delving deeper into understanding human lived experience and illuminating the meanings that will give a greater insight into the research question (Crowther and Thomson 2022).

3.4.1. Heidegger and technology

Heidegger wrote an essay titled 'The question concerning technology' (1977), where he proposed that humans were not passive concerning technology, that it was a means to an end and should be manipulated to '*master it'* (Heidegger 1977 p5). He regarded technology as a way of revealing, but he felt that modern technology, while not dangerous, might overtake human life resulting in thinking and feeling being a commodity instead of human expression (Dibley et al 2020). Video consultations, instead of face-to-face, might be regarded by Heidegger as technology replacing human interaction and therefore in need of mastery or being used carefully and with considerable thought. Cronin (2024) warned, in her opinion piece, about ensuring a balance is struck between using digital tools and

preserving human connection which is so important to healthcare. Heidegger's philosophy is used in the later chapters to help understand the parents' experience of video consultations.

3.5. Reflexivity and its role in Hermeneutic Phenomenological research

An essential component of hermeneutic phenomenology research is reflexivity (Crowther and Thompson 2022, Smythe 2011). Reflexivity is an active process of dynamic self-awareness taking place as an event is happening (Dowling 2006) and helps a researcher to be aware of their influence on the study and facilitates them to increase positive aspects to benefit it (O'Connor 2011). Keeping notes in a journal was one way to manage this influence and helped raise awareness of conscious thoughts and preunderstandings. It was essential for helping to dwell in the data as well as contributing to managing the researcher and research relationship (Dibley et al 2020). Reflexivity challenges us to be more conscious within the research process of ideology and culture (Hertz 1997). For example, journaling helped illuminate unhelpful assumptions that only white, middleclass, British participants might come forward to be interviewed. Being reflexive enabled awareness of the influences affecting the research, for example, political, social, and cultural (Crowther and Thomson 2020). Having also experienced the COVID-19 restrictions I was able to explore my views and adopt a more neutral stance during the interviews.

In this research project, as a health visitor and commissioner of the Healthy Child Programme (Gov.UK 2023), I was able to link my professional experience to the research question as I had experience of video consultations and had shadowed staff undertaking them. Through active reflection, as seen in Figure 5 below, using my journal I was able to

see my impact on the study and its participants, encouraging me to hold myself open to the possibility of what I heard. For example, an extract from my reflexive journal reads:

Figure 5: Excerpt from Reflexive Journal (2 September 2022)

> *"I think I have been practising hermeneutic phenomenology in my own way for years with my 'jigsaw analogy'! I talk to people in coaching and mentoring about everyone having a jigsaw and people give you bits of it (their lived experience) and you place them in your jigsaw to build a picture which gradually makes sense (fusion of horizons)"*

I participated in a preunderstanding interview with Professor Dibley, a professor experienced in hermeneutic phenomenology. As Figure 6 below demonstrates, it helped illuminate my prejudices, underpinning influences, and biases, which enabled me to be open to the narratives told by the participants in their interviews.

Figure 6: Excerpt from preunderstanding interview (19th May 2023, line 323- 328)

> *"But I've kept health visiting as the thread, right the way through. And not all that, while I'm not a hands-on health visitor any longer...it's always been that very strong, nought to five, preventative, healthy beginnings work really".*

This helped to create a balance of understanding, as I reviewed the interview and saw my values, beliefs, past experiences, vested interests, and culture described. I was mindful of them when I was interviewing participants and immersing myself in the data analysis stage.

Smythe (2011) advocates this practice to tell our own stories, and this helped me to become mindful of assumptions and prejudices when carrying out research. Figure 7 is an excerpt from my preunderstanding interview demonstrating my values and beliefs that human interactions are about making judgements, whether they are right or not.

Figure 7: Excerpt from preunderstanding interview (19th May 2023, line 207- 213)

> *"I would say with every interaction you have as a human, there's a judgement made. But as part of your assessment, you're obviously looking at the other aspects of it and looking to see whether your judgments are right or not. Because your first judgement isn't always right. And actually, what you're looking at is you're looking beyond what you see in a lot of cases."*

3.6. Research sample and recruitment of participants.

3.6.1. Sample

The participants needed to be any parent or carer of a child or children under five and have had experience of a video consultation with a health visitor about their child's health and development in order to have the required knowledge to share. To begin with the Ethics approval was granted for children up to the age of three years. This was later amended to three years and eleven months, at the time of interview, to allow for the health review at two and a half to be captured sometime after the event. Acknowledging that memory recall reduced with time elapsed it was felt that only participants with a good recall would volunteer to take part and that they would remember enough of the video consultation to be useful for the study.

Ten participants were recruited using social media and advertising, from the England population. Purposive sampling was used as a sample method, this is where they were intentionally selected because they had the required experience and possessed specialist knowledge, capacity, and willingness to discuss the phenomenon (Creswell 2012). England was chosen due to the practicality that some interviews might be face-to-face and the time and travel this would require. No deliberate selection was made based on demographic characteristics, e.g., age, gender, and ethnic origin (Etikan, Musa and Alkassim 2016). Participants did have different demographic characteristics as they included parents of different ethnic and cultural backgrounds, as well as male and female.

Hermeneutic Phenomenology, informed by Heidegger's (1962) philosophy, required a small number of participants with real information rich, lived experience so that they could provide authentic data from which the meaning emerged (Dibley et al 2020). This was important to ensure that their experience was fully explored and understood (Sharman 2017). Groenewald (2004) stated that the number of participants finally recruited depends on their willingness to engage with the research as well as pragmatic considerations (Vasileiou et al 2018). These were also a deciding factor in how many participants were recruited and interviewed, for example, capacity of the single researcher to transcribe and analyse the interviews. The actual number may be determined by the researcher (Creswell 1998), with consideration being given to the overall purpose of the research; the rarity of the topic and sample size; the methods used for analysis and the depth and completeness of the data collected (Dibley et al 2020). Snowballing, which is a method of gaining more participants by asking current ones to recommend others for interviewing (Groenewald 2004), became a necessary method to advertise the research being mindful that parents

are usually part of groups and might have similar views or experiences (Dibley et al 2020) however this only yielded one additional 'snowball' participant.

3.6.2. Inclusion and exclusion criteria

In hermeneutic phenomenology inclusion and exclusion criteria tend to be few and broad to capture the quality and *Daesin* (Being-in-the-World) of the participant (Dibley et al 2020). Table 5 below details the criteria for this study which ensured that the data collected best answered the research question (Dibley et al 2020). Inclusion criteria are specific characteristics that a participant must possess e.g., age or gender and exclusion criteria are those characteristics deemed inappropriate for inclusion e.g. the health review was by telephone or email (Schneider et al 2014).

Table 5: Inclusion and Exclusion Criteria for research study

Inclusion Criteria	**Exclusion Criteria**
• A Parent with a child under 5 years old • Experience of a child health review with a health visitor within the past 3 years and 11 months in England	• Unable to speak or understand English. • Did not complete the video consultation with the health visitor. • Health review by telephone or email • Inability to give written or verbal (audio-recorded) consent

3.7. Research design overview.

3.7.1. Data collection methods and interview schedule development

In hermeneutic phenomenology research, data collection is the gathering of narratives from participants often by open and in-depth interviews that are conversational in nature (Crowther and Thomson 2020). In this research in-depth unstructured interviews were used with probing questions designed to resemble a conversation because avoiding

leading questions is very important and could be considered a form of bias (Dibley et al 2020). The interview guide presented in Appendix 4 was produced after extensive reading of the literature and discussions with supervisors whilst being mindful that it is only a guide in an unstructured interview. A practice interview with a health visitor friend also informed the approach and technique required to elicit the necessary data. For example, that video recording the interview was too intrusive and distracting as well as interrupting the flow of the conversation, so all interviews were only audio-recorded.

The data collection phase of the research project was preceded by an extensive literature search and scoping review, previously detailed in Chapter 2, including alerts on relevant publications and databases to keep up to date with newly published studies. This informed the study, as well as evidenced the gap in knowledge and justified the research (Munn et al 2018). Completing the literature scoping review prior to collecting data enabled the researcher to be aware of themes in the existing literature and to use this to inform the interviews conducted (Dibley et al 2020).

3.8. Participant recruitment process

Advertising for participants, using the flyer in Appendix 3, began in early June 2023 via WhatsApp, Facebook and MumsNet, as well as in school and nursery newsletters. Many Facebook groups for parents were joined, for example, Manchester Mums, Canterbury parent's group and Autism Support Group, and the flyer with some introductory wording was posted regularly. Only one response from the Manchester mums group was received although this did not progress to an interview. It was not possible to recruit participants through the commissioned health visitor service provider as they declined to assist. The flyer and introductory wording were also distributed to friends and family to disseminate to

their networks to gain a wide circulation. In total thirteen responses were received from potential participants as detailed in Table 7. The flyer asked all those interested to make contact using the university email address and then a standard response, detailed in Appendix 6, was sent. The participant information sheet in Appendix 7 and the consent form in Appendix 8 were also included so the parents could understand more about the research project before participating.

This stage was often lengthy and arduous, trying to achieve the right length of time between ‘prompt’ emails to ask if they had read the information and whether they would like to take part in the research. Aligning to the hermeneutic phenomenological approach, I was inspired by the online course facilitators to compose the poem below in Figure 8 capturing my fear of not being able to recruit enough participants and the impact this would have on the research study.

Figure 8: Poem – The Hard Bit

The Hard Bit

I need 10.
It feels undoable as an individual task,
I need to ask family and friends to help,
But that means revealing more about myself.

I need 10.
It feels like an uphill struggle,
With lots of downs as well,
I'm not sure I want to be this vulnerable.

I need 10.
It feels like online dating with ghosting and rejections,
Sometimes I get a response which feels amazing,
Like an adrenaline rush.

I need 10.
I live in a constant level of anxiety and alertness,
Every family I see I wonder if they had a video call,
It easy to get obsessed.

I need 10.
Will I ever achieve it, it's not for the want of trying,
The searching and email follow up is never-ending,
It's exhausting and I want it to stop!

As part of the recruitment process, a prompt was sent every 10 days and always replied to swiftly. Communication in the emails, seen in Appendix 6, were courteous, respectful, and mindful that parents were busy. Most participants took about a month between initial email inquiry to undertaking the interview and several were communicated with at one time, so the process was smooth, and gaps avoided.

Detailed records were kept ensuring no undue pressure was exerted and it followed the process outlined in the ethics approval. Participants were prompted by email up to three times before entering negotiation about an interview date which, after discussion with the

supervisors, felt balanced. Once the date and time of the interview was agreed a Zoom link was sent for the interview. By the end of July 2023, seven participants from a variety of different backgrounds and sources had been interviewed, gathering some rich and meaningful data. The remaining 3 participants were recruited following a refresh of the adverts and were interviewed in August and September. Table 6 below presents the demographic data of all ten participants giving an overview of the composition for the group and an idea of who participated detailing their ethnicity, employment status, age, location, and how they were recruited.

Table 6: Demographics of Participants

(Ethnicity taken from ONS ethnicity groups category)

Participant Number and Pseud name	**Month of Interview**	**Ethnicity**	**Employment Status**	**Children in household age**	**Video call health review**	**Status of child / family**	**How saw advert / Flyer**	**Snowball Y/N**	**Location**
Participant 1 Anna	July 2023	White British	Employed	1 aged 1y 11 months	9 - 12-month review	No parental health concerns for child	Friend of relative or colleague	N	London
Participant 2 Heidi	July 2023	White British	Employed	School aged and 1y 9m	12-week review	Parental concern around child feeding and sickness	Colleague or friend of relative	N	East Anglia
Participant 3 Dee	July 2023	White British	Employed	1 aged 2 ½ y	9–12-month review	Parental concern around child sickness, breastfeeding and co-sleeping	WhatsApp group	N	London
Participant 4 Abe	July 2023	White British	Employed	3y old and 11-week-old	2 – 2 ½ year and 6-week review	No parental health concerns for child	Colleague's husband or family member	Y	East Anglia

Participant Number and Pseud name	Month of Interview	Ethnicity	Employment Status	Children in household age	Video call health review	Status of child / family	How saw advert / Flyer	Snowball Y/N	Location
Participant 5 Kay	July 2023	White British	Maternity Leave	3-year-old and 11-week-old	2 – 2 ½ year and 6-week review	No parental health concerns for child	Colleague of family member	N	East Anglia
Participant 6 Lucy	July 2023	White; Other	Employed	4 ½ years old	2 – 2 ½ year review	Parental concern regarding Childs' socio-communication skills	Colleague	N	London
Participant 7 Naba	July 2023	Indian British	Housewife	1 ½ years old	6m and 1 year review	No parental health concerns for child	WhatsApp group	N	London
Participant 8 Ivy	August 2023	White: Greek	Employed	4-year-old	2y review	No parental health concerns for child	Nursery WhatsApp Group	N	London
Participant 9 Oona	August 2023	White British	Employed	3-year-old and 18-month twins	2 – 2 ½ year review	No parental health concerns for child	WhatsApp Group	N	London
Participant 10 Tia	Sept 2023	White British	Employed	2-year-old	New Birth Visit	No parental health	WhatsApp Group	Y	London

Participant Number and Pseud name	Month of Interview	Ethnicity	Employment Status	Children in household age	Video call health review	Status of child / family	How saw advert / Flyer	Snowball Y/N	Location
						concerns for child			

To gain the final participants, the link was refreshed and those already interviewed were asked to advertise it to their networks which yielded a few more enquiries. In addition to this a Healthy Beginnings roadshow and a Children's Centre in London were attended and an attempt to recruit parents directly into the study. One of the parents was prepared to advertise the flyer link on local WhatsApp groups, which helped in the recruitment of the final three participants.

Table 7 below, details the recruitment method of participants with the number of participants who enquired or were recruited. It demonstrates that the most successful method was personal recommendation or local place-based WhatsApp groups i.e. 'what's on today in London' rather than in school newsletters or on noticeboards. This demonstrates that people, not surprisingly, respond to personal recommendation rather than cold approaches. Thirteen parents enquired about the study with ten progressing to an interview.

Table 7: Recruitment Method and number of Participants

Method	Number of participants enquired or recruited	Successful interview
Family and friends advertising to their networks	5	Yes
WhatsApp	5	Yes
Facebook	1	No
Face-to-face recruitment at roadshow or children's centre	2	No
School and Nursery Newsletters	0	N/A
Institute of Health Visiting newsletter	0	N/A
MumsNet	0	N/A
Local notice boards in town centre	0	N/A

3.9. Data collection

3.9.1. Interview process

Once the date and time had been agreed, a mobile phone number was exchanged so independent immediate communication could be made if technology failed on the day. Consent, using the consent form in Appendix 8, sometimes had to be gained verbally at the beginning of the interview and a short explanation about the style of the interview was given, a detailed introduction took place once the audio-recording of the interview commenced. Minimal notes were made during the interview to enable full concentration on the conversation and experience being recounted. Once audio-recording started and the introduction and consent gained, an in-depth unstructured interview approach was used, beginning with an opening question, and followed by

prompts and probes to explore further detail on issues raised by participants in their responses, a full transcript of 'Kay's' interview is in Appendix 5 to demonstrate transparency.

The interview guide in Appendix 4 was broadly used although the interview followed a more conversational style suited to hermeneutic phenomenology. The first interview was on MS Teams, but technical issues were experienced, so the remaining nine were conducted using Zoom but following the same interview guide and format. All the participants felt it had been a useful medium for their interview and they had been able to comprehensively share their experience. It was agreed with them that only an audio-recording would be made as it was felt too intrusive to visually record the video call. Field notes were made immediately afterward the interview to aid reflection, memory recall and to provide an aide memoire of context for data analysis (Dibley et al 2020).

The audio recording was transcribed and immediately pseudo-anonymised with all names removed and replaced with pseudonyms and the transcription given a number so only the researcher could identify the participant. See Appendix 5 for participant 5 'Kay's' complete transcript as an example of one of the interviews to demonstrate the credibility of this part of the process.

Table 8 below shows the length of the interview with the range as 25 to 55 minutes and the average 43 minutes, the shortest was due to the participant having another appointment to attend. There were few technical issues, except with the first interview, which were soon resolved. In total, over seven and a half hours of recordings were taken, and one hundred and sixty-six pages of transcripts were analysed.

Table 8: Length of Audio Recording and Number of Pages of Transcript

Participant recording	Date of interview	Length of recording in minutes and seconds	Pages and Lines of transcript
Anna	7/7/2023	42:26	20 pages 674 lines
Heidi	14/7/2023	47:31	18 pages 602 lines
Dee	22/7/2023	43:16	18 pages 584 lines
Abe	23/7/2023	40:03	16 pages 519 lines
Kay	23/7/2023	55:01	19 pages 612 lines
Lucy	24/7/2023	44:33	14 pages 474 lines
Naba	24/7/2023	39:32	13 pages 434 lines
Ivy	18/8/2023	25:97	10 pages 304 lines
Oona	24/8/2023	50:43	19 pages 621 lines
Tia	2/9/2023	42:58	19 pages 552 lines
Total		**430:40 = 7 hours, 17 Minutes**	**166 pages** **5376 lines**

3.9.2. Data storage

The pseudo-anonymised transcripts, on average about 16 pages or 8600 words, were saved on the researcher's student account, on the Essex University 'BOX' secure cloud storage platform, which is only accessible by username and password, while the project was active. Only anonymised transcripts were printed so that notes regarding coding, themes, general impressions, and emotions which aided the data interpretation could be made.

Once all transcripts and paperwork e.g., consent forms, were completed or analysed, they were either shredded or saved to the computer in Box and deleted from the researchers' laptop. Electronic items e.g., audio recordings will be kept in the Essex University 'Box' for five years after the research had been completed. Consideration was made in the participant information sheet in Appendix 7 and the consent form in Appendix 8 for any participant requesting to withdraw from the study. They would be able to do so at any time, but data already collected would continue to be used for the research; this was not an occurrence with this research.

3.9.3. Member checking

The purpose of hermeneutic phenomenology is not to demonstrate an absoluteness or truth but to reveal an understanding given uniquely at the moment in time, and this might be misremembered after the original telling (Dibley et al 2020). Member checking or sending a transcript to the participant to agree the contents, was not undertaken as it is not recommended in hermeneutic phenomenology. This is a change in practice since 2014, and is considered likely to be redundant once the participant has shared their narrative (Smythe 2011). Confidence in the representation

of participants meaning is gained during the interview by recapping phrases for example “so you are telling me that…” and this allows participants to agree an aspect of their narrative (Dibley et al 2020 p147).

The aim of hermeneutic phenomenology is to gain insight into lived experience; thus, data saturation can never be achieved (Dibley et al 2020). Instead, detail of data obtained, and the depth of analysis are used to draw out findings, Malterud et al (2016) refer to this as information power. Whilst data saturation was not sought, it was felt that the narratives of the participants in terms of recurring themes and patterns, regarding their experience of video consultations were enough to answer the research question.

3.10. Rationale for data analysis method and data analysis procedure

Data analysis in a hermeneutic study does not generate a theory or explanation, it is the unconcealment of truth to reveal what to others may be hidden (Heidegger 1962).

Hermeneutic phenomenology involved each interview being transcribed, then added to the researchers interpretation of the other interviews, the analysis was iterative, focused and compatible with the hermeneutic stance (Dibley et al 2020). The participant shared their own unique perspective of video consultations with the researcher. This information was then interpreted and added to what was already understood from the researchers own knowledge and the narratives of the other parents.

There are various ways that qualitative data can be analysed and meaning illuminated, a popular way is using Braun and Clarke’s Thematic Analysis approach (2022). Braun

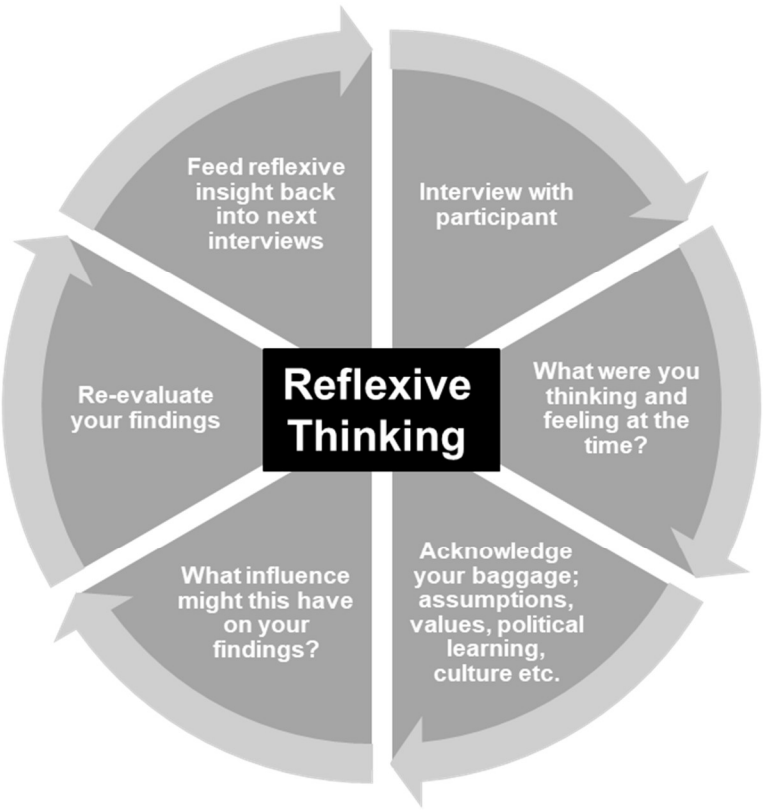
and Clarke provided a framework for ordering, coding, and analysing the data by allowing themes to emerge through reading and understanding the interview transcripts. The more often a theme was referred to by interview participants the more emphasis it was given in the research findings (Braun and Clarke (2022). Hermeneutic phenomenology does not provide a framework for how to manage, sort, categorise and reduce data to be able to make sense of the information contained within the transcripts of interviews (Dibley et al 2020). Depending on the approach (Crowther and Thomson 2022), the interviews can be viewed as a series of narratives and each person's narrative is important to hermeneutic phenomenology data analysis, as it illuminates the participants' '*being-in-the-world'* and how they perceived their experience. According to Crowther and Thomson (2022) each reading of the data enables a new thinking to occur which may enhance, reaffirm, or change the previous interpretation.

However, a structure was preferable for the novice researcher and so Diekelmann, Allen and Tanner's analysis framework (1989) was followed to help gain the best interpretative result from the data. Diekelmann et als (1989) framework determined themes as either relational themes, or constitutive patterns. Relational themes are in some transcripts, constitutive patterns are in all transcripts and can link several relational themes together and usually indicate that there may be something relevant present. Using this framework, it was possible to undergo an immersive process which helped to illuminate the themes and identify the phenomena, and this will be discussed further in Chapter 4.

3.11. Reflexivity in Data Analysis Phase

Reflexivity during this part of the process enabled a considered approach to the participants' narratives, managing the influence of self on the findings. One of the ways hermeneutic phenomenology researchers achieve reflexivity with the data is through the 'Hermeneutic circle' which is not a method for data analysis rather a concept for entering the data (Gadamer 2003). The process can be seen below in Figure 9, the researcher returned to the data and reread it regularly in the light of the other transcripts and knowledge. The hermeneutic circle described the fore-structures that helped the researcher interpret the data alongside fore-having (background context to preunderstandings), fore-sight (how our viewpoints influence how we see the data) and fore-conception (anticipating the interpretations that will be made) (Heidegger 1962).

Figure 9: Reflexive Thinking as Part of the Data Analysis Phase (Thompson (2023), Hermeneutic Phenomenology Summer School)



The hermeneutic circles aim was to avoid only uncovering that which was already known and to look deeper for what was hidden and unknown. Finally, the fusion of horizons was achieved (Gadamer 2003) whereby the researcher and participants reached a shared understanding with a meaningful interpretation of the participants' experience which was necessary for widening understanding (Bhattacharya and Kim 2018). A full discussion of the data analysis methods occurs in Chapter 4.

3.12. Ethical considerations

The ethical principle governing research is that respondents should not be harmed because of participation and that they should give full and informed consent including about the research aim, participation expectations and anonymity (Bowling 2014). There is a requirement to be an ethical researcher to minimise risk of harm to

participants and avoid time wasting and this required ethics committee approval at an early stage of the research process.

3.12.1. Ethical approval

There are a range of ethical considerations for a successful qualitative research project, the first was to seek permission to carry out the research and this was done through the ethics committees of both the sponsoring university and if necessary, the NHS via the Health Research Authority.

Ethics committees protect the participants' human rights and their wellbeing. They establish that the study is required, needed, and will gain new knowledge, that the proposed methods suit the purpose and that it will offer benefits to policy or practice, while not asking participants to do anything considered unreasonable (Dibley et al 2020; Cohen, Zahn and Steeves 2000).

This research required ethical approval and an application to the Health Research Authority (HRA), via Integrated Research Application System (IRAS), was submitted but it was deemed not required due to use of non-NHS sites for participant involvement. The researcher believed that since health visiting was publicly funded, and the parents would consider themselves NHS patients it would be necessary to seek NHS ethics approval. Following this, ethical approval from the University of Essex, for this research project was applied for and was granted on 1 March 2023, reference number ETH2223-0174, details can be seen in Appendix 9.

It was realised after a period of trying to recruit participants, and the commissioned provider declining to gatekeep the recruitment of parents, that some amendments were required to the original ethics approval. These included widening the routes for

advertising for participants to allow social media and advertising in nursery and school newsletters. It also involved increasing the age of the child having the health review from 2 years to 3 years and 11 months at the time of the video consultations, which would capture video consultations that had occurred during the COVID-19 pandemic and could widen the appeal to participate. The ethical amendment, reference number ETH2223- 2257, in Appendix 9 was granted on 4 July 2023.

3.13. Rigour

How to ensure rigor, or how researchers demonstrate the quality of their research, within a qualitative methodology is the subject of much debate, including whether it is possible (Rolfe 2006; de Witt and Ploeg 2006). There was consensus in the literature regarding Guba and Lincoln (1989) and their expression of rigour in research. For example., trustworthiness (the degree of confidence the reader has in the study, enhanced by transparency), transferability (taking the outcome of the study and applying it to their setting) and dependability (the extent to which a study is repeatable) are felt a good model to follow. Alongside the Guba and Lincoln (1989) model, Yardley's (2000) criteria for evaluating qualitative research is also widely used for assessing the robustness of a study, this includes sensitivity to context, rigour, transparency, impact and importance. This research study took a step-by-step approach guided by Dibley et al (2020) to ensure that all aspects were transparent and accounted.

The terms used in this research project are rigour, credibility, dependability, trustworthiness, and transferability (Dibley et al 2020). By ensuring that these elements were understood, demonstrated and transparently applied the resulting

research and thesis would be systematic, accountable and of high quality (de Witt and Pleog 2006). For example, by detailing systematically the decisions taken and why, it enabled the study to be rigorously scrutinised. The Gantt Chart timeline in Appendix 10 outlines the time that was given to each project step, and it detailed how each part of the project was managed.

3.13.1. Recruitment without undue pressure

The second ethical consideration was how to access the participants according to the ethical approval and ensuring the sampling criteria was met and parents knew enough to feel comfortable to sign up to the research. It was necessary not to place undue influence on participants or to have anyone do so on the researchers behalf. Participants needed to be part of the research willingly, knowingly and not for altruistic reasons e.g., personal gain (Gerrish and Lacey 2015).

Participants were advertised for, using social media groups, children's centres and schools, with the recruitment flyer found in Appendix 3, as well as through family and friends, and on community noticeboards. This allowed for them to choose to come forward to take part in the study.

3.13.2. Informed consent

The third consideration was ethically gaining informed and individual consent to participate from each parent. Informed consent, in Appendix 8, forms an integral component of the rigour in the research process. Recruitment of participants was part of the ethical approval process. It included an explanation of the purpose of the study, data collection techniques, data storage in accordance with the Data Protection Act

(2018) and their right to withdraw at any time (Gerrish and Lacey 2015). The information about the study included its purpose, objectives and what participants would expect from joining the research project. Participants were asked to complete and return the consent form before the interview, five did this and it gave the start of the interview a less formal tone. The remainder agreed consent verbally during the audio recorded interview with each of the nine statements being read out in full and them agreeing each statement. They were sent the consent form by email after the interview for their records.

3.13.3. Confidentiality

Assuring and maintaining anonymity for those participants who did not wish to be identified allowed them to feel comfortable in providing information, especially if it was critical of the health visiting service or video consultations (Gerrish and Lacey 2015).

Confidentiality of participants was maintained by giving each participant a pseudonym and quoting this in all subsequent transcripts, text, this thesis and any publications (Dibley et al 2020), this adheres to The Code (NMC 2018) regarding client confidentiality.

3.13.4. Safeguarding

Consideration was given to safeguarding the parents and children and the participant information sheet in Appendix 7 included a statement about what would happen if they disclosed any information that put themselves or others at risk of harm. It was important to make this clear at the beginning of the process, so they knew what to expect and felt comfortable to participate. The contact details for a support agency

were provided in case any of the parents felt they required follow-up support. This would have been either through their own health visiting team or a national helpline; this wasn't needed with the ten participants interviewed.

3.14. Summary

Building on the introduction and literature scoping review chapters, this chapter has demonstrated the process undertaken to ensure this research study is methodologically sound, ethically principled with a transparent set of steps and actions taken that ensure it was rigorous, credible, dependable, and trustworthy. The next chapter will give detailed descriptions of the data analysis undertaken and how the relational themes and constitutive patterns based on the work by Diekelmann, Allen and Tanners analysis framework (1989) were decided upon.

Chapter 4 - Data Analysis

Note: All reference to participants names in this thesis are the pseudonym and not their real name (NMC 2018).

The terms participants and parents are used interchangeably.

4.1. Introduction

Data analysis aims to gain an understanding of the meaning of an everyday experience, video consultations, and to offer possible insights into our interactions with the world we inhabit (Dibley et al 2020). This stage was allocated a large portion of time, six months, (Appendix 10), as it was important to understand and represent the parents' narratives in an honest and authentic way.

This chapter will detail the data analysis process undertaken for each participant interview, figures will be used to show the intensive work involved in identifying themes and verifying them within the data. It will demonstrate the backwards and forwards of the hermeneutic circle, how congruence was achieved, and ten themes finally identified.

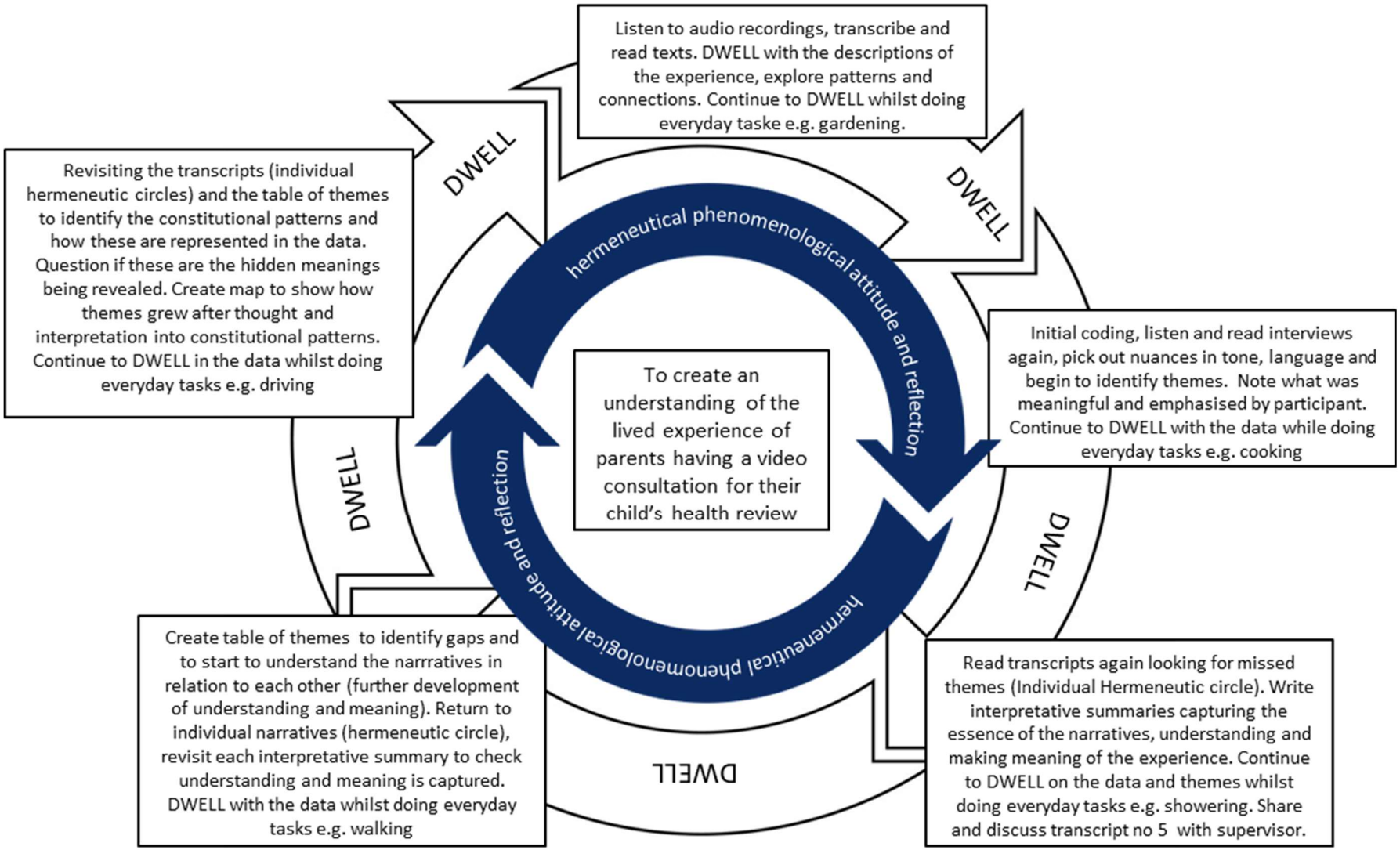
4.1.1. Diekelmann, Allen and Tanner Framework (1989)

The data analysis was guided by the hermeneutic interpretative analysis framework by Diekelmann, Allen and Tanner (1989) based on the hermeneutic circle as previously presented in Figure 9. Using Heidegger's fore-structure, and the hermeneutic circle it enabled interpretation of the participants' interview narratives to be combined with the background understanding of both the participants and the researcher leading to the 'fusion of horizons' (Gadamer 2003). There was a shared understanding to reach a meaningful interpretation of the participants' experience and figure 18 gives a pictorial

representation of the ‘fusion of horizons’. Diekelmann et al’s (1989) framework determined themes as either relational themes, or constitutive patterns. Relational themes are in some transcripts, constitutive patterns are in all transcripts and can link several relational themes together and usually indicate that there may be something relevant present.

