Health Visitor Teaching in Practice: A Framework Intended for Use for Commissioning, Education and Clinical Practice of Practice Teachers (PTs)

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Contents

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Introduction

Context and purpose

The framework is intended for use by Higher Education Institutions, Service and Education Commissioners, practice educators practice teachers and mentors, line managers, service leads, and members of the health visiting team, including all those who have responsibility for the education and support of the current and new health visiting workforce. The purpose of this framework is to improve understanding of the role and the importance of the practice teacher their preparation and responsibilities.

This document sets out the national view of the direction of PTs' clinical and teaching roles within the "Call to Action on Health Visiting" (DH 2011a). However, it is acknowledged that the standards for PTs, their preparation and the meeting of ongoing service needs are the responsibility of the NMC, service providers and HEIs. The framework is intended to support both the service's decision-making and the professional practice of PTs.

The purpose of the framework is also to clarify and strengthen the position of PTs within the health visiting workforce and their contribution to the delivery of the Healthy Child Programme (HCP) (DH, 2009), for the benefit of the children and families they serve; improving outcomes for children, promoting the achievement of optimal health and reducing inequalities for all.

This document will:

- Clarify the role and importance of PTs in delivering the service vision and in support of the current and future workforce, including their role in preceptorship for the newly qualified workforce
- Inform commissioning intentions for the education of current and future PTs
- Provide support to service commissioners and providers in considering innovative ways to supporting the education of Health Visitors in practice settings
- Provide a rationale where providers and service commissioners need to consider an increase the number of PTs, including QIPP, and suggested models of support recognising that the delivery of new PTs will not be within the time frame for the "Call to Action"
- Identify the constraints to undertaking the role and potentional solutions to these constraints
- Identify current skills competencies and best practice
- Scope any additional skill sets/learning needs that are required in order for the PTs to lead the profession and guide its direction
- Identify ongoing educational requirements of PTs to enable them to provide quality practice placements and learning environments within health visiting
- Identify clinical practice considerations for PTs in the delivery of the Healthy Child Programme (HCP).

Development of the framework

This framework has been developed with the engagement of a wide range of partners, predominantly PTs themselves , the Council of Deans (CoD), the United Kingdom Standing Conference (UKSC), Higher Education Institutions (HEIs) and lecturers, the Community Practitioners and Health Visiting Association (CPHVA), service commissioners and health visitors. Throughout this document, health visiting and PT practice is set within the policy context; identified actions and key principles for the future positioning of PTs within health visiting are presented.

The UKSC has supported the scoping of continuing professional development (CPD) needs through a survey of its members, which has informed the development of this document and has helped to determine the level of educational alignment with the new service vision.

fitness for practice will be ensured through maintenance of the NMC standards and validation of education programmes. This document is intended to provide a framework of topics that will support practitioners, service providers, commissioners and education providers to fulfil the needs of the service and the Fitness for Purpose of Practice Teachers. It does not affect the absolute requirements of the regulatory body.

This document does not identify the future funding models rather it identifies in the annex where strong partnerships can identify the level of resources available to support PT development.

Background – the political drivers

The Government's desire to reduce the effects of inequality, by strengthening the early intervention of services to children and families, is paramount to the direction and speed of travel for health visiting and its PTs – the key to the success of the Government's Health Visitor Implementation Plan (HVIP) (DH 2011a).

The HVIP can be considered to have spearheaded this movement; it is this programme that has led to the framework *Educating Health Visitors for a Transformed Service* (DH 2011b) and onwards to this current paper and guidance around PTs.

The political drivers are discussed in Annex One. For a suggested reading list of relevant papers and reports, please refer to the References section.

Role and Importance of the Practice Teacher

This section presents the current picture of PT education and practice; see Annex Two (NMC requirements) and Annex Three (Clarification of PT/mentor roles and support required) for supporting information.

PTs within health visiting currently undergo an academic course of study at an HEI that enables them to be registered with their employers and the HEI as suitably trained to provide clinical practice education for student health visitors and to promote the ethos of clinical education as a whole. In recent years, the model of delivery of PT courses has altered; with educational developments from March 2013, delivery may alter again.

It is a requirement of the NMC that PTs hold a clinical caseload (NMC 2008b); how this is achieved and the level/amount of that caseload differ across the country. Within PTs' clinical work, dedicated time is required for them to undertake the development of their learners; again, how this is managed differs across the country. Alongside their clinical work, PTs act as the interface between the HEI and practice/employing organisation, working alongside HEIs and service-provider organisations on education issues.

With the advent of the HVIP and the expansion of the profession – more health visitor students coupled with an increase in return-to-practice learners and more new colleagues to the profession requiring preceptorship support – the role of the PT has come under increased pressure and scrutiny. How service-providing organisations have aligned the increasing learner numbers to available PTs differs; the NMC has clarified that this depends on the geography of the practice area, the needs of the students, and the skills, knowledge and experience of the PTs and mentors that are employed (NMC 2011b).

Although there are differences across the country in how PTs are managed and how they are able to practice, one thing remains the same: the pivotal role of PTs – not just in the education and clinical-placement training of student health visitors, newly qualified colleagues (through preceptorship) and return-to-practice learners, but throughout the learning and education of this expanding profession. PTs are role models not only to their learners but also to their colleagues. Here lies the PTs' contribution to the successful delivery of the HVIP: as its professional leaders and educators, and through the governance of quality standards and assurance. The Government has acknowledged the lack of recognition of health visiting's critical contribution to health and the wellbeing of our society as a whole. For health visiting to succeed in its desire for the full delivery of the HCP, by this energised and vastly increased body of professionals, PTs must be at the heart of plans for the education and training of the health visiting profession and leadership of service delivery. It is recognised that in order for providers of Health Visiting to meet the values set out in the NHS Constitution enabling quality education, training and leadership to be delivered, attention must be paid to the education, support and CPD of PTs themselves.

