The CPHVA's Response to the UKCC's consultation document

`Requirements for programmes leading to registration as a health visitor`

The CPHVA welcomes this consultation document as a very positive response to the concerns expressed by the profession regarding the nature and kind of health visitor education and preparation over the last ten years. The CPHVA believes that the current policy and professional climate facilitates the development of health visiting as a major contributor to the public health agenda and that this consultation document and accompanying report is very timely.

The CPHVA particularly would like to commend the clarity of both the consultation document and the accompanying report. The latter gives a very comprehensive overview of the professional, research and policy initiatives in the four countries of the UK and the implications of these for both education and practice. The conclusions it draws as to the core functions of health visiting, its contribution to the public health agenda and potential future development provide both clarity and a vision that will greatly enhance the current moral of health visitors and provides a blueprint for the future.

Particularly welcome is the reaffirmation of the public health role of health visitors with groups and communities that has been eroded during the period of GP fundholding. Section 5b of the report demonstrates very cogently the tension created by placing health visiting education within the specialist practice framework. **The CPHVA welcomes this analysis and supports the idea that this has hindered the development of the public health role of health visitors.**

Using the principles of health visiting as a central framework for the development of competencies confirms the CPHVA's view as to their relevance to today's health service. The CPHVA is sure that this framework will ensure a sound basis for developing a family centred public health service. It lays out a clear but ambitious programme on which to base health visitor education and allows a broad and dynamic base for health visiting practice. It is important to recognise that these competencies at the point of registration will need to be developed and built upon through continual professional development and lifelong learning. The CPHVA also welcomes the continuation of the 50% theory and 50% practice split to the programme.

The use of definitions early in the consultation document is helpful. While welcoming the definitions in Section 2 of the consultation document some concern is expressed about the terminology in point 5. The term "living in the same socially deprived area" does not recognise the potential health needs of all areas and social groups and would be better replaced with something more inclusive.

The CPHVA is encouraged that these competencies will map across to other developments within public health education so that health visiting is recognised within a wider public health career pathway.

It is critical that these standards are robust to ensure that variability in interpretation by both educational commissioning bodies and education institutions

is minimised across the UK. With this in mind the CPHVA would like to see some clear recommendations on the following points.

Length of preparation

There is considerable evidence that the minimum requirement of 32 weeks is insufficient to prepare practitioners with the necessary knowledge skills and attitudes that are required for practice and to ensure the proper protection of the public.

Health visiting is a separate registration that has a unique body of knowledge. Standards for programmes of preparation must acknowledge the acquisition of cognitive skills in this area of practice as well as the application of those skills in the complex arena of community and primary care. Although this knowledge may build somewhat on that previously acquired at first registration, there is considerable new knowledge and skills, separate and distinct from that gained at first level registration, to be acquired. There is evidence to suggest that programmes at first level registration do not address issues of health promotion, public health and primary and community care in sufficient depth. This may be especially true for particular branches, Therefore students entering health visitor programmes may have varied educational needs in these areas and a common baseline of knowledge and skills cannot be assumed. There is also anecdotal evidence that suggests some health visitors receive insufficient input in some basic areas of knowledge (e.g. development and nutrition) related to the promotion of family health. There have been mandatory additions to the curriculum such as nurse prescribing without any additional time in length of preparation.

In addition, entrants to health visiting programmes come from a wide range disciplines within nursing and midwifery. They are usually entering the community sphere with little previous experience of it. As such they are disadvantaged when compared to other entrants to community specialist courses and this necessitates a longer period of preparation.

To deliver the whole range of public health competencies, programme leaders and practice educators may wish to ensure that students have experience of different models of practice e.g. HAZ areas, within Surestart projects. This will need to be supported in dedicated time within the programme.

Health visiting is a process over time and the evaluation of tangible outcomes of practice requires long time frames. For students to experience the process of practice and evaluation they require a period of consolidation at the point at which they have acquired the basic competencies.

The CPHVA believes that these standards cannot be delivered in a 32 week programme and we recommend the Regulatory body give a clear indication that a higher figure of at least 48 weeks should become the norm.