Figure 10 below, presents the model by Suddick et al (2020) showing the data analysis process which has been adapted for the activities in this study. It shows the ongoing dialogue and work towards a unified hermeneutic, and phenomenological understanding. To gain this there was a continual back and forth between transcripts, the audio recordings, and the preunderstanding. This helped to develop a coherent meaning of the experience of video consultations by parents for their child’s health review. The stages of the framework in Table 9 give additional detail to that represented in figure 10 below.

Figure 10: Demonstrates the Ongoing Dialogue and work towards a unified Hermeneutic, and Phenomenological understanding (adapted from a model by Suddick et al 2020).



4.2. Approach to Data Analysis

The thematic analysis could be performed using an online programme like NVivo® (QSR 2020, Lumivero 2023) which assists with the sorting and management of lengthy transcripts by 'chunking and coding' the text (Saks and Allsop 2013). The researcher is responsible for the analysis process and conceptualising the data and NVivo manages and sorts the data (Pascal 2010). It was decided that, for this research study, using NVivo® (QSR 2020, Lumivero 2023) would stifle the process of familiarisation with the data. While it may have been quicker to perform coding once the programme was mastered, it would not have facilitated the deep immersion necessary for this hermeneutic phenomenological approach, which enabled the identification of the phenomenon (Smythe et al 2007). Having been familiar with NVivo® from previous research projects, it was felt that hand analysing the data would be the best fit. This would allow for dwelling in the data and to reflect on the praxis of the language used or to uncover the essence of the '*being*' (Ho, Chiang and Leung 2017).

This element of the research study was, as expected, intensive both in terms of time and dwelling with the data, but it enabled the narratives and experiences to be recognised and heard (Smythe 2011). Figure 11 below is of two annotated transcripts to demonstrate this process.

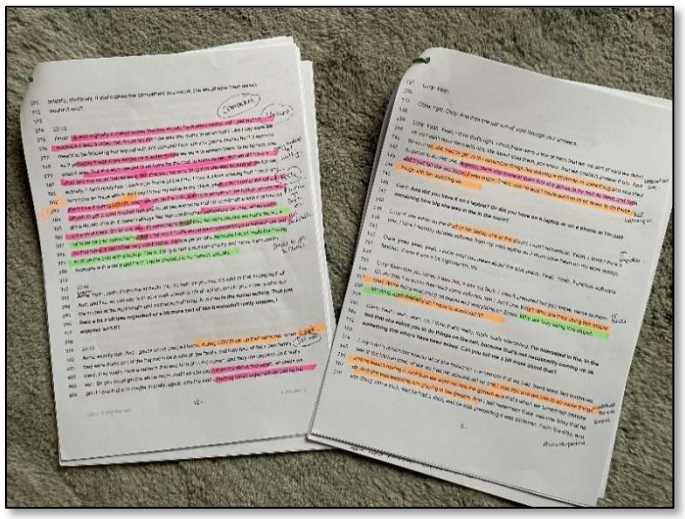


Figure 11: Annotated Transcripts from Pseudonym 'Anna' Participant 1 and 'Lucy' Participant 6

Figure 11 shows the use of pen, paper and highlighter pens to mark each transcript in helpful ways so narrative could be seen, and themes identified. Taking time is key to honouring the narratives told by the parents and enabled familiarity in such a way that the phenomenon was revealed.

4.3. Data analysis process

Data analysis to a novice hermeneutic phenomenology researcher can seem daunting and overwhelming (Peoples 2021). It is common to be left wondering what to do at this stage of phenomenological research Turner (2003). Dibley et al (2020), in their practical guide to hermeneutic phenomenology, give clear guidance regarding initial coding and interpretative summaries but less guidance on the process of analysis.

Diekelmann, Allen and Tanner's analysis framework (1989 p11) with its seven stages provided structure, rather than a procedure, to the process which enabled the best interpretative result to be gained from the data. The analysis examined the transcripts for meanings either 'explicitly or implicitly in the texts'. Each of their stages were iterative and the intention was to go back and forth between the stages until each transcript had been revisited several times. Reading, thinking, and analysis are cyclical rather than linear, making up the 'hermeneutic circle' (Gadamer 2003).

Table 9 below, builds on the detail in figure 10. It shows the action taken to follow the framework and the notes made by the researcher at each step. It details how the framework was used to inform the data analysis of the interviews and transcripts.

Table 9: Alignment of Data Analysis Actions with the Analysis Stages of Diekelmann et al's (1989) Method

	Action	**Notes/Rationale**	**Diekelmann, Allen and Tanner (1989) stages**
1.	Reflective journal completed prior and after each interview.	Need evidence of thoughts and this helps keep the clarity between the interviews.	
2.	Dwell in the data	Mulling, dwelling, and ruminating on the data whilst carrying out everyday tasks helped to give thinking space to the narratives.	
3.	Audio recordings transcribed, anonymised, and pseudonyms assigned as interviews completed.	This makes data more manageable to work with and preserved confidentiality.	
4.	Dwell in the data		
5.	Initial coding on transcripts as interviews completed. Using highlighter pen in text and notes made in margins.	Ensures clarity of themes identified per transcript and kept clarity of thought as the interviews don't merge at this stage.	Stage 1
6.	Dwell in the data		
7.	Return to audio recordings and relisten to all ten.	This helped to keep the voices alive and to dwell in the narratives including the emphasis placed on things by participants.	
8.	Dwell in the data		
9.	Interpretative summaries e.g., Figure 14 written for each transcript (1-10) and began to identify themes and patterns.	Initial identification of individual themes.	Stage 2

	Action	**Notes/Rationale**	**Diekelmann, Allen and Tanner (1989) stages**
10.	Dwell in the data and make notes in reflexive journal		
11.	Transcript 5 (Appendix 5) chosen by first supervisor to initial code. Meeting to discuss (Table 11). 'Phenomenological nod' or 'ah ha' moment.	Rigour enhanced by considering similarities between supervisor and researcher.	Stage 3
12.	Created large table (Appendix 11) with all participants and the themes identified in the transcripts.	This created a visual representation for transcripts missing themes and commonalities became evident.	Stage 4
13.	Dwell in the data and make notes in reflexive journal		
14.	Revisit all transcripts and audio recordings to check if missing themes mentioned or referred to.	Relational patterns (10) considered between participants.	
15.	Dwell in the data		
16.	Analysis of the table (Appendix 11)for relational themes and constitutive patterns	Three constitutive themes identified.	Stage 5
17.	Dwell in the data and make notes in reflexive journal		
18.	All transcripts revisited to confirm relational themes and constitutive patterns	Completion of hermeneutic circle	Stage 6
19.	Ongoing discussion with supervisors on potential findings aligned with previous knowledge.	To inform the writing up of final summary of relational themes and constitutive patterns in the findings chapter.	Stage 7

Reflexivity in the Data analysis process

Being reflective throughout the data analysis process was vital, not only for containing preunderstanding and assumptions but for dwelling with the transcripts narratives, audio recordings and sifting the information to make sense of it. This was often done during everyday tasks such as driving, gardening, and cooking. Davis (2020 p4) describes this part as '*leaving my footprints in the coding journey'* because the relationship built with the participants were emphasised by the analysis. It was a tripartite relationship between the narratives in the transcripts, the participants and myself, my lens of personal philosophy and experience, which influenced the analysis. As Horrigan-Kelly, Millar and Dowling (2016) state being reflexive also helps avoid reaching an interpretation too soon and encourages thorough thought and examination from all angles before concluding the data analysis process.

4.3.1. Stage 1: Read transcripts to gain overall understanding.

Reading the transcript alongside the audio-recording enabled full immersion in the participants' narratives gaining familiarity and understanding. This was initially done three times, twice to transcribe and check accuracy and a third time to start to pull out themes known as 'initial coding' (Dibley et al 2020, p121). The initial coding was annotated on the hard copies of the transcripts using a coloured highlighter pen and

in black pen a note of the theme in the margin. Figures 12 and 13 below show the green, yellow and orange highlighter pens with each colour denoting a different reading and purpose e.g., green was the third reading and interpretative summary data, and the orange highlighter was the fourth reading for missing themes then each transcripts had notes of themes in the margin.

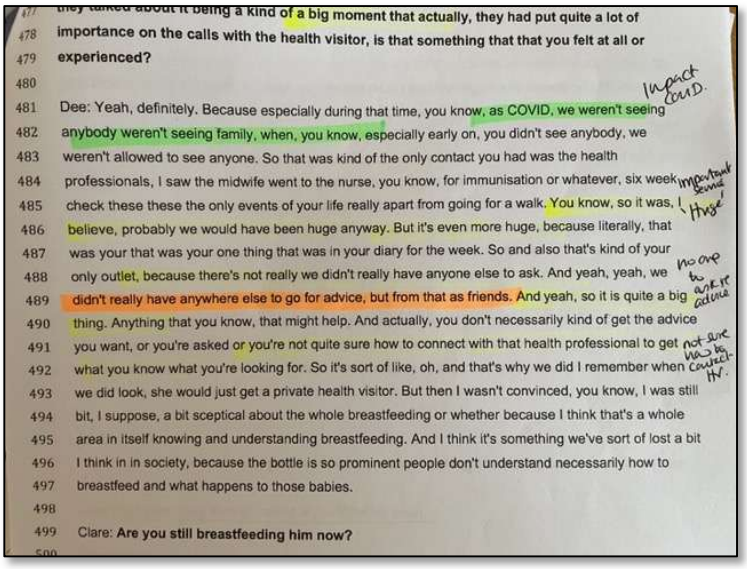


Figure 12: Example from Participant (pseudonym) 'Dee' Transcript 3

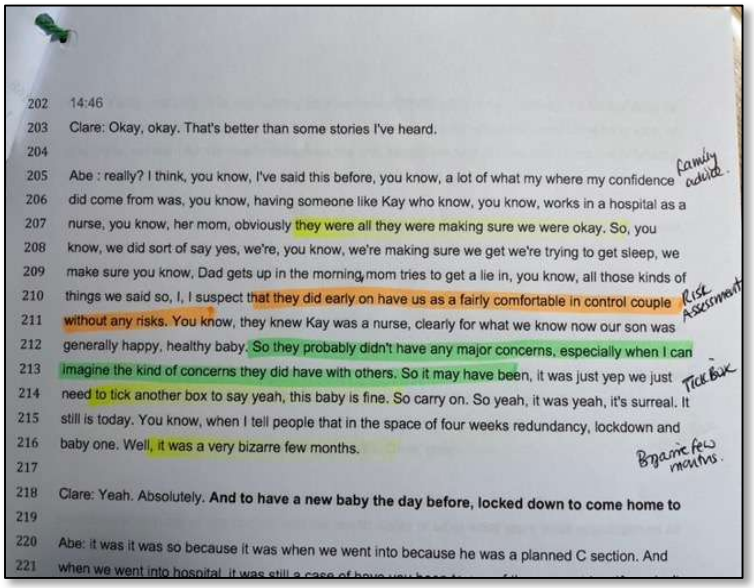


Figure 13: Example from Participant (pseudonym) 'Abe' Transcript 4

The aim was to complete the annotation after each interview before the next one was undertaken, as recommended by Smythe (2011) to allow for dwelling in the interview content and reflecting on the data and possible emergent themes. The hard copy transcripts became the audit trail for the analysis using different coloured highlighter pens and writing in the margins to denote significant phrases, themes, and interpretations this helps to demonstrate the dependability of the research.

4.3.2. Stage 2: Write summary of each transcript; begin to identify themes and patterns.

This was an interesting stage and enabled a feeling of knowing the participants and understanding their experience of video consultations and what they wanted to share.

It was necessary to revisit earlier transcripts and themes as they were reflected upon, read alongside others and new elements came to light weaving the transcripts into a synthesis of understanding or 'fusion of horizons' (Gadamer 2003). It was important to dwell with the data (Suddick et al 2020) as demonstrated in Table 9 and to have extensive reflexive time to make sense of the parents' experience and in time to identify the relational themes and constitutive patterns (Diekelmann et al 1989).

It took several weeks to complete writing the interpretative summaries, which Crist and Tanner (2003) described as a few page summaries of salient points with excerpts for each participants' narrative. Figure 14, below, is the interpretative summary from parent Lucy's interview which tells her experience in a succinct way drawing out the salient points she made pertaining to her experience of video consultations.

Figure 14: Interpretative summary Interview 6 'Lucy'

Lucy is the mother of a four-and-a-half-year-old son and lives in London with her husband. She had concerns about his socio-communicative skills and was given a video consultation appointment for his two-and-a-half-year health review in summer 2021 as COVID restrictions were lifting. She was sent an Ages and Stages Questionnaire (ASQ-3) to complete before the appointment and this served to highlight her concerns as there were things, he was not doing according to the ASQ.

The video consultation was carried out via a video app and was quite 'glitchy' (p2) and she didn't find it very user friendly as it had to be downloaded in advance on her laptop. She described the whole video consultation as 'stressful, intrusive and unpleasant' observing that the health visitor 'pulled a lot of faces' and it felt like they were 'expected to perform' which made it 'stressy and anxiety provoking' and felt 'unnatural' (p2). Lucy recalled feeling more anxious after the video consultation wondering what was wrong with her son and what was the health visitor not telling them, 'all I took from it was oh my god my kids probably autistic and I need to self-refer to MIND because I'm not coping with the situation' (p3). It was heart breaking listening to Lucy's account because as a health visitor, I knew that as soon as it was identified on the ASQ that her son wasn't achieving his milestones this should have been a face-to-face assessment in a supportive environment so her son could be properly assessed, and Lucy given appropriate tools to help him and support to cope. Instead, she reported that 'all I was left with was a really sour taste in my mouth about the whole experience' (p3) thinking that she had missed something enormous about her son and there was something 'massively wrong with him' (p3) and 'feeling judged and insecure as a parent' (p7).

Lucy described the video consultation as a very forced environment, where they had to do things with him at the kitchen table with the health visitor watching from the laptop screen, but her son wouldn't perform so they were asked to go into the garden and the health visitor turned her screen off and

just watched Lucy and her son play but it felt really pressured to persuade him to do some of the activities. She remembers each video consultation as being about an hour long which felt like a long time especially as her son wasn't really engaged and was 'catapulting off the shelves' (p6). She recalls that there were no questions about his physical health e.g., his hearing and it transpired that he had hearing problems and required grommets which made an enormous difference to his progress once he could hear properly.

Lucy categorically would have preferred face-to-face and attributed the unpleasantness of the video consultation to being 50% the online element and 50% the health visitor approach saying it was an 'unnatural interaction in the way you have a conversation with no back and forth but turntakey' (p8). She said the health visitor was focused on the skills her son had in a 'tickbox exercise' type of way (p4). She described it as 'she's in our home without being in our home and hidden from our son' he was 'trying to grab the screen the whole time and couldn't understand he couldn't watch what he wanted on the screen!' (p9). She was looking for reassurance and wasn't offered it because of the video consultation (p12) she was wanting a professional opinion on her son and to acknowledge her experiences with him, giving her a plan of the next steps and what to do to help him (p13).

Lucy too felt the weight of responsibility on her to 'go fix all this stuff' (p14) and wanted someone to 'help her to make the right decisions to say this is good, this is safe, this is fine, this is a sensible thing to do' (p14). She reflected that 'if she hadn't had such a shit experience then maybe she wouldn't have fought [for him] so hard' (p14).

In conclusion, this was a dreadful video consultation experience for Lucy and should have been face-to-face with a proper assessment of her son. The health visitor did try to assess him over the camera, which is unusual in this study's participants' experiences, but this left Lucy feeling watched and judged with increasing concerns and no reassurance.

Each interpretative summary had a table of relational themes at the end as demonstrated in Lucy's in table 10 below. This showed things that were repeated, dwelt upon, and emphasised by the participant or had resonated during the reading of the transcript. It is referred to as the 'phenomenological nod' (van Manen 2016) or 'ah ha' moment (Smythe et al 2007 p1392). While dwelling with their narratives, there were similarities in some of the themes between the parents.

Table 10: Table of identification of potential themes from parent Lucy's interview

Early Relational Theme	**Transcript data**	**Page (transcript)**
Technical Issue/ logistics	Blue Jeans and 'Glitchy', stupid annoying app, that her son didn't understand that the video consultation was interactive and couldn't understand that you could talk back to it. Long calls, the health visitor watched them play from the video consultation / laptop with her camera off, 'She's in our home without being in our home and hidden from our son'. Difficult to schedule calls with health services, people assume with video consultation that you can do it at the drop of a hat with no notice,	P2, p5, p6, p9, p12, p13,
Would have preferred face-to-face	He wouldn't engage with anything that was asked of him because he was at home and wanted to do his own stuff, asked for face-to-face and was told 'no', feels her unpleasant experience was 50% video consultation and 50% the health visitor approach. Unnatural interaction online 'turntakey'.	P2, p6, p8
Hadn't met health visitor before	Not met the health visitor before	?
Tick box	She was just very focused on what are the skills he was doing this tickbox exercise.	P4
No physical examination	No physical health type of stuff, needed grommets,	P6,

Early Relational Theme	Transcript data	Page (transcript)
Parental assessment not professional	I wanted someone to acknowledge what I was experiencing with my child and give me their professional opinion. You want someone to give you permission to do those things because you don't always know if you are making the right decision. The weight of responsibility was totally on me to go fix all this stuff.	P13, p14,
COVID	Review Summer 2021 during COVID, COVID was an inconvenience	P1, p4,
Useful important service	Concerns I wanted to talk about (p1) I was looking for that reassurance… and she wasn't able to give me that (p12)	P1

4.3.3. Stage 3: Agree summary to reach consensus: resolve conflict by returning to original data.

Generally, in hermeneutic phenomenological research, analysis for relational themes and constitutive patterns is a group activity but as a professional doctoral student this was a lone task except for a comparative analysis of transcript 5. This stage of the Diekelmann et al (1989) framework required comparing the identified themes within each individual text for similarities or differences to create independent analysis. The supervisor experienced in qualitative research, chose number five transcript from the ten undertaken and completed an initial analysis of participant 'Kay's' transcript (see Appendix 5) using the framework detailed in Dibley et al (2020 p119-121). Once this was completed, a discussion of the themes that had resonated while reading the transcript was conducted, the details of which are below in Table 11. Any discrepancies were clarified by referring to the original transcript and agreeing the interpretation of them. This was completed to provide a balance and '*dialogic sway'* (Dibley et al 2020

p130) which increases the likelihood that the analysis reflects the phenomenon as it shows itself.

This was a useful exercise, and generated a lot of material to reflect on, it also helped to manage any prejudices which may have threatened the openness to the possibility of other meanings in the narratives (Dibley et al 2020). The analysis and discussion of the fifth transcript also affirmed that the researcher was working along the right lines with their analysis. This is something Van Manen (2016) described as the 'phenomenological nod' or affirmation that the meanings revealed from the lived experience of others resonated with them.

Table 11 below, details the conversation and comparison undertaken with the supervisor of transcript five and the initial coding related to the agreed early relational themes. The column titled 'supervisor' details the coding and interpretation in their view while the righthand column is the researchers coding notes. Comparison took place in a discursive meeting and agreement was reached.

Table 11: Example of Identification of Potential Relational Themes by each Analyst (student and supervisor) from a Single Transcript (5), and Agreement of Early Relational Themes

Early Relational Theme identified	Supervisor	Clare Slater-Robins
Technical Issues/logistics	Line 86: Negatives - online, lack time, lack of preparation for this online appt, on phone as did not have access to a laptop (assumptions by health visitor online call); line 232: Poor technology impacting on appt;	Mobile phone propped up against the sofa while breastfeeding son, tiny picture and never asked to turn it around to show son, technology was a complete nightmare, the screen kept jumping and we ended the call early, difficult to hear the voice call with children running around, the coldness of a computer screen
Would have preferred face-to-face	Clinical background came through strongly. Line 138: Interactions of non-verbal communications are missed online; Line 339: There is more	You can pick up little nuances e.g., eye contact, I feel like online hasn't and won't work. I think it's very strange and uncomfortable, 99% of the time I

Early Relational Theme identified	Supervisor	Clare Slater-Robins
	information collected on a face-to-face (F2F) visit - this mum thinks this is important; Line 412: Views the face-to-face and online particular post section would have been too difficult;	would choose in person, missed personal connection – welcoming someone into your house, online is better than nothing,
Hadn't met health visitor before	Line 74: Not nice - not in area and did not know local area resources for mum and baby - very negative experience,	Someone out of the area, every time you have an online conversation it's with an entirely new person, no personal bond, rapport, connection.
Tick box	Line 101: Mum did not like this but understood there was a list to work through; line 222: This mum is really feeling the online appt is a tick box exercise; Line 486: Again, the interaction or lack of it commented on if online;	It felt disorganised and disjointed ..like she was just rushing through things (p3), Much like a tickbox exercise, ASQ what did you tick… is he latching yes / no tick! so many things asked as yes / no questions, example of breastfeeding given, it needs to be a wraparound not closed questions so people can open up about their experience, more information finding missions than a conversation. Functional,
No Physical examination / Observation	Line 120: Reality of insight into what a health visitor entails - did this mum feel that something was missing - the physical checking of mental health or anything else. Plus, the appt was awkward as mum was feeding baby (early)	Normally we would weight your baby but as we are online, we can't! not able to see where the baby is sleeping and what is in the cot, health visitor couldn't actually see him or have any interaction with him, you can't just follow your toddler around,
Parental assessment not professional	Line 249: This is important and she what was not feeling it in either appts - she wanted to be a mum not the nurse; Line 259: Feels a sense of pressure - and that children need to be assessed in person - I guess this is a difficult point and how to manage expectations here;	You can create quite a snapshot of what you want to portray, I actually feel it put more pressure on me as a parent because it's down to me alone to spot and to know what is normal, I want you to be the professional and it not to have to fall on my shoulders, It feels like a massive pressure, I would like someone else to have a look at him and have an opinion as well. I want it to be a partnership. No one invested in how my kids were doing.
COVID-19	Impact of COVID - people having equipped at home - scale, blood pressure monitor etc,	Discharged night before lockdown, in COVID we had to things a certain way
Risk Assessment by health visitor		Domestic abuse questions – having it online might allow the routine enquiry

Early Relational Theme identified	Supervisor	Clare Slater-Robins
		to be missed, so much potentially missed
Convenience	Line 273: Benefits versus cost for each side NHS service versus mum visiting Interning what this mum is thinking; Line 284: As a mum she feels no benefits of the online option,	I didn't have to hoover my entire house, video consultation takes the pressure off in that way, I can see lots of benefits for the NHS – time, logistics, money saving like not having to pay petrol and mileage and time in between journeys

4.3.4. Stage 4: Re-read all transcripts; identify hidden meanings and relational themes.

The purpose of this stage was to identify the relational themes and to view the transcripts as a whole rather than individual interviews. Once the individual tables of themes were generated, they were combined into a collated table in black font (see Appendix 11 – Relational Themes Table) and the gaps of themes in each transcript became visually apparent. See Figure 15 below for an example of the table in Appendix 11.

Figure 15: Thematic Table Showing Stages of Data Analysis to Identify Themes

	Technical issues / logistics	Convenienc e	Big moment/ important visit / useful service	Box ticking / tick box	No physical examination / Observation	Hadn't met health visitor before	Risk assessment by health visitor	Parental assessment not professionals / the weight of responsibility was totally on my shoulders.	Would have preferred face to face	The impact of COVID-19
1.Anna	Lost signal (p3), who could be seen on screen (p4), virtual waiting room (p5). Used to VC (p6). Child not on camera (p7), uncomfortable on laptop sitting on sofa. (p9, p11, p12)	Convenient to have at home (p3). Loved convenience (p12).	Important review/ assessment 9p4), first time, important opportunity to get advice (p7), support and encouragement (p8),	More of a box ticking exercise (p3), series of things to check and tick off (p8, p14).	Only wanted to see walking (p12)	-	It links to the Social worker side of things if there is a problem at home (p13), they are checking for safety (p14)	More asking us questions (p4), what if we reported it wrong? Are we giving the lady what she needs to see? (p6, p12)	Shame didn't get opportunity to meet in person (p3, p14)	I didn't love it during COVID, when we sat on the sofa, talking to people on the laptop, sometimes difficult to get a good position (p12)
2.Heidi	Propped phone up on dining table (p3), not seeing daughter, not wanting to breastfeed on camera (P3 &4), being sent a link to appointment (p5). Wasn't given a choice of appt (p13)	-	If I'd seen the HV face to face and if it was a confident experienced HV [it would have been a different outcome] (p10)	Scripted (p3), talk and type (p5, p13), just a general chat (p3)	Only held her up to the camera – disagreed she engaged with HV on screen (p2), HV couldn't see quantity of sick or how tiny she was. (p8, p14, p15)	Not met before, Lots of different HV's (p4)	-	I couldn't illiterate to anyone how sick she was, HV couldn't see how tiny she was (p2), you are looking at your baby day to day you're not really noticing if they look small or don't look the right size… its difficult . (p15)	She could have been weighed and her weight loss identified (p2), couldn't go into conversation in a bit more depth (p3), she could have seen the sick (p6,9), would have divulged my worries. (P10,11 &14)	People didn't want to see you in case you had COVID-19 (p7)
3.Dee	Laptop, not seen baby on	-	I got the sense there just	They feel a bit tick boxy	Literally a flash, he	Its harder to build a	They asked a lot of	In the end we bought, like lots	First time mother, being	Born during COVID

All the interviews were listened to, and transcripts re-read forming the *'Hermeneutic circle'.* This checked if any nuance was overlooked and then was added to the table in blue font and the transcripts in orange highlighter pen. The table may appear linear, but the process undertaken is cyclical and complex (Conroy 2003). This was part of the interpretative act, the back and forth with the data which enabled it to settle and to become familiar with the narratives and experiences held within. It was part of the dwelling in the data that was so essential to hermeneutic phenomenology research and enabled the meaning of the participants' experiences to be understood and a 'fusion of horizons' (Gadamer 2003) to be achieved as depicted in Figure 18.

My reflexive journal charts this journey to enlightenment and being reflexive was important at all stages of the data analysis process but especially this stage, giving time to ruminate on what I had heard and read was helpful for the themes to 'bubble

up' and become clear (Dibley et al 2020 p127 figure 7.4). Figure 16 below details the rumination necessary for the meaning in the narratives and themes to become clear.

Figure 16: Excerpt from Reflexive Journal (13th October 2023)

> *"Spent week ruminating on the interpretative summaries I had written and thinking about the experiences being told…. The theme around being unsupported and no one giving an opinion or help is strong in Lucy's, Dee's and Kay's. Every time I read them my heart breaks for the lost opportunities and the obvious lack of support received"*

This stage of the data analysis identified ten relational themes some more interlinked than others but all relating to the video consultation the participants had experienced. There were other themes in the transcripts, as seen in the table in Appendix 11, for example, support from family and friends, or information sources other than health visitors, but these were not relevant to the video consultation experience so were not taken past the initial coding stage.

Table 12 below details the final 10 early relational themes identified during this data analysis phase:

Table 12: Early Relational Themes Established Across Ten Interview Transcripts

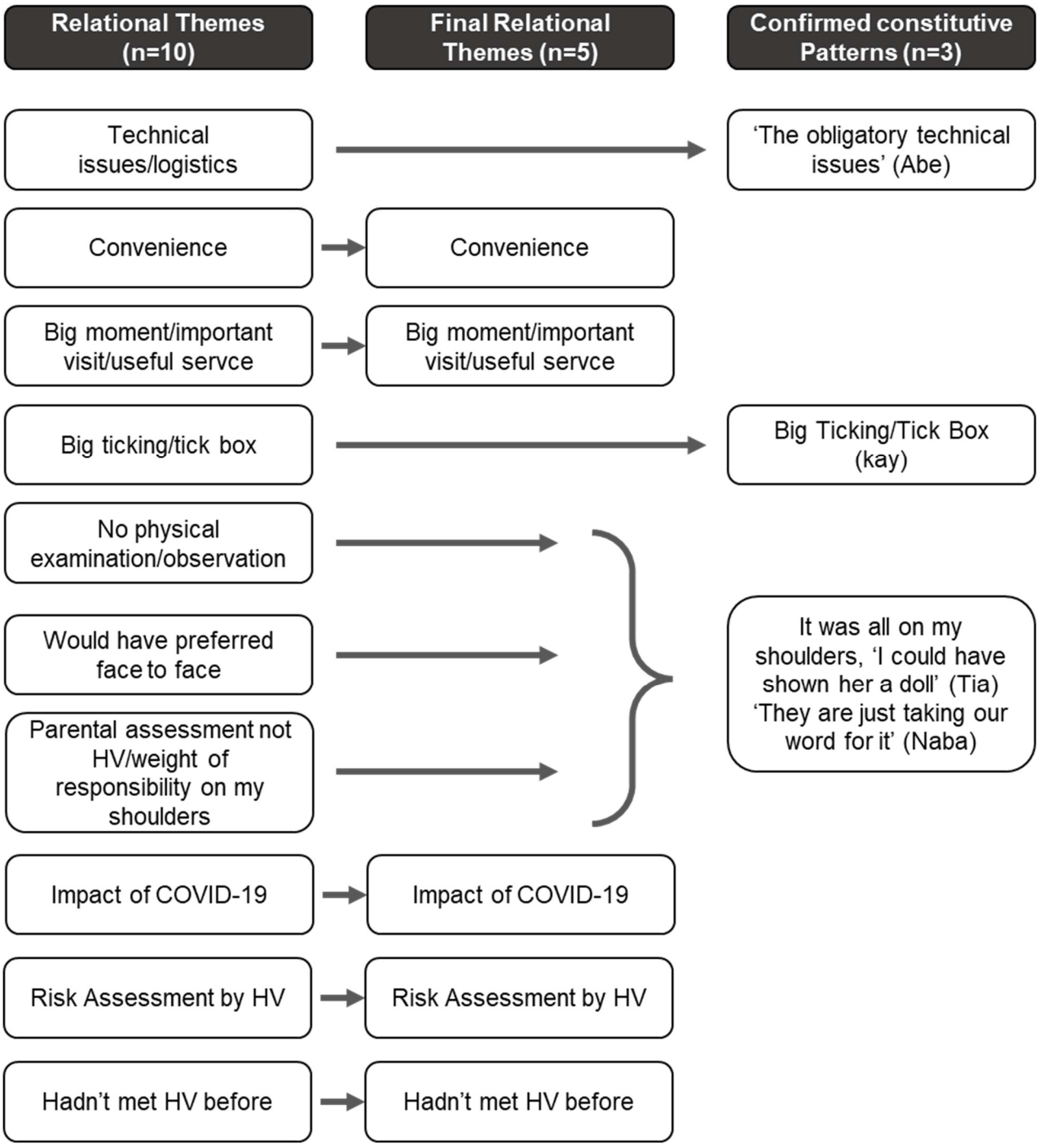
Early Relational Themes	
Technical issues / logistics	Hadn't met health visitor before
Convenience	Impact of COVID-19
Big moment / important visit/ useful service	Risk assessment by health visitor
Box ticking/ tick box	Parental assessment not professionals/ the weight of responsibility was totally on my shoulders.
No physical examination/ observation	Would have preferred face-to-face

4.3.5. Stage 5: Describe constitutive patterns.

Constitutive patterns, according to Diekelmann et al's (1989 p12) framework are present in all the research transcripts and are the highest level of hermeneutic analysis; they express the relationship of the themes identified.

Figure 17 below takes the early themes from Table 12 above and illustrates the organisation and movement of them to relational themes and constitutive patterns which is done following the reflection on their narratives. There were three emerging constitutive patterns which were represented in all the transcripts, 'technology / logistical issues', 'tick box exercise' and 'parental assessment not professional/ the weight of responsibility was all on my shoulders'. The weight of responsibility pattern also incorporated 'no physical examination/ observation' and 'prefered face-to-face' which will be discussed in detail in the next chapter.

Figure 17: Demonstrating the Final Review of Relational Themes and Identification of Constitutive Patterns



4.3.6. Stage 6: Verify results by returning to interview transcripts.

The purpose of this stage was to validate the findings and interpretations made. The individual texts and audiotapes were revisited alongside the interpretative summaries known as the 'hermeneutic circle' (Gadamer 2003). This is the back and forth between the data to gain in-depth understanding of each of the participants' experiences and further validated the relational themes, constitutive patterns and their interpretations. It was important to review the data and mull over the contents of the interviews and how they fitted together as well as how the relational themes and constitutive patterns met my own experience and ontological position. The themes and constitutive patterns identified seemed to resonate with the participants' narratives and the discussion with the supervisor, providing assurance on the plausibility of the data analysis.

4.3.7. Stage 7: Integrate and synthesize findings into an interpretive structure.

This stage is the final analysis detailed in Chapter 5 – Research Findings, where the participants' narratives were used to demonstrate their stories, and the interpretations derived from them.