Constraints, Potential Solutions and Professional Consensus

Constraints to undertaking the role/barriers to supporting students

Through discussions with practicing PTs, the following points were highlighted:

- The increase in numbers of SCPHN health visitor students, newly qualified health visitors requiring preceptorship and other nursing students to support
- Lack of motivation and support from the NHS organisation
- Culture and practice of lack of leadership and team approaches
- Time constraints to the enhanced engagement with HEIs
- Lack of investment in CPD and career opportunities for PTs and health visitors
- High caseload and high levels of safeguarding
- Lack of protected time to mentor/trainee PT support
- Availability of funding for increased establishment of PTs
- Changing and challenging environment in which PTs work

Potential solutions

When considering the constraints identified, PTs offered the following solutions and although it is recognised that not all of these solutions align with the central tenets of Health and Social Care Bill 2012 (HMSO 2012) some can and may be influenced by the new duties on the National Commissioning Board as set out in the act namely:

- The duty to obtain appropriate advice on the protection or improvement of public health
- The duty to promote innovation
- The duty to promote education and training

These solutions can be set out as follows:

Local

- Guidelines and templates for local use
- Professional organisation/representation and employing-organisation support
- Consistent messages between SHA, HEI and employing organisations; stronger tripartite working
- Clinical placement specialists
- New and evolving roles to support public health placements
- Improved communication and partnership working

- Guidance on supporting a non-achieving SCPHN student

National

- Consistency in qualification required for PTs
- Change of culture and clear role expectations
- Strengthened reference to national job profiles
- Strong national profile
- Consistent standards
- Agreed CPD accreditation/points for certain courses
- Development of networking/a forum
- Raise profile of health visitors
- Monitor growth of PT numbers
- Appreciation of need for protected time/reduced caseload numbers for PTs
- Greater use of system levers – SHA plans

Professional consensus of good practice

Examples of best practice and solutions to challenges presented by PTs:

- Development of team-around-the-student philosophy (including clear objectives and planning/review/assessment)
- Development of peripatetic PTs with a reduced caseload to support trainee PTs and mentors
- Utilise APEL portfolio/work-based learning to become a PT
- Utilise PT expertise in service and curriculum development
- Encourage sharing best-practice events and peer support
- Develop group clinical supervision for students and newly qualified
- Development of sign-off PT workshops
- Development of group clinical supervision for PT
- Increased focus on tripartite working

Educating PTs for a Transformed Service

This section outlines the rationale for why practice teachers are key in transforming service delivery and provides detail on the links between the new educational elements and the service vision. It provides a suggested approach for education commissioners, HEIs and lecturers to align PT preparation and CPD with the new service vision.

The information and themes below outline some of the areas that education commissioners, HEIs and lecturers need to consider for inclusion in PT preparation and CPD to ensure that the programmes are fit for purpose and reflect the health visiting service vision, model and delivery of the HCP when assessing student competency.

Many of these areas will already be covered within current PT preparation and CPD; however, this guidance is intended to support programme development and change as and where necessary. For further details on education and practice alignment to the new service vision, and topics for coverage in student placements, please see Annexes Four and Five.

Fitness for practice will be ensured through the NMC standards and validation of education programmes. This document is intended to provide a framework of topics which will support future practitioners to fulfil the needs of the service and does not affect the absolute requirements of the regulatory body.

HEI advice for PTs

Each HEI has its own fitness-to-practice process that will support and advise regarding concerns about a student. Key contacts at HEIs will be available to provide advice and guidance around their processes.

Gathering information for a fitness-to-practice concern can be an arduous process; it is advisable to have a system to record information. Ensure that hard copies of information are available and collated, so that they strengthen the process.

You may wish to seek support/an opportunity to debrief following a challenging situation such as an allegation of bullying/racial harassment.

Professional bodies such as CPHVA and the RCN can offer support if members feel they need professional advice or support.

Similarly, most NHS employers have a telephone support service for staff to discuss issues or concerns at work.

Prompts for HEIs and PTs in assessing/PT preparation and CPD requirements

It is recommended that education commissioners, HEIs and service-provider organisations consider these prompts when reviewing their programmes to ensure that PTs have appropriate theory, knowledge, skills and support to enable them to play their role, contribute and lead the new service vision through clinical practice (for further details, see Annexes Four and Five):

- How do we proactively manage recruitment, career progression and retention?

- How is assurance offered for the ongoing delivery of excellent clinical teaching within the practice setting after qualifying as a PT?
- How well do the current programmes of preparation and CPD for PTs map to and meet the demands of students in being able to demonstrate skills to deliver the new service vision?
- Do current programmes offer sufficient flexibility to meet future demands and, if not, what could be considered further?
- How will you prepare and support PTs and mentors in the new ways of supporting health visitor students and those returning to practice?
- How could the content of the programmes be adapted to support PTs to assess new/higher-profile elements?
- How could you work more closely with SHAs and providers to ensure/identify and increase the number of PTs and to support development of the current PTs?
- How will you ensure that trainee practice teachers are familiar with the new service vision and model of practice?

Key Principles for Future Action

In order to produce quality health visitors, assurance is required not only of the academic provision by the HEI and the suitability of the practice placement, but also of the ability of the PT to mesh the academic and clinical dimensions of learning and present this to the learner, working with them to make it meaningful.

To this end, and linking into the policy context described earlier, three overarching key principles will be presented that form the future direction for the commissioning of PT positions, PTs' education and development, and the support needed to perform their role. These key principles are interlinked; the strategies for their delivery will overlap each other and will depend upon one another to be achieved.

