Controversial questions (part two): should there be a direct-entry route to health visitor education?

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Abstract
This is the second paper in a series of three, drawing on the experience of providing evidence to the Health Select Committee's 2008 inquiry into health inequalities. Material submitted has been adapted and expanded according to three common and often controversial questions. One member of the committee enquired about the relevance of education and training to recruitment issues in health visiting, asking why it is necessary to be a nurse and what would be the barriers to changing this arrangement, which has been in force since the 1960s. This paper summarises some of the longstanding discussions about this issue, which has rarely been off the agenda, and proposes that, since health visiting is no longer in statute, the time has come to take a radical approach and to change current arrangements.

Key words
Health visitor education, recruitment, workforce crisis

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Introduction

This is the second of a series of three 'controversial questions' papers. Questions may seem controversial because there is little consensus about the answer, or they may be considered hostile because they challenge established norms or stereotypes. Both of those apply to the question of whether we should have a direct-entry route to health visitor education. In addition, the question is confused by a wide range of different understandings about the meaning of a 'direct-entry' route to health visiting education, along with various views about how (or whether) this could be implemented to benefit both service provision and the profession.

Sometimes, asking a different question can reduce controversy. In this case, discussing the wisdom of expanding the entry gates to health visitor education has been superseded by a far more urgent question, which is: 'What can we do about the workforce crisis engulfing health visiting?' This major problem is exercising the minds of service managers and workforce planners across the country. However, there is a tendency, called the 'tyranny of the urgent', for urgent matters to crowd out important things.[1] An important and enduring question is: 'How can we enable continued improvements in practice through education?' Educationalists can achieve improvement through programmes that ensure future practitioners are able to function confidently as health visitors, with the depth of understanding, knowledge and professional skill required to meet present and future expectations. However excellent, educational programmes can only succeed in improving practice if there are suitable students on them, and there are two difficulties here. Recruiting suitable students is no easier than the recruitment of qualified health visitors. Also, there are major inequities in career possibilities. Health visitors lead and collaborate in multidisciplinary and multi-agency teams, with colleagues who may wish to progress through health visitor education, but be disbarred by the entry criteria.

This paper will begin by looking in more detail at the imperatives for change suggested above, before exploring the barriers, and then identifying potential mechanisms for fast-tracking students to qualification from a wider range of backgrounds than is currently allowed.

Why is change necessary?

Improving practice through education

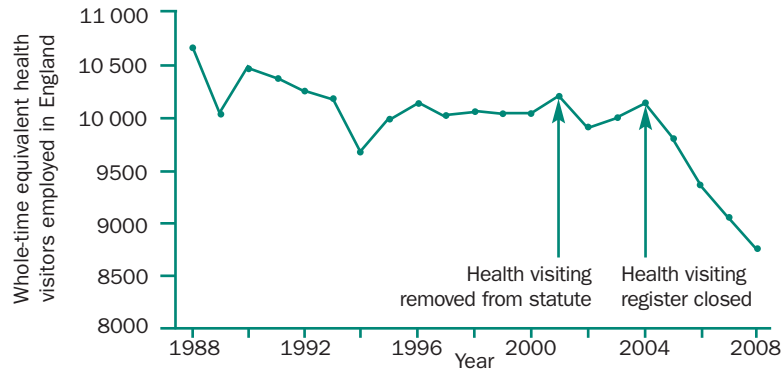
The first, major reason for change is to enable continued improvements in practice, by ensuring that all new entrants to the profession are fit for practice and purpose as health visitors. This should be the primary function of all qualifying programmes, and most higher education institutes (HEIs) provide a statement to the effect that their curriculum aims to achieve this. However, it is strange that this key function has not been the basis for official standards for 15 years, apart from a brief period between 2002 and 2004. Instead, standards set for health visiting programmes – by the United Kingdom Central Council for Nursing Midwifery and Health Visiting (UKCC), then the regulating body – were intended to establish a 'new, integrated discipline' of community healthcare nursing.[2] To that end, the community specialist practitioner qualification (SPQ) framework[3] required at least one-third and up to two-thirds of programme content to be shared with various community nurses, and to focus on the delivery and management of nursing care. With the length of the programme reduced to a minimum of 32 weeks, including 50% in practice, the ability of HEIs to ensure high-quality education was seriously compromised. Soon, various reviews and research studies testified to the inadequacy and inconsistency of the SPQ programmes.[4-7]

A two-year curriculum development project was instituted,[8] leading to a new set of 'requirements for pre-registration health visiting programmes', which was ratified by the outgoing UKCC in 2002.[9] However, when the Nursing and Midwifery Order 2001 removed health visiting from statute, these new requirements could no longer be used as the basis for health visitor education. They were abandoned in 2004, when health visitors, along with SPQ qualified school and occupational health nurses, migrated onto a new register established under the auspices of the new NMC.

