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EXECUTIVE SUMMARY

1.1 In 1999, the government rejected a recommendation that health visiting should be regarded as a specialist branch of nursing. Instead, it reaffirmed the statutory basis of health visiting as a profession, stating that it should continue to be separately registered and have equal representation on Council, alongside nursing and midwifery. This scoping project was commissioned to provide Council with a broad base of information about current and future regulatory issues for health visiting in the light of this statement and current expectations of the profession.

1.2 Health visiting began in the philanthropic public health movement in the middle of the nineteenth century. The statutory basis of the health visiting qualification stretches back to 1909, with nurse registration (currently on Part 1 of the register) becoming a pre-requisite for entry to the training in the 1960s. The UKCC became the regulatory body for health visiting in 1983; before that, regulation had been the responsibility of the Council for the Education and Training of Health Visitors (CETHV).

1.3 The statute specifying the Health Visitor Training Rules was last amended in 1989, before a new approach to health visitor education within the Community Health Care Nursing (CHCN) framework was implemented between 1995 and 1998. There are a number of specific areas in which the CHCN framework is at odds with the statutory instrument. In particular, the academic and professional entry criteria, length of training and underlying philosophy of the programmes differ.

1.4 The CHCN framework allows nurses from any part of the register (except Part 9 - RFN) to enter the programme that leads to a specialist qualification in 'public health nursing: health visiting'. There is no consensus about what knowledge and skills these groups hold in common that are relevant to health visiting, but only nurses (not midwives or any other relevant professional group) may register as health visitors. All CHCN programmes used for health visitor training are officially 'modified courses' under the terms of the statute; educational institutions are encouraged to adapt the learning outcomes to fit the requirements of the specialism or local needs. The present emphasis of health visitor regulation is, therefore, clearly upon entry criteria, rather than on learning outcomes required for practice.

1.5 The approach to the regulation of health visitors by the CETHV and UKCC also differs widely. In the former, the primary focus was on maintaining professional standards by education, research and peer self-regulation; there were no procedures for dealing with misconduct by health visitors. Conversely, the UKCC prioritises misconduct, but has not retained the former procedures for peer self-regulation or the maintenance of professional standards in health visiting practice. Instead, it is assumed that health visiting standards will be maintained via procedures used for the regulation of nurses.

2.1 Since the profession began, there have been heated debates about the role and purpose of health visiting, its relationship to nursing, and preferred approaches to practice. The

debates represent alternative, equally legitimate viewpoints informed by different political perspectives; by the competing professionalising agendas in nursing and health visiting and by the divergent theoretical perspectives that underpin public health and health promotion. It is unlikely that a consensus will be possible about these diverse views, as they are linked to wider, unresolved contradictions that have persisted through centuries of political, professional and philosophical debate.

2.2 The debates intrude into discussions about the most appropriate forms of service organisation, preparation of new practitioners and preferred approaches to practice. In particular, different opinions about the relationship between health visiting and nursing give rise to markedly divergent views about how health visitors should be educated and the profession regulated. Health visitor education needs to prepare practitioners to deal with this high degree of uncertainty and continual contradictions in their everyday work.

3.1 The changing policy context is equally important as a backdrop to how health visitors are to be prepared in future. Enduring and changing priorities in policy have implications for health visiting roles, especially in relation to primary health care, public health and family welfare. Professions and the organisations that employ them are also changing. The rise of 'new public management' has influenced expectations about professional autonomy and regulation; accountability issues and risk management are linked through clinical governance and quality agendas.

3.2 Questions about what needs to be done, how it should be done and who should do it are reflected in decisions about policy, practice and the governance of regulated professions. There is more specialisation as well as more in common across professions and different agencies, and an increased emphasis on the need for flexibility, inter-professional and inter-agency working.

3.3 As with all pre-registration preparation, health visitor education needs to prepare practitioners to be 'fit for practice' within their particular profession. This is not only concerned with the immediate, current expectations of government, but needs to befit practitoners to develop knowledgeably as roles, functions and health needs change throughout their careers, and as new evidence becomes available to inform different approaches to practice. A review of current policy trends and the available research revealed three potential roles that are likely to be both currently acceptable and able to endure beyond the early years of the twenty-first century. These are general family support, family-centred public health and outreach work to vulnerable populations.

4.1 The CHCN framework designates health visitors as 'specialist community nurses'. It assumes that all registered nurses hold the same knowledge and skills as health visitors, but at a less advanced level than that required for 'specialist practice'. Conversely the statute has always assumed that the health visiting programme provides nurses with a new knowledge base for a different profession. A number of difficulties appear to stem from implementing this changed philosophy into educational practice.

4.2 Information was sought through interviews with course leaders from 22 different institutions across the UK; curriculum documents from 16 of these were analysed. Concern about the new programme was widespread; there was no consistency in terms of entry requirements, course length, content, practice supervision or learning outcomes. Few programmes included teaching about all the significant aspects that would be required for health visiting practice.

4.3 The extent of shared learning in the CHCN common core inhibited flexibility and the ability of course leaders to respond to new policy requirements that were central to health visiting but not to nursing. Some course leaders reported hostility from community nursing colleagues, who resisted inclusion of topics relevant to health visiting. This led to problems especially where the programme leader was not a health visitor, since discipline-specific responsibilities in relation to professional self-regulation are no longer clear.

4.4 Shared learning and collaboration with nursing colleagues in primary care was welcomed as a beneficial effect of the CHCN framework, but this was often achieved at the expense of wider opportunities for inter-professional education. This was particularly the case where the CHCN framework had integrated the programme into schools of nursing, instead of maintaining former health visiting course links with, for example, departments of social work, social policy, psychology or education. The new national standards for public health practitioners are not represented in the CHCN programme, nor can professionals who have achieved these standards access health visiting courses unless they are registered nurses. Thus, the CHCN framework restricts health visitor education to a primary care nursing agenda, and lacks the flexibility required for current expectations of public health practice, and of inter-agency and inter-professional working.

5.1 Professional regulation and accountability mechanisms within Trusts require a base of knowledge about what constitutes an 'acceptable standard' of practice. There is no official mechanism for achieving this in health visiting. Despite those aspects held in common between nursing and health visiting, the separate statute means there are different expectations of what health visitors may be held accountable for. Even so, health visitors are not required to practise in the field or maintain their competence in order to retain current health visiting registration. This arrangement differs from the clear expectations for nurses and midwives set out in the PREP regulations.

5.2 The health visiting workforce is generally far older than in the wider nursing field, and numbers currently being trained are unlikely to replace those due to retire in the next 5-10 years. There is inadequate information about the capacity for health visitor education and no clarity about how the newly agreed standards for teachers will affect the roles currently undertaken by designated Community Practice Teachers and Health Visitor Tutors.

6.1 A series of options and five over-arching recommendations are set out, indicating those that require a change to the statute or that could be implemented by changing regulations or modernising the syllabus.

RECOMMENDATIONS

Recommendation 1.

Council should ensure that its structures and procedures recognise health visiting as a separately registered profession.

1.1 The procedures for ensuring professional self-regulation by health visitors need strengthening and clarifying, so that they are visible and auditable throughout the education and registration process.

1.2 On qualifying, health visitors are entering a new profession, so it is important for them to be supported through preceptorship.

1.3 Although there is an obvious potential for health visitors to develop beyond the level achieved at qualification, their separate registration means there is no clear advantage in involving them in a system for regulating 'higher level practice'.

1.4 Health visitors should be required to maintain their competence and demonstrate current practice in the field in order to maintain their registration as health visitors.

Recommendation 2

A national curriculum development project should be set up, to identify the educational needs of health visitor students to enable them to fulfill expectations of a modern role in public health, primary care and family support.

2.1 A full situational analysis, to indicate important factors internal to the health visiting profession and external to it, is needed. This would involve gathering information from a range of stakeholders including consumers and colleagues from across sectors.

2.2 The curriculum project should concentrate, first, on identifying the learning outcomes required by health visitors. These could be used to clarify the suitable academic level, 'normal' length and type of programme, and relevant knowledge held by nurses (or, if the statute changes, any others) that might be accredited as prior learning.

2.3 Key principles should be identified, by which the design and purpose of health visitor education can be assessed to inform programme validations and regain consistency across the regulatory process.

2.4 Attention should be paid to the educational interface and potential for shared learning with a range of relevant colleagues and sectors, including but not restricted to, nurses in primary care.

Recommendation 3

The capacity for educating present and future health visitors should be assessed, in conjunction with workforce planning, replacement and continuing education needs.

3.1 Some reliable workforce data giving the age and likely retirement patterns of current Health Visitor Tutors (HVT) and Community Practice Teachers (CPT) is needed.

3.2 Bearing in mind the need to clarify the processes of professional self-regulation (see Recommendation 1.1), the way the new Standards for Teachers will apply to the former HVT and CPT roles needs examining and explaining.

Recommendation 4

To encourage flexibility without compromising the safety of the vulnerable public, the statute could be modernised to emphasise the knowledge, skills and abilities needed to practice as a registered health visitor.

4.1 The learning outcomes required for health visiting practice should be clarified (as in Recommendation 2.2), and procedures for professional self-regulation strengthened and audited (as in Recommendation 1.1) as a replacement for the current 'entry requirements' approach.

4.2 Pilot projects could then be established to assess the impact of preparing a multi-professional cohort of students for entry to the health visiting register. These would probably need to be post-graduate programmes, and would need sound procedures for accrediting prior learning (including from first level nurse registration).

4.3 A direct entry degree programme for potential students with no prior professional qualifications might be piloted to attract younger applicants, or mature entrants from, for example, community mothers or community development projects.

4.4 If the above procedures were established and shown to be successful, it would no longer be necessary to restrict entry to health visitor training to a single profession.

Recommendation 5

A standing committee should be formed through which the standards of the health visiting profession as a whole can be monitored, maintained and developed.

5.1 Such a committee may form one part of the re-organised structure of UKCC and Boards, to ensure that health visiting matters are represented. It should provide information about 'matters of detail' relating specifically to health visiting and aid the process of multi-disciplinary regulation across the three professions.

5.2 It should be able to provide credible and authoritative information about health visiting to employers, commissioners and policy-makers. It would protect the public by enabling health visiting services to effectively implement the processes of clinical governance and evidence based practice.

5.3 It is important that such a committee maintains the confidence of practising health visitors and consumers of their service.

1 INTRODUCTION AND SUMMARY OF THE REPORT

1.1 Background to Project

When the Nurses, Midwives and Health Visitors Act was passed in 1979, provision was made for it to be reviewed every five years. It was last reviewed in 1997, at which time a recommendation was made that health visiting should cease to be regarded as one of three separate professions regulated by the UKCC, and should be regarded instead as a specialist branch of nursing (J M Consulting Ltd, 1998). This was presented primarily as a proposal to change the register, but recommended changes to the constitution of the Council and the four National Boards proceeded on the assumption that future Acts would be concerned with only two professions, nursing and midwifery. In its response to the recommendations, the government rejected these aspects of the proposals (NHS Executive, 1999), stating:

- CONSTITUTION: response
  We accept the majority of these recommendations. However, we do not agree with the recommendation that health visitors should cease to have representation on Council. We propose that there should be equal representation of elected nurses, midwives and health visitors from each country. We would emphasise the importance of the Council's responsibility to ensure that its procedures do not allow any one of these professions to be outvoted by the others on matters of sole concern to that profession. The Council should choose a President and Vice President from among its members.

- THE REGISTER: response
  We believe that simplifying the register is sensible and practical, and that it is in the best interest of public protection to make it more accessible to employers. However, health visitors will continue to be separately registered. We therefore propose that the register have three parts: registered nurse (RN), registered midwife (RM) and registered health visitor (RHV). Marks should be used to denote specialisms (within nursing), higher level qualifications and enrolled nurse status.

This decision marks a clear departure from the previous trends, that had been reflected in the recommendations made by the Review team and in a number of changes in the way health visiting had been recently represented in official documents and structures. Further, it makes clear that health visiting remains, as it always was in statute, a profession that is distinct from nursing, and not a specialism within it.

The legislation that governs health visiting preparation and registration dates back to the establishment of the Council for the Education and Training of Health Visitors (CETHV) in 1962. Requirements were retained in statute when the CETHV was disbanded and their regulatory function passed to the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) following the Nurses, Midwives and Health Visitors Act 1979. There have been minor amendments to the statute since 1979, but the regulations remain largely unchanged. Given the length of time since the statutory instrument was initially formulated, various anomalies have arisen. Some of these are attendant on changes to the nursing register following the introduction of the 'Project 2000' style of nurse preparation (United Kingdom Central Council, 1986), and others relate to the form of health visitor education introduced when the Community Health Care Nursing specialist framework was implemented(United Kingdom Central Council, 1994).

The UKCC Commission on Nursing and Midwifery Education (UKCC 1999a) was established, in part, to complement the review of the Act. Its terms of reference specifically excluded education for the health visiting part of the register, since this was regarded as 'post-registration study' despite being preparation for a new role. Nevertheless, changes stemming from the Commission Report will introduce another dimension to be taken into consideration in the future preparation and regulation of health visitors. Other matters relate to general changes in society (such as more varied educational opportunities) and to the role and functions that health visitors are now expected to undertake, particularly in the light of the emerging agenda and policy emphasis on public health and family support.

There is, therefore, a need to examine the implications of the government's response to the Review of the Nurses, Midwives and Health Visitors Act 1997, and the suitability of the extant legislation as a basis for preparing and regulating health visitors for contemporary practice. In particular, Council needs a broad base of information upon which to draw when called on to make decisions about current and future regulatory issues for health visiting. This project represents the first step towards gaining that knowledge, by scoping the current and future regulatory issues for the health visiting profession. It has three specific aims:

1.1.2 Aims of project

1. To explore the implications of the extant legislation for current preparation and regulation.

2. To examine the suitability of the current framework as a preparation for contemporary practice.

3. To investigate the educational and regulatory interface with other disciplines, agencies and countries.

1.2 Development of health visiting

Health visiting developed from the philanthropic public health movement in the second half of the nineteenth century. Since that time, the preferred focus of the health visiting service and the best way to organise it has been the subject of strong debate, although most of the decisions that have affected it have stemmed from outside the control of the profession. Dingwall (1977) for example, traces the strong links between central government policies and health visiting, showing how the varied fortunes of collectivism, regionalism and feminism have all influenced its organisation. Cowley (1996) suggests that the different phases of public health (Ashton & Seymour, 1988) are mirrored in the progress of the health visiting profession, starting in the nineteenth century with a focus on environmental control, adopting an emphasis on personal preventive behaviour in the early years of the twentieth century, then shifting towards therapeutic interventions before taking on board the ideals of the 'new public health' in the last quarter of the twentieth century. Although the roots of the profession lie outside nursing, training and regulation of the two professions have become increasingly linked as the twentieth century progressed, as shown Table 1.1. The government's stance has been greeted with surprise by a number of commentators, since it appears that the statutory basis of health visiting had not been widely known, nor had the reasons for it been fully understood.

Table 1.1: Preparation and regulation of health visiting
▪ **1862:** Manchester and Salford Ladies Sanitary Reform Association begin employing working women to visit homes to offer practical help, advice and education about health; this is usually cited as the start of heath 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 (fore-runners of 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 newborn infants. Once local authorities were permitted to raise revenue via the rates to pay for health visiting, qualifications began to be stipulated.
▪ **1909:** Health visitors' (London) Order for London CC Area. First statutory qualification, in London area only.
▪ **1916:** Royal Sanitary Institute (now Royal Society of Health) began co-ordinating qualifying courses for health visitors; still 2 years or 6 months for graduates/nurses
▪ **1925:** Ministry of Health took over responsibility for the training of health visitors. At this stage, qualifications were definitely required for the work; a midwifery qualification was a pre-requisite. Royal Sanitary Institute was the designated examining body.
▪ **1929:** Local Government Act 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
▪ **1945:** Establishment of 1 year Health Visitor Tutors course at Royal College of Nursing.
▪ **1945:** National Standing Conference of Health Visitor Training Centres (now UK Standing Conference of Health Visitor Education and Training Centres) 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 in the UK.
▪ **1950:** Royal Society of Health revised 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 also 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 1973 Act.
▪ **1972:** Health visiting was included in the remit of the Commission on Nursing (Briggs Committee), which led to the formation of the UKCC. This committee recommended replacing the health visitor training with a 6 month, non-statutory certificate in preventive nursing, and that health visitors become known as *'family health sisters'*.
▪ **1979:** Nurses, Midwives and Health Visitors Act 1979 established the United Kingdom Central Council for Nursing, Midwifery and Health Visiting. 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
▪ **1986:** Project 2000 proposals commit future nurse education to a 'health' philosophy and increase community experience at a pre-registration level
▪ **1992:** Restructuring of the functions of the Council and Boards following the Peat-Marwick-McClintock review removed the Health Visiting Joint Committee.
▪ **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. Further guidance (1998) confirms the statutory requirements for health visitors must still be met.

There have been continuing, and sometimes heated debates about the role and purpose of health visiting, its relationship to nursing, and preferred approaches to practice. The debates represent alternative, equally legitimate viewpoints informed by different political perspectives; by the competing professionalising agendas in nursing and health visiting and by the divergent theoretical perspectives that underpin public health and health promotion. The debates intrude into discussions about the most appropriate forms of service organisation, educational preparation of new practitioners and, importantly, about how health visiting is best regulated. In particular, different opinions about the relationship between health visiting and nursing give rise to markedly divergent views about how health visitors should be educated and the profession regulated.

Further details about the background and implications of the regulatory position for practice are outlined in Chapter 2 of this report. The background to the statutory definition of health visiting functions, and the way this has changed over time is provided. Some comments about the nature of professions are included, before detailing formal and rhetorical positions about the relationship between health visiting and nursing. Representative organisations (RCN, RCM, CPHVA, Unison) were interviewed to elicit their formal views, which differed in many important details. The analysis shows the implications for service organisation, preparation and professional regulation according to which of the different perspectives is favoured.

Views about the purpose of health visiting and its relationship to nursing influence the preferred approaches to practice, but there are additonal factors relating to philosophical and evidence-based positions about health promotion. The twin pillars upon which health visiting practice has always rested are home visiting and outreach to vulnerable groups. There is wide consensus within the profession that the practice of health visiting is underpinned by the principles identified in the mid-1970s (CETHV 1977). These emphasise facilitation and a proactive, health enhancing approach with an undifferentiated 'healthy' population, rather than offering 'assistance' to dependent or ill patients, that is central to the majority of nursing roles.

Overall, it is unlikely that a consensus will be possible about the wide range of views about health visiting, as they are linked to wider, unresolved contradictions that have persisted through centuries of political, professional and philosophical debate. After exploring these issues in some detail, Chapter 2 concludes that health visitor education needs to prepare practitioners to deal with a high degree of uncertainty and contradiction in their everyday work.

The changing policy context is equally important as a backdrop to how health visitors are to be prepared in future. Chapter 3 sets out the changing policy context for health visitor regulation, briefly considering the different priorities, changing organisations, management and accountability structures. In looks at the potential future roles for health visiting, bearing in mind current and future trends in health and social policy across the UK. An overview of the direction of policy shows a number of enduring and changing priorities in policy that have implications for health visiting, especially in relation to primary health care, public health and family welfare.

Questions about what needs to be done, how it should be done and who should do it are reflected in decisions about policy, practice and the governance of regulated professions. There is more specialisation as well as more in common across professions and different agencies, and an increased emphasis on the need for flexibility, inter-professional and inter-agency working. In view of this, it is usually only necessary to specify one profession or occupation for a role if there is a need for a particular set of skills that are not found all together or consistently eleswhere or if there is a need to protect the vulnerable public from possible harm due to misconduct or inadequate skills. Professional regulation is particularly important in the second case.

Three potential roles for health visitors that are likely to be both currently acceptable and able to endure beyond the early years of the twenty-first century are identifed from a review of enduring and shifting trends in policy. These are general family support, family-centred public health and outreach work to vulnerable populations; these are used as a basis from which to explore the current educational provision.

1.3 Health visitor education

The curriculum established by the CETHV in 1965 remained in force until 1994, when the new specialist framework for community nurses was announced by the United Kingdom Central Council (UKCC 1994). Since the existing statute was not rescinded at that time, it would theoretically be possible for students to be prepared for registration under the 'old' regulations still. However, schools and colleges were advised that the new education must be implemented by 1998, so its implementation is believed to be complete. Also, transitional arrangements by which students prepared under the former syllabus could claim to be specialist practitioners have now passed, so anyone qualifying now under the 'old rules' could potentially be disadvantaged, if this recognition becomes significant in the future. Table 1.2 compares the requirements under the two systems.

There were some very clear stipulations for operating the former system of health visitor education. Some of these are in statute, while others were in the rules enforced by the CETHV prior to 1983 and subsequently by the National Boards, particularly prior to their reorganisation in 1992. Until that time, for example, a specialist education officer who was a qualified health visitor tutor was appointed by each of the Boards to assure the quality of the educational provision. Removal of the health visiting joint committee was taken as a signal that it was no longer necessary to maintain a specific health visiting perspective, although a 'specialist' viewpoint was still required from an education officer with a community or primary care nursing qualification. Prior to this reorganisation, the regulations were generally quite strictly applied because their statutory base meant some could not be varied; this tended to give rise to the view that all the rules had to be followed without question.

The non-statutory regulations were largely designed to ensure that the preparation of future practitioners was controlled by the health visiting profession. This 'self-regulation by professional peers' led to the past requirement that courses must be run by health visitor lecturers and that qualified Community Practice Teachers (CPTs) must supervise students, for example. In statute, the content was almost entirely 'principles based,' allowing a wide

flexibility in exact subject matter and level, although the CETHV developed a clear syllabus that had been similarly implemented throughout the UK. The key requirement was that the programme must prepare practitioners to satisfactorily carry out 'the practice of health visiting' to be deemed appropriate.

In general terms, the approach to the regulation by the CETHV prioritised maintaining professional standards by education, research and peer self-regulation. Owen (1977) and Wilkie (1979) document the care that was taken to ensure that the educational and regulatory processes were robust and clear. However, there there were no procedures for dealing with misconduct by health visitors; if the need arose, the case was referred to the General Nursing Council for judgement. The UKCC prioritises misconduct for all its registrants, but has not retained the former procedures for peer self-regulation or the maintenance of professional standards in health visiting practice. Instead, it is assumed that health visiting standards will be maintained via procedures used for the regulation of nurses.

TABLE 1.2: SUMMARY OF CHANGES IN HEALTH VISITOR EDUCATION

HEALTH VISITOR EDUCATION: 1965 – 1994 syllabus	PUBLIC HEALTH NURSING: HEALTH VISITING AS PART OF THE SPECIALIST COMMUNITY NURSING FRAMEWORK
Entry Requirements • Part 1 of the nursing register (RGN) • 5 x passes at GCSE, CSE grade 1 or Scottish school leaving certificates; must include English, Welsh or history	***Entry Requirements*** • any part of the current nursing register, including second level (enrolled nurses) but not RFN • 5 x passes at GCSE, CSE grade 1 or Scottish school leaving certificates; must include English, Welsh or history
Length • At least 51 weeks in length	***Length*** • At least 32 weeks; i.e. an academic year or equivalent • May be less with accreditation of prior learning
Content: 5 themes • Social aspects of health and disease • Individual in the group (sociology) • Development of the individual (physical and psychological) • Social Policy • Principles and Practice of Health Visiting	***Content: 4 themes*** • Clinical nursing practice • Care and programme management • Clinical practice leadership • Clinical practice development At least one third in common core with all community nurses; at least one third in specialist area of practice
Academic Level • Not specified until after the advent of Project 2000; all validated at least to Diploma level after 1988. • Wide variation from certificate to post-graduate level before that.	***Academic Level*** • Minimum of degree level • Post-graduate level increasingly common
Theory and Practice • At least one third practice in part one; ie a minimum of 13 weeks • Supervised practice period of at least 11 weeks after completion of 'part one' of the course; i.e. a total of 24 weeks minimum in practice • Regulations governing size/type of caseload allowed for practice experience; alternative practice experience encouraged	***Theory and Practice*** • 50% theory and 50% practice, ie a minimum of 16 weeks in practice in total • Supervised practice no longer required • No specified type of practice/caseload experience required
Supervision • During part one of the course, the student to be allocated to a qualified community practice teacher; one student to one CPT required • In supervised practice (part 2) a different assessor; more than one student allowed • Health visiting courses had to be led by a qualified health visitor tutor	***Supervision*** • No requirements for CPT or supervision; presumption of preceptorship on qualification • Health visitor tutor not required; presumption of adequate specialist skills in teaching team.

As the statute was not amended to take account of changes when the new specialist discipline of community nursing was introduced between 1994 and 1998, some anomalies remain. The statute still requires entrants to be registered on Part 1 of the UKCC Register, for example, but allows 'such other nursing qualification as the Council may in particular case approve as being of equivalent standard' as an alternative. Some accommodation is clearly needed to take account of the new parts of the register opened when the Project 2000 style of education was implemented. The possible 'alternatives' are held to encompass all other parts of the register, except part 10 (midwives). Since a midwifery qualification was an official pre-requisite to health visiting training for nearly 40 years before nursing was, some might argue that midwives would be equally suitable as entrants to the profession.

Also, as health visiting education moved into higher education in the 1960s, it was necessary for entrants to hold the (then) university entry requirements as a minimum. At the time, five subjects at school leaving level or such other educational equivalent as the Council may approve were required; the statute specifies that these must include as a subject English or Welsh or History. Once the new programme was implemented, a more flexible approach was adapted to interpreting some of the rules, to allow Colleges to implement the new courses. However, the statute remains in force and it is clearly important that entrants to the register are approved according to this extant legislation. Table 1.3 outlines the current interpretations of the statutory instrument that are used to enable the Community Health Care Nursing framework to be used as a basis for students to apply to be registered on Part 11 of the register without contravening the regulations.

The specialist practitioner programme is officially regarded as a 'modified course' approved by the Council for purposes of health visitor education. Much of the content of new courses remains similar to the old ones (e.g., they may still include child development or psychology) where lecturing staff continue in post; none are known that are currently running without a health visitor to teach on at least the specialist part of the course. The requirements are much less stringent than before, to enable Colleges to share modules and be more economical with staff usage within schools of nursing. Most local Colleges and consortia continue to allocate students to qualified CPTs, for example, even though this is not an official requirement of Council. This is not necessarily encouraged, though, because it is a model that is not valued (or considered possible) universally across community nursing. There appear to be different interpretations of the current regulations between the four National Boards and even by different education officers as to whether or not this is desirable or necessary.

Increasingly, health visitor lecturers are encouraged to regard the programme as a 'single module' and to participate in teaching on other courses. Before the specialist community nursing framework was implemented, many health visitor courses ran from university departments of sociology, social policy, psychology or community health. This allowed multi-disciplinary teaching of a kind that may be less possible since most health visiting courses are now run from university-based schools of nursing, with the potential to encourage shared learning only with nurses and midwives. However, the flexibility in interpreting the regulations has created some

anxiety about the suitability of the current arrangements. The extent to which health visitors control the preparation of future members of the profession may have been reduced by relaxing the arrangements. There appears to be no formal mechanism by which the Boards or Council can be assured that groups of students taking these 'modified courses' meet the required competencies; it is simply assumed that if students qualify under the new arrangements this will suffice. Chapter 4 of this report details the way the current arrangements appear to be working. This part of the report was informed by empirical data gathered from health visiting course leaders by telephone interview, focus group discussions, informal face to face interviews and by collecting and analysing a number of curriculum documents.

Table 1.3: Health Visitor Training Rules: Nurses, Midwives and Health visitors (Health Visitors Admission Training) Amendment Rules Approval Order 1989 and their current application	
Requirements specified in statute (Statutory Instrument 109)	***Application of the statute to Community Health Care Nursing framework***
Rule 21 (2) Save as may be otherwise provided under or by virtue of these rules, a person wishing to be trained as a health visitor shall attend a course at an approved training institution for a period of not less than 51 weeks during which period he/she shall have at least six weeks study leave.	Rule 24b allows Council to accept modified courses for: ▪ groups of students who have successfully completed a course of study which has provided instruction in certain 'subject matters necessary to acquire the competencies specified in (the Rules)' ▪ as long as the candidates complete the syllabus and the course to the standard as defined in the Rules. ▪ Students taking the Community Health Care Nursing courses that are significantly shorter in length stipulated in the Rules are still required to meet the competencies specified in the Statute ▪ Courses meeting these conditions can be approved as 'modified courses' for groups of students, according to the statute.

Rule 22 (1) a: ***A person entering a course at an approved training institution must –*** be registered on part 1 of the register or have such other nursing qualification as the Council may in particular case approve as being of equivalent standard.	▪ The Council approve registration on Parts 3, 5, 8, 12, 13, 14 and 15 as being 'of equivalent standard'. Registrants on Parts 2, 3, 4, 6 and 7 (second level nurses) may enter the training, but must satisfy the requirements of first level registration prior to qualifying as a health visitor. ▪ Because the statute stipulates 'other *nursing* qualification' Council cannot so approve Part 10 (midwifery), even though it may be considered to be of an equivalent standard.
Rule 22 (1) b: ***A person entering a course at an approved training institution must –*** Hold one of the following qualifications, including as a subject English or Welsh or history i) a minimum of 5 subjects (lists acceptable English and Welsh school leaving certificates) *or* ii) a minimum of 5 subjects (lists acceptable Scottish school leaving certificates) *or* iii) a minimum of 5 subjects (lists acceptable Northern Ireland school leaving certificates) iv) such other educational equivalent as the Council may approve *or* v) a pass in an educational entrance test approved by the Council	▪ This pre-requisite creates difficulties because it appears to negate other, higher educational qualifications, like Higher Education Diploma, for example, and also may appear discriminatory to candidates educated overseas. ▪ Council may invoke point (iv) to accept educational qualifications other than school leaving certificates, if they are satisfied that the level would be equivalent or higher. ▪ Because it is stipulated in the stem sentence that English, Welsh or history are required, other subjects (like nursing) cannot be substituted however high the academic level. ▪ It may be feasible to construct and approve an entrance test, as in point (v), which includes English, Welsh or history (only one of these is required) as an alternative if candidates are being disadvantaged.

There are a number of specific areas in which the CHCN framework is at odds with the statutory instrument. In particular, as outlined above, the academic and professional entry criteria, length of training and underlying philosophy of the programmes differ. The statute assumes that the health visiting programme provides nurses with a new knowledge base for a different profession. Conversely, the CHCN framework designates health visitors as 'specialist community nurses'. It assumes that registered nurses all hold the same knowledge and skills as health visitors, but at a less advanced level than that required for 'specialist practice'. A number of the reported difficulties appear to stem from implementing this underlying belief into educational practice. Concern about the new programme was widespread; there was no consistency in terms of entry requirements, course length, content, practice supervision or learning outcomes. Few programmes included teaching about all the significant aspects that would be required for health visiting practice.

Shared learning and collaboration with nursing colleagues in primary care was welcomed as a beneficial effect of the CHCN framework, but this was often achieved at the expense of wider opportunities for inter-professional education. This was particularly the case where the CHCN framework had integrated the programme into schools of nursing, instead of maintaining former health visiting course links with, for example, departments of social work, social policy, psychology and education. The new national standards for public health practitioners are not represented in the CHCN programme, nor can professionals who have achieved these standards access health visiting courses unless they are registered nurses. Thus, the CHCN framework restricts health visitor education to a PHC nursing agenda, and lacks the flexibility required for current expectations of inter-agency and inter-professional working.

Indeed, the changing employment context and need to consider different career pathways suggests there is a case for exploring the potential for accepting entrants from non-nursing backgrounds (especially from midwifery) on to health visiting programmes. The emerging multi-disciplinary professions of public health and 'early years work' are predicted to become more significant in the fields of work currently covered by health visitors. They, too, could potentially enter a different kind of health visiting programme; indeed, some graduates from these programmes may have skills in areas such as child protection that are more highly developed than those obtained on the CHCN programme. An alternative future may involve focusing solely upon health visiting as a nursing service (with entrants drawn from the child health branch), leaving the majority of the current family and public health work to be undertaken by unregulated workers with no nursing background or allegiance.

Encouraging educational institutions to 'adapt and modify' programmes at the same time as relaxing the former processes used to ensure peer self-regulation of health visiting by health visitors has allowed widespread inconsistency to develop. Some course leaders reported hostility from community nursing colleagues, who resisted inclusion of topics of central importance to health visiting, unless they were also relevant to clinical nursing. This led to problems especially where the programme leader was not a health visitor, since discipline-specific responsibilities in relation to professional self-regulation are no longer clear. Overall, the legislation appears to have become a matter of peripheral concern to the regulation and preparation of health visitors. Instead, the maintenance of professional

standards seems, at present, to depend upon the goodwill and determination of the current workforce.

Given the significant influence of the workplace on education and regulation, Chapter 5 focuses specifically on issues in this sphere. Workforce figures drawn from across the UK are used to explore the adequacy of educational provision for current and future needs. They reveal an ageing workforce that is slowly declining in numbers, with student numbers that appear much as they were reported in the 1950s. Current student numbers are unlikely to replace those due to retire in the next 5-10 years.

Given the pressures and lack of clarity about a number of accountability issues, a legal opinion was sought about four different scenarios drawn from the contemporary working situation. The importance of developing a capacity for making professional judgements as a health visitor was emphasised. Also, professional regulation and accountability mechanisms within Trusts require a base of knowledge about what constitutes an 'acceptable standard' of practice. There is no official mechanism for achieving this in health visiting. Despite those aspects held in common between nursing and health visiting, the separate statute means there are different expectations of what health visitors may be held accountable for. Even so, health visitors are not required to practise in the field or maintain their competence in order to retain current health visiting registration. This arrangement differs from the clear expectations for nurses and midwives set out in the PREP regulations.

1.4 Key points

1.4. 1 In 1999, the government rejected a recommendation that health visiting should be regarded as a specialist branch of nursing. Instead, it reaffirmed the statutory basis of health visiting as a profession, stating that it should continue to be separately registered and have equal representation on Council, alongside nursing and midwifery. This scoping project was commissioned to provide Council with a broad base of information about current and future regulatory issues for health visiting in the light of this statement and current expectations of the profession.

1.4.2 Health visiting began in the philanthropic public health movement in the middle of the nineteenth century. The statutory basis of the health visiting qualification stretches back to 1909, with nurse registration (currently on Part 1 of the register) becoming a pre-requisite for entry to the training in the 1960s. The UKCC became the regulatory body for health visiting in 1983; before that, regulation had been the responsibility of the Council for the Education and Training of Health Visitors (CETHV).

1.4.3 The statute specifying the Health Visitor Training Rules was last amended in 1989, before a new approach to health visitor education within the Community Health Care Nursing (CHCN) framework was implemented between 1995 and 1998. There are a number of specific areas in which the CHCN framework is at odds with the statutory instrument. In particular, the academic and professional entry criteria, length of training and underlying philosophy of the programmes differ.

1.4.4 The CHCN framework allows nurses from any part of the register (except Part 9 - RFN) to enter the programme that leads to a specialist qualification in 'public health nursing: health visiting'. There is no consensus about what knowledge and skills these groups hold in common that are relevant to health visiting, but only nurses (not midwives or any other relevant professional group) may register as health visitors. All CHCN programmes used for health visitor training are officially 'modified courses' under the terms of the statute; educational institutions are encouraged to adapt the learning outcomes to fit the requirements of the specialism or local needs. The present emphasis of health visitor regulation is, therefore, clearly upon entry criteria, rather than on learning outcomes required for practice.

1.4.5 The approach to the regulation of health visitors followed by the CETHV and UKCC also differs widely. In the former, the primary focus was on maintaining professional standards by education, research and peer self-regulation; there were no procedures for dealing with misconduct by health visitors. Conversely, the UKCC prioritises misconduct, but has not retained the former procedures for peer self-regulation or the maintenance of professional standards in health visiting practice. Instead, it is assumed that health visiting standards will be maintained via procedures used for the regulation of nurses.

2 CONTEMPORARY HEALTH VISITING

2.1 Introduction

Health visiting is not a single concept; the term is used to signify the profession and its social organisation, as well as the particular forms of practice engaged in by health visitors. Whichever interpretation is used, 'health visiting' has long been the site of contradiction and contested meanings. Despite the lengthy history of the profession, there is a relative paucity of robust knowledge or agreement about exactly what activities are undertaken by health visitors, and to what purpose these are carried out. There is a growing body of research mainly, as Robinson (1999) points out, undertaken by health visitors themselves in the course of higher degree theses, in an attempt to rectify this lack. Even so, much commentary ignores both this existing knowledge base and the need to develop it further, preferring instead to draw on anecdote, stereotype, accusation or affirmation.

This leads to a diversity of opinions about key issues, both within and outside the profession. This diversity is, itself, cited by some as evidence of role confusion to be clarified by affirming a single direction or preferred way forward; others feel it shows dissent and awkwardness on the part of health visiting practitioners, which should be controlled by firmer management. Yet a third view, to the frustration of those keen to remove perceived divisions, suggests that the different opinions are to be treasured as evidence of fruitful debate and encouraged in the interests of flexible, dynamic practice and development of the profession. As a backdrop to later discussion about the preparation and regulation of health visitors now and in future, this chapter will review the three main areas of discussion, using published research where available. The three areas concern the purpose of health visiting; the relationship between health visiting and nursing, and preferred approaches to practice.

2.2 Purpose of health visiting

2.2.1 From the early years

Throughout its history, the health visiting service has consistently focused on health, not illness. The earliest health visitors were working women paid from funds raised by voluntary organisations; most often cited is the example of 'Manchester and Salford Ladies Sanitary Reform Association' that began employing health visitors in 1862 (Davies, 1988; Dingwall, 1977; Owen, 1977). Initially a very practical response to broadly perceived health needs, these women were employed to offer advice and help to families living across whole areas; the service was delivered to everyone in order to avoid stigma. At that time, as Symonds suggests, health visiting

'. . . evolved not only against the background of the discourses of management of poverty, and management and imperialism, but also of the dirt theory of disease. . . . . The health visitors' concern was that of public health, but the private sphere of the home and motherhood were evoked to tackle the problem' (Symonds 1992: 256)

Despite the apparent contradiction in providing 'public' health in a 'private' sphere, the success of the venture was demonstrated in the way it was taken up as an idea by local metropolitan boroughs. As the service became formalised, so control of the service gradually passed from the lady volunteers to the Medical Officers of Health (MOsH). In the early years of the twentieth century, women sanitary inspectors (fore-runners of today's environmental health officers) were often qualified to carry out health visiting duties as well; it was considered improper at that time for their male colleagues to visit homes or for the women to enforce building regulations and safety requirements upon male landlords or factory owners (Davies, 1988).

In the nineteenth and early twentieth century, the state began to take on responsibility for the health of the population in general and children in particular; health visiting started to be characterised as a specific solution to the problems of high infant mortality and poor child health. The organisation of the health visiting service then, as now, represented something of a compromise between family liberties and state supervision. Dingwall (1982) suggests that fieldworker autonomy and the general ambiguity of the role were essential ingredients in managing the contradictions in this 'Edwardian compromise'. However, he warned of an erosion of confidence in compromise, with consensus and ambiguity being cast as problems rather than solutions by the last quarter of the twentieth century.

Surveillance of the child population as a whole began with the Notification of Births Act 1907, which enabled health visitors to carry out a home visit to each new born baby. Once birth registration became mandatory in 1915, local authorities were permitted to raise funds to pay for this service, formalising the service still further. This duty contributed to the loss of links with sanitary inspectors, and focused health visiting activity even more closely on individuals, rather than the environments in which they were forced to live. It also increased the connection to midwifery and nursing in the years between the two world wars, laying the foundation for the expectations of health visiting when the National Health Service (NHS) was set up. Robinson (1982) sets out the details of the National Health Service Act 1946, which included:

'an express duty upon every Local Health Authority to make arrangements for the care of expectant and nursing mothers and of young children' (Section 22). Section 24 of the Act laid a duty on local health authorities to provide a complete health visitor service, and an extension of her previous function was asked for in Circular 118/47. 'After the appointed day, she will be concerned with the health of the household as a whole, including the preservation of health and precautions against the spread of infection, and will have an increasingly important part to play in health education. She will work in closest co-operation with the family doctor and will not encroach on the province of the nurse . . . or of the sanitary inspector' (Robinson 1982: 13-14)

Child surveillance has continued to be a mainstay of the 'complete health visiting service'. Increasing links with the medical model and the requirement to classify and measure health visiting duties once general management was introduced into the NHS in the 1980s led to an increasingly complex set of child development procedures and

protocols to be followed. However, the cost and clinical effectiveness of these complex and time consuming protocols are now being questioned as hard-pressed Health Authorities look for some way of operating within tight or overspent budgets. Also, while it is widely accepted that they provide an opportunity for 'case finding' of children in need of protection, as well of those with developmental delay, the tension that this creates for practitioners striving to operate within an empowerment model is less well recognised.

Child protection duties have formed part of the remit of health visitors since they were appointed 'infant life protection visitors' under the Children Act 1908; this was subsequently amended in the Children and Young Persons Act 1932, 1933. The post-war period saw the start of specialisation and division of labour between local authority health and social services, with the passage of the Children Act 1948 (Robinson, 1982). In the Children Act 1989, there is an expectation that health visitors will identify cases of children 'in need' or of suspected child abuse, for referral to social services. This responsibility is based on the assumption and continued expectation (Department of Health (DH) 1991, DH et al 1999) that the health visiting service maintains contact with all families where there are pre-school children.

When the community services were eventually transferred from local authority to NHS control in 1974, Section 24 of the National Health Service Act 1946 was repealed; health visitors' child protection and preventive health duties were subsumed into the general provision of maternity and children's services. Concern was expressed about the potential loss of the preventive function and links with local authority colleagues such as social workers and environmental health officers, attendant upon this integration of community and hospital services into a 'unified' NHS. Abbott and Sapsford (1990) suggest that incorporating the health visiting service into a hospital-oriented, cure-focused, management system, inevitably created new problems in defining clearly just what a health visitor is, or indeed what health visiting is for. Certainly the debate about the extent to which health services should be involved in family life increased, rather than reduced, towards the end of the twentieth century, and will be considered further in the next chapter.

2.2.2 Defining the functions of a health visitor

Even if a particular health or social function is deemed necessary, it is not always immediately clear who should be sanctioned by the formal services to carry this out. In most instances, which is of direct relevance to the regulation of a profession, duties will be assigned to an occupational group that have a track record in that particular sphere of activity, and can be shown to have the requisite skills and competence. The most successful occupations are often those that have shown themselves able to adapt to change, rather than adopting a single or fixed definition that restricts them to a particular time. To demonstrate the consistency required for a profession, however, some common purpose and trends need to be present; in the case of health visiting, some continuity is clear from the earliest days, as shown in Table 2.1 (overleaf).

Paradoxically, the flexibility and adaptability of health visiting has been singled out as both a strength and as a key weakness, since health visitors are constantly called on to cover new needs as they arise instead of being able to develop skills in their main areas of interest (Clark, 1973, Dingwall, 1982). The Jameson Report (Ministry of Health, 1956) also recommended that health visitors reduce the amount of work they carried out in clinical fields, such as with old people, diabetics and tuberculosis; it suggested they should instead concentrate firmly on family health, health education and collaboration or facilitation with others to enable clinical and welfare needs to be met.

The role and function of the health visitor has been defined at a number of stages with some specific definitions being enshrined in statute. The statutory definitions tend to be fairly brief, often relying on contemporary working papers to set out updates, clarification and explanation. It is important to note that the establishment of a profession is not synonymous with a statutory definition or with registration. While these both confer a certain legitimacy to the occupation (see Robinson (1982) and Chapter 3 of this report for further discussion), it is left to the profession itself, usually through its professional associations, to clarify and extend the legal definitions and to set out the true 'terms of reference' by which its practitioners operate. Indeed, this form of self-regulation is one of the defining characteristics of a profession. In this respect, the most significant period of development for the profession was between 1962 and 1983, when the Council for the Education and Training of Health Visitors (CETHV), set up in the wake of the Jameson Report, served as its regulating authority. Most of the functions previously ascribed to this body were transferred to the UKCC under the terms of the Nurses, Midwives and Health Visitors' Act 1979.

It is noticeable that once a nursing qualification was confirmed by the CETHV as a pre-requisite for entry to the health visiting training in 1962, the use of the term 'nurse' in definitions became more apparent, with a further shift in emphasis after the recommendation, in 1989, that the health visiting joint committee be disbanded. By the 1990s, the term 'health visiting' had almost disappeared from use in official documents, with the generic terms 'community nurse,' or 'primary care nurse' taking precedence, or incorporating health visiting, as shown in the Roy Report (NHS Management Executive (NHSME), 1991).

Table 2.1: CHANGING DESCRIPTIONS AND DEFINITIONS OF HEALTH VISITING	
1891 Florence Nightingale *cited in Owen 1977: 5*	*Florence Nightingale:* "It seems hardly necessary to contrast sick nursing with this (health visiting). The needs of home health bringing 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."
1899 *cited in Davies 1988: 43*	*Described by a Lady Superintendent:* "The health visitor is usually a superior woman of the class sought to be helped. She is in touch and sympathetic with the people she visits; she understands them and they understand her. Each visitor lives in her own district, in a small cottage or maybe a couple of rooms. She is easy of access at all times, and her home is naturally an object lesson in cleanliness, tidiness, etc. to the neighbours, who of course occupy similar houses. She is regarded as a friend, and proves herself a true one over and over again."
1946 National Health Service Act 1946 (Section 24) *cited in Robinson 1982: 15; HVA 1987*	*Required local health authorities to:* make provision for the visiting of persons in their homes by visitors, to be called 'Health Visitors' for the purpose of giving advice as to the care of young children, persons suffering from illness, to expectant or nursing mothers and to others with the care of young children
1956 Jameson Report *Cited in Robinson 1982: 15*	*The functions of the health visitor. . .* should be primarily health education and social advice. Her contribution would be to act as a common point of reference, a common source of information of a standard kind, a common adviser on health teaching – in a real sense a 'common factor' in family welfare. She could help eliminate continual visiting of one family by a number of workers for purposes that are essentially the same, in particular by relieving others of the need for purely supportive visits.
1967 Council for the Education and Training of Health Visitors	*The Function of the Health Visitor (information leaflet)* The health visitor is a nurse with post-registration qualification who provides a continuing service to families and individuals in the community. Her work has five main aspects: 1. The prevention of mental, physical and emotional ill health and its consequences 2. Early detection of ill health and the surveillance of high risk groups 3. Recognition and identification of need and mobilisation of appropriate resources where necessary 4. Health teaching 5. Provision of care; this will include support during times of stress and advice and guidance in cases of illness and in the care and management of children. The health visitor is not, however, actively engaged in technical nursing procedures. Health visitors are practitioners in their own right, detecting cases of need on personal initiative as well as acting on referrals.
1972 National Health Service (Qualification of Health Visitors) Act 1972; cited in Abbott and Sapsford 1990: 121 and HVA 1985: 5	A health visitor is a person employed by the local health authority to visit people in their homes or elsewhere for the purpose of giving advice as to the care of young children, persons suffering from illness, to expectant or nursing mothers as to the measures necessary to prevent the spread of infection, and includes a person employed by a voluntary organisation under arrangements with a local health authority *(NB. This definition updated the one used in Section 24 of NHS Act 1946, which was repealed under the NHS Reorganisation Act 1973, when health visiting services moved from local authority to NHS control. It is believed to be the statutory definition that is still in use.)*

1977 Council for the Education and Training of Health Visitors p8	The professional practice of health visiting consists of planned activities aimed at the promotion of health and prevention of ill health. It therefore contributes substantially to individual and social well-being, by focusing attention at various times on either an individual, a social group or a community. It has three unique functions: 1. Identifying and fulfilling self-declared and recognised as well as unrecognised health needs of individuals and social groups 2. Providing a generalist health agent service in an era of increasing specialisation in the health care available to individuals and communities 3. Monitoring simultaneously the health needs and demands of individuals and communities; contributing to the fulfilment of these needs; and facilitating appropriate care and services by other professional health care groups.
1985 Health Visitors' Association	The health visitor, by promoting health and health policies, empowers people to take responsibility for health as individuals, families and communities, and thereby helps to prevent and minimise the effects of disease, dysfunction and disability. *(definition first coined for evidence to Cumberlege Review; reaffirmed in 1992)*
1987 Royal College of Nursing	Health visiting is that branch of the 'family' of nursing which is specifically directed to promoting, advancing and preserving the health of individuals, families and communities. The specific characteristics of its practice which distinguish it from other kinds of nursing practice are the emphasis which it places on the proactive search for health needs (as opposed to responding to the demand for care) and on primary prevention (as opposed to treatment, its focus on people as members of groups (families and communities), and its concern with the health of populations as well as individuals.
1991 NHSME: The Roy Report	*In identifying suitable management structures for community nursing under the NHS and Community Care Act 1990, provides the following description:* Nursing in the community embraces the wide range of services provided by district nurses, health visitors, GP-based practice nurses, school nurses, community psychiatric nurses, mental handicap nurses, community midwives and specialist nurses such as Macmillan, stoma and continence nurses.
1997 DH White Paper: The New NHS	*Glossary:* Community Nurses: includes practice nurses, district nurses, health visitors, school nurses
1998 CMO's Project to strengthen the Public health function	*Describes three classifications of public health work, of which one contains . .* a group of 'hands on' public health practitioners [who] spend a substantial part of their working practice furthering health by working with communities and groups. . . . This group includes public health nurses, health promotion specialists, health visitors, community development workers and environmental health officers.
1998 Home Office Green Paper: 'Supporting families' para 1.27	Health visitors are fully qualified nurses who take additional training, covering child development, public health, psychology, sociology, health promotion and teaching. *NB this description appears to relate to the 1965-1994 syllabus*
1999 Department of Health: Making a Difference para 10.8	*In the context of an intention to 'modernise' the role of health visitors:* We are encouraging all health visitors to develop a family-centred public health role, working with individuals, families and communities to improve health and tackle health inequalities. Health visitors need to work in new ways, across traditional boundaries with other professionals and voluntary workers.

