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PROFESSIONAL BRIEFING:

PUBLIC SAFETY AND STATUTORY REGULATION OF HEALTH VISITORS

Unite/CPHVA Unite Health Sector: 2010

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FOREWORD

The Community Practitioners' and Health Visitors' Association (CPHVA) is a professional association in the 100,000 strong health sector of the Union Unite. It represents health visitors and registered nurses who are employed in primary and community health settings. The organisation's National Professional Committee (NPC) is made up of representative health visitors, school nurses and other community and public health nurses and practitioners.

CPHVA members are represented at local, regional and country levels through a committee structure which feeds into the NPC. Through this mechanism, amongst others, members working on the front line ensure that their professional concerns and experiences are discussed and addressed.

The NPC also holds an annual professional forum at its conference where members can discuss important professional issues. Over recent years these feedback structures and the annual omnibus telephone survey of 1000 members have alerted the committee to the many professional concerns which have arisen since the health visiting profession was taken out of statute in 2001 and its register closed in 2004.

The CPHVA firmly believes that it was this removal of health visiting from legislation that was the catalyst for the situation in which the profession now finds itself. There are now depleted numbers of health visitors, diminished recruitment, caseloads stretched way beyond safe boundaries and the resulting inevitable risks to the health and wellbeing of very young children.

Professor Sarah Cowley kindly agreed to prepare this important paper in response to a request from myself as Chair of the National Professional Committee of the Community Practitioners' and Health Visitors' Association. This paper provides the evidence as to how, and why, public safety has been compromised by the removal of health visiting from statute.

We hope that the Nursing & Midwifery Council (NMC), other professional colleagues and policy makers will give this document the close scrutiny it deserves. Furthermore, we hope they will agree that in order to protect children and their families at such a vulnerable time in their life cycle, it is essential to return the health visiting profession to statute and re-open the health visitor register.

Angela Roberts FHEA MA
Chair National Professional Committee
UNITE/CPHVA

SUMMARY

1. Introduction

1.1 It is the contention of Unite/Community Practitioners' and Health Visitors' Association (CPHVA) that public safety has been compromised by changes in the statute governing health visitor regulation, enacted in the Nursing and Midwifery Order 2001. The Nursing & Midwifery Council are asked to explore how the anomalous position of health visiting as a profession, currently existing outside statute, can be regularised.

1.2 Public protection is the primary concern and purpose of statutory regulation, but the line between professional regulation and client safety and vulnerability is complex and indirect. The relationship between professional and client, in most instances, is mediated through large organisations, such as the NHS, who are responsible for providing services. Even so, the 'vulnerable public' who need services at a time of relative weakness, disadvantage or uncertainty should be able to depend upon the suitability of those professionals with whom they are in contact.

2. Occupations and professionalisation: the case of health visiting

2.1 Key markers distinguish an established profession from a single role or function, and health visiting is an established profession. Removing health visiting from statute, and the associated closure of the dedicated register in 2004, implied that health visiting is no longer valued as a distinct profession and qualification.

2.2 Removing health visitors' professional qualification from statute called it into question and delegitimised it. This affected views about the service delivered by health visitors, setting the scene for a steep and devastating decline in the workforce, which has yet to be halted. The staff shortages, in turn, have led to a range of adverse decisions and omissions that cause a major risk to the public.

3. Do we need health visiting?

3.1 Safe and effective health visiting services are required to deal with increasing health and social need. This is recognised in policy and across the political spectrum, but removing health visiting from the framework of statutory regulation has created much confusion for service users, commissioners, employers and practitioners.

3.2 Ambiguity and uncertainty about the meaning and existence of a health visiting qualification, whether it is needed and when, has led to a number of employers and commissioners making very risky choices in staff deployment, often using personnel with insufficiently developed skills.

3.3 Confusion about the regulatory status and need for a health visiting qualification has led to unsafe lines of accountability and unclear decision trails in many organisations. The substitution of personnel with different skills to those of a fully qualified health visitor, and who may be inappropriately confident, creates a considerable risk. This practice differs from standard, safe skill mix or teamwork, but it has proliferated since health visiting was removed from statute.

4. Is health visiting recognised as a health profession, or should it be?

4.1. Specific criteria were established in 2001 by which aspiring health professions that need statutory regulation could be recognised. Health visiting meets these criteria, yet was removed from the framework of statutory regulation in the same year. This perverse decision has left the public at risk from a range of problems arising from the current regulatory arrangements.

4.2. The NMC has no legal mechanism for dealing with professional difference, which perhaps leads them to overstate the degree of similarity between nursing and health visiting, and to obscure, or even negate, the extent and distinctiveness of health visiting knowledge. In turn, this poses a risk to the public, because it encourages the substitution of registered nurses, who are qualified to work in a different way, for health visitors.

4.3. There is a lack of transparency in the regulatory system, so any member of the public wishing to lodge a complaint about a health visitor would be hard pressed to identify a regulatory body responsible for the profession.

5. Is the health visiting profession regulated?

5.1. Despite being included in the Specialist Community Public Health Nursing (SCPHN) part of the NMC register, the health visiting profession is not regulated as such, nor in a manner that can protect the public. Current arrangements are unsatisfactory because of the format of the third part of the NMC register, its lack of specificity for health visiting and the absence of protection for health visitors' professional title.

5.2. There is no official mechanism for ensuring that standards of preparation are appropriate for health visiting, leading to doubts about the suitability of official programmes, and fitness for practice of new registrants. In turn, this is leading to the development of a range of ad hoc and unregulated mechanisms for training.

5.3. Arrangements for revalidation and continued registration are confusing and convoluted, undermining the health visiting qualification and encouraging registrants to claim proficiency in the different fields of nursing and midwifery, regardless of their self-assessed competence.

6. Conclusion

6.1 Removing the health visiting qualification from statute is identified as the root cause of the downturn in health visiting numbers, of preparation and recruitment difficulties, and of the numerous adverse and risky decisions made by commissioners and service managers.

6.2 Deregulation of health visiting has encouraged an atmosphere of disrespect and devaluing of the profession, without regard for research evidence, or for the effect of such attitudes on service provision for the infants, children and families left with inadequate or inappropriate support as a result.

6.3 It is the belief of Unite/CPHVA and many others that the situation for practice and for service users will only improve when health visiting is able to resume its rightful place as a fully regulated health profession, with a qualification recognised in statute.

CONTENTS

1. INTRODUCTION

It is the contention of Unite/Community Practitioners' and Health Visitors' Association (CPHVA) that public safety has been compromised by changes in the statute governing health visitor regulation, enacted in the Nursing and Midwifery Order 2001. This paper builds on an earlier one[1], explaining in detail the reason for this concern. The Nursing & Midwifery Council is asked to explore how the anomalous position of health visiting as a profession, currently existing outside statute, can be regularised.

Statutory regulation began long before the National Health Service and the existence of large employing organisations for delivering professional services, so its purpose was relatively simple and clear. If a person posted a plaque on their door announcing themselves as qualified to work as a professional, such as a doctor, lawyer or midwife, the 'vulnerable public' needed to be assured that the person claiming such skills would, indeed, have a suitable, peer approved qualification, and would also practise within an ethical framework that stopped them from taking advantage of the clients who needed their services at a time of relative weakness or uncertainty. Public protection continues to be the primary concern and purpose of statutory regulation. In today's far more complex world, there is rarely a direct linear relationship between professional and client, in that most services are delivered through large organisations, such as the NHS. Likewise, the line between professional regulation and client safety and vulnerability is complex and indirect.

This paper aims to unravel this complexity and justify the contention that public safety is being compromised by current arrangements for regulating health visitors. It builds the

argument through the next four sections, which explain the regulatory situation for health visiting and the attendant risk to the public.

After this introductory section, Section 2 relates health visiting to our understanding of occupations and professionalisation in the modern world, identifying key markers that distinguish an established profession from a single role or function. It explains our basic claim, that removing health visiting from statute in 2001, and the associated closure of the dedicated register in 2004, implied that health visiting is no longer valued as a distinct profession and qualification. This affected views about the service delivered by health visitors, setting the scene for a steep and devastating decline in the workforce, which has not yet been halted. The staff shortages, in turn, lead to a range of adverse decisions and omissions that cause a major risk to the public.

Section 3 refutes the idea that health visiting is no longer required, detailing the increasing extent of health and social need. This need is recognised in policy across the political spectrum, but removing health visiting from the framework of statutory regulation has created much confusion. Ambiguity and uncertainty about the meaning and existence of a health visiting qualification, whether it is needed and when, has led to some very risky decisions being taken by employers and commissioners, as well as a lack of clarity in decision trails and forms of accountability in practice.

Section 4 picks up the question of whether health visiting is, or should be, recognised as a health profession, as opposed to a single role or a post-registration nursing qualification. The perversity of the decision to remove health visiting from statute in 2001 is shown by examining criteria for recognising whether or not an occupational group should be regulated as a health profession, which were established in the same year. This examination shows clearly that health visiting should be regulated as a health profession. Furthermore, of direct relevance to the points being made in this paper, it uncovers specific risks and problems arising from the current regulatory arrangements.

Section 5 confronts the key question of whether or not the health visiting profession is currently regulated, and concludes that it is not. Health visitors are included in the Specialist Community Public Health Nursing part of the NMC register, but this is unsatisfactory because of its format, its lack of specificity for health visiting and the absence of protection for health visitors' professional title. There is no official mechanism for ensuring the standards of preparation are appropriate for health visiting, leading to doubts about the fitness for practice of new registrants. Arrangements for revalidation and continued registration are confusing and convoluted, undermining the health visiting qualification and encouraging registrants to claim proficiency in the different fields of nursing and midwifery, regardless of their self-assessed competence.

Finally, the concluding section summarises the key points, which illustrate harm to the public, stemming from the lack of statutory regulation. It identifies removal of the health visiting qualification from statute as the root cause of the downturn in health visiting numbers, of preparation and recruitment difficulties, and of a series of adverse and risky decisions made by commissioners and service managers.

