

Health Visiting Matters



re-establishing health visiting



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FOREWORD

Health visiting has a long and proud tradition in promoting health and preventing disease across all sectors of society. With its focus on children and families and an approach which encompasses all that is best in individual and community development, Health Visitors have always been at the forefront of public health.

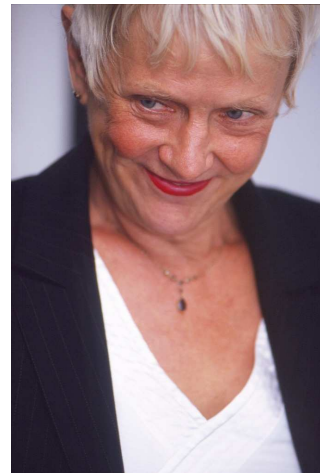
Originating in a radical feminism and a refusal to accept the intolerable conditions in which families and children were forced to live at the turn of the last century health visitors today might appear to have lost the edge and determination essential to tackling health inequalities within the context of the social determinants of health.

However, even a cursory glance at this report will scotch such an impression. Scholarly yet firmly based in reality it will become clear to the reader that despite the constantly shifting sands of political and organisational influences, Health Visitors today are alive to the challenges that confront public health and are in the vanguard of leading the changes essential to reinvigorate and widen the scope and influence of the profession.

The UK Public Health Association is proud to have had the opportunity to play a major role in leading and developing the work that has led to the publishing of this important report which is the culmination of thousands of hours of work from practitioners, academics and user groups all given freely and in a genuine spirit of partnership. The work would not have been possible without support from the Department of Health who have also contributed in an advisory capacity.



Angela Mawle
Chief Executive
UK Public Health Association



EXECUTIVE SUMMARY

2012 is not just Olympic year. It marks 150 years after the 'Salford Ladies' first employed a health visitor. In 2007 this struck a chord with many as the health visiting service was in major decline. That same year, the Family and Parenting Institute (FPI) published a report on declining health visitor numbers and a report of an independent Review of health visiting was also being formulated (Lowe 2007), which identified some of the barriers to delivering a universal health visiting service. The UK Public Health Association's (UKPHA's) Special Interest Group (SIG) for Health Visiting and Public Health issued a response to this Review and, in honour of those first 'Salford Ladies', pushed for the momentum around the issue not to be lost.

The UKPHA Health Visiting and Public Health SIG's response to the health visiting Review identified the need for a specific regeneration project, focusing upon five broad areas of critical importance to ensuring a 'fit for purpose' health visiting service for the 21st Century. In October 2007 the UKPHA organised a symposium at Portcullis House which brought together key leaders, opinion formers and practitioners from across the country to begin the process of developing these five areas. Taking its name from the title of a WHO Report published that same year, "A Powerful Equalizer: Regenerating The Health Visiting Profession", the Symposium articulated the need for a Steering Group to be set up which would progress thinking and agree a way forward. As a result, a multi-agency Steering Group, coordinated by the UKPHA, developed a proposal seeking funding through a public health workforce development programme at the Department of Health to appoint a co-ordinator to bring working groups together to explore these issues, and agree recommendations about how best to deliver a regenerated health visiting service. A preliminary report was considered at a multi-agency workshop, again planned and organised by the UKPHA, in September 2009 and the draft recommendations discussed and refined.

This, the final report was launched at the House of Commons at the end of November 2009 and is also available to download from www.ukpha.org.uk.

SUMMARY OF RECOMMENDATIONS

A. There is a need to establish secure funding for the health visiting service.

Aim

- To re-establish the importance and purpose of the health visiting service as a core provision in promoting health and reducing health inequalities for families and young children, through an effective commissioning model.

Service commissioning is seen as the key. Discussions drew on guidance developed in the UKPHA SIG, jointly with CPHVA (Cowley 2007a, b, Cowley and Bidmead 2009), which set out key principles for the funding and organisation of health visiting services.

Recommendation

- ***Health visiting should be commissioned as a universal service that works in partnership with families to support parenting and address key public***

health priorities and in doing so helps to safeguard children and young people

B. There is a need to establish best practice criteria and leadership to support health visiting

Aim

- To identify a focus for professional leadership in health visiting, at a local, regional and national level, by identifying best practice criteria to support both service provision, and professional leadership in health visiting, as well as exploring options for leadership posts.

Discussions about best practice were informed by evidence, professional experience and guidance about the organisation of health visiting service. There is a need for sufficiently skilled leaders at all levels, to enable best practice to be embedded in the service.

Recommendation

- *To enable expertise about health visiting and best practice to be available at a local, regional and national level, there should be a funded leadership programme and establishment of new roles and career pathways.*

C. Future employment options for health visitors need exploring

Aim

To gain agreement about the key features of a successful provider organisation offering health visiting services, to be commissioned by NHS or other funding bodies.

Health visiting crosses local government and NHS, but does not sit easily or entirely within either. Discussions identified essential criteria needed by provider units that employ health visitors, and speculated about potential organisational forms that would offer sufficient stability and expertise.

Recommendation

- *Health visitors should be employed in an organisation that embodies the criteria identified as essential for developing a dynamic and positive health visiting service, so a focused debate is needed about the new organisational forms to meet this need.*

D. There is a need to improve recruitment, education and regulation

Aim

To enable the development and expansion of the health visiting workforce in a multi-disciplinary arena, by identifying key barriers and supports in the current system of recruitment, education and regulation.

During the life of the project, the workforce crisis has become the most central issue upon which all progress depends. Discussions identified that systemic failures relate to the treatment of health visiting as post-registration nursing, instead of as a distinct profession. Multi-faceted approaches are needed urgently, perhaps modelled upon the current task force for social work.

Recommendation

- ***To capitalise on all opportunities for improving recruitment and retention, a funded task force should be set up to focus specifically on developing the health visiting workforce.***

E. There is a need to strengthen the health visiting evidence base

Aim

To explore options for enabling the body of research knowledge relevant to health visiting to be collated and developed into an accessible format for purposes of commissioning, quality assurance, practice and education.

There is more evidence relevant to health practice than ever before, but it is not readily available, nor is there any organisation or body (such as the medical Royal Colleges, for example) able to provide enquirers with a direction for identifying research-based information.

Recommendation

- ***To explore the feasibility of establishing a body responsible for collating research knowledge relevant to health visiting, in an accessible format for purposes of commissioning, quality assurance, practice and education.***

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BACKGROUND TO PROJECT

In 2007, the Family and Parenting Institute (FPI) published a report on declining health visitor numbers and a report of an independent Review of health visiting was also being formulated (Lowe 2007), which identified some of the barriers to delivering a universal health visiting service. The UK Public Health Association's (UKPHA's) Special Interest Group (SIG) for Health Visiting and Public Health issued a response to this Review and, in honour of those first 'Salford Ladies', pushed for the momentum around the issue not to be lost.

In collaboration with Sarah Cowley (2007a) who chaired the SIG, the UKPHA Health Visiting and Public Health SIG's response to the health visiting Review identified the need for a specific regeneration project, to renew and energise service provision, practice and the health visiting profession. It focused upon five broad areas of critical importance to ensuring a 'fit for purpose' health visiting service for the 21st Century. In October 2007 the UKPHA organised a symposium at Portcullis House, hosted by Barry Gardiner MP, which brought together key leaders, opinion formers and practitioners from across the country to begin the process of developing these five areas.

Taking its name from the title of a WHO Report published that same year, "A Powerful Equalizer: Regenerating The Health Visiting Profession", the Symposium articulated the need for a Steering Group to be set up which would progress thinking and agree a way forward. As a result, a multi-agency Steering Group, coordinated by the UKPHA, developed a proposal seeking funding to appoint a co-ordinator to bring working groups together to explore these issues, and agree recommendations about how best to deliver a regenerated health visiting service. A preliminary report was considered at a multi-agency workshop in September 2009, where the draft recommendations discussed and refined.

In response to the grant proposal, the Department of Health agreed part-funding to take this process further. A part-time project co-ordinator was appointed to start work in February 2009, to convene five working groups focusing and developing the initial ideas, in pursuit of a regenerated and energised health visiting service. In this project, the term 'health visiting' is understood as:

- a proactive, universal service that provides a platform from which to reach out to individuals and vulnerable groups, taking into account their different dynamics and needs, and reducing inequalities in health,
- a form of practice that is based on evidence of what works for individuals, families and groups, and the community as a whole, and
- a profession that has the capacity and vision to contribute to public health through planned activities aimed at improving the physical, mental, emotional and social health and wellbeing of the population, specifically children and families.

The project funding was provided to enable working groups to come together to research and collate the need for health visiting and to hold a symposium where expert delegates considered recommendations about how best to deliver a regenerated health visiting service, before preparing a final report. Each working group was charged with making a single recommendation, no small challenge, given the complexity of the current situation facing health visiting. This report traces the various discussions and changes that have occurred during the lifetime of the project, reflecting a consensus about the suitability of

the recommendations. They do not represent the views of the Department of Health. However, we wish to express appreciation for their support and funding, which has made this project possible.

November 2009
Sarah Cowley, Denise Rudgley

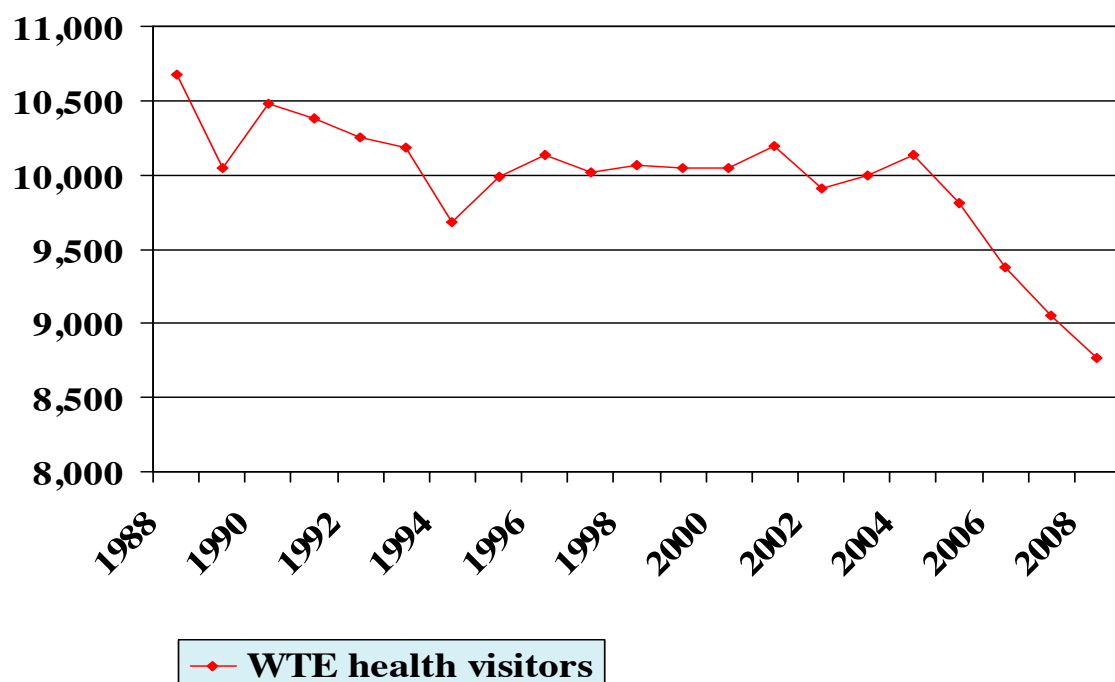
INTRODUCTION

Early childhood development, defined as the period from pre-natal to eight years of age, has been recognized as a key social determinant of health and health inequalities (Irwin et al 2007). It is described as a 'powerful equalizer,' which merits economic investment in all countries and a universal service, delivered by health visitors, is what consumers want (FPI 2007). The evidence for improved health, social and educational outcomes from a systematic approach to support early child development, has never been stronger. Health visitors have always focused primarily on the early years, and still use this base to reach out to the wider community in which children, their parents and families live in order to influence the structural determinants of health (Cowley et al 2007). Yet, at the start of this project, health visiting was in significant decline, with staff numbers lower than at any time in the last 20 years and one in five health visitors already over retiring age (The NHS Information Centre for Health and Social Care (Information Centre) 2009). Since then, there have been a series of substantial changes, falling under two conflicting headings: those which suggest a further, deeply worrying decline in the capacity and coverage of health visiting services, and those which, more optimistically, indicate the potential for improvement in the future.

Further decline

According to Department of Health workforce statistics (Information Centre 2009), the number of health visitors employed by the NHS in England has been falling steadily for some twenty years, and declining rapidly since 2004 (Figure 1).

Figure 1: Whole Time Equivalent (WTE) Health Visitors 1988-2008



Further, the age profile of those working in field is rising; with one in five health visitors now above retirement age, they are the occupational group that tops the list of NHS staff who are retiring. A Care Quality Commission review of arrangements in the NHS for safeguarding children suggests that numbers in the workforce may be even more depleted than indicated by the official workforce statistics (Care Quality Commission 2009). It reports that, taking into account an average vacancy rate of 8% (ranging up to 45% in some areas), the number of health visitors working within English Primary Care Trusts (PCTs) is around 7,800 WTE, which is nearly 1000 fewer than the 8,764 reported in the DH workforce statistics. Indeed, in autumn 2008, 54% of health visitors responding to a union survey indicated that it was not always feasible to provide the core number of contacts set out in local schedules (Adams and Craig 2008). Drastic declines in staffing levels and extreme difficulties in recruitment continue to be reported in the professional press (Ly 2009), giving rise to extreme concerns about the quality and safety of service provision.

Acknowledging the need for change

Since the start of 2009, there has been increasing and widespread recognition of the need to increase the numbers of health visitors on the ground, which gives grounds for cautious optimism. This was pointed out as an imperative within the review by Lord Laming (2009) following the death of Peter Connelly ('Baby P'), in the child health strategy (Department of Health, Department for Children, Schools and Families (DH/DCSF) 2009), and by the Health Select Committee's report on health inequalities (House of Commons Health Committee 2009), all culminating in the announcement of an 'Action Plan for Health Visiting,' led by the Chief Nursing Officer. Less optimistically, the NHS Workforce Review Team proposed that an emphasis on safeguarding may be at the expense of prevention and health promotion (NHS Workforce Review Team 2009), suggesting that health inequalities are not considered a sufficiently important reason to maintain staffing levels. Also, unlike the £58m social work task force (see <http://www.dcsf.gov.uk/swtf/>) the health visiting action plan has no additional funding upon which to call for, for example, additional training places or to support mentoring of newly qualified practitioners, inhibiting the amount of change they can achieve.

However, there are other grounds for optimism. Children have been placed at the heart of the NHS Operating Plan for 2009-10 (Department of Health 2008a), and Transforming Community Services (Department of Health 2008b) requires Primary Care Trusts to commission a portfolio of services, including those for children and for promoting health and well-being, and reducing inequalities. Part of the former National Service Framework for Children (Department for Education and Skills, Department of Health, 2004a) has been updated and developed into a new Child Health Promotion Programme (DH/DCSF, 2008c), focusing on pregnancy and the first five years of life. Health visitors are named as the professionals that should lead delivery of this Programme, which has now been renamed the Healthy Child Programme (DH/DCSF 2009a), and which emphasizes some specific Public Service Agreement (PSA) targets (HM Treasury, 2007) such as breast feeding, infant mortality and reducing health inequalities.

The first major output from the CNO's Action Plan emphasises that health visiting is concerned with both children and families, and with health, well-being and improving public health (Department of Health 2009a). Also, guidance for carrying out the two year

review emphasises the health visiting function in collating and returning health intelligence to local public health departments (Department of Health 2009c). These different initiatives are all raising the amount of pressure on Primary Care Trusts (PCTs) to deliver change and upon the CNO's Action Plan for Health Visiting, launched in May 2009, to achieve some tangible results.

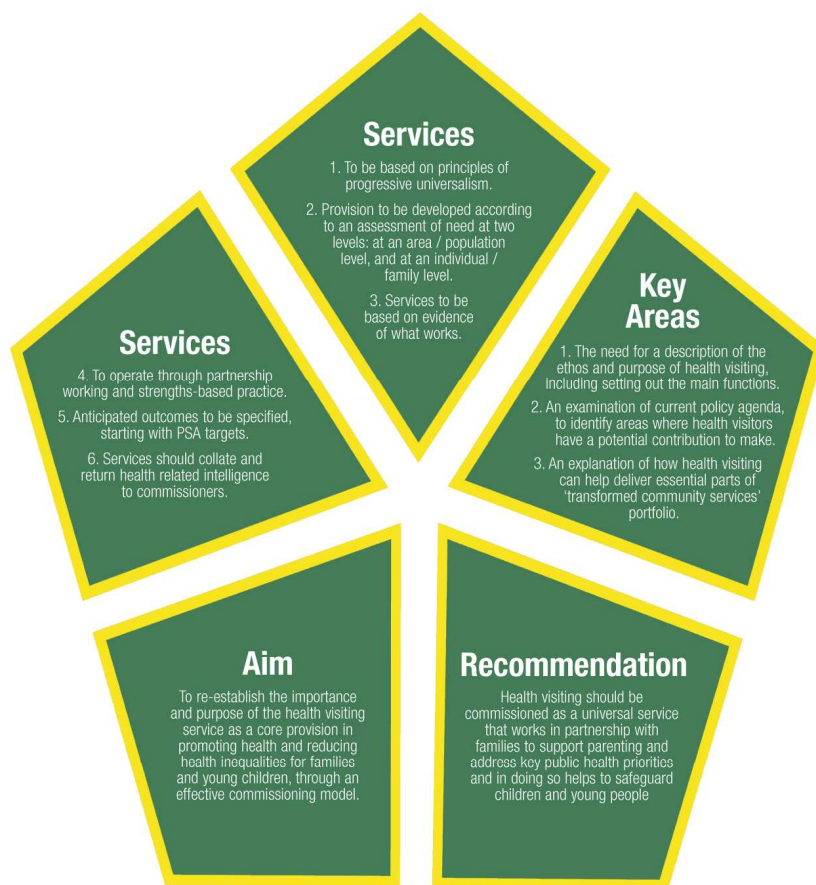
Working methods for the current project

In the face of so much change, the regeneration project has needed to manage the difficult balancing act of maintaining focus, whilst continuing to stay in touch with new pressures and opportunities. It is on a different trajectory, and has a different remit, to the CNO's Action Plan for Health Visiting, providing a complementary and more long-term opportunity to look in depth at some of the underlying issues that have contributed to the current staffing and service delivery crisis.

The five key areas of interest used in this project were first identified by the UKPHA Special Interest Group for Health Visiting and Public Health in 2007, in response to the health visiting review report released that year (Lowe 2007). An interim aim for each area was formulated in the summer of 2008, when part funding was approved, with background papers providing information about policies and literature at the time. Each area is a priority for different reasons, and we would argue that all need addressing in conjunction with consumers and with colleagues across the NHS, children's and public health workforces. In 2009, these key areas remain pertinent, yet their presentation and related policies and pressures, have changed.

Accordingly, working groups were identified to look at each area separately, being charged, in the first instance, with looking at the initial aim and to change, clarify and update the wording to take account of the current situation and new policy. Then, taking into account multi-professional and multi-agency perspectives and relevance to colleagues and service needs, each working group was asked to consider key issues that would reinvigorate and enthuse the profession and barriers to that development. They were to chart a way forward from the project, initially by identifying a single recommendation for discussion at a multi-agency and multidisciplinary workshop held on 9th September 2009 (attendees listed in Appendix 9). Comments and advice from that workshop were further discussed in the steering group and circulated to working group members, before drawing conclusions for this final report, launched at Westminster in November 2009.

A: There is a need to establish secure funding for the health visiting service



BACKGROUND

Why is this an area of interest?

- 'Health visiting' title is an established brand trusted by consumers even though it has been removed from statute
- Independent Review of Health Visiting recognised health visiting as a valued resource
- Early childhood development is a key social determinant of health and health inequalities
- Universal health visiting delivers public health priorities

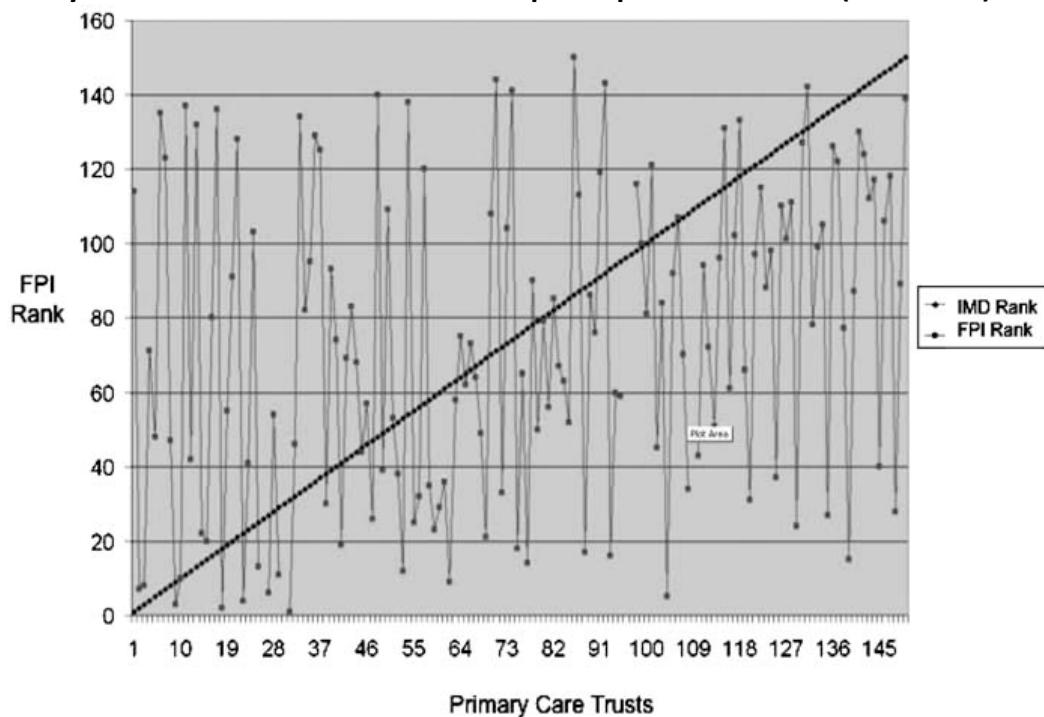
The health visiting workforce has contracted by 13.5% since 2004, with an associated reduction in service provision. The start of this collapse in service provision coincided with a period when use of the term 'health visiting' had been quite controversial, as a result of regulatory changes that removed the profession (and the health visiting title) from statute in 2001. However, the term began to come back into official use with the independent Review of Health Visiting (Lowe 2007), which emphasised the importance of home visiting and the universal service for families and children, set within a public health context. The Review formally recognised health visiting as a valued resource for the health of families and children, stating that most health visitors have an appetite for change and a willingness to rise to the challenges faced by the profession. The Review made a number of recommendations to government, including developing the Child Health Promotion Programme (DH/DCSF 2008c), now the Healthy Child Programme (DH/DCSF 2009a), and the need to clarify a commissioning model for health visiting. Consumer groups such as the Family and Parenting Institute (FPI 2007) and Netmums (Netmums 2006, Russell 2008) also endorsed use of the term 'health visiting' as a trusted brand, claiming parents using the service do not want alternative titles, such as the new official regulatory term of 'Specialist Community Public Health Nursing.' These consumer groups have also led calls to reverse the reduction in health visiting services.