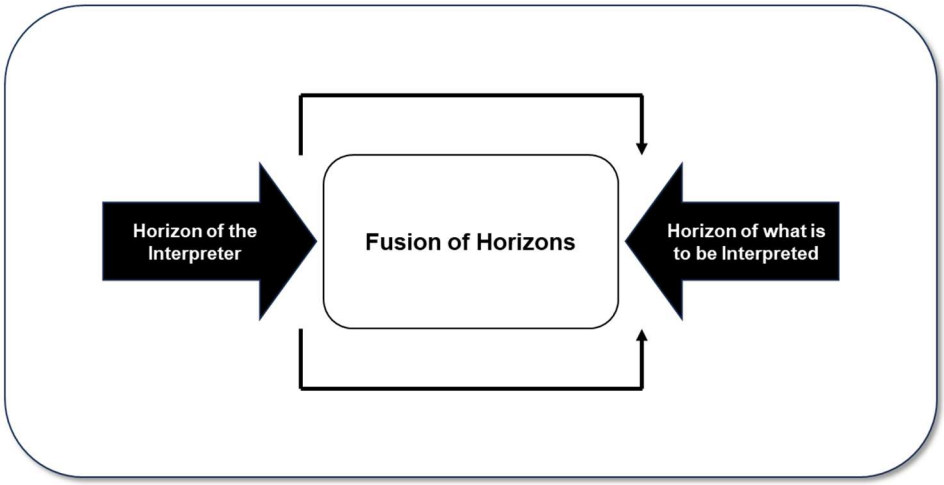
4.4. Summary

This chapter has described the process undertaken to ensure the data analysis component of this research study was coherent, followed a logical and transparent process and did justice to the narratives parents shared in their interviews. It required weeks of time to painstakingly work through all the audio recordings and transcriptions, to identify and name the ten relational themes, then three constitutive patterns. To become all absorbed and 'dwell in the data' of the parent narratives described in this

chapter and this was often done while carrying out every day routine tasks or activities as recommended by Smythe (2011).

Constant reflexivity, as shown in Appendix 12 - Reflexive Piece on Data Collection and Analysis Stage, was necessary to manage the influence of self on the interpretation, and this was also helped by having discussions with the supervisors and interested friends and family seeking the phenomenological nod (Dibley et al 2020). Figure 18 below, shows the 'fusion of horizons' (Gadamer 2003) which was achieved as the resulting interpretation was meshed between the participants' narratives and the researchers' understanding.

Figure 18: Fusion of Horizons Spence (2017)



The detailed description, tables and photos in this chapter show the practical steps taken and evidence the understanding of, and immersion in, the data that will be discussed in more detail in the next two chapters, Research Findings, and Discussion.

Chapter 5 - Research Findings

Note. All reference to participants names in this thesis are pseudonyms and not their real name. (NMC 2018).

The terms participants and parents will be used interchangeably.

5.1. Introduction

The purpose of this research study was to explore the experiences of parents having a child health review with a health visitor using a video consultation. Ten parents were interviewed, and the findings are drawn from these transcribed interviews after analysis using Dibley et al (2020) and the Diekelmann et al's (1989) framework.

In hermeneutic phenomenology research the findings chapter is presented objectively and without speculation or researcher bias (Bloomberg and Volpe 2012). Working from the transcripts, interpretative summaries and the relational themes table identified in Appendix 11 to enable rich data. Narrative data has been used to illustrate context, findings, and enable co-construction, facilitating the reader to consider their own interpretation as they read.

The next two chapters seek to provide an answer to the research questions below through the participants' narratives in this chapter, discussion of the published literature and Heidegger's philosophical notions in chapter 6.

1. *To explore the parents' perceptions of video consultations as it appeared in everyday 'being-in-the-world'.*
2. *To listen to the parents' views of video consultations and understand their lived experience.*
3. *To understand parents' experiences and what they say about using technology as a means of communicating with them.*

This chapter is arranged under relational themes and constitutive patterns and will demonstrate the rich data collected in the interviews. The narratives quoted are deliberately detailed to place the parents' experiences at the heart of this research study (Smythe 2011), and to allow the reader to make their own interpretations alongside the one presented in this study.

5.2. Relational themes and constitutive patterns

There were ten themes in the study, as detailed in the previous chapter, of which three were constitutive patterns, that is to say present in all interviews and five were relational themes which were prominent in most of the interviews. The remaining two relational themes were closely related to one of the constitutive patterns so were combined. Table 13 below shows the relational themes from the narratives before the full discussion of them in this chapter:

Table 13: Early Relational Themes Established Across Ten Interview Transcripts

Early Relational Themes	
Technical issues / logistics	Hadn't met health visitor before
Convenience	Impact of COVID-19
Big moment / important visit/ useful service	Risk assessment by health visitor
Box ticking/ tick box	Parental assessment not professionals/ the weight of responsibility was totally on my shoulders.
No physical examination/ observation	Would have preferred face-to-face

5.2.1. Relational themes

5.2.1.1. 'Convenience'

Convenience refered to the perceived reduced effort of having to attend a face-to-face appointment, with the implications on time, travel, and expense. None of the participants highlighted these specific characteristics but some felt it could be more convenient at home due to not having to tidy or clean the house before a visitor or make an effort to go out and attend a clinic.

Anna found it *"convenient to have the video consultation at home*" (Line 82) and Naba talked about video consultations giving more flexibility (Line 54) and:

> *"if its just a check up… then that's absolutely fine and probably easier and more convenient for everyone".*
>
> (Naba: Lines 263- 265)

Kay felt video consultations had the potential to relieve pressure on having the house neat and tidy:

> *"I didn't have to actually hoover my entire house. There is I think when someone's coming to your house, there is that pressure that you feel like you and the house have to be presentable. And you know, you feel like you're going to be judged if there's a cat hair out of place. So, I suppose it takes the pressure off in that way".*
>
> (Kay: Lines 309 - 312)

These parents, while not specifically identifying what made it more convenient, except hoovering the house, used the phrase in the interviews to convey that they might consider it more convenient to have an online consultation.

5.2.1.2. ‘Big Moment - Important visit - Useful service’

Some of the participants described the importance they placed on seeing a health visitor and having their child’s health and development assessed and progress reported. It seemed for these parents, Anna, Dee, Lucy, Naba and Ivy, that the health review gained significance either because it was the first time they had seen a health visitor or because they had concerns, they wished to discuss. This aspect may also have played a part in the disappointment some felt about their experience because it did not live up to their expectations.

Anna described the health review as *“it felt like a big moment for all of us sort of looking forward to seeing how they were developing”* (Line 135), she *“felt [it was] quite important*” and both her and her husband were present too:

> *“Make it as professional as possible because it was the first time we had done it… and we were both interested in how she’s doing and wanted to talk about her development”.*
>
> (Anna: Lines 223- 226)

She felt *“quite underwhelmed with how it went*”. Dee explained that as her child was born during COVID-19 pandemic the health review took on a greater level of significance:

> *“Especially during that time, you know, as COVID, we weren't seeing anybody weren't seeing family, when, you know, especially early on, you didn't see anybody, we weren't allowed to see anyone. So that was kind of the only contact you had was the health professionals, …. These were the only events of your life really apart from going for a walk. You know, so it was, I believe, probably it would have been huge anyway. But it's even more huge, because literally, that was your that was your one thing that was in your diary for the week”.*
>
> (Dee: Lines 481-488)

Lucy had asked for the health review for her son as "*I had some concerns I wanted to talk about*" (Line 31) but found there was no acknowledgement of her feelings:

> *"No, no, no, none whatsoever. And that made it so much worse, because I was, I was looking for that reassurance, you know, and I was prompting her, and, and she just wasn't able to give me that, that any kind of that that sort of reassurance or, or direction or anything?"*
>
> (Lucy: Lines 389- 391)

Naba placed her trust in the health visiting service feeling that she could share information with the person:

> *"Because you know that you're speaking to a health visitor irrespective of who the person is, for me anyway, if you're a professional, I feel comfortable to share the information. And I hope that you have enough expertise in whatever I'm asking for to be able to give me the correct advice".*
>
> (Naba: Lines 293-296)

Ivy also saw the value in the service offer especially for marginalised families:

> *"It's a very useful service. About obviously, I shouldn't be speaking as a professional, but it's the only service for these ages and are able to go in, interact, identify, support. So I think very crucial to add to that debate to offer a bit more especially to you know, marginalised families and children in need. Imagine moms that don't speak English, or their English is not very good. They're not highly educated to be able to support to do the questionnaire. Understand what they are supposed to observe. Yeah!"*
>
> *(Ivy: Lines 241- 246)*

These parents, for differing reasons, gave significance and importance to the health review for their child and were disappointed or underwhelmed with their experience.

5.2.1.3. ‘Hadn’t met the Health Visitor before’

Lack of continuity with the same health visitor was raised by several participants and this contributed to the difficulty they perceived in building a rapport and developing a relationship with the health visitor where they felt comfortable to ask questions and share their concerns. Parents’ described experiences of the health visitor coming out of retirement to see them or covering from another team which compounded their view that they did not establish a relationship with the health visitor.

Heidi reported she felt it was difficult seeing a different health visitor each time:

> *“It's difficult, really, because I think the first health visitor I had for the very, very, I think the 10 day one. She was someone that I've never met before. And I think she said she was on the bank, or she'd been pulled from a different area. I think that was it. And then the one when you have the six week, then I was asked to go to a children's, like clinic thing for her to be weighed. And then this health visitor was someone completely different again”.*
>
> (Heidi: Lines 125 – 129)

Oona said when she saw the same person twice, she felt it was a coincidence:

> *“Yeah. I think for my three-and-a-half-year-old, I think she's had same lady twice, but I think that might have been quirk of circumstance as opposed to planned, because I know the boys have had different health visitors and I don't again, that might be true staffing. I mean, it's difficult to recruit, isn't it? So there isn't like a continuity of care. I don't think that is the standard practice round here”.*
>
> (Oona: Lines 432 – 436)

Naba felt it was difficult to build a relationship when it was a different person each time:

> *“But it is difficult when every time you're going to have any sort of assessment, it's always a different person, you don't necessarily build a relationship. But*

that's not always feasible to have a set person for every family is it's just not going to work that way".

(Naba: Lines 344 – 346)

Kay said it impacted on the personal connection and perception that anyone else was invested in her children:

"But I can't actually remember anyone's name. …… And then you never see that person again because every online thing you have is with someone else, you know, you don't go to the baby weigh in clinics, because they're not on if you don't go to any of the baby groups, because they're not on either [due to COVID-19]….and you don't have that personal bond, that rapport, that connection, that that feeling, you know, it didn't ever feel like there was anyone else that was invested in how my kids were doing from that perspective".

(Kay: Lines 424 - 432)

Parents eloquently described the sense of being seen by someone new each time and therefore not being able to build a rapport and likely impact this may have had on their willingness to discuss concerns that were troubling them.

5.2.1.4. 'Risk assessment by the Health Visitor'

The parents told the researcher that the health visiting service carried out a risk assessment of all families for vulnerability and used this to tailor the level of intervention they received e.g., to have a face-to-face visit or an online one. None of the parents interviewed would have been considered for safeguarding concerns. Some would have required a greater level of intervention than the universal core health visiting offer due to health or development concerns with their child.

Abe reported that he believed the health visitor would not have had any concerns about them:

> *"I suspect that they did, early on, have us as a fairly comfortable in control couple without any risks. You know, they knew Kay was a nurse, clearly for what we know now our son was generally happy, healthy baby. So, they probably didn't have any major concerns, especially when I can imagine the kind of concerns they did have with others".*
>
> (Abe: Lines 210 – 214)

Ivy also commented on the difference, as she perceived it, between parents.

> *"But my assumption is that the health visitor spoke to a professional, educated, independent resourceful in a way of activities, services, and money resourceful mum, who was not in need, and whose child is doing exceptionally well".*
>
> (Ivy: Lines 266- 274)

Tia also commented on the levels of risk families can present but felt that even as a 'universal' family, support was required,

> *"You know what I felt like it was like okay because you're not high risk, or, you know, you're not hitting that plus plus service, you know, you are one of those universal families that you know, you still you still do need that support and that and that reassurance or just someone asked to say, 'oh, you know, I was really sorry to hear it's been really difficult I'm sorry that happened and it must be very stressful for me', there was none of that!"*
>
> (Tia: Lines 386 – 391)

Kay observed that some issues like domestic abuse might get missed in an online video consultation:

> *"The sort of domestic violence question. I mean, thankfully, I've never experienced that but I can imagine there would be some situations that having your [health review] online would actually allow that question to be missed"*
>
> (Kay: Lines 169 - 172)

Parents identified their personal circumstances as contributing to the risk assessment health visitors carried out e.g. professional education, comfortable environment and were not surprised this element determined the level of care they received.

5.2.1.5. 'COVID-19'

The research was conducted after the pandemic ended, but many of the parents had been affected by the restrictions imposed on the health visiting service by the Government, so it was discussed in the interviews to varying degrees and therefore classed as a theme. Some had experienced the lockdown restricted service for their child, and some experienced the legacy of COVID-19 e.g., no drop-in clinics or routine video consultations.

Abe whose baby was discharged on the eve of the first lockdown in March 2020, eloquently described it to me:

> *"But when you're sort of locked in, you know, no one else around, no one able to sort of confirm it in person. We just weren't sure or certainly I wasn't".*
>
> (Abe: Lines 190- 191).
>
> *"The toughest bit I think just not seeing people not being able to show him off. You know, we were very proud of him. And it was really it was you know, locked in".*
>
> (Abe: Lines 229 – 231)

Anna explained that even during COVID-19 she hadn't enjoyed online calls for socialising:

> *"I don't really like calls, I didn't love it during COVID, when we sat on the sofa, talking to people on the laptop, sometimes difficult to get a good position that you could see everyone that I'm comfortable with that haven't got a double chin*

in. It doesn't always feel that comfortable, particularly as I say, when you've got a child there".

(Anna: Lines 381 – 385)

Dee felt COVID-19 impacted on the service she received:

"I got the sense that just there wasn't really just didn't really have any [health visitors]. You know, the person who we did see initially she was very nice, but she sort of said, well, I'm just come out of retirement to help out really during COVID".

(Dee: Lines 124 - 127)

Tia expressed disappointment that despite 'Freedom Day' she was only offered a video consultation:

"And I then received a message asking me if I had WhatsApp, so and so I said, Yes, I have WhatsApp. So yeah, I was a little bit surprised, I guess. Because I know restrictions have been lifted by that time. I think we'd have the so called Freedom Day, when you know, pubs and restaurants and everything were back open, and I was being visited by the midwife".

(Tia: Lines 55 – 59)

Whilst COVID-19 formed part of the context for this study its prevalence in the narratives seen in Appendix 11 showed how affected parents were by the pandemic and the restricted access to health visitor advice and support, which made it a theme.

5.2.2. Constitutive patterns

5.2.2.1. 'Technological issues and logistics'

Constitutive patterns are themes that occur in all the transcripts and technology issues or logistics were a recurring theme due to the nature of the video consultation, however

while commented upon by participants the level of issues were minimal for most. Some parents experienced logistical issues around the positioning of their phone camera to gain a good view for themselves and the health visitor. The technological Apps also caused user concern either in waiting rooms or downloading specific software to use. Other parents experienced sound or time delay with the video consultation making it disjointed and difficult to communicate.

Abe and Kay seemed to have the most issues with the video consultation from a technological point of view,

> *"And also, there was the obligatory tech issues, you know, one of the calls we had was very noisy, so we didn't really get much, and it was it was stopped halfway through. And it was like, Well, what did we gain from that? We gained? Nothing really, you know".*
>
> (Abe: Lines 275 – 278).

Lucy described the App that her health visiting team were using for video consultations:

> *"I wasn't prepared, ….. Oh my god, I've got to download some software that I don't use. Why? Why are they using this stupid app? We're doing everything on teams and everything on Zoom. Why are they using this stupid, annoying app? And why do I have to download it?"*
>
> (Lucy: Lines 155 – 158)

Oona remembered a virtual waiting room and wondering if she had got the link right:

> *"It was kind of some sort of, it was like a waiting room belonging to the local hospital, so I think they were like, piggybacking off the local NHS hospital. But I was kinda like, I don't know, if we're in the right place here. I suppose it's kind*

of like when you go to the physical hospital, and you're like I don't know if im in the right place".

(Oona: Lines 102- 105)

No parent was given a choice of seeing someone in person or having it by video consultation and some, like Lucy, had specifically asked:

"No, it was the cut and dried. I said, I want a face-to-face and they're like, no"

(Lucy: Line 189)

Lucy found that her son couldn't understand the difference between the laptop that you communicate with and the TV he could just watch programmes on so wouldn't cooperate with the health visitors requests,

"And she's in our home without being in our home and hidden from our son, particularly being so little, not being able to understand that this is a person at the end of the screen that's talking to us and asking you a question and trying to interact with us, rather than you're watching TV, I think made a massive difference. And he was just like I said, he was trying to grab the screen the whole time he was touching it. He couldn't understand why we weren't watching whatever it was that he wanted to watch".

(Lucy: Lines 270- 275)

Tia voiced concerns about people having no access or only had old technology and the issues this might cause them to have a video consultation,

"Because I know about IT and that's fine. But then I thought well actually if somebody doesn't or you know, they've got like an old Skype phone or an old smartphone that isn't compatible with with video calls. Yeah, I'd imagine that would have been really really difficult".

(Tia: Lines 116 – 119)

Having a short call was also something the parents reported with Tia, Ivy and Dee, all saying it was '*brief, short or a quick chat'*. Oona described the calls as:

> *"Like it's always still awkward when you're a video conversation like it's not it doesn't flow as easy as when someone's sitting on your sofa with you".*
>
> (Oona: Lines 201 -202)

And Lucy found them 'turntakey' and remarked:

> *"The fact that, you know, we're having this really unnatural interaction in the way that you have a conversation, you know, it's, it's very turntakey, and not able to actually have a back-and-forth conversation".*
>
> (Lucy: Lines 268 – 270)

Heidi talked about the fact she didn't wish to breastfeed on camera, and this led her to keep the call shorter than she would have liked,

> *"I was breastfeeding Page (pseudonym) so it just didn't feel like, I felt a little bit rushed because I was thinking she needs the boob I know I'm on camera, so I don't really want to feed her on camera"*
>
> (Heidi: Lines 91 – 93)

Anna found fitting everyone in so they could be seen on camera was an issue,

> *"[Our daughter] was walking around and the woman generally spoke to us, but then would be 'can you show us again, how she's walking', but I mean, it is quite difficult on a video call because a child is at that point, they are walking, they're sort of doing things and everywhere. And that's then quite difficult to sort of turn the camera to be and also do, do you want me to turn the camera to be showing you what she's doing right now?*

(Anna: Lines 162 – 166)

… And so, in that respect, I guess it does feel it felt a bit odd with we were just a bit unsure. How should we be doing this again? Where's the cameras focusing on? … Are we giving the lady what she needs to see?"

(Anna: Lines 171 – 173)

Lucy experienced the health visitor trying to assess her child online by asking them to do things with him while they observed, Lucy found it strange and stressful:

"And we went through the questionnaire, and she asked a load of questions. And she pulled a lot of faces, and it was really, it was really unpleasant, If I'm honest Clare, it was really stressful. And we, it was, me, my husband and my son were on the call. And we kind of felt like we were we were having to perform, it felt quite intrusive and quite quite stressy and anxiety provoking it didn't feel natural at all. And she was asking questions, and we were answering them, and she was sort of like, hmm you know, there was some raised eyebrows and things"

(Lucy: Lines 45 – 50)

The health visitor requested that she observe Lucy's son at play:

"And he was trying to grab it and stuff, we couldn't get him to engage in any of the things that we wanted him to engage in, even though there were things that we knew he could do. But he wasn't able to demonstrate it on the video call with her. And then she said, 'I'll turn, I'll turn my screen and my mic off, and I'll observe you guys playing but just you know, pretend I'm not here.... So, we kind of turned, I remember we turn the screen off, we turn the mic off.".

(Lucy: Lines 66- 71)

They were also observed in the garden:

"…we went out into the garden, and I had the iPad set up there. And I just felt like we were being watched, it almost made it worse that the screen was off, because you're sort of aware that there's someone there, but you can't see them. And it just felt like this really forced environment that I was prompting our

son and trying to get him to do things, but he didn't want to do any of those things. Also, we're at home, so he wanted to do what he wanted to do at home, ……So, yeah, it was quite stressful".

(Lucy: Lines 72 – 76)

Naba had some positive ideas to contribute around thinking staff need to be trained in using the technology not just how to send a link and log on,

"It depends on who's doing it as well, how much technology knowledge do they have as well. Is it just knowing how to send a link and log on because… if you're trying to get everyone on to one particular platform or being able to do a hybrid version of online and face-to-face are you've giving enough training to them to be able to use those things as well, which a lot of the times it isn't. So, it's either you just do it because you're being told that you need to do it and you just about you know, then it probably does turn into a tick box exercise if you just about know what you're doing".

(Naba: Lines: 400- 407)

She felt health visitor expertise was crucial to their skillset:

"Or are you one of those health visitors who knows a bit more about it and can be a bit more engaged in the video consultation. So, I think that plays a huge part in it, because the two can coexist very well together. But it's about making sure that you have provided enough training and support to your health visitors as well as make, if you do that, then they can provide the support that they need to do their parents as well. And one or two of those places end up being left out. And that's what ends up breaking down the entire system".

(Naba: Lines 408 – 413)

In summary**,** parents described different experiences of technical logistics issues with video consultations including not feeling comfortable to breastfeed on camera, having stilted conversations that felt turntakey and feeling uncomfortable being observed whilst in their home. These compounded the technical issues like poor sound quality

and not being able to angle their phone camera correctly to see the health visitor or be seen on camera.

5.2.2.2. 'Tick box'

All the participants spoke about feeling the video consultation, to a varying extent, was a tick box exercise carried out by the health visitor. The following quotes describe what the parents meant by tickbox in their experience: Kay described it as '*functional'* and Heidi as '*scripted*'. Anna felt it just seemed like it was kind of '*right yep, that one's done'* (Line 459). They described the health visitors asking closed questions, reading from a list or trying to write while talking. They gained the impression from the video consultations, that they were a task that had to be completed, and this added to their sense of dissatisfaction with the experience and preference for a face-to-face contact.

Heidi described her experience:

> *"If I'm being honest, it felt a little bit scripted and that she's trying to talk to you, but at the same time, just trying to type. So, feels like, you know, a little bit how is a conversation when they are having to just like document it. It felt like she's just trying to answer the questions that were on her screen, I think when it's face-to-face, and you're like, obviously, you've got your laptop or whatever, or you're taking notes, but you're having the more of an opportunity to engage more face-to-face and then being able to have a nice conversation and then write down notes that you feel are relevant for you to then type up after the visit.*
>
> (Heidi: Lines 138 – 145)

Abe dwelt on this part of the video consultation, and it was a recurring theme in his interview:

"But I think more to the point, I just I don't feel I necessarily learned much or that it was anything more than almost a tick box exercise".

(Abe: Line 56)

And without being there to sort of say, right, so you know, this is our concern, or we've got this or we're worried about this, it was kind of a right, well, if we can put the tick in this box, then the forms done, it felt admin based rather than whether the child's got something wrong or everything's going well based

(Abe: Lines 58 – 61)

… So yeah, it kind of stood out as being just a lot of us sort of saying yes, but it was almost a case of if we weren't sure but said yes, they would have just ticked us off anyway

(Abe: Lines 116 – 118)

Tia felt she was asked a lot of closed questions:

"I suppose it because it looked like she kept looking down at her paper, as well as to ask the questions. But I don't remember being asked a lot. If that makes sense. It was quite short, I felt it's almost like, I need to get you know, it's day 14. Okay, she's, she's not a risk".

(Tia: Lines 219 – 221*)*

"It was very much like questions like, am I suffering from anxiety? Do I have depression? and have I had those kinds of things, in my background".

(Tia: Lines 203 – 204)

Kay gave her view of video consultations and the need to have it conversational to be more satisfying:

"I think actually what it feels like is that the online meetings haven't so much been conversations, you know, like in a conversation there is that give and take.… letting it flow freely and explore topics, and you can get that wrap around

> *and more detail and that fluff. Whereas I feel like the online conversations haven't been the same type of conversation, they have been functional, and they've been almost like an information finding mission, rather than a conversation".*
>
> (Kay: Lines 406 - 412)

Dee felt the video consultation were brief and '*just sort of skimmed the surface'* (Line 436) and:

> *"I think because the brevity of you know those sorts of video consults they feel a bit sometimes a bit tick boxy like you know, 'is everything okay? Yes"*
>
> (Dee: Lines 61 – 62)

Several mentioned the Ages and Stages questionnaire (ASQ) which forms part of the assessment of a child health review at 1 and 2 – 2 ½ years. Kay described her experience of it:

> *"Online, I literally feel like we filled in a questionnaire we had the questionnaire in front of us. She obviously had a questionnaire in front of her as well or either that or knew it off by heart, which she may well do. You do a lot of them as health visitor, but it literally did feel like Okay, so question one: What did you tick? question two, what did you tick? Question three, what did you tick? It was a very kind of emotionless and un-interactive, you know, what, what have you ticked I will mark it down on my copy as well, there wasn't kind of any demonstration, there wasn't kind of any discussion around it, there wasn't any interaction really".*
>
> (Kay: Lines 252 – 259)

Kay also described doing the questionnaire on her mental health assessing for post-natal depression on her video consultation,

> *"And I think with the mental health questions as well…. how often on a scale of one to five, are you feeling these thoughts and moods and you know, and actually having those questions asked online felt very disengaged and detached and, you know, I mean, I, I found myself actually looking at and playing with my baby son, and just sort of half kind of listening, which was terrible of me, I shouldn't really have done it at all. But, you know, I didn't feel engaged in that process, and I think when someone asks you on a video call, are you feeling low and mood? Or are you okay? You can go Yeah, no, I'm great. Thanks".*
>
> (Kay: Lines 140 - 148)

The parents described short, quick video consultations that were more perfunctory than conversational and left them feeling underwhelmed or dissatisfied with the experience. Parents felt disconnected from the process and at times were even asked closed questions about their mental health and wellbeing which they reported to be unhelpful.

5.2.2.3. 'Parental Assessment not Health Visitors'

Participants reported being concerned that they were the ones who had to assess their child/ren because the health visitor could not see them for themselves on a video screen. It was a theme spoken about by all of them regarding the weight of responsibility to represent their child and their health and development accurately. Some parents expressed concern that they were not sure what they were looking for with their child and whether they would be able to recognise if something was wrong. The parents reported wanting professional advice and support and being disappointed that this was not able to be delivered online.

Lucy reported:

> *"We felt that there were there was stuff that we wanted to talk about. So, I think I wanted someone to acknowledge what I was experiencing of my child and*

give me their professional opinion on where he's at. He was at that point as a two-and-a-half-year-old, and what our sort of next steps would be, and how, you know, should I be getting additional support?"

(Lucy: Lines 435 – 439)

Anna was concerned that they didn't know about child development and could be reporting it wrong,

"I mean, she did ask to sort of see her walking. Umm, but there was not really much else that she saw. I think maybe because it's difficult to do it by video. But yeah, it definitely felt that [we reported how she was doing]. And then I guess from a parent's point of view, we'd be more worried about what if we said she's done this, but she's not actually and what did that mean?"

(Anna: Lines 111 – 115).

"Like I say were we meant to be following her around with this camera? How are you gonna assess her? It seemed as if probably it was more asking us questions. And we were to answer them, to be honest, was what it was. But she also needed to be there for the odd, to showing her, that we did have a child and she could indeed walk. But that was the only thing that she was looking at".

(Anna: Lines 375 – 380)

Dee, like other parents, bought scales to weigh her baby,

"It was really in that first, sort of five months when he was being exclusively breastfed and we couldn't weigh him, so in the end we bought, like a lot of people did, bought scales from Amazon. But then we didn't really understand the centiles so we're always very worried that he wasn't putting on enough weight which in hindsight now I understand a bit more about it, I think it was fine".

(Dee: Lines 68 – 72)

She was obviously worried about missing things in her observations,

> *"It's like, well, you know, just that you're checking. But you know, is it obviously is important, but not necessarily. Yeah, we didn't really know. And some that we're gonna miss things we didn't know what we didn't know".*
>
> (Dee: Lines 228 – 230)

Heidi illuminated the worry about not noticing if something isn't right,

> *"It could have been onus on me to say, 'Okay, this isn't right', but at the same time and you're looking at your baby day to day, you're not really noticing if they look small, or they don't look the right size …. Should they look a little more chunkier?"*
>
> (Heidi: Lines 510- 513)

Kay wanted a partnership with the health visitor,

> *"I am a paediatric nurse but right now, I want to be mom and I want to be seen as mom….. and I want you to be the professional and it not to have to all fall on my shoulders. Which I don't know, maybe that's a really weird thing to say, because it's my child and I love them dearly and it is my shoulders it falls on at the end of the day. But it feels like I want it to, you know, be a partnership. I want it to be actually yes, I'd like someone else to look at him and to have an opinion as well. And not just me as in my paeds brain I want to be mom".*
>
> (Kay: Lines 282 - 289)

Naba felt the health visitor was just taking her word for it,

> *"It's so misleading, because I could I could just put down 'yes for everything'. I could put down 'Yeah, she's doing great'. And I'm actually doing more damage to her development than good in most cases. Because, yeah, okay, the health visitor might look at that and say, Oh, great, she's on track. But there might be so many other things that I haven't taken into consideration that there's no way of them knowing, and they're just going by our word. Whereas it's supposed to*

> *be an external assessment for a reason….. And those people that might need the help to help their children move further on developmentally may not get the help as a result of not doing the assessment correctly themselves. So definitely, it's just taking our word for it without having done the assessment themselves".*
>
> (Naba: Lines 167 – 176)

Lucy explained the importance of having a professional's opinion:

> *"It's that experience and that wisdom, that's not your mom, that's not someone that's got an vested interest into your child that's putting their perspective. It's someone that's professional and can say, this is okay, you know, this is good, this is safe. This is fine. This is a good sensible thing to do. Yeah, I think that's that's definitely what I wanted at that point. And instead, I was left with just tonnes of questions and the weight of the responsibility was totally on me to go and fix all of this stuff".*
>
> (Lucy: Lines 464 – 469)

Naba had a suggestion for health visitors if video consultations were to continue which would mean an external assessment could take place,

> *'If they were to continue with video conferencing, the particular activities that they want you to do on the assessment, if it was more of a, upload a video of your child doing X, Y, and Z that allows them to allows you to do it in your own time making sure that you've got because they aren't always going to be interested in what you're doing. So, you've got a couple of days to try and get round to getting that video or that picture. And that is if they want to continue doing video conferencing, I think that would be a more informative way of going forward. So, you've got the evidence of the child doing it. And there's possibly other things that they can pick up from that video as well.'*
>
> (Naba: Lines 203-209)

Tia summed it up for all the participants that the health visitor assessment felt so superficial '*I could have shown her a doll!',*

> *"I felt like you're making your own assessment on that because when I brought my phone over and said babies obviously asleep, you know, she wouldn't have known he was fine. Obviously, he was fine, he was breathing, but I could have shown her a doll or, you know, he might not have been okay, you know, and it's, yeah, you do, I felt like I was making my own assessments and everything".*
>
> (Tia: Lines 352 – 356)

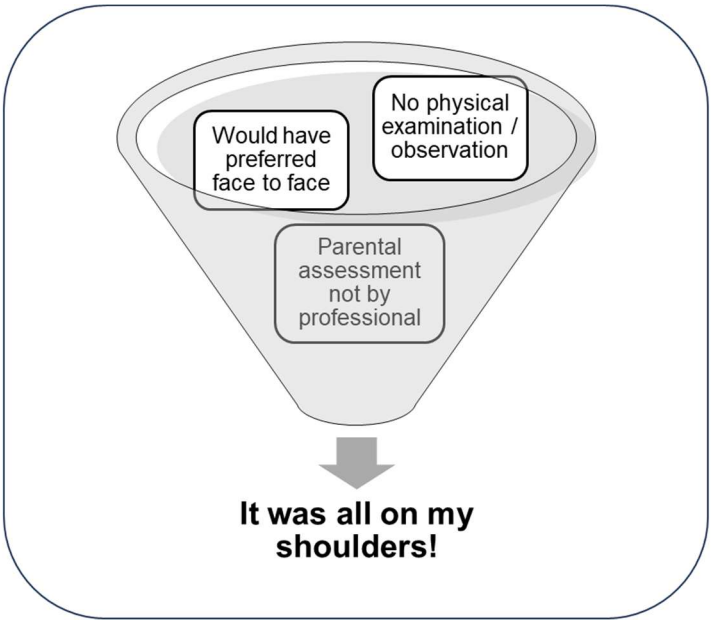
> *…. "But particularly because she wouldn't have had any way of knowing he was okay. Or whether he gained weight, whether his colour was good, because you can't see properly on a phone".*
>
> (Tia: Lines 359 – 361)

Accidently misleading or misrepresenting their child's health and development was a concern for many of the parents and they worried that they would not spot if something was wrong to report it to the health visitor. Some bought scales to weigh their babies but were unable to interpret the centile charts to make sense of it which just caused more concern. Parental reporting seemed to cause concern about the advice they would receive from the health visitor and whether it was accurate if they were not sure of the information they were giving. The video consultation experience left parents feeling doubtful about how their child was doing and unable to gain reassurance about their health and development.

This final constitutive pattern has two sub themes of 'no physical examination or observation' and 'would have preferred face-to-face'. They combine because by not having a physical examination or observation and the reasons participants preferred face-to-face, led to the feeling that the weight of responsibility sat with them to assess their child rather than being shared with the health visitor. Figure 19 below

demonstrates how they combined to illuminate the phenomenon of '*it was all on my shoulders'.*

Figure 19: It was all on my shoulders!



