A Health Visiting Career

Part 1- Support in the First Two Years

Part 2- Supporting Health Visitors to Support Families

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Contact Details	Pauline Watts 285 D, Skipton House 80 London Road Londn SE1 6LH 020797 25717
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Executive summary

This report is for commissioners, practice educators, line managers, service leads and newly qualified health visitors, including all those who have responsibility for the skills, support and experiences of newly qualified health visitors. The purpose is to gain understanding of the current picture, identify areas of good practice, and suggest ways that these can be shared and enhanced.

This is timely because The Health Visiting Implementation Plan (DoH 2011) sets out to increase the heath visitor workforce from the current 8,000 (approximately), to 12,292 by April 2015, which means that a large proportion of the workforce will be newly qualified practitioners. Whilst this is exciting for the profession, it also brings challenges of recruitment, training, support and retention. Appropriate and adequate organisational support and access to preceptorship and development opportunities is essential to deliver the service to a high quality and to have maximum impact on changing outcomes for children, families and communities.

As well as the number increase, the new service vision gives the profession a fresh focus, and aims to ensure we will have a better skilled and more resilient workforce who positively impact not only their own health and wellbeing, but consequently that of the children, families, and communities they serve.

The first part of this report gives an overview of the novice to expert journey and the pathway for newly qualified health visitors in their first two years. The second part gives more detail of the pathway; it includes examples and comments from practice and suggestions for sharing and enhancing good practice.

Part One- A Health Visiting Career- Support in the First Two Years

The Journey from Novice to Expert

Completing the SCPHN qualification is only the start of the journey of continuous learning, growth and professional development. Dr Patricia Benner (1982) introduced the concept that expert nurses develop skills and understanding over time through a sound educational base as well as a multitude of experiences. Newly qualified health visitors must journey through a number of stages before they become "expert".

Benner described five levels of experience as:

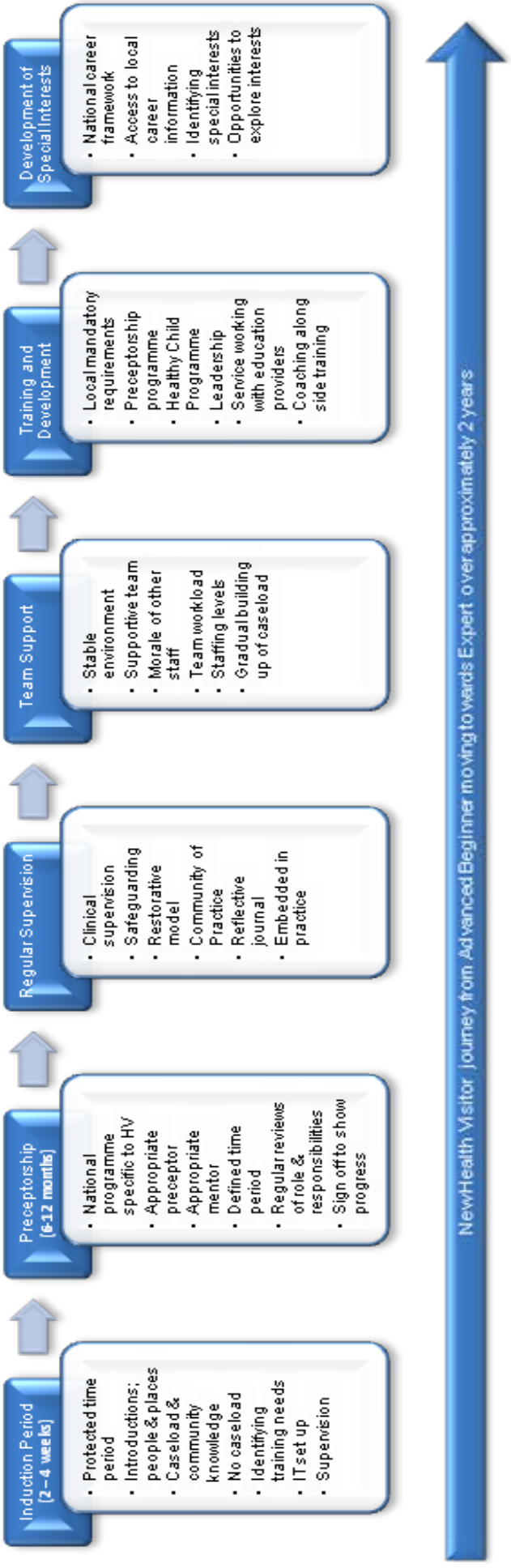
- Novice;
- Advanced beginner;
- Competent;
- Proficient; and
- Expert.