The three key principles are:

- Recruitment, career progression and retention
- Quality assurance
- Education

Suggested actions for recruitment, career progression and retention

- Service-providing organisations to develop an education strategy that includes:
    - an overall plan for how the necessary numbers of students will be supported (including how long-arm mentoring will be supported and quality assured)
    - recruitment plans for PTs; a plan for how the organisation will calculate the ratio of PTs to staff required
    - expectations of PT functions
    - allocation of protected time for PTs
    - consideration of education environment within estates strategy
- Career pathways:
    - mentor pathways
    - specialist roles (linking in with HCP)
    - peripatetic PT roles
    - clinical academic careers
    - Public Health career framework
- Clarity of funding streams

Suggested further actions for quality assurance

As well as the triennial reviews currently required:

- CPD – production of evidence around educational development and learning and assurance of specific CPD in the role of PT
- Specific application of organisational appraisal process capturing the role of PT
- Provision of educational/teaching supervision for PTs (separate from clinical supervision)

- Linked with education, clear HEI and employer pathways for the support/management of PTs not achieving standards
- Links with the Educational Outcomes Framework indicators for Excellent Education

Suggested actions for education

- PT curriculum development – modernised, future facing, with alignment to current national guidelines for health visitor courses and new service vision
- Baseline assessment of PTs' current level of clinical educational attainment
- Competency framework
- Development of modular updates around clinical education
- PT refresher modules
- E-learning units designed especially for PT development

Current Skills and Future Education

Current skills competencies and best practice

The key principles described in this framework (also in Annex Six) acknowledge the need to benchmark PTs' knowledge and attained skills through a competency framework. This is necessary in order to appreciate their high standard of academic knowledge and the theoretical underpinning of practice clinical skills, but also to identify what refreshing and support PTs require so as to deliver the education and clinical practice standards that their learners are expected to achieve (Annexes Four and Five).

Future educational requirements/ongoing CPD needs

In order to lead clinical education and practice, PTs need to be at the vanguard of the new service vision; to be equipped with the latest knowledge and clinical skills to inform their education practice. Annexes Four and Five describe in detail the necessary education and practice, aligned directly to the new service vision, with topics for PTs to include in clinical practice education with learners. Some of these clinical theories and skills are well known practices; some of them are newly identified, research-based methodologies; and some are adaptations from other fields as the NHS moves into a more commercially attuned environment (skills in coaching, knowledge of commissioning and contracting, for instance).

A scoping exercise has been undertaken to gather views on the future educational requirements of PTs and their CPD needs. The key findings included the following:

- The majority of PTs felt that they could support or facilitate health visitor students in all areas of public health, with most areas of public health being applied on a regular basis or extensively. However, 60.4% and 62.7% of respondents, respectively, highlighted that further development was required in educational components of Public Health and Community, including specific coverage of the following topics: Social Capital/Social Marketing/Social Networks and Public Health (international, national and local focus – in order to capture the learning requirements for immigration and migration).
- PTs indicated that they are confident in their ability to deliver the HCP. Nevertheless, constraints were highlighted in relation to available time and competing practice demands. Some comments also identified that PTs feel constrained by the services currently commissioned versus their public health role. Some PTs indicated that they would appreciate updating, particularly in relation to accessing epidemiological data, statistics, new initiatives in public health, policies and commissioning.

Despite the majority of PTs having the knowledge and skills required in public health, PTs stated that they are not currently able to participate fully.

Annex One – Health visiting in the spotlight: The political drivers for future development

A plethora of recent reviews have added to the Government's direction of belief: the work of Dame Eileen Munro (DH 2011a and b), examining how preventative services, rather than reactionary approaches, can reduce the risk of neglect and harm; the work of Graham Allen MP (2011) and Dame Clare Tickell (2011), both considering early-years intervention; and the review of the effects of poverty and life chances by the Rt Hon Frank Field MP (2010) all added to the growing body of evidence of the effectiveness of early intervention with children and families, and the view of the importance of providing help to parents and carers at this time. All reports add agreement that preventative services can do more to reduce abuse and neglect than reactive services; that many services and professions help children and families, so coordinating their work is important to reduce inefficiencies and omissions; and that local authorities and statutory partners work together to secure the sufficient provision of local early help services for children, young people and families.

The Government understands and supports this thinking, seeing the wider public health and social benefits that investing in the care provided for babies, children and families can offer, and how health visiting practice supports the underlying principles of the Government's 'Big Society'. For this reason, the HVIP (DH 2011a) was launched and its findings/recommendations subsequently published in February 2011.

HVIP describes the Government's plans for:

- All parents and children to have access to the support they need to get off to the best possible start
- Early intervention to ensure additional support for those who need it, including the most vulnerable families
- Early intervention: working with families to build on strengths and improve parenting confidence
- Referral pathways for specialist help where required

Health visitors, working in partnership with GPs, midwives, Sure Start Children's Centres and other local organisations, have a crucial role in ensuring that children and families receive the care they require for optimal health and wellbeing, and ensuring that, when school is commenced, children are ready to start their education (DH 2009a, DH 2011a).

The HVIP impacts on every aspect of health visiting: from clients and present workforce to managers of the profession and its commissioners, to educators in HEIs and practice, and to potential recruits, whether first-time recruits or returners to practice. For the HVIP to be successful, the Government understands that the health visiting workforce requires investment. In recent years, the number of registered health visitors has declined for a variety of reasons; the Government is set to turn this around and has set itself an ambitious target of securing an extra 4,200 health visitors to the profession by 2015. This will be achieved through: the almost reinvention of the role and scope of the health visitor; attracting new recruits to the profession and also inviting previous health visitors to reconsider the profession as a career choice; and a choice of flexible entry/re-entry education programmes, which are to be supported by PTs.