A new set of 'proficiencies' was developed rapidly in 2004, primarily to ensure establishment of the specialist community public health nurse (SCPHN) register.[10] Again, the main focus was on enabling development of a different occupational group (SCPHNs), albeit one through which a health visiting qualification could be obtained. The length of the programme was extended once more to 45 programmed weeks (or part-time equivalent). There is a far closer fit with practice than in the former SPQ standards, and at least half of the learning must be focused upon health visiting (or school or occupational health, for those registrants). The focus of these proficiencies is public health. HEIs are responsible for applying them to the specific family and child health context, which they do in partnership with their practice colleagues. As a result, current programmes are more consistent and more confident than was the case with the former SPQ programmes.[11] However, 45 programmed weeks is widely considered to be far too short to satisfactorily encompass all the necessary content, particularly in respect of recent evidence about perinatal mental health, neurobiology, the effect of early child development on future health and health inequalities, understanding and delivery of effective programmes, while also enabling students to master the sophisticated level of professional skill and public health leadership required to function as a health visitor.

Overall, students spend at least four years in education prior to qualifying, but less than one year of that time is concerned with learning specifically about health visiting. Three years is currently spent in pre-registration nursing education, and while commentators generally value some aspects of this, there is no consensus about which elements are essential to health visiting practice. Student nurses learn about levels of consciousness, for example, and most people would agree that, in common with all healthcare professionals, health visitors must be able to recognise and respond rapidly and confidently if faced with an emergency situation where a person collapses or is injured and unconscious. It is less clear that health visitors need to know how to care for an anaesthetised patient or a terminally-ill person lapsing into a final coma, even though those skills are needed for qualification as a nurse. Health visitors do need extremely highly developed communication skills, but requests to specify these within the SCPHN proficiencies were rejected on the grounds that nurses all learn to communicate, thus limiting the opportunity to extend these skills. There are many other examples, with lots in pre-registration nurse education about pathology, illness, medical treatments and determinants of illness, but little about nutrition, family relationships and development, community or the determinants of health. So on the one hand, nurse education equips potential students with some skills and knowledge that they do not need to function as health visitors. On the other hand, by filling the curriculum and setting up an expectation that health visitor programmes should be completed in only 45 weeks, it prevents them from having the time to learn all that is essential for practice.

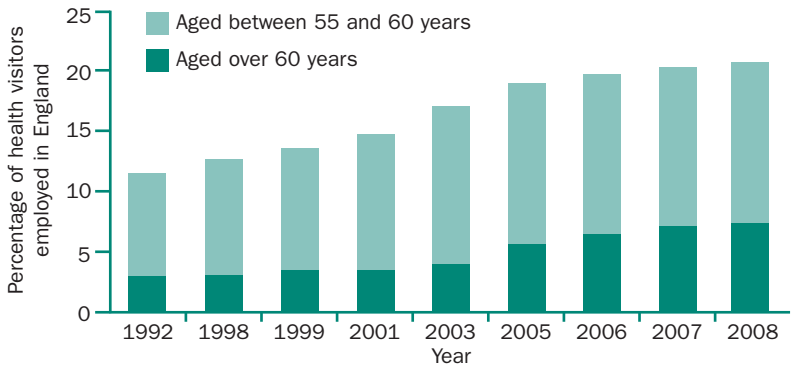
Figure 1. Numbers of health visitors 1988 to 2008[12]