5.2.2.4. 'No Physical examination or observation'

Not being able to complete a physical examination or observation by video consultation was seen to be a limitation by parents interviewed. They described how they would have preferred to have their baby weighed for reassurance about their weight gain and subsequent health. The parents described how they were expecting and needed a full assessment of their child and were disappointed that this element was missing from the video consultation.

Heidi described the fact they were unable to assess how tiny she was online:

> *"I remember a very key moment in my, in that time, [I took her for a weight check] they went, oh, she doesn't look like failure to thrive. And I was like, what does that even mean? And it wasn't a health visitor but someone from that breastfeeding team. They said, well, she doesn't look like a failure to thrive baby. And I was like, what does that mean? And she said, well, they look really gaunt*

> *their cheeks, they obviously like see their bones. And I was just like, oh, God, like this is not what I want to hear….. And obviously, if that health visitor come and looked at her weight at that time, or looked at her, she may have looked at her and said, hmm, she looks a little bit small to me".*
>
> (Heidi: Lines 471 – 478)

She felt that if the health visitor could have seen the volume of sick her baby, with reflux, was producing then there would have been an earlier diagnosis of reflux and treatment with Gaviscon:

> *"Yeah. I mean, obviously, if things were fully okay, then it would be in a different outcome. But for me, I just felt like we delayed this process by nearly four months, because I hadn't really seen anyone face-to-face…. and I thought if this had been picked up sooner, then we wouldn't have had that dramatic drop [in weight], it would have been a slight decline, and then it would have been picked up sooner".*
>
> (Heidi: Lines 180- 187)

She wondered if she was responsible for raising her concerns and how face-to-face would have changed the outcome:

> *"I knew she was sick, but because I didn't know her weight. I didn't know that it really had that impact on her. Until then we had the weight …… you know, it's a worry when they're not gaining weight as they should be. So that time I was like, like, should I? Should I even raise this? You know, more efficiently? Should I have been speaking to people more and more ….. and you kind of think okay, but if I had that, instead of having that video call if I had that actual contact, and if she was there, and she could have seen the sick. She may have just said, 'Let's just weigh her, let's just check it'*
>
> (Heidi: Lines 266 – 275)

Dee described just showing the health visitor the top of her son's head rather than having a full assessment,

"We woke him up and showed her to him. But I mean, I mean, literally a flash like there is a baby here".

(Dee: Line 271)

Interviewer: but in his one-year review they weren't asking to actually see him do blocks or? …
Dee: No, I mean they literally looked at the top of his head.

(Dee: Lines 352 – 354)

Abe felt there were missing elements because it was online:

"All the things you couldn't really check in, in an online environment, because, you know, you can't sort of hold child up to the camera and turn him around kind of thing".

(Abe: Lines 86 – 87)

Tia was expecting a full examination, post Caesarean, of herself,

"I suppose I was a bit surprised just because the health visitor who conducted the new birth visit, wasn't aware that I'd had sort of an emergency section and sort of how difficult that had been. And because, you know, my guess is they would have wanted to have checked the bandage and the scar, and just to, you know, particularly with the breastfeed and how that was going".

(Tia: Lines 76 – 80)

Ivy was expecting and wanted a full examination of her child,

"I wasn't really sure what I was expecting. Or in terms of like, it was maybe 10 or 15 minutes or so. Right, so really short for a whole review maybe I was expecting a full check-up. Why I was expecting something like that, like, you know, check her body, check her ears... You know, whatever the paediatrician does usually, it probably was quite naive of me. I wanted to check her eyesight. I want to check her hearing; I want to check that she didn't have a sore throat

> *infection or something. Her height her weight. Her fine motor skills. That's what I was expecting really".*
>
> (Ivy: Lines 153 – 158)

Parents described their expectation of having a physical examination of themselves and their child despite it being a video consultation and this contributed to their unsatisfactory experience. Parent Heidi described the impact on her baby of not being physically examined and how this delayed a diagnosis of reflux by about four months.

5.2.2.5. 'Would have preferred face-to-face'.

Participants were not given a choice to have their video consultation in person or face-to-face and expressed disappointment with this, they felt they would have preferred to have had it face-to-face. Some of these instances were during the COVID- 19 pandemic but some were after restrictions had been lifted. Not having a choice may have impacted on their perception of their experience:

Naba explained,

> *"But it does kind of raise doubts in your mind that, oh, should I be doing something more. And I think if it was in person, it would have been a bit more reassuring to see what she was able to do. Compared to just kind of going off of the paper, because at no point did she asked me to even show her my daughter, it was just me and her that were talking….If you were to ask me, okay, can you set the phone somewhere, and let's just see what she gets up to. So, if that had been included, maybe it would have been a different outcome to the discussion that we had".*
>
> (Naba: Lines 95 – 101)

Oona felt there were aspects of face-to-face that were irreplaceable,

"Before that the health visitor had come to our house, which was nice, you know, we sat in the kitchen, and she could see where the child was based"

(Oona: Lines 185 – 186)

"So I think the Zoom meetings have got a lot going for them but they can't really replace that that professional being in the room all that experience and looking at the child"

(Oona: Lines 248 – 249)

"I think it was cotton reels she got out of a bag. And she was like, no, look, mom, she can do it. I felt like a bad parent at that stage, but it [online] reduces the spontaneity of the health visitor being able to intervene. And you know, say, because there's only so much you can get over on a zoom call and again, the meetings can be quite long. I mean, as in like, half an hour, maybe so a 12-month-old, would potentially lose interest and just wander off to a different rooms. Whereas when the health visitor is sitting in your kitchen or in like a meeting room, you can pull the child back in and let the child go and pull them back again. So, it's a lot easier to assess".

(Oona: Lines 345 – 351)

Tia felt having someone come to the house was nicer and they would be able to ask how she was,

"And it's just I suppose what I missed is just it's nice to have people come round, you know, particularly health professionals and to and to see that actually, you know, just for that reassurance, knowing that you are doing a good job at feeding babies gaining weight, but it's just about or someone to ask you how you are".

(Tia: Lines 383 – 386)

Kay talked about the warmth of having someone come to the house compared to the '*coldness of a computer screen'* and that 99% of the time she would choose in person for her child health reviews:

> *"You're so hormonal, and you're so sleep deprived, and you're so sore from giving birth, or having a C section or you know, you've just started breastfeeding again, and your nipples are absolutely killing you. That actually, there really is something more comforting about a person being in your house. Than the coldness of a computer screen and also in those very early days trying to faff around and find the laptop and the charger and you know, make sure you've got whatever you need for the online call. Whereas actually, when they come, you know, if it's someone knocks on your door, you just open the door, and in they come. You know, you the pressure is kind of off you to be the organised one".*
>
> (Kay: Lines 477 – 484)

> *"…but I think I, 99% of the time, would personally choose in person".*
>
> (Kay: Lines 336)

And she explains why:

> *"I missed that personal connection, I think that holistic element - Gone really for me with online, I think that that sort of welcoming somebody into your home and them seeing you and baby and being actually a person that a holistic person. Yeah. That whole experience was just very different".*
>
> (Kay: Lines 442 - 445)

Heidi didn't think she would share her worries online:

> *"Or as far if I was feeling a particular way, I don't know if I would have said on a video call. Or if I felt like I needed to get upset, I don't think I would have just because it doesn't feel as intimate. Or, you know, as disclosing as it is, it should be so no".*
>
> (Heidi: Lines 495 – 498)

Face-to-face was perceived by most of the parents as a more satisfactory way for the child to receive their health review. Some described the difference between online and face-to-face and how they preferred the warmth of having someone physically present and able to play with and assess their child which they felt was not possible with a video consultation.

5.3. Summary

This chapter has detailed, using narrative data, the relational themes and constitutive patterns that were illuminated by the parents' narratives in their interviews and transcripts. It helped provide answers to the research questions regarding parent's experience, views, and perceptions of video consultations in their own words. It showed that it led to them feeling the burden of responsibility for assessing their children's health and development, which in turn, left them feeling unsupported and unsure.

The next chapter seeks to combine and discuss the findings of this research study with the existing published literature, Heideggerian philosophical notions and researchers preunderstanding and reflexivity. It seeks to reveal the phenomenon about parents' experience of video consultations with a health visitor to broaden the horizon of understanding.

Chapter 6 - Discussion

Note: The terms participants and parents are used interchangeably in this chapter and all parents are referred to by their pseudonym's (NMC 2018).

6.1. Introduction

This chapter provides an overview of the research findings as discussed in the previous chapter, then a critique of existing literature, Heideggerian philosophy and the researchers' position in relation to the findings. This helps to bring clarity to the study and illuminate the phenomenon that the weight of responsibility was all on the parents shoulders and the health visitor had to take the parents word for whether their child was healthy and developing normally. The discussion chapter is concluded with a summary acknowledging that there is not 'the' answer to the research question but rather 'an' answer (Dibley et al 2020). Finally, the research strengths and limitations are detailed and discussed.

Short quotes from the parents' narratives are used to demonstrate a particular relational theme or constitutive pattern in order to emphasise the point and bring their lived experience to life in this part of the thesis.

6.2. Overview of findings

6.2.1. Themes overview

This study explored parents' experience of child health reviews with a health visitor using video consultation, adopting a hermeneutic interpretative phenomenological approach. It considered what it was like for participants '*being-in-the-world'* and how they understood their lived experience, especially when technology was being used by the health visitor to communicate with them.

The data from the ten participants' unstructured, in-depth interviews were analysed using guidance by Dibley et al (2020) and Diekelmann et als (1989) framework based on the hermeneutic circle. There were 10 themes of which 3 were constitutive patterns, present in all interviews, and 5 were relational themes which were prominent in most of the interviews. The remaining 2 relational themes, 'would have preferred face-to-face' and 'no physical examination', were closely related to one of the constitutive patterns, 'the burden of responsibility is all on my shoulders', so were combined. Table 15 below identifies the themes on the left and constitutive patterns on the right.

Table 14: Relational Themes and Constitutive Patterns

Relational Themes	**Constitutive Patterns**
Convenience	Parental assessment not professionals/ the burden of responsibility was all on my shoulders.
Big moment / important visit/ useful service	(RT) Would have preferred face-to-face
Impact of COVID-19	(RT) No physical examination/ observation
Risk assessment by health visitor	Box ticking/ tick box
Hadn't met health visitor before	Technical issues / logistics

The patterns and themes discussed in this chapter clearly summarise the participants' experience and what this felt like for parents of young children, both during and after COVID-19 when they were not given a choice to have their health review in person or online.

The parents described it as an important event or big moment in their childs' life, despite the technical issues which included sound quality, time delays, and logistical

problems with downloading Apps or fitting everyone on the screen. Some also acknowledged the convenience of not having to attend an in-person appointment.

From their interviews, parents were fully aware that the health visitor service offer was often prioritised and that families at risk or vulnerable were assessed and seen, they recognised themselves as not meeting this criteria. Some wondered if this was why they received the video consultation despite meeting a different health visitor for each appointment. Abe commented "*I suspect that they did, early on, have us as a fairly comfortable in control couple without any risks*" indicating that he was aware *a* different service was offered and was sanguine about it.

Parents described the video consultation as functional or transactional saying there was often *'little conversational element'* (Parent Kay) and health visitors used '*closed questions*' (Parent Abe) or it felt like '*ticking boxes'* (Parent Naba). Parents sometimes felt the video consultations were following the health visitors script and seemed like they were just completing the appointment rather than carrying out an assessment of their child. Parent's felt a sense that the burden of responsibility for knowing if their child was well or developing normally was on their shoulders because the health visitor did not see their child in a meaningful way and was not able to complete a physical examination or observation so just accepted what the parents reported. All the parents in this study would have preferred a face-to face health review and some felt if a video consultation needed to take place, then it should only be for a follow-up.

6.3. Researcher positioning regarding the themes.

As the Commissioner of a health visiting service, I was aware of the challenges during the coronavirus pandemic and research period, for example around delivery of child

health reviews and how some of the decisions to conduct a video consultation might have been taken, especially for assessment of safeguarding concerns. I was surprised by how cognisant the parents were of this, even those who were non- clinical, and their appreciation that services have priorities despite some having additional requirements, like parent Lucy (child not meeting developmental milestones) and parent Heidi (baby lost weight due to vomiting) where a face-to-face would have been beneficial.

I was expecting the parents to be more positive about video consultations and that convenience would be a constitutive pattern, so was surprised that this element, seen so strongly in the literature around adult patients' experience, was not replicated in this study. The Coronavirus pandemic would certainly have had an impact on peoples' experiences as many of the study's participants were also affected by this. It could also have been because so many of them were first-time parents and would have required additional support and advice which they felt required a face-to-face consultation. It may have been because a physical examination or observation of a child is felt to be such an important element of an assessment that the parents prioritised it ahead of convenience and therefore preferred face-to-face.

I was expecting a strong theme around transactional interactions and being a tickbox as this was something I had also experienced with meetings conducted via video; it is often difficult not to conduct it in a '*turntakey'* way (parent Lucy) and the conversational flow can be lost. I was not expecting the phenomenon to be around the burden of responsibility for having to account for their child's health and development to a health visitor who was not physically in the room. It makes complete sense that parents would feel this and links to Heidegger's philosophy of '*presence*' and '*being-with'* but I was

surprised that this was so strongly felt by all participants and articulated so eloquently by many.

This study has been contemporary, informative, and fascinating to conduct, and I found myself sharing, in professional meetings, the early findings when the topic of video consultations was discussed which led to '*ah-ha'* moments for people and the '*phenomenological nod'* (van Manen 2016) giving me reassurance that I had found a phenomenon.

6.4. Study findings in relation to existing literature, Heideggerian philosophy and researcher interpretation.

A review of the existing literature was repeated following the data analysis, searching for matching themes and to become refamiliarized with the literature in the light of the new knowledge from the interview transcripts. The literature scoping review, which was presented in Chapter 2 highlighted both the synthesis of research findings and gaps in current knowledge and will be discussed alongside constitutive patterns and relational themes of the study. All the constitutive patterns helped to address the research objectives and questions, giving insights into the participants' everyday experience of video consultations and how they regarded technology as a means of being communicated with.

6.4.1. Constitutive patterns

Constitutive Patterns are elements present in all the participants transcripts and the following will be considered in detail below: The *burden of responsibility is all on the*

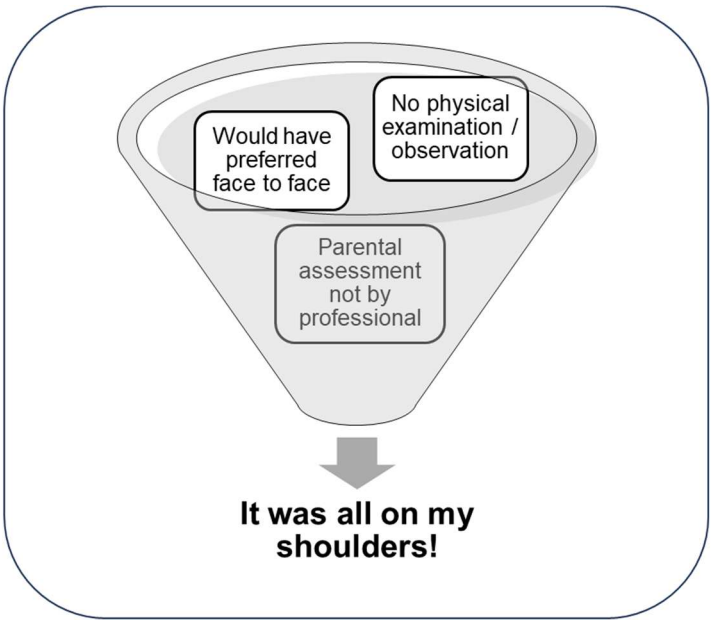
parents' shoulders; *tick box* and the theme *hadn't met the health visitor before* and *technical or logistical issues*.

6.4.1.1. 'The burden of responsibility is all on the parents' shoulders'

Sub-themes: Lack of physical examination and observation; would have preferred face-to-face.

All the participants described the experience of feeling this weight of responsibility for knowing and reporting if their child was well or ill, developing normally or was developmentally delayed. As previously discussed, it also links with the theme of lack of physical examination and observation and leads to the theme of their preference for a face-to-face health review with Figure 19 below demonstrating how they link together.

Figure 20: It was all on my shoulders!



This phenomenon is a unique finding and previous published literature, especially with adult patients, does not identify it. The iHV paper (2021 p5-6) 'Zooming in but missing out' agrees that: *"It's clearly impossible to weigh them and measure their head circumference and length, review their skin integrity for bruising or assess their muscle tone in a video call".* Lindberg et al (2007) found that their study participants had doubts about the professional being able to diagnose neonatal jaundice online and were afraid of underestimating problems with their baby but felt that the video element of the call, rather than telephone, enabled this. The parents in this study were not reassured by the health visitor being able to see the baby online and most reported that they were seen fleetingly '*a quick flash'* (parent Ivy) or superficially '*I could have shown her a doll'* (parent Tia). They described eloquently a sense of loneliness due to the video consultation with strong sentiments that it was '*a weight on their shoulders'* (parent Kay) and the health visitor was *'just going by our word*' (parent Naba) which led to them feeling isolated and unsupported with their baby especially if there were problems as parents Lucy and Heidi found. Parents, Lucy and Tia found it disconnected them from the service, and they did not seek further support, but instead sought other professionals for advice and support e.g., the nursery manager.

The report 'Babies in Lockdown' (The Parent-Infant Foundation et al 2021) emphasised this, parents wanted someone to see their baby to reassure them. Having had unsatisfactory video consultations with the health visitor, parents Heidi and Dee sought professional help and support from other avenues like online breastfeeding classes or the GP and finally found the reassurance that they required. This is echoed by Bailey et al (2022) who found first-time parents turned to professionals for reassurance when they were unsure about their child's development, concluding that the parents needed a clinicians' advice to support their decision making. Sutarsa et al

(2022) and Imlach et al (2020) confirmed in their studies that remote consultations did not provide the full range of clinical interventions which were available during face-to-face interactions. For example, removal of a coil (IUD), which concur with the findings in this study, that there were physical aspects to a professional's assessment that cannot be completed by video consultation e.g., weighing a baby. Ewart et al (2022) argued there was an element of extra safety when a doctor examined a patient rather than by self-examination or self-reporting which could lead to a misdiagnosis. The parents agreed and felt that, as the clinician, the health visitor had experience of assessment and knew about the health of children. Parent Heidi felt that she, seeing the child daily, would not always see the changes in her children and therefore either know what to report or poorly report it due to lack of knowledge. Parents should receive professional expertise regarding their child's health and development which would mean they also received the interventions required in a timely way. This is demonstrated in the case of one parent, in that a referral for lack of weight gain would have benefitted her baby.

Barrett (2016) developed a grounded theory around presence in clinical practice with four categories: operational, clinical, social, and therapeutic presence and noted that the inability to touch or have physical contact was a constraint of video consultations. He found that nurses used strategies to overcome this which included greater use of video consultation over a longer period to help build rapport. Due to the lack of health visitors physical presence to reassure, advise, assess, and support the video consultations caused an unsatisfactory experience for the parents in this study.

Bergers' (2015) interpretation of Heidegger's work was that paying attention was how things came into '***presence*'**, Berger felt that technical mediation led to different experiences of and perspectives on the world. Parents Heidi and Kay commented that

the health visitor typed on the computer while also trying to talk to them and this made the conversation disjointed which they felt physical presence would have mitigated for. Heidegger (1962) raised the notion of our '***being*'**, being grounded in presence, and, while he did not comment on video technology, subsequent researchers like Berger (2015), Blitz (2014) and Brassington (2007) applied this philosophy to the virtual world to help us to understand it. Being able to construct oneself in the virtual world mediated by technology was a '*powerful and addictive activity*' and when we perform activities outside our situated environment, we must imagine ourselves into the virtual world (Ladly 2007 p144). This is relevant to the parents' experience as they needed to communicate differently with the health visitor online (Morton and Adams 2022). Building a rapport with them so they felt comfortable sharing their concerns (parent Naba), being mindful of who could be seen on the screen (parent Kay), and how they helped their child interact with the health visitor for assessment (parent Lucy).

Heidegger (1962) described the '***being-in-the-world*'** as feeling more of our true selves, that worldly presence mattered to how things unfolded or were perceived, and in fact this related well to the research findings. The parents reported the video consultation was not as effective as face-to-face both for having a rapport with the health visitor and also with what could be accomplished e.g. physical examination or reassurance.

Parent Naba described feeling satisfied with her child's online one-year review until she heard about a relatives' face-to-face experience and how the health visitor had interacted with their child and given reassurances that Naba felt she had not received online. Heidegger (1962) relates this to '***being-with'*** **(*mit-sein***), which is something his *being* is, when with other human beings. He discussed technology making the world smaller and that distance is reduced but that '***nearness***' is not. He differentiated

between distance, which could be overcome by online calls, but the '*nearness*' that people feel with '*presence*' was not mitigated for. The parents make this differentiation too, the video consultation reduced the distance, i.e. they do not need to take their child to a clinic but felt it was not an adequate substitute for the nearness that they needed, describing it as a '*coldness of the computer screen'* compared to '*the warmth of having someone in the room'* (parent Kay) and the '*happy emotions'* felt when someone is physically present and is giving support (parent Oona). Blitz (2014) interpreted Heidegger's work, that this was because we must encounter things in their truth and therefore their actuality which with video consultations is only a representation of a person and not a substitute for actual presence. Hvidt et al (2022 p5) also commented on this aspect as their participants said they would need the doctors' 'presence', 'comfort and humanness' and would occasionally want a face-to-face appointment to 'revitalise human contact'. This is an important consideration and one that the parents in this study would agree with, that in certain circumstances, including their childrens' health reviews, there was no substitute for physical presence to assess their child.

Malpas (2000) felt that the ability to see things online obliterated the consequence of distance as described by Heidegger (1962). He purported that the disclosedness of things as fundamentally dependent on concrete presence was overcome as the technology replaced the people themselves with representations, although he acknowledged these can be in an abstracted and reduced form. The ability to replace people with representations would make video consultations ideal if they worked well. However, it is dependent on the people experiencing it and those on the other end, and in this study the parents requirement for physical presence to assess their children overrode the convenience of technology. Despite some positive experiences of video

consultations, all the parents would have preferred their child's health review to have been face-to-face which contrasts with the literature in the scoping review (Powell et al (2017), Ewart et al (2022), Christiansen et al (2022) and Christensen and Danbjørg 2018) which was overwhelmingly positive about video consultations and the interactions with professionals. The Institute of Health Visiting (2020 / 2021) and the Infant-Parent Foundation et al (2021), support the parents views, and both reports urge caution when using video consultations to build relationships with children and families.

Determining why the difference was so apparent between the scoping literature review and this research, Trace et al (2018) felt that parental and child engagement with video consultations was dependent on the child's age. They found that older children engaged with the video call and took part in the conversation but with pre-school children the call was chaotic, and parents disengaged making it unsatisfactory for both participants and clinician. This certainly resonated with the findings of this study and experience as a commissioner of health visiting services and could be an explanation for the parents overwhelmingly poor response to video consultations. Parent Anna described trying to entertain a 1-year-old and speak to someone on a screen and how this was very difficult and resulted in a poorer experience for them. It was easy to appreciate why parents would rather be seen face-to-face than online to have a satisfactory experience when the video consultations has a lack of physical examination and assessment by the professional of the child's development and health.

6.4.1.2. ‘Box Ticking’ and Theme ‘hadn’t met the health visitor before’.

Families appreciated video consultations *if* it was for transactional purposes such as advice giving or managing minor illness (iHV 2021), but this does not chime with the parents’ experience in this study. Parents described their video consultation as being perfunctory, transactional, and lacking in conversational attributes, with closed questions and sometimes the health visitor was obviously reading from a list or ticking boxes. This may have been the style of the health visitor, but it is possible to see that it may also have been a result of the nature of the video consultation especially considering Heidegger’s (1962) philosophy discussed above concerning ‘*presence*’.

Parents described the *tick box* element of the video consultations eloquently and in some detail in chapter 5. Through the narrative, the parents said, that at times, the health visitor was reading from a script or list of questions, and this interrupted the eye contact necessary for the rapport (Parent Heidi). Hvidt et al (2022) participants also commented on the importance of eye contact on the screen and how this made them feel they had the full attention of the professional which increased their satisfaction with the video consultation. Mold et al (2019) agreed with this and stated that practitioners who multi-tasked by writing and talking could lead the patient to feel they were not engaged or attentive in the video consultation. McCabe (2004) agreed and found that patients prioritised patient – centred communication as being effective for them. Parent Kay described having a mental health questionnaire read to her on her child’s health review video consultation to see if she had postnatal depression. She found she disengaged from the monotonous tone, designed not to influence the answers, and gave replies that she felt were expected, she acknowledged it was ‘*terrible*’ of her not to take it seriously but found the exercise very difficult to relate to. Contrary to parent Kays’ experience, the scoping review literature found that mental

health services have been using video consultations for decades (Johns et al 2021) so it would be fair to assume this tendency to disengage is not widespread for everyone or that additional training on skills for online communication for professionals is provided to ensure a more positive experience. This demonstrated how important the persons' experience is of video consultations and how it should be individualised to their circumstances and preferences.

Hadn't met the health visitor before

The parents in this study described their video consultations as a *tickbox* exercise, the literature scoping studies do not report box ticking an element their participants experienced although a number do reference the importance of rapport with the professional (Ewart et al 2022 and Thiyagarajan et al 2020) and in most cases felt that knowing the professional before the video consultation was an essential element to its success (Donaghy et al 2019; Hvidt et al 2022). Not unusually, and possibly due to resourcing issues (Whittaker et al 2021) or being a first-time parent, none of the parents had known their health visitor before the video consultation to build a relationship so all were trying to establish this, virtually, during the call. The iHV (2020) found that the main drivers of dissatisfaction in surveyed parents was lack of continuity of health visitor and appointments feeling rushed. The Government (2021), in their delivery model for health visiting and school nursing, also emphasised the importance of continuity of health visitor for parent satisfaction. Ignatowicz et al (2019) agreed that an existing relationship with the professional helped video consultations work best for patients.

The literature in the scoping review identified a theme around the need for a pre-existing relationship with the practitioner with 10 of the 15 articles citing this as an

issue raised by their participants. It was felt important (Donaghy et al 2019), and, in some cases, a ‘prerequisite’ (Hvidt et al, 2022 p4) but some participants preferred to know the professional and found this increased trust when having a video consultation (Lindberg et al, 2007, Imlach et al, 2020 and Trace et als, 2020). Powell et al (2017) and Ewart et al (2022) felt that the relationship needed to be long term before a successful video consultation could be completed and Christiansen et al (2022) and Christensen and Danbjørg (2018) required a first meeting to be face-to-face to build the relationship. In contrast, Sutarsa et al (2022) participants, felt that the deep caring relationship achieved by face-to-face consultations did not translate into video consultations even with experienced practitioners. Slater-Robins (2024 p182) opined that parents were tired of video interactions post pandemic and were wanting a real live person to ‘see, hear and touch’. The parents in this study said the health visitor was friendly and professional, an element the literature concurred with is important for relationship development, especially online, (Sevean et al 2008, Sutarsa et al 2022, Hvidt et al 2022). Most felt they were given time to ask their questions and received advice and reassurance, (parents Naba, Anna, Oona, Ivy, Abe, Tia), which is also an important point raised in the literature for achieving a positive experience (Morton 2020, Lüchau et al 2021, Sevean et al 2008, Lindberg et al 2007, Trace et al 2020, Ewart et al 2022). As a health visitor and commissioner of a health visiting service the lack of continuity of clinician is a concern as it is so deeply felt by parents to be useful and vital to building a therapeutic trusting relationship (Whittaker et al 2021).

Overall, it was clear from the parents’ reports that the video consultation experience was unsatisfactory and generally ‘*underwhelming’* (parent Anna). The *tickbox* style would have contributed to this feeling and was compounded by the parents not knowing the health visitor before the video consultation to establish a therapeutic

relationship. Heidegger's '*Dasein*' is a shared world and articulated '*being–with'* in terms of being with others and how they interact and communicate with each other (Dahlstrom 2013). In this study the parents found the '*being-with'* on a video consultation was not a substitute for physical presence.

6.4.1.3. 'Technological issues or logistics'

Technical issues experienced by the health visitor and parent on the video consultations were many and varied and ranged from being cut off from the call to poor quality sound and time delay. This element is also reported in the literature and was a dominant theme across several studies, for example., poor sound quality, time lags, frozen screens, having old equipment and internet signal problems were all identified (Trace et al 2020, Johns et al 2021). However, there is a national commitment to moving towards a more digital offer in health services with the NHS Long Term Plan (NHSE 2019) detailing the commitment to creating digitally enhanced health and care services where technology is perceived to be positive for more cost-effective and efficient services.

The issue of patient familiarity with technology having an impact on their experience has been highlighted (Donaghy et al 2019, Sutarsa et al 2022, and Christensen and Danbjørg 2018). Parents in this research felt they were all technologically confident, but it was something parents Oona, Naba, Tia and Dee mentioned as being a consideration; they discussed its relevance to digital exclusion and inequality and the impact of video consultations on this cohort of parents, a view also shared by Cronin (2024) in terms of healthcare provision. The Parent-Infant Foundation et al (2021) reported that digital exclusion remained a concern for low-income families who are less likely, due to lack of equipment or connectivity, to have access to digital mediums

and therefore could miss out on vital services. This is an area of consideration for commissioners of health visiting services when writing service specifications because there needs to be provision made for all parents to access the services and receive the necessary advice, support, and help (Slater-Robins 2024).

Johansson et al's (2017) study noted that patients were the least active participants on a video consultation, making fewest comments and asking minimum questions, suggesting that they were participating to a lesser extent than professionals. This may be for varied reasons including the points the parents made in their interviews; parent Oona described the experience of being held in a virtual waiting room and the uncertainty of whether they had logged into the right link which made her unsure at the start of her consultation which supported findings from Hvidt et als (2022) research. There were logistical issues reported such as arranging the phone so the parent and child could be seen or retrieving the child during a call when they had run off. Which could make it difficult for parents to fully participate in the call in a way the professional would not experience, putting them at a disadvantage.

Heidegger (1977) in his essay 'The Question concerning Technology' suggested the purpose of technology was to unlock energy, maximise output while controlling input and to accelerate processes, he was not commenting on virtual technology and in 1977 this is not surprising as it was not in common use then. He was considered to be against technology, warning that in trying to manipulate technology, we become victims of its effectiveness (Brassington 2007). He encouraged us to engage with and think about the meaning of technology and consider the possibility of technology to do harm as well as good, *'everything depends on our manipulating technology in the proper manner as a means'* (Heidegger 1977: p5) otherwise we risk losing the focus on *being* as we are taken over by technology and its impact. The tenets of his

philosophy are relevant to video consultations, as he encompassed the notion of revealing, whereby a form was given to something that otherwise would remain hidden. He felt that modern technology revealed and '***brings forth',*** so it can then become a tool of modern industry. Stone et al (2023) felt that optimisation and efficiency of interactions become the purpose and can overrule the care needed towards the human and the environment. It's possible to see from this how technology, namely video consultations, could be regarded as restricting our way of thinking and *being* in a Heideggerian sense (Dreyfus 1995) and how this might have impacted on the parents' experience of their children's health review in this study. The parents, specifically Lucy and Heidi, reported that they felt the video consultation was partly responsible for their poor experience and that a face-to-face appointment would have given them a different outcome for example, an earlier diagnosis.

The technological issues and logistical problems really overlap into the constitutive pattern 'feeling the burden of responsibility', because when the connection was poor or the logistics of showing the child or baby on the camera was difficult, then the health visitor could only '*take the parental word for it'* (parent Naba) and the responsibility rested on their shoulders. It may be that within healthcare, the focus might be on efficiency, safety, and cost, meaning there would be a lack of a phenomenological perspective in considering the holistic needs of parents (Carel 2011, Sveneaus 2013). This highlights the need for patient involvement when planning and designing services in the future (Cronin 2024). Heidegger (1977) wanted us to engage with technology with thought and not subconsciously, recognising it as a '*way of disclosing and revealing being'* (Moran 2000: p244).

6.4.2. Relational Themes

Relational themes are present in most of the interview narratives, and the following will now be synthesised with the findings: convenience; big moment or important visit; impact of COVID-19 and a risk assessment performed by the health visitor.

6.4.2.1. 'Convenience'

Only parents Anna and Naba really considered convenience a factor with Naba caveating that video consultations would only really be suitable for a '*check-up'*. However, it was a strong theme in the literature, with 12 of the 15 adult patient studies reporting that it saved time including getting ready for the appointment (Donaghy et al 2019) and it saved travel for appointments which could be six-to-eight hours for each visit (John et al 2021). Participants reported loss of working hours (Christensen and Danbjørg 2018, Sevean et al 2008); and that it saved money both for time off work and travel costs (Powell et al 2017). Some participants reported video consultations increased the flexibility around appointments (Hvidt et al 2022) while other patients observed it reduced uncertainty about finding the venue (Christiansen et al 2022). Finally, participants reported that relatives who were not present with the patient could join the link to take part in the consultation which was felt to increase the support they received (Funderskov et al 2019).

The Professional Records Standards Body (2020) found patient groups reported that convenience was most important for those with a physical disability due to accessing venues. The difference between the experience of adult patients and parents of pre-school children was most pronounced within this theme. Feger (2021) noted that the rise of video consultations was a useful tool for health visitors and parents especially those with new babies or where the whole family wished to contribute. The parents in this study placed the importance of an assessment by the health visitor including a

physical examination or observation, above any inconvenience of attending a face-to-face appointment.