2.3. Professions and professional self-regulation

2.3.1 The nature of professionalism

There is a wide body of sociological literature about professions, as they have been a significant force throughout the twentieth century. As Schön suggests

> 'The professions have become essential to the very functioning of our society. We conduct society's principal business through professionals trained to carry out that business . . . . . We look to professionals for the definition and solution of our problems and it is through them that we strive for social progress. In all of these functions, we honor what Everett Hughes has called the "professions claim to extraordinary knowledge in matters of great social importance" and in return we grant the professional extraordinary rights and privileges. Hence, professional careers are among the most coveted and remunerative, and there are few occupations that have failed to seek out professional status.'
>
> (Schön D, 1983: 3-4)

There is a wide debate, far beyond the remit of this scoping project, about the extent to which either nursing or health visiting can really be regarded as 'professions', although both occupational groups have sought this status. However, the different approaches to defining a 'profession' and criteria by which that is assessed are both of relevance to the issues of maintaining professional standards and of professional self-regulation. There are many different versions of the defining features of a profession, and much commentary about the extent to which the nature of 'professionalism' is, itself, changing (willingly or not) to take account of differences in society at the cusp of the new century. There are varied influences affecting the status, definition and functioning of professions (see, for example, Robinson, 1992, Davies 1995, Symonds and Kelly 1998 , Warner et al 1998, Norman and Cowley 1999, for discussion particularly about how these affect nursing, health and community care). The different influences include the way professional work is generally delivered from large provider organisations instead of small independent practices; a growth of 'new public management' approaches and rational managerialism, especially where those institutions are publicly funded; a massive increase in new technologies and scientific knowledge, leading to major changes in the delivery of professional interventions and finally, the many social changes attendant on the health needs and demography of an over-crowded, unequal, ageing and multi-cultural Western society. Some of these are considered further in Chapter 3.

One result of the multiple changes affecting the organisation of professional work, is the contradictory growth of both specialisation and genericism, which creates a confusing dialogue in relation to aspiring professions. One widely accepted criterion, for example, suggests that a profession can be recognised because it holds a 'unique' body of expert knowledge. There are various caveats about how this knowledge is developed, assessed, transmitted and used, along with a strong sociological critique; Table 2.2 summarises some of the key points. However, one of the key arguments about the relationship between nursing and health visiting concerns the supposedly 'exclusive' and unique nature of the body of knowledge and expertise within each occupation. In this formulation, if one profession 'owns'

a particular sphere of knowledge, the other has no right to exercise any part of it. In reality, few people would admit to believing such demarcations are realistically possible in today's complex health care arena, but such underlying beliefs influence much of the perceived threat from changing roles and claims by 'rival professions'.

Table 2.2 Professions: claim and critique

Unique body of expert knowledge that is: 1. Developed: through theoretical/scientific research; abstract knowledge base 2. Assessed: by examination, as a condition of entry to the profession, 3. Transmitted: through specific educational programmes, that usually involve socialisation by professional peers 4. Used: for the public good, in accordance with a code of conduct decided and regulated by the profession itself.
Sociological critique: a. Disempowering impact of professionally-defined knowledge on clients b. 'Laboratory' knowledge may not relate to people's most pressing problems c. Knowledge defined by professional socialisation processes tends to be class and culture dependent d. Self-regulation may protect professionals more than the client population

Against the apparent inflexibility inherent in defining the 'uniqueness' of a profession, is the drive towards a far greater sharing across professions and the workforce as a whole. Warner et al (1998) identify three key drivers for change as the flexibility of the work context in general, the blurring of boundaries across the health professions and the informal care dimension. The imperatives arising from this shift, in turn, have created two different, somewhat contradictory approaches. The move towards genericism stresses the merging of roles that could be achieved by 'pooling' skills and knowledge. In this scenario, promoted by the World Health Organisation (WHO 1994) and the Health Services Management Unit (HSMU 1996) at the University of Manchester, separate occupations like nursing and medicine would be combined, at least at the point of entry and initial socialisation. Specialisation might occur, but as a feature of an individual and part of a 'portfolio career' rather than as a whole occupational group. This approach analyses the nature of work, regarding professional groups in the same way as any other occupations; paramount are maximising skills, breaking down demarcation lines and promoting organisational efficiency.

The alternative approach is to aim to achieve specialisation and flexibility by promoting team work and inter-disciplinary collaboration across agencies and professions. Warner et al 1998 cite the General Medical Council (GMC) (1993) linking their comments with nursing and health care in general:

'the [GMC's] observation that "there is a redistribution of the tasks undertaken by members of the various caring professions. The overlapping of skills and responsibilities, whilst not diminishing the distinctive role of the doctor, calls for mutual respect and understanding of roles and a capacity for teamwork." This recognises that the trend towards a blurring of professional boundaries will require a flexible, collaborative approach, but not

> one which requires the dissolution of a distinct professional identity.' (Warner et al 1998: 21)

This approach is more sympathetic to the ideals of professionalism so it is, not surprisingly, generally more popular with professionals and their representative organisations. To be successful, it requires two things: first, absolute clarity about the distinctive expertise within and difference between particular professional groups and second, a willingness to recognise common areas of knowledge and skill, which leads to flexibility and sharing of professional purpose and responsibility in achieving particular tasks.

Whether the professional task is achieved by pooling skills in a team of generic workers or through sharing activities across a team of specialists with highly differentiated skills, accountability of individual team members is an important issue. This focuses attention back on to process of identifying the distinctive expertise within a professional group, and how that professional group is, itself, defined and identified. This process links to the notion of 'self-regulation' by professional peers, which assumes that identity and definition of the profession is already clear. However, there is certainly no consensus about the position of health visiting in relation to nursing.

2.3.2 Health visiting and nursing

Debates about the perceived value or harm that accrues from either defining health visiting as nursing or as a separate profession date back to the time of Florence Nightingale (Robinson, 1982), with Nightingale making a clear distinction between the two. There was much debate in the 1960s, before the CETHV finally stipulated that nurse registration (on Part 1 of the register) would become a pre-requisite for entry to health visitor training. Nor did that decision end the division in opinions. As the first director of the CETHV commented:

> The decision to base health visitor training on general and obstetric nursing was highly significant for later developments. It committed the Council to the acceptance of health visiting as part of nursing and it is possible that the implications of the decision were not entirely understood at the time. . . . The step taken in 1964 led inevitably to the incorporation of the Council in the revision of the Nursing and Midwifery Councils proposed by the Briggs Committee in 1970 (Wilkie, 1979): 24-25.

There continue to be at least two contrasting positions about how nursing and health visiting are defined in relation to each other, which each give rise to different logical sequelae in how they should be regulated. The first position assumes that health visitors are professionals because they are nurses: health visiting is an integral part of nursing. In this view, health visitors can and should contribute to the development of the nursing profession by setting standards for education, teaching, registration and so on. In turn, this position holds that nurses can and should contribute to the development of health visiting (which is part of specialist nursing practice), by setting standards for education, teaching, registration and so on. This appears to be the position adopted by J M Consulting Ltd, (1998), when they recommended that health visiting should cease to have separate representation on Council and separate registration.

The second position assumes that health visitors are professionals because they are health visitors. In this view, health visiting is clearly seen as a separate profession; health visitors might be invited to contribute to the development of specialist nursing practice, as might other healthcare colleagues like midwives and doctors, but they do not hold this as a right. In turn, unless invited as valued colleagues, nurses cannot contribute to the development of health visiting by setting standards for education, teaching, registration and so on. This position holds that only health visitors can determine the development of the health visiting profession by setting standards for education, teaching, registration and so on. This appears to be the position adopted by the government in their statement (NHS Executive, 1999) rejecting the recommendation that health visiting should cease to have separate representation on Council and separate registration.

However, such polarisation over-simplifies. Interestingly, no clear rationale was given for either position in the official statements. J M Consulting Ltd commented that the extant position related to 'historic reasons' and the government stated that they disagreed with the recommendation. There was very little public debate or discussion about the issue during the consultation period, although the largest representative organisations of the Royal College of Nursing (RCN) and the Community Practitioners' and Health Visitors' Association (CPHVA) each held meetings and conducted a postal consultation exercise with individual members, providing a heavy steer to agree a recommended stance.

For this report, four organisations were contacted to provide their 'official view' on this matter, with different results. In addition to the RCN and the CPHVA, Unison (which now incorporates the Scottish Health Visitors' Association) and the Royal College of Midwives (RCM) were approached with a view to conducting a tape-recorded, telephone interview on the matter. The RCN declined, but agreed to respond by e-mail to the same questions that would have been posed in the interview. The RCM agreed to discuss the matter and to give informal views, but pointed out that their organisation had no official stance on health visiting, since it is not part of the midwifery profession. They were interviewed but would, therefore, only offer opinions about how health visiting might impinge upon or relate to the work of midwives. A spokesperson from both the CPHVA and Unison were interviewed by telephone, having received the schedule of questions beforehand, and offered views representing their organisations' 'official stance'. Excerpts from the CPHVA and Unison interviews and the RCN written response are offered to illustrate the diversity of opinion.

Question: Do you have a definition of Health Visiting?
RCN (written response):
1) *A health visitor is a registered nurse who had completed a further period of education underpinned by the standards for specialist practice as set out by the UKCC and who is entered onto part 11 of the professional register.*
2) *Health visiting is the practice of the registered nurse described above and centres on the 4 principles of health visiting.*

Unison (in interview)
Health visitors promote health in the broadest terms and the prevention of ill health from the cradle to the grave, so it is a universal service.

CPHVA (in interview)
We use a working definition which is planned activities that promote the public health and work in health promotion for families, communities and whole populations

There was some agreement, in that all of the organisations acknowledged that health visiting required a level of expertise above that acquired at first level registration, and all referred to additional education and training; the focus on health promotion was mentioned by two of the three. There was some difference in the formality attached to the definitions, although none of the respondents referred to definitions written in their own documentation (HVA 1985 cited in 1987, 1992; RCN 1998), and cited in Table 2.1.

Question: What do you perceive to be the relationship between health visiting and nursing?

RCN (written response):
Health visiting is part of the family of nursing.

Unison (in interview)
They are specialist practitioners and they do draw on their first level experience. However, the work that they do is principally to a social model of health and therefore they require a specialist element of . . . or they require specialist training to be able to do that. It is about, there are principles involved in how they apply their skills and it is about facilitating individuals to meet their own needs and also about identifying their own needs, but it is also wider than that because it is about understanding local need and community need and also making recommendations about type of services that could help to facilitate those individuals in maintaining their own health and meeting their own needs.

CPHVA (in interview)
We use a working definition which is planned activities that promote the public health and work in health promotion for families, communities and whole populations. . . the association's view is that health visiting is a specialist branch of nursing and has, but may well be moving towards a sort of public health specialism within nursing because we feel there are very strong links with the other . . . particularly school nursing and occupational health nursing, with a health promoting, public health, whole population focus.

The RCN and CPHVA both supplied copies of their response to the JM Consulting Ltd review, and the principles of health visiting were mentioned by all respondents at some point. The relationship between health visiting and nursing was described through the rather nebulous phrase 'family of nursing' by the RCN and in the papers supplied by the CPHVA; however neither organisation explained what they

meant by the term, which is open to a multitude of interpretations. Varied perceptions of nursing were highlighted as creating difficulties in distinguishing between that profession and health visiting by the CPHVA.

In explaining the difference between nursing and health visiting, there was some common ground in that the specific practice roles were seen as the key to the distinction, if any.

Question: How do you make the distinction between the two (nursing and health visiting)? Or not, as the case may be!

RCN (written response):
The distinction is becoming less definite – although new Government policy initiatives highlight roles specifically for Health Visitors i.e. Sure Start

Unison (in interview)
Health visitors have a caseload, very often when they are working with particularly young children and families, they are not referred they are a caseload which comes about as a result of - someone giving birth, or having children, or being a carer and that is over and above say, for example any other community nurse who would have referrals and they do work in very broad terms. Not only with individual families but with the community and building up relationships between the community and the family.

CPHVA (in interview)
It is about the focus of the work and who you are working with, so I think it is about having the primary prevention, public health, health promotion focus . . . and the whole population kind of approach. So rather than delivering individualised bits of care, having a responsibility over and above that, to promoting health in a wider way . . it all depends on what you think nursing is, this is the problem.

Both the CPHVA and Unison emphasised operating at a community level. The distinction was clearly linked with policy according to the RCN, whilst public health was emphasised by the CPHVA; both family health and the proactive nature of the work were important for Unison.

All the organisations attached an importance to educators being experienced in the field they would be teaching, although the extent to which they would insist on this as a formal requirement varied. This question was inserted in the light of the relaxation of the requirements, highlighted in Chapter 1, that a qualified health visitor tutor should lead the courses and that all students should be allocated to a health visitor CPT. Only the CPHVA respondent referred to this official regulatory position, expressing concern about the potential for variable educational experience and, particularly, about the potential loss of the CPT. Adequate, up to date knowledge was viewed by all as an important issue, whilst the RCN respondent emphasised the potential contribution that could be made by other members of the primary health care team overall.

Question: Do you have a professional opinion about practice education?
e.g. should it be health visitors educating health visitors district nurses educating

district nurses? Do you think it matters or not?

RCN (written response):
Under the current system the majority of health visiting practice is taught by health visitors. Within this there will obviously be input by other members of the PHCT as appropriate. The practice education should be carried out by those who are best able to facilitate the development of practice skills and competencies. If health visiting practice is distinctly different from other disciplines then health visitors are obviously the best teachers of the knowledge and skills needed to underpin this practice. Where roles become blurred then this is less the case.
[practice teaching is] facilitating the development of the knowledge, skills and competencies required to practice professionally and safely. This depends upon demonstration, role-modelling experiment and robust assessment.

Unison (in interview)
I think it is very important that health visitors continue, if I have understood your question correctly, that health visitors continue to supervise health visitors and that there is a practice element in the training and education of health visitors, but also as part of the role of the health visitor, they should be practice educators, so it is very important that that continues and that lecturers in health visiting also have a relationship between practice and education, because it is happening right across nursing, but certainly where in health visiting, where there is so much policy development that those tutors, those lecturers, are fully cognisant and understanding of what is going on out in the community, and able to ensure that they are imparting the correct knowledge to the new recruits.

CPHVA (in interview)
Yes of course [health visitor students need to be taught by health visitors]. . . the regulations are such that they have to have someone with community expertise leading the course – now that does not mean they have to be a health visitor leading the health visitor course, although on the whole they are and we would recommend that because it is fine to bring in other people to do bits of the teaching, but if you are actually integrating the whole thing you need someone with a good understanding of what you are integrating to . . . . in terms of practice, I think it is absolutely vital. I just cannot see how someone who wasn't in practice themselves could teach it. Apart from anything else, the provision of suitable learning placements to be, you know, if you are talking about family centred public health, you have got to be in there doing it, you cannot suddenly find bits of family, bits of community to dodge people into. . . you cannot possibly teach someone the practice of health visiting unless you are in there doing it yourself.

On the whole, the responses offered little insight into the connections between health visiting as a profession (or not) and how that might affect professional regulation, although each of the different organisations revealed distinctly different perspectives. These illustrated something of the continuum of opinion that exists between the polarised views that state only that health visiting is, or is not, part of the nursing profession.

Question: Do you have an official position statement on the JM [Consulting Ltd] Review?

RCN (written response):
Yes – attached to this email. The RCN did not support the continued separate registration for health visitors. Neither does the RCN support direct entry for health visitors.

Unison (in interview)

Well I think actually Unison was almost unique, we felt very strongly that the title of health visitor should remain and we do see health visitors as distinctly different. In the same way that we see midwives although you have got direct entry midwifery, we still feel that a great deal would be lost in terms of all that is required to maintain that specialism and so we were quite clear that we wanted to fight to ensure that the title health visitor remained within the title of the regulatory body.

CPHVA (in interview)
The thing that we put in our evidence that has fallen by the wayside but I think is still worth looking at is . . . actually working in the community requires a different level of expertise. I think in terms of public safety it is very important because people are working autonomously, in very private arenas, in people's homes particularly, are working without direct recourse to colleagues, although they are in teams, are making decisions all the times in those situations and we would have liked to have seen . . . . whereas we have got registration for health visiting, we would like to see that extended to other areas of community practice, so that people have had to have been – there is a minimum level of recognised education and training to work in those areas.

Finally, the CPHVA and Unison both took the opportunity of open questions to express views about the particularly difficult time that health visiting had faced in maintaining its values and role under the last government, by way of explanation for the apparent divisions and defensiveness within the profession.

Question: Are there any other aspects that you think are important in respect of public safety and the health visiting service?

RCN (written response):
No

Unison (in interview)
I think the trouble is that, you know, so much has happened to health visiting and I think they were one of the casualties of the previous Government's reforms and so they were bound to be divided because in practice their work varied, but I think that the way forward is to focus on what the policy initiatives that are happening now and they are quite clear that community health, social exclusion and public health is the way forward, and I think health visitors can rally round that, but clearly need to be involved in shaping all of those areas. . . . . health visitors feel they have contributed to [policy developments] through their representative organisations, and you know, on the primary care trusts, having a voice in the primary care trust developments as well, so I think those are the usual channels. The trouble is that in the past, prior to this new Government, it did not matter what you said, you were not listened to and I think there is a lot of confidence building to be done in terms of health visitors believing they are actually being listened to.

CPHVA (in interview)
The official view was, yes we are a specialist branch of nursing which requires registration in order to protect the public, so it needs separate recognition and separate registration and therefore separate as we go forward, separate directives of health visiting and what have you, and the name included in the new body and all that sort of thing, to maintain the that public health focus because there is, as much as anything I think, I think, in order to flag up the importance of that area of work, because obviously at all levels as soon as you don't keep that flagged up, it disappears into the more pressing need of care and cure.

The change in stance towards consultation with unions since new Labour came to power was highlighted by Unison, and respondents from both organisations implied

that health visiting could face both more difficult times and wider opportunities ahead. Only selected comments from the interviews are included here to give a flavour of the discussion; the overall discussions demonstrated a wide diversity in opinion, perhaps reflecting a degree of disunity which may, as the informants suggested, reflect a loss of professional confidence and identity, given the challenges faced by health visiting since the advent of new public management.

The different perceptions can be linked to different comments recorded in the literature over the last century and are reflected in research dating back to the debates of the 1960s, when the official relationship between health visiting and nursing changed. Robinson (1982), for example, associated the different perceptions of whether health visiting should be seen as nursing or not, with clearly different positions stated by the RCN and the HVA (now CPHVA). Citing contemporaneous documents, she pointed out that the RCN had always been concerned with nursing; they would potentially lose health visiting to their membership if they are seen as a separate professional group. Conversely, the HVA began representing health visitors when they were predominantly drawn from the ranks of sanitary inspectors in the 1890s:

> The Association has represented health visitors since 1895, long before a nursing background became a pre-requisite for their training. Consequently, its natural assumption is that health visiting is an independent profession, linked both to nursing and social work but separate and essentially different from both.
> (Health Visitors' Association, 1970)

The position taken by the CPHVA now appears to represent a change from this earlier statement, and the respondent remarked on the fact that, as all current health visitors have been drawn from the ranks of nursing, it is difficult to take an 'outside view'. Through its parent union MSF, the CPHVA now represents a large spectrum of NHS staff, which may also account for its close relationship with the health sector. Conversely, Unison represents staff drawn from a wide cross section of the public sector, which may help to contribute to its broader stance, reflected in observations about policy matters beyond the health service. To respect their stated position that they held no 'official views' about health visiting, comments made by the RCM spokesperson were not included above. However, some concern was expressed that in the new Council, the nursing and health visiting lobbies could potentially combine forces to outvote midwifery. This concern appears to misunderstand the stated requirement from government that:

> We would emphasise the importance of the Council's responsibility to ensure that its procedures do not allow any one of these professions to be outvoted on matters of sole concern to that profession
> [NHS Executive, 1999]

However, it does help to illustrate the point that each assertion draws from a particular vantage point, and even 'disinterested' commentators are likely to have some form of position to uphold. The representative organisations are not alone in this; the regulatory authority, educationalists, employers and government may each feel that taking one view or another will affect them in particular ways. As remarked at the start of this chapter, such diversity is a source of irritation to some

commentators, for which various prescriptions are recommended. Certainly, it leaves health visiting in a poor situation in respect of one of the cited criteria for 'being a profession.' Professions are all believed to have a professional association that speaks for, develops and maintains the standards of that profession. There are variations on that theme, of course; but the existence of several potential organisations that all vie with one another to take different perspectives would definitely not count in a professionalising agenda.

2.3.3 Regulation: collating the views

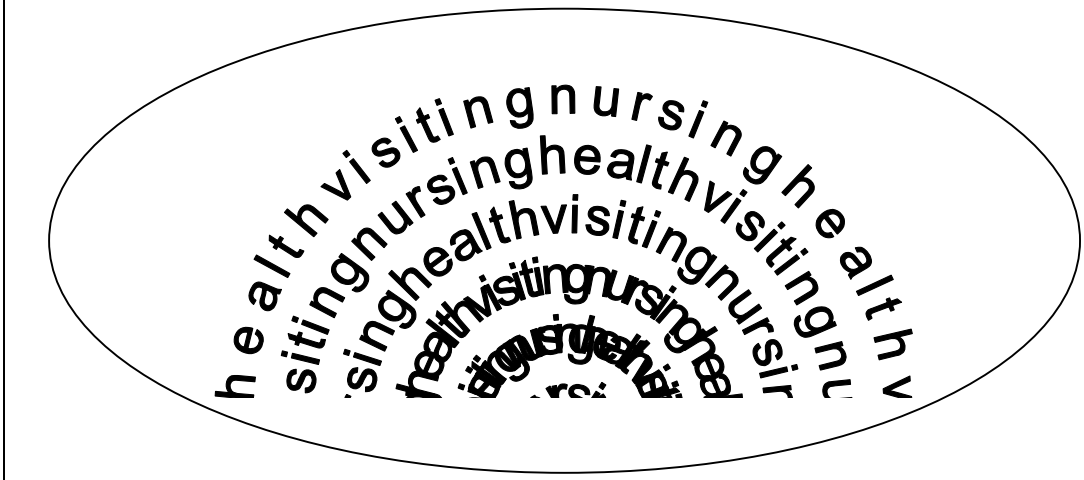
Drawing together the diverse threads from the literature, from expressed views of the representative organisations and general debate, indicates that the polarised views provide little insight into either the necessary regulatory procedures or how health visiting should be organised and developed in future. The different 'vested interests' are reflected in at least five different elements:

1 *Professionalising claims*
These reflect the professional aspirations of nursing or of health visiting, whether those are seen as competing, complementary or quite separate.
2 *Educational claims*
These reflect beliefs about current nursing preparation and the extent to which present preparation of health visitors is suitable.
3 *Regulatory position*
The views expressed at (1) and (2) are reflected in different opinions about how health visiting should be regulated.
4 *Administrative issues*
The development of a profession is not associated only with initial preparation, but also with employment opportunities, organisational effectiveness and policy directives that are reflected in a range of associated views.
5 *Approach to practice*
This is the most apparent, surface manifestation; different perspectives relate to the other four elements.

Tables 2.3 and 2.4 set out these different implications in relation to four positions along a continuum, which show an imperfect fit to the stance adopted by the representative organisations. The 'opinions' listed in those tables are fictitious in that they have not been verbalised by any single individual or organisation, except for the suggestion that the essence of the profession lies in 'the cocktail, not its constituent parts,' which is believed to have stemmed from Grace Owen, a leader of health visiting in her time.

The view that health visiting and nursing are indistinguishable (shown in Table 2.3 and illustrated in Figure 2.1) is, perhaps, closest to the stance adopted by the RCN and was reflected in the recommendations made by JM Consulting Ltd (1998). This first position would allow for health visiting to be regulated as a 'higher level of practice' within nursing, but no special arrangements are needed beyond those which apply to all nursing specialists. Seen as the 'obvious' position by nursing traditionalists, this perspective is portrayed as the least divisive, because it accepts and promotes existing work patterns, encourages the involvement of junior nurses working in health visiting teams and develops a preventive perspective across the whole of nursing.

Figure 2.1: Health visiting and nursing are indistinguishable



The second position in the continuum outlined in Table 2.3 allows for separate divisions within nursing. The CPHVA view describes community practice as a distinct area within nursing; health visiting is seen as a subsection of this, as illustrated in Figure 2.2. The idea of 'direct entry' to the profession could be through developing a separate branch of community or primary health care nursing at pre-registration level. This idea has been floated on occasions, but did not feature in any comments provided by the organisations for this project. In this scenario, health visiting is still perceived as a 'specialist' or 'higher level' of nursing that would require additional, post-registration education that would require regulation, although entry might be limited to those from a primary care branch of the register, should one be established. Portrayed by its supporters as moving forward from either traditional nursing views or the divisiveness of 'separatists,' this perspective is offered as a modern approach that fits with a shifting health service scene, in which primary and community care are seen as the way of the future.

Figure 2.2: Community practice is a distinct area of nursing

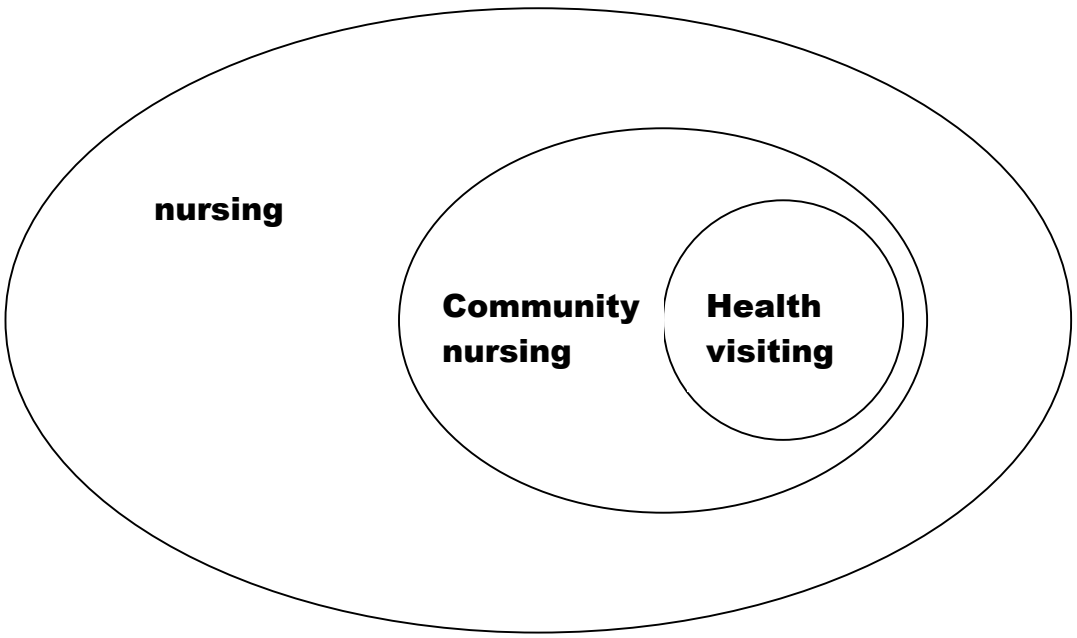


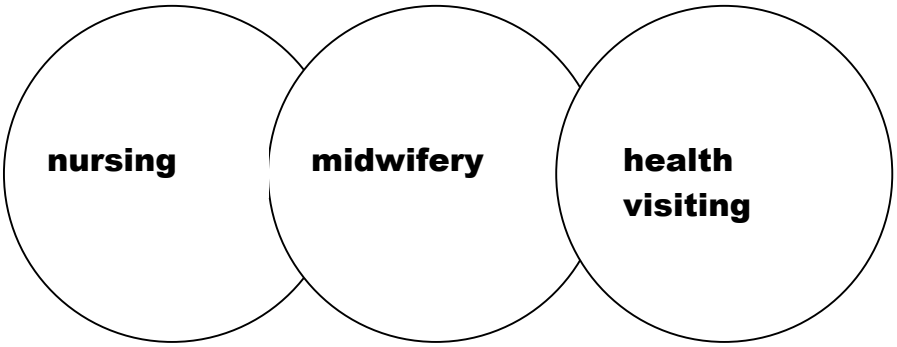
Table 2.3 HEALTH VISITING AS PART OF NURSING	
1. HEALTH VISITING AND NURSING ARE INDISTINGUISHABLE	**2. COMMUNITY PRACTICE IS A DISTINCT AREA OF NURSING**
Professionalising claims Nursing knowledge is drawn from an established, international theory base which is expanding. It includes caring for people who are sick or well, and encompasses health and preventive care for individuals, families and communities. Therefore health visiting is nursing, and to deny this denigrates the position of nursing.	***Professionalising claims*** Nurses working in community settings share key aspects of practice that are distinct and different from those that pertain in institutions. Pooling knowledge and skills will lead to the development of a new 'discipline' of community health care nursing, with its own theoretical and practical knowledge base.
Educational claims Health visitors contribute to a nursing knowledge base and help ensure it is continually expanding, to establish and enhance both their own specialist practice and that of nursing colleagues. The incorporation of 'health' and 'community' perspectives into Project 2000 was in no small way due to the influence of health visitors. The competence and accountability of health visitors is assured because the community health care nursing framework builds on the knowledge and skills they obtained as first level registered nurses, extending them to a specialist level.	***Educational claims*** Project 2000 education includes social science, health promotion and communication skills in the common foundation programme. However, the skills and knowledge needed to work in community settings are distinctive and different, so there should be a separate 'branch' at first level called either 'community nursing' or 'primary care nursing'. This would be a basis from which to build the highly skilled team leaders and specialists like health visitors whose work in the community means they need a level of independence that is greater than in institutions.
Regulatory position As all health visitors are nurses, nurse registration ensures the vulnerable public are protected. All nurses are required to update themselves and to practice only within their level of competence under PREP and 'return to practice' regulations, so no special arrangements are needed for health visitors.	***Regulatory position*** Community specialist practitioners require a higher level of skill than that obtained at first level registration. The specialist level of competence must, therefore, be recognised on the nursing register to ensure the level of competence required to protect the vulnerable public.
Administrative issues Tribal divisions within nursing have inhibited the contribution of the occupation and inhibited the development of nursing careers. Flexibility is of paramount importance in ensuring organisational efficiency, so for health visitors to only work in one sphere of nursing is wasteful. Solidarity among colleagues means that nurses are a powerful force in negotiating working conditions.	***Administrative issues*** The shared values and beliefs that community and primary care nurses hold form a natural bond that makes joint working easier; this includes health visiting There are differences between these nurses and nurses working in institutional settings, but health visitors are natural partners within primary care teams, integrated nursing teams and neighbourhood nursing teams.
Approach to practice A caring endeavour lies at the heart of nursing; this is central to the therapeutic relationship developed between health visitors and their clients even when applied to well families or in preventive situations. Children's nurses have pioneered parental participation in care and health visitors can learn from their skills.	***Approach to practice*** All primary care nurses focus on individuals, families and groups or communities as a whole. The particular contribution of health visiting is to concentrate on prevention and public health; however, this is a feature of all community practice and health visitors will undertake clinical nursing duties if the need arises.

Table 2.4 HEALTH VISITING AND NURSING AS SEPARATE PROFESSIONS	
1. DIFFERENT BUT COMPATABLE	**2. DIFFERENT AND ENTIRELY SEPARATE**
Professionalising claims Health visiting is an eclectic profession, drawing its knowledge base from a wide range of other practice fields like developmental and health psychology, education, nutrition, social policy, health promotion and public health. Its uniqueness lies in the 'cocktail, not the component parts.' Limiting its knowledge and practice to those dimensions drawn from nursing restricts its sphere of action and is therefore damaging to the health visiting profession.	***Professionalising claims*** There is a unique knowledge base, centred around the principles of health visiting and the value of health. Health visiting is a variety of public health practice that encompasses individuals, families and communities. The traditional insistence on nurse training as a pre-requisite is a means of socialising health visitors into obedience to managerial hierarchies and the medical model. This link is harmful to the profession of health visiting.
Educational claims Health visiting requires a distinct base of knowledge and skills that is not met by the current (community nursing) framework, because of the short time frame and common core of up to two thirds with nursing. The only assumed knowledge is from the CFP, in which important topics like psychology and sociology are taught at too superficial a level to suffice for health visiting. Nursing is not the only basis upon which health visitor training could build.	***Educational claims*** Focusing on nursing as an entry point has distracted from the important issues of educational outcomes and competence when deemed 'fit for practice' on entering the profession. An extended curriculum could encompass suitable professionals from a range of fields - perhaps health promotion officers, midwives, social workers, psychologists or environmental health officers, for example, or even for direct entrants.
Regulatory position Self-regulation requires that health visiting should be regulated by health visitors, not nurses or any other professional group. There are common areas of interest in the regulation of any professions, mainly to do with conduct; but the knowledge base, syllabus, approving standards for entry to the profession or return to practice must be determined by health visitors, not others.	***Regulatory position*** A separate regulatory body is needed for health visiting. The nursing regulatory framework has not maintained or developed health visiting as a profession. Development work carried out by the CETHV in 1977-1982 was not carried forward by the UKCC, so the old syllabus was left to become seriously outdated because of pressing needs elsewhere within the 'family of nursing'.
Administrative issues Health visiting fits well in community or primary care, or in public health; it is thus well placed to serve as a bridge between different spheres of practice in health care. Networking and collaborating across disciplines/agencies are central skills which could be used to better effect if health visitors were not only focused on nursing.	***Administrative issues*** The NHS groups health visitors and nurses together so they get to know one another and work well together. If health visitors work elsewhere, as in community development projects or multi-professional teams for children with special needs, they discover they have as much in common with other disciplines and agencies.
Approach to practice Practice is based on the principles of health visiting. The therapeutic relationship developed between health visitors and the population they serve may be extended to encompass families, specific groups and even whole communities. Empathy, support and human concern are centrally important, but there is more emphasis on being a resource, facilitator and enabler than on 'giving care'.	***Approach to practice*** Nursing privileges giving care to the sick or dependent individuals. This traditional nursing emphasis on 'packages of care' distracts from health visiting work in partnership towards empowered communities. Also, there are occasions, as in child protection, domestic violence or public health, when caring will not alter inequitable power bases or structural disadvantage; it may even collude and reinforce them.

Table 2.4 shows the rest of the 'continuum,' encompassing the two different opinions that each regard health visiting and nursing as separate professions. The view that health visiting and nursing are separate but compatible may reflect some of the thinking behind the government's response to the JM Consulting Ltd recommendations (NHSE 1999). The position in statute is that three separate professions are regulated by a single authority, as shown in Figure 2.3. Of the representative organisations, this position seems closest to the views expressed by Unison.

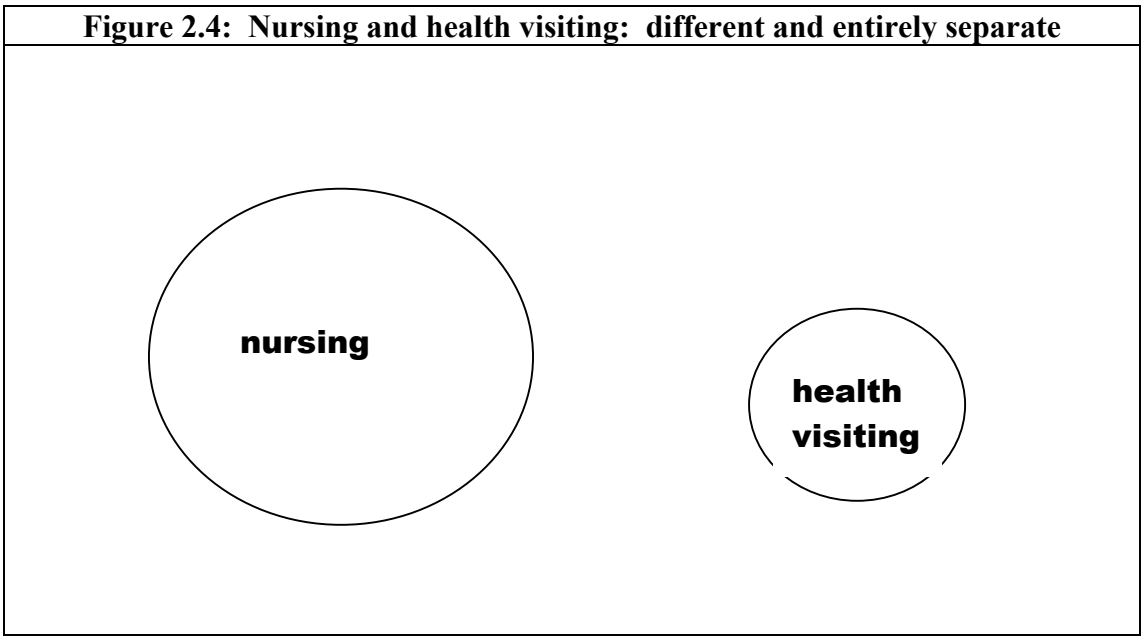
The separate knowledge and skill base needed by health visitors may be seen as analogous to the bodies of knowledge tapped by, for example, nurse managers, nurse educationalists, nurse researchers. In each of those examples, progression requires initiation into a completely separate knowledge base – although, of course, all nurses require some insight and ability to use management, education and research skills. Similarly, the argument goes, all nurses need some insight and ability to use the skills of health visiting; that does not mean the knowledge base is the same, nor does it mean that nursing is the only possible background from which health visitors could be drawn. Likewise, it would be possible to envisage a different form of preparation that accepted entrants from backgrounds other than nursing, which is portrayed as potentially developing a greater flexibility within the profession, since it could more easily extend beyond the confines of the NHS.

Figure 2.3: Nursing and health visiting: different but compatible



Finally, Table 2.4 outlines the view, expressed in some of the literature and shown in Figure 2.4, that health visiting (and, more importantly, the clients the occupation serves) has been harmed by its association with nursing. This perspective was not represented by any of the organisations, perhaps partly because of the defensive fear of job losses and professional exclusion described by respondents from the CPHVA and Unison. However, the view accepts the sociological and public health critique that focusing interventions on individuals rather than on the environment and on the determinants of health can do more harm than good. In this perspective, nursing is seen as inextricably linked with the medical model and the ascendant 'new public management' techniques (Hood 1991) that are so prevalent in the current health service.

Figure 2.4: Nursing and health visiting: different and entirely separate



The regulatory body is held culpable in this view, since it denies health visitors the ability to control their own profession, using nursing as a mechanism through which health visitors can be controlled and socialised into 'acceptable roles' within the NHS. More positively, this last view is portrayed as forward looking and radical, seeing health visiting as the profession dedicated to a practical response to inequalities and public health issues, not confined by current organisational structures within the NHS and primary care or by traditional approaches to practice.

As shown in the interviews and in this analysis, the regulatory position is not only affected by the different views, it also has a circular relationship, in that it creates and feeds into the positions and opinions held by individuals, influential opinion formers and organisations. It also has an eventual impact on the forms of practice adopted by registrants. However, it is far from being the only influencing factor. The most apparent sign of professional regulation is the presence of practitioners adopting suitable and appropriate forms of practice, to address issues designated as falling properly within their sphere of interest. This, too , is affected by a wide range of different influencing factors, and will be considered briefly in the concluding section of this chapter.

2.4 Preferred approaches to practice

The twin pillars of action upon which health visiting has always rested are home visiting and community outreach. These are used as a vehicle for delivering health related messages and health promoting interventions, determined according to the underlying values and principles that guide the service. Another constant has been the universal focus of the service, which has, nevertheless, privileged families with babies, young children and vulnerable groups like travellers, older people or the homeless and refugees. The service has been organised in a variety of different ways, and there are a range of views about how health visiting is best carried out to fulfil its designated role.

Again, the commentary is often contradictory, perhaps linked with prevailing views about how 'health' should be regarded, the role of the NHS and its employees in operationalising these beliefs into practice, and inevitably, how demarcation lines should be drawn between different occupational groups. These issues are explored in more detail in Chapter 3, which examines the influence of managerial views, values and organisational imperatives. Sociological discussions about whether a collectivist or individual focus should prevail are mirrored by public health debates about whether population perspectives or clinical remedies offer the best way forward. Much less attention has been directed at the point where these diverse perspectives meet, but as indicated earlier in this chapter, health visiting developed from a perceived need to bridge the gap between the individual and population-wide policies - that is between the 'public' and the 'private'. These debates are not directly related to health visitor regulation, but they have strong implications for practice. Regulation, in turn, requires a basic understanding of health visiting actions, values and principles and of how the service is organised.

2.4.1 Action

There is a dual dialogue about which approaches to practice should be preferred, of which many stem from the fact that health visiting actions are supposedly proactive, delivering an often unsolicited service aimed at promoting health. The first goal, therefore is to ensure that the client population will either access the service for themselves, or allow health visitors to access them, so that health promotion can take place.

There is a growing body of qualitative research about the process of health visiting that shows the importance for clients of understanding the service and its purpose, and getting to know the practitioners to whom they are relating. As clients use the service, so they begin to understand what it has to offer, and are then more likely to use it effectively (Machen 1996, Collinson and Cowley 1998). However, because health visitors are offering a service that is not solicited, successful ‘entry work’ is necessary before the main work of disease prevention and health promotion can take place (Chalmers 1992). Activities that are perceived as ‘routine’ are more likely to be acceptable, because they have no stigmatising connotations (Chalmers 1992), but there is no way of predicting in advance which visits will turn out to be routine (Cowley 1995a). The assessment process in health visiting involves assessing the

whole situation, taking into account coping factors and resources for health as well as risks and dangers (Cowley 1995b, 2000)

The second side of the dialogue stems from the need, held in common with all health professionals, to be sure that the health promotion actions themselves actually provide some worthwhile benefit, and do no harm. Structured approaches to home visiting have been shown by a wealth of experiments and systematic reviews to be extremely beneficial in preventive terms. Robinson (1999) listed no fewer than 10 areas in which home visiting was demonstrably effective; of six American studies of cost-effectiveness, five showed favourable results, with the costs of home visiting efforts being offset by savings. Almost all the studies cited in this review were carried out in the USA, which limits their immediate transferability to this country. However, the systematic approach and structure used to guide visiting in these successful experiments is quite similar to the approach used in the Child Development Programme pioneered by the University of Bristol. That involves monthly visits to first time parents, starting in pregnancy and continuing until the child is nine months old; partnership and an empowering approach are emphasised.

The clear levels of effectiveness demonstrated in such studies have contributed to recent policy initiatives promoting an extended role for health visitors (Acheson 1998, Home Office 1998). However, the frequency of visiting in all of the cited experiments is far higher than anything that would be possible with the currently reduced resources available in most areas. Indeed, many commissioners regard universal home visiting as an expensive approach to be discouraged in favour of client attendance at clinics. A summary review of studies in the USA suggested a range of principles to underpin home visiting programmes (Gomby et al 1993); paradoxically, these are very close to the kind of universal service that is being discouraged in the UK.

Such debates follow a pattern of continuing and unresolved debates about preferred approaches to health visiting practice throughout the history of the profession. Drawing on health promotion theory, Twinn (1991) relates them to the great debates that have exercised philosophers, politicians and policy makers for centuries. Her research and a health promotion framework describes four so-called ‘conflicting paradigms for practice’ in health visiting; these are:

1. individual advice giving
2. psychological development
3. emancipatory care
4. environmental control

Twinn’s description incorporates the delivery of care to individuals and families through home visiting, as well as encompassing the kind of community outreach, community development and traditional public health approaches. It also shows that empowering approaches may occur at either an individual or collective level; likewise directive and controlling approaches can be played out at different levels. This is a matter of no small importance, since a raft of sociological studies about how the profession affects the public it serves have emphasised the disempowering impact of individualised, strictly focused interventions by health visitors (e.g., Mayall and

Foster 1989, Abbott and Sapsford 1990). This approach is largely attributed to health visitors' close association with nursing and medicine; it is described as the mechanism through which the profession exercises social control over parents on behalf of the state, contributing to the social construction of motherhood, gender, social class and poverty (Abbott and Sapsford 1990, Symonds, 1992).

Most occupational groups choose to focus activities on either individuals or population groups, whereas health visitors may selectively and purposefully shift from one level to another, as the occasion demands (Cowley 1991). Very specific skills are required to know and understand how and when to shift from one approach to another; Twinn (1993) suggests that the four apparently conflicting approaches she describes may be integrated in practice by using the principles of health visiting.

2.4.2 Values and principles

The principles of health visiting were developed through a detailed process of consultation and investigation in the 1970s (CETHV 1977), at the time when health promoters were collectively questioning the prevalent, rather directive and controlling approaches to health education. They were re-examined about 8 years ago; the working group agreed that the terminology seemed inelegant, but alternatives that were debated either reduced or altered the meaning, so substitution was rejected as unacceptable (Twinn and Cowley 1992). Furthermore, the principles were considered to be still relevant and important to contemporary health visiting practice; they formed the basis of a later inquiry into the difficulties of evaluating the health visiting service (Campbell et al 1995).

The four principles are:

1. The search for health needs
2. The stimulation of an awareness of health needs
3. The influence on policies affecting health
4. The facilitation of health enhancing activities

The principles are used to describe the processes through which health visitors carry out their work. The original 'working group' approach used to develop these principles is gradually being replaced as they are beginning to serve as a basis for research (e.g., Cowley 1991, Chalmers 1993, Appleton and Cowley 2000). It is worth pointing out that, quite explicitly, the principles of health visiting eschew activities involved in 'doing for,' which is a mainstay of nursing; instead the principles emphasise an enabling and facilitating approach. This difference is not fully captured in the learning outcomes of the community health care nursing framework, which are listed in full in Appendix 1. An adapted version of the principles were incorporated as learning outcomes for all community health care nurses in 1994. Further changes were made to the wording when the specialist (health visiting) learning outcomes were revised four years later (UKCC 1998); the alterations limited and reduced the meaning of the principles of health visiting.

The proactive stance and breadth of the health visiting endeavour is captured in the principles; they are underpinned by the 'value of health', which provides a guiding basis for the work. Robinson (1985), who has led a movement to develop a sound theoretical base for health visiting, warned that health is too nebulous a concept upon which to base a profession. Even so, the principles provide the nearest thing to an explicit underpinning framework for health visiting practice, and there is wide agreement about their importance across the profession. However, it has certainly been increasingly difficult to maintain a preventive, public health stance in a health service focused on clinical effectiveness, increasing resource efficiency and measurable individual interventions (Cowley 1997).

2.4.3 Focus and organisation of the service

There is a growing body of qualitative research that could be used to guide the way services are organised, in order to help redress some of the sociological critiques of the disempowering side effects of prescriptive health visiting approaches. Beyond these, the question of whether health visitors might be better employed in an organisation that is oriented to health (rather than disease) is an increasing consideration. The overall effect of close integration with primary care services has been debated for decades, reaching a crescendo of dissent when GP fundholders were empowered to purchase health visiting services in 1993 (NHSME 1992). In most instances decisions about which health visiting services should be provided and how they should be organised appear to relate far more closely to a mixture of tradition in a local area and national policy decisions of the day than to research evidence (see, e.g., Cowley and Billings 1999). The current government has repeatedly spelt out the importance it attaches to the development of health visiting and school nursing as public health services, to be offered on a non-stigmatising, universal and widely accessible basis, for example; this will be considered further in the next chapter.

In general terms, the organisation of services is a matter to be decided between the provider organisation that employs health visitors and their commissioners, whether Health Authorities or Primary Care Trusts, as they come on stream. However, there are a number of messy accountability problems that 'fall out' of particular organisational approaches and expectations. Some of these issues would be very similar to the forms of accountability that affect any nurses or, indeed, any registered health professionals. A number of other, rather confusing issues are developing as Trusts and Health Authorities strive to achieve greater effectiveness and efficiency, in the face of rising demand. It has become increasingly common to specify limited core services and offer some forms of 'package of care' to families whose assessed needs suggest this is required. Table 2.5 is drawn from a local study, showing two kinds of typical 'core programme' to be followed.

FIGURE 2.5: CORE PROGRAMMES COMPARED (from Cowley and Houston 1999)	
3 TRUSTS: NORTH LONDON INNER LONDON SEMI-RURAL	
Contact will be offered ('core programme') 1. Antenatally 2. New birth visit 3. Follow-up contact to new birth *Review at* 4. 6 weeks 5. 8months 6. 2 years 7. 31/2 years	**Further contacts will be provided ('above core' programme)** a) in response to perceived need by the health visitor and client b) to newly registered clients with children under 5 years
SERVICE FOLLOWING DISINVESTMENT	
Contact will be offered ('core programme') *1.* New birth visit *Review at* 2. 8 months 3. 21 months	**Further contacts will be provided ('above core' programme)** a) in response to perceived need by the health visitor and client b) to newly registered clients with children under 5 years

There have been two high profile cases in which a large disinvestment of funds was made from the health visiting and school nursing services; each Trust responded differently, but both followed the kind of restricted 'core programme' outlined in Table 2.5. Questions have arisen about whether the service remains a 'health visiting service' if it is not truly proactive and universal, and if the amount of delegation to staff who are not qualified as health visitors is so excessive that control of the service lies outside the health visiting profession.

Four scenarios were derived to explore the accountability issues. To ensure credibility and contemporary relevance, they were based on current or planned practice in Trusts that are struggling to re-orientate their services to cope with serious resource shortages. The scenarios were checked and modified following discussion with practising health visitors who confirmed their authenticity prior to sending them out for legal opinion. They were:

Scenario 1: where a Trust offers no designated health visiting service, although a 'child and family nursing' service is on offer to meet clinical needs.