"*I would position newly qualified health visitors as "advanced beginners". Whilst competent in terms of the skills they possess, they are still learning the role and more specifically, associated values, attitudes and principles – applying theories learnt to practice. They have been taught the specialist skills required to be considered 'fit for purpose', and have been signed off as competent, but this has happened with the support of a practice teacher. Reality hits when away from the comfort zone of a caseload designed to meet their needs. Their apprenticeship really begins when they are in their first post. Here they have to establish links with the community, seek out health needs, make contacts with the multi disciplinary team, form therapeutic relationships with clients, make assessments and decisions for which they are now responsible - accountability is second nature - but responsibility is something new. "This is the time they really learn their trade*" - University lecturer/practice teacher.

Pathway from Qualification to Two-Year Post Registration

After consultation with newly qualified health visitors, student health visitors, practice teachers, service providers, commissioners, SHA leads and education providers, this diagram demonstrates six areas which have been highlighted for consideration to move newly qualified health visitors from advanced beginner towards expert. (Benner suggest that it takes 2 – 3 years to be competent – expert takes much longer.)

The New Health Visitor Journey



Part Two- Supporting Health Visitors to support Families

Induction

The first few weeks in a new role can be daunting. There is much to learn and understand when new to a post. When done properly a newly qualified practitioner's experience of these first weeks in post will lay the foundation for the months and years to come.

A good and effective induction period is therefore crucial to the role. All the newly qualified health visitors who contributed to this report stated that either they benefited from a good induction, or they feel their experience would have been enhanced if there had been a better induction period.

It seems that most newly qualified health visitors are given some form of induction, but this ranges from one or two days to six weeks.

"I feel that time to shadow colleagues and to get to know the community is valuable, and I did get this time, but it was a very short period of time"- newly qualified health visitor.

The content of the induction varies too. Some include mandatory and clinical training, and visits to other partners and agencies, whilst some are a simple tour of the office base with introductions to immediate team members.

"If they have trained in the same area they find a job then induction will probably be fairly simple as the newly qualified Health Visitor will have a good idea about working practices. However, if they are starting somewhere completely different then there will need to be a more full induction.

Newly qualified health visitors may start their first post in an area where they trained or have worked previously. When this is the case some aspects of induction may not be necessary.

New health visitors questioned said how important it was to have protected time before taking on a caseload. Practice teachers also agreed that protected time should be mandatory. Knowledge of caseload systems, corporate or individual, will be required.

"No caseload if possible, for the first two weeks at least. This allows the new practitioner to profile the area, spend time with other agencies and get to know the caseload. Doing visits with other team members in the area to get a feel for the client base would be particularly useful.

This would allow time to know the geographical area, local venues and buildings, to gain an understanding of the local population and their needs. Time is also needed to meet people, the new health visitor will be working alongside midwives, school nurses, safeguarding teams, and

other partners, for example local children centre staff, GP's and social workers. They need to have knowledge of local services, community groups and of voluntary sector organisations operating in the area.

A common theme that emerged when talking to newly qualified HVs was that although a good induction had been planned, it did not always happen according to plan.

It appears to be very important that the induction period is protected and prioritised. The new health visitors all said that being thrown in at the deep end too soon caused stress and anxiety.