6.4.2.2. ‘Big moment or Important visit’

The parents in this study felt that the video consultation health review was an important interaction with the health visitor, parent Anna, reflected on the importance of having their child’s health review and how, especially during the coronavirus pandemic, they relied on the health visitor for advice and support. Parents found the advice and guidance regarding their child’s development invaluable (Parent-Infant Foundation 2022). The scoping review did not identify any literature regarding whether participants considered it an important or valuable moment or visit. This might be a unique aspect of parents finding out how their child is developing which is something they may not already know. As a health visitor conducting this research, this was an interesting point because for the professional the appointment was routine and one of many conducted that day. For some parents, however, it was obviously an important milestone in their child’s health and development journey and as a significant appointment they would be disappointed if their reality was a poor experience.

Most parents could see that their child was doing well compared to others in their social networks, and this was how parents Naba and Dee measured their children’s progress, but the nuances of child development would be illuminated by the health visitor in the health review assessment (Appleton and Cowley 2008). Parent Anna was left feeling ‘*underwhelmed*’ by the video consultation health review which Evans (2020) analysis piece agrees with, as he acknowledged that not all parents were suited to a video consultation. The iHV (2020a) noted that parents found the health visitor service provided an important part of a joined-up response to address their needs and was

felt to be valuable, this was a view shared by parent Ivy, as she felt that it is the only service that can universally '*interact, identify, support'* and was therefore a vital service.

6.4.2.3. 'Impact of COVID-19 pandemic'

The parents had all been affected by the COVID-19 pandemic in some way. The health visiting services in England implemented the National Health Service & Improvement (NHS&I) clinical guidance (2020) during the pandemic and many were redeployed to hospitals leaving caseloads uncovered. They had to use different ways of working and health visitors thinking in innovative ways to see and help parents e.g. meetings in the park or on their front path. Parents Kay and Abe's firstborn was discharged from hospital the night before the first lockdown leaving them with little support and advice for the first few months. Several parents missed or had health reviews online during lockdowns, with no option for a face-to-face appointment; this was common practice as health visitors adapted to the altered service delivery required during COVID-19 (NHSE 2020). The literature reflects the growing use of video consultations during COVID-19 with a surge in published research, during and after the pandemic charting how services and patients coped with new models of service delivery (Ewart et al 2020, Sutarsa et al 2022, Christiansen et al 2022, Imlach et al 2020, Hvidt et al 2022). Heidegger (1977) warns that humans can become a victim of the success of technology and should guard against its impact on their '*being*' or becoming too dependent on it. Parent Kay felt that video consultations post pandemic should be used with caution and under strict guidelines and the Parent-Infant Foundation (2022 p6), found that post-pandemic health visitors needed to see parents in person '*to build trusting relationships; to observe early interactions; to understand parents' wellbeing;*

to assess a child's development, growth, and physical wellbeing' and that use of online mediums should be used with care.

The NHS (2020 a, b and c) issued guidance for professionals using technology with some guides for best practice and the iHV (2020) published key principles for health visitors for supporting video consultation practice. In this study, some parents were more tolerant of video consultations when they knew there was no choice of having it face-to-face, but it did not make it popular with them. Hvidt et al (2022) reported that patients felt a video consultation was better than nothing and several parents discussed this in their interviews.

The Parent-Infant Foundation et al, found in their report in 2021 that during COVID-19, only 11% of parents with a child under two had seen a health visitor face-to-face, which left the parents' feeling unsupported, isolated, and let down. This was certainly one parent's experience as she explained she didn't really think there were any health visitors left and the one she had seen was *'out of retirement to help'*. She asked her health visitor team if she could take her baby to a child health clinic but was told 'no' because her baby had not been born prematurely. One parent described their experience of feeling alone and unsupported, especially around breastfeeding and co-sleeping with no one to confide in or seek advice from. This was a common experience during the COVID pandemic, and it led to parents feeling loneliness, depression, and anxiety (iHV 2021). This research study, conducted in 2023, was a snapshot in time post COVID-19 but it was noted that some of the video consultations, discussed by parents, took place during the data collection phase which was two years post COVID-19 restrictions.

6.4.2.4. ‘Risk assessment by the health visitor’

This theme, unsurprisingly, was not reflected in the scoping review literature as there were no evidence-based studies researching the health visiting service and video consultations. The parents understood the health visiting service conducted a caseload needs assessment and categorised the families according to vulnerability (Conti and Dow 2020). This knowledge traversed both the health professional parents and the children’s social worker parent as well as two lay parents. It served to prepare the parents for their video consultation as they perceived that vulnerable or safeguarding children and families would receive the face-to-face health reviews and clinic attendance appointments.

While there was no reference, in the scoping review literature, to risk assessments by health visitors there is research by Morton and Adams 2022, Parent-Infant Foundation et al 2021 and Conti and Dow 2020 warning of the risks to families of video consultations. They say that problems and vulnerabilities including domestic abuse and mental health issues are unable to be satisfactorily identified and assessed. Parent Kay was particularly concerned about the risk of domestic abuse being undetected and how it would be screened for if there was no way of knowing, on a video consultation, who was in the room. This is a view shared by the iHV (2021) where considerable concerns were raised about the ability to identify these issues on a video consultation. The Government (Gov.UK 2021) has issued guidance for commissioners and providers of the health visiting services in England to return all child health reviews to face-to-face due to the concerns regarding assessment of vulnerable children online but as this research demonstrates in reality, the use of video consultations continues in practice.

6.5. Summary

Using an Interpretative hermeneutic phenomenology approach has enabled the lived experience of ten parents who had all had a video consultation with a health visitor, for a child health review to be explored, illuminated, and understood. It has brought forth a phenomenon that the burden of responsibility is on the parents' shoulders to know how their child is doing and if they are healthy, well and developing normally. This links to Heidegger's philosophy on the meaning of '*presence*' which in this context is felt to be disrupted by the lack of physical presence due to the health review being conducted using a video consultation.

Hermeneutic Phenomenology is not about finding *the* answer, it is the study of human relationships, their meaning, the context of those relationships and presenting these as they are experienced (Dibley et al 2020). The purpose is not to generate theories or generalise but to make sense of and understand the different ways a human can '*be–in–the–world'* (Crowther and Thomson 2022). Heidegger (1962) referred to this as '*Dasein*' where humans were concerned with their own existence but also understand that other things exist in the world. The parents' narratives tell us what it felt like for them to receive the health review online and from their lived experience they have shared what it meant to them to be communicated with in this way. As a health visitor and commissioner of a health visiting service the phenomenon delivered an 'ah ha' moment (Smythe et al 2007 p1392) because it is understandable that the parents felt this considering the discussion above. Overall, all would have preferred the option of face-to-face rather than a video consultation, especially when they had not previously seen anyone regarding their children, or they had concerns about their health or development.

This study has contributed to the evidence-base and knowledge in this area and in the researchers knowledge, is the first study to explore parents' experiences of child health reviews in England with a health visitor using video consultations. Other published literature is from the professional's point of view, the experience of adult patients or using other forms of virtual communications, like telephone or email. It has also added to the body of research using Heideggerian hermeneutic phenomenology embedding its philosophy and methodological approach. Chapter 7 discusses the recommendations for the future, both for research and practice.

6.6. Strengths of the study

This study adds to the body of published literature in two areas, firstly as a Heideggerian hermeneutic phenomenological methodological approach which has taken Heidegger's philosophy and other researchers' interpretations on *technology*, *presence*, *present-at-hand and nearness* to shape the research study and interpret its findings. After studying courses with published experts and following the practical guide by Dibley et al (2020) in relation to data collection and analysis it has facilitated the data leading the study (Smythe 2011), especially in the findings and discussion chapters, to produce a piece of research that is aligned to the methodology. As such this study adds to the body of published research for future hermeneutic phenomenological researchers.

Secondly, the study has provided and contributed to the evidence-base in health visiting research and published literature, especially from the viewpoint and experience of parents. There is a known scarcity of health visiting literature to inform evidence-based decision making and planning (iHV 2021) and this study, while not

conclusive, provides a contextualised view of parents' experiences of video consultations which had not been completed before so will help shape practice in the future.

Thirdly, having the research conducted by a registered health visitor and commissioner of health visiting services gives additional credibility to the findings due to the depth of knowledge being drawn upon during the different phases of the study. While this could also be perceived as contributing to bias, especially as the parents were aware the research was for a professional doctorate in public health (health visiting), (Participant Information Sheet Appendix 7). With the help of the reflexive journal and using the hermeneutic phenomenological methodological approach it became a strength.

6.7. Limitations of the study

This study has five limitations. Firstly, to broaden data collection techniques by including a survey. Secondly, the purposive sample came from only two regions in England. Thirdly, the researcher is a health visitor and commissioner which could introduce bias. Fourthly, the interviews were conducted online despite being about online consultations. Finally, being a novice in hermeneutic phenomenologist research and the impact this has on the study.

In hermeneutic phenomenology, limitations are less relevant because a conclusion is not being sought (Smythe 2011). Findings are not representative but specific to that sample of participants, they prompt more questions and there is always more to be understood. However, most things can be improved, and this research study is no exception.

Firstly, it would, perhaps, have been desirable to broaden the data collection techniques so that a survey was distributed for gathering macro data on people's views of video consultations with a health visitor. From the survey, respondents would have given their personal details to be interviewed about their experience. This would have provided a wider view of the impact of having a video consultation on parents. Qualitative research and especially hermeneutic phenomenology can be undertaken using small sample sizes and generates rich personalised experience data (Smythe 2011). Having a broad range of views first to then focus in on peoples' experiences would possibly have enhanced the research findings.

Secondly, the purposive sample was recruited via social media and the parents who volunteered to participate came from two regions in England: London, and East Anglia. While not problematic in itself and was the result of the way social media advertises and works, it does call into question the transferability of the findings to other regions and health visiting teams. Further research would be required to determine its relevance to other areas and if the findings were transferable.

Thirdly, the researcher is a health visitor and also the commissioner of a health visiting service in England. This study was distant from the service delivery, with less ability to impact the outcome, but there was the consideration of a conflict of interest which must be acknowledged. Informing parents in the Participant Information Sheet (Appendix 7) that the researcher was studying as a student in Public Health / Health Visiting so they could choose not to take part did help to mitigate for this. Advertising through social media, Children's Centres, and Schools rather than the commissioned provider to recruit parents also introduced a separation between the commissioner role and the research study. The parents knew that the researcher was a health visitor and this was evident in their assumptions that they would understand what they were

talking about, and the parents did not explain technical terms e.g. failure to thrive, centile, health review, ages and stages questionnaire. The researcher acknowledged in the thesis, the impact they, as a health visitor, and their preunderstandings have on the research, the interviews and findings. By choosing Hermeneutic Phenomenology as a research method, they were able to utilise this to inform the study in the fusion of horizons.

Fourthly, the interviews for the research were conducted online. The Participant Information Sheet (Appendix 7) gave parents the option to have the interview face-to-face or online and all chose online for the interview. It was acknowledged with the participants, during the interviews, the irony of having an online interview about their experience of an online consultation. Many reported that this interview felt different because it was not a health review of their child and they felt listened to, heard and were able to fully express their views. It also gave the research a broader geographical coverage as travel was not required and widened its relevance as parents in different areas participated.

Finally, I acknowledge myself as a novice to hermeneutic phenomenology and the hermeneutic style of interviewing could have been improved in some interviews. While trying hard to keep the questions open and exploratory, it is evident in some of the transcripts that with quiet or unsure parents, the interview may have been influenced more than recommended. Or parents were not given enough time to express themselves fully before moving onto the next question. The doctoral thesis was a learning tool for me as a researcher, as well as adding to the body of research, and some of the participants reported they felt listened to and benefitted from the time to discuss it. A more developed phenomenological researcher stance was evident as the study progressed.

Chapter 7 – Conclusion and Recommendations

This research has studied parents' experience of child health reviews by a health visitor using video consultations, through individual unstructured interviews, adopting an interpretive hermeneutic phenomenological approach for all stages. It has identified ten relational themes and identified a phenomenon that the burden of responsibility is on the parents' shoulders to know how their child is doing and if they are healthy, well and developing normally rather than resting with the health visitor as the experienced professional.

This chapter will demonstrate the unique contribution of this study to the evidence-base around video consultations and then make practical recommendations for practice and further research as well as consider the researcher's personal journey during this research study.

7.1. Contribution to Knowledge

This study was significant because it was the first known data collected from parents on their views of video consultations for their child's health review. By using an interpretive hermeneutic phenomenological approach, it explored what this meant for their '*being-in-the-world'* and how it synthesised with Heidegger's' philosophy on '*presence*'. The iHV (2021) acknowledged that there was a gap in the research that explored the use of video consultations for assessing families in their homes where there might be vulnerabilities e.g. development concerns about the child (iHV 2021). This research study has contributed to filling this identified gap.

It was carried out by a researcher with a clinical background not only with knowledge of practice as a health visitor, but also a commissioner of the Healthy Child Programme

(Gov.UK 2023). This gave an individual perspective on current working practices and priorities which brought to the research data collection and analysis an additional layer of expertise to inform the study, for example detailed knowledge of what each health review would consist of and how this might be affected by being online.

The new knowledge about parents' experience of video consultations, that they felt the burden of responsibility to know how their child was doing in the absence of a professional seeing them face-to-face, is contrary to current NHS policy (NHSE 2019 / 2022, Department of Health and Social Care 2022) which is embracing technology to drive efficiencies in the system. Without evidence-based research this would present problems for commissioners and service providers when deciding the best model to implement in practice.

This study has illuminated for the first time, parents' views of a communication method that was imposed on them and the health visitors. It was a legacy from the coronavirus pandemic which they generally do not like, nor feel was fit for the purpose of assessing their child's health and development. This new knowledge must be considered by commissioners and service providers when designing the health visiting offer going forward.

7.2. Recommendations for Practice

Hermeneutic Phenomenology findings are individualised and involve participants' intimate narratives of lived experience (Dibley et al 2020). Sharing the conclusions is done in the spirit that hermeneutic phenomenology does not definitively answer questions but rather provides '*an'* answer and is not designed for widespread application. However, dissemination is the ultimate purpose of research to raise

awareness of the '*everdayness*' of situations which might not have been previously recognised, to illuminate new knowledge, fill a gap, question the unknown and change everyday practice or behaviour (Dibley et al 2020). It is important that this study, with its unique findings into parents' experience and views of video consultations, is shared with the health visitor community.

With this, and my own intimate knowledge of the health visiting service, in the foreground I write the **recommendations** for health visiting practice.

Face-to-face is the *'gold standard'* (Donaghy et al 2019) and video consultations should be approached with caution (iHV 2021, Gov.UK 2021). The parents, supplemented by my interpretations informed by my health visiting and commissioner experience, would like the following guidance incorporated into health visiting practice if video consultations are to continue routinely in the future.

1. Give parents a choice whether they want to have face-to-face or video consultations.
2. Meet parents before the video consultation, to be introduced and build rapport.
3. Make the video consultation conversational and friendly, allowing time for questions and discussion.
4. Make sure the baby or child is seen on camera and interacted with in a meaningful way.
5. If developmental reviews are to continue online, then view a parental video recording of the child beforehand so an assessment can take place about their progress.
6. Give full attention to the parent and child, maintaining eye contact throughout the video consultation.

7.3. Recommendations for Research

Video consultations are commonplace and contemporaneous in health visiting practice with some of the participants' experiences taking place during the research study period in 2023, indicating that it is still in practice in some areas, so the need for further research is critical. Anecdotally, in some parts of London, it's easier to recruit health visitors for virtual work than it is for in-person visits, the reasons for this are unknown but it presents a worrying conundrum for the profession and commissioners as it impacts directly on the ability to deliver the service. It was not possible to transfer the research in the literature scoping review from adult patients to parents with babies and pre-school children because, while some of the findings were similar e.g., lack of physical examination, preferring a relationship with the professional before the video consultation and technical issues, the constitutive patterns and phenomenon were very different.

The recommendation is to address the urgent need for research in this area considering the best mode of delivery of the Healthy Child Programme (Gov.UK 2023) so that if video consultations are unpopular, as they were with the parents in this research, or deemed unsafe due to lack of oversight and assessment by the health visitor, then the practice needs to be reviewed and possibly discontinued after consultation with parents.

The research questions, illuminated by this research studies findings, still requiring an answer are:

1. What is the health visitor experience of video consultations?
2. Are video consultations safe for children?

3. If considered safe for children, who should receive a video consultation and in what circumstances should it be face-to-face.

7.4. Personal Learning and Reflection

I am often asked why I chose to do the doctoral programme when it entailed years of work, frustrations, disappointments, and cost. I've done it for self-development and because I really wanted to know an answer to the research question. There would have been easier ways to achieve both, I could have done a short course at a local college and an evaluation at work. But I have never taken the easy path in life and so a doctoral programme seemed an interesting way to achieve my goals. The start of my reflexive journal was in the summer of the first year and just said '*round and round*!' it appeared from other notes that I was deciding my research methodology, and it wasn't going well.

By January 2022, I was clear that Hermeneutic Phenomenology was the match for my ontology and the research question which had also evolved. After the taught elements of the professional doctorate were completed, I was able to focus on the research proposal and applied for ethics, I recognised these built on the learning of the first two years. I started reading around the subject and watching webinars on both hermeneutic phenomenology and how to navigate a doctoral programme and thesis.

I've written in my journal that hermeneutic phenomenology felt like *"a square peg in a round hole and will need adaptations"* as I researched more, I found different ways it had been applied and settled with the decision. Hermeneutic Phenomenology has been a revelation, if anyone had told me that as part of the programme, I would be reading impenetrable German philosophers and writing a poem I would have run away

but that's part of the self-development and I have learnt to philosophise through the lens of hermeneutic phenomenology.

The turning point was meeting Professor Dibley who brought hermeneutic phenomenology to life in an approachable and pragmatic way, and I was totally enthused. My journal recorded:

Figure 21: Excerpt from Reflexive Journal – September 2022

> *"Excitement! – Professor Dibley has agreed to chat with me… how do I do authentic research? Is my personality type relevant? If I want to challenge my comfort zone is that OK? So many questions! …. Amazing lady, reassuring, and validating, after speaking to her I feel validated in my research question, style, and ontological position."*

It was not until I had interviewed my first participant that I finally shook off imposter syndrome and considered myself a researcher. My confidence grew and my excellent supervisors noticed and encouraged me in my studies, praising my enthusiasm, organisation and thoroughness which helped me feel a sense of achievement.

Recruiting the ten participants felt like the hardest part and the poem in figure 8 demonstrates the frustrations felt and the angst this phase caused. In hindsight, although it was a pivotal moment for the study, it had been easy to attract people to be interviewed and I soon had them consented and recorded. I loved conducting the interviews, once I had overcome my nerves about whether they would log on, the hermeneutic phenomenology style of interviewing and potential technical issues, I found them inspiring, rewarding, troubling, and thought provoking.

Transcribing was a necessary activity to lead me to the data analysis and Professor Dibley and my supervisors shared some more sound advice about how to approach

this element. I enjoyed writing the interpretative summaries and the immersion in the narratives to find the themes then piecing them all together to discover the constitutive patterns. Initially, dwelling in the data was daunting as I didn't know exactly what that meant or what it would tell me and was surprised when the phenomenon started to reveal itself in the narratives of the participants while I was doing everyday activities like exercising or gardening. I grappled with my role in interpreting the parents' narratives especially when they appeared to be critical of the health visitors' interpersonal skills and practice. I concluded that it was not my place to judge the practitioners based on the third-party accounts in the interviews and it did not further my quest either to explore parents' experiences or to answer the research question. True to Heidegger's philosophy it was the ordinary '*everydayness'* that could so easily be overlooked that was felt to be important by the parents and I had *an* answer to the research question.

Linking Heidegger's philosophical notions was challenging as I had to read extensively to understand his work and I was aware I did not have the depth of experience that I knew was required for this. Part of the doctoral learning was to challenge my comfort zone, and this part of the process was very challenging. Technology was an easy one to match and understand with a plethora of literature about it, but '*presence*', '*ready-at-hand'* and *'nearness'* required a deeper level of thought and understanding, but as I grappled with his philosophies and the academics who interpret his writing for general consumption it began to become clearer.

Re-reading the transcripts and mulling over the reading about Heidegger's philosophies I recorded in my journal a moment of illumination helped by the literature:

Figure 22: Excerpt from Reflexive Journal – September 2023

> *"On reflection, I'm conscious of Professor Dibley's words that I will know when I've finished because 'it will stop bothering me'. While I'm happy parental assessment, technology and tick box are the constitutive patterns I feel I've arrived there by frequency counting (Crowther and Thomson 2020). So, re-reading the article to gain more clarity about the interpretive leap, it seems it is achieved via the philosophical notions, ones which help to illuminate meaning inherent in the interpretive summaries avoiding a square peg in a round hole"*

For the writing up phase, I turned to my supervisors and online webinars by academics to talk me through the process and read books about how to complete a doctoral thesis in chapter chunks so as to not feel overwhelmed by the task. Concern about the technology was a bubbling issue as I struggled with producing tables and charts that would not conform to my expectations, I was helped by a generous friend to format the thesis which relieved a lot of that anxiety and left me able to concentrate on the content, grammar and phrasing.

I've learnt so much during the doctoral studies about myself, research, philosophers, the academic world and how to keep a project on track. I've immense gratitude and awe for the parents who gave their time so generously to be interviewed and feel a great sense of responsibility to treat and represent their narratives with respect and honesty. I had not expected to get this far and have people read a finished thesis and am so proud of myself for my tenacity, curiosity, determination, and ability to stay enthusiastic and engaged even during the hard parts.

7.5. Summary

"Think deeply and hold ourselves open to possibilities

of what is and what it means to be".

(Dibley et al 2020 Pxviii).

The aim of this research was to explore parents' lived experience of having a child health review using a video consultation, following the interpretative hermeneutic phenomenological approach. This thesis takes the reader through the research process explaining the different elements and justifying decisions made. It is a rigorous piece of research that also presents historical value to the experiences of an aspect of care during COVID-19. In presenting it here, it is hoped that the academic community will value it, and professionals will refer to it as evidence for future practice.

Ten participants were interviewed using an unstructured approach and ten themes emerged from the data, they were analysed in Chapter 4 and explained in detail in Chapter 5, they were synthesised with the literature and Heideggerian notions to reveal the phenomenon, '*It was all on my shoulders!'* in Chapter 6. Parents felt bereft of support and a shared sense of responsibility for the health and development of their children, feeling that the health visitor was '*taking their word for it'* (Naba) in the absence of being physically present with them.

Speaking to health visitor and commissioner colleagues the findings achieved the 'phenomenological nod' (van Manen 2016), demonstrating that the research resonated with people as sounding credible. The best way to carry out a video consultation, which is sensitive and skilful towards the patients' needs ensuring they

feel confident and safe, is yet to be decided (Christiansen et al (2022) but this research contributes to the evidence base.

The research will be disseminated through conferences and publications in professional journals to ensure it is available for future researchers, professionals, and Healthy Child Programme services to inform their thinking and delivery of health visiting.

Thank you for reading.

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APPENDICES

Appendix 1 – Search Terms and Results

Searched MEDLINE and CINAHL, e- journals, open dissertations. **Health Visitor / Parent**			
SPIDER / Boolean Operator	Term	Results	Comments
S, PI	Health Visit* OR SCPHN OR HV Parent* OR Client AND experience of Video consultation AND experience of video consultation OR virtual consultation	11,142	Too many to review
AND D,E,R	Health review AND perceptions OR views OR attitude	8,874	Too many to review
New search on Medline and CINAHL			
	Health Visit*	6	0 met criteria for inclusion
AND	Parent		
AND	Health Review		
AND	Video consultation		
OR	Virtual consultation		
COCHRANE Library			
	Health Visit*	0 changed to 'All text' = 3	0 met criteria
AND	Parent		
AND	Health Review		
AND	Video consultation		
OR	Virtual consultation		
Open Grey			
Search as above		0	0

Searched MEDLINE and CINAHL, e- journals, open dissertations. **Health Visitor / Parent**			
Wiley ON- Line			
Search as above		Search in Key words and 0 returned	0
APA Psych Info			
Search as above		0 in abstract and again in all text	0
MEDLINE			
As above		276	All reviewed and 0 met criteria
CINAHL			
As above		0	0
Taylor and Francis			
As above		362 in all text 0 in abstract	0
Sage Journals online			
As above		115	0 met criteria
PubMed			
As Above		Search in Key words and 0 returned	0
Separate searches of BING, Community practitioner, Nurse researcher, Journal of Health Visiting			
As Above		0	All searches returned 0 results
Google Scholar			
Full research title		0	
		0	

Searched MEDLINE and CINAHL, e- journals, open dissertations. **Health Visitor / Parent**			
‘Parent experiences of child health reviews using video consultations ‘Parent experience of using video consultations		7	7 not met criteria but relevant as context documents.
Google			
As Above		2	0 met criteria
Total		**771**	**0 met criteria**

Searched MEDLINE and CINAHL, e- journals, open dissertations **Patient**			
SPIDER / Boolean Operator	Term	Results	Comments
S, PI	Patient*	449 titles reviewed	5 met criteria
AND	Experiences		
OR	Perceptions		
OR	Attitudes		
OR	Views		
AND	Video consultation		
OR	Virtual consultation		
APA PsychInfo			
As above		129	0 met criteria
Cochrane Library			
As above		0	0
Wiley – On -Line			
As above		0	0
Taylor and Francis			
As above		0	0
Sage Journal online			
As above		0	0
PubMed			
As Above		Search in Key words and 0 returned	0
Separate searches of BING, Community practitioner, Nurse researcher			
As above		0	0
Google Scholar			

Searched MEDLINE and CINAHL, e- journals, open dissertations **Patient**			
Patient experience of using video consultations		1	1 scoping review met criteria
Google			
As above		0	0
Total		**579**	**6 Met criteria**

Appendix 2 - Data Charting Form – Summary of Results

(Pollock et al (2021) and Arksey and O'Malley (2005) and Joanna Briggs Institute (JBI 2020))

Abbreviations in table

F-F= Face-to -ace, VC= Video consultation, GP= General Practitioner, T/C= telephone call, HV= Health Visitor/Visiting

	Article title, Author, year of publication and Journal and study location	**Intervention type** **Duration of intervention**	**Study populations/ participants**	**Aims of study and research methods** **(Context and concept)**	**Methodology** **Inclusion / Exclusion criteria, Sampling** **Ethics process**	**Results / Outcome measures / evidence of effectiveness**	**Strengths and Limitations**	**Gaps in research or key findings**
1.	Donaghy, E. Atherton, H. Hammersley, V. McNeilly, H. Bikker, A. Robbins, L. Campbell, J. McKinstry, B. 2019. Acceptability, benefits and challenges of video consulting: a qualitative study in primary care. UK.	Pre COVID-19 Semi structured Interviews Intervention using 'Attend anywhere'.	21 patients were interviewed. 13 clinicians were interviewed. 6 GP practices in Lothian, Scotland	To explore patients' and clinicians' experiences of video consultation. To explore how video consultations varied from F-F and T/C in terms of length and contact.	Semi structured telephone interviews within 7 days of video consultation. Braun and Clarke Thematic analysis. Recruited by clinician and had to be over 16, needing a follow up consultation but not a physical examination. They had to have an email address and internet	Results – patients reported positive experiences and particularly helpful when working as saved time. Visual aspect of video helpful for picking up cues and also more formal and focused.	Strengths- Experienced team, area of importance and general interest. Limitations – Self selection of participants, access required to expensive technology to take part raising equity issues.	Key findings Generally positive. Participants reported being comfortable with the technology e.g., skype but felt awkward in a virtual waiting room. Video consultation must be more reliable and seamlessly integrated with healthcare systems. For more complex or sensitive problems then face- to-face is

	Article title, Author, year of publication and Journal and study location	Intervention type Duration of intervention	Study populations/ participants	Aims of study and research methods (Context and concept)	Methodology Inclusion / Exclusion criteria, Sampling Ethics process	Results / Outcome measures / evidence of effectiveness	Strengths and Limitations	Gaps in research or key findings
					connected computer. Ethics – obtained from the West of Scotland research ethics committee.			preferable and seen as 'gold standard'.
2.	Johns, G. Burhouse, A. Tan, J. John, O. Khalil, S. Williams, J. Whistance, B. Ogonovsky, M. Ahuja, A. 2021. Remote mental health services: a mixed methods survey and interview study on the use, value, benefits and challenges of a national video consulting service in NHS Wales, UK. BMJ Open.	1 year of data. March 2020 to March 2021. Survey and Interview data of clinicians and patients. Survey (1) – 6 questions for quality rating the video consultation using a likert scale. Survey (2) measured the	3561 participants. NHS Wales Technology Enabled Care for mental health services. Interviews with 81 participants.	Mixed Methods Aim was to extract and analyse mental health specific data from a national data set for 1 year. To capture use, value, benefits and challenges of Video consulting.	Not specific in methodology and philosophical underpinning. Used opportunity sampling i.e. those who answered a survey after being emailed a link. Interview participants were recruited from the surveys where participants gave consent to be contacted.	82% respondents (both patient and clinician) rated the quality of video consultation as excellent, very good or good. 87% said the video consultation appt had prevented the need for a face-to-face one. The highest rated *benefits* in survey (2) from patient were lower risk of infection (COVID-19 89%); no travel or parking; better for environment and	Strengths – mixed methods, large and representative sample for Wales. Limitations – small sample size of some of the cohort e.g. older people. Possible duplication in people completing the survey. Limited demographic information.	Key finding That video consultation is possible both technically and behaviourally for mental health services in Wales. It has a high level of satisfaction and acceptability *especially with patients.* Gaps in research

	Article title, Author, year of publication and Journal and study location	Intervention type Duration of intervention	Study populations/ participants	Aims of study and research methods (Context and concept)	Methodology Inclusion / Exclusion criteria, Sampling Ethics process	Results / Outcome measures / evidence of effectiveness	Strengths and Limitations	Gaps in research or key findings
	UK	benefits and challenges of using video consultation using percentage rating. Follow up Interviews of 81 participants who agreed on the survey to be interviewed.			Inclusion and exclusion criteria not given in paper. Ethics approval gained from the Health Board in Wales.	more convenient (83%) lowest rated were better family support (42%) and no time off work / school (56%) Highest *challenge* was preference for face-to-face appointment (24%). Patients saved a total of 1254 hours of travel. Narrative from interviews Interesting relationship between preference and perceived value. Impact on lowering stress and managing own care.		Which mental health conditions are most suited to a video consultation. Efficacy of blended (video consultation and F-F) approaches. Interesting relationship between preference and perceived value.
3.	Funderskov, K. Raunkiær, M. Danbjørg, D.	6 Months duration. October 2016	11 Patients and 3 relatives. 86	To clarify if, when and how the use of video consultations	Explorative, qualitative study. Descriptive	Video consultations are feasible and facilitate a strengthened	Strengths –	Video consultations are feasible and facilitate a strengthened

	Article title, Author, year of publication and Journal and study location	Intervention type Duration of intervention	Study populations/ participants	Aims of study and research methods (Context and concept)	Methodology Inclusion / Exclusion criteria, Sampling Ethics process	Results / Outcome measures / evidence of effectiveness	Strengths and Limitations	Gaps in research or key findings
	Zwisler, A-D. Munk, L. Jess, M. Dieperink, K. 2019. Experiences with video consultations in specialised palliative home-care: a qualitative study of patient and relative perspectives. Journal of medical internet research. Denmark.	to March 2017. Participant observations during the video consultation followed immediately by semi-structured interviews.	video consultations were conducted.	is feasible and to explore the use of video consultations, experienced by patients and their relatives, as part of specialised palliative care teams at home.	phenomenological approach using Giorgi's 4 steps. Thematic analysis using NVivo. Inclusion criteria – over 18, with a need for specialist palliative care, agreed to participate and use a tablet. Excluded if too cognitively impaired to take part. Purposive sampling. Ethics – Study registered with Danish Data Protection agency.	involvement and communication between patients, relatives and specialist palliative care teams. 3 main themes: 1. Becoming an active patient in own care. 2. Video consultation strengthens communication, despite technical difficulties. 3. Gaining access for relatives.	Combination of participant observations and interviews varied the data collection. Taking a phenomenological approach helped maintain openness and putting preconceptions to one side. Limitations – only one specialist nurse recruited to the study and when she was not available patients were not recruited.	involvement and communication. Early exploratory study – could lead to a quantitative study by helping the development of a questionnaire. Also to investigate health care professionals feasibility in their work and organisational changes that would occur with implementing video consultations.

	Article title, Author, year of publication and Journal and study location	**Intervention type** **Duration of intervention**	**Study populations/ participants**	**Aims of study and research methods** **(Context and concept)**	**Methodology** **Inclusion / Exclusion criteria, Sampling** **Ethics process**	**Results / Outcome measures / evidence of effectiveness**	**Strengths and Limitations**	**Gaps in research or key findings**
4.	Sevean, P. Dampier, S. Spadoni, M. Strickland, S. Pilatzke, S. 2008. Patients and families experiences with video telehealth in rural / remote communities in north Canada. Journal of clinical nursing. Canada.	1 year - 2006 Semi-structured interviews January to March 2006.	10 patients and 4 family members from a range of specialities and several remote communities.	To explore patients and families experiences of telehealth consultations as a method of healthcare delivery in rural / remote communities in northern Canada.	Qualitative approach and thematic content analysis. Purposeful sampling. Inclusion criteria: age 18 or over, physically and psychologically able to participate, had participated in a video consultation in last year and willing to share experience. Ethics- Obtained from University and regional hospital ethics boards.	Video telehealth is an effective mechanism for delivering nursing and other health services to rural / remote communities. The integration of telehealth practice can enhance coordination, organisation and implementation of health care services. 3 main themes – 1. Lessening the burden (costs of travel, accommodation, lost wages and time, physical limitations) 2. Maximising supports (access to family, friends, familiar home environment,	Strengths – Not detailed. Limitations – difficult to generalise and transfer findings as small and geographically focused sample. Interviews conducted through same video consultation medium as consultation.	Telehealth is still being used as a complementary service and has not achieved its full potential to positively impact the delivery of everyday healthcare. The WHO recognises that telehealth can contribute to better health outcomes – but care must be taken not to create new inequalities or unnecessary health services.