Scenario 2: Where a Trust offer health visiting services on a strictly 'targeted basis' to families with identified needs or a specified 'high risk'.

Scenario 3: Where shortage of staff limits the extent to which health visitors can carry out their assigned duties.

Scenario 4: Where health visitors have moved completely over to a family-centred public health role. They deliver the service by leading teams delivering a community development type of approach to families across the locality.

For each scenario, a fictitious 'problem' was constructed and a legal opinion sought about where the accountability lay. The full text of this detail is included in Appendix 2 and the scenarios are explored further in Chapter 5. Two issues are immediately apparent. One concerns the legislative requirement for a 'reasonable service' to be provided, and the other is that qualified health visitors are accountable for their practice as health visitors, even if that qualification is not a requirement for the job. The matter of service organisation, therefore, is one that may well come to the notice of the regulatory body; at that time, a clear view about what constitutes a 'proper standard of health visiting' will be required. The policy context for health visiting is explored in more detail in Chapter 3.

5.4 Key points

5.4.1 Since the profession began, there have been heated debates about the role and purpose of health visiting, its relationship to nursing, and preferred approaches to practice. The debates represent alternative, equally legitimate viewpoints informed by different political perspectives; by the competing professionalising agendas in nursing and health visiting and by the divergent theoretical perspectives that underpin public health and health promotion. It is unlikely that a consensus will be possible about these diverse views, as they are linked to wider, unresolved contradictions that have persisted through centuries of political, professional and philosophical debate.

5.4.2 The debates intrude into discussions about the most appropriate forms of service organisation, preparation of new practitioners and preferred approaches to practice. In particular, different opinions about the relationship between health visiting and nursing give rise to markedly divergent views about how health visitors should be educated and the profession regulated. Health visitor education needs to prepare practitioners to deal with this high degree of uncertainty and the likelihood of continual contradictions in their everyday work.

3 HEALTH VISITING: PRESENT AND FUTURE PROJECTIONS

3.1 Policy context for health visiting

The preceding chapters set out details of the existing legislation along with various past and present influences on current health visiting practice as a basis from which to explore the implications of the legislation for preparation and regulation. Chapter 4 will unravel the way the current (community health care nursing) framework is operating in practice. However, determining the suitability of this form of preparation for contemporary and future practice needs some exploration of how health visiting fits with other occupations and disciplines, as well as examining the interface with agencies other than the NHS as a basis from which to predict trends that are likely to endure in the twenty first century.

All publicly funded services, and the professions that operationalise them, are liable to change according to shifts in political fortune and to vary somewhat from one country to another. This is especially the case for health visiting, to the extent that Dingwall (1977) has even suggested that the occupation provides a clear marker of how successive governments implement social policy, particularly in respect of the rise or fall in popularity of the ideologies of collectivism, regionalism and feminism. Apart from the specific statutes about health visiting, therefore, there are a number of important aspects of policy that affect the occupation and the client group served by them. The policies, in turn, are affected and in a circular relationship with trends that affect the whole world.

A full international, or even national, policy review of all possible influences on health visiting would lie far beyond this scoping project, but Table 3.1 summarises some of the major issues that arise. Giddens (1999) key theme of 'globalisation' and the way this is played out through the interconnected aspects of family and personal relationships, democracy, tradition and risk, is used as a basis to unify the varied and often contradictory themes. These different elements all have some kind of effect on one another, in ways that are not often entirely predictable and that certainly do not follow the distinct, clear lines that might, inadvertently, be suggested by collating them in columns.

At a national level, major changes across the health and social field have affected health visitors as well as their colleagues. Some of the most obvious and time consuming changes have been to the shape and specified responsibilities of the organisations through which health and social policy initiatives are delivered. These have led to a number of restructurings that, at a subjective level for those involved, create a feeling that the services will be profoundly different in future; this is fuelled by a determination on the part of the current government to leave their distinctive mark on the shape and detail of the services. However, over the long term, many of the 'modernising' perspectives introduced since the last election are consolidating trends as much as changing them; despite the differences in detail in the legislation for England, Scotland, Northern Ireland and Wales, there are discernible common themes. A number show continuity with international trends that began in the 1970s, were consolidated in the 1980s, and started to feature in legislative and structural changes in the 1990s.

Table 3.1 CHANGING POLICY CONTEXT FOR HEALTH VISITOR REGULATION				
	CHANGING PRIORITIES	**CHANGING ORGANISATIONS**	**CHANGING MANAGEMENT**	**CHANGING ACCOUNTABILITY**
GLOBAL-ISATION (after Giddens 1999)	***Family and personal relationships*** Social model of health Communication/knowledge WHO: family health nurse	***Democracy*** Consumerism + citizenship Information revolution Greater specialisation Greater genericism	***Tradition*** Power structures: class, gender; nursing vs. medicine Public/private division of responsibility	***Risk*** Loss of confidence in established professions Increasing litigation
UK-WIDE HEALTH & SOCIAL POLICY	***Convergence across government departments:*** Civic community, social exclusion + public health as common concerns → idea of 'joined-up government'. Collaboration as a statutory requirement.	***Rise in:*** Local decision making, Devolution, Regionalism, city mayors, local diversity; Consumerism + social changes: ageing population, working women, early years education (nursery classes).	***New public management*** Managerial accountability. Individualism; short term contracts. Parsimony: efficient use of resources. Effectiveness: emphasis on outcomes. Standards measurement and quality.	***Convergence of risk and quality agendas*** 'Quality protects' Clinical governance + employer liabilities Control of professional freedom: NICE; CHI
FAMILY WELFARE & PUBLIC HEALTH	***'Joined up thinking'*** Joint health/social care priorities; includes e.g. NHS, Local Authorities, Home Office, Lord Chancellor's Dept, voluntary sector. Working across communities + local neighbourhoods HImPs as over-arching local strategies + focus for collaboration.	***Shift to Community + PHC*** Changing control: community trusts → PCTs; health co-ops PCGs, LHGs, etc: nurses on boards, medical dominance. *'Hospitalising the community'* = acute + severe care in community; care pathways Case finding: child protection + children 'in need' to refer to social services.	***Contract driven practice*** Funding priorities define core business: traditional core business of NHS = hospitals, treatments. *Core business* = child and family illness (incl. disability and disease prevention). *Not core business* = healthy families, early childhood, community regeneration → other sectors	***Emerging professions:*** Shift from single professions towards topic based multi-disciplinary professions: - 'Multi-disciplinary public health' profession: standards to be regulated - 'Early childhood studies' as a multi-disciplinary sphere of learning – not regulated
HEALTH VISITING	***Inequalities + social exclusion agenda*** *Convergence 1:* Principles of health visiting and government priorities *Convergence 2:* family support and public health agendas Clear public health + prevention priorities = early interventions, universal home visiting + family support, community outreach.	***Health Visitors in Primary Health Care:*** Public health workers in PHC Key centre for influencing NHS priority setting + local health commissioning As key networker across neighbourhoods/local areas For outreach to registered population: home visiting Main collaborative interface with NHS – illness/hospitals, not family health or welfare.	***Health Visitors in Teams*** - as 'leaders of teams' (efficiency imperative) - in integrated nursing teams - in health visiting teams: corporate/shared caseloads Competing priorities – severe existing conditions (illness, disability, child abuse) take precedence over prevention Emulated 'clinical guidelines' and indicators used to measure performance.	***Regulation*** Legislative requirement: NHS commissioners/ providers must make 'reasonable provision' to cover health visiting services – nursing services alone cannot provide a substitute. Health visiting skills and competences regulated by UKCC: accountability as a health visitor differs from that expected of a nurse.

3.2 Enduring trends in policy

The shift towards community and primary health care began in the 1970s, with influential discussion papers published by the World Health Organisation (WHO 1978) and in the UK (Hicks 1976). Clearer government directions were soon being flagged up (e.g., in the Cumberlege (DHSS 1986) and Griffiths (DHSS 1988) Reports). The 1990s saw a flurry of legislation about primary and community care. The NHS and Community Care Act 1990 brought GPs into health care management through fund-holding, heralding an even clearer trend towards a 'primary care led NHS'. The NHS (Primary Care) Act 1997 preceded the various different primary-care led commissioning arrangements across the UK following election of the Labour government and passage of the Health Act 1999.

This shift has been accompanied by various other developments that challenge any simple division between 'community nursing' and 'hospital nursing'. If it ever was, primary care is certainly no longer a site only for people with either chronic disabilities or mild self-limiting disorders. Indeed, in primary care, there is the need to care for the profoundly ill and people with acute disorders, with attendant demands on nurses from across the disciplines. Pressure for speedier throughput in acute hospitals, to deliver care in the community for people with severe, enduring mental illness and physical and learning disabilities, to provide home care for sick children or people at the end of their lives are all combining to squeeze and challenge the traditionally health-oriented aspects of primary care. Service provision across the primary care field is, therefore, at least as complex and diverse as in hospitals; Figure 3.1 illustrates how it cuts across three domains of acute care, intermediate care and preventive care. The skills required in each domain are likely to differ as widely as, for example, those needed by a paediatric intensive care nurse compared with a rehabilitation nurse working in an old people's home. In terms of preparation for practice, the common features seem as likely to pool within each of the three domains, even across organisational boundaries, as to reside only within the primary health care field.

It is noteworthy that the collaborative interface differs in each of those domains, too. Nurses caring for an acutely ill child receiving chemotherapy in the home, for example, will need to maintain close links with the hospital team overseeing the whole treatment. An increasing amount of care is delivered to acute and seriously ill patients in the home; the 'collaborative interface' for practitioners involved in this field is most clearly focused on NHS hospitals and emergency services, although joint working with the voluntary sector represented by charitable hospices are a significant feature of palliative care.

The 'intermediate care' domain also involves much collaboration between home and institutional care, especially for the classic 'care in the community' groups of elderly people, those with enduring and severe mental illnesses and with learning disabilities. Because so much care for these groups is delivered in the voluntary sector and in conjunction with social services, the proportion of collaboration outwith the NHS is larger in this domain than for 'acute care'. However, there is a growing need to develop links with NHS hospitals and their specialist services, given the increase in rapid discharge, portable technologies and chronic disease management within primary care.

Finally, the preventive care domain, which includes public health in primary care and is the field in which health visiting is located, has a collaborative interface that is largely outwith the NHS hospital sector. Instead, practice in this domain involves networking with various different departments in the local authorities (education, social services, housing, environmental health), social security, police and criminal justice services as well as with local community provision from voluntary or commercial sectors (playgroups, support groups, after school networks and so on). The diversity of this collaborative interface means that its practitioners are especially well placed to contribute to the NHS strategic planning, through Primary Care Groups, Local Health Groups or other commissioning arrangements.

The emphasis on joint working and collaboration is another trend that has developed over the last two decades, along with consumerism, the emphasis on democratic accountability and the rise in citizenship. This imperative to collaborate, particularly with social services and consumers, has been clearly stepped up with the legislative requirement on Health Authorities to develop joint Health Improvement Programmes, incorporating and capitalising on the contributions made by local authorities and the voluntary sector. The potential increase in jointly financed projects, one-off initiatives and core services, is creating a diversity not previously seen in funding arrangements, with a knock-on impact on the expectations, restrictions and potential for health visiting practice.

Also, the push towards regionalisation, typified by devolution and the accompanying difference in detail of strategies across the four countries is now mirrored within the English Regions and potentially, within PCGs or across local health groups and co-operatives. This emphasis on a stronger local determination of services developed according to assessed needs has led to a far higher profile for public health activities, again linked with a strengthening of user involvement in the development of services. The advance of 'new public management' techniques (Hood 1991, Hannigan 1998) and continued resource constraints are creating a climate of strict prioritising according to severity of clinical disorder, and a restricted choice of intervention depending on the strength of experimental evidence. One result of this trend is the closer definition of the core purpose of the different agencies, with the potential for a cash-strapped health service to withdraw even further from the provision of preventive health care. Instead, the prevention and health promotion contributions made by voluntary and other sectors are offered as substitutes, being documented and co-ordinated within strategic health plans that feature disinvestment from core NHS preventive services. This shift from mainstream to ad hoc funding was documented in the HImP of one local evaluation study (Cowley and Houston 1999) and, anecdotally, is becoming a prevalent trend.

The strict definition of responsibilities accepted by provider agencies is linked with the final continuing trend to be considered. The increase in litigiousness of the population, rising complaints that accompany both the 'knowledge revolution' and consumerism and a series of high-profile failures have focused attention on the need for strict mechanisms of accountability, risk management and quality control. These have culminated in the development of a clinical governance mandate at all levels of the health service, of 'quality protects' requirements in social services and the establishment of two national

organisations (National Institute of Clinical Excellence [NICE] and Commission for Health Improvement [CHI]) (NHS Executive 1998) to focus and develop the accountability and governance agenda.

Cross-agency working and accountability is not a new phenomenon for health visitors. At present, health visitors are almost all employed and most training is funded by the NHS, but, as explained in Chapter 2 this is a relatively recent phenomenon in the history of the profession. Indeed, whilst it is unusual to find working nurses whose experience predates their employment in the NHS, it is relatively common for current health visitors to recall their early professional experience as employees of local authorities. Recent changes in policy suggest the situation may be shifting again as the boundaries of health and social care change; a new pattern of employment is beginning to emerge.

Table 3.2 is included to visually represent the changing employment and funding circumstances faced by health visiting since the start of the profession. No attempt has been made to provide a clear, numerical distribution of funds or employment, since only an impressionistic view is possible, even of the current situation. It is important to note that prior to 1974, local authorities held designated responsibilities for matters relating to health; they incorporated 'local health authorities'. The NHS was not responsible for community or preventive, public health services at that time.

Table 3.2:
MAJORITY FUNDING/EMPLOYMENT OF HEALTH VISITORS

Time Period	Voluntary sector	Local authority	NHS/health authority	Other sources
1860-1900				
1901-1948				
1949 – 1973				
1974 - 1992				
1993 – 99				

Key:

Virtually 100%	Vast majority	Definite majority	Substantial minority	Small minority

The reason for drawing attention to this historical and changing situation is twofold. First, it remains important to maintain a distinction for regulatory purposes between the

standards, skills and competences signified by the professional award and admission to the register ('fitness to practice') and the particular role or function for which an employee may be sought ('fitness for purpose'). Broadly speaking, as professionals may change employment and associated roles a number of times in the course of their working lives, 'fitness for practice' needs to be wider and more flexible than 'fitness for purpose', whilst the latter requires a greater precision around local requirements and protocols.

The second point is related to the first; it draws attention to the long term perspective needed for the purposes of professional regulation. It is necessary, when preparing nurses for registration, to recognise that their future employers may encompass a wide range; likewise health visitors may be employed in various different circumstances and the funding for their service come from a mixture of sources. The tendency to associate 'health visiting' with only a particular practice role linked with a single source of designated funding within the NHS oversimplifies the situation. It reduces recognition of the wide range of activities engaged in by health visitors, by virtue of the skills and abilities that are the hallmark of their profession.

There have been many changes in the way that health visiting services are contracted since the advent of the internal market; significant shifts occurred when GP fundholders were empowered to contract health visiting services between 1993 and 1999 (NHSME 1992). Minor shifts in employment and funding have also arisen since the Primary Care Act 1997 enabled direct employment of health visitors by pilots established under the terms of that Act, and further shifts may be envisaged as Primary Care Trusts come on stream. Alongside the merging of funds across budgets that had previously been held as separate sections within the NHS, there has been an increase in short term funding of projects, which may involve joint funding across a range of agencies. It is possible that further movements may occur, particularly given the range of potential funding agencies involved (as identified in Table 3.1, above).

3.3. Shifting trends in policy

Alongside the enduring trends, are some very definite changes in policy that have clear implications for health visiting. Two significant areas of interest concern public health and family welfare, both of which (as indicated in Chapter 2) have been associated with health visiting since the profession began in the mid-nineteenth century.

3.3.1 Public health

The renaissance of public health preceded the current government, and extends across international boundaries. The World Health Organisation have, once more, stressed the importance of public health and prevention in their proposals to gain health for all in the twenty first century (WHO 1999). The Acheson Report (1988) recommended developing the role and function of public health, which began to happen when new powers and responsibilities were conferred on to Medical Directors of Public Health under the NHS and Community Care Act 1990. Following implementation of this legislation, an inquiry into the contribution, role and development of nurses, midwives and health visitors to

public health (Standing Nursing and Midwifery Advisory Committee [SNMAC] 1995) confirmed that there was an important role for all of these professionals. Health visitors were singled out, along with school and occupational health nurses and communicable disease specialist nurses as having a particular contribution to make, being viewed as public health workers in their entire role.

Thus, public health was rising on the agenda prior to election of the Labour government in 1997. At that time, it was propelled vigorously into the forefront of the whole political process, as the government appointed a Minister for Public Health, commissioned the Chief Medical Officer to undertake a project to develop the public health function and established a cross departmental Social Exclusion Unit that reports directly to the Cabinet Office and the Prime Minister. There are three matters that fall out of this continuing public health agenda of relevance to predicting a future role for health visitors which, in turn, will need taking into consideration for the regulation of the role. These are, first, definitions of the role and function arising from the CMO's project and, second, the effect of embedding a public health approach across the policy agenda. Third, a multitude of projects are arising that are relevant to health visiting, but not necessarily directly linked to the role.

The CMO's project to develop the public health function (DH 1998b) was a large multi-faceted project, which culminated in two particular decisions of relevance to this scoping project; the introduction of the notion of a 'public health practitioner' and the decision, announced in 'Saving Lives' (DH 1999a), that public health specialists would not, in future, necessarily be required to hold a medical qualification. Three different levels of contribution to the public health function were identified, and the term 'public health practitioner' was coined to encompass a range of workers, including health visitors. The levels were:

- 'Most professionals' including managers in the NHS, local authorities and elsewhere e.g., teachers and health workers [whose daily work involves] furthering health improvement goals, a role they may not have recognised as public health.

- A smaller group of 'hands on' public health practitioners [who] spend a substantial part of their working practice furthering health by working with communities and groups. . . This group includes public health nurses, health promotion specialists, health visitors, community development workers and environmental health officers.

- A still smaller group are public health specialists who come from a variety of professional backgrounds and experience, and need a core of knowledge, skills and experience. (DH 1998b: 15)

Considerable energy has been devoted to developing the specialist contribution in particular, and all three levels have been targeted in nursing in England through the 'Making a Difference' strategy (NHSE 1999). However, less attention has been paid to exploring either the skills and competences needed by public health practitioners or the career pathways and regulatory interface of this emerging multi-disciplinary profession with existing roles. The implications of these developments for education and training will be considered further in Chapter 4.

The second key feature of relevance concerns the effect of embedding a public health approach across the policy agenda, and its implications for health visiting as a form of public health practice. The government's green paper on 'Our Healthier Nation' (DH 1998a) explained the breadth of vision through which they planned to make public heath part of everyone's – or at least, of every government department's – business. The details were, to some extent, pulled back to former entrenched positions by the time the White Paper was published (DH 1999a). However, this vision was the basis from which to promote the ideas, largely mirrored in Scotland (Scottish Office 1999), Wales (Welsh Office 1998) and Northern Ireland (DHSS 1997, 1999), of increased collaboration across agencies, shared responsibility for health and a determined change in the former strict funding boundaries.

There is considerable convergence, set out in Table 3.1, between health visiting values and principles and the government's public health priorities. The Social Exclusion Unit has policy action teams developing initiatives to improve, for example, shopping for people in deprived areas, and tackle homelessness and drugs, and the so-called 'New Deal for Communities' development initiative aimed at neighbourhood renewal. Particular priorities include reducing teenage pregnancies and domestic violence, cutting juvenile delinquency and supporting long term personal relationships like marriage. Whilst health commissioners may choose one of these national priorities as a focus for their local strategies, local decision making means they may remain outside the NHS priority setting arena, so health visiting may not develop in these fields.

Instead, the role that has been clearly set out for health visiting is to retain their position as family support workers, developing into 'family-centred public health workers' (DH 1999b). This follows the Acheson Inquiry into inequalities in health, which identified a growing body of research to suggest that an open, family support service directed especially at mothers and babies would be likely to pay enormous dividends in the long term, being both effective and cost-effective; this led the inquiry team to:

> recommend the further development of the role and capacity of health visitors to provide social and emotional support to expectant parents, and parents with young children (Acheson 1998: 74)

It has long been known that the early, formative years of a child's life are immensely influential in affecting their health for the rest of their life. There is growing evidence, not only about the extent to which this affects inequalities in health, but also links with educational attainment, social cohesion and crime. This explains the important links made between early interventions and public health, that are picked up by the NHSE in their strategy for nursing, midwifery and health visiting in England. In a rather contradictory role prescription, it proposes that health visitors might combine the regular contact they have with families as a platform from which to contribute more closely to the commissioning agenda within primary health care:

> To take forward our policies we need to modernise the role of the health visitors. We are encouraging all health visitors to develop a family-centred public health role, working with individuals, families and

> communities to improve health and to tackle health inequalities. . . . They will work with Primary Care Groups, Trusts, other local agencies and with local communities to develop and deliver health improvement programmes and actions set out in *Saving Lives: Our Healthier Nation.* We expect health visitors to lead teams to include nurses, nursery nurses and other community workers that will:
>
> - deliver child health programmes and work in partnership with families to develop and agree tailored health plans to address their parenting and health needs.
> - run parenting groups and provide home visits to help improve support, advice and information to parents – and especially to vulnerable children and their families – supporting initiatives such as Sure Start.
> - work through Primary Care Groups to identify the health needs of neighbourhoods and special groups such as the homeless, and agree local health plans;.
> - work with local communities to help them identify and tackle their own health needs, such as measures to combat the social isolation of elderly people or the development of local accident prevention schemes;
> - provide health promotion programmes to target accidents, cancer, mental health, coronary heart disease and stroke (DH 1999b: 60)

This health service version of what health visitors need to do is clearly linked with developing the public health agenda in primary care. However, the NHS and Department of Health are not the only agencies involved with family policy, as explained in the next section.

3.3.2 Family welfare

Family matters have led to some of the most dramatic changes in policy since the Labour government were elected 1997, with important implications for health visitors, amongst others. Views about preventive family health work are deeply contested and there is a direct link with political views that can, broadly speaking, be aligned with two different outlooks. These stem from deeply held political and personal views about whether or not it is reasonable or desirable to expect people to seek or be offered help for sensitive matters that affect health, and which lie within the usual remit for health visiting attention. Some of these issues may, in some people's minds, lie wholly outside the remit or responsibility of a publicly funded health service despite their known links with serious health problems. These include matters like family discord (that may progress to divorce, domestic violence or child abuse), infant feeding (that may set a pattern of unhealthy dietary habits for life), children's behaviour and discipline (that, unchecked, may progress to juvenile delinquency, adult crime and mental ill-health) and adolescent sexual mores (with the potential risk of increased teenage pregnancy rates or sexually transmitted diseases). Such 'everyday life' matters tax the majority of households at some time, yet most people avoid the worst negative health outcomes; this gives rise to two different positions about how health visiting services should be arranged.

The first position on family health holds that universal primary prevention services are a wasteful use of resources. Since 'everyday problems' are mediated within the home with great success in most instances, this viewpoint proposes that it is only when the actual difficulties or problems have arisen that professional input is required. There may

be a recognition that, for some people, it is more difficult to cope with problems than for others, perhaps because of the extent of external pressures like poverty and deprivation in their lives; this is believed to explain some of the prevalence of inequalities in health. In this perspective, it is assumed that better services can be made available by targeting situations in which problems have arisen, since all energies are directed towards those who are 'most in need'.

Home visiting is the traditional approach to delivering family support on a universal basis to all families with pre-school children. This approach has particularly attracted the censure of some commissioners, who (drawing on medically derived notions of clinical effectiveness and the view that only established problems should be treated) suggest that such undifferentiated activities must be wasteful and ineffective. Robinson led a team of researchers examining the effectiveness of 'health visitor domiciliary visiting,' undertaking a systematic review of international studies and a selective review of the British literature on health visiting; it is expected to be published as part of the Health Technology Assessment series by March 2000. Permission has been granted for a limited selection of approved findings to be published; Robinson draws together the strands of the review process, and concludes that a universal health visiting service is essential, pointing out that it is not possible to screen effectively for those at high risk in order to target the service. In advocating a universal service, she points to the:

'advantages in identifying vulnerable populations who are often least able to access services. These populations are not static; degrees of vulnerability and risk change over time in individuals' and families lives. . . . However, within a universally provided service, the content, duration and intensity of visits must be appropriate and sensitive to client need. There is no evidence to suggest that health visitors have ever practised other than by setting priorities of 'need' within a caseload consisting of a 'normal population' to which they attempt to provide a universal service.' (Robinson 1999: 18)

As this excerpt suggests, a universal service assumes health visitors will access families and children across the population they serve, so needs can be met in a timely and unobtrusive manner. This standard health visiting approach fits in with the second perspective on family support; it represents a collectivist position and the other major stance about the best way of achieving family welfare. It presumes all families have a need for support and help at some time and that this should be available on a non-stigmatising basis. The systematic review carried out by Robinson (1999) and her team, the Acheson Inquiry into Inequalities in Health and earlier American reviews (Gomby et al 1993) have provided strong support for the effectiveness of a universal approach.

However, evidence of effectiveness does not answer the personal/political perspective that suggests that family support should only be offered if problems have actually arisen, nor is the NHS required to fund such undirected support. This was underlined when it was the Home Office that issued a consultation document advocating the kind of universal approach that many felt they recognised as the traditional role of health visitors:

Para. 1.26 – 1.34 (excerpts)

- Parents need a great deal of help and advice around the birth of their children, particularly about the health of mother and baby.

Health visitors play a crucial role in providing this help, and where necessary putting parents in touch with local agencies providing health services.

- Health Visitors . . . are ideally placed for advising families on all kinds of problems: no one feels they are a bad parent or their family has failed because they take the advice of a health visitor. That is why the Government is attracted to the idea of building on the excellent service already provided by health visitors, by formally extending the focus of their work beyond 'health' in a narrow sense to supporting families more generally.
- The expanded role of health visitors would involve a shift of emphasis from dealing with problems to preventing problems from arising in the first place.
- We recognise that health visitors already have a substantial work load and would not be able to take on a new role in supporting parents in addition to their existing duties.
- The enhanced health visitor service would focus on the critical stages of a child's early development, when help and support is most needed including: Antenatal Classes, Weekly Visits, Infant Welfare Clinics, Advice on weaning, Sleep Clinics.
- More help could be offered in pre-school years with Toddler Training Groups, Early relationship groups, Advice Surgeries
- School Settling groups, Teenage years groups

(Home Office 1998: 11 – 12)

There was much comment about the extent to which this described the existing role; whether that was viewed as a good or bad thing varied according to people's personal viewpoint about how family welfare was best achieved, and their views about 'traditional' health visiting approaches. No specific funding followed the description contained in this consultation paper, despite recognition that health visitors would not be able to take on this enhanced role in addition to their existing duties. An 'innovation fund' of £1m, payable over three years, was made available in England, but far less attention was paid to specifying roles for health visitors in Wales, Scotland or Northern Ireland. These different levels of interest, support and specification draw attention to some of the complexities involved in deciding what kinds of roles and functions should be incorporated in the professional preparation of health visitors.

3.4 Health visiting in context

Health visiting is not, as some have suggested, a profession that is unique to Great Britain, although it is nothing like as widespread as nursing, nor are there recognised European or world-wide standards for the profession. Greece, for example, operates a direct entry preparation, in which students obtain some nursing experience during their 3 year training in higher education. In Denmark, all health visitor students qualify first as district nurses; training for the two qualifications are combined but remain separately recognised. In a number of other countries, a preventive nursing role exists, although the extent to which this is expected to be carried out in conjunction with curative functions varies widely, along with the type and length of training.

In Ireland, for example, the 'public health nurse' carries out child health and elderly care functions, having qualified as a nurse and a midwife before entering the training. The midwifery pre-requisite may not continue, following a recommendation to change this (Commission on Nursing 1998). The most recent addition to the selected list of

international titles in Table 3.3, is the 'Family Health Nurse' proposed by the World Health Organisation as a new worker to help implement their 'Health 21' targets for the 21st century (WHO 1999). Among these workers, many of the duties and functions are similar, despite different titles; conversely, use of the same title does not always signify adoption of the same roles or purpose. However, the use of the title 'health visitor' does seem to be clearly associated, wherever it appears, with a proactive, public health philosophy, based on the 'twin pillars of action' outlined in chapter 2 – that is, home visiting and community outreach to disadvantaged groups.

Table 3.3 International Titles

▪ Community Nursing ▪ Community Health Nursing ▪ Community Health Care Nursing ▪ Family Health Nursing ▪ Health Visiting	▪ Nurse Practitioners ▪ Primary Care Nurse Practitioners ▪ Primary Care Nursing ▪ Primary Health Care Nursing ▪ Public Health Nursing

In a useful attempt to ground health visiting in a policy context, Robinson (1982) sought a basis from which to evaluate health visiting around twenty years ago. She used a framework that is usually applied to examining the likely continuance of social policies (Hall et al 1978), to evaluate the historical position of health visiting. This framework has three aspects that will be revisited in the light of recent changes. First, having decided in essence '*what needs to be done*,' a focus on the legitimacy of a policy or topic under review asks if this is an issue with which government considers it should be concerned? The call to treat health visiting as a specialist area within nursing was very clearly rejected by the government; this constitutes a legitimation and renewed mandate for health visiting to continue to be regarded still as a specific profession.

The idea that each of the professions of nursing, midwifery and health visiting should have equal representation on Council is clearly not intended as a reflection of the numbers involved in each profession as would be the case in, for example, a trade union or representative organisation. Instead, it reflects the view that establishing a knowledge base, determining the standards that demonstrate a person is 'fit for practice', understanding of accountability issues and the regulatory decisions involved are large and complex tasks in each of the professions. However, as the discussion earlier in this chapter shows, the scope and purpose of health visiting is necessarily reflected by the context in which it is delivered, and is affected by both the long-term, enduring changes that influence all of health and social care, and immediate shifts in policy that influence the way that family welfare and public health are perceived.
Once policy makers have decided what should be done, the next question is *'how should it be done?'* The second part of the framework addresses this by considering the feasibility of the particular issue. This is determined by the prevailing structure and distribution of theoretical and technical knowledge; also:

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it is not entirely independent of who does the judging.  Particular
ideologies, interests, prejudices and information will affect the kinds
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of conclusions which are drawn about the feasibility of different alternatives. (Hall et al 1978: 479)

The extent to which it is feasible for health visitors to carry out the functions being asked of them relate to a wide number of variables, as outlined in sections 3.1 and 3.2. These include the size and expertise of the workforce, prevailing traditions and priorities in the agency that employs them (health service, type of Trust and so on). Among the range of ideologies that are of significance in this regard are those of the 'new public management' (see Table 3.4) which may lead to different conclusions about how a function should be carried out to those reached by professionals or service users.

Table 3.4: New Public Management (NPM)

Elements identified	***Core themes/principles: NPM in the NHS***
1. Stress on private sector styles of management practice 2. 'Hands on' professional management in the public sector 3. Shift to disaggregation of units 4. Shift to greater competition 5. Stress in greater discipline and parsimony in resource use 6. Greater emphasis on output controls 7. Explicit standards and measures of performance *Hood (1991)*	1. Managerial accountability 2. Reduced dominance of professional groups 3. Disaggregation, e.g. purchaser/provider splits 4. Increased competition; use of contracts 5. Emphasis on the efficient use of resources 6. Emphasis on outcomes and effectiveness of interventions 7. Concern for standards, performance and quality 8. Short-term contracts; performance related pay 9. Emphasis on the needs of user/clients in the provision of services *Hannigan (1998)*

Three sets of core values in public management (Hood 1991)		
Sigma-type values: 'KEEP IT LEAN AND PURPOSEFUL'	*Theta-type values:* 'KEEP IT HONEST AND FAIR'	*Lambda-type values* 'KEEP IT ROBUST AND RESILIENT'

The term 'new public management' is usually attributed to Hood (1991), whose research clarifies the origins and ascendance of this doctrine during the last quarter of the twentieth century; he also points to the contradictory nature of some of its core values. Hannigan (1998) usefully reviewed the literature about the movement, as well, revealing certain key features that are particularly prominent in the NHS.

Changing policies inevitably affect the existing distribution of power, influence, benefits, status or values, leading to satisfaction in some quarters and discontent in others. The third element of Hall et al's (1978) framework, therefore, concerns the extent of general support for the policy, or in this case, for the roles being suggested for health visitors or for others carrying out duties that might once have been regarded as 'health visiting'. This leads on to the third question to be considered in this chapter, which is *'who should do it?'* Decisions about this may be influenced by a number of factors, such as service traditions or stereotyped views (held by health visitors themselves, or by others about them) of what constitutes their 'proper role'. However, it is only necessary to name a specific profession or occupation for a particular role in two circumstances:

1. if that profession has specific skills that are not found (or not all found together, to a sufficiently consistent degree) in any other occupational group;

2. if there is a need to protect the 'vulnerable public' from possible harm due to inadequate skills or misconduct on the part of unsuitable practitioners.

A third reason relates to convenience and efficiency; this often arises from organisational requirements that are entirely valid, but not necessarily important in terms of regulation of standards or preparation for practice in a particular profession. In this instance, a local protocol might specify a particular occupational group as taking lead responsibility for an action, but this would only need considering in regulatory terms if there is contravention of a statute. Table 3.5 summarises the different aspects of the 'what, how and who?' questions that need considering for purposes of regulation and educational planning.

Table 3.5: Factors affecting regulated professions

	POLICY	**PRACTICE**	**GOVERNANCE**
What needs to be done?	***Facts and Values*** Ideology and intention; Underlying purpose General knowledge base	***Actions*** Scope and purpose ***Practitioner:*** preferred approaches; skills needed	***Appraisal mechanisms*** Clinical effectiveness Evaluation frameworks and approaches
How should it be done?	***Funding mechanisms*** Priorities according to scope and purpose of agency	***Organisation:*** Constraints/drivers; Preferred approaches to delivery	***Risk management*** Individual and organisational accountability
Who should do it?	***Agency responsible:*** Lead agency? Sole agency? Shared responsibility?	***Specific Occupation?*** Specific skills required? Specified occupational group or profession?	***Vulnerable public:*** Regulatory requirements or not?

3.5 Present and future roles

Whilst it remains difficult to predict exact trends for the future, mapping '*what needs to be done?'*, *'how should it be done?'* and *'who should do it?'* will illustrate a selection of roles that are likely to endure beyond the beginning years of the twenty first century. It helps to illustrate areas of potential overlapping between the different possibilities and aspects of practice that might – usefully or not – be shared, delegated or left to others to fulfil. The impetus for each of the three roles unpacked for the purposes of this project come from a different source, and the potential threats or support vary accordingly. The first (see Table 3.6) 'general family support,' shows a clear convergence between the policy agenda (Home Office 1998, DfEE 1998), the principles and familiar purpose of health visiting (CETHV 1977, Twinn and Cowley 1992). There is good evidence that structured home visiting programmes, early interventions and open-ended emotional and social support for families (especially mothers and babies) are effective in addressing inequalities in health (Acheson 1998, Robinson 1999).

Table 3.6: GENERAL FAMILY SUPPORT			
	POLICY	**PRACTICE**	**GOVERNANCE**
WHAT: General family support	***Facts and Values*** 1. Families are fabric of society; building blocks of civic community and social inclusion 2. Inequalities in health (physical and mental) known to stem from pregnancy, infancy 3. *So*: family support is a public health imperative	***Actions*** - universal family support (emotional, practical) and primary prevention: home visiting + groups - additional outreach in deprived areas and to vulnerable populations: specific projects. - early interventions for identified problems	***Appraisal mechanisms*** Goal directed evaluation: performance monitoring. User involvement and acceptability. Long and short term outcome measures. Interventions + home visiting programmes = clinical effectiveness criteria apply.
HOW should family support happen?	***Funding mechanisms*** Family support is viewed as a public responsibility, but no NHS funding. Potentially can be combined with case-finding and child health promotion protocols followed by HVs in most areas, especially where these are not restricted.	***Organisation:*** 'Core' health visiting service variable across UK – very restricted in some places (e.g., one assessment visit/contact per family unless specific need identified) Home visits to 'help improve support , advice and information'	***Risk management*** No obligation in law to provide a service for every need, but once a need is identified in the context of an existing service, there is an obligation to respond to it. Needs assessment protocols are invalid but may provide some defence against litigation.
WHO should provide family support?	***Agency responsible:*** Not core NHS business, but some ad hoc funding: e.g. lottery/healthy living centres, health visitor innovation fund, HAZs. Lead agency: LA especially social services + education; also voluntary sector All feed into HImP Expectation of joint children's services plans and shared responsibility.	***Specific Occupation?*** Health visitors specified as family support agent in several documents. Specific skills are required for developing programmes of support, co-ordinating other workers in team (e.g., community mothers, nursery nurses, interpreters), drawing on and integrating public health knowledge base.	***Vulnerable public:*** Volunteers + unregulated workers in the field. Health visitor: accountable for exercising specific health visiting skills in identifying need; taking appropriate preventive actions; for activities delegated to team members. Child protection a specific concern. Regulatory requirements – standards, competence, conduct.

Abbreviations: LA= local authority; HAZ = Health Action Zone; HV = Health Visitor; HImP = Health Improvement Programme

Notwithstanding the conceptual and practical coherence in the proposed activities, there is no mainstream funding to implement what is described as an 'enhanced role for health visitors' (Home Office 1998) as a universal service. Current health visiting budgets are being consistently squeezed and 'family support' is not a core function or priority of the NHS. Against this, there is an expansion of 'ad hoc' funding and various family support projects and initiatives being implemented in the voluntary sector and through local authorities; there is a corresponding expansion in types of workers involved in family support. The two criteria for naming health visiting as the occupation for this role are present: as a professional group, they can lay claim to the range of expert and specific

skills needed for family support, and there is a need to protect the families – who include potentially vulnerable infants and children in need of protection – from inadequate skills and possible misconduct. Table 3.7 shows the second possible role.

Table 3.7: FAMILY CENTRED PUBLIC HEALTH WORK

	POLICY	**PRACTICE**	**GOVERNANCE**
WHAT: family centred public health	***Facts and Values*** 1. Public health involves strategic planning to tailor effective NHS provision to local needs/preferences 2. PHC is the 'front door' of NHS: families access for immediate help and guidance about health 3. *so:* family health care and strategic planning can be combined in PHC	***Actions*** - delivery of child health programmes; individually tailored plans about parenting/ health needs - parenting groups + home visits to help improve support, advice, information - identify health needs and agree local health plans through PCGs etc	***Appraisal mechanisms*** Clinical effectiveness of specific interventions and programmes of care assessed through RCTs & systematic reviews. Performance Assessment Frameworks and indicators to assess worth of the services overall.
HOW should family centred public health happen?	***Funding mechanisms*** No specific NHS funding for family centred public health work. General surveillance of families can provide information of use to PHC-led commissioning and strategic plans. Early interventions may contribute to efficiency savings and HImP.	***Organisation:*** Needs assessment procedures concentrate on identifying 'high risk' or 'high priority' cases. Delegation of activities to 'skillmix' or members of teams to reduce costs. Corporate caseloads or integrated nursing teams in PHC; HVs and SNs as 'leaders of teams'.	***Risk management*** Team leader accountable for delegated activities undertaken by other staff: nurses, nursery nurses, community mothers etc. Emphasis on profiling, public health, delegation may distract from skills required for 'face to face' prevention with individuals and groups.
WHO should provide **family centred public health?**	***Agency responsible:*** Shifting focus of NHS commissioning agenda – from HA lead to PHC lead. Statutory requirements for collaborative working and movement towards unified budgets across health and social care Well families/child support – social service lead.	***Specific Occupation?*** Health visitors named in strategy document in England; all community nurses contribute to primary care led commissioning agenda. Need for specific knowledge and skills about child health and family well-being in preventive health care.	***Vulnerable public:*** Health visitor: accountable for delegated duties carried out by junior team members. Practice skills of health visitor differ from that of a nurse, but all CHCNs now trained to assess local health needs. Regulatory requirements – standards, competence, conduct of health visitor.

Abbreviations: CHCN = Community Health Care Nurse HA = Health Authority; HV = Health Visitor; PHC = Primary Health Care; PCG = Primary Care Group; RCT = Randomised Controlled Trial; SN = School Nurse

The need to find a way of addressing the policy emphasis upon family support within limited resources, whilst harnessing health visitors' public health skills to the new agenda, may lie behind the vision of the 'family-centred public health worker' set out in the English strategy for nursing, midwifery and health visiting (DH 1999b). There is a clear imperative, shared in Scotland, Northern Ireland and Wales, to involve health

visitors in the development of primary care led commissioning. Since health visitors have the most regular and frequent contact with families and local communities, they are promoted as the workers who can collect 'local intelligence' to inform commissioning plans through PCGs, LHGs or other local strategic planning fora. In this role, nursing teamwork and national health priorities are emphasised above the provision of 'grass roots' health visiting to families, except where high risk and high dependency situations have been assessed. Assessment skills are, therefore, highly emphasised in this role, along with the ability to delegate tasks and manage teams of workers, who are assumed competent to carry out many functions currently undertaken by health visitors. Apart from the family assessment skills, too, any community nurse is believed competent to carry out the public health role. In contrast to the 'general family support' role, therefore, there is clear organisational support for health visitors to share the general workload in primary health care, but there is less clarity (and some potentially quite marked contradictions) about the practical activities involved. Whilst this blurring of roles reduces the imperative to identify a specific occupation for the role, health visitors are singled out in the policy documents, and the need for expert skills in family health and support remains.

Finally, the role of 'community outreach to vulnerable groups' summarised in Table 3.8 again capitalises on known skills and traditions in health visiting (see e.g. Mackereth 1999) and the convergence of these principles with current policy imperatives, particularly those concerned with social exclusion and inequalities in health. The multitude of different approaches to community development and outreach initiatives are hard to evaluate through randomised controlled trial, so they have little currency within the NHS. However, they are well regarded in local authorities and the voluntary sector, are flexible and responsive to immediate needs and can be readily incorporated into Health Improvement Programmes. As with family support, some of the 'ad hoc funding' involves quite substantial sums and large funding agencies, such as Save the Children Fund and European Union regeneration funds; however, much financial support is small, circumscribed and locally generated. Even though most projects are short-term they may (like Health Action Zones) be funded for up to seven years. However, there is never a guarantee of funding, and practitioners need to understand how to identify sources and how to bid for sums. In addition to sound knowledge of the health and social needs of their clients, practitioners working in this diverse field need strongly developed networking skills, an ability to operate outwith standard organisational systems, at the same time as influencing and advocating within them. The sheer diversity of the projects precludes the specification of one occupation, but there are concerns that this work affects some of the most vulnerable population groups who are – by virtue of their particular position – open to possible exploitation and clearly in need of expert skills.

Table 3.8: COMMUNITY OUTREACH/SUPPORT OF VULNERABLE POPULATIONS			
	POLICY	**PRACTICE**	**GOVERNANCE**
WHAT:	***Facts and Values***	***Actions***	***Appraisal mechanisms***

community outreach and support	1) Social exclusion and inequalities in health are key public health and policy priorities 2) Policy commitment to create a fairer society, 'fair access' to health care 3) *so:* need an expert outreach function to target vulnerable and/or socially excluded groups	- community development: local areas, specific groups - drop-in centres: health advice + range of issues (welfare benefits, l legal rights, housing, etc) + dedicated clinics. - home visiting hard-to-reach groups; intensive one to one or group-work; support and enabling	Hard to evaluate, due to: - breadth, diversity and multiplicity of actions - mobility and special features of vulnerable populations. Emphasis on: - impact and access; - performance management - goal-directed evaluations in short term.
HOW should community outreach and support happen?	***Funding mechanisms*** Mainly ad hoc , one-off and occasional; some substantial, ring-fenced sums involved (e.g. for Sure Start, HAZs, drugs initiatives, crime reduction ['on track'] homelessness, domestic violence). Smaller sums for local projects e.g. from HAs, LAs, charities.	***Organisation:*** Local individual variation; Ad hoc projects tailored to specific needs Short term, intensive 'rolling programmes' Change management high on the agenda. Emphasis on facilitation and working through and with others.	***Risk management*** Co-ordinating across wide range of agencies, + workers - voluntary groups etc. reduces managerial control. High level of unpredictability, sensitivity. Likelihood of ethical and legal dilemmas (e.g., in drugs work, domestic violence, asylum seekers).
WHO Should provide community outreach and support?	***Agency responsible:*** Social exclusion policy co-ordinated from Cabinet Office and designated units (e.g., family unit, women's unit) Range of other interested agencies, who may use outreach or special projects as a way to achieve designated responsibilities.	*Specific Occupation?* None specified; several likely occupations. Health visitors have long track record in outreach and community development work. Ability to promote self-empowerment and enable access to a range of services important; need to influence policies affecting health of these groups.	***Vulnerable public:*** High level of vulnerability, yet high numbers of unregulated workers. Accountability circles rarely straightforward where formal + informal services involved together. High degree of skill for co-ordination and networking; able to operate at multiple levels

Abbreviations: HAZ =-Health Action Zone; HA = Health Authority; LA = Local Authority

Thus, each of the three possible roles show some similarities and overlapping in the core skills required, along with some contradictions and potential dilemmas to be faced by the practitioners undertaking them. Indeed, none of the three are straightforward or consistently supported across all three domains of *'what should be done'*, *'how should it be done'* and '*who should do it.'* In two of the three roles, the ability of the professional to operate confidently across organisational boundaries, not only serving as an advocate for individual clients but also influencing policies that affect the health of particular population groups, is essential. Inevitably, such a position is likely to lie outside mainstream funding, particularly from the organisations (like health and social services) likely to be lobbied to change their policies. In these roles, the health visitor may also feel constantly vulnerable, marginal and marginalised herself: only half a 'foot in each camp,' not fully committed to any organisation, but able to understand several different ways of operating; completely dedicated to the cause of public health and promoting it by providing grass roots support for families and vulnerable population groups. If health visitors are allowed to develop these family support, outreach roles, they could

potentially provide a networking opportunity that reaches out across nursing, to the different local authority functions (education, social services, housing) through a range of environmental, voluntary sector and charitable organisations, providing each with a conduit through which a link can be formed with the health service. Alternatively, concentrating on contributing to the new primary care agenda of commissioning health service provision offers a safer option for health visitors as employees and a more conventional role for organisations to put into practice; less flexibility and a limited potential, but more clearly understandable in familiar settings.

Further details about the research, policy documents and rationale for setting out these three proposed roles are included in Appendix 3. Developing new roles for practice is not a primary purpose of the regulatory authority, but it is important that the educational programmes they they approve reflect both realistic and enduring requirements for practice. The three roles outlined here indicate the need for an identifiable core of skills held by health visitors, supposedly guaranteed at a minimum level because it is a regulated profession that allows entry to practitioners only when they have satisfied their peers that they are 'fit for practice' in this field. Most of the population served in these roles would be classified as 'well', or at least as undifferentiated by medical diagnosis, since they will not usually be actively under medical treatment. Nevertheless, given the vulnerability of infants, children, needy families and the very precarious position of some of the population groups involved, the assurance of professional competence, proper conduct and the non-maleficence of a regulated profession will remain as important in future roles as it has been in the past.

3.6 Key points

3.6.1 The changing policy context is important as a backdrop to how health visitors are to be prepared in future. Enduring and changing priorities in policy have implications for health visiting roles, especially in relation to primary health care, public health and family welfare. Professions and the organisations that employ them are also changing. The rise of 'new public management' has influenced expectations about professional autonomy and regulation; accountability issues and risk management are linked through clinical governance and quality agendas.

3.6.2 Questions about what needs to be done, how it should be done and who should do it are reflected in decisions about policy, practice and the governance of regulated professions. There is more specialisation as well as more in common across professions and different agencies, and an increased emphasis on the need for flexibility, inter-professional and inter-agency working.

3.6.3 As with all pre-registration preparation, health visitor education needs to prepare practitioners to be 'fit for practice' within their particular profession. This is not only concerned with the immediate, current expectations of government, but needs to befit practitoners to develop knowledgeably as roles, functions and health needs change throughout their careers, and as new evidence becomes available to inform different approaches to practice. A review of current policy

trends and the available research revealed three potential roles that are likely to be both currently acceptable and able to endure beyond the early years of the twenty-first century. These are general family support, family-centred public health and outreach work to vulnerable populations.

4 CURRENT PREPARATION FOR CONTEMPORARY PRACTICE

4.1 Preparation for practice

The educational process is crucial in determining standards for practice. Regulation of a profession depends upon a due process by which applicants for regiatration can be seen to have been properly prepared according to the statutory requirements, and that they are genuinely 'fit for practice' upon receipt of their award. This assumes their educational programme has enabled students to learn the things the need to know before registration, so they can practice safely as soon they qualify.

One of the final actions undertaken by the CETHV, following the passage of the Nurses, Midwives and Health Visitors Act 1979, was to form a curriculum working group. Bearing in mind that, at that time, the syllabus had been in operation for some 15 years, it seemed fitting to have some up to date information about what skills and abilities would be needed to pass on to the newly formed UKCC. Later in the 1980s, both the HVA and UKSC looked at the educational needs of health visitors, bearing in mind the changed pre-registration syllabus for 'Project 2000' preparation. Collectively, this represented a huge cadre of work showing what would be required when the health visiting curriculum was finally updated. The learning outcomes proposed by these working groups are reproduced in Appendix 4.