Teaching and Support in practice
The CPHVA has been concerned for some time about the variation across the UK for support for students in practice. It has consistently argued that practice teachers for health visiting and other community specialist practice students should be prepared to the level of practice educator, eventually at Masters level. There is nothing in these standards that dissuades us from this view. The practice teachers that have only achieved the outcomes for the preparation of mentors would not be sufficiently prepared to address the requirements of these standards from a practice perspective. The regulatory body must recognise that, robust assessment of competence to practice and the concomitant protection of the public, require that practice educators must be of the highest standard. Standards for practice placements and the resources to support education in practice as outlined in *Placements in Focus* (1) continue to be poorly developed in community settings. Practice educators must be adequately prepared not only to deliver a better education at an appropriate level but also to act as an educational lead within PCTs. Given that 50% of the course is based in practice and there is uncertainty as to what is best practice in the emerging new primary care organisations, the Council is strongly urged to make standards for practice education in all community specialists explicit.

In addition, it is crucial that programme leaders and those lecturers that have a significant contribution to the planning and delivery of curricula to meet these standards have expertise in the theory and practice of public health and health visiting.

The CPHVA recommends that the standards include clear statements about the standards for teachers and practice educators who are to deliver these programmes

Individual / family/ community focus
While welcoming the approach that recognises the health visitors' role in the wider community, it is important not to lose the considerable expertise and strength of the health visiting service's work with individuals and families. This is important for two reasons. The development of healthy children and families is the cornerstone of public health. Secondly health visitors are increasingly leading teams that deliver child and family focussed health promotion services and need to have knowledge and expertise with which to be credible leaders.

Many families and individuals in vulnerable groups will require individual input before being able to participate in and contribute to wider social groupings. Individual work is a vehicle for identifying hidden health needs and for advocating for priority to be given to those needs. This approach requires considerable expertise in communication, partnership working and reflection in practice. These skills need to be more explicit in the framework.

The CPHVA would also like to see some strengthening of this focus within the standards in particular in relation to the protection of vulnerable individuals and in the area of mental health. Child protection and domestic violence are two areas that illustrate the need for both an individual focus and a wider strategic public health role. The specific skills and competencies for dealing with abusive situations at individual and family level need to be strengthened.

The promotion of mental health needs to be more explicitly described in the standards. The agenda around strengthening relationships within families and supporting parenting

clearly identifies the importance of family centred work in raising both individual self - esteem and developing resilience. This individual work has a direct effect on community capacity building. The recognition and treatment of postnatal depression and its affect on children is unlikely to be addressed at other than individual family level in the first instance.

These issues could be addressed by providing more illustrative examples as to how the framework could be used to support more task focused activity such as the management of child health promotion services, postnatal depression, domestic violence and child protection
Other additions could include;
P9 A3 establishing contacts with *individuals families and groups*

P13 B3 the definition of support could be more properly illustrated by *raising self-esteem, encouraging and enabling self-efficacy, providing active listening and /or non-directive counselling.* Writing letters and making phone calls are part of this process but not central.

P 17 D3 There needs to be some explicit mention of child protection and implementing the principle of paramountcy

The CPHVA recommends that the competencies are strengthened in regard to work with individuals and families so that a balance between this work and that with groups, communities and at a strategic level is maintained.

Leadership and Management
The identification of competencies, which relate to management, decision making, professional leadership and team leadership functions, could be strengthened across all the domains.

Possible inclusions for example
A2 *leading teams to implement planned programmes of care*

A8 *making decisions about redirecting service provision in response to these assessments*

B1 *practice project management skills to participate and lead health promoting campaigns*

C2 (f) add in *vision*

C5 *promote a culture within teams that values honesty reflection and learning from mistakes as tools for improving performance*

D3 *provide support and supervision to team members to ensure clear lines of accountability and responsibility in relation to vulnerable groups*

D4 *leading and managing teams*
dealing effectively with difference and conflict in teams

Professional leadership and team leadership are increasingly important for the future development of public health roles and competencies relating to these should be more visible in the standards.