The workforce crisis

The number of health visitors employed in England has fallen by some 18% since 1988, when there were 10 680 whole-time equivalents (WTEs), including a fall of 13% since their dedicated register closed in 2004, to only 8764 WTEs in September 2008 (see Figure 1).[12] More than one in five health visitors are already over retirement age (see Figure 2), and they are the NHS group that tops the league of numbers retiring.[13] Falling workforce numbers reflect reduced funding for posts, but there are also considerable difficulties in recruiting qualified health visitors, or student health visitors of a suitable calibre. Once, prospective students could be sponsored to join programmes on their current salary, which attracted sometimes senior and experienced nurses and midwives into health visiting. This is no longer the case, and along with the norm of qualified health visitors' salary at band 6 on the NHS

Figure 2. Health visitors above retirement age[12]



Agenda for Change payscale, acts as a disincentive to recruitment. Confusing and onerous re-accreditation requirements for nurses and, particularly, midwives practising as health visitors,[14] may also deter potential recruits. Actions to deregulate the profession, downgrade the starting salary and reduce conditions for education have all spoken far more loudly than any occasional warm words from either government or the nursing profession as a whole over the last 15 years. Overall, the message has been that health visiting is not supported or valued, either as a form of service provision or as a profession. It is not surprising, therefore, that health visiting seems to be regarded as an unattractive career option by nurses and midwives. Some urgent change is needed to fast-track a new generation into the profession.

Equity and diversity in the workplace

Despite the need for salaries to be sufficiently attractive for recruitment, services must be affordable. Skill-mix teams make the service less costly, but it is unhelpful to draw comparisons with other specialisms in which the team leader receives a band-6 salary, with the majority of workers being registered nurses on band 5. As indicated above, registered nurses cannot form the majority workforce in health visiting teams because they are not equipped with the skills to practise in the role. The difference is not simply one of grade, but of the basic knowledge required to be a health visitor. Instead, staff nurses, like other team members such as community nursery nurses (CNNs) or family support workers (FSWs), can undertake some delegated activities but not others.

The D-SCOVOR survey (determining future directions: a scoping survey of health visitor registrants) of 1459 health visitor registrants (response rate=46%), carried out in 2005, included 980 caseload holders.[15] This found that 47% of health visitors delegated to either a CNN or FSW, compared with only 33% to staff nurses. The presence of CNNs in a team was associated with an increase in specific community groups, such as postnatal support, parenting and baby massage ($p<=0.001$, $p<0.004$ and $p<0.001$, respectively), but there was no statistically significant change in working patterns through delegation to staff nurses. Elsewhere, government policy has promoted the idea of a flexible workforce, such as being able to work across teams within the children's workforce[16] or to improve access to new career streams.[17] Yet, despite their acknowledged helpfulness in health visiting teams, CNNs are not able to aspire to a health visiting career unless they first deviate into nursing.

It is not only junior team members who might like health visiting careers. Most programme leaders regularly receive enquiries from non-nurses, and the current recruitment crisis in health visiting is coinciding with a downturn in the economy and rising graduate unemployment. While other professions, such as teaching, are quick to take advantage of this, health visiting is hamstrung by the regulation forbidding recruitment except from within nursing. The D-SCOVOR survey asked, if the law and form of education were both changed, who respondents thought would be suitable as potential health visitor students. Graduates from suitable degrees – family, community or early years studies, public health, psychology, nutrition, sociology – were nominated by 65%, healthcare professionals other than nurses by 43%, nursery nurses by 30%, social workers by 19% and Sure Start workers by 13%. In 2002, the NMC considered the potential for widening the entry gate to the profession when it consulted upon the shape of the register it should set up. Over 80% of respondents agreed that there should three parts to the register, each having a direct-entry route.[18] Despite the excitement generated by the potential for rejuvenating the profession, the Department of Health stepped in to prevent it from happening at that time.

What are the barriers?

Myths and misconceptions

Some of the barriers relate to misconceptions, for instance, the belief that health visitor students without nursing or midwifery education would still follow the same 45-week programme, which would be clearly unsafe. Recruits with no prior education in the field would need to follow a specially designed programme, still at a minimum of degree, and possibly masters', level. Some discussion, as indicated above, would be needed to identify which elements from nursing or midwifery education would be essential within the programme, but the key curriculum question would be 'what is needed for skilful health visiting practice?' rather than 'what can nurses do that contributes to health visiting?' Once that key question is answered (perhaps sufficient understanding of pathology to be safe and effective non-medical prescribers, for example, along with other identified skill-sets), then the curriculum could be designed.