The terms of reference for the PREP working group that developed the community health care nursing framework specified that they should look across community nursing and not at health visiting alone, so the deliberations of this single occupational group were not incorporated in the proposals. However, as indicated in the preceding chapters, there have been considerable changes in policy, practice and expectations upon practitioners since the 1965 syllabus was developed, and even over the last ten years or so. To complement the rather abstract and theoretical presentations in the preceding chapters, and the educational views included in the appendices, three different perspectives are outlined below. The first is a practitioner perspective; it is a personal view that draws upon current experience and policy documents. Two further perspectives are considered after that: one explores the needs of children and how they are met, whilst the other offers a strong public health line.

4.1.1 A practitioner view

At present, health visiting is a multi-faceted, complex role but as a job it contains two main aspects. The first is the face-to face, communicating, client-based work, advising, supporting, helping, reassuring, teaching and listening. The second aspect, carried out for the client base, but this time indirectly, involves a different set of skills. These are the public health skills, that involve leading, collaborating, strategic planning, referring, advocacy work, innovating, committee work and population profiling to name only a few aspects. In recent years changes in delivery of health

care have involved bringing in another layer of work, more focused on the process of the job of health visiting, this involves among other things budgeting, resource planning, team management and supervision of skill mix staff. The English policy document, Making a Difference (DH 1999b), in addressing the career structure of nursing, adds to the problematic nature of what it is that we want the health visitor to do, by stressing the importance of multiple aspects of the role:

> . . responsibility and accountability for the assessment of health needs, planning, delivery and evaluation of routine direct care, for both individuals and groups of patients . . .
> Where it is needed, nurses, midwives and health visitors should play their part in helping shift the culture of the teams and organisations in which they work. (DH 1999b: 35, 48)

This may encourage the workforce to feel that they must be operating on many different levels. It is easy then, to lose sight of the main aim of the role. With regard to the training of students, the challenge for the educator has been to successfully merge these different requirements and produce, at the end of the training period, a practitioner who can cope with all of these different aspects incorporated within one challenging role. This also coincides with a reduction in the course length from at least 51 weeks to a minimum of 32 weeks. The government is encouraging all health visitors to develop a family-centred public health role, stressing that health visitors need to work in new ways. However the health visitor's manager may have different needs in meeting those same ideals. The unit costs of 'care packaging' the need to address resource allocation and budgeting alters the focus of each piece of the caring jigsaw puzzle.

Face to Face Skills

What is it that the health visitor does? How are these skills to be gained to enable the newly qualified health visitor to be 'fit for practice'? Some of the work of the health visitor involves.

- Knowledge of nutrition, the health visitor advises on the nutritional needs of the family. Advice is offered on breast-feeding, childhood nutritional intake, food behavioural problems such as faddy eating, food and body image - anorexia, bulimia, women and diet. Many health visitors run groups dealing with diet and nutrition for women. Nutritional advice is offered in home visits, in clinics and in group settings.

- Knowledge of Child Development: e.g. speech and language development. Health visitors assess speech and language as a first step in the referral process and are asked very frequently, by parents about speech development. The unskilled practitioner may refer everything onwards, to the speech and language therapist, but this creates unnecessary parental anxiety and is unhelpful in waiting list management. The skill in this aspect is not just in knowing the difference between what is normal and abnormal but also in knowing what requires to be fast-tracked

for immediate attention. Much work is done by health visitors in relation to children who have special needs. This type of work is a good example of the role of the health visitor as it encompasses both aspects of the role highlighted earlier. The health visitor is the supporter, listener, advisor of the family but is also their advocate, and their referrer on a more strategic level to help the family to access services perhaps not readily available in their own area. The health visitor works on behalf of the family assisting them in their quest to meet the needs of the special child.

Government policy suggests that in their modern role, the health visitor will:

> deliver child health programmes and work in partnership with families to develop and agree tailored health plans to address their parenting and health needs (DH 1999: 61)

- The ability to work in partnership needs highly developed communication skills and the ability to recognise empowering or disempowering approaches

- Knowledge of child and adolescent development. The health visitor is involved in addressing behaviour management, both pre-school and following school entry.

- Knowledge of maternal health, in the post delivery period and in the following months when the physical, mental and social well being of the mother impacts on the family. This is a strong area of primary prevention, within the family, in the work of health visiting.

- Understanding of family dynamics and relationship work. Much health visiting time is spent on family dynamics, in particular, relationship work. This requires a particular skill and the health visitor is often the first point of contact in this respect because of the supportive listening that he/she is able to offer.

- Group work, understanding group dynamics is an essential skill in the armoury of health promotion tools required by the health visitor working in the community.

It is clear that the government want health visitors to,

> run parenting groups and provide home visits to help improve support, advice and information to parents – and especially to vulnerable children and their families – supporting initiatives such as Sure Start (DH 1999b 61)

Proposed extensions to the role conflict with the current picture of community practice where innovation is difficult in the face of cutbacks to service, but families and children continue to be high on the agenda for health visitors.

- Child and family law/Report writing/Record keeping/Accountability Issues. All of these aspects are important to enable the health visitor to work effectively.

Child protection forms an important part of the health visitor's workload. It is expected that health visitors will identify children in need and highlight cases of suspected child abuse. This remains a core responsibility and expectation:

> The midwife and health visitor are uniquely placed to identify risk factors to a child during pregnancy, birth and the child's early care. Health visitors and school nurses monitor child health, growth and physical, emotional and social development. The regular contact health visitors and school nurses have with children and families give them an important role to play in the promotion of children's health and development and the protection of children from significant harm (DH et al 1999: 33)

This excerpt seems to presume that health visitors currently make and maintain contact (albeit, perhaps infrequently) with all families on a designated list or 'caseload' for which they hold responsibility, and that they can somehow meet the conflicting demands on their time.

4.1.2 Children's needs

Early interventions, reaching out to families in their homes and communities, then enabling the development of resources and capacity for health, are increasingly seen as activities that lie outside the health service agenda and are, therefore, being undertaken by a mixed range of interested professionals and volunteers. As suggested in Chapter 3, this raises an interesting regulatory conundrum, since most of these workers are neither registered with the UKCC, nor accountable to any other formal system of regulation.

The testimony of user groups and volunteers in one focus group study was that the voluntary organisations recognised their own limitations in terms of expertise, and clearly wanted professional 'back up' and support (Cowley and Houston 1999). It is possible to envisage a scenario in which a health visitor may be employed by a coalition of small neighbourhood projects to provide such support, which would raise similar regulatory issues to those faced by nurses employed privately by individuals.

Against this diversity, there is a lobby that only practitioners who are qualified children's nurses should be permitted to work with children. The argument that follows from this view suggests that school nursing and health visiting recruits should all be drawn from the ranks of registered children's nurses. This is held to be particularly important now that there is no longer a requirement to learn about children's physical and psychological development in the health visiting course. At present, only 1,690 (6.7% of total) health visitors hold a children's nursing qualification, although there are 35,307 nurses on Parts 8 and 13 of the register (UKCC 1999b). This small percentage may indicate that health visiting is not an appealing profession for nurses who have chosen to care for sick children. Also, despite the apparently high number of children's nurses, there are recurring reports of shortages in this field.

There are, however, a wide range of other occupations informed by child development studies, such as educationalists and early years workers. If they continue to extend their remit to encompass toddler-hood or even infancy, the range of workers involved with children will continue to increase, possibly working within the 'teams' led by health visitors operating as family-centred public health workers. Also, if workers such as nursery nurses and community mothers become established as part of a 'health visiting team,' the lack of a career pathway to 'team leader' (except by first undertaking a lengthy detour into general nursing) will soon start to seem inequitable. Anecdotally, these scenarios are leading to a different lobby, for workers holding academic qualifications in early childhood studies or other similarly compatible courses to be permitted to enter health visitor training, despite not being registered as nurses. The course leader who supplied the curriculum documents for two such programmes reported that on her multi-disciplinary BA Early Childhood Studies, a whole cohort of students taking the 'health' option would like this opportunity , although it had not occurred to them to train as nurses as a career choice.

Under the 'old' health visitor training rules it was possible to argue that health visitors acquired skills and knowledge to work with children during their health visitor training, because of the requirement to learn about children's physical and psychological development. However, whilst this is still a common feature, these are no longer requirements on the health visitor programme, so it is harder to find grounds upon which to counter the argument. Particular concerns have been expressed about the limited amount of time devoted to learning about working in the child protection field, bearing in mind the legislative requirements and level of accountability needed for this very complex role, especially – as the curriculum analysis shows, in comparison with the early childhood studies. Oldman (1999) undertook a survey of health visitor course leaders, who lamented the amount of time and emphasis placed on 'public health' on the new programmes, in comparison with what they perceived as the 'bread and butter' of health visiting work with families.

4.1.3 Public Health

Public health is the second area that has a considerable bearing on health visiting and school nursing. There is an increasingly clear movement to develop public health into a specialist profession, beyond the narrow confines of the medical directors of public health. Of interest to this project, is the group of workers regarded as 'public health practitioners' (see Section 3.3.1) which contains health visitors along with colleague school nurses, occupational health nurses, communicable disease nurses and possibly infection control nurses. Little attention has been paid to identifying what skills and abilities are needed for this 'practitioner' function in general, although an ENB-commissioned research project has been undertaken that suggests a lack of support for the role in practice (Pearson et al in press; executive summary reproduced in Appendix 5 by kind permission of the ENB). Far more attention has been paid to

the ‘public health specialist’ level, that includes a small group of nurses who contribute to purchasing and the strategic function of public health in commissioning authorities.

A feasibility study carried out by Lessof et al (1999) established the case for national standards that would underpin the development of a new, multi-disciplinary profession of public health, envisaging a career pathway through to the ‘top post’ of specialist in public health. Once agreement had been reached about the necessary ‘base line’ learning outcomes required by all public health workers, these could be set at an academic level of Diploma in Higher in Education; these are reproduced in Appendix 6. Practitioners could then complete a degree in the specific public health area of practice, e.g., in environmental health or health promotion, that incorporated the public health standards. Three organisations; the Faculty of Public Health Medicine, Royal Institute of Public Health and Hygiene, and the Multi-disciplinary Public Health Forum have reached a ‘tri-partite agreement’ about which outcomes are required, and this will form the basis of the national register announced last summer (DH 1999a).

The idea is that, if public health practitioners share a base-line education in these common areas of knowledge, they will be far better placed to develop a career as public health specialists in future. Potentially, future public health practitioners will be able to undertake a first degree that encompasses both their own field of practice and the level of public health knowledge required as a basis upon which to build specialist skills; that would be one further step in career development, perhaps undertaken through a Masters in Public Health degree or similar.

However, under their present system, school nurses and health visitors are already on the second step of their career before they become ‘public health practitioners’ at degree level. Confusingly, they are described then as ‘specialists’ in the field of community nursing; colleagues who share the CHCN framework are not considered to be ‘public health practitioners’ although their different contribution to the public health function is well acknowledged (as detailed in section 3.1). Despite being regarded as ‘specialists’ in a different field, health visitors, school nurses and occupational health nurses will still not have reached ‘first base’ in terms of developing a career in public health, unless the CHCN education is modified to ensure it encompasses the learning outcomes agreed by the other public health practitioners. There is no mention of the UKCC or anyone else being involved in discussions to inform the public health basis of health visitor education, but the development needs of health visitors have been flagged up in Regional and country-wide reviews of public health capacity in Scotland and England. A current review of health visiting in Wales is also expected to show a need to develop their public health skills and activities, as well as a need for more management support for the work.

4.2 Investigating the present situation

Given the number of changes in practice, policy and education, and the diverse needs and views highlighted above, a small amount of empirical data was sought to elicit an overview of current educational practice. This focused particularly on discovering perceptions of how the Community Health Care Nursing framework, introduced between 1995 and 1998 (United Kingdom Central Council 1994), was panning out in practice.

Over a period of six weeks a selection of health visitor course leaders were interviewed using a semi-structured format (see Appendix 7), with the aim of gathering information on how courses were presently being run and effects of the move to the new 'specialist practice' framework. The course leaders were contacted purposefully to ensure a good geographical spread across and within the four countries. Most of the interviews were undertaken by telephone, a few through face to face contact and some opportunistically in a group. Course leaders were asked to supply curriculum documents if possible. In addition, curriculum documents were secured from two non-health visiting multi-disciplinary programmes in the same institution, leading to a BA or an MA Early Childhood Studies. The syllabus for the World Health Organisation's recently proposed 'Family Health Nurse' and the syllabus for membership of the Faculty of Public Health Medicine were also scrutinised.

Overall, for this section of the project, data gathered included:

- Formal interviews with course leaders (interviews x 12; focus groups x 1)
- Representation of courses by country at interview (Scotland x 3; Wales x 3; England x 15; Northern Ireland x 1)
- Discussions with health visitor education officers from ENB; NINB; NBS (there was no health visitor education officer in post in the WNB).
- Formal analysis of 46 curriculum documents using SCPR's 'Framework' (Ritchie and Spencer 1994)

The interviews were not tape recorded, but detailed field notes were taken and some illustrative quotes are included in the report. Information obtained from the interviews is collated under headings drawn from the three key aims of the project, with a comment about the source and rationale for the questions where necessary. A survey of 23 institutions (Oldman 1999) delivering health visitor education in England was published just as this project was being completed, and excerpts from that study are incorporated where they differ or support the findings of these interviews.

4.3 Results of the interviews

4.3.1 Implications of the extant legislation for current preparation and regulation.

a) The educational requirements for entry to health visiting specify five school leaving certificates or equivalent to include history, English or Welsh.

The entry requirements are implemented by the majority of institutions. In England all course leaders were aware of this requirement but for some who had not been in post long, this had only been made clear last year when the ENB issued a circular reminding health visitor course leaders of the necessity. A number of course leaders said such entry requirements today were a nonsense and should be revoked especially as many entrants to health visiting were already at degree level.

b) Community specialist practice including health visiting is now at degree level.

Entrants to level three programmes need to be at diploma level before they start. However it became apparent during the interviews that many course leaders were stipulating additional requirements for those wishing to become health visitors. One course leader said they had eight pre-requisite requirements for admission to health visiting ranging from ENB 998 to having already undertaken work in the areas of health promotion, sociology and research. The majority of courses required students to have an understanding of research methods at diploma level and there were a range of other pre-requisites, such as having to read certain publications, having to write an essay or attend other modules run by the education establishment prior to the course. All reported the willingness of the prospective student to undertake the pre-course work. It was also clear that health visiting was continuing to attract very able students with a number of those interviewed commenting on how different they seemed to the other nurses on the community specialist practice course. When this was probed comments were made like:

" they are not frightened of change"
"they have a wider view"
" they are clearly innovators".

The majority of courses interview students jointly with the service manager from the seconding Trust, as the attitude and understanding of the student was seen as especially important in health visiting. However many course leaders were concerned at the expectations placed on the students both prior to entering the course and during it. The course was seen as very full, particularly in the light of the 50% theory/50% practice requirement, and the need for good practical experience. Lack of time for specialist teaching was one of the five main 'negative effects' highlighted in Oldman's survey:

> Respondents recognised that much of the specialist element would now be taught by the CPT, but this was not without problems as it might lead to a lack of equal opportunity among the student groups, particularly where practice is graded (Oldman 1999: 394)

Some centres ran both a degree and a post graduate community specialist programme and these reported that it was predominately the health visitor students who already held degrees. Presumably it would be possible to check this assertion against the database of students indexed on to programmes of study by the National Boards, although the figures were not drawn for this scoping project. Anecdotally it is not uncommon for health visitor students to undertake studies at an academic level already completed (e.g. Graduates completing another degree, or Masters qualified practitioners undertaking a post-graduate diploma). On the other hand, Oldman reported, as a positive effect of the introduction of degree level course, enhanced:

> Critical and analytical abilities, related to the increased academic level (Oldman 1999: 34)

c) The length of the course was reduced when the new programme was introduced

Until the introduction of community specialist programme the specified length for health visitor courses was 51 weeks. Following introduction of the new curriculum, modification was allowed with some courses being reduced to as little as 32 weeks. From the interviews, there would appear to be few of these very short courses around, with the majority being at least 42/46 weeks. At the request of the education consortia and service now, some institutions have reverted to a whole year i.e. 52 weeks. Oldman also noted the recent extension in length in four institutions, since collecting her data, which showed a greater tendency towards the shorter courses. These varied from below the minimum requirement (30 weeks) in one institution, to 47+ weeks as follows:

Table 4.1: Length of courses (England)
(from Oldman 1999)

Length of course in weeks	Number of institutions
30-36	8
37-41	8
42-46	5
47+	2

Those running the courses that had been increased to a calendar year were very positive about the change. Statements were made like:

"it takes the pressure off the student",
"it enables a much longer period of practice at the end and this is positive experience for the student"
"it gives the student time to put the theory into practice and to adjust to a new level of practising"

The specialist practice framework was seen by many as quite restrictive and narrow and a regular comment was that "*health visiting has missed out".*

A number of those interviewed reported that the anxiety levels of the students undertaking health visiting was especially high. Most gave the reason for this as being the very different role students were training to undertake. One commented included:

"Student health visitors are less likely to have had experience in the community prior to coming on the course and they find the work very different. District nurses show anxiety later when they realise they are now in charge and leading the team"
This contrasts with the situation for many other community nurses where, for example, following initial registration and period of working in hospitals, it is possible to obtain practice experience as a staff nurse in a team of district nurses, learning disabilities nurses, mental health nurses or so on. The knowledge development and role extension, therefore, is demonstrable and clearly follows a 'straight line'.

Research about the changing position of nursing following the introduction of Project 2000 confirms that there are very few suitable career opportunities for junior nurses working in health visiting teams (Maben et al 1997). This is not to deny the potential for teamwork in health visiting; however the most successful skillmix schemes (anecdotally, as there is a dearth of research in this area) involve workers who are nursery nurses, community mothers, clerical and administrative assistants, link workers and community workers – not first level qualified nurses, for whom there is no very clear place. Oldman (1999) comments on the 'design flaw' in the curriculum, which is clearly based on an assumption that similar patterns of teamwork exist in health visiting to those that pertain in other nursing fields. Her analysis also revealed the difficulties for students entering a 'new profession' and undertaking a 'high pressure course' as two negative effects of the new programme:

- Heath visiting students are entering a new profession as they commence the course. This was a different situation in comparison to the other community specialisms where students had usually been working in the specialist area as staff nurses . . . .
- The health visitor students were considered to be under more pressure than peers on other community pathways because of the amount of new material they were covering in comparison to them (Oldman 1999: 394)

The 1997 Review of the Act (JM Consulting Ltd 1998) and 'fitness for practice' report (UKCC 1999a) both refer to Virginia Henderson's famous definition of nursing, noting:

There seems to be a general agreement that Henderson's (1961) definition of nursing has not been bettered:
'The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or recovery that he would perform unaided if he had the necessary strength, will or knowledge and to do this in a way as to help him regain independence as soon as possible' (UKCC 1999a: 15)

This illustrates the different mindset needed for the open, preventive activities of health visiting, that are not focused on the 'doing for' aspects of nursing signified by the idea of 'giving assistance.' Health visiting is not primarily directed at 'individuals' nor, indeed, necessarily to people who are 'dependent' at a time of coming to the notice of the health visitor. These differences create a particular challenge for students and course leaders, highlighted in the interviews carried out for this project:

"*Health visiting is a different role and it is generally something a student has not done before"*
"Health visiting requires new attitudes, a new approach and a great deal more new knowledge than the other community specialities"

In England, the community health care nursing course with core and specialist modules has been operating for up to four years and course leaders have had the opportunity to adapt and develop their courses to overcome initial difficulties. It was clear that much change had been made and that developments such as lengthening the course were being made as a result of evaluation. In Wales, community specialist practice courses at degree level have only been running for two years and are in an earlier stage of development. There, some course leaders seemed to be still adjusting to the changes and, like their colleagues in England, needing to assert the difference in health visiting. In Northern Ireland there is only one course for community specialist practice, which appears well settled and developed.

According to most of the interviewed course leaders, after reductions in the mid-1990s, the number of student health visitors being trained each year had stabilised and were now fairly constant. The numbers for some courses had increased but this was generally due to a closure of another course and a reallocation of students by educational consortia. Most health visitor students attend full-time, with just a few part-time. In Scotland, this was reversed with the majority studying part-time or on distance learning courses over a period of 3 to 4 years. Oldman's survey noted, as one of the positive effects of the new framework:

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Student-focused learning, where student's prior learning is valued
and there are greater opportunities for part-time modes of study
(Oldman 1999:  394)
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Only one course leader said their course was linked to the ENB 'higher award'. This Institution ran one of the shortest HV courses of just 32 weeks and although the course leader said she had initially been opposed to the higher award, she had come to realise that it helped with the leadership development of students. However she repeated several times that it added stress to the student's year. A number of other course leaders said they had considered the higher award but then rejected it. Oldman highlighted that one of the positive effects of the new programme in general was

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Leadership skills, fostered through the inclusion of management modules
in the curriculum (Oldman 1999:  394)
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4.3.2 Suitability of the current framework as a preparation for contemporary practice

a. All course leaders were asked whether they felt their course prepared students effectively and whether, therefore, the students could be considered to be "fit for practice" on qualifying.

As would be expected, the majority answered an initial YES to this question obviously not wishing to see their course as failing. However when the area was probed it was clear that this was only achieved through immense effort by themselves and by the CPT/practice educator. Again, Oldman's survey focused on a similar area, noting the negative effects of the new programme on CPTs:

> CPTs were considered to need more preparation for the new curriculum, especially where they were responsible for grading practice (Oldman 1999: 394)

A number of those interviewed were clear that a period of good preceptorship was required on entering practice and that newly qualified HVs continued to need a great deal of support. This is not necessarily available, as highlighted in a national study of needs assessment by district nurses and health visitors which made the following comment and recommendation:

> Specialist community health care nurses are required to accept a high level of professional responsibility for influencing factors which have an impact on their practice, as well as for continuing to develop their own knowledge base in relation to new developments. The availability of post-qualifying support and preceptorship periods appeared very variable, so the student must have developed this capacity prior to completion of their courses. Particular attention is needed to the transition from student to qualified specialist, and to ensuring that practitioners are able to work independently by the time they qualify. (Bergen et al 1996)

That study, completed in 1995 just before the new curriculum was implemented, also highlighted the central importance of the community practice teacher, and recommended that preparation for the role should be upgraded. In this project, it seemed that the content of the courses was extremely variable and it was difficult to glean from the telephone interviews what was actually happening. However, a number of course documents were obtained and these were analysed to shed some light on programme content; this is reported in section 4.4 below.

b Learning outcomes for community specialist practice are very broad; all those interviewed felt that they were able to adapt them to meet the needs of specific community students.

The learning outcomes were regarded as very 'nursing orientated,' and not always reflecting the different nature of health visiting, as discussed above; this meant that adaptation to the outcomes were almost always needed. The views expressed here generally reflected an opinion that health visiting is a separate profession and has a

distinct knowledge base, so the learning outcomes needed to be written in such a way to reflect that separate nature.

Oldman's survey suggested that the focus on public health had created a 'theory-practice gap':

> Respondents identified a gap between the learning outcomes of the curriculum, many of which are focused on public health work, and the reality of practice, where the CPT's work still may be concentrated on the under-fives and their parents. In this context, respondents were referring to public health as any work focusing on the needs of the local population, rather than the GP practice population, including community development and the promotion of health within the population outside under-fives and their parents (Oldman 1999: 394)

This quote highlights the many contradictions in the work and the particular difficulty where roles are conceptualised or described in ways that are contested or unclear and contradictory. In practical terms, it shows very clearly that a profession cannot be developed through education alone, particularly if the curriculum prescribes learning outcomes that relate to a different area of practice or an idealised view of what roles students *might* fulfil, instead of drawing on reality. There was a strong suggestion, echoed in the recent study carried out by Pearson et al (in press; Appendix 5), that practice within the Trusts had not shifted to reflect the expectations of the new government agenda. However, the changing government perspective is clearly aiming to move health visiting practice firmly into the public health/social care arena, albeit in a way that continues to be rooted in family health. It would be easier for health visitor course leaders to develop their programmes within colleges/schools of nursing if this was reflected in the prescribed outcomes and required learning.

Experienced health visitor course leaders tended to automatically develop their programme in terms of prevention and health promotion, basing it on the principles of health visiting. However some of the newer, less experienced health visitor course leaders expressed difficulties particularly when there was pressure from other nursing colleagues to develop the curriculum in a particular way. One fairly new course leader was unaware of the health visitor training rules and did not know what a statutory instrument was.

The background and past experience of the health visiting/specialist module course leader appeared to be influential in how they saw the development of community specialist courses. Those who had previously taught in a school of nursing, perhaps beginning by teaching community subjects on pre-registration courses were more comfortable with the nursing ethos and said things like:

"*it is a good thing to be in a department of nursing - it strengthens health visiting".*

Other course leaders, who had experience of teaching in higher education and the University sector prior to moving into a school of nursing had a very different view.

These all felt that health visiting had lost out by the move and was being forced down a route that felt uncomfortable. One comment, typical of many, was:

"*The culture of nursing is so different. We are losing the special nature of health visiting and it is hard to hang onto".*

Another experienced HV lecturer said of their change:

"*I no longer feel I am able to do the job I was employed to do. We are so busy with pre-registration matters that I do not have time to write or do research. I am no longer doing the job I was employed to do and developing the profession – forget it".*

It was, of course, a constant complaint that the former 51 week course prevented health visiting academics from developing a research agenda, as it created a non-stop teaching agenda. However, the community programmes overall are led by a range of nurses with a variety of qualifications, so health visitor course leaders may no longer have control of the course, despite running their area of specialist practice. This raises questions about the extent to which health visiting educationalists are able to fulfil the requirements of 'professional self-regulation' by providing a peer assessment of the practice of health visiting and the competency of the student.

c Current educational needs for health visiting practice in the light of the Government agenda?

The length of time allowed for the 'specialist component' was variable in each programme, as was the way such practice was integrated into the course as a whole. This inevitably impinged upon and limited the flexibility of the course leaders to adapt to the new agenda. The majority of those interviewed were concerned that there was insufficient time to teach the students adequately about health visiting and indicated that matters like child development and infant feeding were only skimmed; the practice educator was expected to ensure the student was competent in this area. One typical comment was:

"We have to pack in the theoretical content for specialist practice"

Indeed many seemed to be concentrating on the wider implications of practice in college, offering input on public health and community development rather than practice-linked topics like dealing with behaviour problems. Nurse prescribing was seen as an additional burden and for many had meant a further reduction in the time for specialist input. All course leaders were aware of the proposed developments for health visiting practice but it was not clear whether many were changing their input and curriculum to meet this need. The short time available for the health visiting component of the programme was obviously a restricting feature here, with only two or three people being clearly able to explain how they were re-jigging the course input in the light of current policies outlined in Chapter 3. One experienced lecturer said,

" *this year I decided to revisit the 1965 syllabus and see what could be updated from that content. In many ways it is more relevant to the emerging health visitor role than the community specialist practice curriculum".*

The exploration of the community specialist practice curriculum and the core and specialist modules with course leaders provided some interesting discussions. A number suggested that the present curriculum is not meeting the need of a 'modern and dependable NHS' (DH 1997) as envisaged by the present government. This seemed to apply across the range of specialities; a number of interviewees cited colleagues who were dissatisfied with the course content in the light of changes to the role and functions of all community nurses. Recruitment was not a difficulty for the health visiting courses, but the number of centres able to run a school nursing specialist module was low, because the course was not viable or was running for just one or two students. One health visiting course leader who believed public health should be integral to the whole of community specialist practice, said that for the last 3 years, some practice nurses students had requested to change to health visiting as they saw their present course as too narrow, after learning about public health.

Although they look to ensure that the course content will meet the needs of practice at validation, the National Boards no longer stipulate actual content. It is therefore left up to the institution to ensure the students are adequately prepared and ensure they respond to the developing agenda. In the future in health visiting they will be especially looking for a public health focus.

d The move of health visitor education into schools/colleges of nursing.

In many course leaders' eyes, moving into a school of nursing, which occurred for many as nurse education moved into the university sector, had a detrimental effect on the education provided to health visitor students. For those who had made the move recently, such perceptions were doubtless clouded by the anxiety and stress of change. However, they cited a number of specific problems, as well as feeling that the overwhelming number of their new colleagues, who had no experience of primary care and of health promotion, lacked any real understanding about preventive activities and the role of the health visitor. Many health visiting course leaders felt they had been given a very tough time by their nursing colleagues, as the latter attempted to make health visitor teaching sit within a teaching framework that they felt was unsuitable and to drop input like health profiling or public health. This is directly linked with different priorities in teaching, since (again) matters of practice which are central to health visiting are not necessarily those that are central to nursing practice with ill patients. Some of the more experienced health visiting lecturers were now able to report that since the Government agenda had moved back to public health and a more preventive attitude, life was getting easier again.

However there was a widely held feeling that the influence of nursing and the pressure to teach on pre-registration courses was detracting from health visiting and preventing them developing the profession of health visiting. It was rare for a health visiting specialist course leader to be involved only in health visitor teaching and post registration

education; the majority had a range of other responsibilities such as admissions tutor, module leader for a pre-registration module as well as leading and developing masters courses in related areas. Those course leaders still based in Departments of Sociology or Social Work etc. were a great deal more positive and it was clear their course benefited from being able to collaborate with different disciplines. They made comments like:

"*we are well integrated into the University framework and are valued".*

Others who had been well integrated previously into a University structure and had moved to a school of nursing were clear of how their value had diminished. The leader of one course, who was now within a School of Nursing and Midwifery said:

"We were one of the original health visitor courses established in the higher education sector and were highly respected and valued. This is no longer the case and I have been asked does (…University) still teach health visiting?"

Course leaders operating outwith schools of nursing were still able to offer their students an opportunity to mix with social workers, GP trainees and so on, and to provide some multidisciplinary teaching. For student health visitors being taught on community specialist courses in schools/colleges of nursing, this appeared impossible as either it was not seen as relevant or logistically (because of numbers, time and so on) it was not possible. Interestingly, some course leaders viewed 'multi-disciplinary learning' as being only within and across nursing and were quite surprised at being asked about a wider agenda. This was reflected in Oldman's survey, where a positive effect of the new framework was said to be:

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Shared learning, leading to an increased understanding of other
community nurse roles.  (Oldman 1999:  394)
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Such a limited view of multi-disciplinary work does not reflect the wider perspective of the emerging Government agenda.

e None of those interviewed reported difficulty in recruiting to health visitor courses.

All said there were many suitable applicants; the biggest problem was gaining secondment and in England the stipulation by the Department of Health that health visiting students should be on E grade. This was felt to disadvantage some senior nurse applicants. It appeared that education consortia were only just beginning to address workforce issues in primary care and that this was an underdeveloped area.

In the past, it was a stipulation of the CETHV and then UKCC and the Boards that those running courses of education for health visitors should be experienced in the area of practice and hold a teaching qualification that was recorded with the UKCC in the area they were teaching, that is, health visiting. This requirement is no longer upheld and providing the institution running the courses can show that those involved with the specialist practice element of the course are experienced in the discipline, then the course

may be approved. There seemed to be very few courses where the course leader for health visiting specialist practice did not hold a recorded health visitor teacher qualification. There were 285 Lecturers in Health Visiting whose qualification was recorded with the UKCC in March 1999 (UKCC 1999b). A number stated that they had converted from RNT to a HV tutor and two were in the process of doing so. Again, the less experienced course leaders were unaware of the past requirement, and there were only four new entries for this qualification in the year 1998/1999 (UKCC 1999b).

Again, this change may signify a possible reduction in the ability of the profession to exercise 'self-regulation' of health visiting by health visitors, through the processes of education and professional preparation. However, at present, the majority of those identified as course leaders for health visiting held a teaching qualification or were studying for one. Of those without, all were very knowledgeable health visitors who were well able to articulate the role and function and obviously experienced in teaching and presenting. The role of the CPT/practice educator was also viewed as crucial to the adequate development and preparation of students, a finding that accords with an ENB commissioned study that recommended, among other things, a strengthening of the role (Bergen et al 1996). Most courses did use CPTs, but a number of course leaders were concerned that the National Boards and the UKCC no longer stipulated that they were essential.

A number of course leaders said that they had spent much time in the last few years developing the CPTs and their ability to teach in practice and assess students. There has been a change, in that formerly the student moved from the CPT who supervised their initial taught practice to an assessor for a period of supervised practice. Now, on most courses the student remains with the same CPT throughout the programme, and there has been a need to ensure the CPT 'lets go' and enables the student to move on as they develop just prior to completion. There was not an overall expectation that CPTs would have a degree. However, a number of course leaders said they expected it, or for CPTs to be working toward a degree; others said they had laid down a time limit or used other approaches to try and ensure the CPTs practice was sound and developing.

4.3.3. The educational and regulatory interface with other disciplines, agencies and countries

Apart from the interface with nursing, the interviews shed little light on this aspect of the scoping project; in itself this is an indicator of the insulated 'single discipline' position of most schools of nursing. At present a 'health visiting and school health services review' is being carried out in Wales. Such reviews have not taken place in the other three countries although many Trusts and health authorities have undertaken reviews, often for financial purposes and to look at cutbacks. Some of these were undertaken prior to the proposed changes in the health visiting role and so will need to be re-considered. In

Scotland and England, most energy has been directed at developing the public health function, rather than considering the position of health visiting or school nursing alone. To augment the interviews, the course leaders were asked to supply copies of curriculum documentation where available.

4.4. The curriculum documents

4.4.1 Documentary analysis

Documents can serve as a major source of data, although the documents themselves need considerable preparation to elicit their meaning and function. There are many possible sources of bias; those supplying the documents may censor unflattering material or select elements that show a particular viewpoint. The documents may be incomplete because some parts have been lost, and they do not, in themselves, demonstrate that which they record. That is to say, although curriculum documents set out clear intentions about what teaching and learning should occur and when, there is no guarantee that this is what actually happens. Notwithstanding these drawbacks, the curriculum documents were subject to a detailed analysis, as they show something of the diversity of thinking, planning and intentions driving the teaching within current community healthcare nursing programmes, and the way the course teams have grappled with the need to apply the new requirements in practice.

The analysis involved curriculum documentation from 16 educational establishments that offer preparation for entry to the health visiting register across the United Kingdom, and one offering multi-disciplinary Early Childhood Studies degrees (BA and MA), with no attached professional qualifications. The syllabus for membership of the Faculty of Public Health Medicine, open to non-medical applicants since the 'tri-partite agreement' on standards needed for the multi-disciplinary public health profession, was also examined, as was the curriculum for the new 'Family Health Nurse' promoted by the World Health Organisation.

Each document went through a process of selection and then of interpretation. A content analysis which involves the systematic and objective identification, linking and counting of specified characteristics was carried out. The Social and Community Planning Research (SCPR) 'Framework' approach to qualitative analysis was used to collate the data (Ritchie and Spencer 1994). This method is an analytical approach developed in the context of conducting applied qualitative research in a specialist social policy unit. In common with other qualitative methods 'Framework' develops themes and categories from the data. Unique to this method is the systematic method of mapping and charting used to display the process as analytical typologies are developed. The method of charting provided a useful comparative tool in analysis of the very different curriculum documents.

Curriculum documents were requested from all regions of the United Kingdom. Subsequently 46 documents from the different educational institutions and programmes were analysed. Most provided a complete picture of the courses offered; a few provided student and fieldwork handbooks only. Each institution was allocated to an identifying code letter, which is used in describing the results of the analysis.

4.4.2 Analysis of the curriculum documents

The validation procedure operated by the National Boards is intended to ensure that the programmes incorporate sufficient content and experience to enable students to meet the required learning outcomes and to meet the statutory requirements for students to be safely registered as health visitors. However, the documentary analysis revealed a marked lack of uniformity of course titles and course content, as shown in Table 4.1, which collates the information drawn from the health visiting programmes. The English nursing strategy document states firmly that:

> The NHS needs to know that health visitors are trained to broadly the same standards and have the same skills – wherever they are trained (DH 1999b: 27)

The documentary analysis shows that currently this is not the case. Differences existed in the length of the courses, and also in the modules offered to the student. Some courses offered more specialist modules than others and the core elements were also interpreted differently. The documents did not clarify the exact length of the whole programme. Much of the information was given in hours or weeks according to modules; this is collated in the analytic table included as Appendix 8.

Table 4.2 shows whether or not a Community Practice Teacher (CPT) was used on the course, although the way these educators were used differed from one institution to another . In one instance, (C), the student was overseen by a 'Supervisor'. In others the practice teacher could be an experienced colleague who had undergone a short supervisory course. It was not clear from the documents what support academically was offered to CPT/Supervisors in the undertaking of their role, although this was discussed in the interviews; some Colleges described considerable efforts to provide support. It was also unclear from the documentation the differences in qualification between supervisor and CPT and between CPT and Practice Teacher.

Table 4.2: LENGTH OF COURSES/LEARNING TIME			
	COURSE TITLE	**WEEKS/HOURS**	**Teachers**
A	BSc (Hons) in Applied Community Health Studies (Health Visiting)	38 weeks, full-time 600 hours theory; 600 hours practice 45 hours access to practice 2 'extra practice' weeks 8 practice related modules 6 weeks continuous supervised practice at the end of the academic year	CPT
B	B.Sc. (Hons) Public Health Nursing - Health Visiting	50% theory, 50% practice 16 weeks work based learning 6 modules	CPT
C	BA in Community Health Nursing - Specialist Programme Health Visiting	8 modules 50% theory, 50% practice Course lasting one academic year	**Supervisor**
D	B.Sc. in Community Health Care Studies: E.N.B. Specialist Practitioner Award In Health Visiting, Public Health Nursing/E.N.B. Higher Award	7 units	
E	BA (Hons) Community Health Care Nursing, Public Health Nursing - Health Visiting	Courses last 32 weeks plus 9 weeks consolidated practice 6 modules	CPT
F	B.Sc. (Hons) in Specialist Practice, Public Health Nursing/Health Visiting	8 modules	CPT
G	B.Sc. (Hons) Community Health (Specialist Practitioner)	120 days 7 modules	**Practitioner Teacher**
H	B.Sc. Community Nursing	5 modules	**Practitioner Teacher**
I	B.Sc. (Hons) Community Health Care Studies	7 units Specialist HV group tutorials "Experienced practitioners" … will be "responsible for teaching/mentoring students." "In the long term Practice Teachers, for all the disciplines, will be expected to complete the multi-disciplinary practice teacher or lecturer/practitioner course."	CPT
J	B.Sc./B.Sc. (Hons) Specialist Practice Community Health Care	6 modules - triple module of 45 credits in Public Health Nursing/Health Visiting	CPT
K	BA (Hons) Degree in Community Health Studies	50% theory, 50% practice "Following recommendations by the UKCC the course is now shorter." 9 modules offering 95 hours for specialist practice health visiting.	CPT
L	B.Sc. (Hons) Specialist Nursing Practice Community	8 modules	
M	B.Sc. (Hons) Degree in Community Nursing	42 weeks 50% theory, 50% practice 5 modules plus 2 specific modules for public health nursing/health visiting	CPT
N	Principles and Practice in Community Health Care Nursing	? 4 modules	CPT
P	Postgraduate Diploma in Community Health Care Nursing: Public Health Nursing: Health Visiting		CPT
Q	Postgraduate Diploma in Specialist Practice, Public Health Nursing: Health Visiting		CPT

Again, it is suggested that:

> It is important that, as with medical education, nurses are taught by those with practical and recent experience of nursing. To achieve this we will be setting clear targets for boosting teacher support for students on placements…we are also determined to enhance the status of those who provide practice-based teaching (DH 1999b: 27)

This may be taken to imply that health visitors, too, require suitable role models for practice; this is certainly an important part of 'peer self-regulation' of the preparation. Under the former regulations, each student was allocated to a community practice teacher (CPT) who had recorded a qualification with the UKCC signifying that she had completed a two year, part time teaching course. The CPT worked with a single student during the taught practice of 'Part one' which was the first 40 weeks of the one year programme. Part two of the programme was the 'supervised practice' period of at least 11 weeks, which could be overseen by a supervisor who was an experienced health visitor who had completed the supervisors induction course of two weeks. The former supervisors' courses were phased out in the mid-1980s, with a view to all supervision being undertaken by fully qualified CPTs, although existing supervisors continued to practice.

Not all academic institutions mentioned the UKCC Standards as a basis for their programmes. One course appeared to be based on internal standards only (D). Some produced courses to UKCC 1994/95 standards (E, J, M). Some courses completely integrated materials to meet 1998 standards specifying the exact standard achieved in learning outcomes (A, F, K) (see Appendix 4). The remainder of the courses based their materials on 1998 UKCC Standards. Table 4.2 gives the module titles for all the programmes. Learning outcomes specified by the UKCC (1998) are reproduced in Appendix 1.

There was an attempt made by all institutions to cover major topics such as health promotion, child protection, social policy, public health, research based practice, but it was not possible from the documentation alone to decipher how much time is given in theory and practice to many of the elements. Some important topics fail to appear in many of the curriculum documents, as shown in Table 4.3. The principles of health visiting were not apparent in a number of programmes. Similarly, group work was absent from most of the courses, as was nutrition. Management and leadership appear in almost all the documents analysed. Some establishments chose to offer a complete module on assessing need, whilst others incorporated it as a large feature of another module. Innovations in practice and specialist practice are offered by some programmes as separate modules, incorporated in a small way in another module in others, or as a topic for the CPT to cover in others. Examples included: the student must demonstrate that they have:

TABLE 4.3 STRUCTURE OF HEALTH VISTING PROGRAMMES	
A **Modules:** **(CPT)**	**BSc Hons in Applied Community and Health Studies (Health Visiting)** • Assessing Need • Collaborative Practice • Advancing Practice • Social Science • Health Promotion • Innovations in Practice
B **Modules:** **(CPT)**	**BSc Hons Public Health Nursing – Health Visiting** • Restructuring of Welfare Hospital Community Health Care in Contemporary Britain • Ethics Law and Professional Issues • Management and Quality Assurance • Health Needs(Health Needs Assessment and Evidence Based Care • Principles of Public Health Nursing – Health Visiting • Specialist Practice – Public Health Nursing – Health Visiting
C **Modules:** **(Supervisors)**	**BA in Community Health Nursing Specialist Programme Health Visiting** 4 Principles and Practice of Health Visiting 5 Health Promotion and Public Health 6 Nurse Prescribing 7 Family Health and Child Protection 8 Supervision and Teaching 9 Management and Leadership 10 Research Based Practice 11 Quality and Audit 4 Specialist Themes 1. Analysis of Practice 2 Specialist Issues 3. Managing and Promoting Professional Practice 4. Quality Through Research & Audit
D **Modules:** **(?CPT)**	**BSc Community Health Care Studies ENB Specialist Practitioner Award in Health Visiting Public Health Nursing/ENB Higher Award** • Health Needs Analysis • Care Management in Health Visiting Public Health Nursing • Social and Political Issues in Community Health Care • Methods of Enquiry into Professional Practice • Professional Issues • Clinical Practice Leadership in Health Visiting/Public Health Nursing • Reflective Practice
E **Modules:** **(CPT)**	**BA (Hons) Community Health Care Nursing Public Health Nursing: Health Visiting** • Process in Practice • Reflection and Innovation • Specialist Unit (Framework for Health Visiting) • Management and Professional Leadership • Specialist Unit (Family Health Maintenance and Child Protection • Public Health and Health Promotion
F **Modules:** **(CPT)**	**BSc (Hons) in Specialist Practice (Public Health Nursing –Health Visiting)** • Contemporary Issues in Public Health – Health Visiting • The Promotion and Protection of Child/Adolescent Health • Outreach in Public Health/Health Visiting • Social policy and Politics of Illness and Health Care • Promoting Community Health • Managing Collaborative Care • Research Project • Integrated Practice
G **Modules:** **(CPT)**	**BSc Community Nursing** • Management of Specialist Practice/Health Visiting • Community Health Nursing • Research in Community Health • Experience in Community Specialist Practice • Towards Autonomous Practice • Key Principles Theories and Philosophies • Nurse Prescribing
H	**BSc Community Nursing** (minimal data available)

Modules: H cont'd (CPT)	• Contemporary Community Nursing • Research Methods in Health Care • Public Health: Policy Practice • Specialist Practice Module • Research project in health care
I **Modules:** **(CPT)**	**BSc (Hons) Community Health Care Studies** • Health Needs Analysis • Care Management (Specialist Route) • Professional Issues • Clinical Practice Leadership (Specialist Route) • Methods of Enquiry into Professional Practice • Socio-political Issues • Reflective Practice Group Tutorials on Health Visiting Issues
J **Modules:** **(CPT)**	**BSc/BSc Hons Specialist Practice in Community Health Care** • Empowerment Policy and Provision • Management of Service Provision • Partnership Enablement and Education • Evidence Based Practice • Research Theory and Practice • Public Health Nursing/Health Visiting
K **Modules:** **(CPT)**	**BA Hons Degree in Community Health Studies** • Law • Ethics • Management in Community Nursing • Social Economic and Political Influences on Health • The Human Lifespan: development, adaptation and change • Research • Education • Reflective Practice • Health Visiting
L **Modules:** **(CPT)**	**BSc (Hons) Specialist Nursing Practice Community** • Core: Professional Leadership Individual and Health Community and Health • Specialist: Principles in Practice Towards Specialist Practice (2 Modules) Assessed Practice (2 Modules)
M **Modules:** **(CPT)**	**BSc (Hons) Degree in Community Nursing** • Community Health Perspectives • Management of Community Nursing • Discipline Specific – Theory and Practice • Consolidated Practice • Health Visiting –Public Health (2 Modules)
N **(CPT)** (minimal data available)	**Principles and Practice in Community Health Care Nursing** • Clinical Care • Management • Professional Issues • Quality Through Communication and Interpersonal Skills
P **Modules:** **(CPT)**	**PGD Community Health Care Nursing: Public Health Nursing: Health Visiting** • Evidence Based Decision Making • Health Care Research • Community Health Care Nursing • Health Visiting
Q **Modules:** **(CPT)**	**PGD in Specialist Practice (Public Health Nursing/Health Visiting)** • Research Methods and Their Application to Nursing • Contemporary Issues in Public Health/Health Visiting • Social Policy of Health and Social Care in the Community • The Promotion and Protection of Child and Adolescent Health

	• Promoting Community Health • Extended Scope of Practice • Managing Collaborative Developments • Outreach in Public Health/Health Visiting • Integrated Practice (Practice-based)

"*Identified and gained access to at least one established support group to consult them about unmet needs*" (Practice Handbook E)
"Show knowledge of Needs Assessment and discuss possible interventions" (Practice Handbook N)

Social science and social psychology, regarded by many as crucial aspects for the job of health visiting, were missing from a number of the courses. There is an introduction to these topics in the common foundation programme (CFP) covered by students who qualified through a 'Project 2000' programme. However, in most instances this is a small part of the programme taught at quite a superficial level; the idea is that the topics are picked up and applied to the particular branch later in the programme. Since health visiting students may enter from any of the branches, there should be no assumption that all entrants have prior knowledge from any of the branch programmes; furthermore, the CFP is soon to be reduced from 18 to 12 months, following the recommendations of the Commission on Nursing and Midwifery Education (UKCC 1999a).

Many courses offered modules with titles such as 'Advancing Practice' or 'Specialist Practice' aimed at dealing with the new issues relevant to practice. Reflective Practice was present in only a few courses as a separate module, but was present in other aspects in other programmes. The same was true for the module 'Partnership and Supporting Families'; this appeared in its own right in two courses (H, J) but also as a topic area within other modules in two other courses (F, Q). In many courses it was difficult to trace as an important subject area. Again, this may be the domain of the CPT within fieldwork teaching; however this was not easy to decipher from the documentary analysis. It was noticeable that the programmes offered different subjects, with little in common between them. The government suggests that,

> Health visitors are leading programmes to develop parenting skills and are working with local people to improve their health (DH 1999b 13)

but the teaching of group-work skills to enable this was not evident in the documents. Almost all courses contained health promotion as a subject area. Again, it was difficult to decipher which aspects fell to the CPT to teach, because so many of the handbooks were written in a particular conceptual style, e.g.

"be aware of the role of the nurse within the family's own home" (Practice Handbook N)
"*recognise the basic tenets of primary health care*" (Practice Handbook N)
"*search out health needs from a defined population"* (Practice Handbook E)
"*Demonstrate and justify the technical capabilities required for public health/health visiting underpinned by a range of theories*" (Practice Handbook F)

With only three exceptions, the curriculum documents had a defined module dealing with Research-Based Practice; this would be a requirement for the academic award of honours degree in most Higher Education Institutions. Important though the research component is, it is possible that the need for time to complete this additional requirement was not fully appreciated when the programme length was reduced.

Some curriculum documents focused on Quality and Audit. Some offered modules on Autonomous Practice (G), Education (K), Quality Assurance (E), Marketing (G), Law, (K) and Information Technology (N). Many courses, but not all, incorporated nurse prescribing; again, it is worth noting that courses change following validation and those programmes that did not include nurse prescribing when first validated should, by now, have incorporated this in their teaching programme.

A variety of learning approaches were described across all curricula, these included lectures, student led seminars, the use of a reflective diary, and experiential learning. One course incorporated Mentoring and Supervision (K) but it was in line with the health visitor as a supervisor of others. Nowhere in the course material were the needs of the health visitor catered for as a new and isolated decision-maker, nor was there any apparent recognition that the health visitor would often be the 'sole professional' involved with a family or client. One of the interviews reported in Chapter 2 highlighted the different level of expertise needed for the solitary nature of the role:

in terms of public safety it is very important because people are working and very autonomously, in very private arenas, in people's homes particularly, are working without direct recourse to colleagues…are making decisions all the time in those situations (CPHVA interviewee)

The government suggest that leadership skills are the answer, indicating that:

we need to develop the leadership skills of nurses, midwives and health visitors. . . and we need to improve the preparation they receive so they can develop the competencies needed in a modern service . . . we expect health visitors to be leaders of teams . (DH 1999b 52 + 60)

However, unless the neophyte health visitors are given the opportunity to first learn the basic skills of their role, they will not be well placed to understand how to delegate and lead teams in a safe or empowering way.