Cultural and ethnicity issues
There is no specific reference in the framework to being competent to work in a multicultural society or have an ability to reflect on issues to do with race and ethnicity both for delivering services and in working within teams. This could be addressed both in the introductory paragraphs and in the competencies. For example in Section A the search for health needs there is no mention of cultural or spiritual needs or of ethnicity as a factor affecting health.

The CPHVA recommends that further consideration be given to ensuring that practitioners are culturally competent in relation to public health practice.

Research and evaluation
It would be useful to incorporate some specific competencies about research and evaluation. This is another issue, which may cross domains, but examples of what may be included could be.
Ensuring the use of current research in development of practice
Promote the capacity of self and teams to understand and use research findings
Undertake small research projects in practice
Build appropriate evaluation techniques into all service provision
Enable users groups/clients to be involved in service planning including setting client centred outcome measures

The CPHVA recommends that the standards be strengthened with specific reference to the application of research and evaluation skills.

Entry gates
The CPHVA is aware of concerns and debates about the entry gates to health visiting. There are instances whereby student commissions have not been filled this year because of insufficient students of the right calibre coming forward. This situation is open to geographical variation but is of concern, given the commitment to increase numbers in training over the next few years. As previously discussed students entering the programme have a wide range of backgrounds and a common grounding in relevant areas of knowledge and expertise cannot be assumed. This issue needs to be addressed. In order for parity at exit to be achieved, some consideration needs to be given to addressing the inequitable position of students at entry to the programmes. There is a need for career guidance to those practitioners wishing to access health visiting and a clear statement about suitable routes and flexible programmes of preparation for individuals before entry to courses. Models where students are given experience in the community prior to the course or are actively encouraged to join skill mix teams prior to undertaking the course are to be welcomed but at present depend on the foresight of individual managers and education confederations. Urgent consideration needs to be given to developing a framework for clear career trajectories within nursing.

Other public health nurses and community practitioners
The CPHVA recognises that, in time, this framework will provide a suitable basis for the development of other fields of public health nursing practice including school nursing and occupational health nursing. The public health function of other community nurses also needs to be recognised.
The CPHVA is conscious both of the models for pre-registration education suggested in *Fitness for practice and purpose* (2) and developments in legislation regarding the position of other community practitioners. This requires an urgent look at the educational standards for all community practitioners as an entity in order to establish a coherent and robust framework to prepare a professional workforce that can deliver the whole range of public health and primary care nursing functions. This should include a review of the place of new initiatives, notably those occurring in Scotland with the development of both public health nurse courses and the piloting of family health nursing. In the short term, some consideration needs to be given as to how the present competencies relate to these specific developments to ensure that newly qualified practitioners from these courses can practice safely across settings.

Return to Practice
The CPHVA is concerned about the patchy development of return to practice programmes that meet the professional requirements of both health visiting and other community practitioners. The acceptance of return to practice programmes that are based on nursing and institutional care, as appropriate for community practitioners must be challenged. These competencies will provide a useful framework for the further development of programmes that focus on community and public health as essential competencies for these groups of returnees.

Requirements relating to maintaining registration
The CPHVA notes the position regarding maintaining registration as described on P.9 of the report. Since the requirements of PREP have been enacted, the CPHVA has found this to be an extraordinary anomaly. It may reflect the 'letter of the law' but certainly does not reflect either the spirit of the regulations or proper professional accountability. The CPHVA would like to recommend that the new Council takes urgent steps to ensure that all health visitor registrants and community practitioners specialist are required to meet their PREP requirements within the main area of practice within which they are practicing, for the period of time of that registration. This will be congruent with the high standards of self-regulation, which we believe the UKCC has been instrumental in establishing throughout its term of office.

Other points of clarity
There are a number of references in the appended Statutory Instrument to the role of the boards most notably in the indexing of students, in approving integrated and modified courses and in their role with students who have a non UK public health qualification. It would be helpful to identify the mechanisms by which these functions will be undertaken following April 2002.

References

1. DOH/ENB, 2001, *Placements in Focus. Guidance for education in practice for health care professions*, London, ENB.

2. UKCC, 2001, *Fitness for practice and purpose. The report of the UKCC's post commission development group*, London, UKCC.