Deregulation of health visiting encouraged an atmosphere of disrespect and devaluing of the profession, without regard for the evidence or for the effect of such attitudes on service provision for the infants, children and families left with

inadequate or inappropriate support as a result. The situation will only improve when health visiting is able to resume its rightful place as a fully regulated health profession, with a qualification recognised in statute.

1.1. Key points

- It is the contention of Unite/CPHVA that public safety has been compromised by changes in the statute governing health visitor regulation, enacted in the Nursing and Midwifery Order 2001. The Nursing & Midwifery Council is asked to explore how the anomalous position of health visiting as a profession, currently existing outside statute, can be regularised.

- Public protection is the primary concern and purpose of statutory regulation, but the line between professional regulation and client safety and vulnerability is complex and indirect. The relationship between professional and client, in most instances, is mediated through large organisations, such as the NHS, who are responsible for providing services. Even so, the 'vulnerable public' who need services at a time of relative weakness or uncertainty should be able to depend upon the suitability of those professionals with whom they are in contact.

2. OCCUPATIONS AND PROFESSIONALISATION: THE CASE OF HEALTH VISITING

2.1. Development of a profession

Statutory regulation usually occurs late in the development of a profession. Occupational groups begin because there is a need for a particular skill or service, only becoming professionalised over a period of some years, even decades, if the need persists. An occupation becomes professionalised if their provision is shown to be effective, successful, acceptable and cohesive over a lengthy period, with an accompanying need for the high level of education generally regarded as necessary for professions, and for an ethical code of practice to protect clients from misconduct.

Health visiting began in the second half of the nineteenth century, because of a perceived need for support and health education for families living in impoverished conditions[2]. It was part of the Victorian public health movement, being a voluntary sector response to a belief that the prevalent engineering solutions to squalor and disease would not succeed without a commensurate focus upon the home and family. Current evidence increasingly supports the view that home visiting[3,4], and early interventions that include support for parenting and family life[5], are essential components in combating health inequalities[6] and many modern-day public health concerns, such as obesity[7], interpersonal violence[8,9,10] and mental health problems[4,11].

2.2. Hallmarks of a profession

Longevity and flexibility are hallmarks of a profession, established beyond the requirements of a single role or

function, which are more short term. Their baseline education equips professionals to practise across a range of activities, changing as required, perhaps with some additional on-the-job training, to meet emerging needs and expectations from the public and in policy. As an example, devolution has created a situation in which each of the four parts of the UK use health visitors in slightly different ways[12], albeit with discernibly similar themes and purposes[13], and there were major shifts in expectations even within countries during the Labour administration from 1997-2010. English health visitors were initially expected to focus on supporting families[14], which shifted to community-based activities (called 'public health' at the time)[15,16], then to emphasise intensive home visiting[17], then to combine[18] leading teams to deliver the Healthy Child Programme[19] with a focus on safeguarding children[20].

All these changes occurred within little more than a decade. It would clearly be impractical to deliver full on-the-job training for each role as policy shifted in such a short time frame, but as fully qualified professionals, health visitors are able to incorporate new expectations into their established work patterns. These forms of practice include health visiting delivered through traditional home visiting and centre-based activities[21], but also using modern approaches such as telephone and web-based provision[22,23]. Although the NHS is the main employer of health visitors, some of them work in local government (particularly in Sure Start Children's Centres), others the third sector and, increasingly, in private practice[23,24,25].

The need for a high (professional) level of knowledge and skill to both co-ordinate and deliver the forms of practice and service provided by a health visitor is widely recognised, with a minimum of a degree, and increasingly, Masters level preparation being considered necessary[26,27]. Indeed the need for a professional (now often referred to as 'specialist') level of

education to cope with the complexities involved in this form of activity was first established more than a century ago. In 1891, Florence Nightingale famously wrote in support of the first known programme of education, commenting that 'It seems hardly necessary to contrast sick nursing with this [health visiting]. The needs of home health require different but not lower qualifications and are more varied. She [the health visitor] must create a new work and a new profession for women'[28].

2.3. Statutory regulation and the legitimacy of a profession

In 1919, some 50 years after the first health visitors were employed, the Ministry of Health established a national set of standards for their preparation, which is often regarded as the point at which the qualification was established in statute[29]. So, health visiting was very well established by the time the Local Government Act 1929[30] formally legitimised the qualification through a linked statutory instrument. The profession continued to be regulated through a series of different regulatory bodies and laws (see Appendix 1), until the Nursing and Midwifery Order 2001 was passed through secondary legislation linked to the Health Act 1999[31]. This new regulation removed the terms 'health visitor' and 'health visiting' from statute, so they ceased to have any official (i.e. legal) status. It formally de-legitimised the health visiting qualification and removed statutory regulation of the profession, with existing health visitors being officially relabelled as specialist community public health nurses (SCPHNs) when their former register was closed in 2004. At that point, the newly developed requirements for pre-registration health visiting programmes[32] were discontinued, and generic community public health proficiencies[33] were introduced, through which future health visitors would be educated; these remain in place now.

A different profession became regulated through statute for the first time at the end of the twentieth century, which illustrates the slow and indirect impact on the progress of a profession, and on availability of services. The Osteopaths Act 1993[34] led to a new General Osteopathic Council, established in 1999. It is highly unlikely that any service users will have noticed any immediate difference in their treatments at that time. However, legitimising the profession paved the way for osteopaths to be employed or commissioned by the NHS, which had previously been very rare. Their form of practice was included for the first time in a NICE clinical guideline[35] in 2009, which is likely to extend availability further.

We contend that a similar, but reverse, impact has adversely affected health visiting services and professional progress since it was removed from statute. As noted, when the Nursing and Midwifery Order was passed in 2001, the terms 'health visitor' and 'health visiting' were removed from all the laws in which they formerly appeared, and the dedicated register was closed in 2004. Again, it is unlikely that service users will have noticed any immediate impact, although one soon became apparent, as the services delivered by health visitors began to be reduced. Within five years, the number of health visitors employed by the NHS in England had fallen by 16.5%, from 10,137 whole time equivalents (WTE) in September 2004, to 8519 WTE in September 2009[36]. In some areas, the fall in workforce numbers has been far greater, with qualified health visitor vacancies averaging 8% and up to 45% in some areas[37]. Service users soon began to register an increasing uncertainty about the skills of those delivering health visiting provision[38,39] and a noticeable rise in difficulties accessing a reliable service[40] (see Example 1). In Wales and Northern Ireland[41], robust measures have been taken to ensure the workforce is maintained, but in Scotland a similar large eduction in the number of health visitors has been blamed for an increase in children's mental health problems[42].

Example 1: Service users 'Left fending for themselves'

Netmums survey of 6000 mums[40] found:

- 60% of new mums didn't see enough of their health visitor in the first year
- 46% saw their health visitor only once or twice in the vital first two months
- 70% were not contacted at all by their health visitor after the first two months

Selection from the 1300 comments

Comment 15: After an initial home assessment that placed us at 'low risk' my only way of contacting the health visitor was at a weekly GP drop in afternoon where you had to turn up and wait to be seen. This was completely unsatisfactory as my baby was quite difficult and hence sitting in a stuffy GP surgery for 3 hours was not easy. They would often arrive late as they had been dealing with a problem elsewhere, and sometimes the clinic would not happen with no back up provided.

Comment 65. I have had no contact from a health visitor unless I go to get my baby weighed and ask to speak to someone...there is no privacy at these sessions and health visitors are trying to see lots of people that you have to rush/only deal with the priorities!! Not a great service.

Comment 112. My health visitor for my first child was great. I trusted and valued her opinion, she was available both at my GP's surgery and my local maternity clinic, and she visited me at home often enough in the first few weeks to allow me to get to know and like her. When I had my second child two years later, I couldn't believe how the service in my area had declined. My old health visitor was no longer there, and I don't remember being visited at home by anyone on the HV team. I rarely went to the weigh-in clinic as it was no longer done individually in a separate room where you could talk in private, but done by a team of two in what had been the waiting room. When I phoned to book my baby's 8-month check (letter inviting me for this didn't even arrive 'til baby was 10 months old...) it took ages for the receptionist to even find a HV available to put a meeting in her diary. I never saw the same HV twice.

As the service has become increasingly stretched, so the reputation of health visiting as an attractive career has been challenged, leading to difficulties in recruiting to vacant posts (see Example 2). The calibre of potential students is often unsuitable, and recruitment to training posts is further exacerbated by a reduction in funding and associated reduction in newly qualified health visitors. Many of the difficulties in student recruitment and arrangements for education have been attributed to the way the health visiting is treated for regulatory purposes as a 'post-registration nursing' qualification[43], as explained in Appendix 2.

Example 2: Recruitment

Health visitors:

It is common to receive no response at all to advertised posts, which subsequently remain vacant. An increasing number of Trusts offer recruitment and retention incentives of up to £1500.

Student health visitors:

Response to standard recruitments advertisements is often initially high, but the number of suitable applicants is low: e.g., there were 100 applicants to one university advertising six funded places, but only four were deemed suitable by the joint (NHS and university) panel. The two remaining places were not filled.

2.4. Naming a profession

There was a sudden drop in reference to the profession in policy and presentations by civil servants and ministers immediately after the register was closed in 2004, which helped to fuel the inaccurate impression that health visiting was no longer supported as a form of service provision.

Although this tendency has largely reversed, the resulting reduction in the health visiting workforce, and in the numbers of students preparing for the new (SCPHN) qualification, has persisted. The terms health visitor and health visiting continue to be in common use, becoming once more the title of choice in recent government policy documents despite having no legal standing. This may be because another marker for an established profession lies in use of its title in everyday language. Services and forms of practice are often associated with the professionals delivering them; physiotherapists practise physiotherapy, nurses practise nursing, midwives practise midwifery, and so on. Likewise, health visitors practise health visiting, and deliver a health visiting service.

The use of a professional label to describe services was officially discouraged through the 'Next Stage Review'[44] process and 'Transforming Community Services'[45,46] with health visiting being given as one specific example of a service that should not be commissioned using the name of the profession[47,48]. However, consumers prefer to use the term with which they are familiar[40], and there is evidence to suggest that no acceptable, alternative label has yet been identified to replace the term 'health visiting service[49].'