4.4.3 Comparisons with other programmes

To explore how the current health visiting preparation compare with other professions and disciplines, a similar documentary analysis was completed on three other programmes. The 'Early Childhood Studies' curriculum documents demonstrate a focus and clarity of purpose not present in the health visitor documentation, shown in Table 4.4. The two programmes (BB and CC) contain an interesting problem solving or 'how to' approach with topics like, 'Understanding Children's Behavioural Difficulties' and 'Developing Young Children's Language.' Both would be a welcome addition to any health visitor course as they fulfil the demands of the practical needs of the job of health visiting.

TABLE 4.4: COMPARISON WITH OTHER PROGRAMMES	
AA Modules:	**FAMILY HEALTH NURSE WHO - EUROPE** Introductory Module: Concepts Practice and Theory (2 weeks) Provision of Care 1: Working with Families (10 weeks) Decision Making (4 weeks) Information Management (6weeks) Provision of Care 2: The Family Nurse – Working with Communities (10 weeks) Managing Resources (4 weeks) Leadership and Multi-Disciplinary Working (4 weeks)
BB Modules:	**MA EARLY CHILDHOOD STUDIES (POST-GRADUATE DIPLOMA)** **MA SPECIAL NEEDS IN EARLY CHILDHOOD (PGD)** Constructing Childhoods Methods of Enquiry Behaviour 1. Understanding Children's Behavioural Difficulties Behaviour 2. Promoting Positive Behaviour in Young Children Children's Health & Well-being Direct Work with Young Children Special Needs 1: Understanding Children's Diverse Needs Special Needs 2: Early Intervention to Meet Children's Diverse Needs Strategic Management for Early Years Services Preventive Child Protection Towards Quality in Early Years Practice Childhoods in Europe Understanding Reflective Practice
CC Modules: LEVEL 1. (options) LEVEL 2. (options) LEVEL 3. (options)	**BA (HONS) EARLY CHILDHOOD STUDIES & DIP HE** Early Childhood Studies – First Principles Growth and Development in Early Childhood The Science of Infant Health The Child in Society Health in the Early Years Social Policies and Provision for Young Children and their Families Early Years Practice 1. Adult Learning for Early Childhood Professionals Observation and Assessment in the Early Years Child Protection, Welfare and the Law Social Psychology of Children Play Language and Learning in Early Childhood Early Years Practice 2. Child Health Studies Personal and Professional Development for Early Years Practitioners Young Children with Special Needs Research Methods in Social Science IT and the Child Diploma Project in Early Childhood Dissertation Early Childhood Education Multidisciplinary Care of Sick Children in the Community Developing Young Children's Language Child Health in Majority Countries Working with Young Children and their Families Management in Early Years Contexts The Psychological Development of Young Children with Special Needs Critical Perspectives on Childhood Contemporary Issues in Early Childhood IT Applications and Primary Learning

The reference material in both BB and CC was rich and, whilst leaning toward the educational framework, contained material that would, be most useful in health visitor training. For example, the course uses the seminal work of Duck (relationships), Stainton Rogers (child protection) and Dallos (family dynamics and family therapy). These were not present within the documentation of the health visiting courses. In contrast, the curriculum document AA offered a more traditional training process leaning toward the clinical and acute care, despite claiming a public health and community focus. The key components are similar to those of the 'Five Star Doctor or Five Star Nurse' cited in 'Doctors for Health' (WHO 1996). The suggested competencies are, 'Care Provider, Decision-Maker, Communicator, Community Leader, Manager.' The syllabus contains a wide range of topics; again many would not be out of place within health visitor training.

Finally, Table 4.5 shows the syllabus for membership of the Faculty of Public Health Medicine which, predictably, focuses heavily on bio-medical subjects. However, it is important for these topics to be taken into account when planning future educational programmes, or the 'public health credentials' of health visitors will soon be regarded as significantly lacking in relation to their colleagues and for their career development.

TABLE 4.5: DIPLOMA AND PART I MEMBERSHIP OF THE FACULTY OF PUBLIC HEALTH MEDICINE

Part I Epidemiology	Epidemiology of Specific Diseases Measures of Disease Occurrence Design and Interpretation of Epidemiological Studies Epidemiological Approaches to the Assessment of Health Care Needs, Utilisation and Outcomes Genetics Nutrition Environment Communicable Disease Principles and Practice of Health Promotion Screening Legislation Communication
Health Information	Population Sickness and Health Applications
Statistical Methods	Principles Descriptive Statistics Statistical Techniques Design and Interpretation of Studies
Medical Sociology	Concepts of Health and Illness Aetiology of Illness Health Care Deviance
Organisation & Management of Health Care	Understanding Organisations Management and Change Service Planning Evaluation of Health Care Managing People Self Management

4.5 Current health visitor education

An array of loosely gathered empirical data and a small amount of published research have been scoped to provide a snapshot of current education for health visitor students. This exercise claims no research credibility, although interviews continued until the same themes were recurring, which indicates a degree of 'data adequacy'. It was clear from the brief analysis that there were two constants, and much diversity. The first consistent picture from health visitor education is one of concern about the difficulty faced by students and their teachers (in college and in the practice setting) in trying to maintain and ensure that new practitioners are truly 'fit for practice' on qualifying. The level of anxiety appeared to reflect a deep and genuine concern about the difficulties of maintaining professional standards, as well as considering the impact on stressed students. Most of these difficulties appear to stem directly from implementation of a new curriculum that lacks practical and conceptual coherence with health visiting, and that emphasises topics of central importance to clinical nursing at the expense of those needed for health visiting practice. Importantly, most of the programmes were far too short to allow inclusion of all the topics course leaders regarded as important.

Second, whilst some course leaders had managed to retain control over key aspects of the programme, self-regulation of health visiting by professional peers is being seriously hampered by the current arrangements. This appears to have been a deliberate decision reached at the time that the PREP programme was implemented, but it remains seriously at odds with the existing statute that has been re-affirmed. The government's response to the JM Consulting Ltd (1998) recommendation was unequivocal, making quite clear that health visiting is, and is to remain, a separately regulated profession:

> . . . we do not agree with the recommendation that health visitors should cease to have representation on Council. We propose that there should be equal representation of elected nurses, midwives and health visitors from each country. We would emphasise the importance of the Council's responsibility to ensure that its procedures **do not allow any one of these professions to be outvoted by the others on matters of sole concern to that profession.** (NHS Executive 1999: added emphasis)

However, the course leaders interviewed for this project made clear that many of them were outvoted by colleagues on a regular basis when they attempted to ensure that topics of central importance to health visitors were fully represented in the programme. Neither the current regulations, nor the procedures adopted by the National Boards in overseeing the programmes, afforded them any support in their attempts to maintain self-regulation of the profession. The extent of unpleasantness some described was quite worrying, perhaps making it unsurprising that a majority expressed the view that health visiting was diminished, rather than enhanced, by its connection to nursing. However, most wished to be part of a wider scene, pressing for more rather than fewer opportunities for shared learning and collaboration.

Finally, even bearing in mind the limitations of documentary data and incompleteness of the dataset, the diversity of the programmes must give rise to further concern.

Differences appeared in every element – entry requirements, length of programme, course content, practice supervision and learning outcomes. It would be extremely difficult to identify any common themes to unify the practitioners prepared on these programmes, and only a minority appeared able to include all the key aspects of learning that might have been anticipated in any health visiting programme. The extent of reliance of teaching of topics that were new to the students (such as child development, group work skills, child protection, nutrition, family dynamics and so on) within the practice field added to the inconsistency, as did the assumptions about what knowledge, if any, the students could be expected, consistently, to bring with them from first level preparation in any of the nursing fields.

The assumed knowledge of entrants can be expected to be reasonably consistent in community nursing fields like district nursing, community children's nursing or community mental health nursing, for example, because the students will have all completed the same first level registration, either as Project 2000 students or through 'traditional' nurse training in a particular branch. The CHCN framework is, therefore, designed to develop knowledge that is already held by the nurses from their first level registration. However, applying this philosophy to health visitor students creates major problems for the course leaders and their students. The CHCN framework assumes that the basic knowledge required for health visiting is already held by all first level registered nurses, who need only to extend that base to become specialists in 'public health nursing' in order to become 'fit for practice' as health visitors.

However, the course leaders testified that entrants to health visitor training have a great deal more 'new learning' than their peers in other areas of community nursing. The basic knowledge base, philosophy of practice and ways of working are all very different, and their experience is that students are not able to follow the same kind of 'direct development' from any of the branches of nursing into health visiting. The statute and the government's recent statement about health visitor regulation (NHSE 1999) make clear their view that health visiting is distinct from nursing; the education is therefore seen as pre-registration preparation for a new profession.

Indeed, educationally, there do not appear to be any sound reasons why only nurses or, as stated in statute, why only nurses on part 1 of the register should enter health visitor training. A focus on the skills and competences they need to do the job, rather than to enter the training would seem a far safer approach. Furthermore, a focus on outcomes (which could easily include some nursing skills, if it is felt that these are desirable or necessary) instead of entry criteria would allow far greater flexibility, whilst tightening the 'exit point' so as to ensure a consistency that does not appear to exist at present. The current situation neither allows any true flexibility of entry criteria, nor guarantees a similar knowledge base for entrants, since the common foundation programme (CFP) is the only 'assumed knowledge' held by all entrants. There is a proposed reduction in length of CFP and acknowledgement across the pre-registration programme that a shift is needed to more clinical skills (UKCC 1999a); these can be expected to bring a reduction in teaching content about topics of central importance to health visiting, like social

policy, sociology, psychology, nutrition and health promotion. Certainly, there is a need for a far clearer view of exactly what knowledge base is needed for health visiting; a national curriculum development programme would be of great value.

None of the data gathered for this project gives a direct picture of what happens in practice, as an indirect result of the educational programmes followed by health visitors on the new framework. However, it is clear that allowing 'modified courses' to become the norm for health visitor preparation has created an enormous diversity that potentially undermines the process of professional regulation that is, in theory at least, supposed to ensure a minimum standard of competence at the time of qualifying and entering the register.

A far more detailed and rigorous study would be needed to identify the extent to which the preparation is still, as the course leaders insisted in the interviews, preparing practitioners who are safe to practice at the point of entry to the register. Much of their confidence that it was, despite the difficulties, still possible for health visitor students to be prepared to 'do the job' stemmed from a reliance on current practitioners (especially CPTs) and the experience of health visiting lecturers developed at a time when the regulations both required and empowered them to maintain standards in the health visiting profession. Again, given the variation in current practice, this is a source of potential inconsistency that is at odds with an expectation of clear standards signified by a professional register. Chapter 5 considers that existing workforce and some of the accountability dilemmas they face in practice.

4.6 Drawing Conclusions

Given the aims of the scoping project, data were only collected to shed light on preparation of new health visitors. However, three aspects have surfaced repeatedly that should, perhaps, feature in a future investigation:

1 The extent to which the community health care nursing framework is meeting the needs of practitioners from other areas of practice needs considering. There were a number of suggestions that it is unsuitable and problematic for other community qualifications, for a wide variety of reasons.

2 The needs of school nurses were highlighted throughout the interviews. This may be because of former responsibilities of health visitors to cover school health duties, which has led to a natural affinity and frequent responsibility of health visitor lecturers to additionally cover school health issues. However, school health seems to have been marginalised even more thoroughly than health visiting in many areas, both in practice and in education.

3 It is clear that a profession cannot be maintained by pre-registration education alone, particularly when there is conflict, disagreement about course content and a number of barriers to professional self-regulation. Given this situation, and the enormous

amount of change in the health and social policy field at present, there is a real need to consider the continuing educational needs of health visitors and their teachers, and how these needs are met.

This chapter drew a range of empirical data to gain a view about how the current arrangements for health visitor preparation were working in practice. This revealed a very diverse and inconsistent picture, that gives rise to many questions about the suitability of the current framework as a preparation for contemporary practice. There appears to be an over-reliance on the existing workforce for socialising practitioners into particular activities, rather than maintaining professional standards through carefully planned practice components within well designed educational programmes.

The requirement that only nurses registered in part one of the register can enter health visitor training is clearly anachronistic. However, allowing nurses (but not midwives) from any branch of the register to enter leads to a very confusing situation, since only knowledge from the CFP can then be assumed to be 'held in common' by all entrants, and professionals who, some might argue, work more closely with health visitors than almost any others are debarred from registration on Part 11 of the Register. Given the pending reduction in the period of CFP, and the range of other suitable entrants, such as graduates of health or early years studies degrees, of public health programmes and many other possible backgrounds, it seems unnecessary and inflexible to allow only nurses to enter the programme. Also, there is a (now) well-acknowledged shortage of nurses as a potential recruitment ground for health visiting in future, which might make it seem more attractive to re-open a direct entry route into health visitor education in the future. The entry requirements in the extant legislation, therefore, need to be updated to reflect the changing educational, nursing and multi-disciplinary professional situation.

Overall, the legislation appears to have become a matter of peripheral concern in the preparation and regulation of health visitors. This stance is challenged by the government's re-affirmation that health visiting is still to be regarded as a self-regulating profession. Much of the inconsistency in the current programmes seems to stem from the acceptance as a norm of 'modified courses' for current preparation; the lack of peer supervision (e.g. of health visitor education officers at National Board level) or oversight of programmes is another feature. When the existing legislation was first drawn up, 'self-regulation by professional peers' meant ensuring that health visitors developed educational programmes and were responsible for ensuring that appropriate teaching and learning experiences were available to the student. Not only that, but specialist health visitor education officers were responsible for overseeing the validation of programmes, and checking the consistency and appropriateness of course content; health visitor practice teachers oversaw the student's practice experience, controlled standards and a qualified health visitor tutor affirmed the practitioner was suitable for entry to the register. None of those conditions pertain now. This means there is the potential for as much variation in standards of education as there is in practice, and the regulatory process cannot guarantee consistency.

4.7 Key points

4.7.1 The CHCN framework designates health visitors as 'specialist community nurses'. It assumes that all registered nurses hold the same knowledge and skills as health visitors, but at a less advanced level than that required for 'specialist practice'. Conversely the statute has always assumed that the health visiting programme provides nurses with a new knowledge base for a different profession. A number of difficulties appear to stem from implementing this changed philosophy into educational practice.

4.7.2 Information was sought through interviews with course leaders from 22 different institutions across the UK; curriculum documents from 16 of these were analysed. Concern about the new programme was widespread; there was no consistency in terms of entry requirements, course length, content, practice supervision or learning outcomes. Few programmes included teaching about all the significant aspects that would be required for health visiting practice.

4.7.3 The extent of shared learning in the CHCN common core inhibited flexibility and the ability of course leaders to respond to new policy requirements that were central to health visiting but not to nursing. Some course leaders reported hostility from community nursing colleagues, who resisted inclusion of topics relevant to health visiting. This led to problems especially where the programme leader was not a health visitor, since discipline-specific responsibilities in relation to professional self-regulation are no longer clear.

4.7.4 Shared learning and collaboration with nursing colleagues in primary care was welcomed as a beneficial effect of the CHCN framework, but this was often achieved at the expense of wider opportunities for inter-professional education. This was particularly the case where the CHCN framework had integrated the programme into schools of nursing, instead of maintaining former health visiting course links with, for example, departments of social work, social policy, psychology and education. The new national standards for public health practitioners are not represented in the CHCN programme, nor can professionals who have achieved these standards access health visiting courses unless they are registered nurses. Thus, the CHCN framework restricts health visitor education to a primary care nursing agenda, and lacks the flexibility required for current expectations of public health practice, and of inter-agency and inter-professional working.

5 . EMPLOYMENT AND ACCOUNTABILITY

5.1 Maintaining the workforce

Chapter 4 suggested that the maintenance of current standards was heavily dependent on an existing workforce. This chapter considers the extent to which the current educational provision is sufficient to maintain and develop the health visiting workforce to meet the expectations being placed upon the profession. As in nursing, there have been recurring shortages and recruitment crises in health visiting over the years; anecdotally, for example, there appear to be difficulties in recruitment in the outer London Region at present. The number of student health visitors and new entrants to the register has risen slightly in the last few years (Table 5.1), although there are still markedly fewer than ten years ago. Overall, the numbers appear quite similar to those that pertained in 1950, when according to Owen (1977), some 32 courses trained 700 health visitors annually.

Table 5.1: New Entries to Health Visiting Part of the Register (Part 11)

1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
980	1028	909	814	768	640	609	629	738	758

Source: UKCC database

On 31st March 1999, there were 25, 275 Registered Health Visitors; of those 10, 887 were additionally registered only on Part 1 of the register (See Table 5.2), with the rest holding two additional qualifications (UKCC 1999b). There are now 3,600 midwives who are entered only on part 10 of the register who, under current regulations, are debarred from entry to the health visiting part (Part 11) of the register. This seems surprising, given that nearly half current health visitors hold a midwifery qualification, and there seems no reason to suppose that a knowledge of how to nurse adults provides a stronger basis from which to develop health visiting skills. No figures are available to show how the span is changing in the light of the Project 2000 changes, or of how the total numbers of health visitors registered has altered in the last 10 years.

Table 5.2 Additional qualifications held by health visitors March 1999

Parts 1 and 11 RGN& RHV	Parts 1, 10 and 11 RGN, RM, RHV	Parts 1, 8 and 11 RGN, RSCN, RHV	Parts 1, 3 and 11 RGN, RMN, RHV
10,887	10,268	1690	545

Source UKCC 1999b

Five years ago, the Health Visitors' Association (HVA 1994) warned of a future staffing crisis if student numbers were not increased, because of the age profile of the health visiting workforce. By September 1992, some 47% of health visitors in England were over the age of 45 years. Table 5.3 shows that this percentage remains very similar, with a marginal increase in those over 50 years old since 6 years ago. The percentage of health visitors under the age of 35 years has fallen substantially, but there is an increase between the ages of 35 and 45 years. This may be a peak age for recruitment; however, it is still likely that larger numbers of health visitors will choose to retire in the course of the next

decade than will be replaced at present training rates. The Northern Ireland health visiting workforce is markedly younger than elsewhere; in Scotland and Wales similar trends appear, although the breakdown is only available for shorter period of time, so trends are less apparent.

Table 5.3: Health visitors by age: England

	Sept. 1992 *(source 1)*	% of total *(source 1)*	Sept. 1998 *(source 2)*	% of total *(source 2)*
Under 25	30	0.25	40	0.3
25-29	520	4.32	310	2.46
30-34	1,660	13.79	1,250	9.94
35-39	1,860	15.45	2,160	17.18
40-44	2,100	17.44	2,350	18.69
45-49	2,280	18.94	2,200	17.50
50-54	1,880	15.61	2,190	17.42
55-59	1,230	10.22	1,210	9.62
Over 60	340	2.82	370	2.94
unknown	130	1.08	360	2.86
Total (headcount)	12,040	99.92	12,570	98.91

Source 1 = HVA 1994; cited Department of Health non-medical workforce census
Source 2 = Department of Health non-medical workforce census
Notes:
Figures are rounded to nearest ten
Due to rounding, totals may not equal the sum of the component parts

A Regional and nation-wide breakdown of figures showing the changing age profile since 1995 is included in Appendix 9, which also shows ethnicity of health visitors. Black health visitors are, predictably, mainly concentrated in the Thames Regions and West Midlands, but there is a noticeable lack of Asian representation even in those areas of the country (such as West Midlands) where the population profile has a higher number from this ethnic group. No ethnic breakdown was available from Scotland, Wales or Northern Ireland.

A comparatively small number of men work as health visitors in England, with the number probably being affected by the former requirement to hold a midwifery qualification prior to entering training (see Table 5.4). In 1999, there were 319 men registered on Part 11 of the UKCC register (UKCC 1999b), of whom around half worked in England. Only 6 men were health visitors in Wales at September 1998 (3 part time and 3 full time); neither Scotland nor Northern Ireland could supply a breakdown by gender. English figures are not directly comparable at a Regional level before 1995, because of boundary changes and differences in the way they are collated. Comparisons from 1999 onwards will need to take account of Regional reconfigurations in the southern half of England in that year. Also, there are some differences in the way the figures are collated. In England, the figures relate to registered health visitors; in Scotland, Wales and Northern Ireland they are drawn from individuals paid from a

dedicated health visiting budget. This means, for example, triple or double duty workers (district nurse, midwife and health visitor) who are employed in very rural areas of Scotland may not feature in these figures. They could be drawn from the database on request, and for a fee for anyone not employed in the NHS in Scotland.

Table 5.4: Whole time equivalent (WTE) health visitors

Year	WTE **ENGLAND** *source 1*	Female **ENGLAND**	Male **ENGLAND**	WTE **SCOTLAND** *source 1*	WTE **N IRELAND** *source 1*	WTE **WALES**
1988	10,680			1,518	n/a	n/a
1989	10,050			1,560	n/a	n/a
1990	10,480			1,509	324	n/a
1991	10,380			1,546	395	n/a
1992	10,250			1,497	456	n/a
	source 2	*source 2*	*source 2*	*source 3*	*source 4*	*Source5*
1993	10,180	10,100	80	1479	516	n/a
1994	9,680	9,590	90	1443	468	n/a
1995	9,990	9,870	120	1429	456	n/a
1996	10,130	9,980	150	1426	453	625
1997	10,020	9,890	130	1442	439	642
1998	10,070	9,920	150	1459	434	643

Source 1 = HVA 1994; cited PQ 3966/1993/94 written answer 25th May 1994
Notes: the figure for 1989 should be treated with extreme caution, due to serious under-reporting in the South East Thames Region
The figures for Scotland exclude double duty and treble duty nurses.
Source 2 = Department of Health non-medical workforce census
Notes: Figures are rounded to nearest ten
Due to rounding, totals may not equal the sum of the component parts
Figures exclude learners and agency staff
Source 3 = National Manpower Statistics from payroll/ISD Scotland; includes all staff on 'health visiting' payroll.
Source 4 = Human Resource Management System/ Northern Ireland: shows staff in post with a grade title Health Visitor
Source 5 = Health visiting workforce statistics, Wales

The 'headcount' numbers in Table 5.3 show a small rise, signifying an increase in part-time working. This trend is particularly noticeable in Wales as well. The overall whole time equivalent (WTE) staffing level has gone down by some 5.7% in England in the last ten years, as shown in Table 5.4. A similar (5%) fall in G grade staffing levels has been experienced in Scotland, although the overall WTE figure (including lower grade staff who are presumed not to be health visitors, but paid from health visiting budget) has gone down by only 1.3%. There are nearly 16% fewer WTE health visitors in Northern Ireland than in 1993, although there is a rise since 1990, the first available figure.

The staffing crisis predicted by the HVA (1994) may not have materialised to any great extent, because vacancies have been absorbed as 'efficiency savings' and the introduction of skill-mix teams. The overall reduction in WTE health visitors since 1988 would support this view, despite a slight rise in headcount since 1996 in all four sets of figures. However, given these reductions, it seems quite likely that there will be too few health

visitors to adopt the new, enhanced roles described in Chapter 3, adding to the pressure on current and new practitioners. Indeed, the workforce is ageing; it is not expanding to keep up with new needs or replacement of those likely to retire in the next few years. This is an employment issue; employment is not the responsibility of Council, but accountability matters arising from the practice situation may lead to an inquiry into the conduct of an individual practitioner. Some accountability issues are considered next.

5.2 Accountability and regulation

A legal opinion was sought about four different scenarios relevant to current practice. These were all fictitious examples, but they were drawn from contemporary anecdotes about the kinds of dilemmas that practitioners and their managers either face or fear on a daily basis in some parts of the country at the present time. From those issues, recurring themes relating to the preparation and regulation of health visitors become apparent. Some background information to all scenarios was provided first:

'The obligation imposed by statute on the Secretary of State is to provide a comprehensive and integrated health service. There is no statutory requirement to meet every need on demand. Case law indicates that the duty of the Secretary of State is to make a reasonable provision within the resources allocated by Parliament. This duty is effectively delegated to the various health service commissioning bodies. If a particular service is offered, access will be determined by health professionals and clinical judgement. From an accountability point of view the dilemmas appear to be what level of service ought to be provided and to whom. The legal requirement is for those delivering care to meet an acceptable standard. In that context lack of facilities or lack of resources is no defence. In essence therefore, the choice can be expressed in terms of a first rate service for a small number or a thinly spread service for the greater good.' (Andrews 2000; full text in Appendix 2)

Two elements are clear within this introductory statement, that have particular importance for the education and regulation process. First, the significance of professional and clinical judgement places a large onus of responsibility upon the individual practitioner. This links back to the suitability and success of an educational programme in developing this level of ability in the first place. There are at least two research projects that have focused on the importance of developing the capacity of health visitor students for exercising professional judgement in the highly complex and amorphous practice situations within which they operate (Bergen et al 1996, Twinn 1989, 2000). Twinn (2000) showed that a focus on 'learning tasks' or on circumscribed aspects and activities in practice was inadequate for developing this level of professional skill, and Bergen et al (1996) singled out the development of professional judgement as highly significant for practice at the senior level expected of these practitioners.

Professional judgement is also significant in determining what counts as an 'acceptable standard' of care provision, which is the second key issue to arise from this excerpt. This depends, not only upon an individual practitioner determining what kind of practice she or he will offer, but also upon what is considered reasonable by the whole profession. In turn, this requires a body of professional opinion from so that individual actions can be

judged in that context. The professional opinion of another health visitor may be helpful in guiding a colleague in a particular circumstance. Individuals from other fields (say, a manager, a psychologist or a district nurse) might also help a health visitor reach her own conclusion about the standard or type of practice she is providing in a specific situation; this is clearly helpful in clinical supervision, for example. However, a body of professional knowledge as a whole can only come from within the particular profession. Whilst such a body of knowledge could, and probably should, be developed in the context and awareness of inter-professional working, the final conclusions must be reached by professionals from the particular field in question. Similarly, consumer views are of huge importance and must be taken into account, as must scientific knowledge about the effectiveness of particular approaches and the employment context as a whole.

However, it is inappropriate for decisions about what is or is not an 'acceptable standard of health visiting' to be made by a majority group of individuals who are not health visitors, or no longer practising by virtue of their health visiting qualification. This last point is important, since current PREP regulations do not require health visitors to update and maintain their knowledge in their specific practice field to maintain their registration. As the recent guidance from the UKCC explains:

'. . if you are registered as a nurse or health visitor, you need to have completed a minimum of a 100 days (750 hours) of practice, irrespective of the number of registerable qualifications. [during the 5 years prior to renewal of your registration]' (UKCC 2000, leaflet)

Thus, someone who has qualified as a health visitor, yet never practised in the field, or who left health visiting practice many years previously, can maintain current health visitor registration by virtue of having worked as a nurse. This inevitably inhibits the ability of health visiting to develop a body of specific professional knowledge upon which to base decisions about what constitutes an 'acceptable standard' of health visiting practice.

Bearing these background comments in mind, the four scenarios were opened for legal opinion. The first (Scenario 5.1) describes a very limited service, which fails to identify a severe case of post-natal depression. There are a number of areas where health visitors are, likewise, restricted to making a single visit post-natally in order to make plans for any future family support. This kind of limited service may still be presented as a 'universal family support', and even though there would probably be grounds for dissatisfaction on the part of service users, it would not contravene the statutory expectations of a health visiting service. However, it does not make use of the research that shows the effectiveness of structured home visiting approaches, or of methods of detecting post-natal depression, so it may still be open to criticism.

The health visitor, too, would have been open to criticism for not demonstrating the ability to 'search for health needs' (CETHV 1977), working proactively instead of waiting for her client to attend. The proactive, outreach nature of the work is one hallmark of health visiting.

SCENARIO 5.1: WHERE A TRUST OFFER HEALTH VISITING SERVICES ON A STRICTLY

'TARGETED BASIS' TO FAMILIES WITH IDENTIFIED NEEDS OR A SPECIFIED 'HIGH RISK'.

A mother suffers severe post-natal depression that remains undetected and untreated for two years. It comes to light when a solicitor contacts social services, after being asked to advise on divorce proceedings that threaten to leave the mother and child without a home or income because of her alleged 'unreasonable behaviour' since the birth of the baby. The child does not talk yet; he will not leave his mother's side and is showing signs of considerable disturbance.

- The family live in an area of relative affluence; the health visiting service has been reduced so as to concentrate services in more deprived areas covered by the Trust.
- A health visitor visited when the child was 10 days old and invited the mother to bring the child to a baby clinic, which runs locally once a fortnight. Records show one attendance; the mother says she tried to attend once more, only to find no clinic was running that day. She did not try again.
- The (now estranged) husband claims his wife became weepy, constantly complained of feeling that life was not worth living and that she could not cope within weeks of the baby's birth. This was in marked contrast to her behaviour before the birth, but neither parents considered contacting her doctor as they did not think she was ill.
- No formal screening for post-natal depression is available in this area, because it would require more contacts than specified on the minimum core contract and there is insufficient time. The reported symptoms suggest that the problem could have been detected quite readily by use of the Edinburgh Post-natal Depression Scale, which is in widespread use elsewhere.

Is there an accountability problem? If so, who for:

a. the Trust?
b. the commissioners (Health Authority or PCG/T?)
c. the health visitor?
d. *anyone else?*

OPINION

The Trust appears to be offering a health visiting service to the community which it serves. Presumably because of resource constraints it has decided to concentrate services on specific target areas. The merit of this approach that it should enable health visitors to provide an adequate and professional service when they are actively engaged . Such a conscious policy decision does serve to minimise the Trust's exposure to risk; nevertheless it does leave itself vulnerable to the possibility of a claim in the event of missed 'high risk' cases in the more affluent areas of the community.

There is nothing in the background information which indicates any failure by commissioners which would lead to the possibility of challenge.

The health visitor appears to have accepted the mother and child as evidenced by her home visit and the subsequent clinic attendance. There is nothing to indicate that the health visitor either sought to establish reasons for loss of contact or reviewed the case and made a formal decision to discharge the client. Her failure to take positive action for whatever reason leaves her potentially vulnerable.

It is not clear whether the fact that there is no provision for formal screening for post-natal depression is the result of a conscious policy decision or is something which has developed because of limited time available to health professionals. The fact that the Edinburgh Post-natal Depression Scale is in wide-spread use elsewhere may be indicative of best practice but that does not mean that a failure to use it on a routine basis equates with providing a standard of care that falls below an acceptable level.

The second scenario (5.2) illustrates a situation in which the local health services have decided that their resource situation precludes them from offering the kind of health promoting, preventive service traditionally offered by health visitors. Instead, they concentrate on the provision of a' child and family nursing service'. The scenario presumes that former health visitors working for the trust may be employed as 'community nurses' alongside other nurses who have no health visitor qualification, but

who have been offered in-service training for the role. A situation is described in which poor parenting skills in an isolated family go unnoticed until the child starts at school.

SCENARIO 5.2: WHERE A TRUST OFFERS NO HEALTH VISITING SERVICES, ALTHOUGH A 'CHILD AND FAMILY NURSING' SERVICE IS ON OFFER TO MEET CLINICAL NEEDS.

A child suffers avoidable developmental delay because of poor parental skills and lack of appropriate care since birth. The delay is not detected until the child starts school; by then, the cost of sufficient remedial help from health and educational services is considerable and the chance of the child attaining his full potential slight. The parents have become very distressed since realising how far behind his peers their child is; they live in an isolated rural situation and have little reason to meet other parents or children.

- A nurse visited the family once, as required in the Trust protocol, when the child was 12 days old. At that time, no concerns were noted and the parents did not contact the service again.
- The lack of parenting skill was sufficiently obvious that it would have been easily identified by a qualified health visitor providing a 'routine service', so preventive care could have been offered.
- The likelihood of such severe developmental delay would have been greatly reduced by small changes in parenting behaviour and enhanced play opportunities for the child.
- The response of the parents to health visiting intervention (had it been offered) cannot be predicted, but they claim that they would have welcomed some help and advice about caring for their child.

Is there an accountability problem? If so, who for:

a. the Trust?
b. the commissioners (Health Authority or PCG/T?)
c. the nurse?
d. *Is the accountability the same or different if the 'nurse' also held a health visiting qualification, although she is not employed to use it?*

OPINION

The fundamental question here will turn on defining what constitutes 'a child and family nursing service' and what are the identified clinical needs this service is designed to meet. If problems of the kind set out in this case study are specifically targeted by this provision then clearly the Trust has failed in its duty of care. Provided the causative link can be established that it is more likely than not that but for this failure, the child would not have suffered loss or damage, then the Trust does indeed have an accountability problem.

Without a more detailed picture of the overall services commissioned by the Health Authority or PCG/T it is not possible to say whether what has been offered by the Trust would constitute a 'reasonable provision'.

There is nothing to indicate that the action of the nurse was anything but professional. From the facts set out it would appear that to diagnose the deficiency would require both a health visiting qualification and a 'routine service'. This probably means that the problem would not have been apparent in the context of a single visit.

If the nurse also held a health visiting qualification although not employed to use it, an accountability problem would only arise if the lack of parenting skill was such that it could have been identified in the course of a single visit. In that event, she would be required to make a referral to the appropriate agency to deal with the problem.

The nurse who fails to pick up on the poor parenting would not be held liable, as this specific skill is not part of a nursing role. However, even if a health visitor is employed only to carry out nursing duties, that may not constitute a defence for a failure to identify a problem that would have been obvious in a 'routine health visiting' situation. It is clear from the opinion of this scenario that the statutory distinction between a nurse and a health visitor does, in effect, mean that a different set of skills and level of professional judgement is expected from a person holding a health visiting qualification to that expected from a nurse, even one who may have received training for specific activities.

Resourcing difficulties are, of course, the most obvious source of problems in both these scenarios, and in the next. The third scenario (5.3) shows a familiar situation, indicating what can go wrong when a practitioner is 'too busy' to fulfil assigned duties.

SCENARIO 5.3: WHERE SHORTAGE OF STAFF LIMITS THE EXTENT TO WHICH HEALTH VISITORS CAN CARRY OUT THEIR ASSIGNED DUTIES.

Emergency services are called to a flat by neighbours who are concerned that they have not heard the family moving around all day. The mother is found unconscious from what eventually turns out to be a heroin overdose and her three month old child is dead in the bed beside her. The post-mortem shows the child died of suffocation.

a. The family were not known to social services, having just moved into the area.
b. The health visitor had been notified that a single mother with a young baby had transferred onto her caseload five weeks earlier, but the records were not yet available and she had no information to indicate that there was a drugs problem.
c. The health visitor had made one attempt to contact the family within 10 days of their moving into the area, as required by the Trust protocol. There was no reply at the flat and no contact telephone number, so the health visitor had left a card asking the family to contact her at the surgery or clinic.
d. The health visitor then went on holiday for two weeks, leaving a note for the colleague covering her caseload that this family needed a visit; however, the colleague was off sick for the next two weeks and no alternative cover was available.
e. On returning from her holiday, the health visitor was very busy trying to catch up with all the work that had piled up due to the lack of cover. She had not yet found time to try again to contact the family; nor had she notified her manager of her failure to do so.

Is there an accountability problem? If so, who for:
a. the Trust?
b. the commissioners (Health Authority or PCG/T?)
c. the health visitor?
d. *anyone else?*

OPINION

This problem centres solely on the acts and omissions of the health visitors. There is nothing to indicate failure by the commissioners or anyone else.

The health visitor acting in accordance with her employer's instructions attempted to see the family. The family was out and did not make contact with the health visitor. The health visitor's decision to highlight this family as requiring a visit was entirely reasonable and effectively transferred responsibility to her colleague. The fact that her colleague was herself away for the next two weeks is not an adequate defence to a potential claim the Trust failed in its duty of care. It is a management responsibility to oversee the work of its staff and to ensure that priority needs are met.

The health visitor resumed responsibility for her caseload on her return and for perfectly understandable reasons failed to identify that this family had still not been seen. With the benefit of hindsight the serious consequences of her failure are all too apparent. While others in the chain clearly contributed to the eventual outcome, the eventual accountability rests with the health visitor.

In general, inquiries in child deaths caused by neglect or abuse have tended to focus upon social work failings, since social services are the agency with lead responsibility. However, one (the Doreen Aston Inquiry, DH 19991) clearly highlighted the dilemma faced by health visitors working in a situation of severe resource constraints, as they struggle to maintain a preventive outlook and priority in their work, whilst avoiding the kinds of 'worst case scenario' described here.

When faced with the likelihood of missed cases and an inability to provide adequate care for all families accepted onto a 'caseload' by virtue of simply having met a health visitor, possibly in a single contact only, some areas have considered moving away from that kind of 'assigned population' approach altogether. Scenario 5.4 considers possible difficulties that might arise should the standard 'caseload responsibilities' be dropped in order to concentrate on a family-centred role that truly encompasses public health.

SCENARIO 5.4: WHERE HEALTH VISITORS HAVE MOVED COMPLETELY OVER TO A 'FAMILY-CENTRED PUBLIC HEALTH ROLE.' THEY DELIVER THE SERVICE BY LEADING TEAMS DELIVERING A COMMUNITY DEVELOPMENT TYPE OF APPROACH TO FAMILIES ACROSS THE LOCALITY.

Child development checks are generally carried out by general practitioners in this area, although health visitors contribute to the programme if they realise a child has missed a check. Following one such check, a boy of thirty months old who is not yet walking is brought to the doctor by his mother, who cannot speak English; a link worker accompanies them to offer support and her services as an interpreter. Following investigation and referral, a congenital dislocation of the hip is diagnosed and the child requires extensive surgery.

- The family sought asylum in England when the boy was two months old; they are still living in temporary accommodation, having moved seven times since coming to the country. Their refugee status has just been accepted, but they have not yet achieved permanent registration with a GP.
- The family have remained in the same borough and Trust area during that time. They saw a health visitor once on arriving in the country and when the child was 18 months old for a check. At that time, he was standing alone and cruising around the cot where he spent much of the day; his development was otherwise normal.
- The health visitor recorded (in the personal child health record) asking the interpreter who was present to explain motor development to the mother and to ask her to come back for further advice if the boy was not walking by the age of two years.
- The health visitor arranged for a link worker to visit, suggesting the mother and child attend a group at the local community centre so the child could have an opportunity to move around on the floor and play with other children. Although the link worker visited, the family were about to move to another address in a different part of the borough so they did not attend the community centre.
- Information about the need to observe this boy's walking was lodged in the child health computer, but health visitors have no assigned caseloads, so only the parents are responsible for following up the child's progress.

Is there an accountability problem? If so, who for:

a. the Trust?
b. the commissioners (Health Authority or PCG/T?)
c. the health visitor?
d. anyone else?

OPINION

From the information available here, it is not clear whether the provision of GP support to the family has been on a temporary basis or merely an emergency response in the event of need. In the former case it is possible to argue that some responsibility rests with the doctor. If that is not the case it would appear that it is the Trust which has owed the family a duty of care throughout.

The family was known to the Trust and indeed the diagnosis which was made follows a health visitor's intervention because the child had missed a child development check. This would indicate that, although the health visitors have no assigned caseloads the Trust has in place a system which enables it to be alerted when there is a need to deal with specific identified issues. The Trust was aware that there was a need to observe the child's walking but the mechanism to alert staff that no checks were being made appears to have failed or be non-existent. In either event, the Trust's failure to respond to this identified need will leave it open to obvious criticism and the possibility of a successful claim.

Nowhere is known to have adopted this 'no caseload' approach yet; it takes a broader view of what constitutes 'public health' than the mainly commissioning role envisaged in the English nursing strategy document explored in Chapter 3. It is presented as a serious option given the number of places that no longer feel able to provide what appears to be an effective or universal home visiting service, providing for all families with children under five – let alone for the wider age range suggested in the 'enhanced role of the health visitor' (Home Office 1998).

The impact of a reduced service needs to be considered in terms of the sociological critique of potential 'victim blaming' that arises from individually focused health education, and anecdotal reports of a re-emergence of stigma for targeted families when only high risk and established serious cases are offered the service. In such situations, this kind of changed service orientation might be a feasible option. The legal opinion draws attention to the continuing responsibilities held by the Trust, and that the duty of care is likely to revert to GPs if health visiting services are reduced to the point at which caseload responsibility stops being a manageable alternative. It also draws attention to the interconnected nature of accountability, applying this general statement to all the scenarios:

> For the purposes of this exercise, I have concentrated on the individuals or bodies about which questions have been raised. In reality, if an employee's acts or omissions constitute negligence and these occurred in the course of her duty, the principle of vicarious liability will apply and any legal claim will be pursued not against the individual but against the body which controls and directs the service. (Andrews 2000; full text in Appendix 2)

Apart from the resourcing problems, the wider issue of what constitutes an 'acceptable standard' in terms of provision for the assigned population for whom the health visitor has responsibility needs clarifying. The extent to which this responsibility extends beyond that of immediate assessment in a single visit, or for individuals who may not have been seen by the health visitor for a number of years is currently very unclear. There are a host of variations that might, also, have been subject to scrutiny as case studies. Expecting a health visitor to deliver a service both to particular, named individuals and to maintain a public health responsibility for a wider population continues to be a source of confusion in terms of where the main accountability lies. The expectation that some tasks can be delegated to other team members is another source of continued debate, especially when there is no clear agreement about which activities and judgements fall properly within the province of a health visitor and which actually require health visiting skills and qualifications. In concluding a small local evaluation study, Cowley and Houston commented:

> The lack of clear national standards leads to confusion and concern about the accountability of practitioners and managers. The UKCC provide excellent and very clear guidance for nurses, midwives and health visitors, setting out their responsibilities and accountability in practice. However, 'practice' is generally construed as work with individual patients with identified needs, who are in receipt of care from the registered practitioner. There is a need for far greater clarity about the accountability of school nurses and health visitors in

> relation to those individuals for whom they hold caseload responsibility, but who may not have been seen by the practitioner for a period of weeks, months or even years. In situations where practitioners are unable to 'keep track' of families on their caseload, or to fully know and be aware of potential difficulties, to what extent are they liable if an unidentified need surfaces later? There are very serious implications for clients where, for example, an initially undiagnosed disability or hidden and unidentified child abuse might have been treated more effectively or prevented by earlier intervention. This dilemma is not well addressed in the guidance currently available from the UKCC. (Cowley and Houston 1999: 87-88)

The legal opinion outlined above helps to provide some clarity, yet there is still a need for wider debate and for these issues to be explored thoroughly by the health visiting profession as a whole. The way professional regulation works in health visiting is explored in the final section of this chapter.

5.3 Professional Regulation of Health Visiting

5.3.1 Fitness for practice

Before concluding, this chapter will draw together the threads presented throughout the report, focusing again on the three aims of the project and explicating the key issues for professional regulation of health visitors. The interface between *'fitness for practice'* (primarily a function of regulatory body), *'fitness for purpose'* (primarily a function of employers) and *'fitness for award'* (primarily a function for educational institutions) were set out clearly by the UKCC Commission on Education (UKCC 1999a). First:

> Fitness for practice: the UKCC is primarily concerned about fitness to practice – can the student register as a practitioner? The assessment of fitness to practice depends on the scope and nature of practice and how this evolves over time – on an individual level, as careers progress and on a societal level as health care needs change. Registration, thus, represents an endorsement of the individual's fitness to practice, with the proviso that professional updating is an on-going process (UKCC 1999a 34)

Chapter 2 set out the way that health visiting has changed since its inception, according to changes at a societal level, explaining how the interface between health visiting and nursing became increasingly intertwined throughout the twentieth century. In the last two decades of that century, the regulation of the two professions were linked and there has been an increasing loss of clarity for health visiting since then. However, this has not changed the statutory position for health visitors which is still defined in law, and, as explained in Chapter 3, is associated with some specific roles, skills and expectations that do not apply to nurses, even if they are operating at a 'higher level' or working in the community.

The issue of career pathways is important here. On the one hand, there is an extension of the nursing role and remit into fields, such as public health, that have not hitherto featured very highly in that profession. Some commentators clearly view the government's affirmation that health visiting is to continue being regulated as a separate

profession as somehow inhibiting that development. Others point to the wider career opportunities for health visitors within the 'nursing fold' should an even closer interconnection be pursued between nursing and health visiting.

On the other hand, at a societal level, there is an emergence of 'multi-disciplinary professions' that focus upon a particular broad area of interest, bringing different skills to bear on it, through joint working. Two such emerging professions were highlighted. 'Early years workers' can undertake a number of potential academic programmes that are not linked with any specific professional award; although both the voluntary sector and education (primary, nursery and special needs teachers) are heavily represented in this group, there are strong links to practice across a number of fields. These workers are not regulated, although they may feature in the 'teams' that health visitors are being urged to lead. Their future career needs, as well as the public served by this unregulated workforce, need considering.

The second multi-disciplinary profession, which has progressed further than the first in that an official register is currently being established, is that of 'public health'. The government signalled its wish that clear career pathways should be developed that will allow public health practitioners to become specialists in public health in future (DH 1999a). Given the importance of an adequate knowledge and skills base in these professionals in future, a register is to be set up that will recognise practitioners who meet specific national standards. Neither nursing nor health visitor education have been incorporated into the planning of these standards, nor can public health practitioners access health visitor education unless they are also nurses.

The extent to which the health visiting profession, itself, has been able to progress and develop during the last twenty years is also a matter that was considered through Chapters 2, 3 and 4. The UKCC took over the regulatory functions from the CETHV in 1983. The UKCC was set up with a 'unifying brief' and turned its attention, first to all pre-registration education, then to all post-registration education. Health visiting was included as part of these initiatives, but the UKCC has not undertaken any curriculum development or specific examination of the needs of health visitors in contemporary practice. Curricular work carried out by other organisations was neither implemented nor, apparently, examined by the 'PREP' working group set up in the late 1980s.

At the same time, the impact of the 'new public management,' increasing resource constraints and, at least until the last few years, a government that was firmly opposed to general family support, have all combined to restrict and limit the development of health visiting as a profession. Unsurprisingly, this very hostile environment has given rise to a range of different opinions about the best way forward for health visiting, of which the one that appears to have been adopted by the UKCC is to combine it with nursing. However, the legal opinion cited in section 5.2 has made clear that a basis of professional knowledge must be maintained in order to have a collective view about what constitutes an 'acceptable standard' of service provision in relation to health visiting. It is also essential for health visitor practitioners to be clear about what constitutes an appropriate 'professional judgement' in their particular field; again, a collective view is required

against which to assess complaint, individual self-appraisals, and for the purpose of clinical governance. Notwithstanding the sociological debates about the nature of professionalism, there is an absolute need for a professional knowledge base that is continually revisited and updated as a foundation upon which to build any other regulatory arrangements. Without this foundation, no amount of protocol, procedure or professional intent will succeed in maintaining adequate standards of practice.

As an aside that is, nevertheless, relevant to this particular project, the JM Consulting Ltd. Review (1998) looked at the possibility of setting up a single, multi-disciplinary regulatory organisation for a range of health and welfare professions. There are some issues that are obviously held in common across all professionals that work with the 'vulnerable public;' most of these involve conduct and protecting the public from exploitation and criminality. There are also professional issues that may be shared around particular topics, which is where the idea of 'multi-disciplinary professions' arise. These involve a range of different professionals that each have a different contribution to make to a particular practice area or topic; apart from early years and public health, this pattern is beginning to emerge within the mental health field. Parallels may be drawn with the academic disciplines; 'social sciences', for example encompass a variety of subjects such as sociology, psychology and anthropology. Academic disciplines all hold in common some very clear areas of knowledge and understanding, and sharing occurs across sometimes unexpected interfaces; yet there are also some specific differences between each subject. Likewise, 'multi-disciplinary professions' may develop more flexible service approaches and potential for collaboration by recognising the benefits that come from accepting (rather than seeking to eliminate) diversity and specialisation.

If, as seems likely given the discussion in Chapter 3, this multi-disciplinary approach is the kind of future for professionalism as a whole in future, then all regulatory systems (including the UKCC) will need to shift from a unifying stance to one that accommodates pluralism. Such a system will ensure two things: first, that each profession feels confident that they are able to regulate their own standards, and second that they feel able to contribute to the significant aspects that are held in common across the disciplines without losing their own particular focus or specialism. These have not been consistently available for health visiting, where a determination to bring the profession 'into line' with nursing is currently being played out in many university and health service settings.

5.3.2 Fitness for award

Educationalists, as noted earlier, have the privilege and responsibility of recommending a student as suitable for entering the profession and registration. A multitude of different issues impinge upon this decision, and completion of the educational programme is one key area. Again, the summary in the UKCC Commission on Education offers a useful summary:

> Universities are primarily concerned about fitness for award – has this student attained the appropriate level, breadth and depth of learning to be awarded a diploma or degree? Fitness for award does not mean fitness for purpose, but most employers acknowledge established academic awards

> as markers of achievement. To address these different but related concerns we recommend refocusing pre-registration education on outcomes based, competency principles . . . . (UKCC 1999a 34-35)

Completion of the programme and recognition that a student has achieved the required competencies is a very important point that signifies 'professional self-regulation.' Completion and achievement of an academic award is not sufficient to show fitness for practice, and the fact that the community health care nursing programme ends in an academic qualification is not, in itself, sufficient for health visiting practice. The UKCC requires that the programme is taught at degree level, not that it actually leads to the conferment of a degree (UKCC 1998). However, few universities would consider developing a programme that did not conform to nationally recognised academic standards, or end with a clearly recognised award of some kind. As noted in Chapter 4, most universities will have specified requirements for the amount of research based knowledge that is required for a student to be recognised as a 'graduate.' In a number of instances, there would be an expectation that up to 60 level 3 credits, or half the final year of a degree would be spent learning and demonstrating research skills in order to qualify for an honours degree. As the community health care nursing framework is designed to build on to the Higher Education Diploma (which is the equivalent of the first two years of a degree), it follows that the programmes will often have a heavy research component. Whilst this will usually take the form of a project focused upon the specialist area, the requirement further reduces the limited amount of time available for the practice component.