Early child development is vital in setting the stage for the child's future (adult) health and educational achievements. Evidence for this is now so clear, that it has been recognised as a key social determinant of health and health inequalities (Irwin, Siddiqi and Hertzman 2007), and a critical period for intervention (Shonkoff and Phillips 2000). There is also strong evidence to demonstrate that supporting new parents (particularly mothers) leads to improved health, social and educational outcomes for children (Acheson 1998) (Karoly, Kilburn and Cannon 2005). Following the death of Peter Connelly ('Baby P'), the Lord Laming (Laming 2009) stressed the importance of increasing the number of qualified, fully skilled health visitors in the workforce to ensure children who need safeguarding are identified and protected, a point echoed in the new child health strategy (DH/DCSF 2009b). The long-standing role and purpose of health visiting has been to focus on families with young children, varying the amount of input according to assessed individual and community need. However, since health visiting workforce numbers are in freefall, there is a need to establish secure funding for these services, as a matter of extreme importance. This is the focus of working group A.

The current position

Over the last five years, the government has signaled a strong wish to support families with young children, through ‘progressive universal’ services, which is said to mean to providing some support for all, but more for those with greater needs (HM Treasury, Department for Education and Skills 2005). There has been a strong focus on social exclusion and home visiting (HM Government 2006, Social Exclusion Taskforce 2007), both the traditional preserve of health visiting services. Department of Health workforce statistics show the number of health visitors in England fell from 10,137 Whole Time Equivalent, WTE) to 8,764 (NHS Information Centre 2009) in the same period, 2004-2008, with many practitioners reporting difficulties in delivering the necessary support, because of inadequate capacity (Adams and Craig 2008). Indeed, whilst health visitors focus upon the most vulnerable within their own area, services are not distributed according to levels of deprivation at a national level (Cowley, Dowling and Caan 2009). Figure 2 shows the lack of relationship between the rank of deprivation scores in Primary Care trusts, and the level of health visiting provision, using data obtained by the Family and Parenting Institute (FPI) in 2006. Since then, the number of health visitors in post has fallen considerably, but there is no evidence that distribution has improved.

Figure 2. Rank of health visitor: pre-school child ratios (FPI Rank), against Primary Care Trust rank of Index of Multiple Deprivation scores (IMD Rank)



(Source Cowley, Dowling, Caan 2009)

A robust, public health focused health visiting service could assist commissioners in the delivery of key aspects of the PSA targets relating to life expectancy, infant mortality and health inequalities, for which the Department of Health has a lead responsibility (HM Treasury 2007). The Children and Young People's Plan provides a lever through which commissioners can identify the role for health visiting services to deliver public health

priorities in partnership with both statutory and voluntary agencies. As Children's Trusts extend their responsibility to deliver on children and young people's outcomes, the essential role and function of health visiting services needs to be both understood and articulated.

Transforming Community Services

Children have been placed at the heart of the NHS Operating Plan for 2009-10 (Department of Health 2008a), and Transforming Community Services (Department of Health 2008b). Properly resourced health visiting services can help with embedding the principles of Transforming Community Services (TCS) (Department of Health 2009b), in relation to the Framework for Children, Young People and their Families (Department of Health 2009c) and that for Health, Wellbeing and Reducing Health Inequalities (Department of Health 2009d). The mechanisms required to maximise the contribution of the health visiting team has been clearly set out by the CNO's Action Plan (2009a), which also provides guidance about commissioning a universal service.

The work of the Special Interest Group for Health Visiting and Public Health (SIG) underpins this ethos by stressing health visitors' work towards reducing health inequalities. The UKPHA conference statement adopted by the health visiting SIG is relevant here; it states:

"The Health Visiting SIG will work to reduce health inequalities and promote sustainable nurturing family and neighbourhood environments; utilising both asset and needs analysis, and the sharing and use of robust information at local neighbourhood partnership levels."

TCS stresses that services are to be commissioned according to their target purpose, rather than describing services by the title of professionals delivering them, with health visiting being given as an example of one service that will be affected by this change (Department of Health 2008b). The national level Commissioning Support Programme has worked with all Local Authorities to consider future commissioning and delivery of children's services. From next year (2010), full accountability for all Children's Services, including those delivered through health services, will pass to Directors of Children's Services, so there is a need to engage this group within future provision of community services including health visiting.

DISCUSSION

The starting point for this working group was to look at the principles of a funding model already agreed by CPHVA and UKPHA (Cowley 2007b, c), which had been written as an interim guide to support commissioning of health visiting services prior to the development of the TCS guides. These principles were identified as part of the initial aim for the group, so they were revisited and explored to see if they would still be useful as a basis for discussions with commissioners. The principles were still seen as broadly useful. They included:

- Services to be based on principles of 'progressive universalism'
- Service provision to be developed according to an assessment of need at two levels: at an area/population level, and at an individual/family level
- Services to be based on evidence of what works
- Services to operate through partnership working and strengths-based practice
- Anticipated outcomes to be specified, starting with PSA targets.

Discussions led to the view that a sixth 'bullet point' was needed, to highlight the public health potential and purpose of health visiting services. This was that:

- Services should collate and return health related intelligence to commissioners.

The overall aim of the group was stated as:

Aim

To re-establish the importance and purpose of the health visiting service as a core provision in promoting health and reducing health inequalities for families and young children, through an effective commissioning model.

There were wide-ranging discussions, which encompassed three broad areas:

1. a description of the ethos and purpose of health visiting, including setting out the main functions.
2. an examination of current policy agenda, to identify areas where health visitors have a potential contribution to make
3. an explanation of how health visiting can help deliver essential parts of 'transformed community services' portfolio.

Ethos and purpose of health visiting

The interim funding model described by (Cowley 2007b, c) outlines the health visiting resource, including team skill mix, required to deliver the recommended approach to progressive universalism, taking account of health inequalities, best evidence outputs and outcomes that might be anticipated. It identifies and explains a separate component of the service along with the issues of scope and skill mix. In this way it starts to describe programmes embedded within a generic health visiting service, which is helpful in terms of what might be expected in impact and outcomes. A later paper covers identification of the appropriate ratio of health visitors related to deprivation and local need (Cowley and Bidmead 2009). This form of service supports delivery of the Healthy Child Programme, including additional care for children with particular needs (DH/DCSF 2009a), contributes to the core Primary Care Trust (PCT) role in reducing health inequalities as well as to the 'Being Healthy' outcome within 'Every Child Matters' (Department for Education and Skills, 2004b).

With their longstanding entrée to the home of all parents from birth to school entry, health visitors are uniquely placed to deliver a high impact service. A universal service acknowledges the gradient of health inequalities (Marmot 2004), which is reflected in a gradient of health needs. Needs and risks are widely spread through the population, leading to the so-called 'population paradox,' in which the highest number of needs are found among the more numerous, but lower risk, populations (Rose 2008). This means service provision should not plan a sharp cut-off point, with some families receiving a large amount of support and others either very little, or sporadic, input. Instead, early proactive intervention can enable children to achieve all five outcomes of Every Child Matters (Department for Education and Skills, 2004b), build resilience and develop protective behaviours if proactive and risk-preventing services are commissioned.

Health visitors have the skills to assess the health and well-being of all children of pre-school age and their families through the Healthy Child Programme (DH/DCSF 2008), and to intervene in the lives of vulnerable parents. The family focus explicitly includes mothers, fathers and infants, with infant mental health as a major area of interest and priority. This provides a portal through which a number of public health priorities may be addressed, by promoting their health and well-being and increasing their ability to reach their potential.

Members of a skill mix team can deliver some elements of the Healthy Child Programme. However, full and ongoing assessment of the underlying factors that affect the well-being of families and young children, requires a relationship built upon trust and a level of expertise that allows health visitors to think, assess and act holistically. Sensitive and skilled communication is central (Attride-Stirling et al 2001) and individualised, client-practitioner relationships (that is, not from a team) are highlighted as particularly important by the more needy families (Russell 2008), along with the absence of stigma that comes from knowing they are in receipt of a universal service rather than being singled out for attention (Bidmead and Cowley 2008, Department of Health 2009a). One key strength of health visiting has been its diversity and versatility over the years, although the functions have been somewhat circumscribed by reduction in staff numbers and resource availability in recent years. This may lead to a lack of awareness of the potential breadth of the service. Throughout the discussions, a number of key functions and target groups were emphasised, such as infant mental health, including fathers as well as mothers, using contact with the pre-school population as a base from which to reach out to the whole population.

A key element in service provision is the assessment of safeguarding needs, which supports a decrease in health inequalities by:

- Targeting those children most vulnerable/at risk from social exclusion and harm, offering support and intervention
- Identifying those with needs that increase their potential risk in future, offering support to increase resilience and reduce risk
- Offering improved services and encouragement to those who have the personal capacity, themselves, to attain improved health and wellbeing, embodying the 'fully engaged' scenario outlined by Wanless (2002).

Where needs are identified within families, a higher level of practice and expertise is required to co-ordinate the services to support and protect the child within the family. Expertise in assessment is important to ensure needs and risks are identified in all the situations encountered by health visitors, bearing in mind the undifferentiated nature of the caseload (that is, it has not been filtered through referral from another source).

The Current Policy Agenda

There are many policies that point, directly and indirectly, to a need for the kinds of activities in which health visitors engage, and to which health visiting services can contribute. Service commissioners may not always make this link, but health visiting leaders (see Group B) can do this for them. As an example, a review of documents of the Children's Plan, CAMHS Review, Healthy Lives, Brighter Futures (including the Healthy Child Programme) demonstrated the pivotal role of health visitors in healthy child development, increasing access, and working with others to reduce the adverse impact

of child poverty. The 'getting it right' document from the CNO's Action Plan is also included. Key points are listed in Appendix 1.

How health visiting can help deliver Transformed Community Services

The 'principles of health visiting,' first published in 1977 (Council for the Education and Training of Health Visitors, CETHV 1977), and subsequently updated at intervals (Cowley and Frost 2006) have served as a shorthand form to describe the knowledge base and process of health visiting, helping to maintain the profession's focus on the most disadvantaged and needy as society changes. These principles focus on the underlying needs of families with young children, including social exclusion and poor health and wellbeing, enabling them to be identified and acted upon, in order to reduce the effects of disadvantage.

The principles of health visiting fit well with the framework for Transforming Community Services for Children and Young People and their Families (DH 2009c), which relate to

- Safeguarding systems and processes
- Incorporate the voices of children and young people in service planning
- Creative implementation of public health programmes for example the Healthy Child
- Endorsing the need for accessible and flexible services to suit the needs of children and families, including fathers
- Ensuring services are provided in different settings

Where health visitors are commissioned to work in successful partnerships across the wider children's integrated services, they could deliver against a range of relevant PSA targets, some of which are summarised in Appendix 2, with associated markers of success. There are key links, too, to the framework for Transforming Services for Health, Wellbeing and Reducing Inequalities (DH 2009d); the PSA Target by 2010 to reduce inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth is a vital component of any health visiting service. The six transformational attributes for both core Transforming Community Services that are relevant to health visiting are embedded in health visiting practice, and shown in Box 1. These are reiterated in each of the TCS guides, as well as in 'Getting it right for children and families' (Department of Health 2009a).

Box 1. Transformational attributes

- **Health promoting practitioners**
- **Clinical innovators and expert practitioners**
- **Professional partners**
- **Entrepreneurial practitioners**
- **Leaders of service transformation**
- **Champions of clinical quality**

CONCLUSION AND RECOMMENDATION

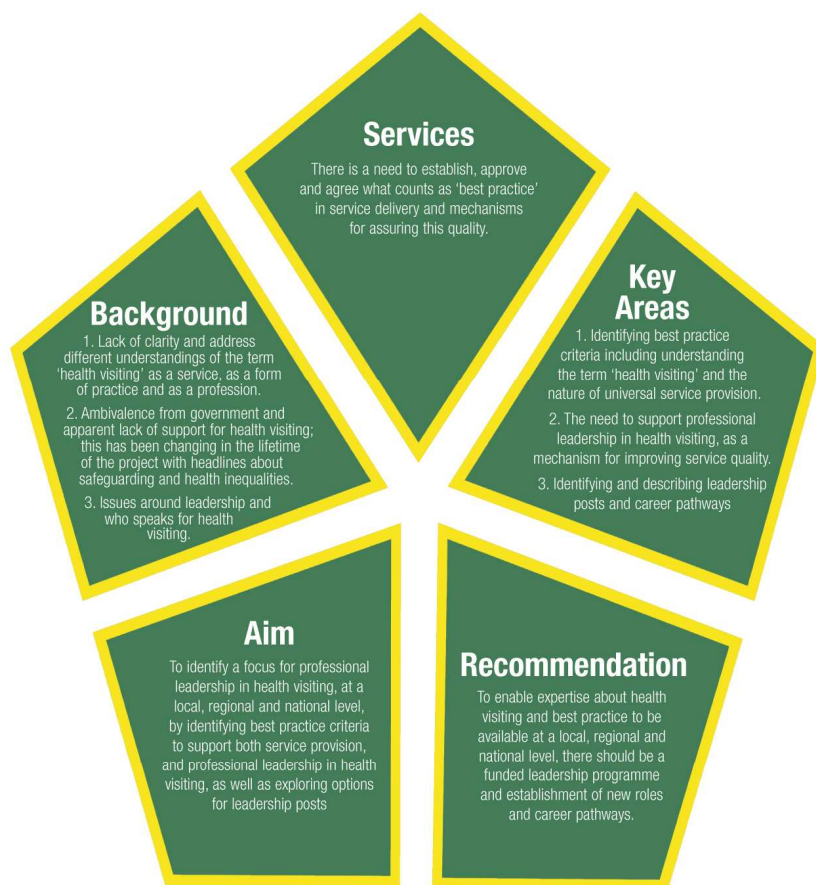
The unique contribution and value of health visiting practice is to help narrow the inequalities gap, particularly through its contribution to early child development. It would help to have a designated local health visiting leader with a role to support and inform the commissioning process (see Group B). The interim funding model for health visiting (Cowley 2007b, c) outlines the resources required to impact positively on child and family public health, giving some initial markers of success and anticipated outcomes from the service. The new policy document about 'getting it right for children and families' (DH 2009a) provides another very useful source of information for commissioners, as well as underscoring the essential nature of health visiting services as one part of the whole transformed community service portfolio.

Health visiting services have been defined as those that are delivered and led by qualified health visitors, but provided in collaboration with colleagues such as children's centre staff and primary care teams (Cowley 2007c). Now, the service needs to be commissioned specifically as one part of services for children, young people and their families, and of services for promoting health, well-being and reducing health inequalities. This offers an important opportunity to expand and reclaim the place of health visiting services as a key part of a multi-disciplinary, multi-agency service.

Recommendation

Health visiting should be commissioned as a universal service that works in partnership with families to support parenting and address key public health priorities and in doing so helps to safeguard children and young people

B: There is a need to establish best practice criteria and leadership to support health visiting services



BACKGROUND

Why is this an area of interest?

- There needs to be clarity about a safe and appropriate form of health visiting service provision
- Health visitors and consumers should be informing commissioners about health visiting provision
- Health visitors are needed in senior posts, in both commissioning and management, to take specific responsibility for health visiting services

Health visiting services are immensely variable across the country (Lowe 2007, Cowley, Dowling and Caan, 2009) having been very severely cut back in some places. The extent of shortfall is explained in detail in the introduction, but two challenges arise from this. First, what should a health visiting service look like? The annual spend on health visiting service provision ranges from £60 to £386 for each pre-school child across 143 Primary Care Trusts (Family and Parenting Institute, 2009). Variance appears unrelated to deprivation or other services in the area (Cowley, Dowling and Caan, 2009), so are services profligate or appropriate where higher costs are in force? And where the annual spend is low, does that mean families are underserved or that the service is ultra-efficient? Some differences are to be expected, given the variation in demography, geography and levels of deprivation across the country, but there is a serious need to reach some clarity about what would be considered a safe and appropriate form of health visiting service provision.

Second, who should decide suitable criteria for evaluating the appropriateness of a service? Surely this needs to be the people who most understand it: that is, health visitors themselves, in conjunction with service users, whose voices are heard far too little in commissioning. This is not a one-off exercise. In each Trust, with each annual commissioning round, someone needs to explain to commissioners how and why health visiting provision justifies the funding required. This is not an easy task, but it is an essential part of public service governance. It means demonstrating why the services are needed in the first place, why they are delivered in a particular way and what effect they can be expected to have in relation to the priority needs and goals for the population they serve. Whilst there is an important role for both consumers and practitioners as part of this process, ensuring this function is successful and providing accountability for service provision is the proper responsibility of service managers and commissioners, who need to identify the required information for these procedures.

The difficulty facing health visiting is that not only has service provision been cut back, but career opportunities have also been truncated, with few senior posts or managers specifically responsible for health visiting services. In many places, practitioners are managed by individuals from a different background, or with a very wide brief (e.g., all the nurses and allied professionals in an area), and no expertise in health visiting or child public health. Traditionally, the role of the practice teacher in developing students was also understood as a lead for continuing professional development in practice and for maintaining leadership in the health visiting service. However, this has been poorly understood, so the significance of this role has been reduced; also a decline in student numbers of recent years (see Group D) has meant a corresponding loss of practice

teachers. Nursing and Midwifery Council (NMC) Standards to support learning and assessment in practice (NMC 2008) have led to a situation in which practice teacher status can be 'lost' to the live register, if there are insufficient students to maintain current teaching experience. However, with a range of new and welcome opportunities, it may be possible to make progress on the two challenges identified above.

The current position

Over the last year, there has been an increase in policy activity in relation to health visiting, notably through the announcement of an Action Plan for Health Visiting led by the Chief Nursing Officer, as part of the Child Health Strategy (Department of Health, Department for Children, Schools and Families (DH/DCSF) 2009b). There is greater clarity about what activities should be included in a health visiting service since publication of the expanded Child Health Promotion Programme (CHPP) (Department of Health, 2008), now renamed the Healthy Child Programme (DH/DCSF 2009a). Health visitors are designated as the professionals to lead the Programme, which provides strong guidance about the minimum universal provision required and responses to some key health needs likely to be encountered by health visitors. Some ambiguity remains about exactly how the guidance is to be interpreted. In the view of some, the Healthy Child Programme (HCP) and health visiting service are synonymous; others regard the HCP as one part of health visiting provision. To add to the confusion, there has been new guidance (see working group A), indicating that services should not be commissioned by the title of professionals delivering them; health visiting was singled out as an example of a form of provision that would need to form one part of a 'portfolio of services' to be commissioned in future (Department of Health, 2008a).

Some of this uncertainty has been reduced by the publication of the 'getting it right for children and families' document by the CNO's Action Plan (Department of Health 2009a). Also, policy action to reduce the variation in service includes two new requirements, announced in October 2009, for Primary Care Trusts to report annually on their health visiting numbers in relation to pre-school children, and the amount they spend per pre-school child (Burnham 2009). This is part of a concerted effort to refute any suggestion of government ambivalence about the value of health visiting services.

Increasingly, children's services are being integrated with local government services in Sure Start Children's Centres. There are plans to provide a Sure Start Children's Centre in every community, with the expectation that there will be 3,500 in place by 2010; there are currently around 3,100. Local government is required to provide integrated early years services, working with the NHS and Primary Care Trusts (PCTs) to maximize benefits and access for young children and their families (Department of Health, 2007a). Public Service Agreement (PSA) targets shared between local government and the NHS include the need to reduce health inequalities, as well as improving children and young people's safety and their health and wellbeing (HM Treasury, 2007). Access to a universal service is a key element in this, and the Child Health Promotion Programme (DH 2008) describes three levels of service provision through the idea of 'progressive universalism.' Each Children's Centre needs to have guaranteed access to a health visitor. The challenge of integrating services means there is an urgent need for someone, in each local (PCT) area, with appropriate child public health expertise to identify what needs doing and how it should be done, then to ensure that this is both commissioned and delivered to an appropriate standard.

DISCUSSION

The contrasting themes of optimism and confusion, identified above, pervaded discussions in this group. There is confusion arising from the service variability and increasing, often conflicting, changes and demands upon a shrinking service, and the effect that these have on practitioners on the ground. Differences in service provision across the country have created confusion about what constitutes an appropriate universal health visiting service. Forms of service organisation that would be considered unsafe practice in one area may be regarded as the norm in another, because staffing shortages have forced a change to a different, often unevaluated way of working. Concerns about unclear lines of accountability and removal of safeguards in practice, often implemented as forms of team work are introduced to cover unfilled health visiting vacancies, have left many health visitors feeling unskilled and lacking in the necessary leadership skills.

These concerns are compounded by low morale amongst health visitors and confusion over roles. There is increasing tension, now that health visiting has been placed firmly back on the public agenda following the death of Peter Connelly ('Baby P'), because health visiting teams need to reconcile the fundamental tension between reducing health inequalities and safeguarding children (Thunhurst, 2009). Public concern has tended focus on the latter, but there are opportunities that need grasping to ensure that the wider public health service provision does not get overlooked in the need to address the immediate requirements for safeguarding children. The current pressures on the health visiting service in child protection leaves little time for health visitors to work with their local communities to address some of the wider social issues that usually lie behind cases of child protection. This creates a dilemma and ongoing issue about how to tackle wider social concerns addressing health inequalities, whilst also helping individuals and families that are already vulnerable.

The working group realised that health visitors' confusion and low morale is sometimes compounded by apparent clarity concerning the need for their services, in the paradoxical face of continual service reductions and persistent demands that health visitors explain their role. Clarity about the need for the service comes from a range of sources. Health visiting was mentioned as a 'key workforce,' along with midwives and social workers, in the consultation document about the most effective strategies for reducing health inequalities in England from 2010 (Marmot, 2009); the need to address workforce shortages in these areas was noted. There is strong evidence that early child development is a key period for influencing health inequalities (Irwin, Siddiqi and Hertzman, 2007) and recommendations that actions to tackle the social determinants of health must focus on the whole spectrum of the population (Kelly et al, 2007). These last two issues both point clearly to the need for a universal health visiting service and this is now underscored by the new 'getting it right' document from the CNO's action plan (Department of Health 2009a). The contradiction between evidence of the need for health visiting services in research and policy, and the apparent lack of value afforded to the service, as shown in the cutbacks and continual emphasis on describing the role (instead, for example, of increasing funding and staff in post), convinced the group of the need to improve leadership in health visiting.

B. AIM

To identify a focus for professional leadership in health visiting, at a local, regional and national level, by identifying best practice criteria to support both service provision and professional leadership in health visiting, as well as exploring options for leadership posts.