The HVIP challenge has been taken up nationally and embraced by all partners to health visiting: by service-provider organisations and commissioners of those services, working together to agree plans for achievement; by HEIs, considering flexible education options for prospective learners; and also by health visitors themselves, in considering innovative, dynamic methods of HCP delivery, ensuring that health visiting re-grasps the public-health mantle and makes a sustained, positive impression on the health and wellbeing of those lives that its profession touches. As momentum grows and 2015 is reached, the expanded and reenergised health visiting workforce will together lead and deliver the Healthy Child Programme of assessment, intervention and support to every baby, child and family nationally (DH 2009b).

Annex Two – NMC requirements

This section sets out the roles and responsibilities of the SCPHN PT on education programmes leading to entry onto the SCPHN part of the NMC register.

Background of the NMC requirements

- The NMC requires that all SCPHN students must be allocated a PT. Traditionally these students were placed with a PT in order to complete and pass the practice element of the pre-registration SCPHN programme. In recent years, this role has been developed by identifying qualified SCPHN health visitors and school nurses who are on active mentor registers and working sufficient practice hours, and placing SCPHN students with them. PTs have supervised and overseen these placements and undertake the ongoing practice assessments and final sign-off as 'fit to practice', as mentors are unable to do this. This approach ensures that practice learning and assessment continues to be safe and effective. Areas where this has become common practice have reported it to be a successful and beneficial system to both the students and the SCPHN teams by sharing learning.
- The HVIP has presented a challenge to HEIs and employers – the need to provide training placements for a greater number of students. In order to meet these needs, guidance is necessary to enhance systems already successfully in place and develop them in areas that have not traditionally used SCPHN mentors that meet the training standards for mentors, practice teachers and teachers required by the NMC (NMC 2008b).
- The NMC standards include 'applying due regard to learning and assessment in practice' (NMC 2008b). This addresses training-placement requirements for students where no practice teachers are in the placement or where alternative (for instance, long-arm) arrangements are in place, whilst applying due regard to the NMC standards. This enabled mentors to be identified who could undertake the practice teaching with supervision from a PT who takes responsibility for guiding and advising the process as well as taking accountability for assessment of the student (NMC 2011a). The PT must also take accountability for signing off the student as 'fit to practice' at the end of the academic and practice programme. The NMC (2008b) Standards to Support Learning and Assessment in Practice sets out in detail the requirements for PTs. Whilst these standards stipulate that practice teachers should support only one SCPHN health visitor student at any point in time, the NMC has clarified that some flexibility can be applied (NMC, 2011b).
- The NMC states that any decision regarding student and PT ratios should be decided locally within the HEI practice governance arrangements. This responsibility is devolved to the HEI by the NMC and any justifications are scrutinised at the NMC annual monitoring review.
- Collaboration between the HEI and the PT is essential and must take into account governance arrangements and provide a safe learning environment for SCPHN students.

- In order to support individuals to become PTs, it is necessary to use this flexible approach. A similar flexible approach may be applied to student support; this allows mentors/trainee PTs to contribute to the practice learning of SCPHN students.
- The NMC circular 27/2007 introduced a way of allowing flexibility in achieving supervised sign-offs which would normally take two years (NMC 2009). A period of preceptorship is required during this time. However, a trainee PT is able to participate in the assessment of SCPHN students, with support and ongoing assessment from a PT with sign-off status (NMC, 2009).
- The PT needs to meet with the student and their mentor/ trainee PT at agreed, pre-determined points to monitor the student's achievements and identify any areas of concern.
- The mentor/ trainee PT may make incremental assessment decisions as agreed in partnership with the PT.
- The PT and the mentor/trainee PT may jointly assess achievement of overall proficiency for entry to the SCPHN section of the register at the end of the SCPHN programme.
- Where PTs are supporting and assessing students in this way, it will be possible for them to support more than one student at a time.
- PTs still need to be able to commit themselves to this role as well as maintaining safe and effective SCPHN practice.
- PTs should, therefore, not normally support more than three student/mentor/trainee PT partnerships in this way at any time (although there may be exceptions; for example, where students are studying on a part-time basis) (NMC, 2011).

Annex Three – Clarification of PT/mentor roles and support required

Role of the PT

‘An NMC PT is a registrant who normally will have previously fulfilled the NMC requirements to become a mentor and who has received further preparation to achieve the knowledge, skills and competence required to meet the NMC defined outcomes for a PT. The NMC requires all students undertaking a programme leading to registration as a SCPHN to have a named PT’ (NMC 2008b). PTs are subject to triennial reviews in order to meet NMC requirements. They are also required to attend an annual sign-off PT update.

Where SCPHN students have a mentor in their practice placement, they can be supported by a PT through a long-arm approach. This does not mean there is a ‘hands-off’ approach. Mentors work under the supervision of the named PT and it is necessary for the student, mentor and PT to meet regularly to discuss progress and map this against the competency framework. The PT should be readily contactable for both mentor and student and cover arrangements put in place should the PT be unavailable for a period of time.

The PT assesses and marks the practice portfolios and is responsible for signing off the student as fit to practice at the end of the programme.

Role of the mentor

‘An NMC mentor is a registrant who, following successful completion of an NMC approved mentor preparation programme – or comparable preparation that has been accredited by an HEI as meeting the NMC requirements – has achieved the knowledge and skills and competence required to meet the defined outcomes’ (NMC 2008b). It is also a requirement of the NMC that mentors are entered on a local register (normally held by employers who provide the practice placements) and are then subject to triennial review. Mentors are also required to attend annual updates.