However, in addition to the academic award, students must also meet the requirements in statute and, in the view of a 'professional peer,' be recognised as able to practice safely as a health visitor. As at entry to any other part of the register, a personal signature is required; however, the level of professional self-regulation has become unclear because the course leader – who may not be a health visitor – may now sign this document. Whilst validating mechanisms are supposed to ensure that adequate teaching expertise is available, it remains theoretically (and practically) possible for students to complete such programme with only minimal exposure to specialists or peers from their chosen area of practice. It would also be presumed that if, during the course of the programme, a student's performance gave cause for professional concern (even if academically their performance was satisfactory) the award would be withheld. However, there is no system to ensure that this decision is made by health visitors about health visitors. The extent to which the course leaders reported difficult negotiations about what was important for health visitor students to learn during the programme, too, must give rise to some concern about how feasible it is to expect them to maintain professional standards.

There were many reported difficulties faced by course leaders in trying to ensure that students achieved the competences they needed for practice, as well as Oldman's (1999) research and reports of trusts requesting a return to the former 51 week length of programme. Overall, these combine to suggest that there is a justifiable cause for concern about the suitability of the community health care nursing course as a preparation for contemporary health visiting practice.

A clear change in regulatory emphasis has taken place between the 1965 syllabus and the 1994 CHCN framework. In the former, there was a combination of three things. First, there was a specific syllabus that was implemented nationally. Second, it was clearly based upon principles and the profession of health visiting; the overall purpose of the programme was straightforward: it was to prepare students to engage in the practice of health visiting. Third, the regulations were such that the programme was entirely controlled by health visitors, and focused upon ensuring consistency across the country. This was presumably intended to ensure (through peer self-regulation) that the programme itself was 'fit for the purpose' of preparing students who could practice safely, and also maintain and develop the standards of the profession. Within those specific parameters, there was a great deal of flexibility. Once the clear requirements for peer self-regulation began to be eroded, the flexibility began to be closer to inconsistency, as shown in this brief review.

The current regulatory system is completely different, in that health visitors are a minority voice in a large community nursing field. There is no system by which genuine professional concerns can be addressed. The learning outcomes in the community health care nursing framework are so broad and can be interpreted so flexibly that – as the curriculum analysis reported in Chapter 4 indicated – they can be used to justify almost any changes to the programme. It is important to note that health visitors are still in charge of the specialist modules, or even of the whole programme in a large number of places. However, this is by chance, not design; overall, the profession is not in control of the professional preparation of its own practitioners. This all implies that there is an urgent need to assess the extent to which, given this situation, students are being adequately prepared for practice. The research just being completed for the English National Board (Pearson et al in press) also suggests that newly qualified practitioners experience difficulty in achieving relevant standards of practice on graduating from the specialist CHCN programmes to (see Appendix 5).

5.3.3 Fitness for purpose

Again, the UKCC Commission on Education gives a clear explanation about how 'fitness for purpose' inter-relates with the other two elements of regulation.

> Prospective employers are primarily concerned about fitness for purpose – is the newly qualified nurse or midwife able to function competently in clinical practice? The speed of change in the context and content of health care makes it difficult to define fitness for purpose – its meaning cannot be fixed. Fitness for purpose depends on the commitment of employers and employees to constant professional updating. Given the pace of change, it seems unreasonable to expect fitness for purpose – other than in the broadest sense – to a purpose of pre-registration education (UKCC 1999a: 34)

There are two key issues for health visiting that come from this brief excerpt. First, continuing professional education is an important area of debate, and second, maintaining standards of the profession is an issue again. The position of health visiting is deeply

anomalous, because it is a pre-registration education that is held to build upon registration in another profession. As indicated in Chapter 4, it is not really possible to identify precisely which knowledge it is supposed to build upon, and as shown additionally in Chapter 2, the question of whether it is extending existing knowledge or establishing a new base is also widely contested. One thing is clear: over the last twenty years, health visitor education has increasingly been treated ***as if*** it were a specialist area of nursing, and throughout that time, the difficulties encountered in making the programmes fit and work within nursing frameworks have not reduced.

It is not clear, for example, how health visiting fits with Higher Level Practice (UKCC 1999c), because it seems impossible to say where the starting point is. Would the frameworks apply to a level of practice that is higher than initial registration so that all health visitors are automatically 'higher level?' Or would it be more reasonable to see health visiting as the base line and recognise only those who have extended above the level of their health visiting peers? In another example, the UKCC Commission (UKCC 1999a) did not consider health visiting, because it was not 'pre-registration nursing or midwifery' and there is nothing in the report to indicate that those involved were aware that health visiting might be affected by their deliberations. However, the proposed reduction in common foundation programme and shift back towards clinical competences in the place of a philosophy of health can be expected to have a marked effect.

It may be time to consider treating the profession ***as if*** it were different to nursing, albeit with some important common areas of interest and regulation. This would allow some flexible thinking about whether strict control of the entry gate could be sacrificed in favour of a clearer focus on learning outcomes, competences and capacity for sound professional judgement as a health visitor. This would need agreement across a range of stakeholders, but discussions could include representatives from the public health professions and potential employers, such as the local authorities and voluntary sector, as well as current NHS and primary care- focused employment.

Finally, the processes (flagged up in section 5.2) by which health visitors are enabled to maintain their registration despite not having practised in that field in the last five years seem very contradictory. This requirement has only just been confirmed, but it seems likely to add to the problems of a profession trying to maintain standards and self-regulation. Although there are undoubtedly a number of situations in which a dually or triply qualified health visitor will use each registration in the course of her work, there are also many situations in which health visitors have reverted to a former area of practice in nursing or midwifery, or may never have practised as a health visitor at all. The contribution that individuals can make to the field in which they are currently practising may be immense, but if more than five year have elapsed since they last practised in health visiting it is doubtful whether their registration should remain current in that field. Allowing it to lapse would not preclude the potential for that individual to undertake a return to practice course to update and re-activate his or her registration. However, it would ensure that only current practitioners were involved in determining the standards of their profession, which is diluted by the current system.

5.4 Drawing Conclusions

This chapter has provided a brief review of health visiting workforce figures, to set future educational needs against the current employment situation. This working context was examined further through some accountability 'scenarios' that were subject to a legal opinion. That exercise illustrated the significance of the employer and official bodies in ensuring that adequate care is provided, and the importance of clarity about how professional judgements of what constitutes an 'adequate provision' are reached. Importantly, it highlighted some areas of accountability that remain generally quite hazy, and the lack of a clear mechanism through which a body of professional knowledge about matters specific to health visiting can be collated. Finally, the mechanisms by which the regulatory processes are supposed to ensure *'fitness for practice', 'fitness for award'* and *'fitness for purpose'* were examined in relation to health visiting.

The maintenance of professional standards in current preparation and regulation appears strongly dependent upon the goodwill and professional skills of the existing workforce, with no clear strategy for succession planning as the older members leave the profession. The extant legislation and the way it is operated provides no clear system for developing or collating a professional knowledge base in health visiting. This is needed as a basis for assessing what constitutes an 'acceptable standard' of health visiting practice. The recent operationalising of the PREP regulations were singled out for comment, since (unlike in nursing and midwifery) they make no requirement for individuals to practice by virtue of their qualification in order to maintain health visiting registration.

The importance of developing a capacity for making professional judgements as a health visitor was highlighted as a specific need in the accountability scenarios. It is not clear from the data presented in Chapter 4 that the current framework provides this kind of preparation for contemporary practice. The importance of continuing development for, not only individuals, but for the profession as a whole was highlighted as a *'fitness for purpose'* issue with clear relevance to clinical governance and accountability.

This chapter highlighted the accountability interface with other disciplines and agencies, which is not entirely dependent on regulation. In particular, the duty of care to individual clients reverts to Trusts and/or GPs if health visiting standards and services are not maintained. There are many links between the employment situation and professional education, that contribute to the whole mechanism for maintaining professional accountability, adequate standards of service provision and protection of the vulnerable public.

5.5. Key Points

5.5.1 Professional regulation and accountability mechanisms within Trusts require a base of knowledge about what constitutes an 'acceptable standard' of practice. There is no official mechanism for achieving this in health visiting. Despite those

aspects held in common between nursing and health visiting, the separate statute means there are different expectations of what health visitors may be held accountable for. Even so, health visitors are not required to practise in the field or maintain their competence in order to retain current health visiting registration. This arrangement differs from the clear expectations for nurses and midwives set out in the PREP regulations.

5.5.2 The health visiting workforce is generally far older than in the wider nursing field, and numbers currently being trained are unlikely to replace those due to retire in the next 5-10 years. There is inadequate information about the capacity for health visitor education and no clarity about how the newly agreed standards for teachers will affect the roles currently undertaken by designated Community Practice Teachers and Health Visitor Tutors.

6. CONCLUSIONS

6.1 Deciding a way forward

This final chapter will return to the overall purpose of the project detailed in Chapter 1; this is to examine the implications of the government's response to the Review of the Nurses, Midwives and Health Visitors Act 1997, and the suitability of the extant legislation as a basis for preparing and regulating health visitors for contemporary practice. Various questions were outlined at the start; these will be revisited, along with various new issues that have been highlighted as significant or problematic by the project.

Council needs guidance when updating their procedures in line with the proposals set out in the Nurses, Midwives and Health Visitors Act 1997, and in the government's response to the proposals set out by JM Consulting Ltd. As each question is revisited and considered, various alternatives will be suggested. Where relevant, the implications of continuing with the status quo and an unchanged statute will be considered. Possible changes that might be made to modernise the statute, training rules and regulatory procedures will be suggested, if these would bring them in line with the government's requirement that health visiting is to continue as a distinct profession. The potential benefits and difficulties of making the alternative changes will be examined, reflecting back on the different perspectives set out in the report and identifying where some additional project work or more research may be indicated. Finally, the summary of options at the end of each section are integrated into some over-arching recommendations to be considered.

6.2 Implications of the extant legislation for current preparation and regulation.

6.2.1.Educational entry requirements and level

The first, perhaps most straightforward, question concerns whether the current educational entry requirements should continue unchanged (i.e., specified school leaving certificates (e.g. GCSE, CSE or GCE) in English, Welsh or history). These requirements are anachronistic given the multi-cultural and educational diversity amongst university entrants, and among the population in general. Should the statute remain unchanged, it would be possible, as pointed out in Table 1.3, to develop an entry test that included English, Welsh or history. This test would need to be approved by Council as 'educationally equivalent' to school leaving level, and include one of the three named subjects to meet the requirements of Rule 22.1 (b) of the Health Visitor Training Rules: Nurses, Midwives and Health Visitors (Health Visitors Admission to Training) Amendment Rules Approval Order 1989: statutory instrument 109.

Alternatively, it would be possible to modernise the statute so that the entry requirements reflect the more usual university entrance requirements these days. While individual institutions and programmes all have their own preferred entry specifications, it is common for mature students to be accepted on the basis of somehow demonstrating that they will be able to meet the demands of the level of study for which they are applying.

Council has specified that, as part of the specialist programme, health visitor training should be at degree level. That is not in statute or in the health visitor training rules, but it does reflect the minimum level of critical thinking required to carry out the role. Also, since around one in three school leavers currently go on to university level education, it seems an appropriate minimum. Indeed, if the current trend towards graduate status for first level nursing continues, it will be increasingly necessary to develop post-graduate level health visiting programmes to accommodate nurse entrants.

Summary of Options

- If the statute cannot be changed, a brief entry test incorporating English, Welsh or history could be constructed to accommodate potential entrants without the pre-requisite school leaving certificates.
- The statute could be amended to permit a more open entry policy, allowing universities to satisfy themselves that entrants have the capacity to undertake the level of study for which they have applied.

6.2.2 Professional entry requirements

Under the current statute, entrants to health visitor training need to be registered on Part 1 (RGN) of the nursing register, 'or have such other nursing qualification as the Council may *in particular case* approve as being of equivalent standard' (Rule 22 (1) a: added emphasis). To take account of changes to the register when Project 2000 was implemented, Council approved entry for all applicants whose names were held on any part of the nursing register (except for Part 9, Registered Fever Nurse), when the Community Health Care Nursing (CHCN) framework was introduced. This block approval does not seem to fit very closely with the precise wording of the statute. Also, while it meets the spirit of the training rules to some extent, this adaptation might be open to legal challenge, since specialist registrations like sick children's and mental health nursing were recognised qualifications at the time the original statute was formulated.

The wording for the standards for entry to the health visiting part of the CHCN framework is somewhat contradictory in relation to midwifery, as it appears they are allowed to enter the training, but not to register as a health visitor. The standard states:

'The nurse should have an entry on ***either*** parts 1, 2, 3, 4, 5, 6, 7, 8, ***10,*** 12, 13, 14 ***or*** 15 of the register.

If a registerable health visiting qualification is required the registrant must also meet the entry requirements as laid down in the Health Visitors rules (see Annexe 1)' UKCC 1998: 17, added emphasis

As midwifery is not a nursing qualification, Council may feel unable to approve this as a suitable alternative to registration on Part 1 of the register, even in a 'particular case'. However, the fact that a midwifery qualification was a pre-requisite at one time might be invoked in support of a claim for someone registered only on part 10 of the register to enter health visitor training and, eventually, be registered as a health visitor. There is, therefore, the potential for some confusion should the entry requirements either continue

(as in statute) to name only nurses registered on Part 1 of the register, or if they continue to permit entry from any part of the nursing register, as in the CHCN framework.

On the other hand, if the statute were to be modernised, some consideration would be needed of three questions:

a) Is it appropriate, in an increasingly flexible multi-professional arena, to limit entry to health visitor training to a single discipline; that of nursing?
b) If a professional (nursing) pre-requisite is to be cited, exactly what is the assumed knowledge entrants bring with them?
c) Could the 'assumed knowledge' (once identified) be equally well included as learning outcomes rather than entry requirements?

The report highlighted the potential difficulties in future career pathways for health visitors wishing to move on to become public health specialists in future or to members of teams working with health visitors who are unable, themselves, to progress their careers into health visiting because they are not nurses. A number of potentially suitable entrants to health visiting were identified, such as graduates of health and social science degrees and colleague professionals from across the range of welfare and caring agencies. The position of direct entry midwives who are barred from entry to the health visiting part of the register is particularly anomalous, given the close working relationships between the two professions.

Once the register is streamlined in line with recommendations made by JM Consulting Ltd (1998), the different parts of the register will not be listed as they are now, but first level education in adult, children's, mental health and learning disabilities nursing will continue. As pre-registration nurse training is adjusted in line with the expectations set out in the 'fitness for practice' report (UKCC 1999a), too, the question of 'assumed knowledge' by entrants to health visitor training will need to be considered with care. It would be hard to make a case for excluding from entry nurses from any part of the register, since each one could be regarded as suitable for different reasons. Health visitors are involved with all age groups, for example, so adult nursing continues to provide an important background from which to develop health visiting skills in population-based public health work and the outreach function. Mental health is a major public health issue, having become one of the top four priorities singled out by the World Health Organisation as significant in the European Region (WHO 1999), so mental health nurses clearly have a useful basis from which to develop health visiting skills. As identified in Chapter 4, there is a strong lobby that health visitors should be drawn from among the ranks of children's nurses, given the important continuing role with families and children and the minimal required teaching about child health in the health visiting programme. The importance of the empowerment model, the long term nature of their work and a strong background in educational and developmental psychology, gives learning disabilities nurses a very positive basis from which to develop the health enhancing and preventive skills needed in health visiting. Thus, nursing clearly provides a useful, if not the only, background from which health visiting students can be drawn.

However, nurses from each of these different branches hold in common only the learning that takes place in the common foundation programme (CFP), which is soon to be reduced in length to 12 months. Indeed, as the new learning outcomes have been developed in preparation for implementing recommendations of the 'fitness for practice' report (UKCC 1999a), it would be timely to visit the whole, new list of first level learning outcomes to identify which are considered essential for health visiting. If entrants to health visitor training need prior knowledge and skills that are not included in the CFP, but that are necessary for them to become 'fit for practice' as health visitors, those aspects will need to be incorporated as learning outcomes for practitioners to acquire before they qualify. Any individual student who has already achieved those skills should be able to have this prior learning accredited; most universities have well developed systems for Accreditation of Prior Learning (APL) and Prior Experiential Learning (APEL). Students that do not have this base of skill and knowledge already would need to cover it during their programme of preparation for health visiting.

Developing a system that would account for the nursing skills and abilities that are considered necessary for nurse entrants from diverse backgrounds would achieve three things. First, it would make them explicit, thus valuing them in a far more complete way than under the current system, when any kind of nursing background is considered better than none, but no-one appears able to explain exactly what the benefits actually are. Second, it would value health visiting skills far more explicitly, by focusing attention on the exit rather than the entry points; this would clarify what is actually needed to be 'fit for practice' as a health visitor. Furthermore, as explained in Section 4.5, this would provide a better safeguard of professional standards than the current system. Third, it would incorporate a flexibility that could easily be extended to include entrants from non-nursing backgrounds, whilst ensuring they had an opportunity to develop any nursing skills that were deemed important for health visiting.

Summary of Options

- Council might consider widening the entry gate to include not only nurses, but midwives and people from other relevant professional backgrounds or through direct entry; this would require a change to the statutory instrument.
- As a less radical alternative, it may be possible to amend the statute so that both registered nurses and midwives can access health visitor training and registration
- Importantly, whether retaining a restricted (nursing only) entry point or not, a wider study is needed to clarify what knowledge and skills are assumed to be held by all first level nurse registrants, and that are considered relevant to health visiting.

6.2.3 Length of programme

As shown in Table 1.3, Rule 21 (2) of the Health Visitor Training Rules: Nurses, Midwives and Health Visitors (Health Visitors Admission to Training) Amendment Rules Approval Order 1989: statutory instrument 109, states that: 'a person wishing to be trained as a health visitor shall attend a course at an approved training institution for a period of not less than 51 weeks during which period he/she shall have at least six weeks

study leave.' Chapter 4 revealed that the overall length of health visitor training programmes varies widely across the UK. A recent trend is the move away from shorter (30 – 40 week) programmes towards a one year preparation once more. This trend might be cited in support of the key role played by Trusts and Educational Consortia in maintaining and strengthening professional standards. However, the opposite trend was also evident. Course leaders reported being pressured to fit health visitor learning into programme lengths that suited the other specialisms, or to concentrate on general nursing skills used within primary health care, at the expense of developing the particular abilities needed for health visiting. In either event, the message was clear: the minimum time stated in the existing standards was too short, whereas a calendar year was manageable.

The whole idea of the 'length of a training programme' is less meaningful now than when the statute was developed some forty years ago. Part-time and distance learning programmes are far more widespread and the process of accreditation is more flexible since modular programmes have become the norm. Professional and vocational training courses are almost all associated with a specific academic level, and few Higher Education Institutions (HEIs) would consider developing a programme of study that had no formal academic award attached to it. There are educational expectations attached to the different academic levels that need to be taken into account when considering the length of programme; these may include research skills or other generic knowledge that contribute to the notions of 'graduateness' or 'mastery' depending upon the level taken.

A modernised statute would, therefore, be more helpful if it stated an expected educational level and clear learning outcomes needed for health visiting, rather than just length of programme. Even so, given the pressure on funding for professional education, some 'normal length' against which to judge the costs does need to be indicated. Given the importance attached to practice in health visiting, as in nursing and midwifery, any stated length of programme needs to consider the time taken to develop these skills. By and large, additional time is needed for vocational programmes, over and above that required for 'pure' academic study. This explains why so many of the 'new' CHCN degree programmes have found it difficult to fit into a 32 week programme both the vocational learning required for a completely new area of practice and the equivalent of a whole year's academic study as well. At post-graduate level, one model that might serve as an example is the two year full time Masters in Social Work developed in a number of places; this includes a professional qualification and academic award for graduate entrants. Table 6.1 provides some options for consideration.

The academic level held in common across all professions and occupations provides a broader basis for understanding career pathways, relative levels of responsibility and transferable skills from one discipline to another. Some progress is being made towards developing a common 'academic currency' across Europe that, likewise, has the potential to improve flexibility. However, it remains important that flexibility should not be bought at the expense of practice-specific knowledge and ability. The extent of inconsistency identified in Chapter 4 should serve as a warning to introduce some very clear minimum critical specifications to serve as markers against which professional standards can be assessed.

Summary of Options

- Decisions about the length of training need to be made in conjunction with academic level, time needed to develop practice ability and specified learning outcomes, but should not be less than the 51 weeks stipulated in statute.
- Preferred and manageable lengths of training will vary depending upon whether changes are made to the assumed knowledge base at entry to the training (see section 6.2.2). The options are summarised in Table 6.1

Table 6.1: Possible options on lengths of training

Years	1. Current model: single route: nursing entry	2. Likely future as specialist and HLP develop	3. If direct entry developed, with no previous qualifications	4. If non-nursing entrants with relevant degree allowed
1	Higher Education Diploma in Nursing with first level registration	Higher Education Diploma or (increasingly) first level degree in nursing at or soon after attaining first level registration	First degree in Health Visiting with professional registration	Masters degree in Health Visiting with professional registration
2				
3				
4	*(Experience as a nurse not in education: usual minimum of 2 years, often longer)*	*Experience and/or degree studies; and/or recognition as specialist nurse and/or Higher Level Practice*		
5				
6	HV training combined with degree in CHCN	HV training combined with PGD in CHCN		
Total time in education (full time equivalent)	4 years	5 years	3 years	2 years
Total Preparation period	6 years minimum	6 years minimum	3 years	2 years minimum

Abbreviations: HV = health visitor; CHCN = Community Health Care Nursing; PGD = Post-Graduate Diploma
HLP = Higher Level Practice

6.2.4 Fit with the Community Health Care Nursing (CHCN) framework

There are three key areas where the statutory instrument governing health visitor education fits poorly with the current CHCN framework. The first are the two issues outlined above, in which specific aspects of the statute (entry criteria [6.2.1] and length of programme [6.2.2]) appear somewhat at odds with the whole framework. The third, possibly most important. area is mainly to do with the underlying philosophy and values that inform the programme. The effect of implementing these differences into educational practice were detailed in Chapter 4. The fact that all the health visiting course leaders had, somehow, managed to develop a training programme that befitted the students for practice is a testimony to the amount of common ground between health visiting and other community nursing programmes. However, the difficulties they encountered in pursuit of this goal also speaks volumes.

Many of the problems in implementing the CHCN programmes related to the different underlying beliefs about health visiting explained in Section 1.3. The statute and the government's recent statement about health visitor regulation (NHSE 1999) make clear their view that health visiting remains distinct from nursing; the education is therefore seen as pre-registration preparation for a new profession. Conversely, the CHCN framework assumes that the basic knowledge required for health visiting is already held by all nurses, who need only to extend that base to become 'specialists' in their chosen area of public health nursing practice. The experience of the course leaders, reported in Chapter 4, is that entrants to health visitor training have a great deal more 'new learning' than their peers in other areas of community practice. This accounted for the additional time needed to prepare health visitor students.

There is very little research that directly addresses the relationship between health visiting knowledge and that held by nurses, so opinions tend to be formed on personal experience and strongly held values. Three aspects were detailed in Chapter 2:

a. Alternative views about the role and purpose of health visiting are drawn from long debated different political perspectives, and preferred approaches to organisation and management.
b. Opinions about the relative importance of the professionalising agendas in nursing and health visiting inform views about the relationship between the two occupations.
c. Divergent theoretical perspectives that underpin public health and health promotion influence views about preferred approaches to health visiting practice.

A critical appraisal of existing research, or a new in-depth study, to examine the respective knowledge base and practice philosophies held by nurses and health visitors would be feasible and may be helpful. However, it seems unlikely that such a study would, in itself, change the fiercely held values and beliefs about the relationships between the two occupational groups as the debates reflect unresolved contradictions that have persisted through centuries of political, professional and philosophical debate. However, health visitor education needs to prepare practitioners to deal with this level of debate, uncertainty and with continual contradictions in their everyday work.

The existence of the community specialist framework has not resolved the dilemma of 'professional level' for health visitors either. Section 5.3.3 outlined the different positions taken in some recent debates concerned with 'Higher Level' practice (UKCC 1999c), which testifies to the continued uncertainty about this. The idea that health visitors might be regarded as operating at a 'higher level' as soon as they qualify as 'community nurse specialists' might seem appealing to some, since they have advanced their skills beyond first level registration. This level might be applied to community children's nurses or district nurses, for example, since they have directly extended knowledge gained at first level registration in acquiring their community specialist qualification. This does not seem to apply in the same way to health visitors. Instead, regarding them as newly qualified practitioners in a different profession makes clear that they still need a period of preceptorship and support, even if they are operating at a 'higher level' than a nurse holding first level registration. Also, as in nursing and midwifery, there is still a great deal of individual development displayed by 'experts' in health visiting practice beyond the level of entry to Part 11 of the register. Whilst this clearly needs acknowledging, there seems little need for further regulation at that point.

Thus, maintaining the statutory position of health visiting as a distinct profession does seem to help to clarify some of this confusing situation and give a firmer basis for developing regulatory standards. Once there is clarity, it becomes easier to identify shared areas and principles that pertain across the professions, as currently occurs between nursing, midwifery and many other professional groups. If there is a wish to continue the CHCN framework in its current form, some mechanism will be required to recognise the philosophical difference between the statute and the regulations covering the other seven areas of practice encompassed within the framework.

Some of the reported tension between health visiting course leaders, their colleagues and other stakeholders might be defused if the UKCC were able to act as a positive role model in accepting and valuing the diversity, as well as the similarities, among the three professions they regulate. However, the issue of shared learning and preparation for inter-disciplinary and inter-agency working is an important factor. Whilst this is not a matter raised in the statutory instrument, it was a powerful driving force behind the development of a framework that anticipated between one third and two thirds of the programme would be held in a common core of learning. It is considered in more detail in Section 6.4.

Summary of options

- A critical appraisal of existing research, or a new in-depth study, to examine the respective skills, knowledge base and practice philosophies held by nurses and health visitors would be feasible, but a level of debate and contradiction is likely to remain. This needs to be reflected in the preparation of health visitor students.
- Recognising that entrants to the health visiting register are embarking on a new profession clarifies their need for preceptorship and initial support, and their potential to develop to a 'higher level' beyond that of 'specialist' CHCN.

- If the CHCN framework is to continue in its current form, some mechanism will be needed to recognise the philosophical difference between the statute (i.e., that 'health visiting knowledge/skills are different to nursing knowledge/skills') and the regulations covering implementation of the framework (i.e., that 'first level nurses all hold the same knowledge/skills as health visitors, but at a less advanced level').

6.3 The suitability of the current framework as a preparation for contemporary practice.

6.3.1 Preparing the future workforce

As shown in Table 6.1, present career pathways leading towards health visiting are fairly lengthy. In theory, it is possible to become a health visitor in four to five years, by following a combined, direct entry programme of preparation for nursing and health visiting. However, the usual pattern is for nurses to qualify, then work for a minimum of two years (and often far more) in their chosen specialism before moving into health visitor training for a further year before they qualify. This minimum six year lead-in means there is, at present, no quick way of increasing the workforce, particularly at a time when nurse recruitment is, itself, facing difficulties. Also, Table 5.3 suggests that the commonest recruitment period into health visiting is between 35–44 years of age. This may be viewed as very positive, reflecting the wide life experience and perhaps valuable professional expertise that recruits bring with them to health visiting. However, it does reduce the average 'working life' of a health visitor to around 15-20 years.

The testimony of the course leaders that there is no shortage of suitable applicants for health visitor training is encouraging. However, the ratio of, usually, a 6-year minimum lead-in to the career, against a probable 20-year working life does raise, once more, the question of whether nursing is the only suitable recruitment ground. Also, although the pattern does not seem to have changed noticeably in the last ten years, the ageing population of health visitors continues to be a cause for concern. Although Northern Ireland has a larger proportion of health visitors under 40 years old than in the rest of the UK, less than 3% of health visitors in England are under 30 years old. Similar ratios pertain in Wales and Scotland.

Some wider debate is needed about whether this general maturity of the workforce is a positive feature to be encouraged and accepted, or if the profession would benefit from an injection of more youthful practitioners. This would be most easily achieved through a direct entry route, of which two options are available. First, the number of current 'dual registration' courses (through which students achieve health visiting and nursing registration on a four or five year degree course) might be expanded, if enough graduates of those programmes enter and remain in health visiting to make it worth while; no studies are known that shed light on this. Second it would be possible to widen the entry gate as suggested in Section 6.2.2, thus potentially attracting recruits who are interested in health visiting but not in nursing. As noted, this would require a change in the statute.

The extent to which the maintenance of professional standards in health visiting appears (as outlined in Chapter 4) to be heavily dependent upon the existing, ageing workforce and their collective memory may be seen in two different lights. It may be viewed as a testimony to the powerful professional identity of health visiting, which is serving to ensure that practice continues to reach acceptable minimum levels of service provision. Alternatively, it may be seen as a mechanism by which a regressive workforce can collectively resist positive opportunities and changes required to meet contemporary health needs. Either way, there is an important need to revive and revitalise the system of health visitor education; this is an area over which the UKCC has considerable influence. Despite the new teachers' standards, the position of both registered health visitor tutors and trained community practice teachers remains very unclear. The age of existing health visitor tutors is not known, but (as noted in Chapter 4) only four new entrants recorded this qualification in the last year. A detailed review of the capacity for health visiting education would be helpful. Educational issues are considered further in the next section.

Summary of options

- The capacity to support health visitor education may be diminishing; it would be useful to carry out a specific review of this.
- Developing one or both of two direct entry options would be a way of attracting more youthful entrants to the health visiting profession, if this is considered desirable.
- The first of these options are the existing direct entry programmes, through which students achieve dual nursing and health visiting registration; these might be expanded without changing the statute.
- A change to the statute would be needed to extend the entry gate to a single registration course, which is the second way to achieve 'direct entry'.

6.3.2. Maintaining professional standards in health visitor education

Section 4.5 summarised how the regulatory approach changed once the CHCN framework replaced the former health visiting courses, to the extent that health visiting has little claim to be a self-regulating profession at the present time. The former approach to 'self-regulation by professional peers' included a requirement that health visitors developed educational programmes and were responsible for ensuring that appropriate teaching and learning experiences were available to the student. Not only that, but specialist health visitor education officers were responsible for overseeing the validation of programmes, and checking the consistency and appropriateness of course content; health visitor practice teachers oversaw the student's practice experience, controlled standards and a qualified health visitor tutor affirmed the practitioner was suitable for entry to the register.

At no stage was it expected that *only* health visitors would teach students or contribute to the overall programmes and learning experience; but at each point, suitably qualified or experienced health visitors were held responsible for ensuring that appropriate learning experience and approaches to practice were taught and experienced by the student. None of these former safeguards have been maintained and no satisfactory alternative

mechanism for ensuring standards or consistency have been implemented in their place. Three particular points in the chain of the educational process were highlighted as problematic; each need considering in relation to the impact they are having on the ability of health visitors to maintain professional self-regulation. These were:

a) Teaching in the practice setting: the issue of Community Practice Teachers
b) Course issues: delivering the programme and approving 'fitness for practice'
c) Programme standard, content and kind: validation processes

The variation of teaching in the practice setting was highlighted in Section 4.4 as a specific concern, particularly given the increased reliance on practice teachers to ensure learning about substantive new topics (like child development, nutrition, group work skills) for students. Despite different views about whether a specific requirement was necessary, there was agreement amongst the representative organisations interviewed for Chapter 2 that the quality of practice teaching was extremely important. Indeed, there is some research evidence (Bergen et al 1996) to suggest that it may be even more significant in enabling students to cope with the new content than college based learning. However, there is no requirement for the former arrangements for community practice teaching to continue, nor any plans to replace them with new arrangements geared to the needs of health visitor students.

Again, the underlying problem seems to lie with the wish for health visitors to fit into arrangements that suit community nursing in general, and the contested view that health visiting knowledge is only an extension of learning gained at first level registration. There has been no history of the 'newer' specialisms like general practice nursing or community children's nursing having named or specially prepared community practice teachers, nor have all the other the groups included in the CHCN framework either used or wanted this approach. Given the 'straight line' of development outlined in Section 4.3.1, it may not be as essential for those groups as it is for health visitor students, who are entering a profession that has an approach and knowledge base that is widely perceived as very different from that encountered in first level nurse training programmes.

The traditional CPT training and approach has not changed for several decades, so there may well be a case to be made for it to be thoroughly modernised and upgraded academically. Such a review would be timely, given that the new teaching standards were due to be published by the UKCC just as this project was being finalised, and some clarity is needed about how they will affect both the current community practice teacher (CPT) and health visitor tutor (HVT) qualifications.. Whether or not the titles and roles change, the functions they carry out provide an essential link in the chain of professional self-regulation and the maintenance of professional standards, and some mechanism will be needed to demonstrate how any new arrangements maintain the links.

The evidence gained through the interviews and documentary analysis provided a worrying insight into the variation and inconsistency of health visiting programmes. Also, it suggested that the course leaders were finding it very difficult to make the

changes required to update programmes in line with the new policy developments that have the potential to affect health visiting quite markedly. One of the problems about having a framework that encompasses the whole range of nursing in community and primary care summarised in Figure 3.1, is that it may inhibit flexibility and change when it is needed for only a minority of students or one sphere of action. This may be the case particularly for institutions that elected to have the maximum 'common core' of two thirds rather than only one third shared learning. Perhaps, as with pre-registration education (UKCC 1999a), the extent of assumed commonality for teaching might be reduced.

The hostility faced by some health visiting course leaders when they flag up the needs of their particular students may be another factor inhibiting the introduction of new learning to the courses. The statutory basis of the qualification suggests that the course leaders have a very specific responsibility to ensure their students are 'fit for practice' and to be registered in their new profession. However, there is a lack of clarity where health visiting course leaders are not in control of the whole programme, and the mandate for maintaining health visiting standards falls to a lecturer from a different discipline. There is no reason at all for health visiting lecturers to be prioritised above their peers from other community specialisms in becoming overall programme leaders, but a regulation that makes discipline-specific responsibilities clear would be helpful for health visiting. This scoping project did not seek views from the other disciplines, but it is possible that course leaders from all the different areas of community nursing practice would welcome clarity about responsibilities for their particular specialism.

The acceptance as a norm of 'modified courses' for current health visitor preparation was identified as a major reason for the apparent inconsistency in the current programmes; this allows a situation in which institutions can select which topics they prioritise for teaching. A far larger and more rigorous study would be needed to identify whether the variation is as extreme in practice as it appears, or if it might conceivably fall within the boundaries of acceptability. There is a very fine dividing line between flexibility, which is generally considered desirable, and inconsistency, which is not. It should be possible to devise some clear principles by which proposed modifications can be assessed, to ensure that students are able to acquire the competencies and knowledge needed to practise as health visitors by the time they have completed the modified programme. These principles might be incorporated into a modernised statute, to set a new standard and avoid the need for all courses to be 'modified;' or they could be used to strengthen application of the current training rules.

The lack of peer supervision (e.g. of health visitor education officers at National Board level) or oversight of programmes was identified as another contributory factor in the apparent inconsistency. Although some specialist input is required in the process, this may be quite minimal. Thus, there is no really visible process to show that 'self-regulation by professional peers' happens in the preparation of health visitors at present, and the legislation appears to have become a matter of peripheral concern. It is not a requirement for health visitors to control standards of the programmes of preparation, either within institutions or nationally. Health visitors are not required to oversee the

practice experience of students or to affirm the practitioner as suitable for entry to the register. Whilst many of these things happen as a matter of good practice, arrangements appear to be varied as soon as they become an encumbrance to organisations as a whole. This leads to the potential for as much variation in standards of professional practice as in education, and the regulatory process cannot guarantee consistency.

Summary of options

- The prevalence of 'modified programmes' as a norm contributes to the apparent inconsistency across courses. Principles by which proposed modifications could be assessed might be incorporated into a modernised statute to set a new standard for programmes, or used to strengthen application of the current training rules.
- The regulations need clarifying and strengthening, to make 'professional self-regulation' as meaningful in health visiting as it is in nursing and midwifery. Clarifying disciplinary responsibilities would not require a change to the statute.
- 'Regulation by professional peers' should be visible and auditable at three levels:
  (1) development of programmes and course content overall (validation processes);
  (2) control of modules and teaching patterns in the everyday running of programmes (delivery of programme);
  (3) assessment of student progress, including approval of 'fitness for practice' and entry to the register.
- The health visitor CPT provides an essential link in the chain of professional self-regulation and the maintenance of professional standards. In the light of the new teacher standards, the preparation and approach to the role might be reviewed with a view to clarifying and upgrading it academically.
- The position of the Health Visitor Tutor needs clarifying in the light of the new teacher standards and the chain of professional self-regulation in health visiting.

6.3.3 Appropriateness of current learning outcomes for contemporary practice

As indicated in Chapter 3, there is little clarity or consensus at present about the most suitable roles and activities for health visitors to engage in. Some difficult accountability issues faced by Trusts and employers were examined, and Section 5.3 unravelled timing differences in considering requirements of 'fitness for practice' or 'fitness for purpose'. In the former, a wide focus and general education is needed to befit students for practice not only in the immediate future, but also in developing a capacity for flexibility and professional development to last them throughout their working lives. A more immediate, topic-specific focus is required to decide if a practitioner is 'fit for the purpose' of carrying out a particular job of work. The primary purpose of professional education is to prepare practitioners to be 'fit for practice' in their particular field, but the different views about legitimate areas of practice for health visitors inevitably creates difficulties. It is particularly problematic for the UKCC as the regulatory body across the four countries, since it is not sufficient for them to be guided only by the roles favoured by the English Department of Health or within the Welsh Assembly, for example; or even (given the changing interface between health and local authorities, and between public

and charitable funding) to focus solely upon the NHS as the most likely employer for health visitors.

For these reasons, a broad approach was taken in scrutinising policy documents in conjunction with both enduring and emerging trends in health care and across different political environments. This approach revealed three potential roles (general family support, family-centred public health worker and community development/outreach work to vulnerable groups); these are outlined in Chapter 3 and detailed in Appendix 1. English policy documents gave the most specific details and tended to name the health visitor more often than documents from the rest of the United Kingdom. However, the suggested roles were described, collectively, as meeting the expectations of the current government, as well as being relevant to the emerging expectations of health visiting in Wales, Scotland, Northern Ireland and England. It was argued that they would also transcend the present political situation and be likely to endure beyond the early years of the twenty-first century. While they all contain aspects that are fairly familiar, a detailed, national curriculum development process would be needed to distil the exact core skills for these three roles; it was emphasised that professional preparation needed to encompass all three roles rather than focus upon only one. This was the outlook that was taken to analysing the interviews with course leaders and curriculum documents collected as data for Chapter 4.

Analysis of those data indicated that few courses were able to include all the learning outcomes listed in the standards for practice (UKCC 1998); instead they were interpreted differently in different institutions. The guidance encourages adaptation, specifying that:

> 13. The content of the programme of education should be adapted to the relevant area of community nursing practice . . . [and]
> 14. The content of the programme of education should be adapted to the area of specialist practice as appropriate (UKCC 1998: 9, 11)

The data showed that the list of given outcomes could be adapted and rendered appropriate; indeed some adaptation was always required, but this was sometimes easier than others. The heavy focus on 'clinical nursing' as the main focus for learning, for example, was clearly unhelpful; it seemed to create difficulties in identifying outcomes that would help shift students towards a primary preventive, health visiting stance. It served as an indicator that nursing, not health visiting, was the main priority for learning. In another example, the principles of health visiting (CETHV 1977) were included as learning outcomes in an adapted format, but the different wording has changed their meaning (see Section 2.4.2). Course leaders are able to change the wording back to the original when planning their curriculum. However, just as every course is now officially 'modified' according to the statute, so it seems that many of the prescribed outcomes need to be 'adapted' to fit the learning requirements of health visiting students.

There were two major problems in implementing the learning outcomes:

a) The lack of time to implement appropriate outcomes once they had been discerned, particularly given the requirements to concentrate on 'common core' issues of central importance to other community disciplines but not to health visiting;

b) The marked inconsistency across courses identified in Chapter 4, stemming from the extent of flexibility allowed by the standards, with associated selection and adaptation of the stated learning outcomes.

The time pressures noted in point (a) led to a necessary degree of selection among the prescribed learning outcomes, so that some institutions appeared to prepare students for practice as general family support workers, for example, maintaining a distinct focus on child development, management of child protection and family relationships. Other institutions provided very minimal preparation for family matters, instead concerning themselves with the issue of public health, interpreting the learning outcomes (as also shown by Oldman 1999 and Pearson et al, in press) in a range of different ways.

Most courses emphasised issues of management and leadership since these were in the CHCN common core, but this was often at the expense of the 'basic essentials' needed for health visiting practice – like dealing with child protection or organising group work in an enabling/empowering way. Thus, students would be prepared, in theory, to 'lead a team,' but their ability to delegate work would be undermined by a lack of confidence in their own ability to carry out the delegated activities. Conversely, very few courses focused on the complex skills needed for the inter-disciplinary and inter-agency outreach work that is such a significant part of the government's social exclusion agenda. It was argued in Section 3.5 that this is one area where health visitors are particularly needed. First, there are high numbers of unregulated workers and correspondingly high levels of vulnerability in this field. Second, it is through this outreach function that health visiting can provide a much needed bridge between mainstream NHS/primary care activities and the more diffuse project work, enabling both to contribute effectively and collaboratively to local HImPs. The current learning outcomes do not encompass the necessary requirements for public health practice as outlined by Lessof et al (1999) either; this is discussed further in Section 6.4.1.

While the superficial nature of the data collected for this project must be acknowledged again, it is worrying that so few of the courses seemed able to include learning outcomes relevant to the whole range of skills and abilities needed for contemporary health visiting practice. Also, since it is only by 'modifying' and 'adapting' that the syllabus can be rendered suitable, it seems that the programme outline, itself, needs to be revisited in the light of contemporary practice.

A national curriculum development project would be very helpful in identifying which learning outcomes are considered essential as a basic minimum for all registered health visitors. This would go some way towards addressing inconsistencies created by adapting learning outcomes across programmes. Relevance to current expectations is an issue for existing practitioners, as well as for health visiting students preparing to meet the requirements of registration; this is considered next.

Summary of options

- Expectations of contemporary practice are not clear or agreed across the UK, but three potential roles were identified from a review of policy trends. A national curriculum development project would be helpful in gaining consensus about which particular learning outcomes are thought necessary as a minimum standard for all registered health visitors.
- The heavy emphasis in the learning outcomes on clinical nursing, managerial and leadership responsibilities distracts from the development of a capacity for basic health visiting as a grounding for flexible professional development in future.
- Shortage of learning time is a major problem, leading to selection, adaptation and further inconsistency across programmes; this problem should be addressed by options suggested in Sections 6.2.2, 6.2.3 and 6.3.3.

6.3.4 Maintaining standards in health visiting practice

The changing nature of regulation, risk management and clinical governance was examined in Chapters 3 and 5, in relation to the different accountability mechanisms and points at which each aspect came to the fore. It is clear that the UKCC has a specific responsibility to ensure that only those deemed fit to practice are actually entered on Part 11 of the register; there is also a regulatory duty in relation to safe practice and the good conduct of practitioners who are currently registered. The PREP regulations were developed to help meet this second requirement.

As currently formulated (UKCC 2000), there is no requirement for health visitors to maintain competence or to be currently practising in the field in order to maintain their health visiting registration. As identified in section 5.2, a health visitor can maintain her registration by virtue of having worked as a nurse. The assumption is, of course, that neither an employer nor a health visitor would sanction a situation in which a practitioner who had not worked by virtue of her qualification for many years, if at all, could be placed immediately into a health visiting role without appropriate retraining and support. However, if that assumption is always justified, it begs the question as to why there is a need to have any regulations requiring registrants to maintain and develop their practice skills; the 'scope of practice' expectations would cover all eventualities. This arrangement is anomalous, since both nurses and midwives are expected to maintain their competence and be currently practising in the field to be able to retain registration. The current arrangement should serve to protect the public from misconduct, which would be judged similarly in nursing and health visiting, but it is doubtful whether it provides any protection against poor performance.

In their review of professional regulation, JM Consulting Ltd (1998) define poor performance as

'performance which departs sufficiently from **accepted good practice** to call into question the continued fitness to practice of the individual (JM Consulting Ltd 1998: 19, added emphasis)

Some means by which 'accepted good practice' can be recognised is necessary, therefore, and can only be achieved by continual updating, development and maintenance of standards by both registered individuals, and in the profession overall. JM Consulting

Ltd (1998) noted that, when it served as a regulatory body, the CETHV had no mechanism through which to discipline misconduct in health visitors; if necessary any such cases were dealt with only through the nursing regulatory system. Conversely, the mechanisms for regulating professional standards, and through them the level of health visitor performance, were prioritised; being highly visible and stringent (see Chapters 1, 4 and Wilkie 1979 for details). The procedures adopted by the UKCC since they took on the regulation of health visiting appear to have reversed this priority, apparently concentrating on conduct at the expense of performance.

However, the need for a basic benchmark by which professional performance may be assessed was further highlighted by the accountability scenarios summarised in Chapter 5. These illustrated the significance of a 'health visiting professional judgement.' Because of the legislative position of health visiting, this is considered distinct from the professional judgement expected of nurses, even those working in the community or with higher level practice skills in different fields. That is not to suggest that the basic cognitive processes embedded in reaching a health visiting professional judgement are either different or superior to those of any other discipline, but the combination of knowledge, skills, principles and practice approaches provides a unique blend that is not found in any other professional. As identified in Section 2.3.3, it lies in Grace Owen's famous analogy of the 'cocktail, not the constituent parts.' A health visitor called upon to provide a professional judgement in a child protection case, for example, would be expected to offer a different perspective from that provided by a practice nurse, a paediatrician or a social worker, even if all agreed on the basic essentials of the case.

As organisations like PCGs, Community and Primary Care Trusts roll out their plans for clinical governance, therefore, it will be important for them to be assured that there is basic reference point against which both 'health visiting professional judgements' and 'accepted good practice in health visiting' can be assessed. The maintenance and development of health visiting as a profession is, therefore, a basic requirement for risk management and accountability at an organisational level, as well as in considering the performance and practice of individual health visitors.

As an important side issue, the data collected for Chapter 4 revealed a need for far more attention to be paid to the on-going education of existing health visitors, particularly in the light of changing practice and changing roles. Whilst there is much convergence, as shown in Tables 3.6 and 3.8, between current government priorities, evidence of effectiveness and the so-called 'traditional approaches' to health visiting, there are many significant differences in the detail of practice. The increased likelihood that health visitors will be employed in projects funded, and possibly operated, from outside the NHS adds to the importance of ensuring current health visitors are fully updated and competent to practice according to standards that are regulated as rigorously as those that cover nurses and midwives.

Summary of options

- In the light of the government's rejection of the view that health visiting should be regulated as part of the nursing profession, Council may consider that health visitors should be required to maintain their competence and demonstrate current practice in the field in order to maintain their registration as health visitors.
- Alternatively, some other regulatory mechanism by which the public can be protected against poorly performing health visitors will be required.
- Maintenance and development of standards of the health visiting profession as a whole are not functions of the UKCC, but regulation and accountability mechanisms require a clear view about what constitutes currently 'accepted good practice'.

6.4 The interface with other disciplines, agencies and countries

6.4.1 Emerging professions

Both family welfare and public health are increasingly high on the national and international scene. The syllabus from the World Health Organisation's 'Family Health Nurse' and that for membership of the Faculty of Public Health Medicine were both examined as part of the analysis. Also, as the expectations of practice change, a wide number of Trusts and health authorities have carried out unpublished reviews of health visiting and, often, school nursing. In Scotland and England, reviews focused on developing the public health capacity, which has raised interest in both health visiting and school nursing; no reviews have been identified in Northern Ireland as yet. In Wales, a country-wide review of these services is just reaching its conclusion. The Welsh review is expected to echo the point made in Section 4.5 and identified by Oldman (1999) and Pearson et al (in press). Professional standards cannot be maintained by pre-registration alone; there is a need for management support for new roles to develop in practice; otherwise students simply become confused that they are being taught one thing in college and seeing another in practice. However, the determination of the current government to raise the profile of public health is clear.

Indeed, the emerging profession of public health practice was singled out for comment in Chapters 3 and 4, since a new register is in the process of being established (DH 1999a). The anomalous position of health visitors and school nurses was detailed in Section 4.1.3, as their routes into a career in public health will be far more difficult and lengthy than for colleague professionals like environmental health or health promotion officers. Whilst there is no direct link to the regulation of health visitors, it is clearly important for the future of the profession that its practitioners should not be so disadvantaged. If the curriculum review project proposed under Section 6.3.3 is initiated, it would be helpful for it to include an examination of the standards required for public health practitioners with a view to incorporating them in the syllabus for health visiting, and for the other 'wholly public health' workers currently educated through the CHCN framework (i.e., school and occupational health nurses).

The opposite position was the case for the other emerging multi-disciplinary group centred around early childhood. While there is an increasing number of unregulated workers in this field, that does not mean they are necessarily unqualified; indeed some

hold high-level qualifications, are very skilled and increasingly welcomed into teams led by health visitors or on projects in which health visitors work. The analysis of curriculum documents in Chapter 4, for example, contrasted whole modules about 'preventive child protection' (MA Early Childhood Studies) or child protection, welfare and the law (BA Early Childhood Studies) with only one day on the topic in some of the health visiting programmes.