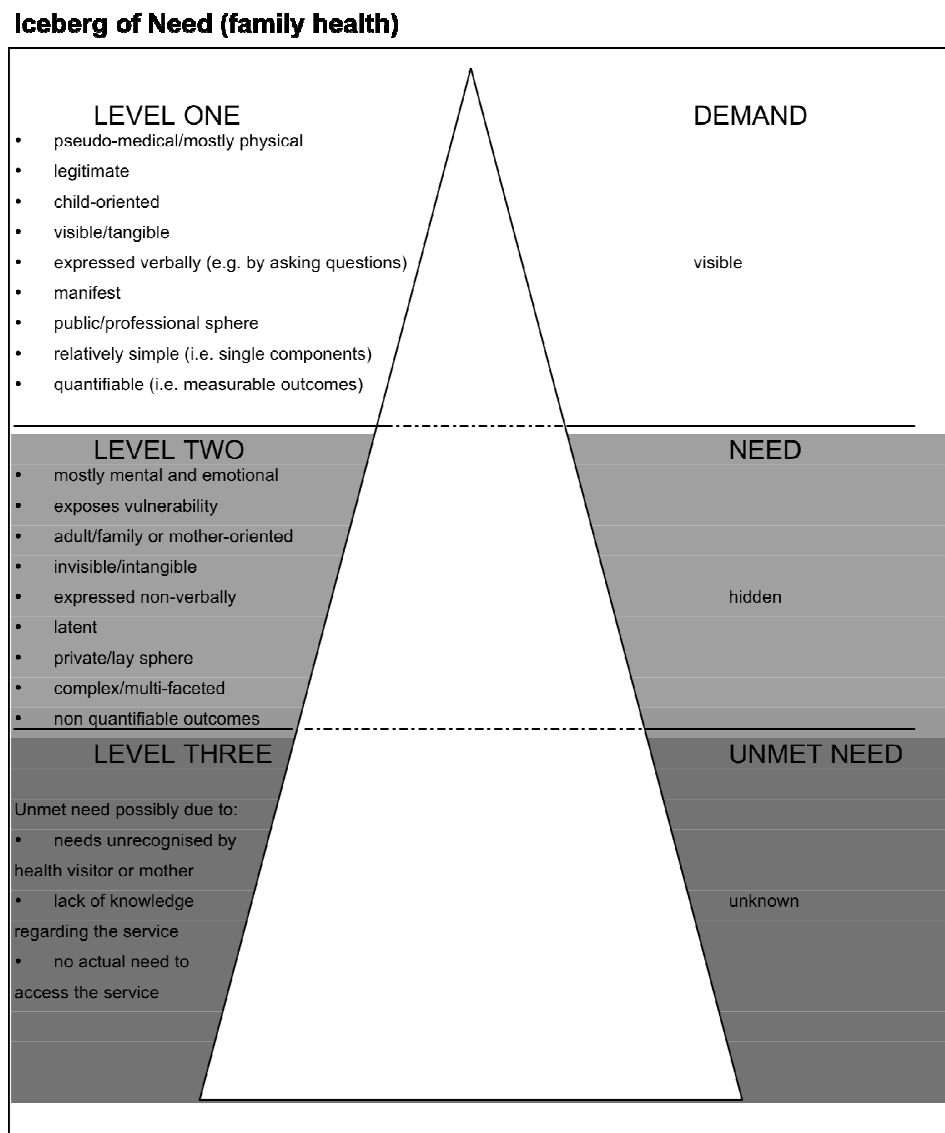
Identifying best practice criteria

With some debate, the group was soon able to reach broad agreement on a format for a 'best practice' universal service (Appendix 3). This paper was developed using a CPHVA paper describing the universal service (Cowley and Adams, 2009), and the funding papers cited by Group A (Cowley 2007b, c). Those documents were, themselves, devised through a process of consensus within the profession, suggesting there is very definite sense in which the health visiting profession knows what it needs to do. The paper prepared for the group (Appendix 3) is offered as example guidance, not as a protocol, bearing in mind the varying requirements in different parts of the country. Group A discussed the principles that underpin the funding of a universal service in more detail, and key indicators highlighted for commissioners are included in Appendix 2. Together, these suggest services should be based on principles of 'progressive universalism,' making provision for all families and more for those who have greater needs. Services should be developed according to an assessment of need at two levels; at an area/population level and at an individual family level, should be based on current evidence about home visiting programmes designed to promote family wellness and prevent child maltreatment, services need to operate through partnership working and specified anticipated outcomes.

A universal health visiting service requires good assessment decisions, which are highly skilled because of the requirement to analyse challenge and identify complex issues that need referral or signposting. Some of the visits or contacts need to be planned in conjunction with the client and health visiting team, according to identified need, and linked with other services, including provision and pathway of the healthy child programme. Service delivery could also be based on tiered interventions for families who are at low, medium or high risk, providing a basis for determining who within teams can carry out different levels of service delivery. Consensus was more difficult to reach about which activities could safely be carried out by skill mix team members, perhaps because delegation needs to be decided on a case by case basis, rather than by protocol (Cowley and Adams 2009). The group considered that it was probably inappropriate to delegate visits before a relationship had been forged between health visitor and client, so recommend that an ante-natal visit, new birth visit at 10-14 days post-natally and further follow up home visit should be carried by health visitors.

Health visitors' education provides them with specialist knowledge and skills to engage with children young people and families to promote health and reduce health inequalities in all families with young children. Their assessment and engagement skills help to achieve this by enabling parents to recognise, reveal and gain support for hidden or submerged health needs, as shown in Figure 4. If attention is focused solely upon the 'tip of the iceberg' of overt needs, which is often the case in areas of staff shortage, inappropriate substitution and dilute skill mix, then neither the underlying health needs nor the causes of health inequalities are identified or addressed.

Figure 3: Iceberg of Need



Source: Cowley S (2008) Health needs assessments. In: **Policy and Practice In Community Public Health: a sourcebook** (ed. Cowley S) Bailliere Tindall Elsevier Edinburgh pages 2-27.

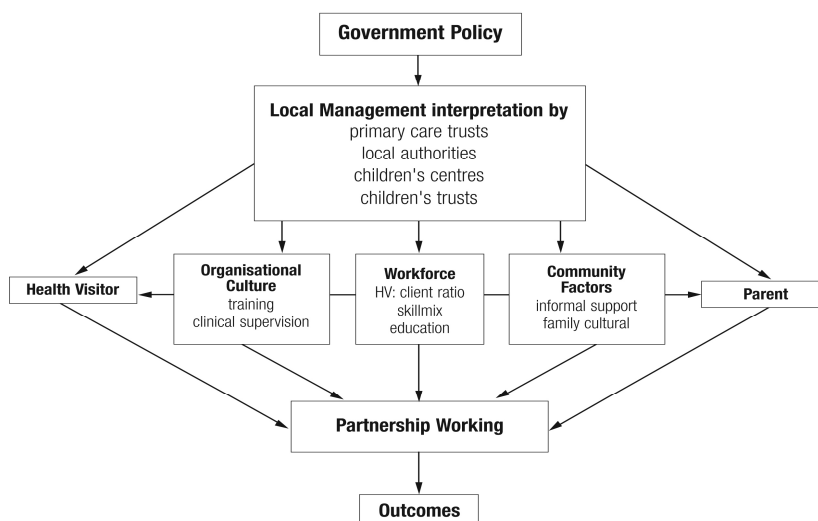
Careful delegation, referrals and liaising with other services are all required to maintain safe, high quality services and the health visitor needs to lead this. However, the discussions highlighted that health visitors do not all feel equipped with the necessary skills and knowledge to lead multi-disciplinary or multi-agency team work, needed as services shift into Children's Centres. This service shift should provide a good

opportunity for health visiting to provide a substantial leadership role (Thunhurst 2009), needed because of the lack of communication and joined up working between different professionals in the children's workforce (Laming 2009). Learning within an inter professional context is key to addressing Laming's requirements, and again draws attention to the important leadership role of practice teachers; leadership and learning go well together.

Leadership and organisational culture

The lack of positive health visiting leadership has a direct impact on the form of service received by clients. There were distressing examples in the discussions of health visitors being expressly forbidden from using their skills in some places, for example, by insisting that they could not act upon their own assessments, where a need had been identified, without first gaining approval from a manager. There were examples from places where excessive workloads were managed, not by transformational leadership and good risk assessments, but by rejecting the professional knowledge and skills of health visitors in practice. Such directive forms of managerialism inhibit the emergence of leadership, oppose the development of good practice and, ultimately, have an adverse impact on the children, families and communities that should be receiving positive health visiting provision. The ability of practitioners to work in partnership with the families they serve is central to the achievement of positive outcomes, but this form of practice can only be achieved if the whole organisation is supportive of this form of practice, which is central to the ethos of health visiting. Figure 4 shows the essential factors needed to demonstrate such support.

Figure 4. Factors affecting parents' and health visitors' ability to work in partnership



Source: Bidmead C, Cowley S. 2008

Supporting professional leadership in health visiting

The vacuum in health visiting leadership has arisen relatively recently, and the discussions identified many ways in which systems failed to support the development of leaders in this field. Overall, organisational development and wide cultural change is needed to overcome the negative influence of authoritarian and directive approaches to management, which appear to prioritise organisational needs above the requirements of good health visiting practice. Anecdotally, these appear increasingly common, and strong professional leadership is only one part of a wider organisational response needed to avoid such adverse conditions and outcomes. However, strong professional leadership cannot develop in a vacuum; it needs supporting.

The group identified features that are needed to support professional leadership, which would be best developed in the presence of the following:

- A transformational vision, which brings together the drivers for change currently shaping children's services and a service delivery model that includes leadership roles and skill mix.
- Workforce development plans which promote leadership development for health visitors but also career and role development for skill mix staff.
- The development of clinical networks to progress evidence based practice, innovation, productivity and quality, with clear leadership roles for practitioners.
- Access to leadership skills training: decision making and leadership within a community setting, managing teams, skill mix, team building and service planning, coaching and mentoring, performance management, business management, data collection and analysis, partnership working and overcoming barriers.

All these need to be put in place, possibly through a nationally led programme to promote transferable career pathways and embed leadership across the service. There are a number of initiatives to develop leadership in other fields, for example the Royal College of General Practitioners has developed an e-learning package about the topic, the Department of Health has invested £2m to develop multidisciplinary clinical leadership fellowships and has a major workstream around 'modernising nursing careers' (Department of Health 2006).

Ideally, leadership development would start with the education and training of health visitors so that students acquire the relevant skills and knowledge to help enable them to lead a multi disciplinary, professional team. This needs to be ongoing when in practice, with education in place to equip health visitors for the wider public health preventative role as well as the safeguarding aspect. Developing suitable practitioners to lead practice education and lifelong learning is central to this issue.

Leadership posts

There are different kinds of leaders; specialist skills will be required to lead on health visiting commissioning for example and for promoting and modelling 'good' leaders. Clinical leadership posts and advocates for children (Department for Education and Skills, 2004b) should be part of all health visiting teams and it should be stated as part of specifications that all health visitors have a leadership role. The loss of leadership function associated with the reduction of practice teachers in post needs to be reversed,

so their broader leadership and educational expertise can be harnessed, once more. The NMC (2008 page 24) set out standards for leadership expectations for this role as:

- Provide practice leadership and expertise in application of knowledge and skills based on evidence.
- Demonstrate the ability to lead education in practice, working across practice and academic settings.
- Manage competing demands of practice and education related to supporting different practice levels of students.
- Lead and contribute to evaluation of the effectiveness of learning and assessment in practice

The health visitors' role as lead professional for delivering child and family health services that takes into account prevention and the broader social issues of communities that impact on health and well being, needs to be more widely recognised. The group explored options for leadership posts in health visiting within universal services, which would help to develop careers as well as enhancing the service. Four posts were identified as examples, as set out in Figure 5:

- **Advanced Practitioner Health Visiting** to provide clinical and professional leadership at an operational level in order to provide high quality, integrated and well coordinated services to children and young people. This suggestion fits with the earlier challenge of finding someone for each local area (PCT) with child public health expertise who can identify what needs doing and how it should be done.
- **Specialist Early Intervention Health Visitor** to be responsible for delivering and supporting a duty system each day, identifying functions that can be appropriately delegated to the skill mix team, to use expertise at the right level for effective care and delivery.
- **Strategic Lead Health Visitor, Healthy Child Programme** who would provide leadership and direction on cross-sectoral delivery of the Healthy Child Programme, working in partnership with the Locality Leads and Sure Start Children's Centres managers, to develop the role of Children's Centres in promoting child health.
- **Specialist Public Health Improvement Practitioner** who would work in partnership across agencies in a collaborative way to raise community awareness of key public health issues and develop projects and programmes to help address this need.

Figure 5: Options for health visiting leadership posts within universal services.

Advanced Practitioner Health Visiting.

- Provide clinical and professional leadership at an operational level in order to provide high quality, integrated and well coordinated services to Children and Young People.
- Be responsible for the leadership, development, supervision and professional direction of the health visiting teams.
- Ensure that audit programmes, supervision and personal development review processes are in place.
- Routine deployment of resources within the teams, using own judgement and initiative and seeking advice when necessary.

Specialist Early Intervention Health Visitor.

- Be responsible for delivering and supporting the duty system each day.
- Establish and develop communication systems for information sharing with the local community, midwifery, Children's Centres, Extended Schools and General Practitioners.
- Where processes and systems are identified as ineffective, to proactively seek out best practice and act to introduce new methods to improve delivery.
- Identify roles that can be appropriately delegated to the skill mix team, to use expertise at the right level for effective care and delivery. To facilitate the development and implementation of appropriate skill unit within the team.
- Work in close partnership with managers and the teams to support all new service delivery developments in line with national policy directives and local delivery targets.
- Contribute to the development and delivery of the Clinical Governance Agenda within the Universal Service.

Strategic Lead Health Visitor, Healthy Child Programme.

- Provide leadership and direction on the delivery of the Healthy Child Programme, working in partnership with the Locality Leads and Sure Start Children Centres managers, to develop the role of Children's Centres in promoting child health.
- Identify health needs within the locality and ensure effective planning, development and review of the Healthy Child Programme.
- Promote and support integrated working across children's centres and health visiting teams
- Develop user groups, including fathers, to influence the planning, development and evaluation of child (and family) focused services.

Specialist Public Health Improvement Practitioner.

- Work in partnership with the Public Health Department and other health and social care agencies to raise community awareness of key public health issues and work collaboratively to develop projects and community developments to address key public health needs.
- To support and develop group activities such as within child health clinics, Children's Centres, ante/post natal groups, smoking cessation and other activities designed to improve the health of the local population.
- To engage in community development initiatives and ensure that wherever possible, the public are involved in developing and shaping local services
- Establish and maintain effective verbal and written communication with partner agencies, groups and individuals in the promotion of the health and well being of local communities
- Develop and sustain partnership working with individuals, groups, communities and agencies, supporting the development of local Children's Centres
- Improve the health and well-being of communities and populations through projects and programmes to address

A range of other posts could be developed, according to local need, such as a consultant health visitor post without a management or clinical role to work across partnerships with commissioners, with health visitors on the frontline and representing the profession at a strategic level. Professional leadership pathways need to be underpinned by good quality education and development, but they are best regulated through employment practice, rather than at a national (NMC) level.

CONCLUSION AND RECOMMENDATION

Current policy, developed during the lifetime of this working group, has helped to reduce much of the confusion about the need for a well-resourced universal health visiting service. The positive messages from government need translating into action now, and there is still much work to be done to achieve this. An effective health visiting service requires strong leadership and this is one element that has been clearly defined by the 'Getting it Right for Families and Children' policy (Department of Health 2009a). That document states clearly that practitioners need the authority to lead and provide the services needed. Action is needed to ensure that the clear vision about best practice set out there, and articulated by this working group, can be transformed into service delivery.

First, individuals operating at all levels need to develop transformational leadership skills. These need to be taught during initial health visitor preparation and updated regularly, so practitioners are able to lead the teams they are expected to, as well as being able to work efficiently with families and other professionals. Second, services need to be organised in such a way that practitioners are enabled to put those leadership skills into practice. Third, those in senior positions, whether as managers or commissioners, need to support the development and implementation of good practice, rejecting the forms of authoritarian and managerialist approaches that inhibit the development of good practice. This involves understanding the criteria for good practice and service organisation in health visiting, as well as acknowledging and nurturing expertise professional expertise at all levels. These senior people also need support to exercise positive leadership within the organisations that employ them.

Recommendation

To enable expertise about health visiting and best practice to be available at a local, regional and national level, there should be a funded leadership programme and establishment of new roles and career pathways

C: Future employment options for health visitors need exploring



BACKGROUND

Why is this an area of interest?

- There is an increasing need for health visiting services, not matched by provision
- Increase in families experiencing disadvantage, whose needs are not well recognised by current providers
- Poorer health and wellbeing outcomes for children and families are strongly linked to areas of deprivation and ethnicity

Public services exist where there is a clearly demonstrable need, so in the first instance, health visitors do not assume (particularly in a recession or economic downturn) that they should be granted employment regardless of public service need. However, the consequences of the current recession will increase demand on health visitor resources. There is already an increasing need for the service that health visitors currently provide including:

- Assessment and identification of need and risk
- Health promotion and protection
- Support to parents and families with infants, children, and other vulnerable groups.

The evidence of increasing need comes from a range of sources. Knowledge about brain and genetic development is rising at an exponential rate, with studies all pointing to the critical period before and immediately after birth, and for the first 2-3 years of life (Shonkoff and Phillips, 2000). Early child development (internationally defined as ante-natal to 8 years old) is so crucial to future health and health inequalities that it has been referred to as a 'powerful equalizer' (Irwin, Siddiqi and Hertzman, 2007). This is a crucial period of development, not only for its own sake (which is important), but also for tackling health inequalities (Acheson, 1998; Wanless 2004), establishing school readiness, reducing later propensity to violence and crime (Hoskings, Walsh, 2005), preventing and identifying both childhood disabilities and parents' health problems, and safeguarding children during a critical period of vulnerability (HM Government, 2008).

In England, the birth rate has risen by 8.5% over the last decade, with one in five births being to mothers who were born outside the UK; this group has a higher risk of delivering low birth weight babies and of experiencing disadvantage in other forms (National Statistics, 2006, Health Statistics Quarterly, 2007). There are increasing numbers of children with special and complex needs, including physical and learning disabilities (Prime Ministers' Strategy Unit, 2005). The number of mothers experiencing post-natal depression or other mental health problems is also rising (Gaynes et al, 2005). In Scotland, the loss of dedicated health visiting posts was linked to a marked rise in child mental health problems and fall in timely referrals to speech and language therapy (Scottish Parliament 2009). The number of teenage pregnancies is higher in England than elsewhere in Western Europe, with 50% of conceptions in 20% of wards, being strongly linked to factors such as low educational attainment and economic deprivation (Department for Children, Schools and Families, 2007). The already high rates of obesity amongst British children are continuing to increase (Association of Public Health Observatories, 2006), and are strongly linked to deprivation and ethnicity (South East Public Health Observatory [SEPHO] 2009).

Interpersonal violence within families and across specific areas, associated with gang violence and illicit drug use, affects families with children of all ages (Department of Health, 2008d). The need to safeguard children and for early prevention continues, and there is concern that lack of health visitors on the ground may contribute to the problem of unrecognised or unsupported children in need of protection (Care Quality Commission, 2009, Laming, 2009). Health visitors often carry more than 20 cases subject to a child protection plan alongside 30-40 other vulnerable families and 400 or more children and families with varying degrees of need on their caseload (Adams, Craig, 2008). The social isolation and lack of social capital in many areas (Petrrou, Kupeck, 2008) focuses attention on the need for more community development and group activities, which had been traditional areas of health visiting activity.

Many of these indicators for health and social and well-being have been negatively affected in line with reduced availability of health visiting staff. This does not demonstrate a cause and effect link, but the need for health visiting is clear. Further detriment to health and social well-being will only be prevented if there are sufficient staff to make an impression on these determinants. The question then arises about which organisation should employ health visitors to carry out this work? Should it continue as now, or change?

Employing health visitors: past and present

Health visiting services began in the voluntary sector in Victorian Britain, becoming established as a statutory service, located in local government, early in the 20th century (Dingwall, 1977). Health visitors, along with their public health and community nursing colleagues, moved from local authority employ into an 'integrated NHS' in 1974. The statute requiring local authorities to provide a health visiting service was not carried forward as an NHS duty at that time. However, this move was recent enough for there to be still some working health visitors who recall being employed by local government; they note the current reverse moves towards 'integration' within local authority children's centres with interest. Various reorganisations since 1974 have seen health visitors employed by different NHS structures in England, including NHS Community Trusts and, most recently, Primary Care Trusts. Different organisations exist in other parts of the UK. A UK-wide survey (unpublished data, D-SCOVOR survey 2005), carried out in 2005 showed around 10% of NMC registrants with a health visiting qualification were self-employed; 31% worked full time; 69% were employed by PCTs and 14% by NHS Trusts; 70% held permanent contracts. Only 1% worked for local authorities and 1% for health authorities.

At present, statutory responsibility for provision of children's services, including promoting the health and well-being of children 0-19years, rests with local authorities through the roll-out of Children's Centres and Trusts across England (Department of Health 2007a). Public Service Agreements (HM Treasury, 2007) relating to these services, including the health, safety and development of children, reside primarily with the Department for Children, Schools and Families, although some are held jointly with the Department of Health. Primary Care Trusts are required to co-operate with the planning and delivery of children's services. Increasingly, health visiting services are integrating with these services, either instead of, or in conjunction with, attachment to primary care teams and general practice. The Child Health Strategy requires that each

Children's Centre should have access to a health visitor (Department of Health, Department of Children Schools and Families, 2009b).

In 2005, Primary Care Trusts (PCTs) were advised of the government's expectation that they should divest themselves of their provider function, moving rapidly to a position in which they would be commissioning organisations only (Department of Health, 2005). In the White Paper, 'Our Care, Our Health, Our Say' (Secretary of State for Health, 2006), the government slowed the process, indicating that PCTs might decide for themselves when to divest their provider function. Most PCTs have now re-organised internally into two distinct and separate areas of operation: commissioning and providing. The NHS Next Stage Review (Darzi Report) (Department of Health, 2007b) renewed the emphasis on new organisational forms and Practice Based Commissioning, with an associated increase in contestability and change to employment situation in many areas. Calls to reduce costs in the face of budget constraints look set to trigger new rounds of organisational mergers and change over the next year or two. Whilst front line hospital staff are largely protected from such reorganisations, they have a marked effect on community-based practitioners.

Aim

To gain agreement about the key features of a successful provider organisation offering health visiting services, to be commissioned by NHS or other funding bodies.

Employing health visitors: future options

In order to develop appropriately integrated services, there is a need to identify what should happen in terms of future employment of health visitors, as PCTs move increasingly into their new commissioning roles. This means addressing:

- issues around where the workforce is best placed and supported (i.e., encompassing health, social, children and families, public health, community etc)
- issues around which public service agency/department should take responsibility for these services

The initial responsibility for securing suitable services lies with commissioners, and for delivering safe and effective provision lies with the profession, but there is, arguably, a need for employers and provider organisations that would prioritise securing commissions and providing high quality health visiting services as a major priority.

Such an organisation would also be actively engaged in developing new, consistent and effective models of service organisation and the kind of desirable employment conditions that would attract the highest calibre of staff. At present, health visiting is located within the NHS and in the nursing workforce, but neither has a strong track record of championing the needs of health visiting service users or health visitors.

These debates were picked up by UKPHA's Special Interest Group for health visiting and public health, who suggested that it would be valuable to explore the various merits or difficulties associated with different employment models (UKPHA, 2007b), including for example:

- Should health visiting be located with the local authorities (and the Department for Children, Schools and Families) rather than the NHS (and the Department of Health) in order to best serve the needs of users and integrate with children's services?
- Do the advantages of close liaison with GPs and nursing colleagues outweigh the disadvantages?
- Should we develop a 'mixed economy' health visiting service with different forms of employment, including social enterprise, health sector and local authority? How?