	Article title, Author, year of publication and Journal and study location	Intervention type Duration of intervention	Study populations/ participants	Aims of study and research methods (Context and concept)	Methodology Inclusion / Exclusion criteria, Sampling Ethics process	Results / Outcome measures / evidence of effectiveness	Strengths and Limitations	Gaps in research or key findings
						nurses familiar to the patient) 3. Tailoring specific e-health systems to enhance patient experience.		
5.	Sutarsa, N. Kasim, R. Steward, B. Bain-Donohue, S. Slimings, C. Dykgraaf, S. Barnard, A. 2022. Implications of telehealth services for healthcare delivery and access in rural and remote communities: perceptions of patients and general practitioners. Australian journal of Primary Health. Australia.	Patients of GP surgeries within the rural are of interest. No duration of the study is given but interviews were between 30 and 60 minutes.	13 participants interviewed from 3 local health districts in rural Australia. 3 GPs and 10 patients were successfully interviewed by telephone.	The study aimed to describe and understand the experiences of patients and GPs using telehealth services in rural and remote settings in Australia. Exploring the conflicting themes around advantages and limitations of telehealth services, patient responses to the assumed narrative that telehealth is the solution and complexity of appropriately	Qualitative study using a phenomenological perspective with data collected via in-depth interviews and data analysed through thematic analysis. Inclusion and exclusion criteria not detailed. All were patients of the GPs who were interviewed. All were over 65 years old, half male, 3 employed, 4 had	Results headings - Fragmented, superficial care and lack of trust - Inequitable access and outcomes - Complementing vs replacing? Participants perceived that the deeper caring relationship achieved through face-to-face **could not** be achieved via telehealth.	Strengths – not detailed. Limitations – due to COVID-19 restrictions study conducted online and by phone leading to some inequity of coverage due to access to technology needed. Only those aged 65+ were interviewed so missed views of younger people.	Key finding – replacing face-to-face with using telehealth alone has potential to reduce trust, continuity of care and effectiveness of rural health services. Telehealth needs to be part of an integrated service delivery. Importance of personal relationships. Video consultation unable to offer the full range of clinical interventions as face-to-face.

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				implementing telehealth in a Rural setting.	chronic health conditions. Ethics – Approved by the Human Research Ethics committees.	Telehealth services often superficial and fragmented. video consultation are distant and lacking in personal touch and risk losing sight of the social circumstances which might then affect trust in healthcare systems. Also need to take into account digital literacy skills of the patient.		
6.	Hvidt, E. Christensen, N. Grönning, A. Jepsen, C. Lüchau, E. 2022. What are patients' first- time experiences with	February to October 2020. Individual semi-	27 patients (17 women and 10 men) who had used video consultation once during COVID-19.	To explore the experiences of Danish patients using video consultation to consult their GP during the COVID-19 lockdown and	Qualitative interpretative design with data analysed via thematic analysis (Braun and Clarke)	- Peruse reactions and concerns (Better than nothing, will it work?) - Use and perceived quality in communication	Strengths – Not detailed. Limitations – No specific section in article. Data	Key findings Convenience, flexibility and efficiency of video consultation

	Article title, Author, year of publication and Journal and study location	**Intervention type** **Duration of intervention**	**Study populations/ participants**	**Aims of study and research methods** **(Context and concept)**	**Methodology** **Inclusion / Exclusion criteria, Sampling** **Ethics process**	**Results / Outcome measures / evidence of effectiveness**	**Strengths and Limitations**	**Gaps in research or key findings**
	video consulting? A qualitative interview study in Danish general practice in times of COVID-19. BMJ Open. Denmark. **Same study data as No 9 Lüchau**	structured interviews. Recruited via GPs, Social media and work related networks all had used video consultation at least once. Interviews mix of face-to-face, telephone and video consultation.		their attitudes towards continued use beyond COVID-19.	Convenience sampling. COREQ (Consolidated criteria for Reporting Qualitative research) principles adhered to. No inclusion or exclusion criteria as small number of participants. Ethics – approval given by Research and Innovation Organisation at University of South Denmark.	(knowing your GP, feeling seen and heard, a focused or rushed consultation type) - Post use reflections about future use (using video consultation for a larger number of needs, the digitalisation development, hoping to use video consultation in the future).	generation and analysis may have been affected by researchers' professional positioning. Use of video consultation was motivated by COVID-19 restrictions. Convenience sampling might affect transferability. Patient perspective only which is critically influenced by clinician behaviour.	High level of satisfaction with video consultation Gaps in research – need for multi method study investigating perspectives of both HCP and patient.

	Article title, Author, year of publication and Journal and study location	**Intervention type** **Duration of intervention**	**Study populations/ participants**	**Aims of study and research methods** **(Context and concept)**	**Methodology** **Inclusion / Exclusion criteria, Sampling** **Ethics process**	**Results / Outcome measures / evidence of effectiveness**	**Strengths and Limitations**	**Gaps in research or key findings**
7.	Christensen, N. Danbjörg, D. 2018. Use of video consultations for patients with haematological diseases from a patient perspective: Qualitative study. Journal of participatory medicine. Denmark.	Semi-structured interviews and participant observation. April to December 2017.	12 patients with different haematology diagnoses living on the small island of Funen.	To identify patients' experiences of the use of video consultations in place of face-to-face consultations, what it means to the patient to save the travel time and how the roles between patient and healthcare professional are experienced when using video consultation. How do they experience the lack of physical contact.	Exploratory and qualitative. Data collected through participant observations and semi structured interviews and analysed in a post phenomenological framework. Inclusion criteria – patients with a haematological disease, able to be assessed via video consultation and approved by the physician. Exclusion was if the physician did not approve their inclusion e.g.	Results in 3 categories - Intimacy is not about physical presence - Intimacy can be mediated through a screen and physical presence is. Not as important as other things. - Handling technology – familiar with IT. Took place in the hospital – patients preferred this to being at home and therefore responsible for the iT. - Technology increases the freedom that the patient desires – it enabled them to be active in their care.	Strengths – Patient quotes used to enhance reliability. The 2 authors conducted analysis together to increase reliability. Limitations – small scale sample but this is normal for Qualitative research. Sample size not representative of all haematological patients. No generalisability.	Key findings Telemedicine is under - evaluated No one size fits all That video consultation gives freedom to the patients because they do not have to spend time travelling to hospital (which is 8+ hours a week). The doctor was felt to be more focused during the video consultation which gave them a feeling of increased intimacy. Patients were given the option of. F-F or video consultation – which increased satisfaction.

	Article title, Author, year of publication and Journal and study location	Intervention type Duration of intervention	Study populations/ participants	Aims of study and research methods (Context and concept)	Methodology Inclusion / Exclusion criteria, Sampling Ethics process	Results / Outcome measures / evidence of effectiveness	Strengths and Limitations	Gaps in research or key findings
					unstable in their disease. Sampling method not specified – but was purposive / convenience sampling. Ethics – registered with the Danish Data Protection Agency.	Reduced risk of infection from public transport.		Intimacy at a distance.
8.	Christiansen, M. Pappot, H. Pedersen, C. Jarden, M. Mirza, M. Piil, K. 2022. Patient perspectives and experiences of the rapid implementation of digital consultations during COVID-19	**T/C and video consultation** Individual interviews by telephone to patients with gynaecological cancer from the Department of Oncology.	32 patients with gynaecological cancer. 16 after a telephone call and 16 after a video consultation.	To explore the experiences and perspectives of the rapid implementation of digital consultations during COVID 19 for women with gynaecological cancer.	Qualitative descriptive study. Braun and Clarke thematic analysis. Inclusion criteria – Oncologist assessed the patient for suitability to	Results – face-to-face was preferred for a first appt to build a relationship. 4 themes – 1. Tackling the dual challenge of cancer and COVID-19. 2. Pro's and con's of digital consultations	Strengths – not detailed Limitations – most of the participants were Caucasian, well educated and technologically able.	Face-to-face encounters create the foundation to establish a trusting relationship from where valuable dialogue arises. Implement with caution as one size doesn't fit all.

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	– a qualitative study among women with gynaecological cancer. Supportive care in cancer. Germany.	April and May 2020 during COVID-19 outbreak.			receive a video consultation and then the patient agreed to participate. Ethics - registered with the Danish Data Protection Agency.	3. The value of face-to-face 4. The favourability of individual solutions for consultations. Needed to be experienced IT users. Perceived as less time consuming. Some technical issues. Relatives could participate too.		Digital inequality. Video consultation = lack of physical examination. Could be a flexible and promising method depending on purpose of consultation and patient preference and needs. Gaps in research – the best way to carry out a sensitive and skilful video consultation that ensure the patient feels confident and safe in the process is yet to be determined.
9.	Lüchau, E. Jepsen, C. Grönning, A. Hvidt, E. 2022. Reciprocal	February to October 2020.	27 patients (17 women and 10 men) who had used video consultation	To analyse the reciprocal dynamics between patients' choice of place and how they	Qualitative, semi-structured interviews. The analysis was guided by Nelly	Results – - video consultation – Home dynamics	Strengths – use of concept of technography of care. Contributed rich data	Key finding

	Article title, Author, year of publication and Journal and study location	**Intervention type** **Duration of intervention**	**Study populations/ participants**	**Aims of study and research methods** **(Context and concept)**	**Methodology** **Inclusion / Exclusion criteria, Sampling** **Ethics process**	**Results / Outcome measures / evidence of effectiveness**	**Strengths and Limitations**	**Gaps in research or key findings**
	dynamics between patient choice of place and how they experience video consultations: a qualitative study. Digital Health. Denmark. **Same study data as No. 7 Hvidt**	Individual semi-structured interviews. Recruited via GP, social media and work related networks all had used video consultation at least once. Interviews mix of face-to-face, telephone and video consultation.	once during COVID-19.	experience video consultations with a GP. Research method not specified.	Oudshoons concept of technogeography of care using Braun and Clarke's reflexive thematic analysis. No inclusion or exclusion criteria as small number of participants. Ethics – approval given by Research and Innovation Organisation at University of South Denmark.	and Balancing boundaries. - video consultation – Workplace dynamics and logistical considerations. - video consultation – body image dynamics and on-screen exposure / privacy and safety of video recordings.	regarding first experiences of patients' and video consultation. Limitations – only transferable to countries with a good level of digitalisation in society.	Patient active in their care Privacy during a video consultation is a consideration – who else is listening. Gap in research – conducting video consultation in the workplace and its impact on telehealth.
10.	Powell, R. Henstenburg, J. Cooper, G. Hollander, J. Rising, K. 2017. Patient	Semi-structured in depth qualitative interviews with adult patients	19 patients successfully interviewed.	To describe patient experience with video visits performed with their established	Content analysis approach.	Results- Overall satisfied with video consultation	Strengths – no described Limitations – sampling limited	Key findings – most reported a positive experience – reduced travel, not having to change clothes,

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	perceptions of telehealth primary care video visit. Annals of family medicine. USA.	following a video consultation with a primary care physician associated with the Thomas Jefferson University.		primary care clinicians.	No eligibility criteria was set. Ethics – Thomas Jefferson University institutional review board	Main benefit was convenience and decreased cost. Primary concerns were privacy – including in the workplace. -Questions about whether the physician could perform an adequate physical examination.	to 2 practices, most participants had experience of video consultations and interviews were sometimes conducted a time after the consultation.	reduced costs and not missing work. Less waiting time compared to GP waiting room. Loss of personal feel from face-to-face. Privacy for having the call – especially if in the workplace. Gap in research – for participants with no prior IT skills.
11.	Imlach, F. McKinlay, E. Middleton, L. Kennedy, J. Pledger, M. Russell, L. Churchward, M. Cumming, J. McBride-Henry,	**T/C and video consultation** 20 April to 13 May 2020	Adults Survey of 1010 participants Interviews with 38 adults.	To explore how patients accessed general practice during lockdown and evaluate their experiences (positive and negative) with telehealth to inform	**Mixed methods** Anonymous online Qualtrics survey with both closed and open questions supplemented	Results - Convenient. Worked best with pre-existing relationship established with HCP. No physical examination possible.	Strengths – Mixed methods approach meaning qualitative findings were triangulated.	Key findings High satisfaction with telehealth. Concern about no physical examination. Not being seen.

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	K. 2020. Telehealth consultations in general practice during a pandemic lockdown: survey and interviews on patient experiences and preferences. BMC Family Practice. New Zealand.	Survey and semi-structured interviews.		how it should be most effectively used in the future. Online survey and in-depth interviews	with in-depth semi- structured interviews with a sample of survey respondents. Self-selected convenience sample. Interviews analysed using thematic analysis – a mix of deductive and inductive coding. Ethics – Victoria University of wellington Human ethics committee	In Survey - Satisfaction 91% for video consultation. 69% happy to have a video consultation again in the future. Interviews – convenience Value for money, and relationships, technology and need to be 'seen'. Technology barriers. Internet access, poor sound and visual quality. Patient preference – might override what was deemed an appropriate health concern.	Limitations- sampling limited access to some groups, the survey allowed people to respond on behalf of others e.g. family member.	Convenience – especially with travel, time, not missing work, Importance of trusting relationship between patient and physician. One size doesn't fit all. Improving the video consultation experience for patients depends on thoughtful communication especially between the clinician and patient. Gaps in research – why and when clinicians have different views on appropriate us of telehealth and how much is due to poor

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								support, skills or clinician preference.
12.	Trace, s. Collinson, A. Searle, A. Lithander, F. 2020. Using video consultations to deliver dietary advice to children with chronic kidney disease: a qualitative study of parent and child perspectives. Journal of Human Nutrition and Dietetics. UK	<u>Pre COVID-19</u> January to May 2018. Semi-structured telephone interviews using an interview guide.	12 families took part – 13 parents and 5 children (aged 9m to 14y). Taken from South West Paediatric Nephrology Network which included 10 general hospitals.	To investigate whether virtual dietetic consultations are acceptable to children and parents.	Sampling: via purposeful maximum variation sampling. All families had received dietetic support before. Inductive framework analysis conducted. Ethics from Health Research Authority.	Six themes 1. Logistics 2. Understanding information 3. Family engagement 4. Establishing trust – Virtual Rapport 5. Willingness to change diet 6. Preferences.	Strengths – Not discussed Limitations – study design included one video consultation experience and few families had established rapport and trust as a consequence of usual care.	Key findings. Satisfaction with video consultation was high – especially with children who engaged with it. Parents felt video consultation was an efficient, trustworthy supplement to face-to-face care. Minor privacy concerns especially if parent didn't want child hearing. Technology issues including connection. Screen sharing of data charts etc was

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								appreciated and better than f-f. Video consultation didn't work as well with pre-school children – it was disorganised and parents disengaged. Video consultation at home was comfortable and familiar and gave a sense of intimacy which was helpful. Gaps in research. Should video consultation be a sole communication method.
13.	Lindberg, I. Christensson, K. Öhrling, K. 2007. Parents experiences of	Pre COVID - 19	9 couples who were new parents.	To describe the parents' experiences of using video consultation when	**Mixed Methods**	Results – - Feeling confident with technology	Strengths – Not discussed	Key findings Video consultation can be helpful for parents

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	using videoconferencing as a support in early discharge after childbirth. Midwifery. Sweden.	Survey of 9 parents for immediate experiences and interviews for reflected experiences. March 2003 and February 2004. The video consultation was continuous but video when parent initiated it.		discharged early from a maternity unit.	Quantitative and qualitative research Inclusion criteria – early discharge from hospital post childbirth. Access to a specific broadband provider. Survey used a four- point response format from very bad to very good. Survey analysed through descriptive statistics. The interview via thematic analysis.	- Feeling confident of having control over their privacy - Feeling confident being face-to-face on video consultation - Feeling confident when worries and concerns were met and answers received.	Limitations – no generalisations as small sample size, the intervention needed broadband network so not available everywhere.	discharged early after childbirth. Wouldn't want video consultation to replace F-F but complement it. Privacy concerns. Cant give practical hands on advice e.g. breastfeeding position. Building trust - Midwife was open, welcoming and had time to spend. Gap in research – into the concepts of empowerment / disempowerment from the perspective that telemedicine might

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					Ethics – Committee in University of Lulea			create a need for constant support.
14.	Ewart, Baharani, J. Wilkie, M. Thomas, N. 2022. Patient perspectives and experiences of remote consultations in people receiving kidney care: A scoping review. Journal of Renal Care. UK.	**SCOPING REVIEW** August 2010 – August 2021 For patients with renal or kidney disease.	8 studies met criteria for scoping review inclusion.	To conduct a scoping review of studies about patients' experiences and perspectives in receipt of remote consultations for kidney care. PICO and flow diagram presented. Also charting the data for themes.	Arksey and O'Malley framework. Inclusion criteria – after 2010, remote consultations, patient experience. Ethics – Not applicable	5 themes – 1. Overall satisfaction with remote services as an effective alternative to face-to-face without compromising the patients' healthcare experience. 2. Benefits to patients e.g. convenience, involvement in care and patient safety 3. Barriers to remote consultations e.g. technical issues, digital literacy, loss if interpersonal communication. 4. Patient concerns – need for a physical examination,	Strengths – inclusion of qualitative and quantitative literature, it focused on patient experience. Limitations – only included 2010 – 2023 so limited number of articles considered, focused on remote consultations so generalisability is not possible.	Key findings **Convenience** Remote consultations offer multiple advantages to patients and should be offered as an option beyond the Covid -19 pandemic. An effective alternative to face-to-face without compromising the patients' healthcare experience. However, there are several barriers that need addressing – technical issues with

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						privacy and confidentiality. 5. Pre- requisites for successful remote care – existing practitioner / patient relationship, stable illness phase and access to technology.		video consultation. Digital literacy and inequality.
15.	Thiyagarajan, A. Grant, C. Griffiths, F. Atherton, H. 2020. Exploring patients' and clinicians' experiences of video consultations in primary care: a systematic scoping review. BJGP Open, UK.	**SCOPING REVIEW** From 2010 to 2018.	7 studies met criteria for scoping review inclusion.	The study aimed to explore both patients' and clinicians' experiences of video consultation in primary care. PRISMA and data chart included.	Joanna Briggs Institute guidance. Findings of studies analysed using narrative synthesis. Ethics – Not applicable.	Benefits - Patients reported being satisfied with video consultation – reduced waiting times and travel. Convenience and improved access. Could build rapport and felt video consultation patient centred but preferred F-F.	Strengths - mapped emerging evidence. Limitations - only included 2010 – 2023 so limited number of articles considered, participants from self-selecting populations.	Key finding – Experiences mixed and context dependent. Video consultation is more convenient for patients but not considered superior to face-to-face. Face-to-face is 'gold standard'.

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						Barriers Technical issues		

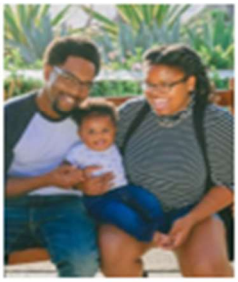
Appendix 3 – Flyer

University of Essex

YOU ARE INVITED TO TAKE PART IN A RESEARCH STUDY

HAVE YOU HAD A VIDEO CALL CHILD HEALTH ASSESSMENT WITH A HEALTH VISITOR?

If so, do you have views you would like to share about this experience?



I am conducting a research project and am interested in hearing about parents experiences of online (Video) consultations and would like to speak to you about it. Please email me to receive the details and arrange a time to talk.

WHO AM I?

CLARE SLATER-ROBINS

I AM A 3RD YEAR PROFESSIONAL DOCTORATE PUBLIC HEALTH (HEALTH VISITING) STUDENT WITH THE UNIVERSITY OF ESSEX.

MY EMAIL IS : cs20074@essex.ac.uk

Any information you share will be treated confidentially and only shared when anonymised.

Appendix 4 - Interview Guide

Research project title: Exploring Parents' experience of child health reviews with Health Visitors using virtual consultations.

The Hermeneutic interview is based on philosophical ways of thinking with the aim of generating meaning and understanding. The aim is to elicit meaning about the lived experience within the historical context of the experiences. Participants who have been purposefully recruited are already ready to tell their stories (Dibley et al 2020)

Research question:

'What are parents' lived experiences of video consultations with their health visitor when undertaking their child's health review'.

This research aims to explore the parents' lived experience of virtual consultations with health visitors.

To explore what benefits and barriers there might be and what the best conditions for carrying out a virtual consultation might be.

To understand whether parents feel virtual consultations can continue to be used by health visitors in the future.

- Introduce self, them and check they are comfortable and have a drink to hand
- Check happy for recording and turn on
- Describe the different style of interview – conversational, few questions, will feel like a conversation (hopefully)
- Check consent and gain recorded verbal consent.

Opening prompt

- Please tell me about yourself, your child and for which health review you saw a health visitor online?

Trigger question

- Tell me about your experiences of virtual (online) assessments of your child?
- Probe and follow up questions – You mentioned XX can you tell me more?
- What do you feel went well / not so well?
- What did you mean by YY?
- Can I take you back to XXX please tell me more
- Can you tell me more about XYZ.
- What was not helpful?
- You mentioned XXX what is it like to have that happen?
- What were you thinking about when XYZ happened?

Follow up question

- Several people I have already interviewed have said XXX what does that mean for you?

Final question

- Is there anything else you would like to share with me about your experience?
- Thank you very much for your time.

- All information will be treated confidentially, and you will be given a Pseudonym e.g., ‘Edith’ which will mean you can’t be identified from any text or quotes.
- The recording and transcript will be kept on a password protected computer for the duration of the study.

Reference

Dibley, L. Dickerson, S. Duffy, M. and Vandermause, R (2020). *Doing Hermeneutic Phenomenological Research: A practical Guide*. Sage Publishing. London

Appendix 5 – Transcript of Participant 5 ‘Kay’s Interview

Interview 5 KF

2023 55:01

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Clare: So, hi, Kay, if I can just go through the consent form with you. So this is I'm going to read through each of the each of the points. I confirm I've read the participant information sheet dated June version two for the above study, I've had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

Kay: Yes, I can confirm that.

Clare: I understand my test participation is voluntary and I'm free to withdraw at any time without giving any reason without my medical care or legal rights being affected. I understand that any data collected up to that point of my withdrawal will be destroyed.

Kay: Yes, I understand that.

Clare: I understand that the information collected about me will be used to support other research in the future and maybe shared anonymously with other researchers.

Kay: Yes.

Clare: Number four, I understand the identifiable data provided will be securely stored and accessible only to the members of the research team directly involved in the project and that confidentiality will be maintained.

Kay: Yes,

Clare: number five, I understand my fully anonymized data will be used for research thesis and publication in professional journals or conference presentations.

Kay: Yes,

Clare: number six, I give permission for the data to be de identified anonymized transcripts that I provide to be deposited in a research data repository, so that there'll be available for future research and learning activities by other individuals.

Kay: Yeah, that's fine.

Clare: Number seven, I understand the information held or maintained by my Health visiting team may be used to help contact me.

Kay: Yes, that's also phone

Clare: number eight, I agree to take part in the research study to explore parents experience a video consultations.

Kay: I do

Clare: and I give permission for the interview to be recorded.

Kay: I do indeed.

Clare: Lovely, thank you. So that's, I've got your email address, I've got your mobile number. So I think that's the consent signed and as I say, I will type it up and get it out to you. And I just need you to then confirm by email that you're happy with it. So if we can just start with the with the interview or conversation, **can you just tell me a little bit about yourself, your children and for which Health Review you saw a health visitor online?**

Kay: Yes. So my name is Kay like you say I'm now 34 years old. I'm a paediatric nurse. So coming at these reviews, probably from a slightly different perspective to some other people. I have two children. My eldest is a boy and he was born March 2020, which we then had a short stay in hospital, which we got out at, I think it was around seven, eight o'clock in the evening, the night before lockdown started the following morning. So pretty much all of his reviews and meetings were online. And then I've recently had another baby boy who was born in May this year, who I've had a one, one

health visit here, he came in person, we had a lot of midwives come in at the beginning, lots of midwife interaction. And then we had one health visitor appointment at the beginning in person. And then the six to eight week check, which didn't actually happen until he was 11 weeks. which funnily enough, I almost sent you an email of the other day, because at the very last minute had a text message to tell me instead of an in person in the morning, it was going to be an online video call in the afternoon. So I'm happy to talk about any of them. There's lots of video calls and interactions to choose from

Clare: super well, we'll probably try and cover we'll probably try and cover all of them. And you can just talk through the experience exactly as you want and and I'll pick up and come back to things if we're if we you know, to explore it a bit further. Does that sound alright? **So tell me about a time when you had a video call with a health visitor?**

Kay: Well, let's use my most recent one first, because that's closest in my memory. So this was last Friday, I was expecting a in person health visitor review for my new site, and it was supposed to be his six to eight week health visitor review. And I had changed childcare arrangements and got everything sorted for someone to come. And my little boy, my oldest was at nursery and all of a sudden I got a text message saying ‘just to notify you it will now be online and an afternoon’. Which was actually I would say disappointing and annoying if I'm honest. Working for the NHS I know we've got staffing shortages everywhere and I'm pretty positive that's probably why it was suddenly changed at short notice, but it did feel quite annoying for it to happen in the

way that it happened. Because like I say I'd I'd organised childcare. My eldest was at nursery, it was you know, it was supposed to be an in person in the morning and pretty much everything about the appointment changed. So it was then suddenly online and a different time of day. So I almost cancelled it actually, because, as well it sort of felt, I didn't really know that I would benefit that much from having it online and I've got to be honest, I didn't benefit that much from having it online. It was a very nice lady, but someone that actually is out of area. So again, I'm assuming it was probably because of staff shortages. She kind of a lot of her answers was, there will be stuff local to you, but I'm not from your area, so I can't actually tell you when and where you could access things like weighing and it kind of felt very much like a tick box exercise. You know, it was, we have to have made this contact so we're going to do it and we'll do it this way. But um, I can't actually say that I felt it was that positive an experience.

Clare: No. **So what was it about it that didn't make it positive? Or was tick boxy? Explain that bit to me.**

Kay: So I think, I mean, first of all, obviously, she explained who she was, she showed me her badge so that I knew that she was the correct person, which is actually, I did like that, because actually, she's one of the only people that has ever proved her identity as such. I mean, you have to go through the various NHS getting on to the web call for many ways. So it's, I guess, protected in that way. But it was quite nice to have her verify her ID but it was it was just things like, it felt like there was a time pressure. It felt quite rushed, It didn't kind of feel like a natural, flowing conversation. I don't currently have a laptop because my old one has gone kaput. So I was literally

doing it on my phone because my husband's laptop was at work because I'd only had short notice that it was going to be online, so I hadn't got anything organised. So I literally had my mobile phone propped up against a sofa while I was trying to nurse my new son. So it kind of all felt very disorganised, disjointed like I say it felt like she was kind of rushing through things. It felt like you know, that one of the first things after showing me her ID was to say, normally this review, we would weigh baby and find out how much he weighs but I can't do that because we're online. So we'll just have to not do that today which kind of felt very, okay, you know, like, great. I actually have my own set of baby scales at home because I'm that person during having had a baby during the first lockdown. I think sales have been probably went through the roof on Amazon but we did buy some so I had actually weighed him that morning, thinking they might have asked what his weight was if we knew so I did say all actually I've just weighed him. And would you like to know his way and she sort of listened but didn't appear to note it or mark it down anywhere obvious. Didn't make any comment on it just okay and then carried on. I would say she obviously had a list of questions. You could see her reading from a list of questions and the way that she was speaking was very much here's my list of questions, and I'm gonna get through it and it just didn't flow like a natural conversation normally wouldn't. Yeah,

Clare: really interesting observations. And I think the that **lack of being able to weigh and see the and see the baby is coming up in the literature, as you know, one of the one of the obviously you can't do it online!**

Kay: No, Well, I have to say as well, that I I was thinking about two things about online calls actually throughout because obviously once I'd agreed to do this study is sort of really got me thinking about various online interactions I've had, and one of them that I was thinking about was actually I was doing one of the calls, I can't remember which one it was, but my mom was on the other side of the laptop saying to me, Do you want a cup of tea? You know, and I could very easily sort of nod and you know, say thank you, and no one was any the wiser. But I was actually thinking to myself, because as part of my paediatric nursing degree, I went out with health visitors so I think I kind of had an expectation in my head when I was going to have children, what health visitor interactions would be like and I have to say, I mean, I went out with a really wonderful health visiting team, and maybe it's just differences in health visiting teams but I've been disappointed in my interactions. And one of the things that I really found was doing it online I think there are genuinely topics and things in person that you can't get from online. Because I was thinking to myself, one of the things that when I was a student and we went out on the health visitor calls was always we would talk about, is there any domestic violence going on in the household. Is there anything you're worried about? How is your mental health? And I was actually thinking to myself, How easy was it for my mum to stand on the other side of the laptop and say, Do you want a cup of tea? in a household where there was something like domestic violence going on, you have no idea if someone has stood on the other side of a laptop, you know, influencing what the person on the side, you can see is saying and doing and actually, that's quite a scary thought for me. You know, that's, that doesn't feel doesn't sit that comfortably that when all of the interactions are online, it feels like there might be some things that were missing by doing them online. And I think with the mental health questions as well, I mean, the one I had the other day, she did go through the

questionnaire about, you know, how often on a scale of one to five, are you feeling these thoughts and moods and you know, and actually having those questions asked online felt very disengaged and detached and, you know, I mean, I, I found myself actually looking at and playing with my baby son, and just sort of half kind of listening, which was terrible of me, I shouldn't really have done it at all. But, you know, I didn't feel engaged in that process and I think when someone asks you on a video call, are you feeling low and mood? Or are you okay? You can go Yeah, no, I'm great. Thanks. And that's, you know, I think sometimes probably, again, comes from having a psychology degree and being a nurse. There are things that actually when someone says, yeah, no, I'm doing okay, when they say it in person, you can pick up the little nuances of the fact they didn't quite make eye contact with you, the fact that maybe their body language changed, the fact they said it faster or slower, or, you know, there's, there's just theres things about those questions and interactions, that I feel like online, just really haven't worked and don't work, maybe.

Clare: It sounds like it was the EPDS if there was quite a lot of questions, and you were scaling them, because the Whooley questions, there's only three Whooley questions and they're much more about, you know, are you enjoying anything? Are you looking forward to anything? And there's only three of them. But I would have thought do EPDS on online having a bit like me just reading the consent out? It? Yeah. It must have felt quite similar experience.

Kay: Yeah. And you know, you, you do kind of end up going like, yeah, yeah, no, everything's great. Yeah. Because you kind of just like, Okay, actually, like, we're now

it is, it's almost like a yes, no, you know, you're not actually engaging someone with, are you enjoying things, you know, are you what are you particularly enjoying about being a mum, what are you finding difficult? So yeah, I think that that element I found really hasn't worked with video and online calls with health visitors. And like I say, the sort of domestic violence question. I mean, thankfully, I've never experienced that but I can imagine there would be some situations that having your online would actually allow that question to be missed.

12:56

Clare: Did they ask it in any of the calls?

Kay: Yeah, she did. She did ask but like I say, I found myself thinking I mean, I literally just said, you know, no, everything's everything's fine thankfully, you know, like, my husband and I, occasionally, were very sleep deprived we've had a couple of arguments. You know, I think that's absolutely natural. That's normal of course. But you know, there's nothing that I kind of I found myself even thinking when I was answering her. How easy would that be? Yeah, yeah. And the other thing as well, that I remember from when I was doing my training with the health visitors is, we always used to get a, sounds awful, but you know, because you asked the question about where is baby sleeping? And are you aware of safe sleep? And this lady that did the phone call on Friday said, Where's baby sleeping? Are you aware of Safe Sleep advice? So I said in a moses basket next to my bed, and yes, I'm aware of Safe Sleep advice and that was literally the end of that question there wasn't any sort of further development or digging for that question. And I think actually, my eldest son as well,

his his two year review, because we didn't have a one year review. But his two year review that we did online also asked about safe sleep. And they asked safe sleeping and again, they didn't kind of dig or delve into that, I just said, are you aware of the safe sleep advice? And actually, I went to a friend's we went to a her little girl was one the other day we went to her birthday party and it really surprised me because she's actually a GP and I used she's got a changing table in a little girl's bedroom, So I use that to change my newborn. And I was really surprised. I went downstairs and said to her, what is that you've got in the cot? And she said, Oh, it's a Snars Poz Isn't it amazing? Its the best thing in the world! And I was like, No, it's a complete and utter SIDS hazard and if you look at any of the Safe Sleep advice, like they're banned, like, get rid of it now, what are you doing with it in there? I said has your health visitor never picked it up and she said, No one's ever talked about it, no one ever asked, they just ask where she's sleeping. So I've always said in her cot, you know, and I think that was the other thing that really struck me that with the online in person, you know, you could see was there a bassinet or a cots or a flat surface with no toys, And these hideous built up SIDS risks kind of in them? Whereas actually, when you ask online, and there's no way of kind of looking or seeing, I was like, has she been sleeping in this for a year? Get rid of it now, please throw it in the bin.

Clare: It's a it is a really interesting insight and yeah, I suppose with a phone and that, you know, you can turn the phone round and take them around the house. And I have heard of, you know, of that being? Yeah, that being the case that actually they've been asked to turn the phone round, and then almost like, do a walking tour of the house and go and show where the babies is sleeping.

Kay: I'm glad that that's quite reassuring to him and I've never experienced that in all the, in all the online things I've had with both my children now, we've never been asked to turn the camera around or show any other view other than the selfie view that we've had, which actually only gives you a really tiny picture. I mean, looking at myself, you know, you might think I like a drink.