However, under the present system, practitioners from these other backgrounds may be disadvantaged in career terms, because of being unable to access health visitor education since they are not nurses. In the long term, again, it is possible that this will adversely affect the future of the profession, if teams and projects choose members and leaders that are not registered health visitors, but hold other relevant qualifications. As indicated in Section 3.5, this is particularly likely to be the case for outreach workers involved with some of the most vulnerable populations, possibly employed in small, local projects rather than in local authorities or NHS Trusts. Of more importance than the position of the professionals, is the potential loss of a 'health perspective' through the link that health visiting provides between free-standing projects and mainstream services, and of the protection offered to a very vulnerable public by the processes of professional regulation.

The UKCC may have no official responsibility to consider the effect of their regulatory practice on the public as whole, except on those individuals identified as patients or clients of nurses, midwives and health visitors. Also, the development of roles to meet particular needs is the responsibility of employers and professionals, not of Council. However, the way the regulatory process operates (particularly initial preparation for registration) does have a long term impact on the types of practitioners available to meet the needs of vulnerable populations. In the long term, a more flexible policy in relation to entry to the health visiting profession may pay dividends for the workers concerned and for the population they serve.

Summary of options

- A curriculum review (as proposed in Section 6.3.3) should consider the feasibility of including the national standards for public health practitioners into the syllabus for health visiting;
- The emergence of multi-disciplinary professions and multi-agency working points, once more, to the need to consider flexible entry points to health visitor education.

6.4.2 Multi-disciplinary working

Shared learning and preparation for inter-disciplinary working, as mentioned in Section 6.2.3, was a powerful driving force behind the development of the CHCN framework. Inter-agency collaboration was high on the agenda when it was introduced, but primary care was seen then, as now, as the key location for service provision. Indeed, as a legacy of GP fundholding, the vast majority of health visitors are now based in GP practices and contracted primarily to deliver pre-scheduled contacts and programmes of care to children under five years of age. This arrangement works very well in many respects, but it limits

the extent to which health visitor students can gain experience of multi-agency teams and community outreach work, and reinforces the 'status quo' of traditional health visiting work. The advent of Primary Care Trusts could allow a more relaxed stance towards locality or neighbourhood working, which promotes greater multi-agency teamwork, but this is neither generally encouraged nor the experience of most health visitors at present.

Given this background, the learning outcomes for the CHCN courses privilege the health visiting interface with primary health care and nursing teams based in the NHS, apparently at the expense of other opportunities for shared learning. The changing nature of primary health care noted in Chapter 3 and Figure 3.1 shows that there is an increasing need for nurses working in acute and intermediate care in community settings to liaise with their hospital colleagues. However, for those working in preventive care – the sphere of interest for health visitors and school nurses – there is a need to rediscover links with, for example, social work, social policy, psychology, environmental health and education workers. Learning to work only within the NHS and across nursing fields is not sufficient to meet current expectations for health visitors to contribute across family support and public health agendas, or to inter-agency and inter-professional working.

It is at least possible that welcoming individuals from backgrounds other than nursing into the health visiting profession would help to promote links between the formal public services (particularly between health and local authorities) and with the voluntary sector. Educationally, as indicated in Section 4.5, there is no logical reason why entrants could not learn such nursing skills as are believed necessary during health visitor preparation, just as nurses need to learn about, for example, public health and child protection before they qualify as health visitors. Appendix 10 includes a syllabus from Greece, to show an example of how this could work. Potentially, having a multi-disciplinary and multi-agency intake would help to break down barriers in line with the vision of 'joined-up thinking' being promoted by the current government. However, before this course of action could be implemented, it would be necessary to have a far clearer idea of what learning outcomes are actually needed by health visitors, whether gained through earlier nursing experience or on the health visiting programme (see Section 6.3.3).

Also, there are a number of organisational barriers to a 'direct entry route', in addition to the ideological ones flagged up in Chapter 2. The statute would need to be changed to focus upon the learning outcomes of health visitor education rather than entry points, although it may be possible to negotiate some pilot, demonstration sites to test the feasibility of different approaches. Both nursing and health visitor education are fully funded by the NHS, and consortia may not feel inclined to use scarce resources to enable voluntary sector or local authority workers to qualify as health visitors. To accommodate the 'common core' and facilitate introduction of the CHCN course, too, most health visiting programmes have moved into schools and faculties of nursing, once the latter became established in universities. Whilst this makes it harder to gain the breadth of learning required by a multi-disciplinary cohort, there is no reason why opening health visiting education to non-nurse entrants should preclude continued shared learning with community nurses in suitable modules and lectures. Perhaps one of the biggest barriers to change in the past has been the way discussions about the relationship between health

visiting and nursing have been characterised, often heatedly, in 'all or nothing' terms. As the analysis in Section 2.3.3 showed, there are a range of options along a continuum; only the most polarised opinions exclude the notion of shared learning.

However, as Section 2.3.2 also revealed, those polarised opinions are held very strongly by protagonists and interested stakeholders across the nursing and health visiting fields. When it was first established, the UKCC was set up with a 'unifying brief' which fitted well with the twentieth century view of professions as unitary entities. The success for nursing as a profession would, in this view, be best secured by integrating all related schools of thought into a single perspective. At the dawn of the twenty-first century, the whole notion of professionalism is changing, and the idea of 'multi-disciplinary professions', as shown in the examples of public health and early childhood working, are becoming more prevalent. Multi-disciplinary professions are a pragmatic response to the contradictory demands, outlined in Section 2.3.1 and Table 3.1, created by a parallel increase in genericism (far more in common between professions than ever before) and in specialism (a need for more in-depth and detailed specific knowledge than ever before).

The JM Consulting Ltd (1998) review indicated that, in future, professional regulation as a whole might usefully move towards a more multi-disciplinary stance. The three elements required to make this successful, it suggested, were that:

- Each profession is treated as an equal, with common standards and principles agreed by all;
- Each profession is able to consider profession-specific issues relevant to it that are of significance to the regulatory body;
- The [regulatory] scheme is not overburdened with matters of detail that will make it too cumbersome, slow and inflexible to respond; and that it can call upon other bodies to assist with advice and guidance. (JM Consulting Ltd 1998: 46)

The UKCC already follows the first two points (which acknowledge genericism and specialism) in considering the needs of nursing and midwifery. Allowing a non-nursing entry into health visiting may make it easier for Council to operate the government's expectation, spelt out in their response to the Review, that health visiting is to be afforded equal representation with nursing and midwifery in future. The suggested national curriculum development project (Section 6.3.3) should provide a firm basis from which to gain enough advice and guidance about 'details' such as those alluded to in the third point above. The project could focus on identifying how a genuine multi-agency and multi-disciplinary agenda for shared learning could be developed, without jeopardising the existing important links within primary care teams and with schools of nursing.

Summary of options

- Consideration could be given to setting up some demonstration sites/pilot projects to test the feasibility of training a multi-disciplinary cohort of health visitor students.
- A curriculum development project looking at the requisite learning outcomes for health visiting (see Section 6.3.3) could be asked, additionally, to explore options for

multi-disciplinary and multi-agency learning that preserve links with primary care and nursing.

6.4.3 Community health care nursing

A brief examination of community nursing options implemented overseas, in Section 3.4, offered no comparable model that appeared immediately useful or transferable to this country, since each approach is country specific and heavily influenced by health service systems. It was noted that the few other places that have health visitors continue to recognise them as distinct from nursing. The many places that have 'community,' 'primary care' or 'public health' nurses all use the terms differently, and without the same connotations implied in their usage in this country.

Community health care nursing (CHCN) was the title chosen by the UKCC to encompass all those nurses working in non-institutional settings, of whom it was assumed there was sufficient common ground for them to become a single 'unified discipline'. This has been disputed, not least by Hyde (1995). Given the different employers, working situations, levels of practice (i.e., individual, family or community as client), usual colleagues and goals of practice across the eight specialisms, she comments that :

'. . community nurses are in fact as diverse in their characteristics, functions, practices and networks as in their individual appearances. . . . . . Perhaps the question which begs addressing is not whether community nursing is unified discipline, but whether it is a discipline at all?' (Hyde 1995: 1 & 23)

Whilst there are, without doubt, a number of commonalties between health visitors and nurses who work in a community setting, Hyde points out that these are equally likely to be held in common with almost any professional group working with people. The shared learning between different community nurses was singled out for positive comment by the health visiting lecturers interviewed for this project and, despite the difficulties, they identified a number of advantages. The CHCN framework has encouraged integration of health visitor education into nursing schools and faculties within universities which has economies of scale; it is administratively easier for educational consortia and for developing national policies that concentrate on broad generalities and strategic planning. However, there was a cost, in that the specific needs of health visiting students and their lecturers were often missed in educational practice. While the situation was by no means all bad, the general impression was that any benefits from the CHCN framework were outweighed by the disadvantages for health visiting students.

The CHCN framework was implemented between 1995 and 1998, so the usual five-year re-validations of programmes are currently underway, with the largest numbers expected in 2001 and 2002. It would clearly be helpful if any changes to be recommended were identified sooner rather than later. However, since health visitor education is now completely integrated into the CHCN framework, changes made to one specialism will have an knock-on effect to the other seven areas of practice encompassed within it.

As it was beyond the remit of this scoping project, no data were sought to discover whether the other areas of practice were more satisfied than the health visiting lecturers with the overall programme. Anecdotally, however, health visiting is not the only discipline to express disappointment with the way the new framework operates in practice. Primary care nurse practitioners continue to seek a recognised qualification for their role, for example, whilst general practice nurses find the teaching time devoted to specialist clinical knowledge (e.g., chronic disease management, cervical screening or family planning) is too limited. Community mental health nurses, likewise, complain of too little attention to specific therapies; in any case, they identify with mental health as a specialism, not community nursing. Community children's nurses, too, seem inclined to see themselves as specialists in child health rather than in ' community'. These allegiances are reflected in the organisation of, for example, the National Boards, NHS Executive and many Trusts and commissioning authorities, that separate the specialisms into 'primary care,' 'mental health' and 'children's services' – not 'community'.

Also, the rise of interest in the nursing contribution to public health overall has raised questions about how nurses who do not wish to enter the specific 'public health specialisms' (i.e., of health visiting, school nursing, occupational health and communicable disease nursing), can gain experience and credit for learning about the strategic and commissioning aspects of public health. Most of these dilemmas reflect the same tensions between genericism and specialisation and in the changing nature of professions and organisations, discussed in the last section and in Chapters 2 and 3. In turn, these aspects draw attention to the facts that professional identity matters; that career patterns and pathways are important and that organisational efficiency and effectiveness need taking into account whatever changes are made to systems of professional education and regulation.

Overall, this project has shown that some changes are needed so that the education and regulation of health visitors can meet the statutory requirements and the need to ensure that those whose names are included in the health visiting register are safe and competent to practice. Whether these changes should be implemented unilaterally or in conjunction with a wider review of the community health care nursing framework is clearly a difficult judgement that will need to be made by Council.

Summary of options

- Because of the close integration of health visitor education into the CHCN framework, any changes to take account of the statutory and regulatory requirements of health visiting will have an effect on other community nursing programmes.
- A wider review of how the CHCN framework is perceived by the other seven areas of practice encompassed in it may be indicated.

6.5 Conclusions and recommendations

6.5.1 Health visiting as a profession

Two conflicting views of health visiting have featured throughout this report. The first is the view, increasingly adopted by the UKCC in its structures and procedures, that health visiting is a specialist branch of nursing. The second is the view enshrined in statute, that health visiting is a profession in its own right, allied to nursing and regulated by the same regulatory body as nurses and midwives, but retaining a distinct identity. This second position represents the formal statutory position that was reaffirmed by the statement made last year (NHSE 1999).

As the UKCC and Boards are re-organised to take account of the full recommendations of the JM Consulting Ltd (1998) report, they will need to establish procedures, as required, to ensure that each of the three professions they regulate are equally represented and that none of them can be outvoted by the others on sole concern to that profession. The first recommendation to come from this scoping project, therefore, reiterates the statutory position and links it with four issues that have surfaced in the report.

Recommendation 1.

Council should ensure that its structures and procedures recognise health visiting as a separately registered profession.

1.1 The procedures for ensuring professional self-regulation by health visitors need strengthening and clarifying, so that they are visible and auditable throughout the education and registration process.
1.2 On qualifying, health visitors are entering a new profession, so it is important for them to be supported through preceptorship.
1.3 Although there is an obvious potential for health visitors to develop beyond the level achieved at qualification, their separate registration means there is no clear advantage in involving them in a system for regulating 'higher level practice'.
1.4 Health visitors should be required to maintain their competence and demonstrate current practice in the field in order to maintain their registration as health visitors.

6.5.2 A curriculum for health visitor education

The report has demonstrated an relative lack of attention in the regulatory process, to the skills, knowledge and abilities – the learning outcomes – that students actually need to acquire before they register as health visitors. The confusion is compounded by a lack of agreement about what relevant skills, knowledge and abilities nurses bring with them when they enter the training, by the changing expectations of policy across England, Northern Ireland, Scotland and Wales, and by some striking differences between what is stated in policy and what actually happens in contemporary practice.

There has been no specific examination of the learning needs of health visitor students since the former curriculum was established in 1965. The Community Health Care Nursing framework implemented in 1994 was the third report in the series about post-

registration education and practice (PREP) that intentionally set out to examine the whole of nursing and community nursing, incorporating health visiting within that brief. As this report shows, the health visitor education process has become skewed by concentrating on entry qualifications instead of learning outcomes, and focusing solely on nursing roles in primary care at the expense of inter-sectoral and inter-professional activities. The second recommendation, therefore, proposes a national (UK-wide) curriculum development project that concentrates on the educational needs of health visitors.

Recommendation 2

A national curriculum development project should be set up, to identify the educational needs of health visitor students to enable them to fulfill expectations of a modern role in public health, primary care and family support.

2.1 A full situational analysis, to indicate important factors internal to the health visiting profession and external to it, is needed. This would involve gathering information from a range of stakeholders including consumers and colleagues from across sectors.
2.2 The curriculum project should concentrate, first, on identifying the learning outcomes required by health visitors. These could be used to clarify the suitable academic level, 'normal' length and type of programme, and relevant knowledge held by nurses (or, if the statute changes, any others) that might be accredited as prior learning.
2.3 Key principles should be identified, by which the design and purpose of health visitor education can be assessed to inform programme validations and regain consistency across the regulatory process.
2.4 Attention should be paid to the educational interface and potential for shared learning with a range of relevant colleagues and sectors, including but not restricted to, nurses in primary care.

6.5.3 The capacity for health visitor education

The project highlighted the age and dwindling workforce of health visitors, and that the numbers of new registrants are currently insufficient to replace the number likely to retire in the next five to ten years. Also, the extent of change being expected of health visitors points to a significant need for some continuing education of existing practitioners. There have been major structural re-organisations affecting health visitor education in a number of Higher Education Institutions and many Health Visitor Tutors (HVTs) are fully or partly engaged in pre-registration nurse education. Not all Trusts or educational institutions currently use Community Practice Teachers (CPTs). The recently agreed Standards for Teacher Preparation have implications for both HVTs and CPTs and the roles they formerly adopted in ensuring standards in health visitor education. Thus, there is a need to consider the capacity for health visitor education as a whole.

Recommendation 3

The capacity for educating present and future health visitors should be assessed, in conjunction with workforce planning, replacement and continuing education needs.

3.1 Some reliable workforce data giving the age and likely retirement patterns of current Health Visitor Tutors (HVT) and Community Practice Teachers (CPT) is needed.
3.2 Bearing in mind the need to clarify the processes of professional self-regulation (see Recommendation 1.1), the way the new Standards for Teachers will apply to the former HVT and CPT roles needs examining and explaining.

6.5.4 Expanding the future potential

The need to consider a wider range of possible entrants to health visitor education has featured throughout the report. The statute specifies registration on Part 1 of the nursing register as an entry requirement, which is clearly out of step with contemporary nursing education. At the very least, the statute will need amending to take account of the simplification of the nursing register recommended by JM Consulting Ltd (1998). It was argued that the current alternatives (only Part 1 of the nursing register, or all registered nurses – but not midwives – allowed to become health visitors) are confusing. The requirement encourages an inflexible approach to multi-sectoral and multi-professional education, particularly in relation to career patterns in public health and early childhood/family support work. Furthermore, concentrating on entry requirements instead of learning outcomes distracts from what practitioners need to learn in order to be safe practitioners of health visiting. The fourth recommendation would require a change in statute to address these difficulties.

Recommendation 4

To encourage flexibility without compromising the safety of the vulnerable public, the statute could be modernised to emphasise the knowledge, skills and abilities needed to practice as a registered health visitor.

4.1 The learning outcomes required for health visiting practice should be clarified (as in Recommendation 2.2), and procedures for professional self-regulation strengthened and audited (as in Recommendation 1.1) as a replacement for the current 'entry requirements' approach.
4.2 Pilot projects could then be established to assess the impact of preparing a multi-professional cohort of students for entry to the health visiting register. These would probably need to be post-graduate programmes, and would need sound procedures for accrediting prior learning (including from first level nurse registration).
4.3 A direct entry degree programme for potential students with no prior professional qualifications might be piloted to attract younger applicants, or mature entrants from, for example, community mothers or community development projects.
4.4 If the above procedures were established and shown to be successful, it would no longer be necessary to restrict entry to health visitor training to a single profession.

6.5.5 'Accepted good practice'

The report highlighted the difficulties that are likely to arise if there is no established view from the profession as a whole about what constitutes 'accepted good practice' in health visiting. Likewise, there is a need for a basic standard against which to assess a 'health visiting professional judgement' if individual practitioners are called to account. Most risk management procedures, clinical governance and accountability procedures presume that such benchmarks exist, and pre-registration education is based on an assumption that students are learning an acceptable level of professional competence. However, there is no formal system by which such professional standards are developed, articulated or assessed in practice or education.

The responsibility for maintaining and developing professional standards in practice may not be part of the official remit of the UKCC, but it is still a necessary part of the regulatory process. Accordingly, the final recommendation flags up the importance of this missing link.

Recommendation 5

A standing committee should be formed through which the standards of the health visiting profession as a whole can be monitored, maintained and developed.

5.1 Such a committee may form one part of the re-organised structure of UKCC and Boards, to ensure that health visiting matters are represented. It should provide information about 'matters of detail' relating specifically to health visiting and aid the process of multi-disciplinary regulation across the three professions.

5.2 It should be able to provide credible and authoritative information about health visiting to employers, commissioners and policy-makers. It would protect the public by enabling health visiting services to effectively implement the processes of clinical governance and evidence based practice.

5.3 It is important that such a committee maintains the confidence of practising health visitors and consumers of their service.

Appendix 1

Learning outcomes required in currrent preparation of health visitor students. Extract from:

STANDARDS FOR SPECIALIST EDUCATION AND PRACTICE

United Kingdom Central Council for Nursing, Midwifery and Health Visiting 1998

Standards for specialist community nursing education and practice

13 Common core learning outcomes

Whilst the content of the programme of education should be adapted to the relevant area of community nursing practice, the following are pertinent to all areas.

The nurse should achieve the following core outcomes:

Clinical nursing practice

13.1 Assess the health and health related needs of patients, clients, their families and other carers and identify and initiate appropriate steps for effective care for individuals, groups and communities;

13.2 Plan, provide and evaluate skilled nursing care in differing environments with varied resources. Specialist community nurses must be able to adapt to working in people's homes and also small institutions, health centres, surgeries, schools and places of work;

13.3 Support informal carers in a partnership for the giving of care. The majority of care in the community is given by informal carers. They need guidance, support and resources to carry out tasks so that there is continuity of care for the patient;

13.4 Assess and manage care needs in a range of settings. These are complex activities which call for informed judgement to distinguish between health and social needs recognising that the distinction is often a fine, but critical, one;

13.5 Provide counselling and psychological support for individuals and their carers;

13.6 Facilitate learning in relation to identified health needs for patients, clients and their carers;

13.7 Prescribe from a nursing formulary, where the legislation permits;

13.8 Act independently within a multi-disciplinary/multi-agency context and

13.9 Support and empower patients, clients and their carers to influence and use available services, information and skills to the full and to participate in decisions concerning their care.

Care and programme management

13.10 Advise on the range of services available to assist with care. The services may be at local, regional or national levels. Knowledge of these services will need

to be kept up-to-date and advice given to people on how to access and use them;

13.11 Recognise ethical and legal issues, which have implications for nursing practice and take appropriate action;

13.12 Identify the social, political and economic factors, which influence patient/client care and impact on health;

13.13 Stimulate an awareness of health and care needs at both individual and structural levels. Activities will include work with individuals, families, groups and communities and will relate to those who are well, ill, dying, handicapped or disabled. Those who are able should be assisted to recognise their own health needs in order to decide on action appropriate to their own lifestyle. Those who are not able will require skilled and sensitive help;

13.14 Identify and select from a range of health and social agencies, those, which will assist and improve the care of individuals, groups and communities;

13.15 Search out and identify evolving health care needs and situations hazardous to health and take appropriate action. This is a continuous activity and involves being pro-active, it must not be dependent on waiting for people to request care;

13.16 Initiate and contribute to strategies designed to promote and improve health and prevent disease in individuals, groups and communities;

13.17 Empower people to take appropriate action to influence health policies. Individuals, families and groups must have a say in how they live their lives and must know about the services they need to help them to do so and

13.18 Provide accurate and rigorously collated health data to employing authorities and purchasers through health profiles in order to inform health policies and the provision of health care.

Clinical practice leadership

13.19 Act as a source of expert advice in clinical nursing practice to the primary health care team and others;

13.20 Lead and clinically direct the professional team to ensure the implementation and monitoring of quality assured standards of care by effective and efficient management of finite resources;

13.21 Identify individual potential in registered nurses and specialist practitioners, through effective appraisal system. As a clinical expert advise on educational opportunities that will facilitate the development and support their specialist knowledge and skills to ensure they develop their clinical practice and

13.22 Ensure effective learning experiences and opportunity to achieve learning outcomes for students through preceptorship, mentorship, counselling, clinical supervision and provision of an educational environment.

Clinical practice development

13.23 Initiate and lead practice developments to enhance the nursing contribution sand quality of care;

13.24 Identify, apply and disseminate research finding relating to specialist nursing practice;

13.25 Undertake audit review and appropriate quality assurance activities;

13.26 Create an environment in which clinical practice development is fostered, evaluated and disseminated and

13.27 Explore and implement strategies for staff appraisal, quality assurance and quality audit. Determine criteria against which they should be judged how success might be measured and who should measure success.

14 Content of programme of education

The content of the programme of education should be adapted to the area of specialist practice as appropriate:

14.1 Health promotion, education and health need identification;

14.2 Biological, behavioural, sociological and environmental studies;

14.3 Development of the individual;

14.4 Nature and causation of disease and/or conditions and their physical, emotional and social consequences;

14.5 Advanced pharmacology studies and nurse prescribing from a nursing formulary, where the legislation permits;

14.6 Diagnostic, therapeutic, resuscitative and technological procedures and techniques;

14.7 Ethics of professional practice and relevant literature/legislation;

14.8 Care and case management;

14.9 Problem solving and decision making;

14.10 Preventative strategies and intervention techniques for abuse and violence;

14.11 Negotiation and person-effectiveness skills;

14.12 Counselling, supportive, communicative and related therapeutic techniques;

14.13 Quality assurance – evaluation of standards and outcomes of nursing, health and care interventions;

14.14 Leadership management and resource management skills;

14.15 Health economics and policy;

14.16 Community development skills;

14.17 Research approaches, methodology and techniques and application to practice;

14.18 Appreciation of information technology and its application to practice;

14.19 Approaches to education and teaching skills and

14.20 Clinical supervision of practice, peer review and peer assessment techniques.

Standards for specialist community nursing education and practice – public health nursing/health nursing/health visiting

23 Standards for entry

The nurse should have an entry on either parts 1, 2, 3, 4, 5, 6, 7, 10, 12, 13, 14, or 15 of the register.

If a registerable health visiting qualification is required the registrant must also meet the entry requirements as laid down in the Health Visitors Rules (see Annexe 1).

24 Specific learning outcomes

The nurse should achieve the following specific outcomes applied to the area of public health nursing – health visiting:

Clinical nursing practice

24.1 Assess, plan, provide and evaluate specialist health care interventions to meet health and health-related needs of individuals, families, groups and communities;

24.2 Undertake diagnostic, health screening, health surveillance and therapeutic techniques applies to individual family and community health maintenance and

24.3 Initiate action to identify and minimise risk and ensure child protection and safety, working in partnership with families.

Care and programme management

24.4 Build health alliances with other agencies for health gain;

24.5 Search out health-related learning needs of individuals, families, groups and communities and stimulate an awareness of needs at local/national levels;

24.6 Empower individuals, their carers, families and groups to influence and use available services, information and skill to the full and act as advocate where appropriate;

24.7 Identify appropriate resources to meet needs, plan and initiate measures to promote health and to prevent disease;

24.8 Support and empower individuals, families and communities to take appropriate action to influence health care and health promotional activities by means of a community development approach;

24.9 Initiate the management of cases involving potential or actual physical or psychological abuse and potentially violent situations and settings;

24.10 Work with key personnel in health and other agencies to address and/or achieve agreed health goals and local policies;

24.11 Collect and interpret health data and develop and initiate strategies to promote and improve individual and community health and evaluate the outcomes and

24.12 Establish and evaluate case load and workload profiles and devise programmes of care and monitor strategies of intervention.

Appendix 2

SUMMARY OF OPTIONS AND RECOMMENDATIONS

1 Implications of the extant legislation for current preparation and regulation.

1.1.Educational entry requirements and level

- If the statute cannot be changed, a brief entry test incorporating English, Welsh or history could be constructed to accommodate potential entrants without the pre-requisite school leaving certificates.
- The statute could be amended to permit a more open entry policy, allowing universities to satisfy themselves that entrants have the capacity to undertake the level of study for which they have applied.

1.2 Professional entry requirements

- Council might consider widening the entry gate to include not only nurses, but midwives and people from other relevant professional backgrounds or through direct entry; this would require a change to the statutory instrument.
- As a less radical alternative, it may be possible to amend the statute so that both registered nurses and midwives can access health visitor training and registration
- Importantly, whether retaining a restricted (nursing only) entry point or not, a wider study is needed to clarify what knowledge and skills are assumed to be held by all first level nurse registrants, and that are considered relevant to health visiting.

1.3 Length of programme

- Decisions about the length of training need to be made in conjunction with academic level, time needed to develop practice ability and specified learning outcomes, but should not be less than the 51 weeks stipulated in statute.
- Preferred and manageable lengths of training will vary depending upon whether changes are made to the assumed knowledge base at entry to the training (see section 6.2.2). The options are summarised in Table 6.1 on page

1.4 Fit with the Community Health Care Nursing (CHCN) framework

- A critical appraisal of existing research, or a new in-depth study, to examine the respective skills, knowledge base and practice philosophies held by nurses and health visitors would be feasible, but a level of debate and contradiction is likely to remain. This needs to be reflected in the preparation of health visitor students.
- Recognising that entrants to the health visiting register are embarking on a new profession clarifies their need for preceptorship and initial support, and their potential to develop to a 'higher level' beyond that of 'specialist' CHCN.
- If the CHCN framework is to continue in its current form, some mechanism will be needed to recognise the philosophical difference between the statute (i.e., that 'health visiting knowledge/skills are different to nursing knowledge/skills') and the regulations covering implementation of the framework (i.e., that 'first level nurses all hold the same knowledge/skills as health visitors, but at a less advanced level').

2 The suitability of the current framework as a preparation for contemporary practice.

2.1 Preparing the future workforce

a. The capacity to support health visitor education may be diminishing; it would be useful to carry out a specific review of this.
b. Developing one or both of two direct entry options would be a way of attracting more youthful entrants to the health visiting profession, if this is considered desirable.
c. The first of these options are the existing direct entry programmes, through which students achieve dual nursing and health visiting registration; these might be expanded without changing the statute.
d. A change to the statute would be needed to extend the entry gate to a single registration course, which is the second way to achieve 'direct entry'.

2.2. Maintaining professional standards in health visitor education

- The prevalence of 'modified programmes' as a norm contributes to the apparent inconsistency across courses. Principles by which proposed modifications could be assessed might be incorporated into a modernised statute to set a new standard for programmes, or used to strengthen application of the current training rules.
- The regulations need clarifying and strengthening, to make 'professional self-regulation' as meaningful in health visiting as it is in nursing and midwifery. Clarifying disciplinary responsibilities would not require a change to the statute.
- 'Regulation by professional peers' should be visible and auditable at three levels:
  (1) development of programmes and course content overall (validation processes);
  (2) control of modules and teaching patterns in the everyday running of programmes (delivery of programme);
  (3) assessment of student progress, including approval of 'fitness for practice' and entry to the register.
- The health visitor CPT provides an essential link in the chain of professional self-regulation and the maintenance of professional standards. In the light of the new teacher standards, the preparation and approach to the role might be reviewed with a view to clarifying and upgrading it academically.
- The position of the Health Visitor Tutor needs clarifying in the light of the new teacher standards and the chain of professional self-regulation in health visiting.

2.3 Appropriateness of current learning outcomes for contemporary practice

- Expectations of contemporary practice are not clear or agreed across the UK, but three potential roles were identified from a review of policy trends. A national curriculum development project would be helpful in gaining consensus about which particular learning outcomes are thought necessary as a minimum standard for all registered health visitors.
- The heavy emphasis in the learning outcomes on clinical nursing, managerial and leadership responsibilities distracts from the development of a capacity for basic health visiting as a grounding for flexible professional development in future.

- Shortage of learning time is a major problem, leading to selection, adaptation and further inconsistency across programmes; this problem should be addressed by options suggested in Sections 6.2.2, 6.2.3 and 6.3.3.

2.4 Maintaining standards in health visiting practice

- In the light of the government's rejection of the view that health visiting should be regulated as part of the nursing profession, Council may consider that health visitors should be required to maintain their competence and demonstrate current practice in the field in order to maintain their registration as health visitors.
- Alternatively, some other regulatory mechanism by which the public can be protected against poorly performing health visitors will be required.
- Maintenance and development of standards of the health visiting profession as a whole are not functions of the UKCC, but regulation and accountability mechanisms require a clear view about what constitutes currently 'accepted good practice'.

3 The interface with other disciplines, agencies and countries

3.1 Emerging professions

- A curriculum review (as proposed in Section 6.3.3) should consider the feasibility of including the national standards for public health practitioners into the syllabus for health visiting;
- The emergence of multi-disciplinary professions and multi-agency working points, once more, to the need to consider flexible entry points to health visitor education.

3.2 Multi-disciplinary working

- Consideration could be given to setting up some demonstration sites/pilot projects to test the feasibility of training a multi-disciplinary cohort of health visitor students.
- A curriculum development project looking at the requisite learning outcomes for health visiting (see Section 6.3.3) could be asked, additionally, to explore options for multi-disciplinary and multi-agency learning that preserve links with primary care and nursing.

3.3 Community health care nursing

e. Because of the close integration of health visitor education into the CHCN framework, any changes to take account of the statutory and regulatory requirements of health visiting will have an effect on other community nursing programmes.
f. A wider review of how the CHCN framework is perceived by the other seven areas of practice encompassed in it may be indicated.

Recommendation 1.

Council should ensure that its structures and procedures recognise health visiting as a separately registered profession.

1.1 The procedures for ensuring professional self-regulation by health visitors need strengthening and clarifying, so that they are visible and auditable throughout the education and registration process.
1.2 On qualifying, health visitors are entering a new profession, so it is important for them to be supported through preceptorship.
1.3 Although there is an obvious potential for health visitors to develop beyond the level achieved at qualification, their separate registration means there is no clear advantage in involving them in a system for regulating 'higher level practice'.
1.4 Health visitors should be required to maintain their competence and demonstrate current practice in the field in order to maintain their registration as health visitors.

Recommendation 2

A national curriculum development project should be set up, to identify the educational needs of health visitor students to enable them to fulfil expectations of a modern role in public health, primary care and family support.

2.1 A full situational analysis, to indicate important factors internal to the health visiting profession and external to it, is needed. This would involve gathering information from a range of stakeholders including consumers and colleagues from across sectors.
2.2 The curriculum project should concentrate, first, on identifying the learning outcomes required by health visitors. These could be used to clarify the suitable academic level, 'normal' length and type of programme, and relevant knowledge held by nurses (or, if the statute changes, any others) that might be accredited as prior learning.
2.3 Key principles should be identified, by which the design and purpose of health visitor education can be assessed to inform programme validations and regain consistency across the regulatory process.
2.4 Attention should be paid to the educational interface and potential for shared learning with a range of relevant colleagues and sectors, including but not restricted to, nurses in primary care.

Recommendation 3

The capacity for educating present and future health visitors should be assessed, in conjunction with workforce planning, replacement and continuing education needs.

3.1 Some reliable workforce data giving the age and likely retirement patterns of current Health Visitor Tutors (HVT) and Community Practice Teachers (CPT) is needed.
3.2 Bearing in mind the need to clarify the processes of professional self-regulation (see Recommendation 1.1), the way the new Standards for Teachers will apply to the former HVT and CPT roles needs examining and explaining.

Recommendation 4

To encourage flexibility without compromising the safety of the vulnerable public, the statute could be modernised to emphasise the knowledge, skills and abilities needed to practice as a registered health visitor.

4.1 The learning outcomes required for health visiting practice should be clarified (as in Recommendation 2.2), and procedures for professional self-regulation strengthened and audited (as in Recommendation 1.1) as a replacement for the current 'entry requirements' approach.

4.2 Pilot projects could then be established to assess the impact of preparing a multi-professional cohort of students for entry to the health visiting register. These would probably need to be post-graduate programmes, and would need sound procedures for accrediting prior learning (including from first level nurse registration).

4.3 A direct entry degree programme for potential students with no prior professional qualifications might be piloted to attract younger applicants, or mature entrants from, for example, community mothers or community development projects.

4.4 If the above procedures were established and shown to be successful, it would no longer be necessary to restrict entry to health visitor training to a single profession.

Recommendation 5

A standing committee should be formed through which the standards of the health visiting profession as a whole can be monitored, maintained and developed.

5.1 Such a committee may form one part of the re-organised structure of UKCC and Boards, to ensure that health visiting matters are represented. It should provide information about 'matters of detail' relating specifically to health visiting and aid the process of multi-disciplinary regulation across the three professions.

5.2 It should be able to provide credible and authoritative information about health visiting to employers, commissioners and policy-makers. It would protect the public by enabling health visiting services to effectively implement the processes of clinical governance and evidence based practice.

5.3 It is important that such a committee maintains the confidence of practising health visitors and consumers of their service.

Appendix 3

Additional evidence and detail about:

PRESENT AND FUTURE ROLES FOR HEALTH VISITORS

Supplement to Section 3.5

Introduction

Whilst it remains difficult to predict exact trends for the future, mapping 'what needs to be done', 'how should it be done' and 'who should do it' provides a selection of roles that are likely to endure beyond the beginning years of the twenty first century. It helps to illustrate areas of potential overlapping between the different possibilities and aspects of practice of the context in which health visiting is currently operating, a legal opinion that might – usefully or not – be shared, delegated or left to others to fulfil. Three overlapping, possible future roles and functions for health visitors: providing general family support, family centred public health, and community outreach/support of vulnerable populations were considered in Chapter 3; this Appendix includes more detail about the issues that each potential role raises for practice and education.

General family support

Universal family support has long been a mainstay of health visiting practice, but the last twenty years have seen a gradual reduction in its scope, medicalising of expectations and tightening of its focus. The need to produce minimum data sets and to specify contracts in a format that accorded with the core business of the NHS has led to various anomalies that affect the way the work has been constructed (Cowley 1994). This has generally been played out, for example, by a requirement to record interventions with individuals (e.g., number of children seen) which negates the existence of 'families' as a unit.

Also, there is a prevalent belief that the health service (and, significantly for the purposes of this discussion, particularly the nurses and doctors in the health service) exists to deal with *health problems*; it is there for when things have gone wrong. Prevention has been conceptualised in very disease-specific terms in the health service, so that, for example, delivering an immunisation is acceptable, because it is possible to measure the risk to the infant of not receiving it; screening for post-natal depression is likewise measurably useful. Providing a welcoming atmosphere in a baby clinic so parents can chat, make friends and, perhaps, swap information about where to buy the cheapest baby food or fresh vegetables this week might link theoretically to a reduction in social isolation, mental health problems and poor nutrition. However, the connections are tenuous and hard to trace and measure, so such actions may simply be viewed as 'inefficient' and wasteful of professional time.

Internationally accepted philosophies would question the suitability of promoting either an individual or an illness perspective in primary health care, emphasising instead the importance of whole families and communities participating in creating their own health (WHO 1978). However, the combined predominance of the traditional bio-medical model in UK primary health care and resource-led 'new public management' approaches (Hood 1991, Hannigan 1998) have combined to restrict and condemn the perceived inefficiency of unfocused, non-specific family support. Table A1 (as in table 3.6, chapter 3) summarises some of the key issues affecting general family support.

Table A1: GENERAL FAMILY SUPPORT

	POLICY	PRACTICE	GOVERNANCE
WHAT: General family support	***Facts and Values*** 1. Families are fabric of society; building blocks of civic community and social inclusion 2. Inequalities in health (physical and mental) known to stem from pregnancy, infancy 3. *So*: family support is a public health imperative	***Actions*** - universal family support (emotional, practical) and primary prevention: home visiting + groups - additional outreach in deprived areas and to vulnerable populations: specific projects. - early interventions for identified problems	***Appraisal mechanisms*** Goal directed evaluation: performance monitoring. User involvement and acceptability. Long and short term outcome measures. Interventions + home visiting programmes = clinical effectiveness criteria apply.
HOW should family support happen?	***Funding mechanisms*** Family support is viewed as a public responsibility, but no NHS funding. Potentially can be combined with case-finding and child health promotion protocols followed by HVs in most areas, especially where these are not restricted.	***Organisation:*** 'Core' health visiting service variable across UK – very restricted in some places (e.g., one assessment visit/contact per family unless specific need identified) Home visits to 'help improve support , advice and information'	***Risk management*** No obligation in law to provide a service for every need, but once a need is identified in the context of an existing service, there is an obligation to respond to it. Needs assessment protocols are invalid but may provide some defence against litigation.
WHO should provide family support?	***Agency responsible:*** Not core NHS business, but some ad hoc funding: e.g. lottery/healthy living centres, health visitor innovation fund, HAZs. Lead agency: LA especially social services + education; also voluntary sector All feed into HImP Expectation of joint children's services plans and shared responsibility.	***Specific Occupation?*** Health visitors specified as family support agent in several documents. Specific skills are required for developing programmes of support, co-ordinating other workers in team (e.g., community mothers, nursery nurses, interpreters), drawing on and integrating public health knowledge base.	***Vulnerable public:*** Volunteers + unregulated workers in the field. Health visitor: accountable for exercising specific health visiting skills in identifying need; taking appropriate preventive actions; for activities delegated to team members. Child protection a specific concern. Regulatory requirements – standards, competence, conduct.

Abbreviations: LA= local authority; HAZ = Health Action Zone; HV = Health Visitor; HImP = Health Improvement Programme

The changed policy stance towards open family support stems from a convergence between facts and values, leading to new endorsement about 'what should happen' in this regard. Current political values lean towards the collectivist view that all families need and deserve non-judgemental and unconditional support. Emerging scientific evidence about ways to reduce inequalities and enhance health (summarised by Acheson 1998 and Robinson 1999) show the long-term effectiveness of home visiting programmes combined with the varied community and group support activities traditionally engaged in by health visitors. Acheson suggests:

> . . . social and emotional support of parents, particularly mothers, may enhance their capacity to protect their children, especially when they are trying to do so in disadvantaged circumstances. . .
> Policies should be based in the community, should be family-centred and should meet the needs of families living in disadvantaged circumstances (Acheson 1998: 74, 76)

Qualitative research indicates that managing the apparent ambiguity of these approaches is a necessary and skilful part of the process of delivering health visiting (Cowley 1991, 1995). Acceptability of the service relates, not only to the personal, non-judgemental style of the health visitor (Machen 1996) but also to the presentation of problematic events and issues as 'normal' and thus non-stigmatising (Chalmers 1992). This fits well with the approaches described in the Home Office (1998) consultation document as an 'enhanced role for health visitors':

Para. 1.26 – 1.34 (excerpts)

- Parents need a great deal of help and advice around the birth of their children, particularly about the health of mother and baby. Health visitors play a crucial role in providing this help, and where necessary putting parents in touch with local agencies providing health services.
- Health Visitors . . . are ideally placed for advising families on all kinds of problems: no one feels they are a bad parent or their family has failed because they take the advice of a health visitor. That is why the Government is attracted to the idea of building on the excellent service already provided by health visitors, by formally extending the focus of their work beyond 'health' in a narrow sense to supporting families more generally.
- The expanded role of health visitors would involve a shift of emphasis from dealing with problems to preventing problems from arising in the first place.
- We recognise that health visitors already have a substantial work load and would not be able to take on a new role in supporting parents in addition to their existing duties.
- The enhanced health visitor service would focus on the critical stages of a child's early development, when help and support is most needed including: Antenatal Classes, Weekly Visits, Infant Welfare Clinics, Advice on weaning, Sleep Clinics.
- More help could be offered in pre-school years with Toddler Training Groups, Early relationship groups, Advice Surgeries
- School Settling groups, Teenage years groups

(Home Office 1998: 11 – 12)

However, there remains an underlying mismatch between the sharply focused and purposeful requirements of medico-managerialism within a cash-strapped health service and the apparent expectation that health visiting be delivered to all families even if they have no named 'condition' that needs treatment. As a result of this mismatch, much energy has been directed at trying to discover mechanisms through which health visitors could predict needs, in order to 'target' their attentions more efficiently. A number of health commissioners expect to receive information about the nature and type of families who are selected to receive 'additional' health visiting time for some specified reason, for example. Indeed, many have used emulated 'clinical guidelines' that are not valid, reliable or based in sound research (Appleton 1997), as a means of determining and tracking the activities of health visitors.

One approach to needs assessment attempts to associate systems used for assessing need at a locality or ward level, such as deprivation scores, into a mechanism for weighting caseloads and deciding staffing levels. In this approach, practitioners are asked to gather information from individuals by assessing whether particular 'risk factors' are present. This approach is loosely linked with public health approaches designed, through population-based strategies, to distribute resources to the most needy or deprived areas and most vulnerable groups. This may involve changing historical distribution of staff that traditionally depended only on population figures or numbers of GP practices; this has the potential to redress former inequitable

resource distribution, or simply to disinvest in areas where global measurements of deprivation are satisfactory. It is clearly promoted in the notion of 'family-centred public health work,' considered below.

The second 'needs assessment' idea is based in the 'episode of care' approach, which assesses whether a family meets particular criteria as a mechanism through which to access suitable 'packages of care' designed to meet the identified needs. This kind of assessment acts as the equivalent to a 'diagnosis', offering the potential to delegate 'prescriptions' in the form a planned package of care to a less expensive member of the team, or to remove families diagnosed as having 'no needs' from the health visitors' active caseload. Whilst over-zealous enforcement can act to oppose the universal focus and proactive stance of health visiting, both approaches to assessment are promoted as methods of ensuring the most appropriate clinical care reaches individuals with identifiable needs. Through these mechanisms, it is presumed that it is possible to identify children in need and cases of suspected child abuse, which remains a core responsibility and expectation placed on health visiting:

> The midwife and health visitor are uniquely placed to identify risk factors to a child during pregnancy, birth and the child's early care. . . . Health visitors and school nurses monitor child health, growth and physical, emotional and social development. The regular contact health visitors and school nurses have with children and families give them an important role to play in the promotion of children's health and development and the protection of children from significant harm (DH et al 1999: 33 + 51)

This excerpt seems to presume that health visitors currently make and maintain contact (albeit, perhaps infrequently) with all families on a designated list or 'caseload' for which they hold responsibility. However, this is not always the case, particularly in areas of the country where services have either been severely cut back following a disinvestment, or have gradually withered due to continuing small reductions or non-investment in the face of increased local population needs.

In summary, then, this 'family support' role is conceptually consistent and clear. It is in line with current government thinking and there is good evidence that it is an effective and cost-effective way of reducing health inequalities and social exclusion in the long term. Furthermore, it has the potential to contribute to a multi-agency agenda, through enhancing community capacity and resources for health in a way that improves the social environment at a more general level. However, despite its current political popularity, it remains a contested public function and mainstream funding for general family support is not available. The role, therefore, appears contradictory and contrary, since it does not readily 'fit' into current expectations and administrative arrangements.

Family-centred public health work

The need to find a way of addressing the policy emphasis upon family support within limited resources, whilst harnessing health visitors' public health skills to the new agenda for primary care led commissioning, may lie behind the vision of the 'family centred public health worker' promoted in the English strategy for nursing, midwifery

and health visiting (DH 1999b). The label draws heavily on the traditions of health visiting in working with families and on the public health roots of the profession. There is a determined prescription of exactly how this is to be delivered and what is to be done:

> To take forward our policies we need to modernise the role of the health visitors. We are encouraging all health visitors to develop a family-centred public health role, working with individuals, families and communities to improve health and to tackle health inequalities. . . . They will work with Primary Care Groups, Trusts, other local agencies and with local communities to develop and deliver health improvement programmes and actions set out in *Saving Lives: Our Healthier Nation.* We expect health visitors to lead teams to include nurses, nursery nurses and other community workers that will:
>
> - deliver child health programmes and work in partnership with families to develop and agree tailored health plans to address their parenting and health needs.
> - run parenting groups and provide home visits to help improve support, advice and information to parents – and especially to vulnerable children and their families – supporting initiatives such as Sure Start.
> - work through Primary Care Groups to identify the health needs of neighbourhoods and special groups such as the homeless, and agree local health plans;.
> - work with local communities to help them identify and tackle their own health needs, such as measures to combat the social isolation of elderly people or the development of local accident prevention schemes;
> - provide health promotion programmes to target accidents, cancer, mental health, coronary heart disease and stroke (DH 1999b: 60)

This description of the family-centred public health worker differs from that of general family support mainly in the detail of 'how it should happen', as summarised in Table A2 (also shown in table 3.7, chapter 3). The clear imperative and priority in the stem of this statement is to contribute to the development of primary care led commissioning, as set out in 'The New NHS: Modern, Dependable' (DH 1997). The organisational details differ in Scotland, Wales and Northern Ireland, but there is a shared intention to see service planning and NHS strategies being developed within primary health care, and to utilise the public health skills and local knowledge of health visitors in delivering this agenda.

Table A2: FAMILY CENTRED PUBLIC HEALTH WORK			
	POLICY	**PRACTICE**	**GOVERNANCE**
WHAT: family centred public health	***Facts and Values*** 1. Public health involves strategic planning to tailor effective NHS provision to local needs/preferences 2. PHC is the 'front door' of NHS: families access for immediate help and guidance about health 3. *so:* family health care and strategic planning can be combined in PHC	***Actions*** - delivery of child health programmes; individually tailored plans about parenting/ health needs - parenting groups + home visits to help improve support, advice, information - identify health needs and agree local health plans through PCGs etc	***Appraisal mechanisms*** Clinical effectiveness of specific interventions and programmes of care assessed through RCTs & systematic reviews. Performance Assessment Frameworks and indicators to assess worth of the services overall.
HOW should family centred public health happen?	***Funding mechanisms*** No specific NHS funding for family centred public health work. General surveillance of families can provide information of use to PHC-led commissioning and strategic plans. Early interventions may contribute to efficiency savings and HImP.	***Organisation:*** Needs assessment procedures concentrate on identifying 'high risk' or 'high priority' cases. Delegation of activities to 'skillmix' or members of teams to reduce costs. Corporate caseloads or integrated nursing teams in PHC; HVs and SNs as 'leaders of teams'.	***Risk management*** Team leader accountable for delegated activities undertaken by other staff: nurses, nursery nurses, community mothers etc. Emphasis on profiling, public health, delegation may distract from skills required for 'face to face' prevention with individuals and groups.
WHO should provide **family centred public health?**	***Agency responsible:*** Shifting focus of NHS commissioning agenda – from HA lead to PHC lead. Statutory requirements for collaborative working and movement towards unified budgets across health and social care Well families/child support – social service lead.	***Specific Occupation?*** Health visitors named in strategy document in England; all community nurses contribute to primary care led commissioning agenda. Need for specific knowledge and skills about child health and family well-being in preventive health care.	***Vulnerable public:*** Health visitor: accountable for delegated duties carried out by junior team members. Practice skills of health visitor differ from that of a nurse, but all CHCNs now trained to assess local health needs. Regulatory requirements – standards, competence, conduct of health visitor.

Abbreviations: CHCN = Community Health Care Nurse HA = Health Authority; HV = Health Visitor; PHC = Primary Health Care; PCG = Primary Care Group; RCT = Randomised Controlled Trial; SN = School Nurse

Local health plans are co-ordinated at a broad level through Health Improvement Programmes laid at the Health Authority, Region, Country or Health Board, but the idea is to lead this process from within primary care. First, the process of strategic planning is generated from a neighbourhood level (i.e., the population served by a single primary care team) then co-ordinated at a level broad enough to wield a significant influence on commissioning of services, that is in the local health group, co-operative or PCG. Since primary care is the 'front door' through which the population as a whole access the rest of the NHS, this is held to be a potentially useful mechanism for gathering 'intelligence' through health needs assessments, community profiles and networking contacts across the local area. As public health practitioners, health visitors are believed to have the skills to collate this information and present it

through PCG boards or equivalent local forums. In particular, they are promoted as the workers who have the most regular and frequent contact with families and who, therefore, can use as a basis from which to inform strategic plans laid within primary health care.