DISCUSSION

Service commissioners are focused on the needs of users and meeting PSA targets and service priorities, which is not unreasonable, since that is their function. A key requirement, therefore, is to find a model in which the health visiting service, focused on the needs of their users, will be championed by the organisation responsible for their provision, in order to secure commissions. The working group began by considering which features would be present in a successful provider organisation for health visiting services; in other words, how could it be judged as 'successful,' and therefore appropriate for this function. To decide, four key questions were considered.

1. Who could employ health visitors?

We need to consider who currently employs health visitors and where they could be employed. Health visiting developed within the voluntary sector in the nineteenth century, and health visitors were employed in local government for most of the twentieth century. At present, the NHS employs most health visitors, although a few are seconded or jointly funded by local government. This proportion may increase as Children's Centres and Trusts develop. Social Enterprise Organisations or Charitable Trusts are also alternatives. In New Zealand, for example, a national charitable body employs Plunket Nurses, who are similar to British health visitors, although the service is wholly funded by government.

We also need to consider the Transforming Community Services (TCS) programme and how we could fit with this model. Practitioners may oppose any move away from the NHS, with pay and conditions being a key issue. There needs to be an understanding of the changes currently affecting PCTs and Children's Trusts, who have different requirements and commission services differently.

2. Who would make a good employer?

Working group members expressed their own views and experiences, and advocated for others. Some had experienced improved working conditions and benefited by moving to local government, particularly around pension plans by gaining extra years service entitlement and the ability to pay additional contributions. When transferring to a new employer, TUPE (The Transfer of Undertakings (Protection of Employment) Regulations) preserves employees' terms and conditions, but experiences were not uniformly positive. One example was given of colleagues transferring to a Social Enterprise organisation that folded within three years, resulting in loss of continuous service benefits. Transfer to an alternative employer is a major undertaking, therefore, and working group members felt that pay and conditions must be commensurate with the NHS.

NHS provider organisations currently enjoy ‘preferred provider’ status, but commissioners are not bound to use them if they are unsatisfactory. Funding for alternative models of service provision would need to be explored, and the advent of integrated children’s services means there is an increasing diversity already. One cohort of students, discussing their job-seeking experiences, reported that they found a multiplicity of potential employers confusing. They would like one employer only when changing jobs, but this need not necessarily be the NHS.

3. Can this organisation provide a health visiting service?

The NHS may continue to be the best employer for health visitors, but it is essentially focused on clinical conditions and a medical model, which does not fit well with the more social and preventive models of health embraced by health visiting. This doesn’t always help with creativity in service delivery or gaining the best outcomes for children and families. Managers are key and need to lead, which may be more feasible in an organisation specifically concerned with child public health. Some health visitors may want to set up Social Enterprise schemes, and they have the right to request this. Such an organisation might allow establishment of a national body, with local on-the-ground provider organisations. The Social Enterprise Investment Fund (SEIF) may be an avenue for this. A key question for commissioners would be, can this organisation deliver the health visiting service?

4. What should a key provider of a health visiting service look like?

This was seen as the ‘crunch question,’ since many current provider organisations would fail to meet the key features we considered essential in a good health visiting provider organisation. These features were identified, as shown in Box 2.

Box 2: Essential features of a health visitor provider organisation

- Embodies the ethos, values and purposes of health visiting, yet able to operate within multi-disciplinary and multi-agency situations.
- Pay and conditions at least commensurate with the NHS
- Includes explicit user involvement
- The ability to engage and influence service commissioners
- Facilitates and recognises leadership and professional development
- Builds on a basis of quality mechanisms that recognise the need for regulation and education and training
- Enables practice that reflects the values and principles of health visiting to deliver required outcomes, in a holistic way that embraces a broad, social view of health.
- Able to articulate, measure, evaluate and evidence positive health and social needs, service outcomes and benefits
- Uses strong, nationally standardised systems to safeguard children and young people and adult protection
- Supported by robust IT systems and resources
- Has a robust performance management, governance and accountability system.
- Able to enthuse, advocate for and support staff in carrying out their role
- Able to operate within a multi-agency arena, particularly in respect of local government children’s services and the third sector
- Has the capacity to lead the development of good practice, being recognised by other agencies as a national service delivering high quality care

The working group felt that, particularly in the face of managerialist experiences outlined by Group B, and the emphasis on illness and the medical model highlighted above, few current provider organisations would be able to meet all of these criteria. Whilst most NHS primary care organisations would meet some of them, the form of organisations currently employing health visitors militates against the achievement of them all. This led to the next question, about whether it would be possible, with some radical thinking, to identify the kind of organisational form that would follow function? What kind of organisation would facilitate achievement of the key criteria, identified above, as essential for developing and maintaining a robust health visiting service, geared to meeting the identified health needs of the local area?

What would a new organisation look like?

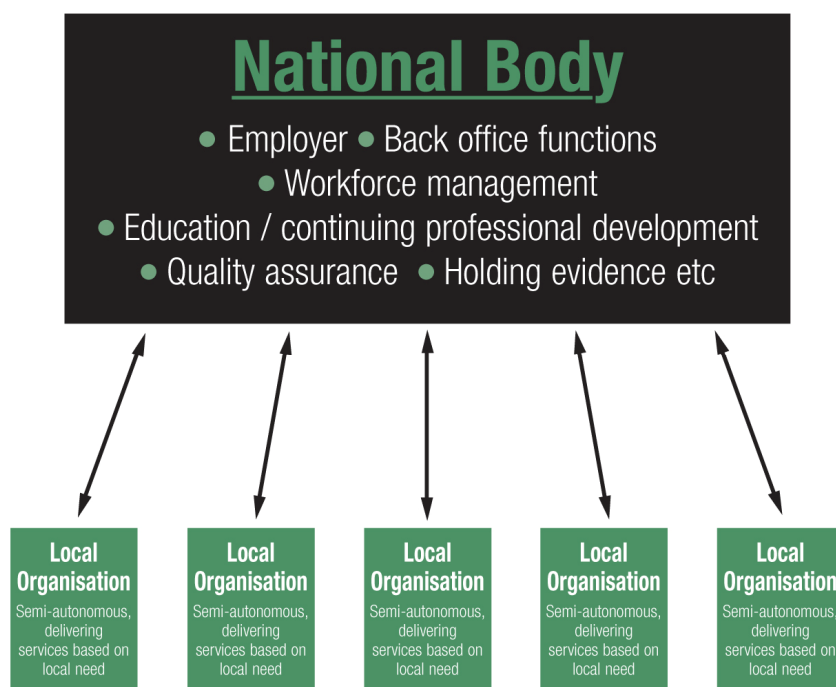
The working group felt it would be possible to develop an organisational structure that allowed some form of national body, with outreach, possibly federated locally autonomous organisations, to ensure on-the-ground expertise and grass roots intelligence was maintained. Their vision was of a national organisation responsible specifically for child public health, which would provide a base of expertise about preferred forms of practice, service organisation and evidence, advising about quality standards and providing advice and support to local, autonomously managed provider organisations. This national body could provide many 'back-office' functions, which would lead to economies of scale, and could encompass all staff engaged in child public health functions (e.g., school nurses, community nursery nurses etc). It would also be able to advise commissioners seeking e.g., best practice guidance and information about education, regulation and service delivery in the field of child public health. Such an organisation would overcome the current problems arising from the fact that child public health (of which health visiting services are one part) is a very small element of NHS service provision, which needs to operate somewhat different from clinical provision. The local outreach idea within the model would be key to ensuring that organisations maintain local integration, responding to needs identified at the grass roots.

Indeed, health visiting services differ from community-based clinical services and general practice led primary health care, so managers find they use much energy explaining or arguing about essential, but different, aspects of health visiting service delivery, within an illness-focused health service. The shape and organisation of health visiting services depends greatly upon the calibre and expertise of local managers, yet with each successive NHS reorganisation the services are fragmented in different ways, so organisational expertise is dispersed and there is limited opportunity for senior, leadership positions within child public health. As a result, the system itself inhibits development of good practice and service organisation within health visiting. The idea of a national body with local provider organisations operating through a federal system, or a form of spoke-and-hub format, could overcome this difficulty (see Figure 6).

The notion of a central body as proposed by the working group is a strong one. It could be developed as a form of national NHS Trust, as a registered charity or as a nation-wide, independent not-for-profit organisation owned by its members. Such an organisation would employ health visitors and embrace parent involvement. It would serve the perspectives and concerns of its members. A network of regional members

could support the delivery of specified level of service where the local Children's Trusts, if they continue to exist, are accountable for the local provision of service. Health visitor numbers can be based on national family/health visitor ratios that are further determined by local levels of deprivation and need. There could then be some flexibility and creativity as to the type of organisations that delivers the local service. These could include the different funding streams e.g. NHS, Social Enterprise and Local Authority to deliver different parts of the service in partnership. It would provide an independent strategic voice; it would define service quality, develop evidence based practice and promote mutual support and cooperation amongst its membership. There may then be greater scope for diversity of role, leadership and personal development.

FIGURE 6: SCHEMATIC REPRESENTATION OF NEW ORGANISATIONAL FORM



100-150 semi-autonomous local organisations fully integrated into neighbourhood and services but able to call on expertise and support lodged at national level

The Royal New Zealand Plunket Society (www.plunket.org.nz) provides an example of a successful model. As a charity with a sound governance structure and community involvement ethos, it receives central government funding to employ Plunket Nurses who deliver the 'Well Child Service' to 90% of newborn babies across New Zealand. The integrated seamless package of complementary and paid workers is unique. It leads on training issues and provides information systems that report on the delivery of health outcomes achieved by its services.

In England, another similar example might be the way the Family Nurse Partnership is being introduced across the country with a national body overseeing its introduction into local services, but providing all the expertise, clinical governance and supervision centrally. Another emerging example of this type is Parents 1st (<http://www.parents1st.org.uk/>), a social enterprise set up to support health visiting practice relating to UK Community Parent initiatives. In that model, coordinators share concerns about isolated practice and lack of understanding of the community development concept. The social enterprise aims to be a national advocate promoting better understanding of the model and overcoming fragmented practice. It develops both accredited training for parent volunteers as well as CPD and learning networks for coordinators. Transforming Community Services (Department of Health 2008b) provides an opportunity with the 'right to request' to become a social enterprise, including the ability to transfer pension rights, without being penalised. These are new ventures and it is still too soon to comment on the success of those in the early stages; however it is welcomed as a positive way forward.

Should such an organisation be developed, in addition to being capable of meeting the key criteria identified above, it would also be able to achieve some 'value-added' extra elements not currently available through the multiplicity of provider organisations, such as:

- Leading the development of good practice, through the national body with associated local, or outreach, organisations operating through a federal structure.
- Being able to both enhance the quality and consistency of service provision, and be acceptable to practitioners.
- Being able to effectively liaise and be recognised by other agencies as a national service delivering high quality care – yet know about need at a local level and be capable of being fully integrated into local services.
- Providing a large enough structure to enable the development of strong career structures and national expertise
- Being able to assure consistent service provision and a national overview of key issues relevant to the service
- Offering economies of scale for back office functions such as employment issues, education and continuing professional development
- Would provide a national overview of workforce for planning and recruitment purposes
- A unified body providing a strategic lead for health visiting services would offer continuity of pay and conditions.
- Would have the potential to encompass other professionals e.g., nursery nurses, school nurses and community staff nurses involved with child public health as well as health visitors.

- Might expand to include other public health professionals working in community public health.

At this stage, the most important point seems to be that the current organisational forms makes it very difficult to meet the functions required for by a 'successful provider of health visiting services.' Despite seeming somewhat radical, the approach outlined above has the potential to offer an exciting and potentially successful alternative.

CONCLUSION AND RECOMMENDATION

The idea that organisational form should follow function leads us to conclude that some serious thought should be given to identifying a more suitable system for employing health visitors, so that health visiting services can be provided in a more consistent way. It is important to maintain ownership and control at a local level, but also to find a mechanism for ensuring consistency and leadership at a senior level. Employment of health visitors by a national body with local organisations based firmly within the community it serves would appear to offer the best potential for transforming health visiting practice. A clearly defined strategy, shaped in partnership with service users, would be based on best outcomes for children and families.

Most importantly, it would exploit the unique combination of clinical and social models that underpins the value of health visiting, and enable greater integration across the many services operating to promote child and family public health than at present. Enabling local flexibility to ensure greater integration would overcome dislocated and fragmented employment across diverse local delivery sectors allowing innovation and partnership to flourish. Simultaneously providing robust national support and leadership would enable a strong and consistent service to develop across the country.

Recommendation

Health visitors should be employed in an organisation that embodies the criteria identified as essential for developing a dynamic and positive health visiting service, so a focused debate is needed about new organisational forms to meet this need.

D: There is a need to improve recruitment, education and regulation



BACKGROUND

Why is this an area of interest?

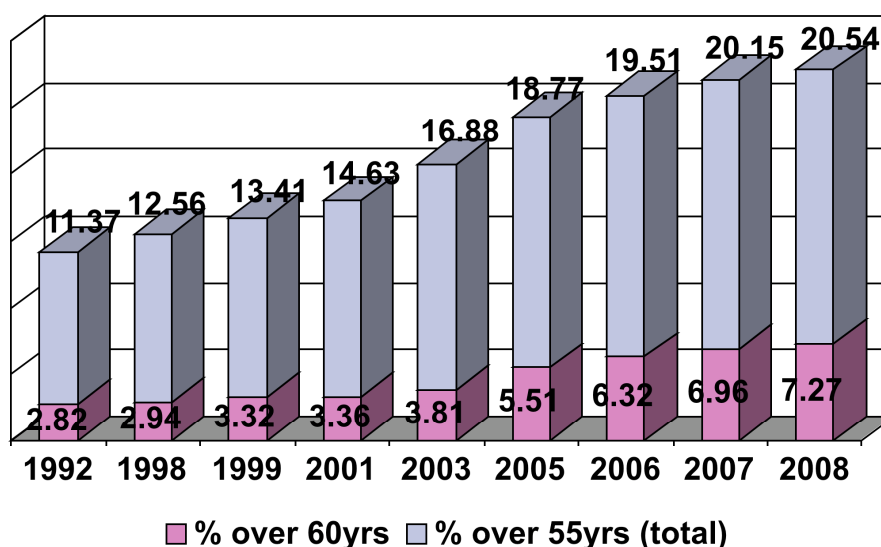
- There is a major workforce crisis in health visiting, with difficulties in recruitment at all levels of the profession
- Educational programmes are undersubscribed with an uncertain infrastructure in terms of e.g. numbers of practice teachers or availability of sufficient and appropriate programmes
- Regulation is through nursing, which has a limiting impact and raises questions about public protection.

The workforce crisis in health visiting has escalated over the past five years, and this is now having a clear impact on service delivery, so there is an urgent need to improve recruitment to the field. This means reviewing education and training with regard to establishing new curricula and discussing mechanisms for multi-disciplinary recruitment and preparation. Such approaches would facilitate direct or a wider entry to health visiting than the nursing or midwifery route that currently exists, although changes would be needed to the regulatory framework to achieve this. Health visitors are currently regulated as nurses, with an additional qualification of Specialist Community Public Health Nursing (SCPHN). If this programme is completed in the health visiting area of practice, it is currently annotated on the SCPHN register, although this is under discussion once more.

The current position

The number of health visitors employed by the NHS in England has been falling rapidly since 2004, and the age profile of those working in field is rising, as shown in Figure 7.

Figure 7. Health visitors over retirement age (%)

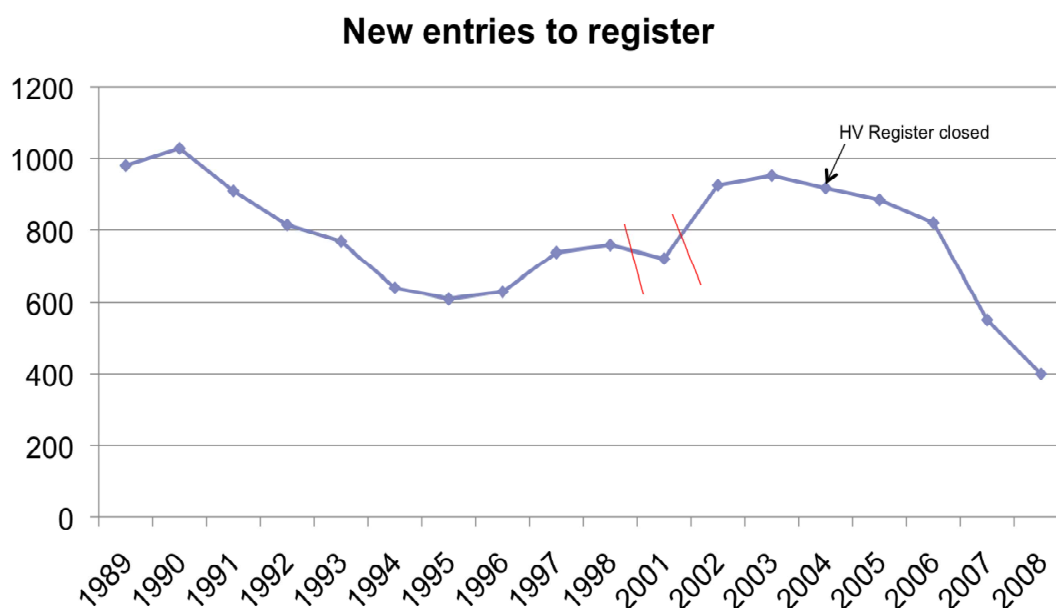


Source: The NHS Information Centre for Health and Social Care 2009

There has been increasing and widespread recognition of the need to increase the numbers of health visitors on the ground since the start of 2009, but this has proved problematic, because recruitment is so difficult. It is hard to recruit both qualified health visitors and students onto programmes, leading to an average 8% vacancy rate in English PCTs, rising to 45% in places (Care Quality Commission 2009). Shortage of staff has become the major problem facing the profession, and urgent attention is needed to increasing the workforce. Recruitment on to health visitor programmes is also problematic, with anecdotal reports of unfilled, funded spaces after five or more rounds of interviews.

The Nursing and Midwifery Council was established in 2002, initially maintaining the register held by the former regulatory body, the UKCC, until the new format, three-part register was opened in August 2004. There are some missing data stemming from the hand-over period 1999-2002, but there has been a large annual fall in the number of new entrants to the register since that time. Figure 8 shows the number of new entrants to the health visiting part (part 11) of the former UKCC register from 1989-2004, and then the number of new entrants to the SCPHN register from 2004, who were additionally annotated as having trained in the health visiting area of practice. Student numbers are believed to have increased again in the current academic session (2009-2010).

Figure 8: Health visiting register 1989 – 2004; SCPHN register (HV) Aug. 2004 – 2008



Missing data 1999, 2000, 2001

Source: UKCC database + NMC response to Parliamentary Question 6th July 2009, by Maria Miller MP

Entry requirements

At present, it is necessary to be registered with the NMC as a nurse (from any branch) or a midwife prior to commencing health visitor training. This requirement has been legally enforced since the early 1960s, although it was common before that. Whilst health

visiting shares common ground with nursing and midwifery, it also uses knowledge and skills drawn from other fields, such as epidemiology, psychology, sociology and early years studies. These are seen as essential attributes for operating within the children's workforce. The question of whether the majority of skills and expertise needed to work effectively with families, children and young people are primarily derived from nursing is highly contested. However, there is agreement that strong educational programmes are needed to ensure the 'health professional' status of health visiting is maintained. Additional skills found within the wider children's and public health workforces are essential for providing targeted interventions that increase health gain.

In 2005, a national survey of 1459 NMC registrants holding a health visiting qualification asked for respondents' views about 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 (Cowley, Bidmead, 2009). The Family and Parenting Institute has begun to campaign for health visitor education to change and expand its entry gate (Family and Parenting Institute, 2007, Family and Parenting Institute, 2009), drawing on comparisons with midwifery, which is a more clinically focused profession with an optional non-nurse route to qualification. Notwithstanding these consumer views, there is a strongly held opinion in some quarters that health visitors have credibility with the public only because of their nursing qualification, and official opposition to a change to the entry requirements (Cowley, Bidmead 2009).

Widening the entry gate beyond nursing would have added value in terms of achieving the five outcomes of Every Child Matters (Department for Education and Skills, 2004b) as well as increasing numbers in training. This takes account of newly developing professions that work to the Common Core of Skills and Knowledge for the Children's Workforce (DfES 2005) and enormous interest in the profession from non-nurse graduates and others working in similar fields. This contrasts with the lack of interest in a health visiting career from within the nursing profession. However, a change is currently not permitted under legislation that requires all entrants to the Specialist Community Public Health Nursing register to be previously registered with the Nursing and Midwifery Council (NMC). This is the only mechanism through which health visitors can qualify at present.

Educational requirements

Programmes using the current proficiencies for Specialist Community Public Health Nursing (SCPHN), through which health visitors qualify, began to be validated in 2005. This process that was not complete until September 2008, so it is still very early to identify their suitability. The main focus of the SCPHN proficiencies is on public health, but Higher Education Institutions (HEIs) are responsible for ensuring that health visiting students learn how to apply them in their practice with children, young people and families.

There are Public Health National Occupational Core Standards (Skills for Health 2004, 2007) for the public health workforce (which are met by the SCPHN Standards), as well as National Occupational Standards for Work with Parents (Lifelong Learning UK 2005) and The Common Core of Skills and Knowledge for the Children's Workforce (DfES 2005), although these are not required in SCPHN programmes. The Nursing and Midwifery Council worked with the General Teaching Council and the General Social

Care Council on a statement of values for integrated work with children, which has been endorsed and embedded within the Children's Workforce Strategy (Department for Children, Schools and Families 2008). There is evidence that health visitor students taking the new SCPHN programmes will meet the National Occupational Standards for Working with Parents (Cowley, Houston, 2008). Health visitors are expected to contribute to the training of colleagues, such as community nursery nurses (CNNs), who achieve these standards so they can function as part of the teams led by health visitors. However, there is no career route by which CNNs, or any other workers can access health visitor programmes, unless they are registered with the NMC already.

Regulation

Health visiting had been a profession in statute, with its own regulatory Council (Council for the Education and Training of Health Visitors, CETHV) until 1983, when it was absorbed into the UK Central Council for Nurses, Midwives and Health Visitors. In turn, that regulatory body was wound up, and its function passed on to the current Nursing and Midwifery Council in 2002. At that time, health visiting ceased to be recognised as a profession in its own right, being regulated instead as a post-registration nursing qualification. This was a controversial move at the time, and there have been renewed calls to restore health visiting to statute (Unite/CPHVA 2009), because there are concerns about the lack of public protection and the inability to develop the profession whilst it is constrained within the current regulatory framework. The dedicated health visiting register was closed in 2004, and that point that the number of health visitors employed began to fall quite dramatically. Whilst other factors were clearly important, Unite/CPHVA (2009) point to the key issue that removal from statute made a very clear statement about the lack of government support for the profession, paving the way for substitution by less skilled workers. In particular, the designation of health visiting as a post-registration nursing qualification reflects official enthusiasm for substituting nurses into health visiting roles.

In response to criticisms that nurses are not qualified to carry out health visiting functions, the Nursing and Midwifery Council (NMC 2009) are planning to strengthen the public health competencies developed during pre-registration nurse training. Whilst it is likely that the focus on nursing sick people will remain the priority, the competencies in the specialist community public health nursing (SCPHN) programmes will be revisited, in order to ensure that they are complementary to the updated pre-registration standards. There is a risk that this will diminish the suitability of health visiting programme still further, as happened between 1995 and 2004, when the health visitor programme was reduced in length and scope on the grounds of the health content of the then Project 2000 programmes.