"The team had good intentions at the beginning when I first started, and had a three-week induction planned, but unfortunately due to staffing levels, only some of my protected time happened. I soon felt that I would have to take some visits, to help the team out"- newly qualified health visitor.

In addition, an understanding of local policies and procedures is important, and time to do this during the induction is advisable. Being set up on email and appropriate IT systems is also an important task during the induction period. The induction would also be a good time for the new health visitor to find out about their safeguarding and clinical supervision, to make contact with their supervisors and find out when and where their first sessions will be held. If the new health visitors are nurse prescribers, this would also be a good time to ensure they have a prescription pad and do all necessary preparation in relation to their prescribing role.

One practice teacher suggested the induction package could take the form of a booklet containing some short term objectives and a time frame in which it must be completed. (It is worth noting that some induction appointments may occur outside of the induction period).

Week 1	Morning	Afternoon
Monday	Introduction to preceptor and mentor, immediate team members, tour of base/office/building. Time with named preceptor to identify needs and plan for the induction period	Tour of geographical area of caseload, significant buildings and venues with mentor
Tuesday	Time with IT department, setting up on systmOne (or equivalent) and email	Time for reading and familiarising with local policies, procedures, and standards
Wednesday	Time at the local Children's centre, meeting staff, understand the groups and services offered. Understanding the roles of, and the relationship between health visiting and children's centre	Time at local GP surgery meeting staff, doctors, practice nurses, receptionists, practice manager etc…
Thursday	Mandatory training	Mandatory training
Friday	Mandatory training	Mandatory training

Week 2	Morning	Afternoon
Monday	Time with preceptor to review week one and plan week two, identifying needs, issues and potential problems.	Time to arrange safeguarding and clinical supervision, make contact with supervisors, find out dates, times and venues. Familiarise with local policy regarding supervision
Tuesday	Time to familiarise with caseload, particularly high need families, shadowing mentor on visits	Time to understand systems for organising and prioritising work load in the team
Wednesday	Basic introductory training for local tool of choice for parenting and behaviour management e.g. Solihull	Basic introductory training session for local policy and programmes in relation to infant feeding and nutrition
Thursday	Basic introductory training on the locally chosen development assessment tool e.g. Ages and Stages Questionnaires	Basic introductory training on local pathways and tools of choice for maternal mental health
Friday	Time for making contact with (phone, email etc…) other agencies in the local area, e.g. social services, education providers, children's partnership boards, public health directorate, and booking face to face visits during the preceptorship period	Review of induction period with named preceptor and mentor, plan for preceptorship programme and next steps for integration into the team and caseload

The following summary of suggestions and key points may be helpful:

a. Separate to the generic Trust induction days, a two - four week (pro-rata) planned and protected induction period would be beneficial for all newly qualified health visitors during which they have no caseload responsibilities.

b. Adaptations may be made to the programme if the new health visitor has worked in the organisation previously.

c. Introductions to the immediate and wider teams of health professionals with whom the HV will be working alongside, as well as other partners and agencies providing services for children.

d. A geographical introduction to the local community, significant buildings and venues.

e. Time dedicated to familiarising with the caseload and needs of the local population.

f. Time dedicated to arrange appropriate training, safeguarding and clinical supervision.

g. Time allocated for familiarisation with local policies and procedures, IT systems.

h. Time allocated for making arrangements in relation to prescribing.

Preceptorship

The Nursing Midwifery Council (NMC) suggests a period of preceptorship when moving from student to registered nurse or midwife. Although it is not quite the same for new health visitors because they are already registered, it would seem sensible to offer the same type of preceptorship programme given the change of role. After the induction period the new health visitor should be ready to start a preceptorship programme. This is a formal process, and there seems to be consensus amongst practice teachers that it should last between six - twelve months. During this period the new health visitor should work through a programme with a named preceptor, which is subsequently signed off by both preceptee and preceptor at the end of the programme. The aim of preceptorship is to support the preceptee to gain the experiences, skills and knowledge to move along the novice to expert continuum. Newly qualified health visitors can also be supported in practice by experienced health visitors and mentors.