Health visitors deliver the public health part of provision for children, and provide a child, family and community focus for public health services. The lack of a statutory label for health visitors adds to the confusion for policy makers, employers, practitioners and service users alike, and suggests there is no legitimate place for their practice. It is now extremely difficult to access clear, unequivocal information about the education, skill-set and regulation of this occupational group. This point, and the impact of the lack of full statutory regulation of health visitors, is picked up in the following sections.

2.5. Summary

New occupations develop often in response to a short-term demand, but professions take far longer to become established. Health visiting developed gradually over the second half of the nineteenth century, and shows all the hallmarks of an established profession. It is flexible, being able to respond to changing needs, and requires a high (specialist) level of education and practice. The first statutory qualification was agreed early in the twentieth century, and the Local Government Act 1929 confirmed health visiting as a profession to be regulated in statute.

In 2001, the Nursing and Midwifery Order reversed this position. Health visiting ceased to be recognised as a profession in statute and the dedicated register was closed in 2004. This implied that the health visiting service was no longer valued and the qualification no longer legitimate or required, as shown by the steep decline in the workforce. There were 16.5% fewer health visitors employed in 2009 than five years earlier, which has led to a significant fall in the safety of services and difficulties recruiting. This has been exacerbated by a reduction in educational places and the number of newly qualified health visitors, which has been attributed to the way the NMC treat health visiting as a post-registration nursing qualification. Employers, service users and practitioners are confused by the lack of clarity surrounding the qualification and its title.

2.6. Key points

- Key markers distinguish an established profession from a single role or function, and health visiting is an established profession. Removing health visiting from statute, and the associated closure of the dedicated register in 2004, implied that health visiting is no longer valued as a distinct profession and qualification.

- Health visitors' professional qualification was called in question and delegitimised when it was removed from statute. This affected views about the service delivered by health visitors, setting the scene for a steep and devastating decline in the workforce, which has not yet been halted. The staff shortages, in turn, have led to a range of adverse decisions and omissions that cause a major risk to the public.

3. DO WE NEED HEALTH VISITING?

The question of whether we need health visiting is important because professions do not exist for their own sake, but only because there is a health or social need for their service. Recognition and naming in policy occur later in the development of professions.

3.1. Health and social need

We recognise that the NMC has no direct responsibility for maintaining staff numbers, but it is expected to work with employers, who are required to ensure that their workforce has the necessary skill-set to deliver services that are needed. Also, we contend that removing the statutory regulation of health visiting as a profession created an impression that there is no longer a need for this form of practice and service. The ensuing staff shortages, in themselves, have put the public at risk because of an absence of provision for many, and because, all too often, inappropriately prepared staff are used as substitutes for qualified health visitors. This is explored further under Section 3.3.

In contrast to the inaccurate impression that health visiting is no longer needed, current public health and social needs are such that, if health visiting did not exist already, it would be necessary to invent it. This is indicated in a range of policy documents and eminent inquiries. The Independent Inquiry into Health Inequalities in 1998 identified the importance of supporting parents (especially mothers) and babies, specifying that the health visitor role should be strengthened to achieve this[50]. A decade later, the updated, independent Marmot Review on health inequalities[6] pointed out that:

> 'A key challenge is the recruitment of appropriately skilled and qualified staff in the context of critical shortages of some professionals, such as health visitors.' (page 97)

A Parliamentary Health Committee Inquiry into health inequalities[51] also identified the need for health visiting-type of services, stating:

> 'We have been told repeatedly that the early years offer a crucial opportunity to 'nip in the bud' health inequalities that will otherwise become entrenched and last a lifetime. While there is little evidence about the cost-effectiveness of current early years services, it seems odd that numbers of health visitors and midwives are falling, and members of both those professions report finding themselves increasingly unable to provide the health promotion services needed by the poorest families, at the same time as the Government reiterates its commitments to early-years' services.' (page 7)

In Scotland, child and adolescent mental health services were subject to inquiry[42], and their parliamentary committee identified that:

> 'At the crux of whether statutory services are able to identify mental health problems in the very young is the way in which those services interact with that group. This key role was traditionally fulfilled by the health visiting profession, who would uncover such problems in the course of general, unstigmatised interaction with families with young children.' (para. 112)

Further, in relation to children's speech and language development, crucial for later learning and settling at school, the same committee heard evidence:

> 'that "one real problem" was that health visitors were no longer doing much in the way of universal services and were instead focusing from the outset on additional services and on the children who have complex and intense needs. The universal service that has been provided is beginning to slip away. As an illustration, I can tell the committee that traditionally about half - 40 or 50 per cent - of referrals to speech therapists in the pre-school period used to come from health visitors. The Royal College of Speech and Language Therapists carried out a review at the end of last year about how much had changed post "Health for all Children," and it found that the figure is now about 15 per cent.' (para. 114)

In terms of safeguarding children, Lord Laming[20] stated clearly: 'There is a desperate need for more health visitors,' (page 43), before going on to recommend urgent action to achieve this. He explains:

> 'Of greater challenge still is the need to address the status, training and responsibilities carried by health visitors. Evidence to this progress report makes clear that there are a number of challenges to be addressed in this service. The work of health visitors requires immediate action to increase the numbers, confidence and competence of staff.' (page 6)

This wide range of substantial, independent reports show there is a clear need for health visitors, even though the qualification is no longer regulated in statute. Indeed, the list of reports pointing to a need for health visitors could be longer: domestic violence, asylum seekers and refugees, accidental and non-accidental injury, looked after children, teenage pregnancy, alcohol and drugs, the obesity epidemic, the rise in autistic spectrum disorder, children and young people with disabilities, increasing referrals to Child and Adolescent Mental Health Services (CAMHS), popularity of books by unqualified, self-styled 'parenting experts' and the overall public health need for prevention and promotion. There is further evidence of need from a rising birth rate and an exponential rise in admissions to hospital of children with preventable diseases such as dental decay, obesity and respiratory conditions, and the higher risk faced by rising numbers of expectant mothers who were themselves born outside the UK.

These harms arising in children and families suggest that reduction of the health visiting service is now being demonstrated in the very population the profession is designed to protect. Evidence of the full list of issues affecting families with young children that would be best ameliorated by health visitors working with families in the home and community is too long to include in this paper, but we would happily furnish details if needed. There is also evidence that health visitors (given the opportunity and sufficient staff) can help older children and young people, vulnerable adults such as travelling or homeless families, and older people[3]. Taken together, these examples indicate clearly that health visitors are needed, and their numbers should be expanded, not reduced.

3.2. Need for health visiting in current policy

The existence of a health or social need does not always give rise to government policy to meet it, and family policy is traditionally one of the most contested political spheres. The coalition government formed in May 2010 is too recent, at the time of writing this paper, for their views to be known. However, it appears likely that they will acknowledge the continued need for health visiting, because of a broad agreement across the political spectrum that health visitors are needed.

In 2007, the Labour government set up an independent review of the role and function of health visiting[18], and accepted most of its recommendations[52]. In 2009, the Conservative Research Department published an enthusiastic endorsement of the part health visitors could play in helping new families[53], which led to a policy commitment to increase the number of health visitors by 4,200 (that is, by around 50%), should they be elected. The Liberal Democrats, likewise, developed a commitment to increase the number of health visitors[54]. The Scottish Parliament abandoned plans to introduce a generic community nurse to work across the spectrum of health needs in all age groups[12] following a critical report from their Health and Sport Committee[42].

In 2009, the Labour government responded to the challenge identified by Lord Laming, and announced a joint (Department of Health and CPHVA) Action Plan on Health Visiting, to be led by the Chief Nursing Officer. The first phase led to publication of a guide setting out the contribution of health visitors to both children's services, and to services directed at promoting well-being and reducing health inequalities, even

though health visiting services are no longer commissioned by name[46]. The second phase is under way, focusing on career structures, recruitment and workloads. This Action Plan led to an instruction in the NHS Operating Framework[55], that Primary Care Trusts (PCTs) should monitor workforce and caseload figures (ratio of health visitors to pre-school children) in their local area. These data have been collated, but not yet released.

Overall, these changes in policy direction suggest an increasing awareness of the harm caused by the fall in the health visiting workforce. However, the workforce is continuing to shrink, and recruitment of both qualified health visitors and students remains problematic. These difficulties, and the attendant harm to the public in receipt of reduced services, seem likely to continue until the profession is returned to statute.

3.3. Need to name an occupational group

There has been a recent shift in national policy away from naming specific occupational groups as responsible for meeting identified health needs, along with a relabelling of services according to their purpose and population served, rather than the professionals delivering them. This is intended to enhance flexibility, but there are still occasions when it is appropriate to identify an occupational group by name.

3.3.1. Skill-set

Service providers need to demonstrate that they have staff with appropriate skills to deliver services as commissioned, and specifying the number of staff with a recognised and appropriate qualification is one way of doing this. It would be impractical for a manager to separately assess each person's whole skill-set every time a policy changes or a new member of staff is taken on. Instead, a recognised qualification, along with good employment practice, provides clarity about what can be expected from a named employee or group of staff. The Laming Report, for example, linked the need for more

health visitors explicitly to the skill-set required for safeguarding children. Substituting staff with inappropriate skills, or inadequate capacity to carry out the full range of functions and activities for which health visitors are prepared is extremely risky, but all too common since the health visiting qualification has been removed from statute. Sometimes this is a response to staff shortages and the CPHVA fully support the use of carefully developed skill-mix, in which a health visitor who is in a position to accept full accountability for the work, delegates activities to team members, who may be qualified in other fields or not[56]. However, the dilution of skills is often too great for safety (see Example 3).

Example 3: Dilute skill-mix: practitioners' perspectives

Unite/CPHVA's annual survey of 829 health visiting members in England (2008)[57] revealed:

- 29% were responsible for more than 500 children
- 35% said the level of skill-mix did not allow for safe and effective practice
- 47% said they were not involved in decisions regarding the mix of staff

As yet unpublished CPHVA survey data from 2010 suggests that 45% of health visitors now have responsibility for more that 400 children and 26% for more than 600 children. Lord Laming advised in 2009 that the optimum caseload should not exceed 400 children[29]. The CPHVA regard this as the absolute maximum, recommending an average of 250 children per health visitor, and fewer in areas of high need[58].