There is no health visitor representative on the Council of the NMC, nor is there a committee or any organisational representation for health visiting within the structures of the regulatory body, so there is no mechanism to assure the suitability of programmes for health visitors. This is because the NMC is not legally empowered to regulate health visiting as an occupation; they are only charged and enabled to regulate nurses and midwives. Indeed, the NMC (2009) have indicated that those currently on the SCPHN part of the NMC register may arrange to move across to the UK Public Health Register if they do not consider that they fulfil the current requirements to maintain their initial nurse or midwifery qualification. This suggests that the NMC would not welcome a change in legislation enabling them to fully regulate health visitors, like their predecessor body the

UKCC. However, the debate about future health visitor regulation is ripe for development and there is increasing support of expanding the entry gate.

DISCUSSION

The working group were very conscious of the urgency of the workforce crisis, and had little doubt that the expanding the entry gates to health visitor education would be a positive and important way forward. It was felt the case had been made forcefully (Cowley and Bidmead 2009), and that there is wide support for such a move. Notwithstanding that this would be the most positive way forward, given the extent of official opposition to this change and prohibitive statutory position, the group decided to examine other options to increasing recruitment in the first instance, before looking at the education options and regulation. The aim for the group was:

Aim:

To enable the development and expansion of the health visiting workforce in a multi-disciplinary arena, by identifying key barriers and supports in the current system of recruitment, education and regulation.

Objectives:

1. To formulate a report that gains support and confidence from service users, practitioners, educational commissioners and employers, regulators and cross governmental departments.
2. To identify factors in the recruitment process that support or hinder development and expansion of the workforce in a multi-disciplinary arena
3. To identify the capacity of the educational infrastructure to enable development and expansion of the health visiting workforce
4. To clarify the relationship of current health visiting standards (SCPHN proficiencies) to those obtained through pre-registration nursing programmes
5. To discover how the NMC as an independent statutory regulator for nurses and midwives, links with other bodies and workforce development groups concerned with the public health, children and young people in respect of health visitor education and regulation.

Recruitment

Student recruitment is difficult in an increasing number of areas of the UK (Lindley et al 2009), with frequent reports that it takes several rounds of interviews to fill funded student places, dissatisfaction with the calibre and suitability of applicants and difficulties with funding of student places. We looked at the system of health visitor education and recruitment, thinking about how it affects applications to enter SCPHN programmes, which is the only mechanism for gaining a health visitor qualification.

We identified at least 12 points that have a bearing on this, revealing how a number of key points help or hinder recruitment of health visitor students. Overall, many of the underlying reasons for recruitment difficulties appear to be bound up with the fact that health visitor education is seen, currently, as a post-registration qualification, despite the lack of a specific pre-registration qualification. This is an anomalous situation, since neither nursing nor midwifery are pre-registration health visiting qualifications. There is no pre-registration health visiting qualification and adding more public health to pre-registration nursing programmes (as proposed in the current revisions, NMC 2009) will

not change that situation. The result is that issues that are intended to help career pathways and recruitment, instead, lead to many problems in practice. These are summarised in Box 3 and detailed in Appendix 4.

Box 3. Recruitment issues	
<p><i>Issues concerned with nursing careers</i></p> <ul style="list-style-type: none"> • Health visiting is a well-established and respected profession. • Health visiting is a career option for qualified nurses and midwives. • Student nurses and midwives are exposed to health visiting practice as part of their pre-registration education. • Specialist education is required for practice as a health visitor. 	<p><i>Issues related to finance</i></p> <ul style="list-style-type: none"> • Specialist education required for health visiting is funded by the NHS • Prospective health visitors are supported by the NHS to acquire the relevant qualification • Student support includes salary at a fixed rate
<p><i>Issues related to a lack of health visiting voice</i></p> <ul style="list-style-type: none"> • Health visitor education is the main instrument of workforce planning. • Careful screening of applicants before acceptance on the programme • Student health visitors are allocated to a qualified practice teacher to oversee the practical elements of the programme. 	<p><i>Issues related to the restricted entry gate</i></p> <ul style="list-style-type: none"> • A nursing or midwifery qualification is a pre-requisite for entry to a health visitor programme. • Health visitors are required to maintain active registration as nurses or midwives in addition to their SCPHN registration.

Issues concerned with nursing careers:

Traditionally, health visiting has been viewed as a desirable senior post to which nurses may aspire, but this has broken down in recent years, partly because of many other competing senior clinical roles and because students' learning experience with health visitors (if they occur at all) may be negative due to current stress in the service. A health visiting qualifications (SCPHN) is designated at a specialist level. However, since it was removed from statute, the need for such a qualification is taken less seriously, with an increasing degree of substitution of other workers into health visiting roles. In turn, this diminishes the overall attractiveness of health visiting as a potential career. Nursing career frameworks (e.g., Department of Health 2006) assume the starting point is at the initial, pre-registration qualification point, whereas the initial qualification for health visiting is the point where practitioners gain the SCPHN qualification.

Issues related to finance

Conditions for students have been standardised at a less favourable level than once pertained, so it is hard to attract nurses or midwives who are very experienced, as they would need to take a fall in salary to gain the qualification. Comparatively, salaries of health visitors are lower than those of clinical specialists or for other equally high responsibility posts; whilst stress levels and lack of respect for professional expertise means that the conditions of service seem far less desirable. Despite seeming unattractive to recipients (health visitors and potential recruits), the salary costs for the service seem prohibitive to commissioners, because they are inappropriately compared to different nursing services (e.g. in hospital teams).

Issues related to a lack of health visiting voice

Education is the major instrument for workforce planning, yet it is both unwieldy and unsuitable, because the system is based on an assumption that all post-registration qualifications build upon a prior pre-registration qualification. It is also very difficult for managers to develop or raise workforce planning models at PCT level, because numbers are comparatively low, so issues get lost within the wider nursing workforce. This also has an effect on the ability of managers to adequately influence educational programmes and conditions, such as practice support or contract setting with universities, for students' learning, where it differs from that required for pre-registration nurse education. Although the system is supposedly in place, it is constantly under pressure to conform to requirements suited to other parts of the workforce.

Issues related to the restricted entry gate

Recruitment from within the nursing workforce has become increasingly difficult, but other potentially suitable entrants cannot be considered, because the statute governing health visitor education (Nursing and Midwifery Order 2001) prohibits it. The same Order creates complex re-registration constraints that particularly affect midwives who do not hold a nursing qualification. This inhibits recruitment from that field, whereas midwives were traditionally a major recruitment pool for health visiting. There are many positive reasons for widening the entry gate to health visitor education, but the calls are not about removing all nursing elements from the programmes; instead, they are largely about removing health visitor education from a restrictive system that is unsuited to the task of promoting and developing the workforce (Cowley 2003).

The mechanism for funding post-registration qualifications, for example, assumes 'on-the-job' training, whereas initial health professional qualifications are funded on the basis of students being supported through protected learning time and a full educational programme leading to a regulated qualification. Most of the problems of recruitment, therefore, come down to a mismatch between the system within which health visitor education is managed, which is geared to post-registration nursing, and the different requirements for enabling students to learn a new profession.

Educational infrastructure

Higher education institutes (HEIs) have indicated through the United Kingdom Standing Committee (UKSC) (Lindley et al 2009) that there may be a shortage of practice teachers if training places are substantially increased. It is therefore essential that any decisions made in relation to increasing the numbers of health visiting students take full account of the capacity within the higher education institutions and placement settings, to adequately and appropriately support them. Urgent work is required to accurately map this missing data.

Clarification of skills

Key differences between pre-registration nursing skills and those required for health visitor education were identified by drawing a comparison between the two sets of standards, as shown in Appendix 5. The public health skills and development framework (Skills for Health 2008) is helpful in identifying the skills required for Level 6 and Level 7 public health practitioners. This framework also maps the skills (competencies) and knowledge needed to the NHS Knowledge and skills framework (KSF), which provides a useful comparison of the different levels (Appendix 6). Many of the national occupational standards are replicated in the SCPHN standards of proficiency (NMC 2004), so these can be used as a guide to skills acquired for Part 3 of the NMC Register.

A key point highlighted in this mapping exercise is the context and complexity of the situation within which health visitors operate. This requires generic skills such as communication ability, decision making or report writing, to be applied in a different way to within a clinical nursing situation, rather than using a completely different set of skills. This point helps to explain why many practitioners say, simultaneously, that they often use nursing skills, but cannot manage without health visitor education. Of course such generic skills are also held within other occupations. Since the main variance lies within the context, application and situation, it is very difficult to specify precise differences, particularly when describing skills at a high, or abstract, level. As well as similarities, it also helps to explain the extent of difference. All health professionals need knowledge of physiology and pathology and good communication skills, for example. However, the varied contexts in which they apply this knowledge accounts for the major differences between professions, for example between radiographers and nurses, or between physiotherapists and midwives, as well as between health visitors and nurses.

Educational options

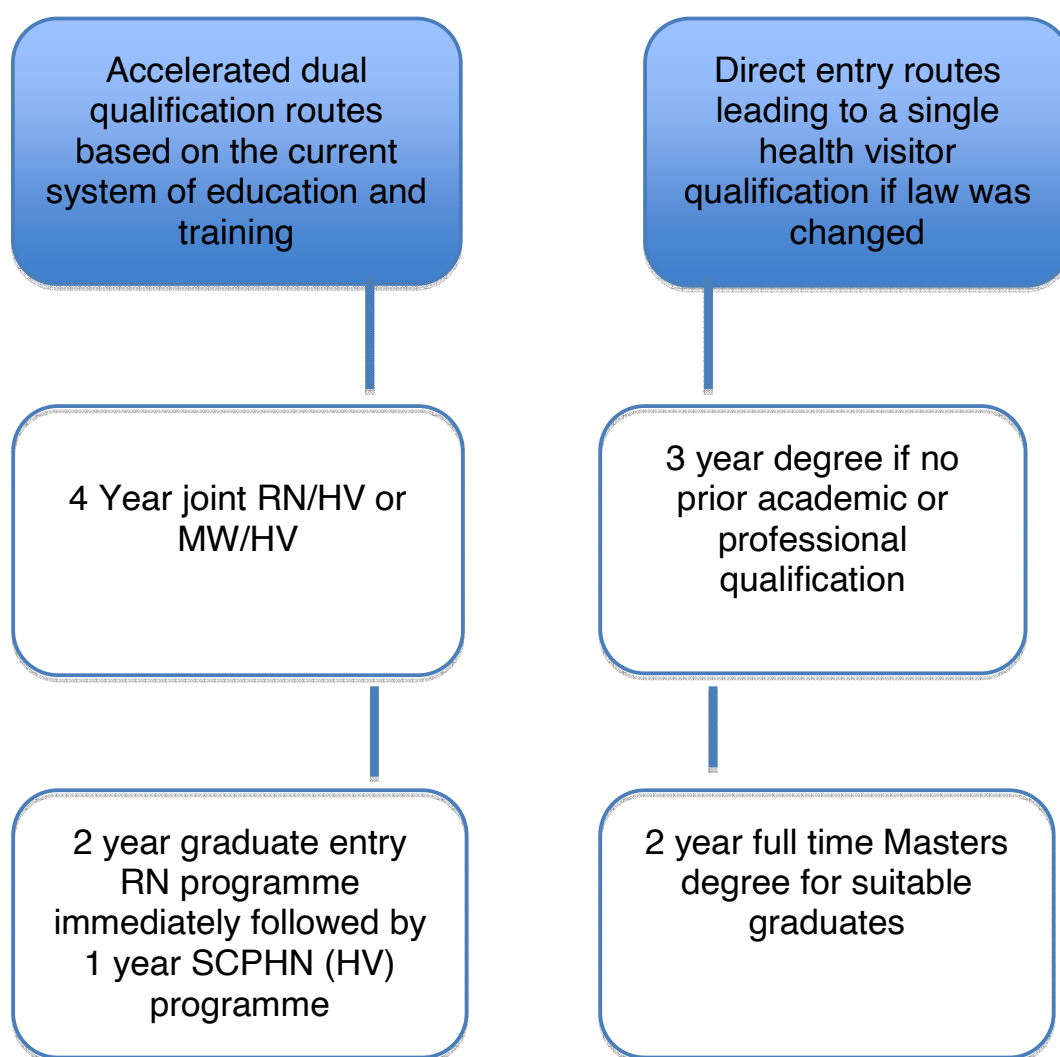
It is too soon to have a clear view about whether the current (SCPHN) proficiencies are ensuring new entrants to health visiting are well prepared for their role, since the majority of HEIs have only experienced one or two cohorts qualifying through this route. There is discontent with the length of the programme, which is too short to include all the relevant content, and whilst the public health basis of the programme is clear, proficiencies required for working with children and families are less evident as requirements. Every Child Matters is based on the need for more effective working between different practitioners within the children's workforce. The concept of integrated working is being strongly promoted through various workstreams, for example the Integrated Qualifications Framework (IQF), which has led to the creation of new tools to facilitate multi-agency work, such as the Common Assessment Framework and the information-sharing resource, ContactPoint. The (then) Department for Education and Skills established a Children's Workforce Network (CWN) to take collective responsibility for aspects of the Children's Workforce Strategy, comprising those sector skills bodies and regulatory bodies responsible for the children's workforce, and local government and the Department of Health as the key employers in the field. The General Teaching Council, General Social Care Council and NMC have been members of this Network, the latter representing the healthcare regulators. The network is now finishing due to the creation of a new strategic partnership network.

One of the key premises of the Children's Workforce Strategy is the need for services for children and their families to be organised around the needs of the child and not the silos and historical boundaries of historical professions or providers (Department for Children, Schools and Families 2008). Potentially, a specially designed, new health visiting programme could draw upon the skills of a variety of workers across the public health and children's workforce, as well as nurses. Enabling colleagues from multi-disciplinary environments, such as social workers, allied professionals, graduates from related fields, such as family or community studies, environmental or public health, to enter a specially designed programme could meet their career aspirations, as well those of colleagues working in health visiting teams, such as community nursery nurses, community mothers or family support workers.

New programmes could be developed at degree and Masters Levels, with the potential for health visiting teams to include workers at different levels of expertise and on different pay grades, but all with the skills required for the job. Such programmes would be able to focus entirely on the skills and capacities needed to function successfully as a health visitor, drawing on the many different fields of knowledge, like mental health, public health, education, family and social policy, early years development and, as now, of nursing. In particular, such a programme would clarify which skills and knowledge, currently obtained through nursing and midwifery programmes, would need to be learnt by those without such qualifications at the start. This form of education would avoid the need for all potential recruits to spend three years training as nurses or midwives, before being considered for entry into an education programme designed for practice in health visiting. This would enable a far faster track route into the profession than at present. is a range of options, set out in Appendix 7 and summarised in Figure 9, but essentially there are two main routes:

- Direct entry routes leading to a single health visitor qualification
- Standard or accelerated dual qualification routes (nursing and health visiting) based on the current system of education and training

Figure 9: Education Options



The direct entry route leading to a single qualification has the potential to offer qualification routes at BSc and MSc level, recruiting from a much wider pool than the current route. With the ability to draw on the prior knowledge and skills of applicants from allied health professions, education and social care (already working to relevant National Occupational Standards), the experience and skill base of new registrants is likely to be enhanced. If a new programme suited to a wider pool of entrants were to be developed, this would offer the opportunity to ensure that the education and training is tailored to the specific skills required to work as a health visitor, with the added bonus of promoting multi-disciplinary working. If this route were developed without accompanying legislative change, the qualification would be unregulated, since the NMC are not empowered to regulate health visitors (except through the SCPHN and nursing qualification).

Accelerated dual qualification, particularly a back-to-back qualifying programme (such as a shortened, graduate entry nursing programme followed immediately by a one-year health visiting programme) has the benefit of meeting the requirements of existing regulations. However the recruitment of applicants of suitable calibre is still likely to be a long-term issue with the initial nursing programme reducing the opportunity to focus specifically on the wider public health role. Alternatively, a pre-registration public health nursing programme could be developed, which would act as a 'feeder' route into the SCPHN (health visiting) programme. Such an arrangement would not reduce the length of time needed for training, but may improve recruitment. European Union legislation is in force governing the length and content of nursing education, which would need addressing for a new nursing, but not a new health visiting, programme.

Developing regulated options seems increasingly urgent, since there is increasing anecdotal evidence suggesting that a range of alternative education and training frameworks are being developed and delivered to a skill mix of health visitor support workers. These are being designed by HEI's to meet the service delivery needs of local primary care trusts, or by the PCTs themselves without accompanying academic qualifications and with no national overview or quality assurance. As they are currently being developed ad hoc, they risk fragmentation of skills and knowledge that are not readily transferable between communities and have the potential to compromise consistency, safety and quality of service delivery from a national perspective.

CONCLUSION AND RECOMMENDATION

Having reviewed evidence that has been made available, current issues raised from this paper are specifically related to education and recruitment of health visiting practitioners, which is affecting service delivery to children, young people and families. This current crisis provides a timely opportunity to revisit both the entry requirements and the skills base required to work effectively with this important population group. Following on from the discussion points raised above there is a need:

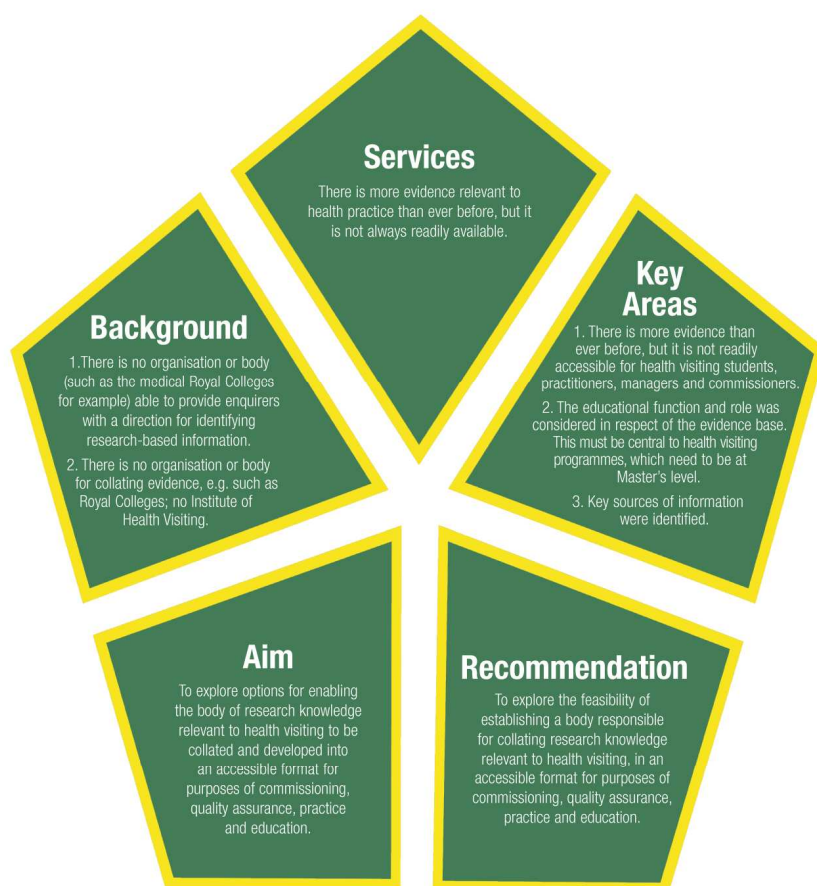
- To consider in more detail the two options outlined above for changes to the entry requirements and educational pathways for this workforce.
- Whatever pathway is determined it would be desirable for the workforce to be registered under one regulatory body.
- Further discussion on ways forward for funding students.
- To unravel the barriers to recruitment within the current system.

The social work workforce is facing a similar recruitment crisis and a specially formed taskforce has been set up, with a £58 million budget, largely to cover educational costs, but also concerned with recruitment, retention, educational programme design and supporting development of the profession as a whole. There is much that health visiting could learn from their experience. The urgency of the workforce crisis, and the complexity of the causes and potential solutions, led us to recommend that a similar task group is needed to encompass the complexities facing health visiting at present.

Recommendation

To capitalise on all opportunities for improving recruitment and retention, a funded task force should be set up to focus specifically on developing the health visiting workforce.

E: There is a need to strengthen the health visiting evidence base



BACKGROUND

Why is this an area of interest?

- Information relevant to health visiting comes from a wide range of disciplines and topics
- There is no organisation or body responsible for collating evidence
- The evidence needs to be collated in a format that reflects the needs of practice and is useful to commissioners, managers, practitioners and for education

The need to develop, strengthen, co-ordinate and disseminate the evidence base for service organisation and practice should be seen as an imperative. Whilst there is more evidence about health needs and appropriate interventions than ever before, three key difficulties remain:

- Health visiting encompasses a broad, multi-disciplinary and multi-agency area, which crosses numerous different research fields and themes. The challenge is to collate the evidence base in a format that reflects the needs of practice (health visitors and their clients), and is useful to commissioners, managers, practitioners and for education.
- There is a large and strong evidence base for some interventions and far less clearly defined evidence for others; however, neither systematic reviews nor randomised controlled trials are useful for informing the way services are organised and commissioned.
- There is a paucity of research about service organisation, including workforce profiles (e.g., team and skill-mix), home or centre based service delivery, best practice for caseload and work locations (e.g. GP attached, geographic), integrated services and age ranges served.

The current position

Evidence for the interventions encompassed within health visiting services is more available than it has ever been, in the form, for example, of evidence briefings (Bull et al 2004), meta-analyses (Macleod and Nelson 2000), systematic (Elkan et al 2000, Hannula et al 2008, Roberts et al 1996) and integrative reviews (Dowswell and Turner 2002, Karoly et al 2005), and the review of reviews (Barlow et al 2008) used in updating and expanding the Child Health Promotion Programme (CHPP) (Department of Health; Department for Children Schools and Families. 2008c). A range of NICE guidance and clinical guidelines have direct relevance to health visiting is shown in Box 4.

There are many more examples that could be cited under each heading. However, information relevant to health visiting comes from such a wide range of disciplines (e.g., paediatrics, mental health, social work, early years studies, community and primary care etc), and topics (e.g., child development, family studies, relationship issues, domestic violence, child protection, welfare rights, housing, health, complex and special needs/disabilities etc), that it represents a formidable challenge to collate the information or to synthesise it in a format that would be useful to service commissioners, managers, practitioners and for education.

Box 4: Selected NICE guidelines relevant to health visiting

NICE Clinical guideline: 2005. Depression in children and young people.

<http://www.nice.org.uk/guidance/CG28>

NICE Clinical guideline: 2006. Routine postnatal care of women and their babies.

<http://www.nice.org.uk/guidance/CG37>

NICE Clinical guideline: 2007a. Antenatal and postnatal mental health: clinical management and service guidance. <http://guidance.nice.org.uk/CG45/?c=91523>

NICE Clinical guideline: 2007b. Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children.

<http://guidance.nice.org.uk/CG43/?c=296726>

NICE Clinical guideline: 2008. Guidance for midwives, health visitors, pharmacists and other primary care services to improve the nutrition of pregnant and breastfeeding mothers and children in low income households. <http://guidance.nice.org.uk/PH11>

NICE Clinical guideline: 2008. Preventing the uptake of smoking by children and young people. <http://guidance.nice.org.uk/PH14>

NICE Clinical guideline: 2008. Promoting physical activity for children and young people. <http://guidance.nice.org.uk/PH17>

NICE Clinical guideline: 2009: When to suspect child maltreatment.