This report found that many employing organisations have a preceptorship programme. These are, however, often generic or for a particular area, but not specific to health visiting.

“I am aware that there is a preceptorship programme for newly qualified staff; however this is purely focused on newly registered mental health nurses, not at all focused at newly qualified HVs. I feel that a preceptorship programme aimed at HVs would be beneficial”- newly qualified health visitor

One issue highlighted is the difference between a mentor and preceptor. The terms seem to be used interchangeably with no clear definition of either role. One practice teacher suggested a distinction be made between the preceptor and mentor and, ideally, a newly qualified health visitor would have both. The preceptor would be someone objective from outside the team, with responsibility for goal setting, signing of competencies and taking the role of a critical friend, a practice teacher would be ideal. A mentor would be an experienced member from within the team, and would be responsible for the more practical, day to day issues of supporting the newly qualified health visitor through the preceptorship programme.

“If this model was applied the new health visitor would have regular meetings with the preceptor every two-four weeks, which may even take the place of clinical supervision”- practice teacher

A key issue identified is the importance of the named preceptor/mentor having the required attributes and experience for the role. The person with day to day responsibility for supporting the new health visitor should be experienced and knowledgeable about the team, caseload, and local area so that he/she can share this.

This places responsibility on local organisations to ensure they have enough adequately experienced and qualified preceptors and mentors, and new health visitors are matched to them appropriately.

"A preceptor was assigned to me with whom I feel comfortable talking to. A negative aspect to being assigned a preceptor was that it happened at a time of staff being moved, leaving both my preceptor and I not being knowledgeable of the area in which we worked"- newly qualified health visitor.

A standardised preceptorship programme with competencies would provide a standard for newly qualified health visitors wherever they work, with flexibility to make local adaptations.

The following summary of suggestions and key points may be helpful:

a. Consideration should be given to the development of a standardised preceptorship package for newly qualified health visitors.

b. A preceptorship package specific to health visiting should be available to all newly qualified health visitors commencing after the induction period.

c. Consideration should be given to a band six health visiting competency framework being incorporated into the preceptorship programme.

d. A named and appropriately qualified mentor from within the team, who has good knowledge and experience of the local area should be allocated to the new health visitor for day to day support with the preceptorship programme.

e. A named and appropriately qualified preceptor, possibly a practice teacher, from outside the team, should be allocated to the new health visitor to formally oversee and sign off the preceptorship programme.

f. Roles, responsibilities and expectations of the preceptor, mentor and preceptee should be discussed and agreed at the beginning of the induction period.

g. Sign off from the preceptorship package and competencies should happen after six - twelve months and provide evidence of the practitioner moving along the novice to expert continuum.

Supervision

There are a number of different types and models for supervision within health visiting; clinical, safeguarding, managerial and restorative. One Strategic Health Authority has developed a document entitled, Regional Guidance for Best Practice of Clinical Supervision for East Midlands Health Visiting Teams (East Midlands Strategic Health Authority, 2011). The document outlines best practice for clinical supervision within health visiting and is a useful reference for developing practice around clinical supervision for all staff, including newly qualified health visitors.

When asked, the newly qualified health visitors identified two forms of supervision that they saw as essential, these were safeguarding and clinical supervision.

Safeguarding supervision is usually mandatory and all health visitors must access this in line with local policy no matter how long they have been qualified. The Munro report says this regarding safeguarding, *"Intuitive and analytic reasoning skills are developed in different ways, so child protection services need to recognise the differing requirements if they are to help practitioners move from being novices to experts in both dimensions. Analytic skills can be enhanced by formal teaching and reading. Intuitive skills are essentially derived from experience. Experience on its own, however, is not enough. It needs to be allied to reflection – time and attention given to mulling over the experience and learning from it. This is often best achieved in conversation with others, in supervision, for example, or in discussions with colleagues".*

Generally the experience of safeguarding supervision for newly qualified health visitors was found to be good.