Clare: They all look like full bottles to me, Kay, I don't think you are having enough to drink!

Kay: If you look closely enough the glasses have dust on them which will tell you when they were last used. But anyway, you know, I've been, online again, you can create quite a snapshot of what you want to portray, can't you? So it's actually quite nice to know that people have done that we're walking around bits. But But yeah, definitely my online experience hasn't been what I was expecting health visitor interactions to be

Clare: no. And you say you said you went out with health visitor as a student? Which is, so you are coming at it with, as you say, expectations and knowledge. **Tell me about your eldests two year review online? Because that's quite different from a baby one, isn't it?**

Kay: Yeah, well, so I mean, the, when I was a student, we did some where we invited people to come into a Children's Centre, and we did some where we would visit them at home. And I think both of those have pros and cons obviously, the children we used to invite into the Children's Centre were always quite nervous and new in their surroundings. And sometimes children will do something when they're at home and comfortable and not, you know, in person. So it was always quite interesting to see the difference between at home and in the Children's Centre but actually online, I don't, you know, the, the way that I did it when I was a student was we had the questionnaire that we would have sent out to parents to fill in beforehand. And we got sent the questionnaire in the post, and we dutifully filled it out beforehand, and you know, there were some things that we hadn't tried feeding, you know, threading a bead and various other things and so we, you know, tried and did that. And actually, yeah, so he can do that, or he can't do that. And I felt that the in-person element of it would be if you'd ticked that they couldn't do it, The health visitor would often kind of engage and see, you know, are they doing any element of it? or are they completing not engaging? Or actually some of the things that you took, they could do everything as well, you could sort of test a little bit of it out. Online, I literally feel like we filled in a questionnaire we had the questionnaire in front of us. She obviously had a questionnaire in front of her as well or either that or knew it off by heart, which she may well do. You do a lot of them as health visitor but it literally did feel like Okay, so question one: What did you tick? question two what did you tick? Question three, what did you tick? It was a very kind of emotionless and un-interactive, you know, what, what have you ticked I will mark it down on my copy as well, there wasn't kind of any demonstration, there wasn't kind of any discussion around it, there wasn't any interaction really. Technology was a complete nightmare that day as well. She said that I can't remember where she was

working from, I think she was up in an attic in her sister's room or something and was trying to make it work and it wasn't and the screen kept jumping and halfway through someone saying something, it would stop and then jumped sort of halfway into the next word. So actually, the technology was so bad. I think we ended the call early I seem to remember as well and didn't actually finish. Anyway, it kind of just ended up being a okay, so if you've got any concerns, great. Well, then, you know, we're here till you're five but we won't actually routinely see you again. Kind of felt very like one one thing I would say as well as the whole, the whole way that the online things have been working, I actually feel has put more pressure on me as a parent. Because I feel like it's been down to me alone sometimes to spot and to know what is normal. And I am really grateful that I am a paediatric nurse because I have got that sort of base knowledge but actually you can be a paediatric nurse for hundreds of years and having your own child is very different being a paeds nurse. And actually, there are some times I have literally wanted to say to people I know you know, I'm a nurse, but right now I want you to see me as a mom. Because it very much felt like and I think my husband has said to me on times, like the other day when when it turned out that they were going to do an online call rather than in person. My mom's reaction and my husband's reaction because I had abit of a moan to them was well, it's probably because you know, they're not worried about you, you're probably quite a low risk person because when they came to you the first time, everything was great, and you're a nurse, so they're probably not worried. And I was like, but you know what? I want to be mom right now. I am a paediatric nurse but right now, I want to be mom and I want to be seen as mom. And I know I've got paediatric nursing and you know, yes, wonderful. But I want to be mom and I want you to be the professional and it not to have to all fall on my shoulders. Which I don't know, maybe that's a really weird thing

to say, because it's my child and I love them dearly and it is my shoulders it falls on at the end of the day. But it feels like I want it to, you know, be a partnership. I want it to be actually yes, I'd like someone else to look at him and to have an opinion as well. And not just me as in my paeds brain I want I want to be mom.

Clare: And that's something Kay that has come up in some of the other other people I've interviewed they're only taking my report. For how he's doing, or she's doing, they're not actually doing their own assessment.

Kay: And it does, it feels like a massive pressure. And it always, you know, that I, I would say I mean, I assess a lot of children in my job and actually, I'm one of the sisters on the wards, so often I'm called to assess someone else's patient because they're worried about them so want that second opinion. So you know, I assess a lot of children. But actually, when you're then trying to assess your own child, and you're the only one that is physically seeing and assessing your own child, you really start questioning yourself, and you go round in circles and then I'm like, what if I am missing something? Or what if I'm making too much of this thing? Or? Yeah, it really that I think has felt a very strange and uncomfortable thing and basically, I'm not much of a fan of the online as you probably get the impression. I think everyone should see people in people.

Clare: Yeah, yeah, are there any benefits of it, do you think?

Kay: I mean, I didn't have to actually hoover my entire house. There is I think when someone's coming to your house, there is that pressure that you feel like you and the house have to be presentable. And you know, you feel like you're going to be judged if there's a cat hair out of place. So I suppose it takes the pressure off in that way. I can see there are lots of benefits from a logistics, NHS time and money saving sort of format, you know, you're not having to pay for petrol and mileage and take the time in between journeys. But as a parent, I'm actually not sure that I feel like there is, because it's not even like I would say maybe you know, you know more what time it's going to happen. So you can plan your day. Because obviously, sometimes if someone was coming in person, they would say, Oh, we're gonna come in the morning or the afternoon so you'd have to be up and ready between whatever hours and just, they would turn up. Whereas in person, you know, like a booked appointment, you would have like a set time, you can actually plan your day better than actually all the online interactions, I've had a very much been a, we're going to text you the day before or the morning of, to confirm what time it will be so not even that element has really, really been that helpful. So from like a logistics, NHS money, all of that element, I can totally see benefits. But from being a mum, I can't say that I personally feel there's been any, like I say other than having to deep clean my house. No.

Clare: Or take them to a clinic?

Kay: I again, I I guess you know, for people that have transport issues, and like I had a C section with both of my boys for medical reasons, so obviously couldn't drive. So the taking, you know, if I'd have had to been to a clinic rather than people come to my

house, that would have been hard because it would have been relying on neighbours or families to give me lift or public transport what's my husband was back at work so from that element that I think could be really helpful. But there's also I think so much more benefit from being seen in person. I kind of feel like if there was an option that you could have a we'd like to do this review, would you like to come in person or would you be happy to have an online that would be lovely but I think I, 99% of the time, would personally choose in person.

Clare: Yeah, yeah. And I I'm being I'm being kind of that's put Yes Probably quite a common, quite a common view of the parents that I've certainly I've spoken to. **So you talked about it being a tick box. Do you want to expand on that a little bit? Maybe with some of the other ones you've had?**

Kay: Yeah, I mean, I guess, I guess I'm just thinking about things like, so I've breastfed both my children. And obviously, as on the ward, we at university got given some training about breastfeeding and would occasionally be asked to help parents breastfeeding. And you would try and use the theoretical knowledge, but actually doing it personally is completely different to what the expert says. But you know, with with my first son, I basically made up completely what I was doing. So you know, the health visitor would say, so how are you feeding? And I would say, we're exclusively breastfeeding, and they'd say, How's it going? And I would say, I think it's going well. And then they this is where the the tick box would come in, they would sort of say, so is he latching? Is it pain free? And that would be a yes or no, that'd be like a tick. They would say, you know, how many times in 24 hour period is he feeding? So that would

be a number to write down in the tickbox, then it would be a, you know, are you feeling like your breasts are emptying? tick box. It, you know, I didn't ever feel like it was ‘So tell me how your breastfeeding journey is going’. And maybe that's not so much about it being online. But that's about the way we're questioning and phrasing the questions. You know, we're asking, we're asking closed questions, not open ended questions. We're not getting people's lived experience of breastfeeding we're asking them specific questions about how many wet and dirty nappies is it pain free. Oh. And I think, again, and you know, you can try and look at a latch online and a lot of a lot of really great charities that the breastfeeding network and everything did do latching assessments online, during COVID. But actually, there's something very different about feeding a baby on camera. I mean, I don't think not everybody would be comfortable actually feeding on, you know, things like TV programmes make it seem like anyone could be watching the conversation we're having right now let alone when you’re breastfeeding. You know, some people might not feel comfortable doing that on camera. And I think actually seeing someone breastfeed and actually being able to go, Okay, do you mind if I touch because actually, you just need to bring baby back this way a bit more, or this way? Or they're not quite straight? Or, you know, have you tried a cushion actually is very different to just, it was just it was just, yes/ no questions. So, so many of the things I feel like they’ve been yes, no questions. Thinking of another thing that I think was quite tick boxy was things like baby led weaning. So it would be you know, has your child soft solids? Yes, or No? tickbox! You know, so I would say, Oh, yes, we've been, you know, we've been starting baby led weaning, and I would, then I would openly talk about it, because I'm quite a chatter. But I think other people may have just said yes or no and it would be interesting to know how they felt that experience was whether they actually asked the questions they wanted to ask, because it did feel on

certain certain occasions and certain meetings like it was, there was a list of questions, we've got to ask them once you've answered I don't I'm not really worried about the fluffy bit. I just want to know the the answer.

Clare: Hmm, Fluffy bit?

Kay: which actually isn't a fluffy bit, It's actually where the truth is. That, you know, that's, that's if you've got a question, Have you started weaning yes or no? And you've ticked yes or no, the rest of the stuff that someone then gives you all that additional rich information, which isn't really I think, as a professional, what I would want to gather from that question. I don't think people asked online calls

Clare: functional?

Kay: Yeah, yeah. Yeah. Good word for it.

Clare: Yeah. Yeah. That just that kind of I'm, I've got this purpose. What I've got to do and missing out on the conversational wrap around.

Kay: Yeah, yeah. And I think so much so much of what I have discovered about parenthood is that wraparound is actually sometimes what you need, you need to say and you need people to hear because actually it's within that kind of detail that it comes out that actually you are struggling a bit or you are finding this bit not enjoyable or actually feeding has been hard or you know so many other things like actually yes, that's normal most people's nipples hurt to begin with, you know, yes. You know, that

all that sort of information. I think it's such a detail rich, you know, when you let someone talk and when you can have a conversation, I think actually what it feels like is that the online meetings haven't so much been conversations, you know, like in a conversation there is that give and take. And there's that you're kind of letting it flow freely and explore topics, and you can get that wrap around and more detail and that fluff. Whereas I feel like the online conversations haven't been the same type of conversation, they have been functional, like you say, and they've been almost like an information finding mission, rather than a conversation.

Clare: Yeah, that's a really good is a really good point. **And with the conversation goes other elements of the relationship, doesn't it?**

Kay: Yeah, I mean, I have to say, I had to fill in a form the other day, and say who my health visitor was, and even though I'm under the same health visiting team for both my children, and my eldest who is now he's three years and three months old, and youngest is now 11 weeks old, I can't actually tell you the name of a single health visitor, because I don't have a health visitor, I, you know, I don't, obviously, we don't tend to anymore in the NHS as such, assign one person do we because they might be ill, or you might have to have contact with people so you have a health visiting team. But I can't actually remember anyone's name. Because at the beginning of a conversation, you know, on an online thing, someone says, ‘Hi, I'm picking a name out of thin air.. Angela’. And then you never see that person again because every online thing you have is with someone else, you know, you don't go to the baby weigh in clinics, because they're not on if you don't go to any of the baby groups, because

they're not on either. You know, actually, every time you have an online conversation its with an entirely new person, and you don't have that personal bond, that rapport, that connection, that that feeling, you know, it didn't ever feel like there was anyone else that was invested in how my kids were doing from that perspective. Obviously, family and friends and you know, everyone else, but from like a professionals perspective, it didn't feel like there was that.

Clare: Yeah, **it's it's the richness of it, isn't it that's missing from what you're describing.**

Kay: And that that probably is quite a lot to deal with the type of person I am. Having to thinking about wearing answers right now with my psychology degree is like, so intregued because I'm like, oh, that's actually quite a lot about me as a human being. But I do I missed that personal connection, I think that holistic element - Gone really for me with online, I think that that sort of welcoming somebody into your home and them seeing you and baby and being actually a person that a holistic person. Yeah. That whole experience was just very different.

Clare: **And would you say that the video calls felt different at the different age stages of the children?**

Kay: Um, I think, I think, in some ways, yes. And in some ways, nice. Like, in the very early days, when you have a child that you're breastfeeding, and actually, most of the

time they're on you, and all you can hear is them screaming, it's quite difficult to hear the voice call anyway. And then at the age of my, my eldest is now you're trying to have a voice conversation while they're running around, and you're trying to make sure they're not climbing on a cupboard. You know, so from that perspective, that's different. But the rest of it, I would say, you know, not not necessarily. I mean, with with my eldest, he was literally he came out of hospital, just just before the very, very first lockdown. So actually, a lot of the interactions in his first year, we didn't actually have those interactions at all. They weren't online, they just didn't happen. The first kind of online interaction we had, I think, was actually his one year check. We had someone turn up at the doorstep and sort of wave from my doorstep and sort of make sure I guess we were all still alive. And then we had one very strange experience about I can't remember how old he was but she came in, put some scales down, fully PPE'd up and left and we weighed him, put him on the scales and stepped away and you know, so bizarre interaction. And that was very weird. But actually, I can't sort of say what those interactions in his life were like online because they didn't happen in the first year with my youngest because we we didn't have a stay in hospital with him. But we did have he dropped 10.1% of his birth weight, which actually I think is a misnomer anyway because I had to be fluid resussed during the C section because my blood pressure plummeted. So I think his birth weight was actually elevated incorrectly, rather than he actually dropped it because he's he's literally stayed on the 25th percentile ever since. But according to his birth weight was on the 75th percentile So I'm a bit like, actually looking at pictures, he's really oedematus as well. Anyway, I digress, Sorry, So I think when I think about the the midwife and health visitor appointments we've had with my youngest, if those had been online, rather than in person, I think I would have found them harder because at that stage as well, you're so hormonal, and you're so sleep

deprived, and you're so sore from giving birth, or having a C section or you know, you've just started breastfeeding again, and your nipples are absolutely killing you. That actually, there really is something more comforting about a person being in your house. Then the coldness of a computer screen and also in those very early days trying to faff around and find the laptop and the charger and you know, make sure you've got whatever you need for the online call. Whereas actually, when they come, you know, if it's someone knocks on your door, you just open the door, and in they come. You know, you the pressure is kind of off you to be the organised one. Yeah, I like I say, I didn't have that in our eldest's first year so I can't make a comparison because nothing happened. It wasn't online, it just didn't happen but with my youngest, I'm trying to think you know, if some of those interactions have been online, rather than in person, I think it would have been harder.

Clare: And in what way, do you think it might have been harder?

Kay: Just because so like I say, he was, you know, supposedly on the 75th centile when he was newborn and lost 10.1% of his bodyweight and blah de blah and I found that quite upsetting. And, you know, it was it was day five milk coming in hormones, hideous, sleep deprived, what have I done having a second one time, you know, really like, Oh, God. We love him very much but at that moment,

Clare: I totally remember that

Kay: I was like, we were just sleeping through 12 hour night, why have we done this! And, you know, I was I was quite sort of when when we weighed and his weight had dropped again, you know, I was upset, I was sad, because I knew that there was that number that they were looking for. I had just decided at this point that his birth weight was just incorrect but they obviously had that target that they were looking for and we hadn't reached it again so I was upset and having someone actually here in person, they could see that I was getting upset and some of them I'll say, actually, I'll quantify this, some of them were very good at reading that and actually kind of being quite comforting and nice. (Hey, honey, you, okay? Come on) being quite comforting and nice. And, you know, they could read my feelings and kind of tailor what they were doing. Whereas I think if they'd have been online, I might have been able to hide slightly more how disappointed and upset I was, but then probably would have been more disappointed and upset afterwards, because I wouldn't have got that bit of support. But yeah, I wouldn't, I don't think I'd have kind of let my emotions go as much online because I wouldn't have wanted to have looked like I was breaking down on a computer call and I could have hidden slightly more. How upset you know, I'd just been like, okay, yep, fine, we'll do that, then. You know, whereas I think in person. It was, you know, I'm not very good at hiding, you know, in person. If someone says to me, are you okay? If they're nice to me? I cried.

Clare: Yeah, yeah. That's the Yeah, it's an interesting. **It's an interesting observation, isn't it about the sense of having somebody actually in the room with you?** That you, you know,

Kay: I think I mean, I think it's, you know, it's a well known phenomenon, isn't it that people troll, because online, you feel like you can say and do things that you couldn't do in real life. But I think that works in reverse as well, I think online, I could present myself as a different person and to feeling differently to actually being in front of someone in real life. You know, I think I think in in many ways, it's easier to gloss over how you're feeling online than it is when someone's actually sat in your house. Personally,

Clare: yeah, yeah. And it's the, one of the previous people I've interviewed sort of talked about the fact **that the child wasn't really present, despite the Health Review being about them. It didn't feel like they were really present in the call, would you agree?**

Kay: I would definitely say that because, you know, there's, there's been times when the health visitor call that he had the other Friday when I had my phone propped up, you know, initially I'd set it all up nicely, he was quite happy and he was on a play mat and we were doing, we just so happened, we were doing sort of some playmat stuff at the time that the call came through so you could see him on the play mat doing his stuff, but then he needed feeding. So I ended up picking him up and feeding him, at which point, the health visitor couldn't actually see him. And I was too busy feeding him to adjust my phone so that she could see him, you know, do anything else. So yeah, it was it was just me on the call to her, you know, I don't, there wasn't that sort of interaction and view of him. And things like it the two year check, You know, like I say, when my experience as a student, was actually they would have engaged with

him, they would have looked at him, they would have seen the things that he wasn't wasn't doing, you know, they would have got that sort of bit more. But yeah, online, I mean, even even when I think you know, what, he came and sort of looked at the camera, maybe went like ‘ooh what you're doing mum’ and then was like I'm off to do whatever, and you can't just, you know, follow your toddler around with with the camera all the time It's just it's not really. See, I would say I’d agree with that statement that the other person made, it's, it doesn't feel like there was much engagement from the actual children. I think it's about I don't know, maybe, maybe there was less opportunities for dad to get involved online as well. Because I think in person as well, when there's two people sat there, sort of by force, unless you're going to be really rude, you're actually going to look at both people. Whereas, you know, sometimes I think it ended up being, with the online conversations, one of us would be taking care of the baby things that needed to do like changing a nappy or feeding or, you know, making sure he wasn't climbing on a cupboard, and the other person would remain on the call. So that kind of didn't feel like there was much of a chance to have that sort of interaction between the three, you know, three adults sort of thing. There wasn't much of a I don't know, I mean, I know that my husband has always you know, I've I've been quite insistent on checking that he feels engaged and kind of asking him if he's got any questions. And I don't think many of the people that we spoke to online, necessarily addressed him specifically either.

Clare: And that's a common theme. And even in well, anywhere, isn't it about I mean, there's even a document written isn't there called The Invisible Man, a safeguarding document, isn't it? So, you know, that is a, as you say, That's a common experience. **And it must be just so difficult for fathers to then be engaged.**

Kay: Yeah, yeah. Yeah. And also, I think, as well, it's, I don't know, I mean, some men obviously have have a lot of experience with childcare. But I think normally, a man when he has a child, it's maybe their first experience of that kind of childcare, whereas maybe a woman, and this is a real generalisation. But you know, maybe when when we as women have friends that have babies, we get more involved in their babies and asking them how their experience of breastfeeding whatever was, whereas actually, I'm not aware that my husband before we had a baby had ever asked any of our friends. So what was it like when your wife was breastfeeding? You know, or how was your experience of breastfeeding? You know, What decisions did you make? Or, you know, I've got nephews, and he's brilliant with them but he's, you know, I don't think he and my brother have ever spoken about the experience they had. So I think his real first exposure to that kind of 24/7 baby was having a baby. So yeah, it's a massive kind of missed chunk. Isn't that we do miss quite often?

Clare: Yeah, no, absolutely, definitely. So really, you've covered so much. But no, not at all. And lots of it resonates in the literature, a lot of the things you've mentioned, you have brought up some some new ones. I think your your, obviously Heidegger talks about the lived experience doesn't he, that's what I'm interested in is your own lived experience of it. And I think your nursing and your Health Visiting experience, as you know, it brings a different perspective to it. And you've obviously done some reflecting on it as well. So the bit you've talked about, about the domestic abuse and the question and having the EPDs actually ready to actually read to online

Kay the most bizarre thing in the world.

Clare: Yeah, yeah. And, **I mean, tell just tell me a little bit more about that. That bit of the experience.**

Kay: I mean, I just, I, you know, obviously I'm aware of that questionnaire from the work that I do, and I just, It really did feel. I don't know, it almost felt like, like I can't even sort of describe how it felt it just it felt very disengaged very kind of cold. Very, you know, I found myself like I say, kind of almost not listening to half questions and drifting off a bit and actually thinking to myself, what actually, if I was feeling like that, I wouldn't tell you anyway, you know, kind of just very much felt like someone Someone was reading something And I was just kind of nodding along, you know, yes, no, yes. No, yes. No. Oh, look, the sky is blue. Oh, that my kitchen wall is yellow Oh, yes. No, You know, like, it wasn't, You know, the whole, my understanding is, the whole point of that questionnaire is you're supposed to be as honest and truthful in your answering of that questionnaire as you can be, and that that questionnaire is there for a purpose and actually, you know, I don't even think the lady, she just said to me, part of the review that we do at this stage is to ask some questions about how you're feeling is it OK if I ask those questions, there wasn't kind of any more information about the questions than that there wasn't kind of any, you know, you know, please try and be as honest as you can, you know, like answering you know, in a certain way isn't going to influence anything. You know, it was it was just we're going to ask you some questions and here's the list of and, actually, when I read them out to you in quite a monotone - cuz I'm trying not to influence your answers- Voice. Yeah.

Clare: Yes. Not inclusive to finding out and it's interesting that she didn't say we're really interested in knowing how you're feeling.

Kay: Yeah.

Clare: And we're gonna use these questions to elicit that or

Kay: no, it literally it did It really felt like we're okay, I'm going to ask you some questions Like, if you could answer them, that'd be great. And it was it literally felt just so disengaged. If I had been feeling low I don't think I would have told that lady, because the way it was done and phrased in questions, and everything else just wasn't, wasn't there, (calls to husband - Yeah, I'll feed him Hun it's fine)

Clare: I'm conscious unconscious, that he sounds like he wants something to me. I'm pretty much there. I've wrapped up to all the things that I was thinking, **Is there anything just that you'd like to just add that I haven't covered or that you thought about?** I think,

Kay: I think, obviously, like I say, you know, when I was reflecting on this, before we had this chat, I was thinking, Gosh, I'm going to come across as a real negative for sort of online. And, you know, I do understand that in the changing world of healthcare, there is real, you know, benefits to doing things online. And I think for some people

online, may be great, you know, there's people that don't drive can't get places easily they're not close to a child care sort of thing. But I just think, you know, my, my experience of it is the richness of having the personal interactions with someone actually, physically there. That whole richness and holisticness is lost and both as a as a mom, and as a professional, I don't like I, I just feel like there's so much potentially missed. And there's so much potential to be missed. And some of those families that we could be really missing it. You know, excuse me. I can hear who's hungry.

Clare: (talking to the baby) you don't want to talk to me. That's fair enough.

Kay: (starts to breastfeed) Yeah, kind of, I think, you know, I get that during COVID We had to do things in a certain way. And it was great that we were able to continue to do some of the things that we did because like I say in in my eldests first life there was really so much that actually just didn't happen. We hadn't quite figured out how to do online calls and you know, everyone was sort of trying to think a lot of health visitors and midwives were taken to work on the wards anyway. So you know, there were there was a lot that didn't happen in any way shape or form. So I guess, in that perspective, online is better than nothing. Yeah, not a fan. Really.

Clare: No, no, and neither are most of the people that I've spoken to although most people and yourself as well. I can see some benefits of it in certain circumstances for certain people. And obviously, as you're saying, COVID you there really wasn't a choice. It was it illegal to do much else You know, to do much else, wasn't it? But I think it's yeah, it will be interesting to see. Obviously, I'm not looking at finding anything

that's generalizable or transferable from this I'm just, I'm just looking at people's experience of it. And then I'll you know, put all that together and and take a view really. But yeah. Whereabouts do you live? Are you in Cambridgeshire?

Kay: Yeah, South Cambridgeshire,

Kay: and if someone says to me, who's your health visitor? You know, I got a when someone says like, who is your I expect it to kind of roll off my tongue? And actually, I go, the Cambridge Health Visiting team. Question, Mark. You know, I can't tell you any more details than that. I don't know anyone by name. It's just the Cambridge Health Visiting team, which feels like quite a big geographical area as well.

Clare: yeah, it probably is. Yeah. Really helpful. Thank you, I'm so conscious that I'm taking up busy people's busy people's times. But hopefully, there's been a you know, like, it's not all one way that there's been a sort of a bit of a benefit of just chatting about it. And, and

Kay: we're more than happy to help. And, you know, I just apologies about how many times we've left you. So you've been very patient. So thank you. I hope it has helped. And I really hope we've I mean, I certainly have enjoyed actually having sort of a bit of a reflect on it. And it it will be really interesting to see, you know, what happens in the future with online appointments and stuff, because

Clare: it's interesting to hear that your this six to eight week at 11 weeks, was offered because it is in where I work in London, It's very much alive. And well as a as that Yeah, very much as one of the tools for for seeing people. So it's interesting that you're also it's also still in use outside of London, because obviously London has a unique shortage of health visitors more than the rest of the country. But it's interesting that it's still you know, you were offered it only last week. So it's obviously Cambridgeshire, obviously still using it too for whatever reason.

Kay: Yeah, I mean, I, I think you know, when when I think back again, harking back to being a student. I really did have some very good health visitor mentors, it must be said, but you know, those those first few visits, there was so much that came out in them. And it was a, you know, I kind of felt a real privilege and honour kind of being part of those conversations. And the experience I had last Friday just wasn't wasn't that it did make me laugh that yes, the six to eight week was at 11 weeks, but you know,

Clare: yeah, well outside of their KPIs. I'm going to turn the recording off now we can carry on chatting.

Appendix 6 - Responses for Email Enquiries

Initial enquiry

Dear XXX

Thank you so much for enquiring / volunteering to take part in my research study on '*Exploring parents experience of child health reviews with Health Visitors using video consultations'.*

I am attaching the participant information sheet and the consent form for you to read. If you would complete and sign the consent form and return to me then I can set up the interview at a time convenient to you.

If you have any questions, please ask and I can answer them before we meet or when we meet.

Your time in helping with this research study is really appreciated.

Thank you

Attach PIS and Consent form and invite letter

Once consent form signed and returned

Dear XXX

Thank you so much for returning the signed consent form and I hope the participant information sheet answered most of your questions.

I now need to set up an interview with you, and your partner if they would also like to join us, so will give you a ring on the mobile number you've provided to arrange a convenient time for it to take place.

I look forward to speaking to you and thank you for taking the time to get involved in this research study.

Best wishes

Once the interview has taken place – send the thank you letter with this cover email

Dear XXX

It was so good to speak to you last week and thank you so much for your time.

Im attaching a thank you letter which gives you some detail again about what happens next.

Your time has been really appreciated and I wish you and XXX well in the future.

Appendix 7 - Participant Information Sheet

February 2023

Research project title: *Exploring Parents experience of child health reviews with Health Visitors using video consultations.*

In this research study we will use information from you. We will only use information that we need for the research study. We will let very few people know your name or contact details, and only if they really need it for this study.

Everyone involved in this study will keep your data safe and secure. We will also follow all privacy rules.

At the end of the study, we will save some of the data in case we need to check it. We will make sure no-one can work out who you are from the reports we write.

The following information pack tells you more about this.

Research Investigator: Clare Slater-Robins

My name is Clare, and I am a Student on a Professional Doctoral in Public Health in the Department of Health and Social Sciences at the University of Essex. I would like to invite you to take part in a research study. Before you decide whether to take part, it is important for you to understand why the research is being undertaken and what it will involve. Please take time to read the following information carefully. Thank you.

The Purpose of the study

Thank you for considering participating in this research. During COVID-19 many health professionals started using video consultations as a way to continue to see their parents when social distancing was advised. Following the relaxing of this restriction many services have continued to offer video consultations as a way of seeing parents and children. This research seeks to listen to parents' views of this change in seeing their health visitor and to explore their experience to understand what it has been like to receive their child's health review this way.

This research aims to explore the parents experience during video consultations with health visitors.

To explore what benefits and barriers there might be and what parents lived experience of the video consultation was.

To understand whether parents feel video consultations can continue to be used by health visitors in the future for their child.

To address this question, I will be conducting interviews with parents who have seen a health visitor using a video / virtual/ online method e.g., Microsoft teams, Zoom.

Questions for you will be focused on:

- Understanding your reason for seeing the health visitor
- Seeking your perspective on your experience of how health visiting can be conducted via an online means e.g., video consultation.
- Seeking your reflections on your video health visitor contact.

- Understanding your views on what the Health Visiting service and the commissioners might be able to do to improve the delivery of the service this way.

What will happen to me if I take part and why have I been invited?

The research aims to recruit and interview about 10 parents in England to participate either face to face or by video depending on the parents' choice. You have been asked to join because you have experience of having a child health review with a health visitor via an online consultation e.g., Zoom, Blue Jeans, MS Teams, Attend anywhere etc within the last four years.

There would only be one interview, either face to face or online, which would be between 30 and 60 minutes long and consist of a few questions designed to help you recall the health review you received and your experience, perceptions and views of it. It will be voice recorded to help the researcher, Clare, get full recall and details of the conversation for the research.

Your contributions would be confidential, added to the research project and analysed anonymously. Any quotes used would be assigned to a pseudonym for example 'Edith said..'

This research is independent of the health visiting service and would have no impact on the care you have received or will receive in the future.

If you experience any expenses e.g., travel to a venue then this would be reimbursed before the interview took place in cash. Otherwise, no renumeration can be offered due to the research project being undertaken as part of a professional doctorate and is therefore unfunded.

Do I have to take part?

It is up to you to decide whether you wish to take part in this research study. If you do decide to take part, you will be asked to provide written consent before the interview is arranged. You are free to withdraw at any time, without giving a reason but data already collected from you will continue to be used by the researcher. Withdrawal with have no impact on the service from a health visitor you are offered now or in the future.

What are the benefits of taking part?

This research is designed to help the researcher, Clare, to explore and understand your experience, views and perceptions of a change in the health visitor service delivery that you have not had a chance to influence before. By taking part you would be helping the researcher to understand your perspective and experience which would then be added to others she interviews and would be written up into a research piece which will be published and will help health visiting services to decide whether to continue to offer video consultations.

What information will be collected?

The interview will be audio recorded and then transcribed. Once it is transcribed it will be anonymised and given a pseudonym. Only the researcher, Clare, will know that this pseudonym applies to you and this will be kept confidential. The only information collected will be yours and your child's demographics, e.g., name, age and contact details.

How will we use information about you?

We will need to use information from you for this research project.

This information will include your:

- Name and initials
- Age
- Contact details

People will use this information to do the research or to check your records to make sure that the research is being done properly. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.

We will keep all information about you safe and secure. Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

Will my information be kept confidential?

Yes, during the research project the recording will be kept in the Essex student space which is accessed via a personal password from a computer. The researcher, Clare, will not be storing it on their personal computer. The researcher, Clare, will be the only one to knows which pseudonym is given to which parent. The interview is to be transcribed by the researcher, Clare, which maintains confidentiality in relation to this project.

If there is a chance that, during the research interview, you disclose information that leads the researcher, Clare, to believe that you or others are at risk of harm, Clare may have a duty of care to inform an appropriate authority e.g., the health visiting service. This would be done following discussion with you.

The University will support Clare to manage your personal data in accordance with data protection law. You can find out more in our general research privacy notice at the following link: https://www.essex.ac.uk/disclaimer/research . There is a consent form for this research project that you will need to sign to take part.

The Data Controller is the University of Essex and the contact, if needed, is via the University Information Assurance Manager (dpo@essex.ac.uk).

What are your choices about how your information is used?

You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.

We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Where can you find out more about how your information is used?

You can find out more about how we use your information :

- https://www.essex.ac.uk/disclaimer/research
- our leaflet available from cs20074@essex.ac.uk
- by asking one of the research team

What should I do if I want to take part?

If you decide to give your time to be interviewed for this research, please read, and sign the consent form and return it to Clare, the researcher by email.

Clare will then contact you to arrange a suitable time and venue to be interviewed. This can be face to face at your home or a place nearby for you or virtually using MS Teams.

You do not need to do any preparation for the interview, but it would be helpful if you could identify the virtual child health review you would like to talk about before the interview.

If you decide to withdraw before the interview, you only need to let Clare know, and it will be cancelled.

What will happen to the results of the research study?

The research is being undertaken as part of a professional doctorate in Public Health (Health Visiting) and so the primary reason is to write them up as part of a 40,000-word thesis that Clare must produce. However, as she also expects the results to be informative to health visiting, although they may not change practice, the intention is also to publish parts of the findings in professional journals and present at conferences. Both the research thesis and the journal articles would be anonymised, and your data would not be identifiable.

You would be welcome to receive a copy by email of the completed thesis and you should ask for this at the end of 2024 to cs20074@essex.ac.uk

Funding of the research?

There is no funding for this research project. Clare is undertaking it as part of her Professional Doctorate in Public Health (Health Visiting) and is self- funding.

Ethics approval for the study?

This research project has received Ethics approval from the University of Essex Sub-Committee 2.