All registered practitioners have a responsibility to support learners, and in the case of SCPHN registered nurses this support extends to SCPHN students. It is a rewarding experience and one of the best ways of keeping professional practice up to date and of a high standard. A good mentor who is an excellent role model helps to shape the future of the profession.

In the case of SCPHN mentorship it is recommended that a preparation programme for this role is put in place by employers, in partnership with HEIs and PTs. This would include information about the SCPHN pre-registration programme, the role of the mentor, the supervisory and assessment aspect of practice teaching, and meeting the needs of students when concerns arise.

Mentors facilitate the practice-experience needs of students under the advice and guidance of a PT, who assesses and marks the practice portfolios. Mentors, PTs and student SCPHNs meet regularly to discuss progress against the competency framework and ensure that practice-experience needs are met.

Student SCPHNs are expected to undertake self-directed learning and will agree with the mentor and PT their practice programme. This is spread across three areas:

- Intended Field of Practice (IFP)
- Potential Area of Practice (PAP)
- Community and Public Experience (CPE)

This means that the teams in which SCPHN students are placed (IFP) will help to meet their learning needs. In addition, they will have one-to-one time with their mentor and wider experiences will come from spending time with other professionals and agencies (PAP and CPE) in a wide range of settings.

Support for both PTs and mentors

SCPHN mentors have a supervising PT with whom they can discuss mentorship issues. Students will be made aware that their mentor may, from time to time, seek advice and guidance from the PT if they have concerns. Concerns should be treated as confidential to the student, mentor and PT unless unsafe practice or significant inappropriate behaviour has been identified. It is best practice to inform students of any discussions taking place about them but sometimes mentors may require prior advice before raising difficult issues in order to approach them in a sensitive and appropriate manner.

PTs and mentors work in partnership with HEIs, employers, fellow PTs, mentors and workplace colleagues. This acts as a further support network. Students will be made aware that their PT may use this network for advice and guidance when concerns arise. Concerns should be treated as confidential to the student, mentor and PT unless unsafe practice or significant inappropriate behaviour has been identified. It is best practice to inform students of any discussions taking place about them but sometimes mentors may require prior advice before raising difficult issues in order to approach them in a sensitive and appropriate manner.

N.B. The need for consistency in practice teacher and mentor training is paramount to ensure appropriate high-quality teaching, assessment, student support and clinical advice. However, innovative practice should be actively encouraged.

Annex Four – Areas of education and practice mapped against the new service vision/family offer (DH 2011b)

1. Community

This service includes interactions at community level:

- Human ecology/population health and epidemiology
- Social capital/social marketing/social networks
- Building networks and understanding communities
- Building community capacity
- Influencing and developing policies and strategies for health and wellbeing
- Public health and inequalities

Rationale

Four principles underpin the health visiting approach to SCPHN working practice: the search for health needs; the stimulation of awareness of health needs; the influence on policies affecting health; and the facilitation of an awareness of health needs.

These principles are embedded in all aspects of their work on the Healthy Child Programme. It is also recognised that health visitors will identify and lead the development of resources within the community to meet the needs of the children and families within that community.

When connecting with people and services, practitioners' skilful support enables families to:

- Understand the impact of community and environment on children's growth and development
- Develop the self-efficacy necessary to create positive relationships with other local families and community groups, building social capital
- Make use of additional services they may require

Skilful support also helps practitioners share details of/make referrals to other local services (e.g. children's centres, housing agencies, voluntary agencies, etc.) which will support the achievement of their goals.

Public health is an essential part of the health visitor's role as a specialist in community public health. Therefore, it is essential to consider key elements of education relevant to this function and the impact of this work on delivery of the HCP, including:

- Health inequalities
- Social capital
- Population methods

- Universalism
- Prevention and health promotion
- Individual topics (smoking, obesity, drugs and alcohol, etc.)
- Communication – including relationships and social networks, and professional partnership relationships

2. Universal (Child and Family)

This is a service for all families, which includes:

- Early childhood development
- Self-efficacy
- Motivation and motivational interviewing
- Change processes/changing nature of families
- Neuroscience
- Attachment and parenting
- Relationship building
- Research and evidence-based practice/new health knowledge relevant to children and families
- The Healthy Child Programme

3. Universal Plus

This is a service that any family may need some of the time, including:

- Maternal mental health needs
- Relationship building
- Role modelling and mirroring
- High-level communication
- Motivational conversations/strengths-based approach
- Assessing and evaluating evidence and outcomes
- Understanding practice – relationship base and parent empowerment
- Solution-focused therapy/approaches to behaviour change

Rationale

Families move between the Universal and Universal Plus services. Therefore, much of the rationale for Universal Plus is the same as that for the Universal service, including:

- Promoting and enabling successful adaptation to parenthood
- Promoting family efficacy and responsibility for health and wellbeing

- Enabling parents to provide an environment which fosters their children's physical, social, emotional and cognitive development and monitoring
- Assessing the child's progress

The goals of the HCP include:

- Transition to parenthood and positive parenting
- Strong family relationships and attachment, resulting in improved social/emotional wellbeing
- Care which promotes health and safety
- Increased breastfeeding, healthy nutrition and increased physical activity, prevention of communicable diseases, readiness for school and improved learning
- Early recognition of growth disorders and risk factors for obesity
- Early detection of deviations from normal physical and neuro-developmental pathways

There are a number of theoretical constructs:

- Needs and approaches to support the delivery of these goals, including early childhood development; neurological, physical, social and emotional child development and relationship to adult health
- Motivation and behaviour change, incorporating self-efficacy; motivational interviewing
- Promotional interviewing
- Solution-focused approaches
- Communication, relationships and social networks
- Healthcare process, practitioner and relational competences

In addition, there are a number of key stages of universal health visiting HCP practice:

- Developing relational processes through engagement and agenda matching
- Exploration and reflection
- Sharing knowledge and understanding
- Analysing and recognising patterns
- Decision-making
- Future plans
- Connecting with people and services

It is recognised that parent, child and family engagement will be influenced by:

- Nature of parent and child strengths and concerns
- Beliefs and concerns about help seeking and engagement
- Desires and concerns about change

- Attitudes and beliefs about services
- Expectations and match between parent/child and practitioners' outcome priorities
- Wider family, social circumstances and culture

Health visitors need knowledge and the ability to use and adapt evidence-based intervention strategies to assist parents and families to manage problems and difficulties as they arise. For example:

- Relationship and attachment difficulties
- Behavioural management strategies
- Smoking cessation strategies
- Childhood illness and management of long-term conditions
- Knowledge of relevant local resources and services, and the ability to facilitate parents' use of them

Health visiting tasks where parental adaptation is challenging will need to include:

- Intervening to support behaviour change for more attuned, responsive and committed parenting
- Building skills, strength and resilience
- Preventing problems becoming entrenched
- Supporting change to reduce risks to family health and wellbeing
- Promoting change in enduring behaviour patterns
- Ensuring families with additional needs have access to specialist services, e.g. specialist paediatric services, social care agencies, mental health services, etc.

Skills in communicating with all parents and enabling them to adapt and change are essential and include the ability to help parents to use a range of methods and approaches that promote wellbeing and adaptation and the ability to manage difficulties that arise within parental and wider relationships.

Health visitors also need to embody a range of personal and professional qualities and have good working relationships with other local services.

Communication skills include:

- Concentration/active listening
- Prompting, exploration and summarising
- Empathic responding
- Quietly enthusing and encouraging
- Negotiating and guiding to enable exploration
- Sharing knowledge and expertise in respectful, understandable, meaningful and useful ways

- Enabling change in feelings, ideas and actions

4. Universal Partnership Plus

This is a service for vulnerable families requiring ongoing additional support, including safeguarding and child protection concerns. It involves:

- Team functioning and team leadership
- Leading outside of sphere of influence
- Safeguarding children
- High-level communication
- Leading service improvement for children and families
- Group facilitation

Rationale

Relational processes are essential where there is complexity. Therefore, it is important that:

- The practitioner establishes a trustful partnership with the family and clear, shared expectations of family professional contacts, showing respect for the family's values, priorities and capabilities
- Families with additional needs may need an ongoing relationship with a familiar practitioner to achieve change
- Families with complex needs will potentially require a longer-term, more personal relationship with a consistent practitioner to achieve change

Family adaptation/behaviour change is most successful when:

- Families anticipate and successfully adapt to the next stage of HCP development; families with additional needs are able to adapt and change in accordance with their circumstances (e.g. family able to understand and apply behaviour-management techniques, successfully overcome post-natal depression, etc.)
- Families change behaviours to promote family health (e.g. stop smoking, reduce alcohol consumption)

Change in families with complex needs is not easy because:

- Change is not easy for everyone
- The expressed need for change can cause people to feel uncomfortable, criticised and defensive
- Change may be particularly hard for parents who have difficult and stressful lives

The potential for change is improved when:

- A helping relationship is established
- Families' aspirations are elicited and respected

- Ambivalence is explored
- Plans for change are made collaboratively
- There is good evaluation and review of impact, progress and outcomes, and they reflect together on further strategies, plans and actions required

Health visitors work with other professionals and agencies to agree a range of contributions, interventions and opportunities for each family. Their preparation must ensure that the health visitor is able to act as the lead professional for some families, coordinating the work and progress.

Fitness for practice will be ensured through the NMC standards and validation of education programmes. This document is intended to provide a framework of topics which will support future practitioners to fulfil the needs of the service and does not affect the absolute requirements of the regulatory body.

Annex Five – Key topics for PTs to cover as part of clinical practice with students

This section sets out the key recommended topics in the areas of theory to practice skills that PTs particularly need to cover with students in order to ensure practical application to the theory during clinical placements. This will support service change. In order to reflect the transformed health visiting services, the topics are based on (*Educating health visitors for a transformed service*, DH 2011b).

Public and community health

- Leading service improvement for children and families
- Assessing and evaluating evidence and outcomes

Child and family health and wellbeing

- Motivational conversations/strengths-based approach/family dynamics and relationships
- High-level communication skills required to deal with complex cases and complex multi-partnership working
- Solution-focused therapy/approaches to behaviour change
- Understanding practice – relationship base and parent empowerment
- Role modelling and mirroring/model of practice

Child and family health and wellbeing

- Attachment and parenting
- Motivation and motivational interviewing
- Change processes/changing nature of families
- Safeguarding children/vulnerable adults (e.g. considering people/clients with learning disabilities and teenage parents)
- Neuroscience
- Maternal mental health needs/post-natal depression

Leadership and teams

- Group facilitation
- Team leadership
- Relationship building

N.B. It is important that caseload management and lone working are considered when planning clinical practice.

Annex Six – Key principles

Recruitment, career progression and retention

Recruitment and retention of PTs

For successful achievement of the HVIP, all service-providing organisations are looking at the number of additional health visitors they require; the same should be considered for PT roles also. Along with the recruitment of PTs, how organisations can retain the employment (and skills) of those staff members is crucial in these times of competition for posts/employment.