"I feel the most positive experience for me was having safeguarding supervision. We had this as a group for newly qualified Health Visitors, and individually once a month. I found I received great support from my supervisor, and knew that I could ring in between if needed. They also supported with case conferences. This gave protected time for a small group of newly qualified HV's to get together and share experiences, and support each other"- newly qualified health visitor.

Clinical supervision is not mandatory in all organisations and therefore the uptake is more variable than safeguarding supervision. Making clinical supervision mandatory may help newly qualified health visitors to embed this as an integral part of their practice, giving it the priority that is needed and deserved.

The benefits of clinical supervision for supporting staff are documented by Professor Sonya Wallbank, Associate Professor Child Health, University of Worcester, who, using the restorative model of supervision with health visitors in West Midlands showed significant improvement in staff retention, productivity, stress and burn out. Many new health visitors said they very quickly began to feel stressed, which would seem to add weight to the argument that a restorative model of supervision for newly qualified health visitors should be adopted.

Crucially, as Webb (2011) points out supervision, *"Is not a managerial control system and this understanding is key to the idea of professional support as a tool to use in ensuring high quality practice".* It is felt that although managerial supervision may be helpful for newly qualified health visitors, but they should have access to clinical supervision with a supervisor who is not part of their line management.

One practice teacher suggested, *"Keeping a reflective journal to be reviewed monthly with a practice teacher, preceptor, or as part supervision. Experience alone is of limited value if workers are unable to learn from it".* Reflective practice offers; *"a window through which the practitioner can view and focus herself within the context of her own lived experience in ways that will help her confront, understand, and work towards resolving the contradictions within her practice between what is desirable and actual practice", (Driscoll, 2000,p34).* Remember, *"We do not learn by doing but by doing and realizing what came of what we did". (Dewey,1929 p367 cited in Fawbert 2003)".*

The development of a Community of Practice would facilitate peer supervision and time for reflection. Monthly meetings led initially by a practice teacher which become internally led over time. Defined in part, by the social learning that occurs when practitioners with common interests meet to develop new or shared ways of thinking, (Lave and Wenger, 1998), research suggests that members of a Community of Practice benefit most from the sharing of expertise and ideas. True 'competency' requires that practitioners acquire or "learn" new "ways of thinking". Peer review and supervision would facilitate this journey of self-discovery by enriching individual perspectives, encouraging reflection on their own work and developing the critical reasoning skills needed for lifelong learning and future self-assessment, (Ashcroft and Palacio, 1996) – practice teacher / university lecturer.

The following summary of suggestions and key points may be helpful:

a. Consideration should be given to making supervision, both safeguarding and clinical supervision mandatory.

b. Consideration should be given to using the restorative model.

c. Local policy regarding supervision should be made available to all newly qualified health visitors in the induction period.

d. During the preceptorship period clinical supervision may be carried out though meetings with the preceptor, but the new health visitor should have opportunity to access separate supervision should they want to.

e. Clinical supervision should be a regular experience for the newly qualified health visitor, ideally every four-eight weeks.

f. A named supervisor, format and frequency of meetings should be agreed during the induction period.

g. Consideration should be given to the development of Communities of Practice for newly qualified health visitors.

h. Newly qualified health visitors should be encouraged to keep a reflective journal.

Team Support

One of the factors that impact the experiences of newly qualified health visitors the most is the team in which they are placed. Working alongside experienced staff who can guide and support in the early days makes a big difference.

"I had a nice team with supportive colleagues at the beginning, and I took to the area I was working in well. I used team members for support generally by asking and sharing any queries I had"- newly qualified health visitor.

Working with colleagues who have low morale and/or high levels of stress is very difficult for newly qualified health visitors.

Several new health visitors reported the transition from training to being qualified was difficult since the SCPHN programme prepares students for health visiting in an ideal world, yet the reality has often been different. With the extra recruitment planned, and the implementation of the new service vision, the role should be closer to what they have trained for in the future.