There is a surprising resistance to the idea of young people entering the profession, often stemming from the unflattering myth that health visitors are simply 'surrogate grannies' whose function is to substitute for the extended family. Given the age breakdown in 2008,[12] when more than three times as many working health visitors were over 60 years of age (815 headcount) as under 30 years (237), youth is not a problem for the health visiting profession. Since at least a three-year degree would be needed as a baseline, the minimum age at qualification would be 21 years, and (drawing on experience from similar professions such as midwifery or social work) a later age of entry is likely for the majority. There is no evidence, in any case, that families would find young professionals unacceptable – competence is what counts.

Another myth is that the public trust health visitors because they are nurses, even though it is suggested that they often do not know about this professional background.[19] The Family and Parenting Institute (FPI) commissioned a YouGov survey of 4775 parents in 2007, asking them first whether they felt they needed support and advice with parenting (83% did), and if so, who they would prefer to deliver this.[20] Just over three-quarters (76%) said they would like this from a 'trained and up-to-date health visitor,' preferably at home, whereas only 33% cited nurses as their preferred source. However, noting that some health visitors are inadequately prepared for practice, the FPI went on to suggest that recruitment and education should be changed to allow a wider entry gate,[21] an approach they have continued to emphasise.[22,23] They drew parallels with the situation in midwifery, suggesting a change to direct-entry university courses that could include some 'medical training', but be focused toward the sort of work expected of health visitors. Apart from improving skills, they point to the opportunity to develop a better career structure, with junior health visitors on a lower band who could progress up a career ladder.

Professional protectionism

Perhaps recognising the low esteem afforded to health visitors by the nursing profession, many colleagues draw on their initial qualification as a mechanism of boosting their acceptability. Some are unaware, or unconcerned, that health visiting is further undermined in this way. Indeed, the nursing qualification is cited as necessary so frequently (not always by practising health visitors), that it is increasingly suggested that health visitor education is optional for practice in the role, particularly by colleagues who believe that 'having a nurse is important. You get everything in one person' (p3).[24] Calls to substitute staff nurses into health visiting posts, or to extend their role beyond the otherwise helpful boundaries of team skill-mix, imply that a health visiting qualification is not really necessary. This takes no account of the levels of risk associated with substituting staff who are either inappropriately confident or unaware of their own level of ignorance. It also places an entirely improper burden of responsibility on both under-qualified staff and those required to supervise them.

The restrictive entry gate to health visitor education is out of step with the diversification taking place across other fields, which recognises the importance of interdisciplinarity and multi-agency working. Until 1998, for example, directors of public health (DsPH) had to be medically trained. It was clear to the emerging public health profession that it was not only doctors who had valuable skills and knowledge to bring to the job, so DsPH accepted that they should open the entry gates to people from other backgrounds. To be sure that standards did not fall, they established occupational standards and a multidisciplinary register that is currently voluntary, but which clearly ensures that anyone applying for the post has suitable skills and knowledge.[25]

Given the precedents in both midwifery and public health, it seems strange that there remains any resistance to widening the entry gates to health visitor education, but perhaps the alleged lack of acceptability is another myth. When asked in the D-SCOVOR survey how long a changed health visitor education would need to be for entrants not registered with the NMC, 18% of the 1459 respondents said two years, 34% said three years and 13% said four years. Less than a third (29%) said it should not happen. The same survey asked what respondents felt was the relationship between nursing and health visiting – 8% regarded them as the same, whereas 18% regarded them as completely different. Between those two extremes were 35% who thought them somewhat similar, and 39% who said they were somewhat different.

Key points

- The need for students to hold a nursing qualification prior to entering health visitor education has been controversial since becoming an official pre-requisite in the 1960s
- This restriction should arguably be lifted to improve health visitor education, to help solve the workforce crisis, and for reasons of equity and diversity in the workplace
- Myths and misconceptions that serve as barriers to educational change are explored
- Options for developing new programmes to prepare health visitor students are outlined
- The radical option of developing better programmes outwith the existing regulatory system is raised for consideration

What is the way forward?

The urgency created by the workforce crisis in health visiting leads to a serious risk of inappropriate and unhelpful organisational responses, such as wholesale substitution of inadequately prepared staff, or task-focused modules in place of the specialist-level education required for health visiting. However, it also provides an unprecedented opportunity to develop some radically different approaches to education, focusing on the imperative to use educational programmes to ensure that future practitioners can function confidently as health visitors, with the depth of understanding, knowledge and professional skill required to meet present and future expectations.