Concerns and Complaints

If you have any concerns about any aspect of the study or have a complaint, in the first instance please contact the principal researcher for the project, Clare Slater-Robins, using the contact details below. If are still concerned, you think your complaint has not been addressed to your satisfaction or you feel that you cannot approach the principal researcher, please contact the departmental Director of Research in the department responsible for this project, Camille Cronin,camille.cronin@essex.ac.uk

If you are still not satisfied, please contact the University's Research Governance and Planning Manager, Sarah Manning-Press at sarahm@essex.ac.uk.

Clare Slater-Robins 3rd Year Professional Doctorate Student cs20074@essex.ac.uk

Appendix 8 – Consent Form

CONSENT FORM

Title of Project: *Exploring Parents experience of child health reviews with Health Visitors using video consultations*

Name of Researcher: Clare Slater-Robins

Please sign the Box

1. I confirm that I have read the participant information sheet dated..... (version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. I understand that any data collected up to the point of my withdrawal will be destroyed ☐
3. I understand that the information collected about me will be used to support other research in the future and may be shared anonymously with other researchers ☐
4. I understand that the identifiable data provided will be securely stored and accessible only to the members of the research team directly involved in the project, and that confidentiality will be maintained. ☐
5. I understand that my fully anonymised data will be used for the research thesis and publication in professional journals or conference presentations ☐
6. I give permission for the data as de-identified (anonymised) transcripts that I provide to be deposited in a research data repository so that they will be available for future research and learning activities by other individuals ☐
7. I understand that the information held and maintained by my health visiting team may be used to help contact me. ☐
8. I agree to take part in the research study to explore parents experience of video consultations ☐
9. I give permission for the interview to be recorded ☐

Name of Participant	Date	Signature
Researcher Name Clare Slater-Robins	Date	Signature

Contact details:
Parent Name-
Parent Email Address:
Parent Mobile Number:

Appendix 9 – Decision Ethics Committee

From: ERAMS <erams@essex.ac.uk>
Sent: 01 March 2023 14:27
To: Slater-Robins, Clare R <cs20074@essex.ac.uk>
Subject: Decision - Ethics ETH2223-0174: Mrs Clare Slater-Robins

Dear Clare,

Ethics Committee Decision

Application: ETH2223-0174

I am pleased to inform you that the research proposal entitled "Exploring Parents experience of child health reviews with Health Visitors using virtual consultations" has been reviewed on behalf of the Ethics Sub Committee 2, and, based on the information provided, it has been awarded a favourable opinion.

The application was awarded a favourable opinion subject to the following **conditions**:

Extensions and Amendments:

If you propose to introduce an amendment to the research after approval or extend the duration of the study, an amendment should be submitted in ERAMS for further approval in advance of the expiry date listed in the ethics application form. Please note that it is not possible to make any amendments, including extending the duration of the study, once the expiry date has passed.

Covid-19:

Please note that the current Government guidelines in relation to Covid-19 must be adhered to and are subject to change and it is your responsibility to keep yourself informed and bear in mind the possibility of change when planning your research. You will be kept informed if there are any changes in the University guidelines.
Yours sincerely,

[redacted]
Ethics ETH2223-0174: Mrs Clare Slater-Robins

Ethics Amendment – July 2023

From: ERAMS <erams@essex.ac.uk>
Sent: 04 July 2023 14:31
To: Slater-Robins, Clare R <cs20074@essex.ac.uk>
Subject: Decision - Ethics ETH2223-2257: Mrs Clare Slater-Robins

University of Essex ERAMS

04/07/2023
Mrs Clare Slater-Robins
Health and Social Care
University of Essex
Dear Clare,

Ethics Committee Decision

Application: ETH2223-2257

I am pleased to inform you that the amended research proposal entitled "Exploring Parents experience of child health reviews with Health Visitors using virtual consultations" has been reviewed on behalf of the Ethics Sub Committee 2, and, based on the information provided, it has been awarded a favourable opinion.

The application was awarded a favourable opinion subject to the following **conditions**:

Extensions and any Further Amendments:

If you propose to introduce an amendment to the research after approval or extend the duration of the study, an amendment should be submitted in ERAMS for further approval in advance of the expiry date listed in the ethics application form. Please note that it is not possible to make any amendments, including extending the duration of the study, once the expiry date has passed.

Covid-19:

Please note that the current Government guidelines in relation to Covid-19 must be adhered to and are subject to change and it is your responsibility to keep yourself informed and bear in mind the possibility of change when planning your research. You will be kept informed if there are any changes in the University guidelines.

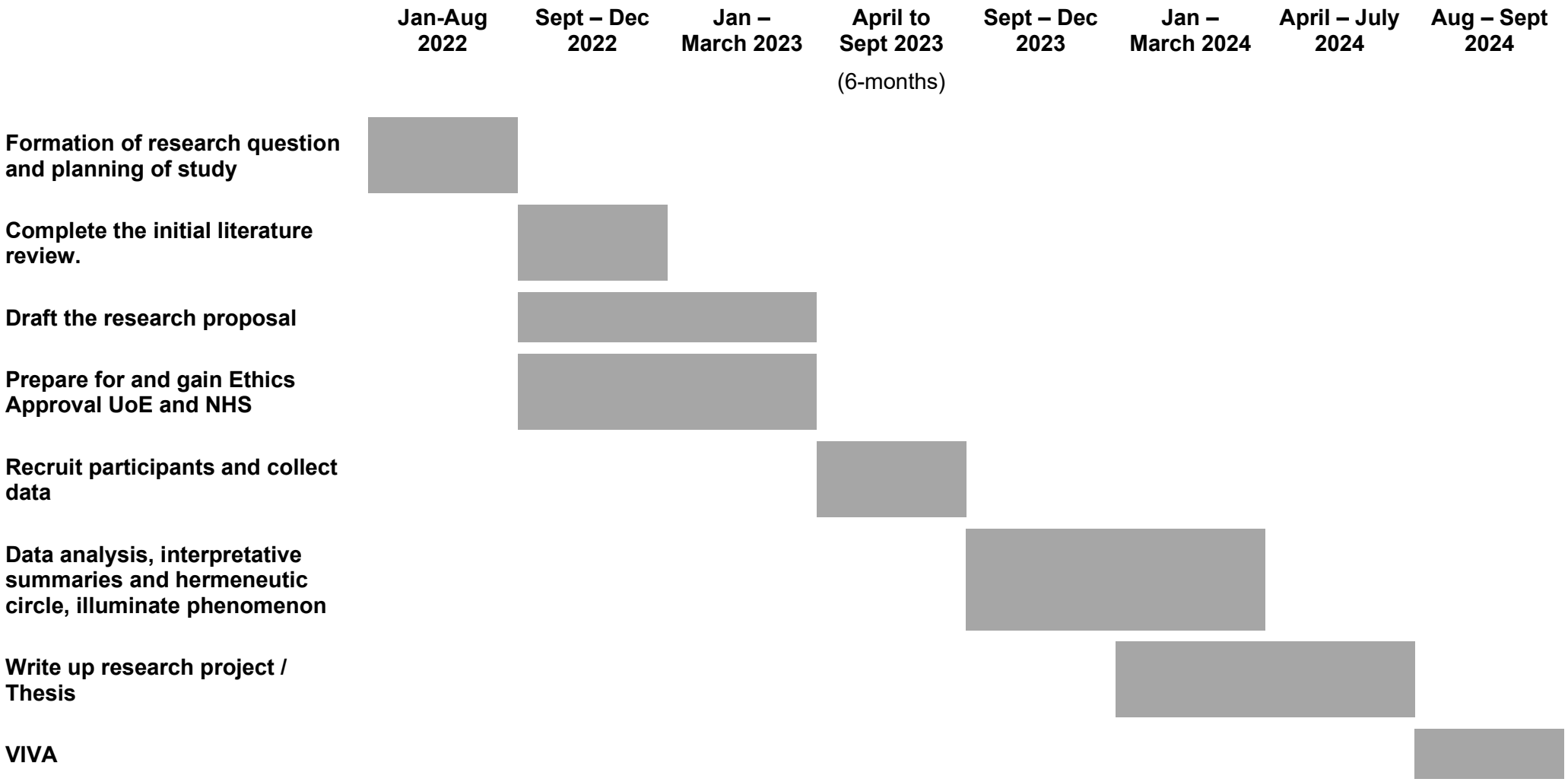
Yours sincerely,

[redacted]

Ethics ETH2223-2257: Mrs Clare Slater-Robins

This email was sent by the University of Essex Ethics Review Application and Management System (ERAMS).

Appendix 10: Gantt Chart for Research Project Timeline



Appendix 11 – Relational Themes Table

Relational themes across all transcripts
Black is written during the first read
Blue represents the reread for missing themes

Abbreviations in table
F-F= Face-to-face, VC= Video consultation, GP= General Practitioner, T/C= telephone call, HV= Health Visitor/Visiting

	Technical issues / logistics	Convenience	Big moment/ important visit / useful service	Box ticking / tick box	No physical examination / Observation	Hadn't met health visitor before	Risk assessment by health visitor	Parental assessment not professionals / the weight of responsibility was totally on my shoulders.	Would have preferred	The impact of COVID-19
1.Anna	Lost signal (p3), who could be seen on screen (p4), virtual waiting room (p5). Used to video consultation (p6). Child not on camera (p7), uncomfortable on laptop sitting on sofa. (p9, p11, p12)	Convenient to have at home (p3). Loved convenience (p12).	Important review/ assessment 9p4), first time, important opportunity to get advice (p7), support and encouragement (p8),	More of a box ticking exercise (p3), series of things to check and tick off (p8, p14).	Only wanted to see walking (p12)	-	It links to the Social worker side of things if there is a problem at home (p13), they are checking for safety (p14)	More asking us questions (p4), what if we reported it wrong? Are we giving the lady what she needs to see? (p6, p12)	Shame didn't get opportunity to meet in person (p3, p14)	I didn't love it during COVID, when we sat on the sofa, talking to people on the laptop, sometimes difficult to get a good position (p12)
2.Heidi	Propped phone up on dining table (p3), not seeing daughter, not wanting to breastfeed on camera (P3 &4), being sent a link	-	If I'd seen the HV face-to-face and if it was a confident experienced HV [it would have been a different outcome] (p10)	Scripted (p3), talk and type (p5, p13), just a general chat (p3)	Only held her up to the camera – disagreed she engaged with HV on screen (p2), HV couldn't see quantity of sick or how tiny she	Not met before, Lots of different HVs (p4)	-	I couldn't illiterate to anyone how sick she was, HV couldn't see how tiny she was (p2), you are looking at your baby day	She could have been weighed and her weight loss identified (p2), couldn't go into conversation in a bit more depth (p3), she could	People didn't want to see you in case you had COVID-19 (p7)

	Technical issues / logistics	Convenience	Big moment/ important visit / useful service	Box ticking / tick box	No physical examination / Observation	Hadn't met health visitor before	Risk assessment by health visitor	Parental assessment not professionals / the weight of responsibility was totally on my shoulders.	Would have preferred	The impact of COVID-19
	to appointment (p5). Wasn't given a choice of appt (p13)				was. (p8, p14, p15)			to day you're not really noticing if they look small or don't look the right size… its difficult , (p15)	have seen the sick (p6,9), would have divulged my worries. (P10,11 &14)	
3.Dee	Laptop, not seen baby on screen, bit of a faff downloading the app for the video consultation (p16)	-	I got the sense there just weren't really any HVs, it [the health review] was huge, it was the only thing in your diary that week – your only outlet. (p4, p15)	They feel a bit tick boxy – is everything OK yes / No, 'just checking', it sort of just skimmed the surface, (p2, p3, p6, p7, p13)	Literally a flash, he could be dead a year… and no one would know (p8, p9), I mean they literally looked at the top of his head (p16)	Its harder to build a rapport on a video consultation (p3), I think it is possible, but I think its quite a skill (p10). Hadn't built relationship or rapport (p14, p16)	They asked a lot of questions like do we have a car and how many bedrooms; it wasn't relevant to our situation and how we were coping. (p7),	In the end we bought, like lots of people scales .. but we didn't really understand the centiles (p3), We're gonna miss things we didn't know what we didn't know, (p7), Son asleep for health review., Don't know what a healthy new-born looked like, giving our reports. doing own research, there wasn't really any professional to go to for advice. (P7, p8, p10, p11, p12, p13)	First time mother, being a bit anxious (p4), would have liked face-to-face (p9), hard to build a rapport on a video consultation (p10), to see my whole child (p11). Explain the centiles, spend a bit more time, more reassuring, may be in person they would have picked that up (p16)	Born during COVID lockdowns (p4), We weren't seeing anybody, the HV was just out of retirement to help with COVID, no red book due to COVID (p4, p6, p15)

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4.Abe	Arranged via letters or emails (p3), Obligatory tech issues, one call was noisy and was stopped halfway through (p9)			Almost a tickbox exercise, if we can put a tick in that box then the forms done, to tick another box to say yeah this baby is fine, have you got a garden and going outside? OK great Tick!, less interaction (p2, p7, p8, p13)	All the things you couldn't check in an online environment because, you know, you cant sort of hold the child up to the camera and turn him round, showed the HV the cradle cap and umbilicus. They could see what he was doing, or how he reacted to a phone ringing, (p3, p12)	I did feel more comfortable asking Kay a question in person than the nurse I'd only just met online. (p14)	They were making sure we were OK, I suspect they did early on have us as a fairly comfortable in control couple without any risks. They knew Kay was a nurse, so they probably didn't have any major concerns especially when I can imagine the kind of concerns they did have with others. (p7)	If we weren't sure but said 'yes' they would have just ticked us off anyway, wet and dirty nappy example, (p4)	missing the 'person to person confidence that we got from someone' seeing them face-to-face, didn't involve our son as much as an in person one would, ive just never got into the zoom culture, I much prefer talking to people in person. (p6, p12, p14)	COVID was all kicking off, whole new world we were trying to navigate, the toughest bit was not being able to see anyone and not being able to show him off, They did their best (p, p3, p7, p12) but when you are locked in no one else is around no one able to sort of confirm it in person (p6)
5.Kay	Mobile phone propped up against the sofa while breastfeeding son, tiny picture and never asked to turn it around to show son, technology was	I didn't have to hoover my entire house, video consultation takes the pressure off in that way, I can see lots of benefits for		It felt disorganised and disjointed ..like she was just rushing through things (p3), Much like a tickbox exercise, ASQ	Normally we would weight your baby but as we are online we cant!, not able to see where the baby is sleeping and what is in the cot, Hv couldn't actually	Someone out of the area, every time you have an online conversation its with an entirely new person, no	Domestic abuse questions – having it online might allow the routine enquiry to be missed, so much potentially missed (p5, p17)	You can create quite a snapshot of what you want to portray, I actually feel it put more pressure on me as a parent because its	You can pick up little nuances e.g. eye contact, I feel like online hasn't and wont work. I think its very strange and uncomfortable, 99%b of the	Discharged night before lockdown, in COVID we had to things a certain way (p2, p17)

	Technical issues / logistics	Convenience	Big moment/ important visit / useful service	Box ticking / tick box	No physical examination / Observation	Hadn't met health visitor before	Risk assessment by health visitor	Parental assessment not professionals / the weight of responsibility was totally on my shoulders.	Would have preferred	The impact of COVID-19
	a complete nightmare, the screen kept jumping and we ended the call early, difficult to hear the voice call with children running around, the coldness of a computer screen P3, p6, p7, p12, p13,	the NHS – time, logistics, money saving like not having to pay petrol and mileage and time in between journeys (p9)		what did you tick… is he latching yes / no tick!, so many things asked as yes / no questions, example of breastfeeding given, it needs to be a wraparound not closed questions so people can open up about their experience, more information finding missions than a conversation. Functional, (p3, p7, p10, p11)	see him or have any interaction with him, you cant just follow your toddler around, (p3, p5, p14, p15)	personal bond, rapport, connection. (p3, p12)		down to me alone to spot and to know what is normal, I want you to be the professional and it not to have to fall on my shoulders, It feels like a massive pressure, I would like someone else to have a look at him and have an opinion as well. I want it to be a partnership. No one invested in how my kids were doing. (p6, p7-8, p8, p12)	time I would choose in person, missed personal connection – welcoming someone into your house, online is better than nothing, (p5, p8, p9, p12, p17)	
6.Lucy	Blue Jeans and 'Glitchy', stupid annoying app, that her son didn't understand that	-	Concerns I wanted to talk about (p1) I was looking for that reassurance… and she wasn't able to give me that (p12)	She was just very focused on what are the skills he was doing this tickbox exercise. (p4)	No physical health type of stuff, needed grommets, (p6)	Not met the HV before	-	I wanted someone to acknowledge what I was experiencing with my child and give me	He wouldn't engage with anything that was asked of him because he was at home and wanted to	Review Summer 2021 during COVID, COVID was an

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	the video consultation was interactive and couldn't understand that you could talk back to it. Long calls, the HV watched them play from the video consultation / laptop with her camera off, 'She's in our home without being in our home and hidden from our son'. Difficult to schedule calls with health services, people assume with video consultation that you can do it at the drop of a hat with no notice, (p2, p5, p6, p9, p12, p13)							their professional opinion. You want someone to give you permission to do those things because you don't always know if you are making the right decision. The weight of responsibility was totally on me to go fix all this stuff. (p13, p14)	do his own stuff, asked for face-to-face and was told 'no' (p6), feels her unpleasant experience was 50% video consultation and 50% the HV approach (p8). Unnatural interaction online turntakey (p8) (p2, p6, p8)	inconvenience (p1, p4)

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7.Naba	It depends on who is doing it as well and how much technology knowledge do they have – is it just sending a link and logging on? it was several portals before you were allowed in, training and support to HVs (p12, p13)	More convenient, flexibility of being able to do a video consultation, (p8, p2)	If you're a professional I feel comfortable to share information with you and I trust you have enough expertise to help me (p9)	It sounds very textbook based in a sense, so I can see how it does end up being a tick box exercise, (p11)	Didn't even ask to see her daughter during the video consultation (p3)	You know you are speaking to a HV, and irrespective of who the person is, if it's a professional then I feel comfortable to share information, the six month one was a lot more reassuring, its always a different person and you don't necessarily build a relationship, (p9, p11, P13)	-	They are just taking our word for it, the HV assessment was based on what she was saying (p2-3), its so misleading because I could have just put down 'yes' for everything and yeah she's doing great and I'm doing more damage to her development, its just taking our word for it without having done the assessment themselves, (p2, p3, p5, p6)	I would have liked a follow up in person to reassure us, I think in person would have been a bit more reassuring to see what she was able to do, I think it would have made a huge difference seeing the HV in person, face-to-face does actually trump video consultation, in a video consultation it might not be as easy to open up, (p2, p3, p5, p11)	Even post COVID, it more difficult to get an appointment, (p9)
8.Ivy	Short and not very helpful, link on phone and they tried to see her on camera as well, no IT	-	It's a very useful service, it's the only service for these ages to be able to go in, interact, identify and support so I	Tickbox not specifically mentioned 'A quick chat' (p5)	A quick chat, her height, her weight, her fine motor skills, her eyesight and hearing, (P5)	-	The HV knew she was 'on it' and there was no need for anything else, she was speaking to a	But its always good to check with a professional, mostly what you said she was like, there was	For a in-depth physical examination like they have in my country, (p5, p2)	Review during lockdown restriction in 2021 (p3)

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	issues, (p2, p3-4, p6)		think its crucial (p8) its always good to check with a professional (p3)				professional, educated, independent resourceful in a way of activities, services and money resourceful mum who was not in need and whose child was doing exceptionally well' (p4, p8)	nothing that needed to be explored or discussed about her health and development (p3, p7, p9)		
9. Oona	She used an iPad or laptop, joined a waiting room and was sitting for ages wondering if she was in the right place. Awkward and not flowing, doesn't think zoom calls would cause a problem for the majority of children, difficult to access the		I wouldn't skip any [health reviews] as I think its useful like the HV was able to signpost to speech and language services (p5)	Theres quite a few questions – 40 so we would have talked through them all (p6)	My daughter wasn't weighed after 12 weeks, you cant measure across zoom, (p9, p10)	Different HV each time have a child health review (p6), there isn't any continuity of care, aware of patchy service, (p6, p13, p17)	Felt as a teacher by background she was assessed by HV service as not needing much, (p5)	Just going to be chitchat, I would notice if my child wasn't really growing in height, relies on me as a mother taking my child [to clinics] and if as a mother I'm not informed and I don't think theres an issue going on then I worry children will fall off the radar. Story about cotton reels p11 and importance of	Nice having face-to-face… she could see where the child was based, the best system for me is when the HV comes to my house or in a private room somewhere', theres only so much you can get over a video consultation, cant replace the professional being in the room with all their experience	Post COVID I think we are headed [for more virtual], (p16)

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	HVT (P3, p4, p7, p9, p10)							HV assessment, someone professional confirm [her speech delay] and go yeah! I think she needs some intervention'(p4, p16, p11, p12)	and looking at the child, easier to assess, if something was going to be a shock I would rather have that face-to-face, easier to see if they are upset or need comforting, if Hv comes to your home shes seeing you have a safe environment, (p6, p8, p11, p13, p16)	
10.Tia	Text message and video consultation via WhatsApp, camera on, very short call – 10 minutes, I know about IT but what if someone doesn't or has an old slype phone which	-	I wouldn't have phoned them [HV] if I'd had a problem (p5)	Box ticking exercise, the Hv kept looking down at her paper as well as to ask the questions, and the questions were closed e.g., am I suffering anxiety? do I have	my guess is they would have wanted to have checked the bandage and the scar [from the caesarean] and how the breastfeeding was going, had the midwife not come and weighed the baby I would have been really	New birth visit contacted by HV (p2) this was my first contact (p14)	Ok because you aren't high risk, you aren't hitting the plus plus service you are one of the universal families, but you do still need reassurance. (p13)	she just needed to see him' (p4) but she felt that 'I could have shown her a doll', she wouldn't have any way of knowing he was okay or whether he gained weight, whether his colour was good because	Felt the video consultation put her off contacting the HV service again for problems, it's nice to have people come round, particularly health professionals for that	COVID restrictions, Freedom Day -restrictions had been lifted so disappointed it was a video consultation (p2) after COVID you don't want to be exposing

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	isn't compatible with video consultation, (p2, p3, p4)			depression (p3, p8, p7)	anxious about whether he'd gained weight. (p3, p4)			you can't see properly on a phone'. The HV can normalise the experience. (p4, p12)	reassurance, knowing that you are doing a good job.. and for someone to ask how you are. It's really different (p5, p13, p14)	them to loads of germs (p9

Appendix 12 - Reflexive Piece on Data Collection and Analysis Stage

Mindful that reflexivity is a self-critique of how my experiences might influence the research process (Patnaik 2013) when embarking on the research study I wrote the following piece on 22 November 2022 to help illuminate my preunderstandings and assumptions and be aware of my ontological position. It was updated at different stages of the research study for example literature scoping review and data collection and analysis on 13 February 2023 and 19 November 2023. I used the framework questions in Patnaik (2013 p 105-6), Hsuing (2008) and Dibley et al (2020 p140-145) to pose and answer questions.

General pre-understanding questions (Written: 22 November 2022)

How has my personal history influenced the choice of topic?

- Being a HV and knowing how the relationship with parents is key to achieving a positive outcome for the child.
- Experience in Covid and knowing that virtual communication is a skill that needs developing.
- Being a commissioner, I am aware that video consultations have continued in practice but that there is not the evidence that they are meeting the parents / or service needs.
- Desire to involve / know what parents view is of something that's been imposed on them – I've always been interested in parents' views / feedback.
- I have a knowledge of what is covered in a health review and whether the parent would be happy with what they have received when they describe it.

What are my personal value systems that may influence the process of research?

- Fairness – I have a heightened sense of fairness and feel its unfair to impose a way of communicating on people if it doesn't suit them.
- I believe in good health and wellbeing and that people are entitled to have knowledge that helps them to achieve good health.
- That all are entitled to live a life that is informed by good healthy choices.
- I believe in autonomy and that people should have a say in how they are interacted with.
- I am interested in how people think, feel and experience things – qualitative!

How do my gender, culture and professional background influence my positioning in this topic and my relationship with the participants?

- I am coming to this project as a health visiting professional with a potential bias towards the HVs who conduct the video consultation. This can be mitigated by active listening and giving the parents the time to elucidate their views and experience.
- I have worked in the health system since I was 17 and it is a golden thread through my life. I believe that people have the right to make choices that are best based on advice and information.
- I would imagine most of the parents I will be interviewing will be the mothers and therefore female – I might therefore find them easier to relate to being a female too.
- I am white British, and this may have a cultural influence that I need to be mindful of e.g. understanding peoples experience of the HV service and video consultation.

What are the alternate roles I might be called upon to play while interacting with the participant, apart from my primary role as researcher?

- There is a risk, as a HV myself, that I might be expected to give advice, help and support especially if the parent had a negative video consultation experience. Given my nature and desire to help and 'fix it' I shall have to be very mindful not to turn the interview into a professional consultation!
- The technical aspects of the interview – if it's a virtual one – would also place me in a position of authority which might inhibit the conversation and information given and gained.
- Recording the interview needs technical skills.

What are the possible advantages that I have in terms of personal history and professional competence?

- I have extensive experience of interviewing people – mostly for jobs but some for my MSc research. I also have extensive experience in professional mentorship and coaching as well as 1-1's with people for investigations and management. While different, the techniques employed will, I imagine, be a little similar and the active listening that I have learnt over the years will be helpful.
- I hope that I will exude a sense of trustworthiness and confidence that will help put the parents at ease and feel they can talk to me about their experience.
- That my inherent knowledge of the health review i.e. that I used to carry them out will help me to understand what they are describing and show authentic empathy towards them.

What might be the barriers that my personal history and professional competence can create during data collection?

- There is a danger that I will make assumptions and judgements based on my own knowledge rather than digging deep and probing about their experience.
- That I will identify with them and not ask further questions that might illuminate the difference between their experience and my own.
- They may not wish to talk to me believing that I am on the HV 'side'.
- That I may be too confident, and problems and issues may arise that I wasn't expecting. I need to put myself in their shoes and plan everything about the interaction so it's positive for them.

How are the emerging data assimilating with my prior knowledge; making me revisit an earlier stance? (Written: 19 November 2023)

- There are aspects I would expect to see in the data e.g., issues with technology, the video consultation being a bit of a tick box exercise, benefits of convenience. And my own view would be that video consultation is convenient as there is no travel time or finding parking places for appointments. I was expecting COVID – 19 to be an influencing factor in the video consultation being arranged for some parents.
- However, there are surprising elements too around participant knowledge that the health visitor probably assesses parents and decides the level of care required and they might have received the video consultation because they were considered low risk.

- I hadn't expected the phenomenon to be around the fact the parent had to perform their own assessment of their child because the HV was not present in the room and that most felt unequal to this role and wanted the HV to do it. This caused some of the dissatisfaction with the video consultation as the mode of completing the child's health review.

What is it about me that helps or hinders the project, and what, if anything, do I need to do about it?

- My professional background as a HV and my current role as a commissioner could be seen to help and hinder in different ways e.g., it would help in that it gives me credibility with the parent that I understand children and their health and development. However, it could hinder the process because the participants might assume I knew what they were speaking about and not elaborate on their experiences.
- The qualitative interviewing probing would be essential and to be aware of this aspect, so I probe and don't assume I know what the participants mean.

Why am I interested in this topic? Who will it benefit?

- See above answer regarding personal history affecting choice of topic. The benefiters from this research would be children and their parents. If there are ways of improving video consultation so that it meets the service and parents needs, then this would be an improvement. Hearing the parents experience will inform the debate about how to carry out video consultation safely and there may be some aspects this research uncovers that help.

- The health visitor service delivery would also benefit from more research evidence about video consultation as it is probably a cost-effective way of delivering some of the health reviews and evidence is required to support it as an intervention if positives are experienced by the parents.

Is there another way of investigating it?

- This could have been a quantitative research project using a survey with a variation on the research question which would find out parents' experience of video consultation and might have gained more responses.
- However, I believe that this would not give the depths of answer this needs in order to find out and explore what parents experience were of a video consultation and to give them the time and space to talk about it and what they feel were barriers or enablers.

Literature scoping review (Written: 13 February 2023)

Does this research article help my question?

- The articles were carefully selected following a wide literature scoping review to be the most relevant to my research question.
- I used a inclusion and exclusion criteria and a timeframe of 23 years (2000) to enable me to get the most relevant.
- All the articles except two pertained to adults and it will be interesting to see if my research reflects the themes in the article's participants experience.

Am I only choosing it because it supports my original view?

- I think there was a risk of this as I read the title and abstracts but I was conscious that it was important to find articles of all viewpoints so my search words were broad e.g., video consultations, experience, parents rather than anything that might be considered leading.
- I'm not sure I have preconceived ideas of the findings of the research study as it may be that it's such an individual experience based on personal history, bias and experience.

Am I holding myself open to the 'other' and considering alternatives?

- I was mindful that this was important which was why I conducted a scoping review rather than a literature search as I wanted to gather everything available on video consultations.
- On reading the articles, especially as they were predominantly concerned with adult patients views and experiences, I was mindful that this may not be the whole story and that a parent's experience could be very different or be similar.

Recruiting study participants

What is it about me that will likely encourage people to participate?

- I'm hoping that participants will find the topic interesting, important and have a view on it.
- I'm presenting as a professional who wants to make a difference in this area and may be influence policy in the future.
- I will present as friendly and professional and acknowledge that they are busy people whilst being very thankful for their time.

- I am able to access local place-based WhatsApp groups which may be regarded as personal recommendation.
- My friends, family and colleagues are prepared to use personal capital to help recruit participants and this may help recruitment.

What will likely discourage them?

- I am not offering an incentive for taking part.
- They need to read the participant information sheet and then consent before even giving me an hour of their time for the interview.
- Its time that they probably don't have especially being parents of children under five!

Data collection (Written: 19 November 2023)

What am I hearing from the participants and is it coloured by my preconceived ideas?

- I'm hearing their own personal stories coloured by their circumstances, professional background (in some cases) their personalities and experience.
- I was able to build a rapport with them and they all seemed comfortable to share their stories and to share intimate details.
- I was surprised by some of what I heard so I don't think it was coloured by my own preconceived ideas although quite a bit was also expected.
- I heard that choice of how they received their child's health review was important as was having it in a conversational and non-judgemental way.

- I was expecting them to be more positive about having video consultations especially the convenience and time-saving element, but this was not their experience.

How do I rephrase this issue to the participant without negatively prejudicing it (introducing bias)?

- I asked as few questions as possible and had an opener that just asked them to tell me about their experience of having a child health review using a video consultation.
- With some I had to do more probing and as the interviews progressed, I became more competent at asking hermeneutical phenomenological questions and active listening.
- It is acceptable in hermeneutic phenomenology to ask questions about an issue that has arisen with previous participants but overall, I tried not to do this.
- I always asked if they had anything further to share with me and this usually produced some more interesting narrative.
- Keeping the questions to a minimum and keeping it conversational and friendly seemed to allow the participants enough time and space to share their stories without me guiding it (introducing bias).

Have I adopted the phenomenological attitude which keeps me open to the possibility of 'other'?

- I think for the most part, being a novice hermeneutic phenomenology researcher, I was able to do this. My individual reflexive pieces after each interview charted my

view of whether I had achieved this or not and in 8/10 I felt that it had gone well, and I had managed to keep the hermeneutic phenomenology attitude and manner foregrounded.

- Asking broad open questions allowed the participants to speak about their experience in their own way, and not taking notes but being able to fully absorb what was being said helped me to be focused on listening and non-verbally encouraging them to share their experience.
- There are definitely parts of the transcripts which are not relevant to video consultation but allow the participants to tell their story uninterrupted which then leads to a relevant insight.

Data analysis (Written: 19 November 2023)

Am I seeing what I want to see here?

- I don't think I am.
- I think I have read the transcripts and coded them very honestly without interpretation, making note of the things they say about their and their childs video consultation experience.
- I have then taken the notes and written the interpretative summaries and a table of themes which have then been combined into the collated table of themes.
- I think because they are each person's personal narratives, and they are very alive to me as the researcher, and I immersed myself in their stories it is possible to keep them from being too mixed up in my own expectations because they are obviously someone else's story and experience.

- I want to keep true to the participants and not misrepresent them in any way mindful of my responsibility to conduct ethical research, so I have been very mindful of this aspect throughout the process.

Am I seeing what I expect to see here?

- There are aspects I see that I expected. I expected to see a theme around technology because of the topic video consultation.
- I expected to see a theme around convenience because it was an active theme in the literature scoping review and while it was present it wasn't spoken about or appreciated much so isn't a constitutive pattern.
- There's so much that I didn't expect too, I didn't expect the experience to be so influenced by the persons personal views and circumstances e.g., if the baby was ill the video consultation was poorly tolerated and disliked or that being a healthcare professional by background didn't mean they liked it or felt it was useful.
- I didn't expect such a range of experiences and for them to be influenced by so many factors e.g., a ten-minute new birth video consultation, for the health visitor to only glance at the baby on camera, for the health visitor to ask to observe the child playing while having their camera and microphone off.
- I didn't expect my main constitutive pattern to be the lack of health visitor assessment of the child and parents feeling the burden of responsibility for knowing what was normal or what was wrong with their child, which was universally mentioned and disliked.

Am I keeping myself open to the possibilities of alternative meanings and explanations with this data?

- Absolutely!
- This is part of the hermeneutic phenomenology attitude that is so vital to the data analysis part of the research, and I have consciously been doing this.
- I have allowed ample time for ‘dwelling’ in the data whilst doing everyday tasks, I have listened to video tutorials on Heidegger’s philosophy and read widely around his philosophy to help me to be open to ‘other’ meanings in the transcripts.
- I have discussed them with my supervisors, family, and friends as well as colleagues to garner their insights into the content and to test out my understandings and analysis.
- I have listened to the recordings again and again to glean any nuances that may have been overlooked to ensure I represent them in the fairest, truest way possible.