"The negative part of my experience was going into a team with a high workload, and staff who were feeling despondent and stressed. It is difficult when you start and feel enthusiastic, and the response is sceptical. Unfortunately then you just follow them and become entrenched in the day-to-day running of the caseload. Training as a health visitor was an excellent experience. I truly felt ready for the role when university ceased, however due to the lack of staff and resources, the current health visiting role does not compare to the role I trained for"- newly qualified health visitor.

The stability of teams who have newly qualified health visitors is significant. In many organisations there have been frequent movement of staff, most probably in response to staffing issues, vacancies, sickness, maternity leave etc…However legitimate the reasons, the frequent movement of staff means teams are unlikely to get past the forming and storming stages, and are rarely given time to norm and perform (Tuckman, 1965). This is difficult for all staff, but perhaps experienced staff members are more likely to have the resilience to cope better than newly qualified health visitors.

"Three months into being qualified the teams were changed and there was high levels of staff sickness. I found myself in the team with not much support, which was difficult for me"- newly qualified health visitor.

The attitude of other health visitors in the team made a difference too. It is important for the new health visitor to be surrounded by team members who are empathetic towards newly qualified staff. This places the responsibility on managers to give thoughtful consideration to the placement of newly qualified health visitors. “New practitioners need a safe base to be open and honest. Research suggests that learners most value the interpersonal skills of a mentor when in practice. These skills can often make the difference between a practitioner staying or leaving, (Neary et al, 1996; Petty, 2004). ‘Time given’ is also seen as an essential component of any future success, how the staff make the practitioner feel is important. If they welcome newly qualified staff and try to help them out it is better”, (Kelly, 2006). If we want to empower practitioners to achieve to their highest potential, we must give them, “respect, empathy and genuine people to relate to”, (Dewey, 1929 cited in Fawbert, 2003: p 233) – practice teacher / University lecturer.

The new health visitors who contributed to this report all said they felt a gradual building up of a caseload would be helpful. To be given a large caseload from the very start felt daunting and overwhelming.

“It is important to make the new HV's feel supported and not feel like they have to rush into working a full diary. Hopefully with the HV Implementation Plan, and when we've got more HV's on the ground working the caseload they won’t feel the pressure to run before they can walk. It is important to get the support in early to help retain staff and keep them motivated, so that they don't get dragged down by the low mood of other staff about the role. This would then help move the service forward”- newly qualified health visitor.

A commissioner who contributed to this report said,

“We don't put anything different in the specification regarding newly qualified HV’s although I would probably not expect delivery of all the KPI’s (key performance indicators) from day one. I have in the past changed thresholds for delivery of KPI’s to reflect pressures on the workforce and this would be one I would consider”- Commissioner

Perhaps if teams knew there was some flexibility with performance expectations they would feel more able to allow the newly qualified HVs to have the protected time and support they need without rushing them into caseloads they are not ready for.

The following summary of suggestions and key points may be helpful:

a. Wherever possible, newly qualified health visitors should be placed in stable teams where they will be adequately supported throughout their induction and preceptorship period, and frequent movement of staff avoided.

b. Support and training may be required for team members to ensure they understand and can meet the needs of newly qualified health visitors.

c. The team should facilitate the gradual increase of the newly qualified health visitor’s workload as and when the team and new HV feel it is appropriate to do so.

d. It may be helpful for commissioners and service providers to discuss flexible thresholds for key performance indicators when a newly qualified health visitor joins a team.

e. Newly qualified health visitors should have the opportunity to discuss concerns regarding their work outside of the team, through clinical or managerial supervision.

Training and Development

There are a range of views about the amount of training and development that should take place in the first two years after qualification. Newly qualified health visitors often feel unsure about what is expected of them in terms of continuing professional development (CPD). “Training requirements were not clearly identified”, newly qualified HV. One school of thought is that, “Other than mandatory training I don’t think newly qualified HVs need to develop further in the first year, as they need to consolidate their practice”- practice teacher.