This presupposes, as pointed out above, that health visitors continue to maintain contact with all families; the additional public health purpose helps to justify the cost of universal surveillance and child health promotion. Formalising what has been always been an accepted, if rather ambiguous dual function in health visiting – of collecting information for planning purposes whilst providing preventive advice and care for identified needs – has the potential for creating some practical and ethical tensions that do not appear to have been fully considered yet. Also, these 'public health in primary care' aspects of the role, combined with the clinical effectiveness agenda and a need to ensure measurable outcomes from activities, tend to shift the emphasis away from generic family support towards the more medically focused, disease-specific activities.

It is important to note that the 'family centred' aspect of this role is the only part that is singled out for health visitor attention, since all primary care workers are expected to similarly contribute to a collective public health endeavour. In particular, the general practitioner is specified as the lead professional. However, there is a strong emphasis on collaboration and team working, which is expected to operate at three levels.

First, the health visitor is expected to 'lead a team' of workers to whom she can delegate specific functions – once a need has been diagnosed, as explained above. The accountability issues are no different to those affecting any skillmix teams based in the community, perhaps headed by a district nurse or community mental health specialist, for example. There is an assumption that a number of functions can be delegated that do not need specific health visiting skills, so they can be safely and effectively carried out by the team members mentioned. This is an area where there has been much rhetoric and accusation, but little or no sound research to show whether such substitution should be a frequent or occasional feature of health visiting. The only sound evidence to shed any light on this has come from a review of American trials of home visiting effectiveness; the overall conclusion was that professional training was an important feature of successful programmes (Gomby et al 1993). In the majority of the experiments, a nurse with additional training was used as the home visitor, although some featured psychologists or graduates from education or similar background; again, additional training in the home visiting programme was needed.

There is a paradox to be considered that affects the extent to which activities can be delegated to junior members of the team, too. First, Cowley (1995) illustrated the complexities of dealing with the often risk-filled and ambiguous 'normal' situations encountered regularly by health visitors undertaking so-called 'routine visits'. The extent of unpredictability in this field suggests that there are comparatively few instances where the health visitor can be sufficiently clear about what to expect before the encounter to allow safe delegation. The accountable practitioner needs to have sufficient knowledge to be able brief the junior team member, and be sure she is not being asked to operate beyond their level of competence. The paradox is that, despite,

this unpredictability and the high level of skill required to manage these complex situations, they are generally regarded as 'normal;' indeed Chalmers (1992) showed that an essential part of being able to access families to deliver health promotion was the ability to portray their particular concerns as 'routine' or within the boundaries of 'normal.' In other health care fields, being 'normal' is regarded as a reason for either discharging the person or not accepting them on to a caseload in the first place; in health visiting it is a basis from which to begin provision of the service.

Also, the phrase 'lead teams' does imply a clear difference from the collaborative teamwork highlighted in community development (that will be considered as part of the 'community outreach' function) and family support work, where the priority lies in co-ordinating voluntary effort and lay networks, and in being a resource upon which the local population can draw. It appears to differ from the increasingly popular idea of shared, or 'corporate,' caseloads as well, when several health visitors cover a larger section of a defined population or locality between them (possibly with skillmix support), instead of singling out a smaller geographical area or section of a general practice list. Such patterns of organisation mainly lie outside the conventions for organising and delivering medical and nursing care, so may be viewed as inappropriately uncontrolled in 'new public management' terms.

The second level of teamwork and collaboration involves a range of 'teamwork ideals' that are promoted as mechanisms through which health visitors can be incorporated more closely into primary care. A new interest and emphasis on the notion of 'integrated nursing teams' has been superimposed upon the continued stress on primary care teamwork and inter-professional collaboration. Integrated teams may or may not feature delegated management functions, direct employment by general practice (through Primary Care Act/PMS pilots, for example, or in Primary Care Trusts) and a range of idiosyncratic, novel or generic functions across several disciplines within primary care. Again, there is a dearth of research to assess the extent to which such patterns of organisation contribute positively to health care, so (despite their present high profile) their place in future health visiting roles can only be speculative at present. However, as indicated at the start of this chapter, there is an enduring shift across all health and social care towards shared agendas and joint funding, through inter-agency, multi-disciplinary and inter-professional working. That is the third level of team working and collaboration that will feature in health visiting as in other professional roles in the future; it needs to be a clear focus in the preparation for the role.

In contrast to the 'general family support' role, the idea of a health visitor as a 'family-centred public health worker' has considerable administrative appeal. It appears to have been actively construed to fit in with the current policy agenda and familiar organisational settings in which health visitors. In contrast, too, it has less conceptual coherence or clarity. There are a number of conflicting requirements stemming from the different levels of operation, the continuing drive towards clinically effective interventions for established, high risk cases instead of early interventions and primary prevention; and likely substitution of a lower cost workforce to undertake the highly skilled preventive work that had formerly been the province of the health visitor.

Community outreach to vulnerable groups

The ability to network across a whole range of different organisations and levels is a key skill for the third potential role for health visitors, which is to concentrate on community outreach functions for vulnerable groups who are not well served by mainstream health care. Health visitors have a long track record in reaching out to travellers, homeless populations, refugees and asylum seekers and many other minority groups or specific areas of deprivation. The approaches that have been developed are multi-faceted and often encompass health and social care, drawing in skills from the population themselves and acting as an informed resource, facilitator and advocate.

Whilst health visitors have always been involved in delivering such diverse services, there has been a significant shift in attitude towards what constitutes 'health' since the current government came to power. Public health has begun to be considered in relation to local authorities, the environment, social cohesion and the civic community. 'Health' is no longer seen shorthand for a service sector, but is regarded as a value to be striven for and worked towards across an increasingly wide arena. This represents considerable convergence, as set out in Table 3.1, between health visiting principles and those being promoted by the government.

Funding has been made available from a variety of different sources for public health projects like Health Action Zones, Healthy Living Centres and Surestart centres. Whilst most of these projects make little, if any, mention of health visiting, they serve to support and convey a legitimacy to the underpinning beliefs, principles and values to which health visiting subscribes quite explicitly (CETHV 1977). However, because most of these projects lie outwith the health service arena, they may effectively lie out of reach of health visiting practitioners. This is particularly the case for those who have not learned enough about the mechanisms of funding and social policy, to be able to capitalise on these opportunities, or whose Trusts neither wish to apply at a managerial level, nor to support their practitioners in seeking funds for 'unconventional' activities. Table A3 summarises the issues in this third projected future role for health visitors.

Public health has been redefined as part of the social exclusion agenda since the change of government in 1997. This has led to an upsurge in ad hoc funding for a variety of projects, particularly those directed at very deprived areas, like Health Action Zones, Healthy Living Centres and Sure-start centres, but also for specific topics and named vulnerable groups, like domestic violence, teenage pregnancy or asylum seekers. In addition to the funded initiatives, there are whole range of government priorities that might fall quite properly within the remit of health visitors, but that generally lie outside the specific requirements and responsibilities of the health service or of the usual community trust functions. Many of these stem directly from the Social Exclusion Unit, which has policy action teams developing initiative to improve shopping for people in deprived areas, and tackle homelessness and drugs, and the so-called 'New Deal for Communities' development initiative aimed at neighbourhood renewal. Particular priorities include reducing teenage pregnancies and domestic violence, cutting juvenile delinquency and supporting long term personal relationships like marriage, topics that are all likely to be of great interest to health visitors.

Table 3.8: COMMUNITY OUTREACH/SUPPORT OF VULNERABLE POPULATIONS			
	POLICY	**PRACTICE**	**GOVERNANCE**
WHAT: community outreach and support	***Facts and Values*** 1) Social exclusion and inequalities in health are key public health and policy priorities 2) Policy commitment to create a fairer society, 'fair access' to health care 3) *so:* need an expert outreach function to target vulnerable and/or socially excluded groups	***Actions*** - community development: local areas, specific groups - drop-in centres: health advice + range of issues (welfare benefits, l legal rights, housing, etc) + dedicated clinics. - home visiting hard-to-reach groups; intensive one to one or group-work; support and enabling	***Appraisal mechanisms*** Hard to evaluate, due to: - breadth, diversity and multiplicity of actions - mobility and special features of vulnerable populations. Emphasis on: - impact and access; - performance management - goal-directed evaluations in short term.
HOW should community outreach and support happen?	***Funding mechanisms*** Mainly ad hoc , one-off and occasional; some substantial, ring-fenced sums involved (e.g. for Sure Start, HAZs, drugs initiatives, crime reduction ['on track'] homelessness, domestic violence). Smaller sums for local projects e.g. from HAs, LAs, charities.	***Organisation:*** Local individual variation; Ad hoc projects tailored to specific needs Short term, intensive 'rolling programmes' Change management high on the agenda. Emphasis on facilitation and working through and with others.	***Risk management*** Co-ordinating across wide range of agencies, + workers - voluntary groups etc. reduces managerial control. High level of unpredictability, sensitivity. Likelihood of ethical and legal dilemmas (e.g., in drugs work, domestic violence, asylum seekers).
WHO Should provide community outreach and support?	***Agency responsible:*** Social exclusion policy co-ordinated from Cabinet Office and designated units (e.g., family unit, women's unit) Range of other interested agencies, who may use outreach or special projects as a way to achieve designated responsibilities.	*Specific Occupation?* None specified; several likely occupations. Health visitors have long track record in outreach and community development work. Ability to promote self-empowerment and enable access to a range of services important; need to influence policies affecting health of these groups.	***Vulnerable public:*** High level of vulnerability, yet high numbers of unregulated workers. Accountability circles rarely straightforward where formal + informal services involved together. High degree of skill for co-ordination and networking; able to operate at multiple levels

Abbreviations: HAZ =-Health Action Zone; HA = Health Authority; LA = Local Authority

In many instances the lead is being taken by agencies other than the health service. Local authorities are clearly reasserting their interest and role in promoting and protecting health, not only through social services for people with enduring health problems, but by working proactively through environmental policies, housing and, importantly, through early education and community based projects. Alongside them, an extending range of voluntary agencies and charitable organisations are capitalising on opportunities to gain money and set up projects, some of which may choose to employ health visitors in the future. This diversity is particularly noticeable in the field of children's well being and family support, and there is an emerging cadre of workers who have completed degrees in early childhood studies or some other similarly suitable preparation, although they may have no professional qualifications. Whilst the lack of professional regulation allows rapid responsiveness and flexibility,

there is an unresolved issue about accountability and protection of these very vulnerable groups from exploitation or misconduct.

While health visiting is one regulated profession that has several decades of experience in this kind of work, there is a clear wish to develop this kind of outreach function as a generic role for all nurses working in primary care:

> 10.5 Nurses midwives and health visitors working in primary and community care are developing their roles to help provide modern and dependable services. They act as health promoters, giving information to patients, assessing health risks and screening for early signs of treatable disease. They are public health workers, focusing on whole communities as well as individuals, fulfilling the public health functions of community profiling, health needs assessment, communicable disease control and community development. Health visitors and community nurses, working close to where people live in local communities, are acting as advocates for vulnerable groups and people who are socially excluded, making sure they have access to mainstream health services. We want to encourage, sustain and extend these developments (DH 1999b: 59)

This third role, then, is one that is very consistent with the principles and practice of health visiting, and one for which the practitioners often feel a great affinity. However, the activities lie largely outwith the health sector and there are many other workers in the field, with a greater or lesser claim to suitable expertise.

Appendix 4

Report of two curriculum working groups on health visitor education

1. 1982: COUNCIL FOR THE EDUCATION AND TRAINING OF HEALTH VISITORS

2. 1989: NATIONAL STANDING CONFERENCE OF REPRESENTATIVES OF HEALTH VISITOR EDUCATION AND TRAINING CENTRES (now UKSC)

COUNCIL FOR THE EDUCATION AND TRAINING OF HEALTH VISITORS
Report of the Working Party on Curriculum Development 1982

(Reproduced from an appendix in 'ALL FOR HEALTH' Perspectives on Education and Training of Health Visitors (Health Visitors Association 1989))

LEARNING OUTCOMES AND ASSOCIATED KNOWLEDGE BASE

1. Identify and Systematically Review Health Care Needs in the Practice Area

2. Methods of Reviewing, Apprising and Assessing

Concepts and definitions of health: sociological and psychological theories and studies of health and illness; physical, social, environmental and occupational influences on health; cultural and class-related beliefs, values, expectations and practices.

Concepts of need: of individuals, families and communities; predisposing factors leading to stress and illness (including poverty, affluence, unemployment, social/geographical mobility).

Nature and determinants of health visitor practice area.

Epidemiological data on patterns of health and disease.

Vital Statistics; sources, interpretations and limitations.

Research: appreciation; data sources.

3 Ascertain National and Local Policies affecting Health and Identify Available Resources

Central and local government: structure and organisation.

Health, Social and Education Services:
- structure and organisation;
- legislation relating to those Services;
- aims, policies, provision and uptake.

Influences and constraints on policy-making.

International, national and local guidance on policies affecting health.

Nature and availability of resources, statutory and voluntary:
- means of mobilisation;
- constraints and limitations;
- self-help groups;
- health centres;
- clinics.

Health Economics

4 Review Health Visiting and Related Records in an Assigned Population

Range and location of health visiting and related records: concepts of confidentiality.

Methods of reviewing

Determinants of health visitor practice area.

5 Determine Health Visiting Practice

Health Visiting:
- aims of Service;
- development and parameters of service;
- principles;
- role and responsibilities of the health visitor;
- rationale for home visiting;
- selective and routine home visiting;
- the law and legal proceedings in the context of health visiting;
- research related to health visiting.

National and local guidance on policies affecting health

Decision-making processes: influences on decision-making.

Principles of organisation and management;
- use of time and resources;
- selection of priorities.

6 Formulate and Implement Health Visiting and Health Education Programmes

Principles of organisation and management: use of time and resources; programme planning.

Health Visiting:
- aims and parameters of Service;
- role and responsibilities of the health visitor;
- the Law and legal proceedings in the context of health visiting;
- research related to health visiting.

Health education;
- aims and scope;
- topics relevant to age, stage of development,
- needs (e.g. childcare/management, preparation for parent hood, personal hygiene, dental care, home safety, diet, drug abuse, smoking, alcohol, etc.)

7 Establish and Maintain a Pattern of Home Visiting

Health Visiting; rationale for home visiting; selective and routine home visiting.

Principles of Organisation and management: use of time and resources.

8 Establish and maintain professional relationships with clients, colleagues, and others as appropriate.

Interpersonal interaction: verbal and non-verbal communication.

Professionalisation and professionalism: Ethics; Code of Professional Conduct.

Clients' rights and obligations.

9 Carry out surveillance and screening of all children, and of the adult population as appropriate

Purpose, methods and tools of health surveillance.

Screening: general principles;
limitations and validity of screening programmes;
infestation;
cervical cytology;
tests (developmental, vision, hearing, CDH, PKU, Mantoux, Heaf, scoliosis).

Human growth and development throughout the lifespan:
basic principles of genetics;
critical periods and experiences throughout life (including pregnancy and childbirth, adolescence, middle and old age, separation and bereavement).

Child care and management

Influences of the physical and social environments on development:
predisposing factors and characteristics of family violence;
hypothermia;
deprivation; poverty; affluence;
drug abuse; smoking; alcoholism.

10 Monitor the health and developmental progress of children of all ages, including those in the care of daily minders or attending day nurseries, nursery schools or playgroups, referring as required.

Concepts and definitions of health: physical, social and environmental influences on health.

Growth and development of children: critical periods and experiences of childhood.

Influences of the physical and social environments on development: predisposing factors and characteristics of child abuse; hypothermia; deprivation; poverty; affluence.

Legislation relating to the day care of children: roles and responsibilities of health and social care workers and agencies, statutory and voluntary, in relation to children in the care of daily minders or attending day nurseries, nursery schools or play groups.

Communication networks and channels; methods of liaison and co-ordination; referral mechanisms.

11 Identify individuals, families and groups requiring help and support, taking into account physical, psychological and social needs and the help being given by, or available from, other agencies.

Concepts of need:
- of individuals, families and communities;
- predisposing factors leading to stress and illness (including poverty, affluence, unemployment, social/geographical mobility, alcoholism, drug abuse);
- factors indicating need for specialist services.

Handicap and disability: concepts of stigma; theories of; labelling.

Nature and availability of resources, statutory and voluntary.

Theories relating to behaviour: deviancy; alienation; separation and attachment.

12 Plan health goals for and in co-operation with, individuals families and groups.

Theories of learning and teaching; teaching techniques; audio-visual technology.

Interviewing, advising and counselling; principles; approaches and techniques.

Health and social factors likely to affect learning.

Measure to promote and maintain health;
- principles of prevention;
- primary, secondary and tertiary prevention;
- means of detecting and of preventing or alleviating ill health; immunisation and vaccination procedures and programmes;
- prevention, control and eradication of communicable diseases.

International, national and local guidance on policies affecting health.

Health education: aims and scope; topics appropriate to age, stage of development, needs (childcare/management, preparation for parenthood, personal hygiene, dental care, home safety, diet, drug abuse, smoking, alcohol, etc.)

Nutrition: dietary needs; infant feeding; ethnic, culture and class-related habits; health problems associated with food intake.

Epidemiological data on patterns of health and disease.

Vital Statistics: source, interpretations and limitations.

Social control/ change Theories of authority and conformity; behaviour modification.

Theories relating to attitudes: formation and change; values; prejudices.

Group dynamics; interpersonal interaction; verbal and non-verbal communication.

Research relevant to the practice of health visiting.

13 Mobilise resources; refer to other agencies and promote self-help groups as appropriate.

Nature and availability of resources, statutory and voluntary: means of mobilisation; constraints and limitations; self-help groups.

Role and function of other health and social care workers and agencies, statutory or voluntary.

Communication networks and channels methods of liaison and co-ordination; referral mechanisms.

14 Participate in school health activities and form a link between the home, school and other workers

School Health Service:
aims and development of Service;
legislative framework;
organisation and administration;
health provisions for the school age child, including those with special needs.

National and local guidance on policies affecting the health of the school age child.

Health visitor's role and responsibilities in relation to the health care of school children and with the organisation of the School Health Service.

Role and responsibilities of school nurses and others involved with the care of school children and with the organisation of the school health service.

Health surveillance of school children: purpose, methods and tools.

Screening principles; techniques and tests.

School Clinics: types; administration.

15 Undertake the organisation and administration of matters pertaining to health visiting activities

Principles of organisation and management: use of time and resources; accessibility of the

health visitor; delegation and accountability; programme planning; selection of priorities.

Health Visiting;
- aims of service;
- development and parameters of service;
- principles of health visiting;
- skills and professional practice;
- role and responsibilities of the health visitor;
- health education;
- home visiting;
- clinics.

16 Keep accurate records and prepare reports

Record Keeping, reports and other written communications:
- principles and purpose;
- range of records;
- systems of record keeping;
- information retrieval;
- concepts of confidentiality.

17 Manage workload using skills and resources of other where available and appropriate

Principles of organisation and management:
- use of time and resources;
- delegation and accountability;
- selection of priorities.

Nature and determinants of practice area: parameters of professional practice.

Nature and availability of skills and resources of others: means of mobilisation.

Communication networks and channels method of liaison and co-ordination; referral mechanisms.

18 Initiate and contribute to teamwork, particularly in relation to primary health care

Primary Health care:
- concepts;
- aims and objectives;
- organisations;
- delivery of care;
- primary health care teams;
- identification of target groups.

Communication networks and channels:
- methods of liaison and co-ordination;
- referral mechanisms.

Group dynamics;

concepts of teamwork and leadership
interpersonal interaction;
verbal and non-verbal communication.

Role and responsibility of others involved with giving primary health care.

Theories relating to attitudes: prejudices and stereotypes.

19 Identify circumstances which have legal implications in the context of health visiting, and take appropriate action.

Health Visiting:
aims and parameters of service;
role and responsibilities of the health visitor;
the Law and Legal proceedings in the context of health visiting.

National and local guidance on policies affecting health.

Citizens' rights and obligations.

20 Initiate, participate in, and carry out health surveys and participate in research

Research:
appreciation;
methodology;
data sources;
dissemination of information.

Studies relevant to health visiting practice.

21 Contribute to the work of committees and working groups as appropriate

Committees and working groups:
structure;
principles and procedures.

Group dynamics:
interpersonal interaction.

Decision-making processes: influences on decision making.

22 Participate in the training of students

Professionalisation and professionalism:
ethics;
code of practice

Theories of learning and teaching: barriers to learning.

Interpersonal interaction; barriers to communication.

Theories related to attitudes:
formation and change;
values;
prejudices and stereotypes.

Health Visiting.

23 Review own performance and assess achievements in relation to set goals

Methods of reviewing, appraising and assessing.

Criteria of effectiveness.

Self-appraisal/self-assessment

Goal planning and setting: influences on goal attainment.

24 Consider alternative methods of practice and restate or modify goals as appropriate

Goal planning and setting: influences on goal attainment

National and local guidance on policies affecting health

Research related to health visiting practice.

25 Evaluate and modify health visiting practice in the light of current knowledge and changing health needs

Means of evaluating
methods of reviewing,
appraising and assessing.

Research and developments in health visiting practice.

Epidemiological data on patterns of health and disease.

Vital statistics: sources, interpretations, and limitations.

Concepts of need: health needs of individuals, families and communities.

Health Economics

26 Exert influence to effect changes in local and national policies and practices affecting health.

Central and local government: structure and organisation.

Health, Social and Education Services:
structure and organisation;
legislation relating to those services;
aims, policies, provisions, and uptake.

International, national and local guidance on policies affecting health.

Health Economics.

Role and responsibilities of the health visitor.

Communication networks and channels

Social control/change: theories of authority and conformity; pressure groups.

National Standing Conference of

Representatives of Health Visitor Education and Training Centres

Excerpt from the report of a study conference weekend

May 1989

HEALTH VISITOR EDUCATION AND TRAINING: THE WAY FORWARD

Seven core components of a revised curriculum were identified;

Research methodology

'Project 2000' style nurse education would equip students with an appreciation of research and the ability to utilise research findings in the clinical setting. An advanced course in research methods including sampling, data collection and analysis in relation to qualitative and quantitative research styles is required to facilitate a more objective approach to e.g. the community profile.

Health Promotion

It is assumed that models of health education/promotion will be included in basic RGN programmes therefore critical analysis and application of models will be required at this level. In addition marketing and promotional skills will be required.

Interpersonal Relationships

One-to-one and group skills will be further developed Models of counselling and experiential techniques; team building and collaborational skills.

Principles of Practice

Principles of health visiting as proposed by the CETHV (1977) remain relevant and should form the basis for this component. The specialist practitioner in health promotion will need to further develop models of care to suit the needs of the family and the community as well as the individual. Ethical aspects will be an important aspect of this component.

Political Awareness

Social policy will be a core component of RGN training, however application in the community context will be required. There will be a developing need for the health visitor to have, not only understanding of the socio political factors which influence individuals and communities, but also to underpin practice with current research findings in this field.

Adaptation to the Life Cycle

Physical and psychosocial development, pre-conceptually to old age, having been included in basic training, this component will focus on potential areas of crisis throughout the life cycle and the adaptation and coping models.

Management skills and organisation

This component will build on management and organisational skills already acquired and assist in application within the health-visiting context.

It was felt that these components would lend themselves to a modular system of education and also to common modules for health visitors / district nurses/CPN/CNMH etc. The standard of qualification was not definitely agreed upon but it was felt that it warranted diploma level and above.

Figure 1 – Location by Discipline on a Public Health Continuum

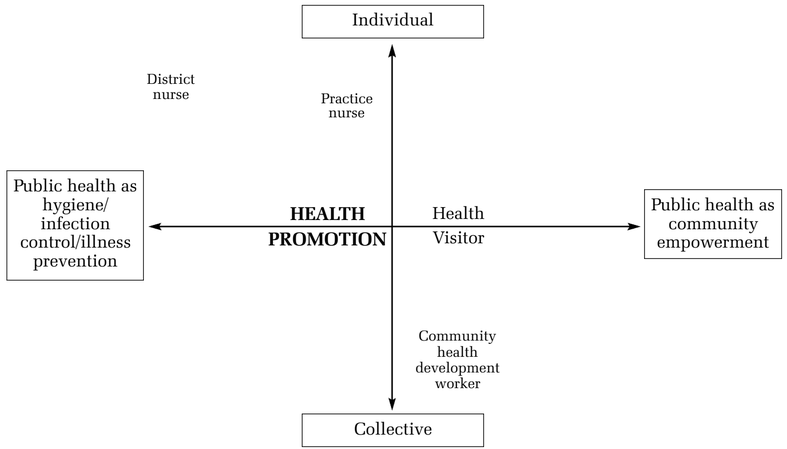
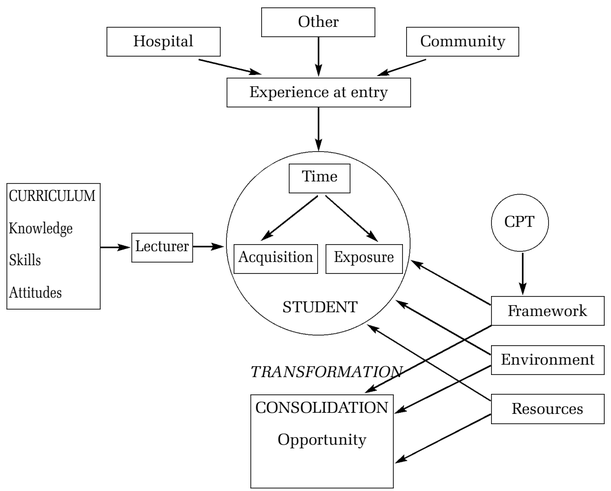


Figure 2 – Learning about Public Health Work



HIGHLIGHTS

Further information

For copies of the Research Highlights and the Report, please contact:
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Method

The study was designed in three strands. The first two, looking at courses and practice settings, sought to provide a broad overview of developments in public health nursing. The third strand used a multiple case design, with each case selected to offer a different perspective on the phenomenon of 'education into practice', bringing together educational and practice settings, practitioners and students, to allow a more detailed exploration of the processes of curriculum delivery and practice development.

Strand One was a questionnaire based survey of course programme directors (n=10) and route module leaders (n=42) from community specialist programmes. Strand Two collected the views of senior nurses in each Health Authority and Trust in England (n=109) about public health work in community specialist nursing. For Strand Three of the study data was gathered at each site using focus groups and individual interviews (n=76) as well as public health incident logs, curriculum documents and local policy documents. The data gathered looked at respondents' perceptions of public health, the nature of the educational experience of the students in relation to public health, and the way in which this was translated into practice, together with factors which acted as barriers or levers in the latter. r

Details about the Project

Commissioned by the English National Board for Nursing, Midwifery & Health Visiting, and part-funded by the UKCC, this project was undertaken jointly by the University of Newcastle and the University of Northumbria at Newcastle. It commenced in April 1997 and was completed in September 1999. It was designed in three strands. Strands One and Two were national questionnaire based surveys, of educationalists and Health Authorities/Trusts respectively. Strand Three used a multiple case design to examine the phenomenon of 'education into practice' for public health. The study's findings will be useful to those responsible for developing or delivering non-medical education programmes for public health work, and to community specialist practitioners exploring or working in public health.

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RESEARCH HIGHLIGHTS

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research HIGHLIGHTS

Evaluation of the Developing Specialist Practitioner Role in the Context of Public Health

Abstract

This study examined the preparation of community specialist practitioners (health visitors, district nurses and practice nurses) for public health work, and how this is used in practice. There were three parts to the study: National postal surveys were completed (1) for course providers and (2) for practice settings (Health Authorities and Trusts). (3) A case study approach was used in four districts to look at how education translates into practice. Public health work is seen as difficult to define, and not 'core' work by nurses. It tends to take second place to work which is more concretely measurable. Practice-based learning is viewed as important. Community Practice Teachers are a key influence. It is concluded that effective practice-based learning should be developed and strategies explored to support public health work alongside more immediate health care demands. r

Main Findings

Strand One: Educationalists

The people who ran courses leading to community specialist practice qualifications felt that the main public health priority was about targeting poverty and inequity in terms of employment, housing, education and health care provision. For everyone except those running district nursing routes, health promotion was a strong common theme in provision. District nursing leads tended to prioritise disease prevention. Programme strengths were identified as rooted in shared learning through inter-professional collaboration and good clinical links with community practitioners and community practice teachers. The main weaknesses identified appeared to be around the problems of integrating theory and practice. Shortage of time to deliver the programme adequately was seen as adding to this difficulty. National policy documents featured most strongly as influencing preparation, however, a range of literature from professional and educational bodies was also mentioned. The strongest identifiable public health function across all disciplines was health needs assessment. However, there was great variation in the level of detail described and the prioritisation of issues.

Strand Two: Health Authorities and Trusts

The data mainly reflects the views of senior nurses working in Trusts. The major influence in determining public health priorities was seen as the information and direction received through national documentation. Local priorities were often determined through targeting of specific groups, pregnant teenagers and ethnic minorities or refugees often featuring strongly. The key functions of the public health nursing role were seen as health needs assessment, health promotion and service and policy development. Obstacles and opportunities to public health work were also explored for each group. Lack of resources (both time and money) was highlighted as an obstacle by many respondents, closely followed by employers' attitudes. Opportunities lay in the interdisciplinary nature of primary health care, and in existing patterns of access to populations. Public health posts in practice were identified as including both specialist posts (for example TB nurses, AIDS specialists, accident prevention health visitors, infection control and communicable disease nurses mainly, but a large range of posts mentioned) and 'community nursing' posts (mainly described in terms of health visiting and school nursing, although district nursing was mentioned). Factors facilitating public health nursing were seen as diverse. Four areas dominated responses. Respondents wanted more emphasis on multi-disciplinary training for public health, more secure funding, policy guidance with clear aims and objectives, and greater collaboration.

Strand Three: Case Studies

At all sites, respondents found it difficult to articulate what public health work might be, though all provided examples of public health practice. The balance between University based work and learning in practice was seen as important, with the models of public health available in the practice setting seen as central to learning. Community Practice Teachers were seen as a key influence on students' practice, but in their own practice struggled to balance public health work with other responsibilities. Public health work was seen by them as 'add-on' work, not highly valued by colleagues and managers. Time was seen as a major constraint to effective learning.

Outlining their concept of 'public health' proved to be a challenge for almost all respondents. Responses could be described on two axes (see Figure 1). The first of these lay between individual and collective activity. The second spanned a continuum from infection control or 'hygiene' on the one hand to community empowerment on the other. The various practitioner groups can be provisionally located on this two-dimensional outline.

Despite difficulties in explaining exactly what public health might mean as a concept, a majority of respondents appeared to have no difficulty in describing public health activity in which they were involved. The activities described ranged widely, from domestic violence support to prevention of falls in older people. It was however clear that a considerable proportion of the examples cited were either still at the planning stage, or had met with apparently insurmountable problems in moving them forward. Many of these had related either to available time or to other resource. The few which had got off the ground had been subject to some evaluation but the outcomes examined had largely been 'soft'. However, it was noted that in contrast 'mainstream practice' was usually not evaluated at all. The health benefit cycle has been suggested (SNMAC 1995) as a framework for evaluating methods and systems for promoting health in communities. The cycle consists of seven key steps. These were examined in relation to the examples provided:

1. Defining the health problem

   All of the examples put forward incorporated at least a brief definition of a specified health problem - for example teenage pregnancy, toddler behaviour problems.

2. Identifying potential solutions

   In each case one or more potential solutions had been identified, often, but not always involving the development of a group, or use of local networks.

3. Agreeing health priorities and outcome objectives

   Agreement of health priorities was generally implicit rather than explicit - for example in the prioritisation of resource for toddler behaviour management.

4. Specifying interventions and standards required

   Where individuals described detailed planning processes it appeared that this would produce a more clearly specified intervention - as for example in the case of the domestic violence helpline. Clear standards were not always specified.

5. Delivering the interventions

   Relatively few examples had reached this stage.

6. Auditing the processes of delivery against the standards specified

   As stated above, where initiatives had progressed into action, evaluation was quite common, though often relatively 'soft' - for example asking attenders their views of the initiative.

7. Re-assessing the health problem after delivery of the intervention

   Where impact had been less than anticipated, modifications to approach were proposed - for example in looking at healthy eating for young people, changing the target group slightly.

The major barrier to undertaking public health practice was seen as the pressure to undertake mainstream, 'hands on', practice. The Community Practice Teacher was seen as having a key role in bridging the theory-practice gap, and helping students to see how University based teaching made sense in the practice context. Where students remained locked into 'hands on' models, learning was about *"getting [them] to stand back"*.

Learning about Public Health Work - An Outline Model

An outline model is described in Figure 2 which offers a way of describing the inter-relationship between factors identified at different points in the educational process as impacting on learning about public health work. Firstly, many respondents talked about the student's prior knowledge being an influential factor in their learning. The students themselves experienced time as a constraint in acquiring knowledge, skills and attitudes and in gaining experience of practice. The curriculum was delivered substantially by lecturers who found it relatively easy to articulate their notions of public health, but harder to describe practice. The lecturers saw their role as helping students to 'see' public health work, and enabling students to believe that they were *able* to make changes in people's health experience. Community Practice Teachers on the other hand perceived their role as constrained by the demands of practice, and the need to balance 'mainstream' community nursing or 'bread and butter' health visiting with public health. Community Practice Teachers were responsible for providing students with an appropriate framework within which to progress the development of a public health role. One of the most common frameworks used was the principles of health visiting, which respondents adapted to their own needs. The practice environment in which learning occurred was noted by many respondents to offer different opportunities if it was urban or rural, affluent or poor.

Transformation takes place from student to practitioner. There is then an informal period of consolidation - seeking to make sense of practice and get to grips with what is required. Similar issues arise in looking at consolidation as in the initial course time. The frameworks which have been provided continue to be used. The environment in which the new practitioner works offers opportunities for public health work which may be few or many. The resources available to develop public health work in this period also contribute to the new practitioner's development of activity in this area. The time available to the practitioner is her key resource, and respondents make clear that 'bread and butter' health visiting at this stage will often be time-consuming. However, if there are active voluntary groups, or established workers with whom to collaborate, as in some of the examples given, newly qualified practitioners will begin to plan for, and sometimes undertake, public health activity.

Discussion

Public health work is not generally seen as 'core' work by community specialist practitioners, even health visitors. It tends to take second place to mainstream practice and areas of work which are more concretely measurable. How can the status of public health be raised, and in particular, where resources are finite, how can public health work be supported alongside more immediate health care demands?

The concept of public health is constantly changing. This requires those working in public health to possess skills which can grow and develop to meet needs as they emerge - flexible and transferable skills. In addition, the environment in which learning takes place and the resources available must be assessed in the light of current approaches to public health. Course Programme Directors and others will need to address how best curricula can enable practitioners to obtain a flexible portfolio of skills.

Community specialist roles remain in transition. Different disciplines have different perceptions of public health, suggesting that they might apply core skills in different ways. A review should examine how far the core skills required are held and used in common. Students learn to do public health work through learning to see 'the wider picture'. Though Community Practice Teachers appear more influential in shaping public health practice than lecturers, they are not always supported in this task. Further work is required to explore how CPT support is best done. In addition, post-qualification support in developing practice must be addressed.

Conclusion

This study has examined how far programmes of education can successfully prepare community nursing specialist practitioners to carry out a public health role, and some of the factors which act as aids and hindrances in the translation of theory into public health practice once they are qualified. Practice examples were reviewed in relation to the health benefit cycle. They generally conformed to the early stages but were not precise. In curriculum documents, learning objectives of relevance to public health were few.

The study team looked at how current and future specialist roles might develop and considered students', course teams' and service managers' perceptions of current and future public health roles. The research team also considered the implications of potential developments in post-registration education on public health for pre-registration education and practice, and discussed the implications of the Peach Commission's recently published report (UKCC 1999). Prior experience in community settings appeared to be important in further learning about public health work. Incorporating interdisciplinary learning within curricula would provide a strong base for collaborative working. Developments in practice based learning and assessment may be transferable from other settings to deal with issues raised in relation to community specialist courses and in particular, to span the theory-practice gap.

Box 1 Illustrative Quotations

"All you're doing is sowing the seeds of what they could do when they get out there with their own workload, drawing their attention to the possibilities that they could become involved in." CPT

"...I think you are influenced a lot by the CPT, because you put them on a pedestal and see them as someone very knowledgeable, they do it every day, where someone from college comes in for a couple of slots that week." Student

"Workloads and caseloads and referrals, people having to prioritise in terms of their time, what they can delegate and what they can't delegate, so I guess that's the main barrier." Professional Lead - District Nursing

"In a lot of the trusts around here there is still that medical model so that what they are employed to do are things like developmental assessments and running baby clinics and you know visiting new mums. Now I'm not demeaning that in any sense of the word but that is the contractual bit and appears on job descriptions... They don't see the public health role as being part of the top agenda for health visiting and that is a trust problem." Lecturer

"Political with a small p, things like housing, things like poverty affecting all of those groups... That is really strong for me but I don't know whether our employer would see that as public health." HV

"It was very difficult to get her to actually see what public health was because she was much more still, I felt then, in a sort of clinical role, she had come from midwifery and felt that a hands-on approach was what was wanted." CPT

"I feel part of the training is being able to present, to put things over clearly... a lot of public health is actually being able to change people's ideas or influence them, the uptake of things, and I think you have got to be quite good at communication to get that across especially to GPs." CPT

"In an ideal world we would all like to work differently I think but at the end of the day there are things that you have to get done and the routine child health surveillance is the thing that takes priority." HV

"[there are health visitors who are] in effect public health beacons, but I get the impression that that is not what they were trained to do and they have this kind of subversive look to them, and if they're not properly doing their job, they're doing another job." Director of Public Health

"I know they are supposed to learn that... but I think it's got to be reinforced because once they start getting into their caseload and going to the universal screening and things like that... they don't always actually lift their heads up and look at the real needs of the population." Locality Manager

HIGHLIGHTS
HIGHLIGHTS

Appendix 6

NATIONAL STANDARDS FOR PUBLIC HEALTH SPECIALISTS

Elicited through a feasibility study of the case for national standards for specialist practice in public health

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London School of Hygiene and Tropical Medicine

1999

Key areas of competence to which standards might apply in order to improve the health of the public

Key areas will clearly be the subject of detailed debate and consensus building but a possible starting point for discussion might be a set of competencies or objectives to which standards might apply, set out at a level of detail along the lines suggested below.
. . .

1. Understanding health and disease; measuring disease status

- to understand human health and disease and to determine and understand the major biological, political, social, environmental and lifestyle factors influencing health status and the burden of ill health.
- To examine known risk factors and the evidence of risk
- To develop the techniques of health impact assessment to make it more reliable, useful and routine

2 Disease surveillance and control

- To monitor the instance of disease both communicable and non-communicable; maintain appropriate records and report findings effectively
- To take effective action to prevent and control the spread of communicable diseases.
- To address and control the risks to the public health posed by non-communicable disease and lifestyle choices
- To monitor and control the impact on health of environmental hazards

3 Promoting health and well-being

- To understand the key determinants of behaviour change and how these characteristics vary across populations
- To identify the essential characteristics of negotiating strategies and which work best on different groups and in different circumstances to improve the population's health
- To understand community development and partnership approaches to addressing social and economic factors that underpin poor health
- To develop measures of effectiveness for public health initiatives that aim to promote health and well-being.

4 Evaluating and improving the effectiveness and efficiency of health care

- To understand and apply measures of effectiveness and efficiency in making (or informing) management choice and developing health services
- To use resources efficiently to maximise health benefit
- To develop the methods by which the actual contribution of improved population health to economic and social development can be reliably assessed.

5 Evidence based decisions, information management and research

- To understand and interpret different sources of information and to be able to evaluate and use them effectively whether they are statistical, epidemiological or qualitative
- To seek out evidence and research before taking decisions and to take decisions in line with the best evidence available
- To maintain an up to date knowledge of relevant research and research methods and to manage information sources effectively

6 Advocacy

- To determine the policy sectors which can influence the key determinants of health and identify how they rank in terms of public health consequence and their effects on other aspects of public life.
- To identify the key 'common cause' factors for moving these policy sectors nationally and locally; to be aware of the means of exerting influence and to understand where the areas of resistance lie.
- To understand how to track the policy change process to measure the real factors which can contribute to, or block progress towards, greater health gain.

7 Communications and co-ordination

- To set out detailed local measures of outcome and quality and disseminate them, being explicit about what specialist public health has to offer
- To provide clear messages that are accessible to client groups and collaborators alike and allow them to participate in debate
- To co-ordinate efforts effectively to ensure links across agencies and to avoid duplication

8 Inter-sectoral and collaborative working

- To recognise and appreciate the contribution of the diverse disciplines, groups and professions that contribute to the health of the public and to actively encourage their participation, facilitating links across sectors and encouraging full participation
- To be expert in determining how 'public health' should position itself between the multiple sectors with public health influence and to actively seek involvement with them in pursuit of health gain
- To ensure that public health policy is informed and directed by the full range of specialists, disciplines and skills involved and that decision making is based on consultation and the best evidence available.

9 Management and leadership

- To provide effective strategic leadership for public health initiatives at all levels of policy making

- To marshal the relevant information, research and knowledge of best practice to ensure that change is planned, implemented and evaluated efficiently
- To run a cost-effective and well-led service that maximises the public's and it's own staff's health.
- To put in place mechanisms for appropriate and ongoing multidisciplinary professional development and acknowledge the contribution it makes to specialist public health practice

10 Modelling the future of public health

- To develop the capacity to use public health knowledge and theory to forecast future public health outcomes in a rapidly changing world.
- To apply management tools that facilitate the use of forecasting in planning and decision making and ensure the review, assessment and refinement of such forecasts.

Appendix 7

INTERVIEW GUIDE AND PROCESS OF GATHERING INFORMATION FROM DESIGNATED HEALTH VISITING COURSE LEADERS

PROCESS

1. An initial telephone contact will be made with as many course leaders as possible to:

    a. set up a telephone interview as per attached interview guide
    b. to obtain documentation about their course especially the specialist HV input

NB. The contacts will be mapped to ensure a good geographical spread of courses to include all four countries.

2. A second telephone contact will be used to interview the course leader using a semi-structured format as per attached interview schedule. With permission the conversation will be recorded in note format.

NB. initial plans to tape record the telephone interviews were abandoned for logistical reasons, mainly because more interviews were carried out opportunistically than had been anticipated at the outset.

3. Following analysis of the second contact, if necessary a third telephone contact will be made to explore any issues requiring further understanding.

INTERVIEW GUIDE

NB. This was used as a guide to the main topic areas, with probes to elicit further information where possible. The interviews were closer to the format of a 'guided conversation' than to a structured questionnaire.

Personal Details

NB. Assure that informants' confidentiality will be maintained: personal details for mapping purposes only

Name

Qualifications
(especially teaching qualification ie. HV tutor, CPT, Nurse tutor)

Role and responsibilities

How long involved with Health Visitor Education

Experience of HV education – probe and explore

College/University Details

What is the extent of the structural change, if any, within your College/University?

Are you linked to the School of Nursing?

When did it become part of the University?

What effect, if any, have the changes had on the HV course?

Do you have any links with non-nursing courses? What are they?

What links to you have with courses for other health professionals?

Programme Details

Ask for copy of course/curriculum material if possible

1. What is the programme that covers HV education

   What specialities are involved?

   Which programmes are actually running?

   For England: is it connected to the ENB Higher Award?

2. When was it validated

   Have any changes been made since it was validated ie. change in length, content etc.

   If so why, pressure from whom, meet service need etc?

   Will you be making changes at next validation?

3. How many students do you have – in which specialities?

   Have the numbers of HV and SN changed in recent years?

4. Should the current entry requirements for HV education continue unchanged (GCSE, GCE in English, Welsh or History) plus registration on part 1 of register

   Does your organisation have specific entry requirements for HV course?

Are there any different ones for HVs or the same for all community specialisms?

5. What is your understanding of the statutory requirements for Health Visiting

   What is your understanding of the Board requirements?

   How are these implemented in practice? Gather examples

   What issues arise for you in respect of the apparent lack of fit between the statutory instrument for HV education and the specialist practice framework that informs educational preparation for specialist community practice

6. Who teaches on the courses?

   Of the nurses, how many hold teaching qualifications?

   Of those teaching HVs, how many are health visitors and how many are HV lecturers?

   What contact time do HV students have with qualified HV lecturers?

7. How is your course broken down – core, specialist and supervised/consolidated practice?

   How much multi-disciplinary education is undertaken during the course?

   Has this changed since your validation as a community specialist course?

8. What is the main content of your course – issues from current policy?
   issues from research
   social policy, psychology, sociology

   What is the main content of specialist practice – topics?

   Where does public health fit in?

   How is nurse prescribing being included in the course

   Are you validated to undertake nurse prescribing yourself or do you still license it?

9. Do you use CPTs? How?

   Do they teach on the course?

   What is expected of them in practice?

Is it an expectation that they have a degree themselves?

Are they paid at H grade?

10. Is your course examined within the University Examining structures?

    Do you use an external examiner with HV expertise?

11. What additional courses do you teach of relevance to HV and SN eg, CPT, child protection?

12. Do you feel comfortable with what is happening to community specialist practice and in particular Health Visiting?

    How 'Fit for Practice' do you feel the students are on qualification?

    How competent do employers feel HVs are on qualification?

    Are the learning outcomes specified for community health care nursing appropriate for health visiting?

    What learning outcomes do you think are required to meet the current policy agenda for HVs?

13. What would you like to see happen to Health Visitor education?

    What are your views on the JM Consulting Review?

14. What are your views about nursing as the only basis for HV studies?

Appendix 8

DETAIL OF ANALYSIS OF CURRICULUM DOCUMENTS

A Modules: (CPT)	BSc Hons in Applied Community and Health Studies (Health Visiting) Assessing Need Collaborative Practice Advancing Practice Social Science Health Promotion Innovations in Practice
B Modules: (CPT)	BSc Hons Public Health Nursing – Health Visiting The Restructuring of Welfare Hospital and Community Health care in Contemporary Britain Ethics Law and Professional Issues Management and Quality Assurance Health Needs(Health Needs Assessment and Evidence Based Care Principles of Public Health Nursing – Health Visiting Specialist Practice – Public Health Nursing – Health Visiting
C Modules: (Supervisors)	BA in Community Health Nursing Specialist Programme Health Visiting Principles and Practice of Health Visiting Health Promotion and Public Health Nurse Prescribing Family Health and Child Protection Supervision and Teaching Management and Leadership Research Based Practice Quality and Audit 4 Specialist Themes Analysis of Practice/Specialist Issues Managing and Promoting Professional Practice/Quality Through Research&Audit
D Modules: (?CPT)	BSc Community Health Care Studies ENB Specialist Practitioner Award in Health Visiting Public Health Nursing/ENB Higher Award Health Needs Analysis Care Management in Health Visiting Public Health Nursing Social and Political Issues in Community Health Care Methods of Enquiry into Professional Practice Professional Issues Clinical Practice Leadership in Health Visiting/Public Health Nursing Reflective Practice

E Modules: (CPT)	BA (Hons) Community Health Care Nursing Public Health Nursing – Health Visiting Process in Practice Reflection and Innovation Specialist Unit (Framework for Health Visiting) Management and Professional Leadership Specialist Unit (Family Health Maintenance and Child Protection Public Health and Health Promotion)
F Modules: (CPT)	BSc (Hons) in Specialist Practice (Public Health Nursing –Health Visiting) Contemporary Issues in Public Health – Health Visiting The Promotion and Protection of Child/Adolescent Health Outreach in Public Health/Health Visiting Social policy and Politics of Illness and Health Care Promoting Community Health Managing Collaborative Care Research Project Integrated Practice
G Modules: (CPT)	BSc Community Nursing Management of Specialist Practice/Health Visiting Community Health Nursing Research in Community Health Experience in Community Specialist Practice Towards Autonomous Practice Key Principles Theories and Philosophies Nurse Prescribing
H Modules: (CPT)	BSc Community Nursing Contemporary Community Nursing Research Methods in Health Care Public Health: Policy Practice Specialist Practice Module (minimal data available)

I Modules: (CPT)	BSc (Hons) Community Health Care Studies Health Needs Analysis Care Management (Specialist Route) Professional Issues Clinical Practice Leadership (Specialist Route) Methods of Enquiry into Professional Practice Socio-political Issues Reflective Practice Group Tutorials on Health Visiting Issues
J Modules: (CPT)	BSc/BSc Hons Specialist Practice in Community Health Care Empowerment Policy and Provision Management of Service Provision Partnership Enablement and Education Evidence Based Practice Research Theory and Practice Public Health Nursing/Health Visiting
K Modules: (CPT)	BA Hons Degree in Community Health Studies Law Ethics Management in Community Nursing Social Economic and Political Influences on Health The Human Lifespan: development, adaptation and change Research Education Reflective Practice Health Visiting
L Modules: (CPT)	BSc (Hons) Specialist Nursing Practice Community Core: Professional Leadership Individual and Health Community and Health Specialist: Principles in Practice Towards Specialist Practice (2 Modules) Assessed Practice (2 Modules)
M Modules: (CPT)	BSc (Hons) Degree in Community Nursing Community Health Perspectives Management of Community Nursing Discipline Specific – Theory and Practice Consolidated Practice Health Visiting –Public Health (2 Modules)

N (CPT)	Principles and Practice in Community Health Care Nursing Clinical Care Management Professional Issues Quality Through Communication and Interpersonal Skills (minimal data available)

Appendix 9

HEALTH VISITING WORKFORCE FIGURES

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