Furthermore, the expanding use of colleagues with different skills creates two potential problems that place the public at risk: inappropriate confidence and confused lines of accountability. These have become increasingly frequent since the health visiting qualification was removed from statute, leading to the inaccurate impression that anyone can do health visiting work.

The problem of inappropriate confidence arises when team members 'don't know what they don't know.' Close supervision is not possible when staff work alone in the home, so careful delegation and reporting back are both important. Inappropriate confidence is particularly likely to develop in situations where staff (such as community nursery nurses) have no clear career ladder, so remain in the same post gaining more and more practical experience without the breadth or underlying theoretical knowledge to support decisions. The lack of statutory regulation prevents the development of career routes for such staff. Also, when team members have a different qualification, notably a first level nursing registration, lack of awareness of one's own limitations can become problematic, leading to inappropriate and unknowingly risky practice (see Example 4).

Example 4: Inappropriate confidence

When a family with a pre-school child moves house, a contact is required to assess and transfer records. Some organisations specify that a community staff nurse must always carry out this 'removal in visit' instead of a health visitor, unless the family is known to have particular high level needs. Such a protocol was in place in the case example below.

Unite/CPHVA health visitor member comment:

'Three months after my staff nurse completed the removal-in visit and reported all was well, I visited a family when a child protection concern was raised. I found a three year old showing significant signs of undiagnosed autism. The staff nurse insisted the child had been fine when she saw him, despite the fact that autism is a developmental disorder that does not arise suddenly. The mother reported having no opportunity to raise her concerns before I visited.'

Inappropriate confidence has become a common concern since the SCPHN qualification (now the only way that health visitors can qualify) was designated as a form of post-registration nursing, instead of health visiting being regulated through its own statutory register. The skills required for health visiting practice are subtle, complex and sophisticated, but not easy to articulate. Removing the qualification from statute has created the wrong impression that they do not exist separately from those required by nurses, so exacerbating the problem of inappropriate confidence.

3.3.2. Clarity and accountability

Confusion surrounding the need for a health visiting qualification, when it is required and who should decide has increased exponentially since closure of the register. Importantly, since the legitimacy of the health visiting qualification has been undermined by closure of the register and statutory regulation, it is not always considered essential to have input from health visitors themselves about such decisions. There is an unacceptable risk when an organisation derives a protocol requiring a staff member to undertake activities that they are not qualified to complete in a safe manner. This form of protocol, which encourages inappropriate confidence (see Example 4 above), has become more prevalent since the dedicated health visiting register closed. Whilst there are a number of reasons for developing such protocols, of interest to the NMC is when they are developed because of a belief that health visiting is 'predicated on nursing,' suggesting that all registered nurses must, therefore, be competent to function as junior health visitors. This is unsafe and presents a significant risk to the public.

The requirement for student health visitors to have a nursing qualification creates an anomaly, once summarised in the statement that 'Health visitors are nurses, but health visiting is not nursing.[59]' There is no pre-registration (first level) nursing programme linked to the SCPHN part of the register, and neither pre-registration nursing nor midwifery qualifications prepare students to function as health visitors. Within each of the four nursing branches, there are some proficiencies that are helpful (particularly in the proposed new programmes), so staff nurses are able to carry out delegated activities where a health visitor is able to first assess both client needs and the particular skills of the nurse. In such situations, of course, the nurse is accountable for carrying out those delegated activities and the health visitor retains case responsibility and accountability as the senior, delegating practitioner.

However, this form of accountability is over-ruled where an organisational protocol requires, for example, that staff nurses complete all new birth visits (i.e., first contact visits), all removal-in visits (where clients are new to an area), or perhaps specified developmental checks where a family may not have been seen by a health visitor for a year or more (see Example 5). In such cases, the health visitor who has case responsibility may have no knowledge of the person being visited or of the activities being carried out, so is not in a position to know whether the activity should be undertaken by the nurse or any other team member, such as nursery nurses, family support workers, psychology graduates and so on. This situation may also arise where heavy workloads prevent the health visitor from maintaining knowledge about all the families for whom she is responsible, even if there is no protocol in place.

Example 5: Health visiting by numbers: protocols

- CPHVA were recently informed of a PCT where the health visitors had been told that they must meet the PCT protocol for home visiting. This included staff nurses carrying out new birth visits to so-called 'non vulnerable' clients, with first or subsequent births. The expectation was that this would include 70% of the births. Health visitors were also asked to ensure all necessary assessment, support and advice was completed in this single contact and to reduce later checks in respect of perinatal mental health.

- Health visitors consider the new birth visit to be one of their most important contacts with new families as it provides the base line for subsequent contacts.
  It requires a highly trained and skilled professional to conduct an efficient new birth visit where sensitive issues are examined such as the parent's response to their new infant and the effect of the baby on family dynamics both in the nuclear and extended family.

- Both issues may be significant to the parenting style and should help to determine future visiting patterns and suitable delegation to more junior members of the team such as staff nurses. In the view of the CPHVA this contact should never be delegated to a more junior team member.

Whatever the cause, the health visitor cannot protect the client or adequately exercise accountability as required by the NMC Code of Conduct, unless she has knowledge of the family situation to predict which activities are needed, and can be sure the nurse (or other team member) is competent to carry them out. The CPHVA has opposed protocols that involve the blanket substitution of nurses into health visiting roles[60]. Where these protocols exist, registered nurses are expected to function according to their scope of practice; but their

different skill-set and knowledge base means (as in Example 4) that they may not know they are working beyond their level of competence, thus placing the client at risk. Also, CPHVA officers regularly encounter situations where employers have failed to ensure that health visitors are aware of their accountability for the practice of junior team members, or managers may be unaware themselves.

Furthermore, clients may be unaware of the qualification of the person visiting them. In one example, a 'staff nurse pilot' is being carried out in which staff nurses with some additional training are being used to carry out all new birth visits, unless a midwife has raised concerns. Yet a series of focus groups commissioned by the service and reported to the local authority scrutiny committee identified that parents were often unaware that the person visiting was not a health visitor[61]. Some suggested that this would only matter if they were given inappropriate advice, but the point is that parents may be unable to assess its credibility or suitability; this reverts to the key reason for having professional regulation; which is to protect the public when they are vulnerable.

Example 6: Who is visiting?

Comment 41 from Netmums survey[40]

o 'After my youngest was born I started suffering from panic attacks after a bad experience while giving birth to my son (later realised through your site that it was anxiety - post-natal illness - very grateful for your site) I thought it was a health visitor that came out for the routine check-up but turns out she was a community nurse. She was very nice but didn't give any definite help for me - kept saying she would get me this or that but never came back with anything. She stopped contacting me after about a month - turns out she went off sick for months - when my anxiety was at its worst and a new health visitor took over but never contacted me at all as she wasn't aware of any problems I was having.'

These examples of adverse leadership and confusion surrounding health visiting practice have increased since the dedicated register was closed. It is no longer clear where professional leadership should come from, even within the NMC, where the lack of a SCPHN committee and absence of health visitors on any of the practice committees or as Council members was the subject of an earlier CPHVA professional briefing[1].

In terms of health visiting provision it is, likewise, not clear that there is a need for leadership or representation from within their own profession, to lead the development of suitable forms of service organisation, negotiate commissions and ensure updating and supervision of practising health visitors. Where these functions are carried out as a generic function, or as part of a nursing remit without sufficient health visiting leadership, we are regularly witnessing the development of inappropriate procedures and policies (such as the one highlighted in Example 5), which cause potential harm to the public. Also, poor practice may develop on the part of individual health visitors, simply because they are given insufficient opportunity to update themselves, or to access supervision at a senior enough level.

Professional leadership is not the direct responsibility of the NMC, but we contend that removing statutory regulation has led to an impression that there is no need for health visitors to be involved in the commissioning, management and development of protocols used to deliver the health visiting service. As a result, we see a number of organisations requiring staff to carry out or delegate activities in a way that health visitors believe to be unsafe. Distressingly often, these protocols or expectations require substitution of a registered nurse into an experienced health visiting role, with health visitors being threatened with disciplinary action if they disagree or attempt to use professional judgement in the

interests of their clients. The NMC offers no support or guidance in such circumstances, perhaps because of the (unjustified) belief that registered nurses are capable of operating as junior health visitors.

3.3.3. Organisational convenience

Organisations need to be able to identify which personnel are in a position to carry out required functions. It makes sense, therefore, to name health visiting as the occupational group responsible for leading the Healthy Child Programme, because they are in regular contact with this age group and national policy indicates this is the government's expectation. It is unusual to specify occupational groups in policy or at a national level. However, it is part of the everyday functioning of provider organisations to take such decisions. Organisations need to be able to segment their workforce for purposes of description, recruitment, management functions and future planning. Without occupational titles, including those associated with professional qualifications, these functions would be impossible. Despite being in common use, the title 'health visitor' is no longer protected in law, an issue that is picked up under Section 5. Conversely, the SCPHN title, which is not specific to health visiting and has no common currency, is protected.

3.4. Summary

Health visiting is still needed, which is recognised in national policy, but the workforce has been in freefall since the qualification was removed from the system of statutory regulation. The title 'health visiting' is still in common use, despite having no meaning in law, which leads to considerable confusion. The staff shortages and lack of clarity about use of the title 'health visiting,' and about the status of the qualification, lead to working practices that create a risk to the public. The next section examines the question of whether health visiting is a profession that should be regulated.

3.5. Key points

- Safe and effective health visiting services are required to deal with increasing health and social need. This is recognised in policy and across the political spectrum, but removing health visiting from the framework of statutory regulation has created much confusion for service users, commissioners, employers and practitioners.

- Ambiguity and uncertainty about the meaning and existence of a health visiting qualification, whether it is needed and when, has led to a number of employers and commissioners making very risky choices in staff deployment, often using personnel with insufficiently developed skills.

- Confusion about the regulatory status and need for a health visiting qualification has led to unsafe lines of accountability and unclear decision trails in many organisations. The substitution of personnel with different skills to those of a fully qualified health visitor, and who may be inappropriately confident, creates a considerable risk. This practice differs from standard, safe skill-mix or teamwork, but has proliferated since health visiting was removed from statute.

