Institute of Health Visiting
Excellence in Practice

# An audit of practice education infrastructure for Specialist Community Public Health Nurses (SCPHN) in Greater London


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## Acknowledgements

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# Executive Summary

Specialist Community and Public Health Nurses (SCPHN) in health visiting and school nursing have decreased by more than 40% in England - **London is one of the hardest hit areas!**

### A programme of education and training to address SCPHN workforce shortages in London

To address workforce expansion needs, the London SCPHN workforce were offered a wide range of training and educational programmes to support practitioner professional development and growth of a learning culture. Reversing workforce shortfalls requires action to expand and improve training opportunities. Specifically, SCPHN workforce education infrastructure was identified as an important factor which could impact on the sustainable expansion of SCPHN Student community placements across all London 0-19 provider organisations.

### An audit of practice education infrastructure

The Institute of Health Visiting (iHV) completed an audit of practice education infrastructure at two separate time points - when the training was introduced and 6 months later. The audits explored whether targeted investments in practitioner development had been matched with an upturn in the organisational learning culture and infrastructure to support learning. The audit questions were framed using the four levels of learning (reaction, learning, behaviour, results) from the Kirkpatrick Evaluation Model[2]. Within this report, the findings for behaviour and results have been combined under the heading "impact".

## Impact - key audit findings:

### Initial reactions to the training and educational programmes

- ✓ There was good engagement in the training and educational programmes provided, with over 80% of Nursing and Midwifery Council (NMC) -registered practitioners participating.
- ✓ Most practitioners found the training and educational programmes relevant.
- ✓ The way in which the training was introduced was important to them and impacted on engagement.
- ✓ The mode of delivery needs to be considered. A blended approach (mix of face-to-face and online) is preferred.

### Participants' learning

- ✓ Knowledge improved following training.
- ✓ Confidence to apply learning improved between audits.
- ✓ Evidence of increased use of learning and reflection in practice.
- ✓ The importance of reflection was emphasised by practitioners.

### Impact after training (participant behaviours and results)

- ✓ Reported improvements in the learning environment (in all areas questioned) across the duration of the project.
- ✓ There is evidence to suggest that the education infrastructure and learning culture within London has been strengthened with:
  - » Practitioners reporting greater use of learning in practice over time
  - » Examples of perceived ability to provide better care
  - » Improved professional development
  - » Improved job satisfaction
  - » An improved learning environment.
- ✓ Factors considered important to support learning in practice included:
  - » Supervision and a supportive learning environment
  - » Embedding learning for impact
  - » Improved time and capacity for practitioners to participate in Continuous Professional Development (CPD).

# Recommendations for practice

## Key ingredients for a supportive learning environment

1. Continue to invest in the education infrastructure for all SCPHN teams.

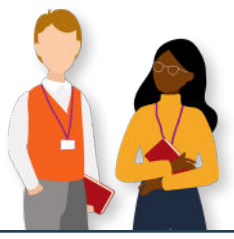
2. Ensure there are mechanisms for embedding and sharing learning.

3. Continue to build a supportive learning environment through:
   - Supervision to support learning activities.
   - Systems and processes to listen to practitioners to understand their needs.
   - Equality and anti-discriminatory practice.

4. Increase the number of NMC-registered practitioners who hold a teaching and learning qualification to enable leadership for high-quality practice learning and the ongoing development of supportive supervision and assessment.

5. Provide short course training in practice education to enable supervisors and assessors to meet the learning and assessment needs of students in line with regulatory requirements.

6. Develop a career pathway with further training and development to support career progression and retention.



**Supportive learning environment**

# 1. Introduction and background

SCPHN health visiting (HV) workforce numbers in England have dropped by more than 40% since 2015, and the school nursing (SN) workforce has experienced similar losses[1]. London is one of the hardest hit areas and services are struggling to fill significant gaps in Specialist Community Public Health Nursing (SCPHN) substantive posts[3].

SCPHN workforce education was identified as an important factor to support the sustainable expansion of SCPHN student community placements across all London 0-19 provider organisations. London NHS England Workforce Training and Education Directorate (NHSE WTED) commissioned a wide range of programmes of education for SCPHN workforce education and development to address this need. These included access to modules at local universities, leadership programmes, and attendance at conferences and webinars.

As part of this ambitious programme of work, the Institute of Health Visiting (iHV) was awarded funding by London NHSE WTED to complete an audit of the practice education infrastructure for SCPHN practitioners in Greater London.

The aim of this project was to identify at two separate time points:

- The 'state of learning' for SCPHN students and practitioners within London community settings. The audit, delivered by an electronic survey, sought evidence on the existing education infrastructure and, thereby, learning culture.
- Whether investments in practitioner development had been matched with an upturn in the organisational learning culture and overall infrastructure to support learning.

# 2. Audit and evaluation approach

## 2.1 Stages of the project

The project was delivered in seven distinct stages (see Figure 1).