<http://guidance.nice.org.uk/CG89>

The same is true of the specific details of health needs, some of which were listed by Group C above. There is both more information than ever before, and less synthesis and readily useful information. Whilst it may seem reasonable to expect some of this synthesis to be undertaken at the workplace, there are very few people who have the skill, knowledge, time or interest in doing this, and no funding is available to cover the time and cost. The health visiting review (Lowe 2007) might have provided an opportunity, but no resources were made available to do this, and the government rejected the recommendation that it be undertaken (Department of Health 2007c), on the grounds that research to inform the CHPP/Healthy Child Programme (Barlow et al 2008) would suffice. Likewise, an early part of the action plan formulated by the social exclusion task force included a commitment to collating relevant research information (HM Government 2006). This has not happened, although they have published a new guide to help identify research about services for vulnerable people (Social Exclusion Task Force 2008). The CNO's Action Plan on Health Visiting has a work stream concerned with research, so this may be developed during 2010.

A further problem arises from what Robinson (1998) referred to as 'the social construction of health visitor domiciliary visiting through research'. This occurs when

programmed interventions that can be subject to randomised controlled trials are approved for commissioning, but funding for the infrastructure and universal service is not included; nor is there recognition of the professional skill and knowledge required to deliver it in totality. This appears to be what is happening, through government support for Olds' intensive home visiting service ('Family Nurse Partnership') for young single parents and the enhanced child health promotion programme, but not for the remainder of the health visiting service. The introduction of the Olds programme is reported to have led to closure of a number of existing local initiatives for teenage parents (Barnes et al 2008). Anecdotally, a number of embryonic but promising local programme developments have been similarly undermined, because the early evaluations were insufficient to compete with established programmes from overseas.

The funding model papers used by Groups A and B (Cowley 2007b, c) tried to describe the whole service in programme terms, but (despite the wealth of studies in some areas) there is a lack of research in many of the key areas needed to inform service commissioning. This is particularly the case in respect of responsive services for indicated prevention (i.e., 'extra health visiting' offered where needs are identified on assessment), which takes up the majority of health visiting time. There is also little research about best health promoting practice for children aged between one year and school entry. Parenting education programmes are mainly validated for older children, rather than pre-school age. Research about school-aged children is largely focused on a small number of key lifestyle issues, such as obesity, smoking, sex education and drugs, with less attention to behavioural and mental health concerns or how best to support children experiencing disruption and distress at home.

There is also a significant lack of research about how best to organise services, or how the introduction of specific additional programmes influences the universal service. Often, changes are made to key areas such as team/corporate working, extent and nature of skill mix, home or centre based service delivery, caseload size, work locations (e.g. GP attached, geographic, integrated with children's services) and age ranges served, with no evidence to show whether it will improve or detract from the effectiveness of services.

Officially, the government supports evidence based interventions, and a great deal of funding has been made available to support specific research programmes, of which an increasing number are relevant to health visiting. Government commitment to increased contestability in commissioning (Department of Health 2008b) is likely to exacerbate the difficulty in developing research-based information or robust evaluations for the service, since this approach supports the 'social construction of health visiting through research,' as outlined above. To support the need for evidence, a Child and Maternal Health Observatory (ChiMat), to take a national lead in child health, is a welcome new development launched early in 2009 (http://www.apho.org.uk/default.aspx?QN=CHIMAT_HOME), and a new Centre for Excellence in Outcomes for Children has been set up (www.C4EO.org.uk). These are extremely useful new developments, of direct relevance to health visiting.

DISCUSSION

The group agreed strongly that a sound research base is essential for maintaining effective services and for the development of the profession, and considered there is a need for this issue to be taken more seriously in the education of health visitor students

(although lack of time in the existing programme is an issue), and in their subsequent professional development.

Pressure to commission only evidence based programmes has increased with the Transforming Community Services agenda (Department of Health 2009a). The idea is that a portfolio of services will be commissioned to meet needs in an area, under heading such as 'children, young people and their families (Department of Health 2009c) and 'health, well-being and reducing health inequalities' (Department of Health 2009d). This is likely to mean the lack of evidence about how health visiting services are, or should be, organised will be felt even more keenly, but there is no single point to which commissioners (or managers or practitioners) can look for information. It is not anyone's (or any organisation's) specific responsibility to ensure the evidence base for health visiting is developed, compiled or made available in a way that is accessible for these interested stakeholders. Further, the apparent lack of interest within government circles is matched by a lack of capacity within the profession.

Historically, the Council for the Education and Training of Health Visitors (CETHV) had a specific responsibility for research development, which was transferred to the National Boards when the CETHV was wound up in 1983. When the National Boards were closed down in 2001, no further arrangements were made for carrying forward the research brief for nursing, midwifery or health visiting. This has left a vacuum in responsibility for health visiting research. There is no specific Institute or College for Health Visiting, although these exist for a number of other specialist occupations and professions, and no other body is known that is either interested or able to fill the vacuum.

AIM

To explore options for enabling the body of research knowledge relevant to health visiting to be collated and developed into an accessible format for purposes of commissioning, quality assurance, practice and education.

Research problems that arise in all fields are also relevant to health visiting; a global knowledge base would be too large and difficult to manage, for example, so would need narrowing down. At the same time the breadth of knowledge should be extended around and beyond parenting and child development; public health issues need taking into account. Before deciding what research is needed, it would be important to identify how commissioners allocate their funding for health visiting services, and what criteria to use for this professional group. In order to produce evidence for commissioners, quality assurance, practice and education (maybe service users), we need to establish whether evidence about the value of health visiting exists.

Primary Care Trusts are moving towards Children and Family Directorates that will commission services across ages 0-19 years. There will be a probable need for future practice to consider school nursing in the skill mix team. There needs to be cross disciplinary organisational research and an evidence base around domiciliary visiting to consider issues such as specificity, how interchangeable are the roles, is this safe practice? Commissioners need to understand the different skill sets.

The need to carry out two reviews was discussed: one relating to commissioning and quality assurance in health visiting, and one for health visitor practice and education. Various questions and issues were raised, as below, but no conclusions reached.

- What evidence do service users need about the value of health visiting and equally how can service users contribute to the evidence base for health visiting?
- Taking account of policy, for example Darzi, foresight, brighter futures, NICE guidelines that might relate to health visiting.
- Multi professional agency perspectives - health visitors cannot improve population health on their own, they need to work with colleagues who understand their particular contributions and vice versa.

It is also the case that much generic research in the fields of public health, mental health, child and family health are relevant to health visiting.

Education

There is a need to educate practitioners to use evidence that is pertinent to practice. There would be huge merit in involving health visitors who already contribute evidence. It is also important to have the views and research of colleague professionals represented within this body of evidence. There are large gaps in evidence for health visiting, particularly in terms of service organisation and workforce issues, such as skill mix teams, issues around support and working across different agencies and suitable staffing levels required to deliver programmes required in the universal service. Modes of practice need to be understood better, and practitioners need:

- to appreciate, understand, appraise and apply research,
- to recognize where there are gaps in current professional knowing/evidence
- to be able to undertake practitioner research.

Academics could make suggestions for different types of research to be undertaken using the established routes for submitting research titles to Health Technology Assessment boards and National Institute for Health Research. However, as identified above, whilst this is possible, it is not the primary responsibility of the academic workforce. Also, they may submit individual proposals for research but there is no national overview or mechanism through which individual researchers can find out if anyone else is working in their chosen field.

Responsibility for collating and disseminating the evidence

The group considered the possibility of establishing a body responsible for collating research information for purposes of commissioning quality assurance, practice and education. Having such a body, whether called an Institute, a Faculty or a College of Health Visiting would be an ideal scenario. This would support the idea of re-establishing health visiting as a profession in its own right. In turn, such a move would help to improve recruitment, provide a basis for developing and improving education and improving services. It would provide a platform from which to engage service users, to ensure their voice is heard, which does not exist at present. The group noted that, as part of their work to re-establish social work as a credible and attractive profession, the DCSF have proposed setting up a College of Social Work. Given the shared history of

health visiting and social work, it seems reasonable to ask that similar consideration be given to establishing a College of Health Visiting.

Such a body could be affiliated to one of the existing Royal Colleges or possibly other organisations, but funding would be needed and may not be forthcoming. Options for obtaining this would need to be explored. In the interim, a way forward might be an electronic database using a programme that can catalogue by searching by themes for example: child mental health, obesity. Existing services that operate through email alerts and electronic data (e.g. ChiMat) might provide a model. Could such a body become part of an already established organisation or designated as a specific responsibility of another? Options were identified, such as a virtual faculty or work stream of another, already established body: e.g., ChiMat, NAPP (National Academy of Parenting Practitioners), UKSC (UK Standing Conference of Specialist Community Public Health Nursing Education), CPHVA (Community Practitioners' and Health Visitors' Association). Identifying a suitable partner would not remove need for funding, and the extent which each option either reduced or enhanced the credibility of reports would need considering.

CONCLUSION AND RECOMMENDATION

In general terms, discussions held within the working group and with a wider constituency indicated that the time is probably ripe for establishing an organisation specifically concerned with evidence and the professional knowledge base for health visiting. A small number of potential partner organisations signalled interest in taking the ideas forward, but the major difficulty that remained unsolved was the lack of funding to support such an idea.

Recommendation

To explore the feasibility of establishing a body responsible for collating research knowledge relevant to health visiting, in an accessible format for purposes of commissioning, quality assurance, practice and education.

CONCLUDING COMMENTS

This report marks the conclusion of the funded project about what is needed to regenerate and, potentially, re-establish the health visiting workforce and profession, with a view to improving services. The contributors to the working groups and consensus discussions have all focused upon the need for service provision to improve child and public health, and to reduce health inequalities.

Health visitors are conscious of the privilege extended, when the mother and father of a new baby invites them to enter the family's homes and lives. There is ever-increasing evidence of the importance of the early months and years to an infants' later health, and of the opportunity afforded by a focus on this age group to reach out to others in the family and community. The birth of a baby offers a window of opportunity through which to begin by working with a family on specific issues, before extending their support to other family members, age groups and the wider community. In this way, it is possible for health visiting activities to improve maternal and infant mental health, child and family health, public health and health inequalities. However, the work requires subtlety and skill, and sufficient time to engage families with both obvious and hidden health needs, and to work with those who have yet to recognise their own levels of vulnerability. The particular skills and place of the health visiting workforce have developed gradually since the Victorian era of philanthropic public health, changing and adapting over the years to meet new challenges and health needs. This project has revealed very broad support for the continuing a modern form of this work. There is a consensus that the low point for profession at the start of the 21st century, when this project began, should be seen as a starting point for regeneration and development.

This final report is the product of much deliberation and time, from the 38 working group members, 18 steering group members, 52 people attending the consensus workshop in September 2009 and numerous other occasional comments and support. The range of organisations, disciplines and consumer organisations that have indicated interest and support for the need to ensure that health visiting is re-established as a force for health improvement is truly impressive. This project report has been compiled with their help and contributions, which we acknowledge and appreciate, although (as always) any errors are the responsibility of the authors alone. We hope the thinking and ideas reported here will help to re-establish health visiting as a service, as a form of practice and as a profession that has the capacity and ability to continue the important work of supporting families and communities to improve public health and health inequalities.

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APPENDIX 1: EXAMPLES FROM THE CURRENT POLICY AGENDA

Children's Plan:

- 1.19 Effective home visiting, outreach and other outreach service can make a difference to families who cannot or choose not to access services providing important information and access to services such as childcare and family support.
- 1.26 Important that services can recognise and support people through periods of instability.
- Box 1.4 Health visitors play a vital role in maximising the reach of services and helping excluded families to access community based support. The most at risk children need an intensive preventative programme that begins early enough to make a difference.
- 1.72 Help children to develop strong social and emotional skills from the early years on
- 1.76 Universal services could play a more effective role in promoting emotional wellbeing and mental health of children, young people and families
- 1.79 Poverty inequalities and improvement in prospects
- Box 1.6 Housing affects life chances. Cool damp housing harms children's health and can contribute to post-natal depression. Development of children in poor housing conditions significantly affected.

CAMHS Review:

- 4.4 Recommends health visitor to make the focus on early intervention, prevention and health promotion one of their priority areas.
- 4.5 Parents value a child and family centred approach from practitioners. Establishment of a trusting on-going relationship with one or two key practitioners is central to effective partnerships. Assessment is a skilled process that requires practitioners to be sensitive and attuned to needs as well as being able to negotiate and agree next steps with the child young person and family

Healthy Lives, Brighter Futures:

- 3 Parents need the right information at the right time to promote the healthy development of their child.
- 3.49. We will ensure that within local services Health Visitors have clear responsibilities and support to LEAD the Healthy Child Programme.
- 3.50 Health Visitors can best provide support and supervision for outreach work and home visiting with families in pregnancy, with a new baby or child, to secure safe and high quality care and practice and clarify accountabilities in local settings.

Healthy Child Programme

Specifies that the health visitor is to lead team delivering the 0-5 year old component of this programme. The guidance gives details of activities and engagement required at designated points. It includes clear details of the level of skills needed on the part of the practitioners, evidence to underpin activities and the expectation that this will form the basis of the core provision offered by the universal health visiting service.

Getting it Right for Children and Families:

The whole document is focused on what health visiting can achieve (the 'ambition'); what is needed in terms of commissioning and service delivery to ensure that this achieved (the 'action'); and a range of audit points that will show progress towards this (the 'achievement'). Defines the function and role of health visitors in relation to the Healthy Child Programme (HCP), in particular,

- leading and delivering the universal HCP
- being the named health visitor in Sure Start Children's Centres
- supporting vulnerable families
- defining the specialist skills in protecting children
- creating and developing effective teams.

APPENDIX 2: ANTICIPATED OUTCOMES, STARTING WITH PSA TARGETS

Relevant PSA Targets and indicators are listed here as they appear in HM Treasury 2007, so figures may not appear sequentially. See Cowley 2007c for more information about the 'markers for success.'

PSA delivery agreements and indicators	Markers of success
<i>Joint DCSF and DOH lead: Improve the health of children and young people</i>	
Indicator 1: Prevalence of breastfeeding at six to eight weeks	Year-on-year improvement in breastfeeding at six weeks and at six months.
Indicator 3: Levels of childhood obesity National target for 2020	Measurement of weight and length/height at two years and school entry. Uptake of activity groups/advice sessions. Year-on-year improvement in prevalence of obesity at school entry.
Indicator 4: Emotional health and wellbeing, and child and adolescent mental health services (CAMHS)	Number of children with emotional and behavioural issues supported through tiers 1 to 2 integrated mental health and health visiting teams. Uptake of family support services. Improved school readiness at foundation stage assessment. Number of high-risk families to intensive programmes.
Indicator 5: Parents' experience of services for disabled children and the 'core offer'	Measuring timeliness of identification: Identified pre-school; length of time problems existed prior to diagnosis. Percentage of children with disabilities identified, compared with numbers expected.
<i>DCSF lead: Improve children and young people's safety</i>	
Indicator 3: Hospital admissions of children with injuries	Year-on-year reduction in hospital admissions, and in A&E attendance. Improvement in play spaces and in first aid knowledge.
Indicator 4: Preventable child deaths as recorded through child death review panel processes	Children identified as at risk of significant harm recorded on the child protection register. Families of concern identified.
<i>DCSF lead: Raise educational achievement of all young people</i>	
Indicator 1: Early years Foundation Stage (EYFS) attainment	Improvement in EYFS attainment and in uptake of early learning initiatives. Timely referral for special educational needs. Successful tier 1 and 2 support for conduct problems.
<i>DCSF lead: Improve educational attainment in disadvantaged children</i>	
Indicator 1: Achievement gap at EYFS	As above
<i>DCSF lead: Increase the number of children and young people who find the path to success</i>	
Indicator 1: Reduce percentage of 16 to 18 year-olds not in education, employment or training (NEET)	Audit of contribution to children's services for ages 0 to 19 years. Evaluations for dedicated/specialist services.
Indicator 2: More participation in positive activities	Uptake of services by all parents. Participation in group provision.
Indicator 3: Reduce the proportion of young people using illicit drugs and alcohol	Contributions across children's services. Dedicated/specialist services evaluated.

Indicator 4: Reduce the under-18 conception rate	Reduced conception rate for under-18s, improved birth spacing.
Indicator 5: Reduce first-time entrants to criminality aged 10 to 17	Number helped by parenting education or referred for specialist help.
<i>DH lead: Promote better health and wellbeing for all</i>	
Indicator 2: Starting with children aged under one year, to reduce, by 2010, by at least 10% the gap in mortality between the 'manual' socio-economic group and the population as a whole	Year-on-year improvement in infant mortality. Post-neonatal (four weeks to one year) mortality is of key significance to health visiting services. Immunisation rates.
Indicator 3: Smoking prevalence	Year-on-year reduction in number of pregnant women and parents who smoke.
<i>DH lead: Ensure better care for all</i>	
Indicator 1: The self-reported experience of patients/users	Percentage of parents engaged in home visiting, clinics and attending groups. Percentage of parents with mental health problems supported in primary care (tiers 1 and 2).
Indicator 4: Number of women who have seen a midwife or maternity healthcare professional by 12 weeks of pregnancy	Year-on-year improvement overall, including rate for second and subsequent babies.
Indicator 6: GP services including primary care teams	Ability of clients to access health visitors via general practice. Quality of liaison with general practice.
<i>Department for Communities and Local Government: Build more cohesive, empowered and active communities</i>	
Indicators 1 to 4: Percentage of people who get on well with locals from different backgrounds, who feel they belong to their neighbourhood and can influence local decisions	Percentage of health visitors involved in community liaison committees. Engagement of families in group and community activities. Measures of social capital in area.

APPENDIX 3: REGENERATING HEALTH VISITING

This work is based on three papers :-

‘THE UNIVERSAL HEALTH VISITING SERVICE’ CPHVA and UNITE UNION,
By Professor Sarah Cowley, Professor of Community Practice Development,
Florence Nightingale School of Nursing and Midwifery, King’s College London and
Dr. Cheryll Adams, Lead Professional Officer, Strategy and Practice Development,
Unite/Community Practitioners and Health Visitor’s Association, Unite the Union.

A funding model for health visiting: baseline requirements – part 1
Sarah Cowley, *Community Practitioner* 2007;80(11): 18 – 24.

A funding model for health visiting (part 2): impact and implementation
Sarah Cowley, *Community Practitioner* 2007; 80(12): 24 -31

An Ideal Progressive Universal Service

Introduction

Health visiting is recognised as the primary universal service for pre-school age children. It is a service delivered by a team of specialist practitioners to promote good health and prevent ill health. The team is led by a health visitor and may also include community nursery nurses, community registered general nurses and health visitor assistants. The health visiting service is an integrative service that also works closely with other professionals to meet the needs of families and communities. A crucial aspect of the health visiting service is that it has the potential to influence health inequalities by focusing on early child development, delivering the service on the principles of progressive universalism (Irwin, Siddiqi and Hertzman, 2007).

Early intervention by the health visiting team can make a substantial contribution to improving the long term health of the nation by contributing to the PSA Delivery Agreements as the following demonstrates: by encouraging mothers to breast feed (1), advice on weaning and continuing advice on diet helps prevent childhood obesity (2) and diseases such as coronary heart disease, diabetes, cancer and strokes. Guidance on diet and encouraging parents to take their child to see a dentist at an early age helps prevent dental caries. By giving advice to parents of new born

babies health visitors have contributed towards the considerable reduction in the number of cot deaths. Early advice and support can help prevent post natal depression and early intervention on infant problems such as crying, sleeping and feeding helps promote a healthy attachment between parents and their infants reducing the number of referrals to the Child and Adolescent Mental Health Services(4)(5) Guidance and support will also help reduce hospital admissions caused by unintentional and deliberate injuries to children.(3) Advice and guidance on play, stimulation and accessing local services which promotes inclusiveness, encourages early child development, enabling a child to take full advantage of the opportunities available when commencing primary school. (5)(6)(7)(8)

Health Needs

Services should be developed according to an assessment of **need** at two levels:-

- An area/population level, to ensure that more health visitors, as well as enhanced children's services overall, are provided in areas of greatest need;
- At an individual/family level to ensure all those with health needs are identified, then to determine and personalise the particular provision required, according to a specialised 'health visitor needs assessment' (Cowley, 2007a) (Cowley, 2007b).

'There is a gradient of health needs, from those who are largely self sufficient, but who may need focused, often short term periods of support at transition points (like the birth of a new baby, school entry and so on) and when particular worries or difficulties arise, through a range to those who need very intensive support most of the time. Timely early interventions, support for parenting and good preventive care have all been shown effective at helping families to increase resiliency and to overcome the risk of being caught in a repeating cycle of disadvantage' (UKPHA, ? date).

'A meta- analysis of preventive programmes has shown that a multi-component, strengths based approach to service delivery, involving both home visiting and group or community-based activities, is most effective in improving family well being and reducing child maltreatment' (Macleod and Nelson, 2000).

Basic requirements of a generic health visiting service.

The basic requirements of a health visiting service as outlined by (Cowley, 2007b) are as follows:-

- 'Universal prevention providing support for all, with the intensity of support varying according to levels of need in the area (progressive universalism)
- Provision for selective and indicated prevention (specialist and extra health visiting)

- Assessment of need at two levels: area based and in partnership with each family
- A minimum of 12 contacts (including home visits) over a period of at least 6-12 months, to promote family wellness and prevent mal treatment in the first year of life
- A multi-component programme (centre-based services, groups, outreach and home visiting) using a strength based approach
- Specification of anticipated impact'

Levels of prevention.

Levels of prevention have been described as (Gordon, 1983) (World Health Organisation, 2004)

'Universal prevention

Selective prevention.

Indicated prevention'

The level of service needed for a family would be determined by a family needs assessment carried out by a health visitor over a number of visits.

Health Visitor assessments require professional judgement (Appleton and Cowley, 2003) based on a high level knowledge and skill, and implemented in partnership with clients (families, children and parents), (Davis, Day and Bidmead, 2002).

Universal Prevention

'Universal prevention is defined as those interventions that are targeted at the general public or to a whole population group that has not been identified on the basis of increased risk. This is the basis for providing 'support for all' through a universal health visiting service, as part of progressive universalism'.

SUGGESTED SERVICE PROVISION

Consumer surveys show parents want advice and support from health visitors (Russell, 2008) (Family and Parenting Institute, 2007) preferring to receive it at home.

This service allows for 12 plus contacts in the first year which is the number of contacts suggested to be most effective by research so far (Cowley et al, 2007) and professional experience. It includes 6 home visits and is a multifaceted programme incorporating the Healthy Child Programme (Department of Health, 2008).

A/N Contact 32-34 weeks gestation

Health visitor assessment and introduction to the health visiting service. Needs to be timed to be as near birth as possible so parents will remember the service and to allow for possible premature births.

10 – 14 Day Contact

28 Day Contact

These 3 contacts are for assessment of the family and to provide information on services available. They should be carried out by a health visitor. The visits should be used to explore the parent's attitudes and feelings towards parenting which should form the basis of the assessment. The visits should include advice and guidance according to the Healthy Child Programme.

6 weeks, 8 weeks, 3months and 4months.

These contacts should be home visits and could be done by a health visitor support worker who would have specialist training and would receive supervision from a health visitor.

5, 6, 7, 8 10 months and 1year contacts should be carried out by a health visitor support worker in the community receiving supervision from a health visitor.