4. IS HEALTH VISITING RECOGNISED AS A HEALTH PROFESSION, OR SHOULD IT BE?

The Health Professions Council (HPC) was set up at the same time as the Nursing & Midwifery Council, under a parallel statute (Health Professions Order 2001), also linked to the Health Act 1999. The powers of the two organisations differ somewhat, although both share a common aim of protecting the public by regulating certain named professions. Because it was specifically set up to regulate some professions that had not previously been named in statute, the HPC developed clear guidance about how to distinguish which occupational groups should be recognised as 'health professions' and regulated as such[62].

We offer a comment on each of these criteria to provide some validation of our belief that health visiting is, indeed, a health profession that should be regulated. It has been suggested that health visitors may prefer to be regulated by the HPC under some circumstances[63], but this is not the reason for drawing attention to these criteria. We use the HPC criteria because the NMC do not have any similar guidance, and because they provide an officially recognised way of understanding professional regulation in the contemporary world.

The HPC deems an occupation eligible for regulation if it is engaged in at least one of the following activities:

- Invasive procedures
- Clinical intervention with the potential for harm
- Exercise of judgement by unsupervised professionals which can substantially impact on patient health or welfare

Health visitors are occasionally involved with the first two of these, and almost all of their practice involves the unsupervised exercise of judgement, which can substantially impact on patient health or welfare. The level of independence is stressed by the HPC, who generally regulate health workers who are not otherwise supervised, practising autonomously, making professional and independent judgments on treatment, and taking full responsibility for their actions. We contend that this description applies to health visitors, who are independently responsible for an undifferentiated caseload, but not to the team members with different qualifications such as nursery nurses, or first-level registered nurses working in the context of health visiting teams. The HPC do not regulate occupations that are already regulated by other means, and Section 5 will consider the question of whether health visitors are currently regulated or not; we think not.

Once it is established that an occupational group requires regulating, the HPC then applies certain criteria to establish whether or not it is sufficiently mature and distinct from other occupations to merit its own register. We contend that health visiting meets these criteria, and that it is perverse to have removed health visiting from the regulatory statute at the same time as establishing a mechanism showing it is a health profession that should merit its own register. Considering each of the criteria in turn, below, explains our view that health visiting is a profession that should be regulated in statute, and also shows how some difficulties have arisen that lead to a risk to the public, as a result of closing their dedicated register.

4.1. Health visiting covers a discrete area of activity displaying some homogeneity

This criterion is concerned with the profession's scope of practice, and that the applicant occupation practises activities that:

- Are distinctly its own

- Are common across the occupation
- Are distinct from the scope of practice of other occupations, although there may be some overlap

Health visiting has been a distinct profession for almost 150 years (see Appendix 1). Its provenance has been continually contested and changing during that time, varying according to prevailing health needs, contemporaneous knowledge and policy expectations. It developed separately from nursing, initially having much in common with 'sanitary inspectors' who were the forerunners of today's environmental health officers[64]. Health visiting drew closer to midwifery, and through that route to nursing, in the middle years of the twentieth century[65], although a nursing qualification did not formally become a legal pre-requisite until the 1960s[2]. In the third quarter of the twentieth century, health visitors seemed to have much in common with social work, but after some debate, separate Councils were established for the Education and Training of Heath Visitors, and for Social Work[66]. The emergence of Health Promotion Specialists led to suggestions of overlap between their work and that of health visitors, with their focus on educational rather than clinical concepts[67]. Public health models of practice have been used and applied to health visiting with some success[68,69]. Most recently, health visiting seems to have much in common with Early Years Practitioners and Parenting Practitioners[27], not least because of expectations that the children's workforce should all acquire a 'common core' of competences[70].

Through all of these shifts and changes, and through the rapidly changing policy expectations listed in Section 3.2, health visiting has maintained a cohesion and clarity about its practice, often providing stability in services that would be otherwise subject to a destructive level of turbulence. However, the variations and changes outlined above provide a basis for considerable flexibility and independence in the profession,

and also contribute to the view that nursing knowledge is only one part amongst many in the whole health visiting repertoire[71]. There is agreement that health visiting and nursing overlap somewhat, but the extent has been contested and the subject of continuing debate since the inception of the two professions[72]. Shortly after the health visiting register closed in 2004, a survey of 1459 health visitor registrants asked what respondents felt was the relationship between nursing and health visiting. On a four point Likert scale, only 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[71]. There has been relatively little research comparing the two occupations, but some reviews identifying the distinctive nature of health visiting are included in Appendix 3.

It is interesting to consider, as a different example, the extent of shared knowledge and forms of practice between doctors and nurses. Again, the amount is contested, with agreement that there is some overlap, but that is not considered sufficient reason for suggesting that medicine and nursing are the same, and should be regulated as if they were a single profession. Likewise, some shared knowledge and forms of practice between health visitors and nurses should not be considered sufficient reason for suggesting that those two occupations are the same. Many of the recent difficulties have arisen because of the difference in practice between the two groups, which are not well accounted for within the regulatory framework. In themselves, the continuing difficulties and debates attest to the difference between the two groups, and to the distinctive nature of health visiting practice.

Restrictions within the Nursing and Midwifery Order 2001 prevent the NMC from recognising health visiting as a profession, so they treat it as a type of nursing (the SCPHN

proficiencies are said to be 'predicated upon nursing'). Unlike the HPC, the NMC has no legal mechanism for dealing with difference, which perhaps leads them to overstate the degree of similarity between nursing and health visiting, and to obscure, or even negate, the extent and distinctiveness of health visiting knowledge. In turn, this poses a risk to the public, because it encourages the substitution of registered nurses, who are qualified to work in a different way, for health visitors. This substitution is being undertaken without being researched in a robust way, and with no evidence to show that it is a safe or effective (see Examples 4 and 5 above).

4.2. Health visiting applies a defined body of knowledge

There is a large body of knowledge specifically about how health visitors practice, including their distinctive approach to implementing the considerable generic evidence base (about child and family health, mental health and well-being, epidemiology and health inequalities, community practice and so on) upon which they draw. This profession-specific research includes a large number of theory-building qualitative studies, showing how health visitors practise. A comprehensive review of this literature was carried out as part of a curriculum development project commissioned by the UKCC in 2001, to inform development of competences for pre-registration health visiting programmes[13]. Some of the vast number of studies about how health visitors implement evidence in their practice come from an 'insider perspective,' that is, carried out by health visitors themselves, but a great deal has been carried out by other disciplines, across the medical and social sciences.

The defined body of knowledge used by health visitors is too extensive to be summarised in a single paper, but can be found in a large number of health visiting text books[73,74,75,76], and in a short guide for commissioners produced by the CPHVA in 2007[77]. In particular, the so-called 'principles of health visiting' are used as a unifying mechanism for education and research, as they illustrate how the skills, ethos and knowledge base of health visiting are combined into a unified form of practice across the profession[78,79]. Regulating health visitors as if they are the same as nurses undermines and damages this careful knowledge base, which has developed over many decades. In terms of the vulnerable public, the health visiting emphasis on the value of health and the accompanying responsibility to identify and deal with recognised and unrecognised needs provides an assurance that the practitioner will focus sensitively and thoroughly on prevention and promotion of health. There is a risk of 'failure to prevent' once this assurance is removed, which is of particular relevance to the NMC, since it represents a risk of harm to (particularly) children whose preventable conditions, health difficulties or need for safeguarding may not be identified or adequately dealt with.

4.3. Health visiting practice is based on evidence of efficacy

The extensive body of knowledge and evidence base about preventive and public health needs is generic, in the sense that much of it is shared across professions. Evidence about how to deal with these needs is less well developed, but still extensive enough to demonstrate efficacy[3,80]. The scope of health visiting is broad, but focuses particularly upon child and family health, including mental and physical health, development and safeguarding, public health and health inequalities, including work with individuals, groups and communities. Their main area of practice is in the area of promoting health in pre-school children and their families for which there is good evidence of efficacy[81], but there is broad evidence of the effectiveness of their work with other age groups, and defined vulnerable populations[3].

In terms of this paper, there are two key issues. One is the complete lack of evidence of efficacy for the forms of role substitution and dangerously dilute skillmix (detailed in Section 3) that have developed since health visiting ceased to be a statutory qualification. Second, some commissioners and service managers prefer to promote practice that is not evidence based in order to reduce immediate costs, which creates considerable risk for the public. We contend that the lack of statutory regulation, and accompanying lack of support for the health visiting qualification, promotes acceptance of such irresponsible approaches and inhibits development of support for practitioners who try to protect service users by resisting them.

4.4. Health visiting has at least one established professional body, which accounts for a significant proportion of that occupational group

The majority of health visitors are members of the CPHVA, which was founded in 1896[29]. This association began with a professional and educational remit, and has always maintained these elements along with its trade union functions, increasing this focus after the Council for the Education and Training of Health Visitors (CETHV) was disbanded in 1983.

The National Standing Conference of Health Visitor Training Centres was established in 1945, and continues to function as the UK Standing Conference on Specialist Community Public Health Nursing Education (UKSC). Higher education establishments that run health visitor programmes belong to the UKSC.

4.5. Health visiting has operated a voluntary and a statutory register

The Royal Sanitary Institute, now the Royal Society for Public Health, maintained the first register for health visitors on what would be regarded now as a voluntary basis in the first instance and after regulation was established in statute in 1929. The CETHV took over as the statutory regulating authority from 1962 to 1983, and then the UKCC (following the Nurses, Midwives and Health Visitors Act 1979) until 2002.

The NMC maintained the statutory health visiting register through the transitional phase of its inception from 2002 until 2004. At that time, the health visiting register closed and registrants from there were transferred to the Specialist Community Public Health Nursing (SCPHN) part of the register. A voluntary system of annotation was developed by the NMC, initially to differentiate those registrants who qualified under the former system, but also to distinguish between health visitors and others on the SCPHN part of the register.