NB. Discussions will need to take place with commissioners, not just in terms of service provision and key performance indicators, but also commissioning of CPD to meet the needs of the new workforce, including new health visitors.

In line with the Implementation Plan and new service vision, health visitors should be using evidenced based models, tools and packages of care. Many of these are outlined in the Healthy Child Programme. All health visitors should be encouraged to complete the Healthy Child programme e-learning modules which cover:

- Communication
- Family health
- Safeguarding
- Parenting
- Development and behaviour
- Speech and language
- Growth and nutrition
- Immunisation
- Health promotion
- Screening

More specific training will be required for tools, models and care packages of choice in any given local organisation. For example:

- Ages and Stages Questionnaires
- Solihull Approach
- Preparation for Pregnancy Birth and Beyond
- Motivational Interviewing
- Solution Focused Therapy
- Promotional Interviewing

Following feedback from the health visiting teams and higher education institution's in West Midlands, a two day interactive experience has been developed called MARSIS. It combines learning from Solihull Approach, Motivational interviewing and Restorative supervision. It allows professionals to leave with a clear clinical application of the skills from these programmes without the current time commitment. It is particularly aimed at less experienced staff, so would be ideal for newly qualified health visitors to complete in the first two years in post.

Whatever the choices of local organisations regarding tools and care packages, training should be given to newly qualified health visitors in the induction period where possible, and certainly within the preceptorship programme.

It is becoming more widely recognised that training alone is not enough to embed change and new practice, but alongside training needs to be ongoing support and coaching. Local organisations should give consideration to the use of coaching alongside training for the most effective outcomes. A number of the early implementer sites who are show casing the new service vision and family offer have taken this approach, providing good quality clinical supervision, restorative supervision and coaching alongside the training they have been providing for their staff.

An area that has been consistently highlighted as a need for health visitors is training and coaching in leadership. There are several leadership programmes running, but one in particular which has been evaluated well is run by The East Midlands Leadership Academy, and called the Health Visitor Leadership Development Programme. Information about the programme can be found at: www.leadershipeastmidlands.nhs.uk/programmes/leading-childrens-service/

"We feel that the HEIs should be delivering more training. We currently pay for all the students to do the promotional interviewing during their training and we buy it via Warwick University using LBR funding"- Service Manager

"Training and development in the first two years of qualification is not something we have been involved in, however I think there may be a role for education providers to offer CPD and this is an area that we could have discussion with the local service providers about". - SCPHN University Lecturer

The following summary of suggestions and key points may be helpful:

a. Mandatory training requirements should be identified and either completed during the induction or preceptorship period.

b. The main focus for the first year should be on mandatory training and the preceptorship programme in order to give time for consolidation.

c. Training required for the use of locally chosen tools, models and care packages should be given in the induction or preceptorship period.

d. After the preceptorship period has been successfully completed, consideration may be given to complete the Health Child Programme e-learning modules.

e. After the preceptorship programme has been successfully completed, consideration may be given to undertaking a leadership programme.

f. Consideration may be given to MARSIS or similar bespoke programmes.

g. It may be helpful for conversations to be initiated between service providers and education providers to explore how continuing professional development and training can be best delivered locally.

h. Consideration should be given to the use of supervision and coaching alongside training.

Developing Special Interests

Currently there is no clear career pathway for health visitors and it would really be exciting for one to be developed, both locally and nationally. In most areas the only way to move from band six to a band seven post is to become a practice teacher, or to be a team leader and move into management. If one of the only ways to progress is into management, we will lose the skills and knowledge of some of the most experienced health visitors, depleting the workforce of their expertise which will be much needed for mentoring and supporting less experienced staff. With the move towards clinical leadership, it is important to keep health visitors with valuable attributes in practice and not lose them to management posts because there is no other route for them.