To encourage a trusting relationship which is the foundation for successful working with parents the aim should be for the family to have the same health visitor support worker supervised by the health visitor who did the initial assessment visits.

Healthy Child Programme

Walk in child health clinic.

A walk in child health clinic is central to the role of the health visitor. All parents/carers should have access to a walk in child health clinic which should be staffed by a health visitor and other members of the health visiting team. This is essential as it is the most vulnerable who miss out when this service is not available e.g. those on low incomes with little or no credit on their mobiles to phone for an appointment; those who have difficulty in speaking English, vulnerable new parents who have difficulty in keeping to appointment times and/or accessing the service by phone. Each health visitor should be available at a clinic on a weekly basis. Such a service is easily accessible and responsive at a time of vulnerability when early intervention can be at its most effective. Walk in clinics should be made available to all pre-school age children.

Health Visitor Appointments

Appointments to see health visitors at clinics should be available for those who would prefer an appointment.

Liaison with Primary Care Team

Duty Desk

Health visitors have always been available by phone on a daily basis to respond to queries from clients and professionals and this should continue.

Other services available

Group activities such as baby massage, new parents group (e.g. a session a week for 6 weeks covering relevant topics), access to a breast feeding support group; ongoing health promotion groups covering such topics as immunisations, sun protection, minor ailments, accident prevention, play and stimulation, sleeping and feeding. These activities could be carried out by other members of the health visiting team and allied health professionals in children's centres and other venues in the community. Topics for health promotion groups would be flexible according to needs of clients, area, national programmes and epidemiology.

Access to local children's centres, toy libraries, mother and baby drop in groups and other specialist advice services e.g. housing and income should also be available.

Selective prevention

'Selective prevention targets individuals or sub groups of the population whose risk of developing a disorder is significantly higher than average, as evidenced by biological, psychological or social risk factors. A service based on progressive universalism will provide additional proactive support in areas of multiple deprivation, possibly through dedicated, specialist provision for high risk populations.' The index of multiple deprivation indices provides a link to the extent of family disadvantage.

Key Indicators of Family Disadvantage

- Neither parent in work
- Family lives in poor quality or overcrowded housing
- No parent has qualifications
- Mother has mental health qualifications
- At least one parent has longstanding limiting illness, disability or infirmity
- Family has low income below 60% of median
- Family cannot afford a number of food or clothing items

Families experiencing 5 or more disadvantages are concentrated in 10% of the most deprived areas and their children are at high risk of adverse long term outcomes and as such would require selective prevention programme.

Examples of client groups requiring selective prevention would be:- young teenage mothers; asylum seekers; children in care.

SUGGESTED SERVICE PROVISION

In some areas there may be specialised intensive programmes of home visiting such as the Olds' intensive home visiting scheme or specialised health visitors.

Where these services are not available a more intensive home visiting programme would be required which should be provided by a health visitor. In the most deprived areas a suggestion for the health visiting service would be:-

A/N contact at between 32-34 week	Home Visit
10-14 days new birth visit	Home Visit
3 weeks	Home Visit
4 weeks follow up	Clinic
6 weeks	Home Visit
8 weeks	Clinic
10 weeks	Home
12 weeks	Clinic

Twice monthly clinic contacts, one at home and one in the clinic until a year.

Monthly contacts alternating between home and clinic in the second year

Three monthly contacts in the third year

Healthy child programme

Extra Support and Family Services

These families would also need extra family and support services and may also need the advice of other specialist organisations e.g. education, benefits, housing, day care; legal advice, interpreters in addition to the services provided by the universal prevention

Indicated prevention

'Indicated prevention targets high-risk people who are identified as having minimal but detectable signs or symptoms indicating pre disposition for a disorder but who do not meet diagnostic criteria for disorder at that time. This is the progressive element of 'more support for those who need more'.

SUGGESTED SERVICE PROVISION

Indicated prevention is a service required where early needs have been identified. These families require extra health visiting in addition to the universal programme. Time needed for indicated prevention and the relevant practitioner to provide it will vary according to the specific health needs identified

Examples

e.g. Post- natal screen for 6-8-listening visits in the case of post natal depression;
groups for sleeping and behaviour problems;
Feeding/nutritional advice
Safeguarding/Child protection

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Russell S. 2008. Left fending for themselves. A report on the health visiting service as experienced by Mums. Netmums: www.netmums.com

UKPHA press release where next for health visitors? (are they essential or expendable?)

World Health Organisation (WHO). 2004. Prevention of Mental Disorders: Effective interventions and policy options. A Report of the World Health Organisation, Department of Mental Health and Substance Abuse in collaboration with the Prevention Research Centre of the Universities of Nijmegen and Maastricht. Geneva: WHO

(1) PSA Delivery Agreement 12: Improve the health and wellbeing of children and young people (April 2008) **Indicator 1: Prevalence of breast feeding at 6-8 weeks**

(2) PSA Delivery Agreement 12: Improve the health and wellbeing of children and young people (April 2008) **Indicator 3: Levels of childhood obesity in children under 12**

(3) PSA Delivery Agreement 13: Improve children and young people's safety (October 2007) **Indicator 3: Hospital admissions caused by unintentional and deliberate injuries to children and young people.**

(4) PSA Delivery Agreement 12: Improve the health and wellbeing of children and young people (April 2008) **Indicator 4: Emotional health and well being, and child and adolescent mental health services (CAMHS).** *Early and timely intervention by the health visiting service would considerably reduce the number of necessary referrals to CAMHS and problems referred early picked up by the health visitor would respond more quickly to treatment.*

(5) **PSA Delivery Agreement 14:** Increase the number of children and young people on the path to success. **Indicator 2: More Participation in Positive Activities**

(6) **PSA Delivery Agreement 10:** Raise educational achievement

(7) **PSA Delivery Agreement 11:** Narrow the gap in educational achievement

(8) **PSA Delivery Agreement 23:** Make communities safer

Prepared by Elaine Benihoud for Working Group B
31/07/2009

APPENDIX 4: WHAT HELPS AND WHAT HINDERS RECRUITMENT OF HEALTH VISITOR STUDENTS?

ISSUE	How does it help?	Are there any difficulties?	Can the difficulties be overcome?
1. Health visiting is a well-established and respected profession.	It offers an interesting and satisfying alternative career option for experienced registered nurses and midwives looking for a different direction and place in which to use their skills and knowledge.	The reputation of health visiting has suffered in places. It does not sound 'new and exciting,' like some of the more recently established posts and competes within nursing for a range of more highly paid clinical posts.	Health visiting would benefit from some marketing as a career option, and possibly from a form of 'rebranding,' such as happened in the 1960s, when the radically different education led to what was labelled a 'new breed' of health visitors.
2. Health visiting is a career option for qualified nurses and midwives.	Nursing is a broad-based profession, with large numbers qualifying each year. Although acute, hospital based care is predominant, long term, preventive or public health elements are included in pre-registration education. Mental health and learning disabilities branches are particularly strong on the community, relationships and a long term, educative outlook.	Many of the key attributes, motivations and skills for nursing, particularly in the acute sector, differ substantially from those required for health visiting. Adult and child health nursing programmes are very geared to acute hospital care, or to severe and long-term conditions in the community, rather than to public health and prevention.	A pre-registration public health nursing option could be developed. This would be in addition to the four branches that are currently available, and would be the pre-registration element of the third part of the NMC register (SCPHN), rather than linked to the first (nursing) part. It should be possible to improve public health input in pre-registration programmes, not forgetting mental health and learning disabilities nursing.
3. Student nurses and midwives are exposed to health visiting practice as part of their pre-registration education.	The idea is for students to be exposed to public health practice, so they can understand its importance as well as having a concrete experience upon which to base future career plans.	Students' learning experiences may be negative, due to low morale, staff shortages and resulting limited working patterns in health visiting. They may gain a distorted picture of health visiting, with reduced opportunities to see or understand its full potential.	Content and format of pre-registration programmes could change, with better use being made of alternative learning experiences that promote health visiting as a career.

ISSUE	<i>How does it help?</i>	<i>Are there any difficulties?</i>	<i>Can the difficulties be overcome?</i>
4. Specialist education is required for practice as a health visitor.	<p>Specialist education for health visitors provides a marker of the quality of the service, helping to ensure it is safe and can deliver the provision required to meet the policy requirements (PSA and national targets) and local public health needs.</p> <p>This is the basis of a health visiting career.</p>	<p>Skill-mix and role substitution are increasingly common, suggesting that the 'requirement' for specialist education is not taken seriously everywhere. The qualification has no legal status since health visiting was removed from statute, which promotes inappropriate substitution.</p> <p>Concerns are sometimes expressed about the suitability of the education (see Issue 5).</p>	<p>The need for a health visiting qualification in practice would be clearer if it was recognised in law, i.e., if it was a statutory qualification.</p> <p>Developing a clear career pathway and explicit workforce planning would help avoid inappropriate role substitution (see Issue 6).</p>
5. Specialist education required for health visiting is funded by the NHS	<p>Employers control the process, working in partnership with their contracted Higher Education Institutes (HEIs) to identify suitable candidates, programmes and practice experience.</p> <p>In many (possibly most) places, this arrangement is satisfactory, except where the qualification is treated as post-registration continuing professional development.</p>	<p>The HEI contracted to deliver pre-registration nurse education is usually the one with whom NHS managers have most contact. Health visitor education may be delivered by a different HEI, but contracts may be insufficiently flexible to accommodate variation.</p> <p>Managers may feel their voices are not heard in respect of programme content, or even which university is contracted where there is a choice. Employers sometimes express frustration that newly qualified health visitors have a less highly developed skill base than required.</p>	<p>Designating health visiting as a profession that is distinct from nursing and midwifery might help employers to raise issues in education meetings.</p> <p>Resume use of the term 'post-initial qualification,' which was used for some years in the early 1990s. This distinguishes required qualifications from other forms of continuing professional development used to promote progress and promotion across nursing and midwifery.</p>

ISSUE	<i>How does it help?</i>	<i>Are there any difficulties?</i>	<i>Can the difficulties be overcome?</i>
6. Health visitor education is the main instrument of workforce planning.	<p>Employers can 'horizon scan' their future workforce needs and ensure they have sufficient student places with their own practice teachers, which helps avoid unfilled vacancies.</p> <p>They can feed information into NHS Employers and the NHS Workforce Review Team about workforce issues to inform succession planning and a national overview.</p> <p>Funding is made available on a post-by-post basis, for each PCT.</p>	<p>Local control of education may inhibit a national overview of numbers in the profession. The NHS Workforce Review Team did not identify recruitment concerns in health visiting until 2009, by which time the shortage had reached a crisis level.</p> <p>Employers of health visitors, needing to discuss their requirement for two or three students, may find it hard to be heard in SHA conversations about two or three hundred students across nursing and midwifery.</p>	<p>A national overview of the health visitor workforce is required, which could be through a national team, or by designating this as the specific responsibility of one of the workforce task groups, e.g., children's workforce group, public health task force, etc. It is not clear who (if anyone) holds national responsibility at present.</p> <p>Some SHAs have recently established 'health visiting task groups' or similar to look at recruitment, career pathways etc.</p>
7. Prospective health visitors are supported by the NHS to acquire the relevant qualification	<p>Funding is channelled through the Strategic Health Authority (SHA), which ensures equity (e.g., in salary and conditions offered to students, availability of backfill funding etc) across the area, and enables them to fulfil their own remit in terms of ensuring NHS organisations have appropriately skilled staff in place to meet their obligations.</p> <p>Education for all health professions is funded through a similar workforce planning process, but it is unusual for 'post-qualification' programmes.</p>	<p>Backfill for seconded students is not always forthcoming and the reasons for needing this, and full time qualifying programmes, are neither widely understood nor fully accepted, since they are unusual within non-medical 'post-qualification' programmes.</p> <p>On qualification, health visitors may move to a different employing organisation or out of area, so the seconding Trust does not always gain a qualified recruit at the end of the programme.</p>	<p>Part-time programmes help to reduce concerns of both student and employer that students may qualify as health visitors but have no job to go to.</p> <p>A national overview would reduce pressure on planning and allow movement.</p> <p>Contracts extending beyond the training period would emphasise the two-way commitment between employer and employee.</p>

Issue	How does it help?	Are there any difficulties?	Can the difficulties be overcome?
8. Careful screening of applicants before acceptance on the programme	<p>Employers control the process, working in conjunction with their contracted Higher Education Institutes (HEIs) to identify suitable candidates.</p> <p>Employers usually advertise secondment opportunities and interview prospective students jointly with HEIs to identify suitable candidates, which benefits both organisations, by ensuring academic and practical aptitude for health visiting.</p> <p>Recruitment rounds cannot begin until student support funding has been confirmed by SHA.</p> <p>Overall, attrition from health visitor programmes is low, suggesting that investment in student selection and support is worth making.</p>	<p>It is increasingly difficult to identify applicants of a suitable calibre, with reports of funded student places remaining unfilled, or taking many rounds of adverts/interviews to fill. The exact reasons are not known. Possible reasons include:</p> <ul style="list-style-type: none"> - the mismatch between seconding and starting salaries (see point 9) - increased expectations/demands on health visitors - mis-perceptions of health visiting - low morale (staff survey shows health visiting is the NHS role with most stress) (see point 3) - staffing shortages: inappropriate role substitution/skillmix - continual cutbacks and changes to the health visiting role - closure of dedicated health visiting register (indicates a lack of official support for the role) - changes to nurse education over the last 10-15 years (see point 2) - competing/more attractive alternative nursing careers (i.e., better paid, clearer career routes, better regarded within nursing, less stressful overall) (see point 1 + staff survey) 	<p>Positive marketing (see point 1) could help.</p> <p>Improved salary, avoiding further changes to the role and clear support for existing staff to improve morale would help to counter the negativity.</p> <p>Recruitment rounds need to start earlier and opportunities to be more predictable, to allow planning ahead by candidates and employers. Organisation of funding at a national (or at least regional) level would help to encourage longer term planning.</p> <p>Some universities have begun to promote health visiting at nursing career fairs, targeting e.g. newly qualified graduate nurses, or to actively seek out individuals within their own schools/faculties.</p> <p>Widening the entry gate would help, as there are many excellent applicants from non-nursing backgrounds (see point 1). Multi-disciplinary and multi-agency working within Sure Start and children's centres appears to be one factor here; graduate unemployment is another.</p>

Issue	How does it help?	Are there any difficulties?	Can the difficulties be overcome?
9. Student support includes salary at a fixed rate	Student secondment is available through NHS primary care organisations (PCOs), which may arrange a package including salary (typically mid-point of NHS Band 5), tuition fees and the requisite practical experience.	<p>The recruitment process is a complex system that is not always well understood by potential students before they actively enquire, so they are unlikely to come across it and consider this as a career option.</p> <p>Seconding students on mid-point of Band 5, regardless of their entry salary, has an inhibiting impact on recruitment from more senior nurses and midwives, who had traditionally been attracted to health visiting. Even at this level, it is regarded as expensive by employers and there are suggestions that salary support will not be available in future</p>	<p>Lack of a clear career pathway, starting with a junior grade and leading through defined stages to a senior, leadership position, is at the root of this problem.</p> <p>Developing a pre-registration public health nursing programme or widening the entry gate to health visitor education, would help (see points 2 and 11).</p> <p>Some Trusts boost the salary to top of Band 5 from vacancy funds, to aid recruitment of suitable students. In the short term, acknowledgement of the seniority required by prospective health visitors may help, and wider advertising of the system is needed.</p>
10. Student health visitors are allocated to a qualified practice teacher to oversee the practical elements of the programme.	<p>Research shows the importance of this role. The best practice teachers are an inspiration to their students, ensuring excellent future health visitors.</p> <p>They can also promote health visiting to pre-registration nursing students by being a positive role model. By promoting best practice across the organisation, they promote recruitment of students and qualified staff alike.</p>	<p>Learning time spent in practice (50%) does not always contribute as much or as well as it should to the students' programme.</p> <p>There are shortages of qualified practice teachers, some of whom lack appropriate skills.</p> <p>There may be reluctance to pay staff for taking on this additional responsibility, or to reduce their caseload responsibilities to free time to meet students' learning needs.</p>	<p>Better recognition of the importance of the practice teacher role by both NMC and employers would help.</p> <p>Unhelpful parallels are drawn with mentorship in pre-registration nursing, which misses the point that this is specialist education, with the practice teacher responsible for 50% of the learning programme. Comparison with the relationship between GP trainer and trainee would be more appropriate.</p>

Issue	How does it help?	Are there any difficulties?	Can the difficulties be overcome?
11. A nursing or midwifery qualification is a pre-requisite for entry to a health visitor programme.	<p>This is the familiar 'status quo,' having become established by custom and practice long before it was made a statutory requirement in the 1960s. It mirrors practice in many (possibly most) other countries. There is wide agreement that some elements of nursing or midwifery education are useful for health visitors, but no consensus about which aspects are important.</p> <p>Some people believe a nursing qualification gives health visitors credibility.</p>	<p>The recruitment pool is restricted, so potentially valuable applicants from other backgrounds (e.g., graduates from suitable degrees, other health professionals, colleagues in children's centres and members of health visiting teams) cannot be considered.</p> <p>This arrangement prevents the development of a clear career framework, which deters applicants, including those who are eligible.</p>	<p>Legislative change would be needed to change the entry requirement, but this has been strongly resisted by the nursing hierarchy to date.</p> <p>A wider entry gate would need a different form of education, e.g. a three-year degree programme, or a two-year full time Masters degree.</p> <p>Some consumer groups have begun to campaign for health visitor education to allow non-nurse entrants, citing the success of the dual routes into midwifery as an example.</p>
12. Health visitors are required to maintain active registration as nurses or midwives in addition to their SCPHN registration.	<p>Health visitors are registered on the Specialist Community Public Health Nursing (SCPHN) part of the NMC register, which does not stand alone.</p> <p>In addition to the 450 hours practice as a health visitor required to justify revalidation of their registration in each third year, health visitors must additionally demonstrate that they have spent 450 hours in either nursing or midwifery practice.</p> <p>No national record is maintained to show the level of impact.</p>	<p>Treating the SCPHN part of the register differently from the nursing and midwifery parts demonstrates that the qualification is not regarded seriously for purposes of regulation. Most importantly, this raises doubts about protection of the public; but it sends a negative message to potential recruits as well.</p> <p>The requirement particularly affects health visitors from a midwifery background. Unlike nurses, they cannot 'double count' activities as contributing to both registrations. This creates difficulties in practice, which are influencing recruitment.</p>	<p>The Nursing and Midwifery Council would need to implement a rule change to overcome this difficulty.</p> <p>There is an unresolved difference of opinion about whether or not legislative change is needed. This led to the situation of the NMC first approving such a rule change following national consultation, then later reversing it, apparently at the behest of the Department of Health.</p> <p>Replacing health visiting in statute, or legislative change to expand the entry gate to education, could be the way forward.</p>

APPENDIX 5: ANALYSIS OF NMC SKILLS CLUSTERS	
Essential skills clusters for pre-registraton nursing programmes leading to Part 1 NMC registration (NMC 2007)	Difference in skills for SCPHN programmes leading to Part 3 NMC registration
Skills are under broad headings that are fundamental to best practice	Skills are totally related to public health role of the SCPHN and are mapped to the 10 occupational standards for public health (Skills for Health 2004).
Skills relate to all fields of practice	Skills relate to public health practice only
Skills reflect patient expectation of new qualifiers in specific areas	Skills reflect the service user expectations of a newly registered SCPHN
Skills complement existing NMC outcomes and proficiencies (NMC 2004)	Skills are developed from a wide public health basis and do not match with the previous expectations of the requirements for pre-registration health visitor programmes (NMC 2002).
Skills are required to be incorporated into all pre-registration nursing programmes and require specific testing	Skills are required to be achieved by all SCPHN disciplines (Health visitor, school nurse, occupational health nurse, family health nurse in Scotland).
Skills required to be demonstrated before entry to branch programme and prior to registration	Skills required to be demonstrated before access to Part 3 of the NMC register
Skills will be subject to monitoring and ongoing review	Skills need to be reviewed in the light of recent reports and service needs.

- The Public Health skills and development framework (Skills for Health 2008) is helpful in identifying the skills required for Level 6 and Level 7 public health practitioners. I see Health visitors on BSc (Hons) programmes falling in level 6 and MSc health visitors falling in level 7.
- The public health skills and development framework also maps the skills (competencies) and knowledge needed to the NHS Knowledge and skills framework (KSF).
- As many of the national occupational standards are replicated in the SCPHN standards for proficiency (NMC 2004) these can be used as a guide to skills acquired for Part 3 of the NMC Register.

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APPENDIX 6: DIFFERENT LEVELS OF SKILL (KSF)

The table below identifies the NHS Knowledge and Skills Framework (KSF) Dimensions, Levels and Indicators and attempts to **identify the differences between skills for registered nurses on Part 1 of the NMC Register and how these are built onto and developed for the SCPHN role on Part 3 of the Register**. It is often the context and complexity of the situation the health visitor finds themselves in which requires skills to be applied in a different way rather than a different set of skills.