There are two risks to the public from this form of voluntary identification. First, its continuity is not assured because it was developed by the NMC and is not a statutory requirement. Concern about the possible loss of this annotation is enhanced by the lack of recognition of health visitors, and the absence of health visiting (or SCPHN) representation on any of the relevant NMC committees. Second, this form of voluntary annotation, instead of statutory regulation, implies a minimal difference between the various qualifications now regulated through the SCPHN register, promoting inappropriate role substitution.

4.6. Health visiting has a defined route of entry to the profession

The entry route to the health visiting register has been through completion of a recognised programme of preparation and examination since early in the twentieth century. Officially, entry is now through completion of the SCPHN programme, with all practice experience in the field of health visiting. However, staff shortages and a lack of clarity about the need for, and meaning of, a health visiting qualification is giving

rise to a variety of optional routes, either through role substitution or by the development of ad hoc and unregulated educational options. This variation creates a risk to the public since the quality of the programmes is not assured. It adds to confusion about the direction for health visiting and the risk to the public from unregulated programmes of preparation.

4.7. Health visiting has an independently assessed entry qualification

As above, NMC validated programmes for a SCPHN qualification are independently assessed. However, there is considerable discontent about the suitability, specificity and length of the programmes. Unlike other programmes validated by the NMC, no 'essential skills cluster' has been specified for health visiting, which suggests a lack of value attached to the programme (a start was made on developing this information, but the work was discontinued before completion). This increases the risk of variation in the qualification across the country and strengthens the belief of some local providers that they could improve upon the official programmes.

4.8. Health visiting has standards of conduct, performance and ethics

Health visitors are expected to adhere to the NMC Code of Practice.

4.9. Health visiting has disciplinary procedures to enforce those standards

The NMC disciplinary procedures are supposed to apply to health visitors. However, unless service users are aware that the NMC is their regulatory body, it would be extremely hard for them to identify this, as shown by the results of the brief internet search shown as Example 7. Indeed, a document downloaded from the NMC website entitled 'Who regulates health and social care professionals?[82]' makes no mention of health visiting, nor does advice for the public on their webpage, about referral to the NMC[83]. Any risks to the public may go unreported, because of the lack of transparency about which organisation, if any, regulates health visitors.

Example 7: Brief internet search for register or regulation of nurses, midwives and health visitors

- Google.co.uk: top response to search for 'nursing register' or 'midwifery register' is NMC, followed by many other contemporary (mainly NMC) pages.
- Google.co.uk: top response to search for 'health visiting register' is an agency for private health visitors, followed by many historical references to health visiting register (pre-2001)
- Ask.com: who regulates nurses? NMC features under 'NHS careers' and in its own right, within top five responses (others outside UK)
- Ask.com: who regulates midwifery? NMC is top response, also features lower down page and under 'Jeeves suggests'
- Ask.com: who regulates health visitors? Top response is the review of Nurses, Midwives and Health Visitors Act 1997. NMC features in an article lodged in University of West of England library, at the end of the first page

Date of search 08-04-10

4.10. Health visiting is committed to continuous professional development (CPD)

The NMC requires registrants to complete at least 35 hours of learning relevant to their area of practice in the preceding three years, as part of the requirement to revalidate their registration[84]. Concerns about the unsuitability of the revalidation requirements are explored further under Section 5.

4.11. Summary

This section has highlighted a number of concerns about current regulatory arrangements made by the NMC, by focusing on nationally recognised criteria for identifying whether or not an occupational group is a profession that

should be regulated in statute. There is a clear distinction between a profession, capable of carrying out multiple functions and with the flexibility to adjust to changing needs, and a single job or role. Health visiting is a profession, which meets the criteria for regulation. We contend that it is perverse to have removed health visiting from the group of occupations regulated in statute at the same time as establishing a mechanism for other, newer professions to be recognised in this way.

Since health visiting has been regulated under a law designed only for nursing and midwifery, the standards of education are increasingly compromised and the body of knowledge diluted, because there is no formal mechanism by which health visitors can influence the development of their own profession. In turn, this adversely affects standards of practice, which leads to a risk for the public. However, any member of the public wishing to lodge a complaint about a health visitor would be hard pressed to identify which regulatory body is relevant. The key question this raises is whether health visiting is, in fact, regulated through the current arrangements.

4.12. Key points

- Specific criteria were established in 2001 by which aspiring health professions that need statutory regulation could be recognised. Health visiting meets these criteria, yet was removed from the framework of statutory regulation in the same year. This perverse decision has left the public at risk from a range of problems arising from the current regulatory arrangements.

- The NMC has no legal mechanism for dealing with professional difference, which perhaps leads them to overstate the degree of similarity between nursing and health visiting, and to obscure, or even negate, the extent and distinctiveness of health visiting knowledge. In turn, this poses a risk to the public, because it encourages the substitution of registered nurses, who are qualified to work in a different way, for health visitors.

- There is a lack of transparency in the regulatory system, so any member of the public wishing to lodge a complaint about a health visitor would be hard pressed to identify a regulatory body responsible for the profession.

5. IS THE HEALTH VISITING PROFESSION REGULATED?

The preceding sections focused on the continuing need for health visiting, and showed that, if it were assessed by the criteria applied to any other occupational group, it would be regarded as a health profession that should be regulated in statute. When the health visiting register closed in 2004, health visitors migrated on to the Specialist Community Public Health Nursing (SCPHN) part of the NMC register, but this has not proved a satisfactory alternative to statutory regulation, as detailed below.

We contend that health visiting is not regulated, because it is regarded as a subsection of SCPHN, which is regulated as a sub-part of nursing, which is a different profession to health visiting. The NMC carries out its constitutional remit to regulate nurses and midwives but does not regulate health visiting. There are three central requirements of statutory regulation, which are the form of register, standards of proficiency and revalidation of individual practitioners. The NMC use such a perverse and inhibitory approach in meeting these requirements in respect of health visiting, that the profession is no longer regulated.

5.1. The form of professional register

A register of practitioners approved to practice, and therefore to use the title of the profession, is the first formal requirement for statutory regulation. This form of registration is necessary to avoid confusion, enabling employers and colleagues to recognise the approved skill-set and proficiencies held by a practitioner, and to inform the vulnerable public of what to expect from this particular health professional. Pre-requisites for these functions are a specific route to entry, including preparation and examination, and a title that is formally recognised in law.

5.1.1. Specificity of the register

Entry to the register is through preparation and examination, with standards (considered below) agreed by the profession in conjunction with employers and service users, and validated on their behalf by the regulating authority, in this case the NMC. A profession may carry out a number of roles and functions, but the register needs to be specific to the profession rather than a single role. Arrangements for joint qualifications, accreditation of relevant prior learning (APL) and so on, are common across professions.

The SCPHN part of the NMC register is unique in placing a greater importance on qualifications required at entry to the preparation (ie, the nursing or midwifery registration) than on competence demonstrated at entry to the third part of the NMC register (ie, the health visiting/SCPHN qualification). The NMC could have worded their documentation to acknowledge that some relevant learning required by health visitor students will have been acquired by entrants with a nursing or midwifery qualification; that is they could have regarded the prerequisite as a form of accreditation of prior learning. That approach would have valued the nursing elements of the work, and acknowledged the distinctiveness of the health visiting qualification, without changing any

proficiencies or programme arrangements. Instead, the NMC chooses to treat the prior registration and education as more important than the preparation needed to function as a health visitor. This approach compromises the specificity of the register and the requirement for practitioners to be fit to practice on obtaining their health visiting qualification, thus undermining the whole process of 'registration' as a form of regulation.

The process adopted by the NMC means that, despite being labelled a 'part of the register,' the SCPHN part operates as a sub-part of the nursing and midwifery parts of the register. The health visiting qualification is an insecure and poorly acknowledged subsection of that sub-part. The development of appropriate standards for qualification as a health visitor, and new approaches to career development, are prevented because the programme is treated as a form of minor 'top up training,' instead of a full professional preparation. In turn, that inhibits recruitment, with increasing reports of difficulty in attracting recruits of a suitable calibre, which adversely affects standards of practice and creates a risk to the public. An additional risk arises (see Section 3), because the arrangements create the inaccurate impression that any qualified nurse or midwife can be substituted for a health visitor, despite their lack of appropriate preparation for this role.

5.1.2. Statutory title

Employment of a range of different occupations into health visiting posts and teams, with inappropriate substitution and lack of full preparation for the role, has come about in part because anyone is allowed to call themselves a health visitor whether or not they are suitably qualified. Although it is relatively unusual to hear of 'bogus health visitors' (see Example 8), occasionally individuals present themselves in this way for purposes of gaining access to children.The title of a register is formally noted in statute so the qualification has a

Example 8: Bogus health visitor

12-01-10. News release. Police in Lymington are appealing for information from local residents about a possible bogus health visitor.

'Officers have received a report from a resident in Norley Wood, claiming that a woman called at her home in December stating that she was from the local doctor's surgery and had come to see her child or children. When challenged about which surgery she was from, the caller stated that she was there to do the weights and measures of the woman's child or children. The caller did not appear to know anything about the family and tried to push the door open but was refused entry. '

http://www.lymingtonandpennington-tc.gov.uk/News/2010/January/Police_in_Lymington-warn_of_possible_bogus_health_visitor.html

meaning in law; that is, it is a statutory qualification, which protects the public by preventing misuse of the professional title. Unlike the Health Professions Council, the NMC are not permitted to protect titles other than those used to label the parts of their register. The HPC, for example, protect both the titles 'podiatry,' preferred by the professionals, and 'chiropody,' in common use by the public for the same profession. The title 'Specialist Community Public Health Nurse' is protected in statute, but it has no common currency. Neither health visitors nor any of the other registrants on that part generally use it as a label, and the public do not recognise it. In contrast to SCPHN, the professional title of 'health visitor' is in common use. It is recognised as the 'preferred brand' title by the public, yet it has no legal standing. The statutory title is the one that is supposed to bring clarity about the qualifications and employment expectations (as shown in Table 1), but in this case, it creates confusion.