Suggested action

- Service-providing organisations should develop an education strategy considering this area and an overall plan for how the necessary numbers of students will be supported, coupled with any recruitment plans for PTs. This will include how long-arm mentoring is supported and quality assured. The document would incorporate all aspects of what the service provider would expect PTs to deliver and also what support they would provide for the PT (supervision, protected time for attending meetings, supervision, sessions with learners, etc.).
- Development of career pathways within organisations is possible, even within a flat structure such as that of PTs. Added dimensions to roles (for example, PTs as leads for certain topics, or secondments for periods of time to look at professional development subjects – both would link into the delivery of the HCP) will potentially add to the retention rate of staff.
- PTs' skills should be used to support newly qualified staff, particularly as up to 50% of the workforce after 2015 will require preceptorship.
- PTs' skills should be used to support research and the ongoing development of the current health visiting workforce.

Funding considerations

If the PT's responsibility as clinical practice educator is considered a pure element of their role, the subject of additional funds to support this is raised. Although the number of student health visitor places is decided by service providers and commissioners alongside HEIs, the number of PT positions within a service-provider organisation is at that organisation's own discretion. The commissioning of PT positions is a decision that service leaders make, based on the funding available (whether this funding was created within the service/organisation or from the current establishment of PT vacancies, for instance) or from locally secured MPET funding. Commissioners and providers should work in partnership with Local Education and Training Boards regarding the inclusion of health visitor students in the Multi-Professional Education and Training tariff or any other additional support to be paid to the service-provider organisations that support the educational/academic function of the PT and the maintenance of that element of the role.

Suggested action

- Discussion is required regarding the provision of a percentage of funding per student to be paid to the service-provider organisations to support the educational/academic function of the PT, supporting the maintenance of that element of the role.

Quality assurance

PTs undergo a rigorous academic and practice-based learning process in order to qualify. PTs and mentors undergo the triennial review; does completion of this assessment provide rigorous quality assurance of the suitability of the clinical practice placement and the skills of that PT? Could more be done to provide quality assurance? The question of how the practice of clinical education and teaching quality is measured and assured post-qualification is an issue for consideration – how do PTs evidence their continuing professional development (CPD) in relation to teaching? Do PTs consider their teaching practice in relation to receiving supervision? (Is teaching supervision required?) And how is the role of the PT covered within the operational management appraisal system?

CPD – production of evidence around educational development and learning, and assurance of specific CPD on the role of PT

As with all professions, assurance of professional practice and educational update is maintained through registration with a professional body; for nursing, this is the responsibility of the NMC (NMC 2008a). Although PTs – like any other nursing registrants with the NMC – are required to produce evidence of CPD (as well as a declaration that they have undertaken the required number of clinical hours for the part of the register for which they are seeking ongoing registration), little assurance is formally sought as to the PT's ongoing educational/academic/teaching professional update. Some HEIs hold a number of mandatory updates for PTs who support students attending their courses, whereas some purely hold regular meetings relating to the students' course.

Suggested action

- PTs are required to produce CPD evidence for both aspects of their role: the clinical element and the educational element. This can be achieved by recording in their portfolio not only attendance at certificated events, but also reflection of how clinical changes can be taught to learners and how they have managed the educational path for challenging learners, etc.

Specific application of organisational appraisal process capturing the role of PT

Another consideration regarding assurance rests with the employing organisation. Service-provider organisations may cover the PT element of PT/health visitor employees' performance and CPD in their annual appraisals. However, this depends very much on how the organisation manages its appraisal process in general. Also, individual line managers, even within the most prescriptive of appraisal processes, are not necessarily educators and may not have the ability to offer a meaningful, critical appraisal of the PT/health visitor employee's performance as an educator.

Suggested action

- Service-provider organisations should assess PTs' education/teaching performance separately (utilising whichever method they choose to employ), with a dedicated appraisal for this aspect of their role. The rationale for this is to highlight the importance of the role and to ensure that aspects of the PT's clinical practice do not override topics in relation to the role of PT. If the PT's own manager does not have the necessary skill set, an appropriately trained manager/educator would preferably undertake this dedicated appraisal.

Provision of educational/teaching supervision for PTs

The need for nurses to receive support (i.e. to feel supported) for undertaking their clinical roles is a subject often discussed. Clinicians seek and enjoy support from a variety of sources – peer support, meetings with their managers and attendance at organisational meetings, for instance. Within the arena of support, the provision of and uptake of supervision is a more formal supportive mechanism which is commonplace within nursing. Various types of supervision are provided to clinicians, depending on their roles; for instance, child-protection supervision is mandated within the field of health visiting, whereas general clinical supervision is offered in many areas of the country and further work is being undertaken regionally and nationally, looking deeper into this topic. However, the subject of the provision of formal support for PTs in relation to educational supervision appears to be less discussed. For PTs, once qualified, there is little to no supervision dedicated to their practice as teachers of the profession's learners. From conversations with partners, responses to the question 'What supervision is available to PTs?' range from attendance at PT meetings to attendance at meetings with their current learner and the HEI's lecturer regarding that year's progress.

Suggested action

- A formal mechanism for educational supervision, periodically throughout the academic year, would provide PTs with a formal outlet to reflect on their performance and would offer service-providing organisations a level of quality assurance in the service they are receiving from PTs/ providing to learners. The question of who should/can act as an educational supervisor is one to be debated and could be decided locally; this could be a member of an HEI faculty (commissioned as part of the educational contract for student health visitors), a suitably qualified member of the organisation's structure, or peer supervision from the organisation's/regional pool of PTs.

Education

PT curriculum development – modernised, future facing, with alignment to current national guidelines for health visitor courses

The health visiting curriculum – and that of its teachers – needs to be as dynamic as the profession itself; with the speed of developments within the field of health visiting, both the students' and their practice teachers' curricula need to be revised annually, with consideration for future proofing – considering topics that are on the horizon. For instance, during the development of this framework, PTs have proposed changes to the curriculum to cover innovations in health visiting service delivery, such as management in practice, managing

service delivery to achieve core offer (five levels of intervention), coaching training, audit, team engagement, commissioning changes, negotiation and updating of teaching skills. Inclusion of such topics would add practical benefits for PTs and service-provider organisations alike. Within the consideration of alternative topics for inclusion in curricula, attention to the development of clinical-practice approaches (such as multi-agency team working and working with children's centres – in general, inter-agency working with local authorities) is warranted; such developments have altered the team landscape around the role of health visiting and impact on the functioning of the team and the care delivered to the children and families they serve. The NMC provides guidance on the subject matter to be covered within educational courses; whilst this needs to be embedded into the curriculum, scope for negotiation on other subject matter is required.