Skills level pre-registration nursing programmes Part 1 NMC Register	Skills level SCPHN programmes Part 3 NMC Register
<p>KSF Core Dimension 1: Communication Level 3: <i>Develop and maintain communication with people about difficult matters and/or in difficult situations</i> Skills: assertion, breaking bad news, encouraging and supporting people, explaining issues, outcomes of activities/interventions, exploration of difficult issues, facilitating meetings, helping people make difficult decisions, scripted presentations, representing views, sharing information, supporting people in difficult situations, record keeping, report writing.</p>	<p>KSF Core Dimension 1: Communication Level 4: <i>Develop and maintain communication with people on complex matters, issues and ideas and/or in complex situations</i> Skills: how to influence effective communication, appreciate how your perspective, reactions and responses can affect the desired communication outcome: challenging self, presuppositions, prejudices,, perspective, beliefs, responses to communication process, advocacy, assertion of position or view, breaking bad news and supporting those receiving it (Safeguarding), delivering presentation without script, lobbying, encouraging participation of service users, (needs assessment), explaining strategy(PH priorities), facilitating process (policies into practice) motivating people (facilitating health enhancing activities), negotiating outcomes (project management, family court), representing and articulating different viewpoints, resolving complex issues (domestic violence), seeking consent (referral to Social services), sharing decision making with others including service users (community development work). Recording activities, report writing to agencies (Court, housing), legal advocacy, citizen advocacy, peer advocacy, self-advocacy, formal advocacy.</p>
<p>KSF Core Dimension 2: Personal and people development Level 3: <i>Develop oneself and contribute to the development of others</i> Skills: coach & role model to others, teaching skills, demonstration, facilitating learning sets, providing information & advice, professional supervision, supporting others in the workplace, confidentiality, evidence based practice, keeping up to date, accountability</p>	<p>KSF Core Dimension 2: Personal and people development Level 4: <i>Develop oneself and others in areas of practice</i> Skills: partnership working (across agencies, professionals, communities), dialogue & learning together (user & professional, Sure Start, Children's Centres), empathy, enablement, acceptance, genuineness, empowerment (Health improvement activity), managing conflict, leadership, management, implementation, evaluation, facilitation of health enhancing activities, (programmes leading to</p>

	health improvement, skill mix teams of professionals & service users), facilitating networks, sharing skills and experience, organising and managing student learning, team development, supporting colleagues on projects., managing training and development budget (PCT & Local Authority multi-agency teams).
<p>KSF Core Dimension 3: Health, safety and security.</p> <p>Level 3: <i>Promote, monitor and maintain best practice in health safety and security</i></p> <p>Skills: manage risk, monitor, report, compliance to risk assessment strategies, accident & incident reporting, contribute to maintaining organisation policies & protocols, support others in managing risk, medicines management.</p>	<p>KSF Core Dimension 3: Health, safety and security.</p> <p>Level 4: <i>Maintain and develop an environment and culture that improves health, safety and security</i></p> <p>Skills: medicines management (developing and managing prescribing protocols), patient group directives, administration of medicines, risk management systems, clinical governance, quality & risk management (safeguarding children, vulnerable groups, asylum seekers, refugees), defining risk, risk assessment (use of CAF), managing risk to personal safety (Lone worker policy), using frameworks to assess needs (models, collaboration, facilitation of need, search for need), evaluation of public health activity/interventions, ensure information is processed & used securely & legally, ensure people know the factors that may adversely affect their health (health protection), allocating resources (Team, money, facilities),</p>
<p>KSF Core Dimension 4: Service improvement.</p> <p>Level 3: <i>Appraise interpret and apply suggestions, recommendations and directives to improve services</i></p> <p>Skills: negotiation(involve service users in decision making), analysis, interpretation, audit, meeting, reflective practice, risk assessment, structured observations, surveys (user involvement), analysis and interpretation of policies, focus groups, networks, meetings, reflective practice.</p>	<p>KSF Core Dimension 4: Service improvement.</p> <p>Level 4: <i>Work in partnership with others to develop, take forward and evaluate direction, policies and strategies</i></p> <p>Skills: undertake small scale research, evidence based enquiry, research methodologies, statistical analysis, epidemiological priorities for community, analysis, interpretation, implementation of public health policies, health improvement, addressing inequalities. Application of models and approaches to policy analysis, influencing policies (lobbying, professional representation, conference presentation, publications), political know how, work effectively with others to formulate strategies & objectives that are consistent with values, direction & policies, operationalise policies in health visiting (Every Child matters), feed views into the system for change, work effectively in multi-agency team to evaluate the impact of effectiveness of policies (immunisation programme, Child health programme).</p>
<p>KSF Core Dimension 5: Quality</p> <p>Level 3: <i>Contribute to improving quality</i></p> <p>Skills: working as an effective team member, work within governance structures, application</p>	<p>KSF Core Dimension 5: Quality</p> <p>Level 4: <i>Develop a culture that improves quality</i></p> <p>Skills: leadership, management, organisation of team (team leader), strategic leadership (PND</p>

of leadership skills, prioritise, manage, evaluate workload	support group, drop-in) strategic analysis (current HV service), stakeholder analysis (is Hv service meeting needs, focus group), identifying strategic options (using evidence to develop services), evaluating & selecting strategic options, communicating the strategy, aligning culture & strategy, reviewing progress & amending strategy
KSF Core Dimension 6: Equality and diversity Level 3: <i>Promote equality and value diversity</i> Skills: enable others to promote equality & diversity and non-discriminatory culture by acting as a role model, enabling others to reflect on behaviour (clinical supervision), identify training & development needs	KSF Core Dimension 6: Equality and diversity Level 4: <i>Develop a culture that promotes equality and values diversity</i> Skills: Actively promoting equality & diversity, public health practice is about addressing inequalities, focussing resources where the need is greatest (Target vulnerable, priorities from PH report), involve community in decisions, listen to experiences & views of different groups and act upon them
Dimension HWB 1: Promotion of health and wellbeing and prevention of adverse effects on health and wellbeing Level 3: <i>Plan, develop, implement and evaluate programmes to promote health and wellbeing and prevent adverse effects on health and wellbeing</i> Skills: promote health and wellbeing in tertiary, secondary & primary care, support others in delivering programmes that educate on health issues, patient education for health	Dimension HWB 1: Promotion of health and wellbeing and prevention of adverse effects on health and wellbeing Level 4: <i>Promote health and wellbeing and prevent adverse effects on health and wellbeing through contributing to the development, implementation and evaluation of related policies</i> Skills; working with the well population: Project management, targeting public health issues through assessing the need, analysing the issues, planning the service, delivering, evaluating, review the success (community development, project management, effective leadership).
Dimension HWB 2: Assessment and care planning to meet health and wellbeing needs Level 3: <i>Assess health and wellbeing needs and develop, monitor and review care plans to meet specific needs</i> Skills: assessment of need, research methodologies, evaluation, audit	Dimension HWB 2: Assessment and care planning to meet health and wellbeing needs Level 4: <i>Assess complex health and wellbeing needs and develop, monitor and review care plans to meet those needs</i> Skills: surveillance, assessment, using appropriate & different assessment tools, identification of need, community health needs assessment, screening programmes, population screening, multi-agency assessment (Health impact assessment), Encouraging self-determination & motivation in service users (most vulnerable in society), use of information and methods of evaluating provision, measuring health need, collecting & structuring data to create a profile of need, assessing information collected, communicating data & information.
Dimension HWB 3: Protection of health and wellbeing Level 3: <i>Implement aspects of a protection plan and review it's effectiveness</i> (*differs from	Dimension HWB 3: Protection of health and wellbeing Level 4: <i>Develop and lead on the implementation of an overall protection plan</i>

<p>HWB 1)</p> <p>Skills: care plans as appropriate, referral, liaison, infection control policies, barrier nursing.</p>	<p>(*differs from HWB 1)</p> <p>Skills: working knowledge of impact of environmental health protection (swine flu) health & safety of community (Play areas, hazards to health, like incinerator), infection control, interpreting codes of practice with regard to environment & wider community. Working with pandemics, infection outbreaks (Measles)</p>
<p>Dimension HWB 4: Enablement to address health and wellbeing needs</p> <p>Level 3: <i>Enable people to address specific needs in relation to health and wellbeing</i></p> <p>Skills: respect individual wishes, use of evidence based guidelines, evidence based practice, public health priorities, education for health before leave hospital, primarily working with the sick person</p>	<p>Dimension HWB 4: Enablement to address health and wellbeing needs</p> <p>Level 4: <i>Empower people to realise and maintain their potential in relation to health and wellbeing</i></p> <p>Skills: working with well population, empowering people to take responsibility for their health and wellbeing is the role of the health visitor with children, families, groups, communities. Enabling individuals to become expert in managing their health & social care needs, raising self-esteem,</p>
<p>Dimension HWB 5: Provision of care to meet health and wellbeing needs</p> <p>Level 3: <i>Plan, deliver and evaluate care to meet people's health and wellbeing needs</i></p>	<p>Dimension HWB 5: Provision of care to meet health and wellbeing needs</p> <p>Level 4: <i>Plan, deliver and evaluate care to address people's complex health and wellbeing needs</i></p>
<p>Dimension HWB 6: Assessment and treatment planning</p> <p>Level 3: <i>Assess physiological and/or psychological functioning and develop monitor and review related treatment plans</i></p>	<p>Dimension HWB 6: Assessment and treatment planning</p> <p>Level 3: <i>Assess physiological and/or psychological functioning and develop monitor and review related treatment plans</i></p> <p>working towards</p> <p>Level 4: <i>Assess physiological and/or psychological functioning when there are complex and/or undifferentiated abnormalities, diseases and disorders and develop, monitor and review treatment plans</i></p>
<p>Dimension HWB 7: Interventions and treatments</p> <p>Level 3: <i>Plan, deliver and evaluate interventions and or treatments</i></p>	<p>Dimension HWB 7: Interventions and treatments</p> <p>Level 3: <i>Plan, deliver and evaluate interventions and or treatments</i></p> <p>working towards</p> <p>Level 4: <i>Plan, deliver and evaluate interventions and or treatments when there are complex issues and/or serious illness</i></p>
<p>Dimension HWB 6: Biomedical investigation and intervention</p> <p>**</p>	<p>Dimension HWB 6: Biomedical investigation and intervention</p>
<p>Dimension HWB 9: Equipment and devices to meet health and wellbeing needs **</p>	<p>Dimension HWB 9: Equipment and devices to meet health and wellbeing needs **</p>
<p>Dimension HWB 10: Products to meet health and wellbeing needs</p> <p>Level 3: <i>Prepare and supply specialist products**</i></p>	<p>Dimension HWB 10: Products to meet health and wellbeing needs</p> <p>Level 3: <i>Prepare and supply specialist products**</i></p>
<p>Dimension EF **</p>	<p>Dimensions EF **</p>

Dimension IK 1: Information processing Level 3: <i>Monitor the processing of data and information</i>	Dimension IK 1: Information processing Level 4: <i>Develop and modify data and information management models and processes</i>
Dimension IK 2: Information collection and analysis Level 3: <i>Gather, analyse, interpret and present extensive and/or complex data and information</i> (differs from IK 1)	Dimension IK 2: Information collection and analysis Level 4: <i>Plan, develop and evaluate methods and processes for gathering, analyzing, interpreting and presenting data and information</i> (differs from IK 1)
Dimension IK 3: Knowledge and information resources Level 3: <i>Organise knowledge and information resources and provide information to meet needs</i>	Dimension IK 3: Knowledge and information resources Level 4: <i>Develop the acquisition, organisation, provision and the use of knowledge and information</i>
Dimension G 1: Learning and development Level 3: <i>Plan, deliver and review interventions to enable people to learn and develop</i>	Dimension G 1: Learning and development Level 4: <i>Design, plan, implement and evaluate learning and development programmes</i>
Dimension G 2: Development and innovation Level 3: <i>Test and review new concepts, models, methods practices, products and equipment</i>	Dimension G 2: Development and innovation Level 4: <i>Develop new and innovative concepts, models, methods, practices , products and equipment</i>
Dimension G 3: Procurement and commissioning Level 3: <i>Commission and procure products equipment and services, systems and facilities</i>	Dimension G 3: Procurement and commissioning Level 3: <i>Commission and procure products equipment and services, systems and facilities</i> working towards Level 4: <i>Develop, review and improve commissioning and procurement systems</i>
Dimension G 4: Financial Management Level 3: <i>Coordinate, monitor and review the use of financial resources</i>	Dimension G 4: Financial Management Level 3: <i>Coordinate, monitor and review the use of financial resources</i> working towards Level 4: <i>Plan, implement, monitor and review the acquisition, allocation and management of financial resources</i> (Differs from G3 & G5)
Dimension G 5: Services and project management Level 3: <i>Prioritise and manage the ongoing work of services and/or projects</i>	Dimension G 5: Services and project management Level 3: <i>Prioritise and manage the ongoing work of services and/or projects</i> working towards Level 4: <i>Plan, coordinate and monitor the delivery of services and/or projects</i> (Differs from G4)
Dimension G 6: People management Level 3: <i>Coordinate and delegate work and review peoples performance</i>	Dimension G 6: People management Level 3: <i>Coordinate and delegate work and review peoples performance</i> working towards Level 4: <i>Plan, develop, monitor and review the recruitment, deployment and management of people</i> (Differs from G5)
Dimension G 7: Capacity and capability Level 3: <i>Contribute to developing and sustaining capacity and capability</i>	Dimension G 7: Capacity and capability Level 4: <i>Work in partnership with others to develop and sustain capacity and capability</i>
Dimension G 8: Public relations and marketing	Dimension G 8: Public relations and marketing

Level 3: <i>Market and promote a service/organisation</i>	Level 3: <i>Market and promote a service/organisation</i> working towards Level 4: <i>Plan, develop, monitor and review public relations and marketing for a service/organisation</i>
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2009-06-24 University of Southampton

APPENDIX 7: EDUCATION OPTIONS FOR HEALTH VISITOR STUDENTS

Dual qualification format

1. Current programmes are all based on a dual qualification format. If suitable recruits can be found, the number of students could be increased.
2. Options for alternative educational formats are included in Table A1 below.
3. There are currently around 45 Higher Education Institutes (UK-wide) validated to run SCPHN programmes. Validation confers permission to recruit a specified number of students annually, usually between 10 and 30 per annum. This can usually be increased relatively quickly, if suitable recruits can be found.
4. Students all need to be allocated to a specific, qualified practice teacher. This is where the biggest bottleneck is likely to occur, inhibiting recruitment beyond a certain number (see UKSC report to Council of Deans; Lindley et al 2009).
5. Programmes to prepare new practice teachers could run from January 2010, in preparation for students commencing in September.
6. An experienced 'sign-off' practice teacher can be paired with 1-2 student practice teachers. Some universities may have the capacity to supply outreach sign-off teachers.
7. Some universities may have capacity to release health visitor-qualified lecturers to work in joint practice/education posts: numbers are not known.

Single qualification format

1. The options to develop single qualification routes (at BSc and MSc levels) are set out in Table A2 below.
2. There is enthusiasm at a number of universities and an increasing appetite across the workforce for the careful development of some of these options.
3. A curriculum development group would need, in the first instance, to develop a programme suitable for a three year degree programme. This should look, explicitly, at which elements of shared learning would be needed with nursing students.
4. The curriculum for a two year MSc programme for selected graduate entrants would be developed, once the required content has been clarified by the BSc curriculum development group. The two levels might be considered together.
5. Practice support would be needed for these options, too, so an increase in qualified practice teachers would still be needed.
6. Some universities may allow speedy development of programmes through 'major modifications' to existing health visitor programmes as a mechanism for validation of programmes so September 2010 might be feasible for a small number of initial pilot sites.
7. Others will need a longer period for validation of a completely new curriculum with first entry in September 2011 or 2012.
8. Starting points in mid-academic year are also feasible, or initial 'stand alone modules' that can later be incorporated into students' academic profile so that programmes can start urgently.
9. Statutory regulation will need attention for the single qualification format. This could be through amendments to secondary legislation (e.g., amendments to the Nursing and Midwifery Order, enabling NMC to additionally regulate health visitors) or health visitors could be regulated through the HPC or UK Public Health Register.

Table A1. Dual qualification routes				
Status	Overview	Advantages	Issues	Regulation
Current	Two sequential qualifications Entails initial registration as a nurse or midwife (first qualification) with health visiting as a subsequent qualification obtained and regulated through Specialist Community Public Health Nursing (SCPHN) register	Current, familiar and known route Relative speed to completion of second qualification, as obtained in one year (45 programmed weeks) Full, part time and distance learning routes available. Degree and Masters level programmes in place.	Recruitment is difficult: too few applicants of suitable calibre. None of the branch nursing programmes are specifically geared towards child and family public health, as they are designed for a different purpose (i.e., mainly nursing ill people) 45 programmed weeks is too short for health visiting qualification and, in any case, obscures the true length of programme (minimum of four years) Funding for full time routes is becoming problematic, because the second qualification is regarded as post-registration development.	Only the first qualification (nursing or midwifery) is fully regulated, because SCPHN 'register' does not stand alone
Not current	Dual qualifications: nursing and health visiting obtained through a single, joint programme.	Popular and successful 'combined degree programmes' that ran from early 1960s for 30 years+. Popular with young, high-achieving applicants, many of whom went on to hold high-level senior posts.	These programmes were all disbanded when a two-year period of 'consolidation' from first qualification became a requirement prior to accessing 'Specialist Practitioner Qualification' in 1994. That requirement was, itself, repealed in 2002. EU regulations mean that new programmes would be unable to include maximum amounts of public health and primary care experience, as happened in earlier years.	Permitted under current regulations, but little appetite for redeveloping the programmes. Some interest in the 'new' idea of combining midwifery and health visiting into a single qualifying route, but regulatory difficulties seen as prohibitive.

Widely discussed	Two back-to-back qualifying programmes. Would act as a de facto joint dual qualifications route	Idea makes use of current on-the-books programmes, such as shortened, graduate entry programmes that enable qualification as a nurse within two years. Applicants are sought for sponsorship onto those programmes, with a view to immediate transfer onto 45-week health visiting programme on successful completion of initial qualification.	Discussions are currently in progress in at least one university, but none known that are currently in progress. Concern that the applicants' interest in health visiting/public health may diminish or be frustrated during the initial concentrated nursing programme; this would need managing.	Makes use of existing regulations.
New idea: not current	Serial dual qualifications, but with new pre-registration public health nursing route	A pre-registration public health nursing programme could be developed as a 'feeder' for the current SCPHN register. The programme would need to include elements of public health relevant to all occupational groups currently included in the SCPHN register. Would help to improve recruitment to SCPHN programmes, and supply junior team members	EU regulations require students to have a high level of clinical (i.e., illness) experience, so it may be necessary to derogate from those regulations, or find a different title to 'nurse' to allow sufficient public health experience. Care would be needed to ensure graduates from such a programme were not regarded as 'cheap health visitors.'	Existing regulations may allow the NMC to make a rule change accepting this variation, without changing the law, but this needs clarifying.

Table A2. Single qualification routes				
Status	Overview	Advantages	Issues	Regulation
Approach not currently in use	<p>Single qualification as a health visitor, through a three year degree programme.</p> <p>The content would need to be developed and agreed by the profession, employers and other stakeholders etc.</p> <p>A single qualification health visiting route existed from late nineteenth century until 1965.</p>	<p>Preparation would be specifically for the qualification, i.e., educate students to be health visitors, rather than to be nurses, as at present. This should feed through into improvements in practice.</p> <p>This would be the 'baseline programme' against which all other variations would be measured, in terms of content.</p> <p>Collaboration across professions would be easier (e.g., children's workforce, public health workforce). Full, part time and distance learning routes possible.</p> <p>Wider entry gate would expand recruitment pool.</p>	<p>Change would need managing as it raises concerns that the value of nursing education may be diminished.</p> <p>Relevant elements from nursing would need to be identified and included in the new curriculum.</p> <p>In this route, emphasis is on the learning outcomes from the programme, rather than entry requirements (as for dual qualifications). The new programme must enable practitioners to practice fully and effectively as health visitors.</p> <p>Concerns about the potential suitability of applicants would need handling by careful recruitment.</p>	<p>Not permitted under current regulations. Such programmes would be unregulated, unless the law was changed.</p> <p>Could either change the remit of the NMC (to include nurses, midwives and health visitors, as with its predecessor body – UKCC) or find an alternative regulator e.g. HPC or UKPHR.</p>
Approach not currently in use	<p>Single qualification as a health visitor, through a two year full time Master programme.</p> <p>Basic content would need to be as for three year degree, but shortened route to allow for graduates' prior learning.</p>	<p>As for single qualification degree programme, but quicker.</p> <p>Full, part time and distance learning routes possible.</p> <p>Makes possible recruitment of suitable high-calibre graduates (of whom many express interest in health visiting as a career)</p>	<p>As for single qualification degree programme.</p> <p>Need to specify which degrees and/or forms of education and experience would be suitable as a basis for entry (e.g., psychology, social studies, early years etc).</p>	<p>As for single qualification degree programme.</p> <p>Regulatory changes needed would be to secondary legislation only.</p>

Approach not currently in use	Access programmes to single qualification routes could be developed, notably through Foundation Degrees in health and social care	<p>Various options could be developed to expand the recruitment pool, should it be necessary.</p> <p>The Children's Workforce and Public Health Workforce offer potential recruits, with multi-disciplinarity and flexibility being encouraged from the start.</p> <p>Distance learning options could be explored.</p>	<p>Too many new variations at one time may be presented favourably as pilots, but might be perceived as being rather ad hoc.</p> <p>The key would be to use all as variations to the agreed main baseline degree programmes, and to ensure they are seen as entry points and recruitment opportunities, not as proxy health visiting qualifications.</p>	Regulation is not an issue for access programmes.
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APPENDIX 8 WORKING GROUP: MEMBERSHIP AND PROCESS

<i>Working Group A Members</i>	<i>Meetings</i>
Chair – Jan Mitcheson Elaine Bielby Sarah Cowley Rowena Harvey Liz Plastow Margaret Buttigieg Brenda Griffiths Mary Kiddy Denise Rudgley	Group A held two face-to-face meetings, one teleconference and email communications.

<i>Working Group B Members</i>	<i>Meetings</i>
Chair - Gail Walker (co-chair) Julie Matthews (co-chair) Elaine Benihoud Sarah Cowley Denise Edgecombe Jane Greaves Mary Lendor Alison Lewis-Smith Clare O’Riordan Denise Rudgley Karen Waterfield	Group B held three face-to-face meetings, and email communications.

<i>Working Group C Members</i>	<i>Meetings</i>
Chair –Karen Adams (co-chair) Dawn Taylor (co-chair) Margaret Buttigieg Sarah Cowley Maggie Harris Kate Henderson Jo Pritchard Denise Rudgley Celia Suppiah Wendy Wigley	Group C held one face-to-face meeting and email communications.

<i>Working Group D Members</i>	<i>Meetings</i>
Nicky Cocklin – Chair Woody Caan Sarah Cowley Marianne Cowpe Mary Crowley Janet Gargiulo Mary Kiddy Linda Mages Liz Porter Denise Rudgley Alison Wall	Group D held three face-to-face meeting and email communications.

<i>Working Group E Members</i>	<i>Meetings</i>
Palo Almond – Chair Sarah Cowley Liz Meerabeau Karen Rees Denise Rudgley Karen Whittaker	Group E held one face-to-face meeting, individual telephone and email communications.

APPENDIX 9: Participants in Workshop 9th September 2009

Cheryll	Adams	CPHVA
Karen	Adams	Working Party member
Palo	Almond	Working Party member
Walter	Barker	Expert adviser
David	Bartlett	The Fatherhood Institute
Margaret	Black	UKPHA
Neil	Boot	Plymouth PCT
Audrey	Chapman	
Nicky	Cocklin	Working Party member/ Greenwich University
Sarah	Cowley	Project Lead
Dilys	Daws	Tavistock Institute
Renee	De la Haye	Family Nurse Partnership
Georgina	Esene	Wolverhampton University
Maggie	Fisher	Working Party member
Ruth	Fretz	
Deborah	Futers	South Staffordshire Primary Care Trust
Jean	Glynn	Haywood Hospital
Jenny	Grant	
Jane	Greaves	Working Party member
Brenda	Griffiths	Working Party member/ Bolton PCT
Dr Kati	Hajibagheri	CPHIG, RCPCH
John	Hills	DH Social Enterprise Unit
Susan	Jalali	Working Party member
Sara	Jones	NHS Telford and Wrekin
Mary	Kiddy	Central Lancashire PCT
Lynne	Lainé	NHS Birmingham East and North
Claire	Langford	Shrewsbury and Atcham Locality
Linda	Mages	University of the West of England
Angela	Mawle	UKPHA CEO
Helena	McKeown	RCGP
Margaret	McNeill	Wolverhampton PCT, Young People & Families Directorate
Liz	Meerabeau	Working Party member/ Greenwich University
Jan	Mitcheson	Working Party member/ One Plus One
Julie	Owens	NHS Cumbria
		Wolverhampton PCT, Children, Young People & Families Directorate
Julie	Plant	
Diana	Robinson	Shropshire County PCT
Maria	Robinson	
Jean	Rowe	Public Health Specialist
Denise	Rudgley	Project Co-ordinator
Patricia	Suarez	The NHS Confederation
Celia	Suppiah	Parents 1st
Dawn	Taylor	Working Party member
Sharon	Terry	Department of Health
Val	Thurtle	University of Reading
Pam	Truman	Skills for Health
Valerie	Umaefulam	Wolverhampton University
Gail	Walker	Working Party member/ Darlington PCT
Allison	Wall	Working Party member/ NMC Adviser
Wendy	Wigley	Working Party member
Heather	Wood	