Table 1: Use of professional titles

Context	*Statutory professional title*	*Rationale*
Professional regulation	Name of register leads to protected title. Should always be used accurately to describe registrants and their professional qualification. Not varied unless changed in law.	Protection of the public stems from absolute clarity and expectations about the standard, skills and conduct of the named professional; it provides 'kite-mark' in terms of qualification. Illegal for anyone who is not a registrant to use the statutory title.
Job titles	Usually, but not necessarily, linked to statutory title. Sometimes used with stem or suffix, or may be omitted from job title altogether.	In some posts (especially in multi-disciplinary or multi-agency working), the stem or suffix might explain the role more clearly than statutory title. Flexibility is important.
Services	Services no longer commissioned or labelled according to the title of the professional providing them.	Modernised services focus on the needs of those using them, not the professionals providing them.

Source: adapted from Cowley 2003[85]

There are an increasing number of private/independent health visitors, who may be completely unregulated, but there is no legal right for the NMC or other organisations to question their work or qualifications. Health visitors may have any one of a range of employers (NHS, local government, Children's

Centres, social enterprise, voluntary sector etc), who, likewise, may or may not require their health visiting employees to hold a regulated qualification without contravening any laws. The current casual approach to naming of the profession creates an unacceptable risk to the public and shows that the profession of health visiting is not regulated.

5.2. Standards of proficiency

The key purpose of professional regulation is to ensure that practitioners are capable of functioning fully and competently, demonstrating so-called 'fitness to practice' on entry to the specific register. This is generally achieved through a programme of preparation designed for the specific profession. In the case of health visiting, when the register was closed in 2004, the carefully developed 'requirements for pre-registration health visiting programmes'[32], ratified in 2002, were discarded. In their place, a set of proficiencies[33] based on the generic standards for public health was implemented.

These (current) proficiencies are very broad and abstract, with no accompanying essential skills cluster, so there is wide latitude about the manner in which they are taught or applied in practice. Again, this adds to the impression that specific health visiting knowledge is not required to function as a health visitor. The wording of the principles of health visiting[78,86] has been used without acknowledging the source, and they have been relabelled as 'domains,' which distorts their meaning. There are no specific requirements for the extent of learning about maternal or mental health, infants, children, families or positive health and well-being, about the particular evidence or relational and communication-based skills required for health visiting practice; nor about the organisational skills required for independently managing an undifferentiated caseload. In short, if a person wants to know about the skills and proficiencies required by a health visitor, they will find very little useful information by looking at the NMC guidance for SCPHN programmes.

Universities running the programmes often compensate for the deficit, using the skills of experienced programme leaders who ensure relevant information despite many other pressures on the compressed one-year timetable[27]. However, ad hoc dependence upon the availability of staff with the seniority to develop and insist upon the content of programmes does not count as full and proper regulation, and there is a popular view that newly qualified health visitors may not be 'fit for practice' (see Example 9).

Example 9: Official preparation programmes are not always sufficient

There have been a number of studies demonstrating that programmes of preparation are not always sufficient. In one recent example, a doctoral study[87] examined preparation for practice, bearing in mind the strong evidence of need for mental health promotion and policy imperatives for health visitors to be able to intervene in these areas. It contained two parts:

1. A survey of data from higher education institutions responsible for educating and training health visitors in 2006, which found considerable variability in the content of the curriculum for interventions in fields such as postnatal depression, domestic violence and promoting positive parenting practices.
2. A survey of 931 health visitors in 2005, which found that reasonable numbers rated the adequacy of their formal training in these areas as being 'very adequate' or 'good;' 70% for managing postnatal depression, 61% for managing domestic violence and 49% for promoting positive parenting. However, there were very significant numbers who believed their preparation to be poor or inadequate.

Part of the survey was repeated in 2010, and the numbers rating formal training in these areas as good or adequate had fallen by around 10%.

The CPHVA, as the main organisation representing health visitors, is invited to comment on NMC consultations and the professional officer responsible for SCPHN attends UKSC meetings. Such liaison occurs as a courtesy rather than a right, and there is no established, formal mechanism by which the health visiting profession can ensure standards used for qualification are suitable. Experience of attempts to communicate concerns is that comments tend to be ignored or, worse, regarded as promoting 'factional interests,' rather than protecting the public served by health visitors.

5.3. Revalidation

The contentious requirement for SCPHNs to maintain their prior registration as a nurse and/or a midwife was the subject of an earlier paper from the CPHVA[1]. That document noted the requirement for health visitors to show they can meet the criteria of being a midwife or nurse rather than their specific, specialist practice competencies, in order to renew their health visiting registration every three years. Guidance on the NMC website explains how health visiting duties can be treated as nursing activities in order to justify this dual revalidation. As with entry to the SCPHN register, the emphasis is upon meeting nursing or midwifery criteria, and the ability to perform appropriately as a health visitor is regarded as of secondary importance only. This places the public at risk, because the system downplays professional competence and knowledge of health visiting by practicing health visitors. Return to practice programmes for health visitors, likewise, are based upon requirements for a return to nursing. Practical experience may occur within a health visiting setting, but there appears to be no expectation or requirement to update relevant theoretical knowledge. This lack of regulatory safeguards means there is a risk to the public from the application of outdated or inappropriate theoretical information, even if the practitioner has recently been returned to the SCPHN register.

Quite apart from the many concerns about the risks to health visiting service users identified in this paper, there is a risk to the public stemming from the way skilled health visitors are automatically re-registered as competent to practice as nurses[1]. Under the NMC Code of Practice, registrants are expected to ensure they do not practice beyond their areas of ability, yet practitioners who state that they are only competent in the health visiting field are automatically re-registered as nurses. This is deeply contradictory and goes against the stated philosophy of requiring reflective honesty and awareness of one's professional competence. The NMC is reviewing its revalidation procedures at present[88], but the question of enforced re-registration in an unfamiliar field, against the wishes and professional beliefs of individual practitioners, is not under consideration.

5.4. Summary

The NMC regulate nursing and midwifery, but they do not regulate health visiting. Health visiting stopped being regulated as a profession when the register closed in 2004. The replacement arrangements regulate registrants by virtue of their nursing or midwifery qualification, which has not provided a satisfactory alternative.

The SCPHN part of the NMC register operates as a sub-part of the nursing and midwifery parts, and health visiting is a subsection of the SCPHN part. The health visiting title is not protected, so anyone can claim to be a heath visitor, which encourages unsafe substitution of unsuitably qualified practitioners into health visiting roles. There is no clear method for including health visitors in developing programmes, and the proficiencies for the SCPHN part of the register are too generic to guarantee fitness for practice. Revalidation arrangements are confusing and convoluted, and encourage practitioners to claim proficiency in a different profession, regardless of their self-assessed competence and wishes. This amounts to condoning dishonesty and is unsafe.

5.5. Key points

- Despite being included in the Specialist Community Public Health Nursing part of the NMC register, the health visiting profession is not regulated as such, nor in a manner that can protect the public. Current arrangements are unsatisfactory because of the format of the third part of the NMC register, its lack of specificity for health visiting and the absence of protection for health visitors' professional title.

- There is no official mechanism for ensuring that standards of preparation are appropriate for health visiting, leading to doubts about the suitability of official programmes, and fitness for practice of new registrants. In turn, this is leading to the development of a range of ad hoc and unregulated mechanisms for training.

- Arrangements for revalidation and continued registration are confusing and convoluted, undermining the health visiting qualification and encouraging registrants to claim proficiency in the different fields of nursing and midwifery, regardless of their self-assessed competence.

6. CONCLUSION

The lack of full and proper regulation of the health visiting profession has created confusion for service users, practitioners and employers, as outlined in this paper. In turn this has led to a dramatic reduction in the workforce, inappropriate role substitution, and the emergence of various ad hoc forms of training that, collectively, create a considerable risk to the public.

Unite/CPHVA recognises that much of this risk stems from staff shortages and from poor commissioning and management decisions about how to handle that. However, we contend that removal of health visiting from the regulatory framework sent a public message that misled decision makers and created an atmosphere in which disrespect and devaluing of the profession has become the norm. There has been neither regard for the adverse effect of that on children and families using health visiting services, nor attention to the lack of evidence to support the unsafe decisions taken about alternative forms of service organisation and provision.

Removal of the profession from statute can, therefore, be regarded as the root cause of the downturn in health visiting numbers, of problems with the preparation and recruitment difficulties and with a significant risk to the public. We have noted with satisfaction that since the workforce crisis arose, the former government and mainstream political parties have all made unequivocal statements of support for health visiting. However, neither these statements, nor the ongoing CNO's Action on Health Visiting programme (which CPHVA actively supports as a co-partner) have so far reversed the downward trend in the health visiting workforce. They have

not improved recruitment or retention, nor reduced the flow of adverse and dangerous management decisions in respect of the health visiting profession. The root cause of the difficulties must be dealt with.

The time has come to renew the statutory nature of the health visiting qualification, and to regulate the profession once more, to protect the vulnerable public – infants, children and families – who so badly need the services of this once-proud profession.

6.1. Key points

- Removing the health visiting qualification from statute is identified as the root cause of the downturn in health visiting numbers, of preparation and recruitment difficulties, and of the numerous adverse and risky decisions made by commissioners and service managers.

- Deregulation of health visiting has encouraged an atmosphere of disrespect and devaluing of the profession, without regard for research evidence, or for the effect of such attitudes on service provision for the infants, children and families left with inadequate or inappropriate support as a result.

- It is the belief of Unite/CPHVA and many others that the situation for practice and for service users will only improve when health visiting is able to resume its rightful place as a fully regulated health profession, with a qualification recognised in statute.

