# *NMC Consultation on the proposed competency framework for specialist community public health nurses*

*Response from the Community Practitioners' and Health Visitors' Association (CPHVA)*

As a leading professional organisation and trades union representing a significant majority of community practitioners and health visitors affected by the outcome of this consultation process, the CPHVA is pleased to be able to offer its response.

This response has been compiled following consultation with our general membership and builds upon existing organisational policy.

## Introductory comments

In our response to the previous consultation concerning the potential for a third part of the register, the CPHVA welcomed the fact that registration on this part of the register should relate to practice in a public health and population based context. This practice is distinct from general nursing, which largely involves the provision of care to ill people, and midwifery - the provision of care to expectant and new mothers and neonates.

Furthermore, we accepted the title 'Public Health Practitioner' for the third part of the register as a suitable descriptor for the broad group of practitioners (including school nurses and health visitors) engaged in public health and population based working. Subsequently, the title 'specialist community public health nursing' has been adopted. Although this is not the title we would have preferred, it is in place and we are prepared to work within it. However, we still believe it is important to recognise the specific competency sets associated with current roles.

For example, health visitors are well recognised as having specific competencies which they make available to individuals, groups, and communities. We believe that titles such as health visiting describe well-established roles even though these may change and develop in the future. Being able to define roles through the competencies required to execute them, and preventing those without those competencies from doing so, is also an essential asset so far as public protection is concerned.

As such, the CPHVA was, and continues to be pleased to see that health visiting is recognised within the third part of the register, and we support the continuing use of the health visitor title for those practitioners who believe it is the best descriptor of their practice.

Other groups of practitioners, for example school nurses and occupational health nurses, who readily identify with the descriptor 'public health practitioner' will also be eligible for registration on this third part of the register.

Again, whilst they will, by definition, be public health practitioners, they should be able to use their current titles as a useful marker of the competency sets they possess and make available to their respective client / patient groups.

The CPHVA appreciates the need for the NMC to adopt competencies which are sufficiently broad as to capture all potential registrants claiming eligibility for registration on the third part of the register, but in giving consideration to the above points we do not feel that the competency framework being proposed is sufficiently detailed to provide continuity in defining health visiting and school nursing roles in particular. Neither does it provide sufficient detail to enable employers to identify practitioners with competency sets they require to perform specific roles, nor does it provide educational institutions with enough of a guide to design curricula enabling the delivery of practitioners capable of providing highly specialised contributions to public health.

The NMC may dispute this being its role, but the CPHVA believes that if a broad competency framework is to be adopted so far as access to the third part or the register is concerned, that Council must be forthright in producing companion guidance stressing the need for employers to ensure that practitioners have adequate specificity of competence to fulfil well established roles in primary care such as health visiting and school nursing. This must surely be in the interest of the public and practitioner alike.

Turning to the proposed competencies specifically, we are pleased to see resonance with the tried and tested principles of health visiting but detect a warping of these values as the Council seeks to capture a wider range of practitioner within the third part of the register. In particular, there is an underlying theme of individualistic care provided through a biomedical focus and pathogenic approach to health improvement favoured by public health medicine and clinically oriented nurses. This differs from the positive health / holistic approach favoured within health visiting, school nursing and midwifery and represented within previously agreed and utilised competencies for health visiting practice. Both approaches are necessary in addressing the health development needs of individuals, families and communities, however it is important to recognise that specialist community public health practitioners should major on preventative strategies rather than acute intervention once ill health has been identified.

**Section one**

**1. Areas of principle and domains of the competency framework for registration as a specialist community public health nurse**

We would agree with the broad tenets of the areas of principle but wish to comment on concerns around 1C and 1D.

Bearing in mind what has been said above about the broad nature of the competencies, we believe that the statements in 1C and 1D should be

augmented by the addition of the words ‘of individuals and communities’ after ‘health needs’ and ‘policies affecting health’ in the respective statements. This emphasises the ability of the practitioner to work at an individual level, with a family or group of people, and also engage in public health work on a community or neighbourhood scale. It is important that practitioners are able to exhibit the degree of flexibility and that individual and family needs are met in addition to adopting a macro community approach to public health.

## 2. Domains defining the areas of principle

### A. The search for health needs, including surveillance, assessment and ethical management

We broadly agree with the competencies A1, A3, A4, A5, and A6, but have difficulties with the wording of A2. The emphasis on screening in A2 again tends toward a medical model approach. Likewise, previous health visiting competencies contained the ability to ‘search for health needs’ and this is under represented in a competency based around the ability to ‘screen’. We feel this could be clarified by rewording A2 to read ‘Assess and screen …’.

### B. The stimulation of health needs including strategic leadership, and promoting and protecting health.

We would agree with the general intent of the domain but consider the competency set to be rather vague. We would wish to see increased emphasis on the ability to network within communities and work collaboratively with other health and social care agencies and informal organisations. Competency B2 hints at this but needs to be more specific.

### C. The influence on policies affecting health, including developing quality and risk management, policy and strategy development, plus research and development.

We would agree with the competencies outlined in this section but consider them to be rather reactive. We believe there should be an additional competency with respect to the practitioners ability to influence and participate in the derivation of novel policy and research rather than exclusively responding to existing policy and altering practice on the basis of the work of others.

### D. The facilitation of health enhancing activities, including developing services and programmes, plus working with and for communities.

Again the competencies are generally reasonable but we would wish to see elaboration on the theme of ‘working with others’ as per comments relating to B above.

Additionally, whilst the intent of D4 is reasonable the risk management approach to public health is not necessarily appropriate for the attainment of

public health objectives in the long term. We would wish to see reference to the ability of the practitioner to work with groups and communities to identify long term health goals and potential barriers to achieving them with the ability to develop strategies to overcome these.

**Q.3. Competencies supporting the domains**

The competencies as laid out by and large relate to the domains they are associated with. However our comments above indicate that these competencies need to be amended as suggested and added to in order to ensure we have practitioners able to fully meet the intent of the domains.

**Q.4. Length of the programme**

There is an overwhelming opinion amongst CPHVA members, be they academics, practitioners, or those engaged in providing educational opportunities in the workplace, that the proposal to have a course length of 32 weeks is inadequate. The CPHVA believes that in order to properly educate the public health practitioners of the future a course length of a minimum of 40 weeks will be required. We are satisfied with the 50:50 practice to theory split.

**Q.5.**

The CPHVA is a professional union for community practitioners and health visitors.

**Q.6.**

The current membership of CPHVA is 20 000.

**Q.7.**

This response has been compiled following consultation through our Executive Committee (members of which have been democratically elected through local and regional representative systems), and with CPVHA centres (the forum for meeting and discussion at the base of the organisations' structure).

**Q.8.**

The CPHVA has a headquarters building in London but operates throughout the UK with a significant number of members working abroad, primarily within agencies working with families of service personnel.

**CPHVA**
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