Suggested action

- HEIs, service-provider organisations, commissioners of the service and PTs need to jointly consider curricula and agree subjects that need to be covered, in addition to the NMC guidance. Discussions with partners suggest that subjects such as coaching skills, role modelling, leading service delivery and new aspects such as dual registering warrant inclusion in curricula.

Baseline assessment of PTs' current level of clinical educational attainment

As the Government has acknowledged the requirement for re-energising the workforce within the HVIP, this principle needs to include health visiting's PTs also. Together with re-energising the PT workforce, attention needs to be given to how service-provider organisations, their commissioners and HEIs can be assured that PTs have developed their practice in line with the changes to service requirements that have occurred in health visiting since they qualified. Although future-specific CPD is presented within this framework as an action, there is a need for a baseline assessment of PTs' current knowledge, skills and abilities to undertake the role. This is required because health visiting has been moving into a new age of practice (in terms of new clinical skills and how PTs use their current skill set, coupled with how they are nationally/regionally/locally organised as a profession to deliver services), and the educational and clinical practice curriculum has adapted to ensure that learners are equipped to meet these challenges. PTs need to acquire the skills that we need and expect our newly qualified staff to hold on completion of their course. Many PTs will possess these skills and knowledge, having gained/refreshed them through various CPD activities; some, however, may need an opportunity to refresh their skills – to be re-energised. In order to provide assurance of PTs' knowledge and skill base, and also to ascertain any development requirements that PTs may have, a competency framework would provide a baseline from which PTs can develop, both clinically and educationally.

Suggested action

- A PT competency framework should be developed that mirrors the national competency standards for health visitor learners and includes academic developments in the field of practice education. This would be formulated at an advanced level, ensuring that PTs have the necessary knowledge and skills to be able to proficiently provide a practice learning environment and teach any health visitor learner in the clinical environment. The PT would work through this document and then, together with their designated educational supervisor/line manager, would produce an action plan addressing any areas for development that are identified. If proficiency is evidenced at this baseline assessment, the tool could then be used as part of the annual dedicated PT educational appraisal.

Development of modular updates around clinical education

Provision needs to be made for instances where completion of a baseline PT competence framework highlights levels of update that require more formally supported development. For instance, by undertaking a PT refresher module, the PT would gain the opportunity to update a variety of knowledge and skills. Completion of such a module would afford assurance of the quality of that PT's baseline in providing the clinical educational lead for student health visitors who undertake their clinical placement with them.

Suggested action

- Development of PT refresher modules will be undertaken jointly by HEIs and the commissioning service-provider organisations. By working together, they will develop flexible modules, so that the individual needs of PTs who have been highlighted as benefitting from re-energising their skills and knowledge can be met successfully.

Along with all three elements included within the key principle of education, academic and practice learning and also updates of new methods of clinical education support and delivery for all health visiting learners (including new registrants in their preceptorship period) are worthy of note. With the advent of mentors and long-arm PT support, the PT and associate mentors need awareness of new methods of teaching delivery and support that can be utilised in the practice learning area and enrich the overall learning experience. These include the use of action learning sets, e-learning packages (such as the suite available from e-Learning for Healthcare – Healthy Child Programme) and group learning techniques, plus the use of technical aspects of the business environment, such as videoconferencing, to undertake clinical teaching/supervision if staff are spread out over a large area.

Annex Seven – Understanding mentorship, preceptorship and supervision

Below are some definitions to support understanding of the terms ‘mentorship’, ‘preceptorship’ and ‘supervision’.

Mentorship

“Mentors do more than teach skills; they facilitate new learning experiences, help new nurses make career decisions, and introduce them to networks of colleagues who can provide new professional challenges and opportunities. Mentors are interactive sounding boards who help others make decisions.”

Dracup, K and Bryan-Brown, C (2004), *From Novice to Expert to Mentor: Shaping the Future*, 13: 448-450, American Journal of Critical Care

Preceptorship

“A period of structured transition for the newly registered practitioner during which he or she will be supported by a preceptor, to develop their confidence as an autonomous professional, refine skills, values and behaviours and to continue on their journey of life-long learning.”

Department of Health (2009), *Preceptorship Framework for Newly Registered Nurses, Midwives and Allied Health Professionals* (HMSO: London)

Supervision

The NHS Management Executive (1993) defines clinical supervision as ‘a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex situations’.

Cited by NMC (2008), *Clinical Supervision for Registered Nurses* (NMC: London)

Educational or formative supervision is used towards the development of the practitioner or fulfilment of potential (Proctor, 1986). Managerial supervision is used for the promotion and maintenance of quality standards, adherence to policies and good practice (Kadushin, 1992). Both forms of supervision should be undertaken by the PT.

Restorative supervision (Proctor, 1986) is described as a formal way of delivering support to the professional. The specific model of restorative supervision (Wallbank, 2007) underpinned by the Solihull Approach, motivational interviewing and leadership theories, has been shown to reduce stress and burnout and to increase compassion satisfaction (the pleasure one derives from doing their job) (Wallbank & Hatton, 2011). It enhances PTs’ engagement with their service and increases their resilience to undertake their clinical casework and support of student practice (Wallbank, 2012).

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