Appendix 1:

Preparation and regulation of health visiting

- **1862:** Manchester and Salford Ladies Sanitary Reform Association agree to begin employing working women to visit homes to offer practical help, advice and education about health; this is usually cited as the start of health visiting.
- **Late 19th/early 20th century:** Courses of lectures run by Medical Officers of Health and various institutions throughout the country. Qualified women sanitary inspectors (forerunners of today's environmental health officers) were employed to undertake health visiting duties in addition to their other work.
- **1890s onwards:** Increasing number of certificated courses for health visitors; these were usually for 2 years, or 6 months for graduates, qualified teachers or nurses.
- **1907/1915:** Birth Notification Acts: beginning of a national service based on home visiting to new-born infants. Local authorities were permitted to raise revenue via the rates to pay for health visiting; so qualifications began to be stipulated.
- **1909:** Health visitors' (London) Order for London CC Area. First mention of qualification in statute, in London area only.
- **1916:** Royal Sanitary Institute (now Royal Society of Public Health) began co-ordinating qualifying courses for health visitors; still 2 years or 6 months for graduates/nurses.
- **1919:** First statutory qualification established by Ministry of Health, based on scheme set up by Royal Sanitary Institute.
- **1925:** Ministry of Health took over responsibility for training of health visitors. At this stage, qualifications were definitely required for the work; midwifery qualification was a pre-requisite. Royal Sanitary Institute designated as examining body.
- **1929:** Local Government Act required provision of a health visiting service. Associated Statutory Rules and Orders (1930 No. 69.) laid down qualifications for health visitors and tuberculosis workers; later adjustments in Public Health Act 1936 and Education Act and School Health Service Regulation 1959. Register of those holding the qualification maintained by Royal Sanitary Institute.

- **1945:** Establishment of 1-year Health Visitor Tutors course at Royal College of Nursing.
- **1945:** National Standing Conference of Health Visitor Training Centres (now UKSC) established.
- **1948:** National Health Service (Qualifications of health visitors and tuberculosis visitors) Statutory Instrument No. 1415; possession of health visitor certificate confirmed as a statutory requirement for practice as a health visitor; updated in 1972 when health visitors moved from local authority to NHS employment.
- **1950:** Royal Society of Health revised health visiting syllabus and extended training from 6 to 9 months minimum for qualified nurses and midwives.
- **1956:** Jameson Committee reports on health visiting: recommends establishment of the Council for the Education and Training of Health Visitors (CETHV).
- **1962:** CETHV established as the regulating authority. They developed a curriculum for a 'new breed of health visitor', based on a 51-week course (implemented 1965). Nursing qualifications became a statutory pre-requisite for entry into health visitor training. CMB Part 1 or Registered Midwife still required prior to entry to the training at this stage.
- **1964:** National Health Service (Qualifications of Health Visitors) Regulations (para. 2a). Wording updated and statutory status of qualification confirmed in NHS Reorganisation Act 1973.
- **1972:** Health visiting was included in the remit of the Commission on Nursing (Briggs Committee), which led to the formation of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC).
- **1979:** Nurses, Midwives and Health Visitors Act 1979 established the UKCC. This became fully operational in 1983, at which time the CETHV ceased to function.
- **1983:** Health visiting register transferred from CETHV to the UKCC + regulation of health visitor education and training transferred to the four National Boards. Under

Clause 7 (2) of the 1979 Act, health visiting matters needed to be approved by a Health Visiting Joint Committee (i.e. 'joint' between Council and Boards) before they could be implemented.

- **1992:** Restructuring of the functions of the Council and Boards following the Peat-Marwick-McClintock review removed the Health Visiting Joint Committee with no replacement safeguards for health visiting.
- **1994:** New framework for preparation of specialist practitioners sets out syllabus for 'Community Health Care Nurses' to include health visiting as one area of practice. Programmes to be a 'minimum of 32 weeks' long. Further guidance (1998) confirmed the statutory requirements for health visitors must still be met.
- **1998:** J M Consulting Ltd Review of Nurses, Midwives and Health Visitors Act.
- **1999:** Government rejected two of JM Consulting's recommendations: that the health visiting register should be closed, and that they should cease to have representation on new Council (HSC 1999/030).
- **2000:** UKCC set up curriculum development project to develop new competences for health visiting, ratified in 2002.
- **2001:** Nursing and Midwifery Order passed through Parliament. Health visiting removed from regulatory framework and from all laws in which it had previously been mentioned.
- **2002:** Nursing & Midwifery Council set up. Newly developed requirements for health visitor registration ratified.
- **2004:** Health visiting register closed and registrants migrated on to Specialist Community Public Health Nursing part of the register. 2002 health visiting requirements discontinued; replaced with new generic public health proficiencies.
- **2006:** NMC restructured, so there is no SCPHN representation on Council or major committees.

Appendix 2:

Treating health visiting as a post-registration nursing qualification exacerbates recruitment difficulties

The UK Public Health Association hosted an 'expert consensus' project through a series of working groups, multi-disciplinary and multi-agency discussions and consultation of experts, to investigate the reasons for the rapid decline in health visiting, and identify what would be needed to regenerate it[43]. The group concerned with education and regulation looked in detail at issues of recruitment and concluded that treating health visiting as a post-registration nursing created systemic problems for recruitment and workforce management. Whilst these difficulties would be readily resolved by changing the system, that is, by recognising health visiting as a professional qualification in its own right once more, there would no other simple solution to the interconnected problems caused by placing health visiting within the system designed for nursing. Their deliberations are summarised below.

Issues concerned with nursing careers

Nursing career frameworks[89] tend to 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. 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 qualification (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.

Issues related to finance

The mechanism for funding post-registration qualifications 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. Conditions for health visitor 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 their professional expertise means that the conditions of service seem far less desirable. Despite seeming unattractive to recipients (health visitors and potential nursing recruits into the training), 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 the way it operates is both unwieldy and unsuitable for health visiting. This is because the system is based on an assumption that all post-registration qualifications build upon a prior pre-registration qualification, yet there is no first level health visiting qualification. It is 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 adverse effect on the ability of managers to adequately influence educational programmes and conditions for students' learning, such as practice support or contract setting with universities, 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 (i.e., the Nursing and Midwifery Order 2001) prohibits it. Yet, salary levels and student support regarded as unattractive by experienced nurses are likely to appeal to new graduates in other similar fields, such as psychology and family studies. Calls to widen the entry gate to health visitor education 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[85]. The Nursing and Midwifery Order also 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.

Appendix 3:

A discrete area of practice with some homogeneity

The amount of qualitative research, and number of literature reviews and syntheses that describe and explain health visiting practice, is too large to be included here in full. A small selection of specific reviews and studies is included as an illustration of the range of work and specific approaches to practice.

1. Prime Research and Development Review

As part of the curriculum development project initiated by the UKCC in 2000, Prime Research and Development[13] (which was later incorporated into Skills for Health) carried out a rapid review of recent literature. Eleven key points and descriptors were put out to consultation, after which a twelfth point was added (as 3(d) below). They are listed below, under three added headings:

1. The underpinning philosophy and professional perspective:
    a) A health-focused perspective with health being treated as a process (not a state of being) and a consideration of health in its overall socio-cultural context
    b) Maintaining an openness to others' concepts of health and wellbeing and how they wish to live
    c) Providing an accessible and non-stigmatising service
2. Service provision:
    a) A focus on social groups, with families being one form of social group
    b) Provision of a service to address the factors that are likely to affect health and wellbeing (i.e. often working at the 'pre-need' stage)
    c) Acting as an interface between groups and individuals in the population and population-based approaches
    d) Developing the capacity and confidence of groups and individuals to improve their own health and wellbeing
    e) Improving service provision for groups and communities
3. Capabilities and skills:
    a) An ability to develop effective relationships based on trust and openness
    b) An ability to work in a range of settings acting flexibly with other services
    c) An ability to assess risk in complex situations
    d) An ability to deal with conflicting priorities and ambiguous situations, knowing when to use different, sometimes contradictory theories and perspectives.

These elements have obvious relevance for the kinds of competences required by health visitors, and were used to inform the 2002 'requirements for pre-registration health visiting programmes[32]'. Although these were superseded when the SCHPN proficiencies[33] were introduced in 2004, the more detailed and directly relevant health visiting requirements appear to be still influential in many current programmes[27].

2. Assessment of health visiting practice
A major educational study, completed in 2001, focused on identifying and classifying key components of health visiting practice, as a means of identifying whether students were fit to practice on qualifying[90]. A range of necessary capabilities was identified, which demonstrate the unique combination of knowledge and skills required by health visitors. Importantly, health visitor students needed to demonstrate the capability of *knowing when* to use particular elements of their overall repertoire.

3. Nursing and health visiting practice in public health
A secondary analysis[91] of three research studies involving health visitors and community nurses identified four areas of practice that are often viewed as 'either/or,' dichotomous, concepts (see Figure A3.1). The analysis suggested that these concepts might be better regarded as lying on a continuum, with the nursing focus at one end, and the health visiting focus at the other. The point is not that either profession always, or never, apply one end of the conceptual continuum or the other. Instead, the frequency, familiarity and use of approaches, ethos or attitudes to practice tend to distinguish between them.

Figure A3.1: ***Polarised concepts and priorities in public health***	
Individual/ population	This encompasses not only service responsibilities, but also points to the dilemmas inherent in choosing between personal rights and collective responsibilities within society as a whole.
Public/ private	Access and use of public services such as health and nursing care is related to both personal perceptions and wider social views about what they should be for, and what remains 'properly' private.

Figure A3.1: ***Continued....***	
Determinants/ treatments	Services may be designed to directly target the determinants of health ('root causes') or to treat established problems by offering clinical treatments to affected individuals.
Social/ biomedical model	Views are changing and contested about whether a social or biomedical view of health is considered paramount in promoting the public health.

4. 4. The principles of health visiting
These were first identified in the 1970s, through a lengthy process of investigation led by the Council for the Education and Training of Health Visitors[86]. The principles are:

- The search for health needs
- The stimulation of an awareness of health needs
- The influence on policies affecting health
- The facilitation of health-enhancing activities

These statements were initially described as principles through which the process of health visiting is carried out, and they have become a valuable framework for integrating health visiting knowledge, skills, research and practice. Specifically, the principles show that health visiting is concerned with health promotion, not assistance, which is the usual focus of clinical nursing. They provide an integrating framework, rather than a list of competences or skills, and they are all underpinned by a particular value and view of health[79]. The principles continue to be used as intended, in practice, education and research and their value has been repeatedly reaffirmed in the years since their inception[77,78,92,93].

5. What characterises an effective health visitor?
Research (www.mendas.com) has been commissioned to carry out a review of the characteristics of an effective health visitor, to inform the CNO's Action on Health Visiting Programme of career development work. Results are not yet available from this work in progress.

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