One practice teacher who did his MSc dissertation on the motivations of registered nurses and midwives to engage in CPD suggested,

"There needs to be identified special interests – a bit like advanced skills teachers in education – or perhaps thresholds built into the pay structure where HV's with experience or skills in particular areas can see that their expertise and skills are rewarded. Currently we seem to be standing still and there is little incentive to develop. That is what came out of my research, unless the individual was motivated to develop there was no structure within the profession to encourage 'real' development".

The Munro review (2011) recognises the importance of having expert practitioners in their field, and there does seem to be a range of new specialist posts emerging. This is providing a way for health visitors to progress and stay in clinical leadership. Below are some of the specialist roles that are emerging, or that already exist:

- Practice teaching
- Safeguarding (named or designated nurse role)
- Hospital liaison health visitor
- Infant feeding and nutrition
- CONI
- Hard to reach/travelling families/homeless
- Maternal mental health
- Infant mental health
- Children with special needs
- Public health
- Link HV to Children Centres
- Child development/children with special needs
- Domestic abuse
- Drugs and alcohol
- Young parents

Upon qualification the new health visitor may have an idea already about what career path he/she would like to take, but it is more likely that areas of special interest will develop as the practitioner progresses. Thought needs to be given to how practitioners are supported to develop their interests.

Klein (cited in the Munro Review, 2011) identified four key ways in which practitioners become experts in specific areas:

- Engaging in deliberate practice, and setting specific goals and evaluation criteria
- Compiling extensive experience banks
- Obtaining feedback that is accurate, diagnostic, and reasonably timely
- Enriching their experience by reviewing prior experiences to derive new insights and lessons from mistakes

Areas of interest should be ascertained whenever possible, but should be a standard discussion point in the preceptorship meetings and appraisals. Once special interests have been identified action plans should be developed, adequate time and resource should be given to pursuing these, and relevant learning opportunities identified that will further the skills required for these where possible, and opportunity to reflect on that learning.

This may be counter cultural to how the profession has worked in recent years. With high workloads and low morale, health visitors have not prioritised developing themselves and gaining areas of expertise. There will need to be a shift in mind-set for health visitors to feel empowered to prioritise their career progression, and doing what is needed to do so. Active encouragement and practical support will also be required.

The following summary of suggestions and key points may be helpful:

a. During the preceptorship period and at every appraisal, developing areas of special interest should be identified and recorded.

b. Newly qualified health visitors should be able to access a career framework and information about career progression opportunities.

c. Consideration may be given to the development of clinical leadership in areas of special interest.

d. Opportunity should be given for exploration of specialist interests, including shadowing and time for reading and research.

Summary

The entry of so many newly qualified health visitors into the workforce is exciting for the profession. Never before has health visiting been in the spot light at such a high political level and now is the time for us make the most of this opportunity to make a difference for the children, families and communities we serve.

However, we must not underestimate the challenge that this presents. For all these new health visitors to be retained in the workforce, and developed to maximum benefit for their communities, there is much work to be done. It will require thoughtful consideration at all levels to the points raised in this report and how they can be addressed. It will require the priority and resources that are necessary to make it happen. It will require sharing of good practice, and there are indeed many examples out there to learn from.

There is already pressure on practice teachers and mentors with the increased number of students, so the added responsibility on practice teachers and experienced staff to support newly qualified health visitors will be immense. Every health visitor with at least two years post qualification experience will have to stand up and play their part in training and supporting the students and newly qualified health visitors.

This will require a culture change within the profession to embrace the opportunity and the responsibility. Praise must be given to those areas that have the greatest challenge in terms of increasing their workforce, yet their health visitors have a sense of ownership and have really embraced the massive increase in students and newly qualified health visitors. This attitude needs to become more wide spread.

To make this work it will take all involved to agree actions for the way forward. Education, service providers, and commissioners working together to develop a shared vision for our future workforce, so that they will be the practitioners who have the skills, support, confidence and motivation to positively impact the outcomes for children.

“If you want to build a ship, don’t drum up the men to gather up the wood, divide the work and give orders. Instead teach them to yearn for the vast and endless sea”. Antoine de Saint Exupery.

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