First, a baseline degree programme (the minimum level required for healthcare professionals) could be developed to incorporate competencies considered relevant to current practice, including any agreed elements of nursing or midwifery considered necessary. Suitable entrants with either no prior experience, or including (for example) team members such as CNNs or Sure Start workers without academic credentials, might qualify through this programme, which would need to be a minimum of three years in length. This would have the bonus of providing a career route for workers from disadvantaged backgrounds, possibly appealing to members of minority ethnic groups or those whose religion or culture inhibit traditional routes to health visiting. Required proficiencies would need to be agreed by the profession and a standard curriculum approved, albeit one that (as now) would need to have some flexibility for different HEIs and areas of the country.

Second, graduates from the wide range of cognate degree programmes (that is, with some similar content) could follow a two-year full-time masters' programme, to meet the required proficiencies more quickly. A timetable of, for example, one day a week in practice and the rest of the week in college in the first year, then one weekly study day but the rest of the time in practice in the second year would seem feasible. This could capitalise on the availability of high-flying, well-educated enthusiasts from a range of backgrounds, who would bring much-needed new energy and excitement to the exhausted and flagging health visiting workforce.

Since health visiting is no longer recognised in statute, there is nothing in law to prevent universities from developing such programmes, although they would need to work in conjunction with the local health economy in order to support students through the programme, through practice experience and into employment at the end of the programme. Such professionals would be unregulated, unless the government was prepared to alter the inhibiting law that prevents the NMC or any other regulator from taking on this function. A voluntary register, possibly operating along similar lines to the UK public health register, could be considered.

Third, qualified nurses and midwives could continue to be educated as now, but perhaps alongside other suitable healthcare professionals such as graduate mental health workers, various therapists and others, who could follow a professional entry programme as at present – 12 months, or perhaps 18 months like the shortened midwifery programme, given the pressure on content – to meet the required proficiencies. Again, legislative change would be needed to expand the entry gate

and recruitment pool, if current regulatory arrangements are to be followed through the NMC.

Finally, better use could be made of the current situation, by understanding the limitations to existing restrictions. As indicated above, both improved conditions for student sponsorship and an increase in educational commissions would help recruitment. Registrants from any branch of nursing or midwifery are permitted entry to the health visiting programme, although recruits are overwhelmingly from within adult nursing. Part-time qualifying programmes, following current regulations, could be used more widely. Also, the restrictive requirement for qualified nurses and midwives to gain two years of experience prior to entering the SPQ programme in 1994 was abandoned in 2002, yet is still sought by many sponsoring trusts. Of course, care is needed at recruitment, because secondment conditions that appear unattractive to an experienced nurse may be regarded as an easy route to a degree and promotion early in a nursing career, despite lack of aptitude or interest in health visiting.

Many universities run two-year programmes, through which graduates from suitable degrees can become registered nurses. Some have begun to explore options for an effective three-year programme, through which a graduate might enter a two-year fast-track nursing programme (perhaps specifically geared toward public health), and then move directly onto a standard SCPHN/health visiting programme immediately after registration. If carefully planned and fully funded, using current proficiencies, these could operate in a similar way to the former 'dual qualification' degree programmes (nursing and health visiting), which operated successfully from the 1960s until the SPQ requirement for a two-year break led to their demise.

Conclusion

The term 'direct-entry programme' creates much confusion and, in any case, the urgent need to improve recruitment and fast-track a new generation of prospective health visitors to qualification is currently driving the agenda. There is the risk of a continuing decline in the calibre of student applicants and of adverse solutions such as ad hoc and occasional task-focused modules for team members, who continue to be disbarred from access to a health visiting career, except through a lengthy deviation into nursing. However, since health visiting is no longer named in statute, there is an exciting opportunity to develop programmes of preparation in new ways, to genuinely meet the learning needs of students and recruit the very best applicants for the job. Such a move would take courage and co-operation across the profession and between the NHS and HEIs to avoid fragmentation and risk, but if that is achieved, such a change could mark the start of a new and promising dawn for health visiting.

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In the next issue, the final paper of this series of three will ask: 'Is there randomised controlled trial evidence for health visiting?'