**Figure 1 - Stages of the project**

| | |
|---|---|
| **1. Inception** | Established project governance including project management from the iHV. |
| **2. Co-design** | Co-design group established to guide the survey design and data analysis to collate barriers, strengths and learning needs. |
| **3. Phase one: data collection** | Dissemination of the audit survey to sixteen 0-19 provider organisations across London. |
| **4. Analysis** | Data from the audit survey analysed and findings considered. |
| **5. Refinement of data collection** | A second co-design group delivered to refine aspects of the data collection. |
| **6. Phase two: Data collection** | A second audit survey disseminated to sixteen 0-19 provider organisations across London. |
| **7. Analysis and reporting** | Data from both audit surveys analysed and findings considered.<br>Report completed alongside infographics and PowerPoint presentation ready for dissemination. |

## 2.2 Approach

The audit was completed using a survey, with data collected through a questionnaire, to explore practitioners' uptake of staff development opportunities offered and their engagement in learning activities. Demographic data were also collected to explore whether there was any correlation between these factors and the demographics, roles and grades of the survey respondents. Repeating the audit at two time points provided an opportunity to examine any changes in factors contributing to shaping the educational infrastructure. The timeline for the audit is shown in Table 1. It should be noted that a wide range of programmes of education for SCPHN workforce ran simultaneous to the audit exercises.

**Table 1 - The audit timeline**

| Timeline | Audit phases |
|---|---|
| **April - May 2023** | **Design phase:** The audit survey questionnaire was developed in collaboration with a small co-design working group comprising Greater London practitioners and Higher Education Institutes (HEI) representatives (n=10). The co-produced questionnaire was framed using Kirkpatrick's four-level training evaluation model. |
| **June - October 2023** | **Audit phase one:** The electronic audit questionnaire was circulated to sixteen 0-19 provider organisations across London. Data analysis was completed and a second co-design meeting (n=1) was held to identify whether modifications to the audit process were required in advance of the second audit. Due to low attendance at this meeting, an email was sent to the co-design group members (n=10) enabling them to share their feedback. |
| **November 2023 - February 2024** | **Audit phase two:** The first audit questionnaire was replicated in this phase. Minor modifications to questionnaire content were made where required. The majority of the questions remained the same so that comparisons could be made between the two data sets. The second audit questionnaire was circulated to service and education leads across the same sixteen 0-19 provider organisations across London. Data analysis was completed and compared to data from audit one to identify key themes and learning. |
| **March - May 2024** | **Reporting phase:** During the reporting phase, the iHV team prepared the following project outputs: A short report, a PowerPoint presentation for local dissemination, and two infographics illustrating results. |

The audit was framed around the Kirkpatrick Evaluation Model which is widely used as an approach to training evaluation in healthcare[4,5]. It is a four-level training-evaluation model[2], focusing on:

- **Level 1 - Reaction** - Do learners find the training offered engaging and relevant to their training needs?
- **Level 2 - Learning** - Have learners acquired the intended knowledge and skills through the training programme?
- **Level 3 - Behaviour** - Can learners apply their new skills or knowledge in real-life situations?
- **Level 4 - Results** - Have there been positive organisational outcomes as a result of the training and educational programmes?

The audit aimed to reach 'data sufficiency'which would provide sufficient insight into the topic with multiple views from a range of participants. The audits included a mix of both open and closed questions to enable participants to express their own views, reasons, and explanations. Initial analysis was inductive with key themes then mapped to the Kirkpatrick Evaluation Model which provided an explanatory model for analysis.

# 3. Data analysis and findings

After data cleansing, the sample size comprised 116 complete responses for audit one and 69 complete responses for audit two.

The survey was aimed at NMC-registered participants who had been offered programmes and courses. However, we did have non-registrants responding and their data was collated as part of the analysis. Where applicable, data was compared between different staff groups – those who held a NMC-registered nursing qualification (audit one: n=85, audit two: n=56) and those who were non-NMC registrants (this has been indicated where relevant). It is important to note that the sample size for non-NMC registrants was low across both audits (audit one: n=24, and audit two: n=9). Like all surveys, the results are based on a sample of the SCPHN workforce and not the entire workforce. Consequently, results are subject to margins of error and readers should exercise caution with comparisons with the workforce as a whole due to local variations in the SCPHN delivery models.

## 3.1 Participant demographics and background information

**Age**
Both audits had a higher participation rate of staff approaching retirement age. Thirty-five percent of the participants in audit one were between 50-59 years of age; similarly 30% of participants in audit two were aged between 50-59 years. A national survey of health visitors (n=1,323) reported that 17% of health visitors in the UK are aged between 50-59 years of age[6]. Based on figures for those SCPHN staff completing this audit, it is possible that London has a higher proportion of SCPHN staff who are approaching retirement age than the rest of the country.

**Gender**
Both audits found that the workforce in London is predominantly female (94% for audit one and 93% for audit two). This aligns with national data whereby 88.6% of nurses and health visitors are women[7].

**Ethnic Group**
Nearly half (48%) of the participants in audit one, and 33% of participants in audit two, were white. Black/African/ Caribbean/Black British–African made up 28% of participants in audit two compared to just 9% in audit one.

## 3.2 Current job role of participants

Participants in both audits worked in a variety of roles across London. Qualified SCPHNs were the highest group of participants, with evidence of more health visitors participating than school nurses. However, this is relative to the different proportions of health visitors and school nurses in the workforce (see Figure 2).

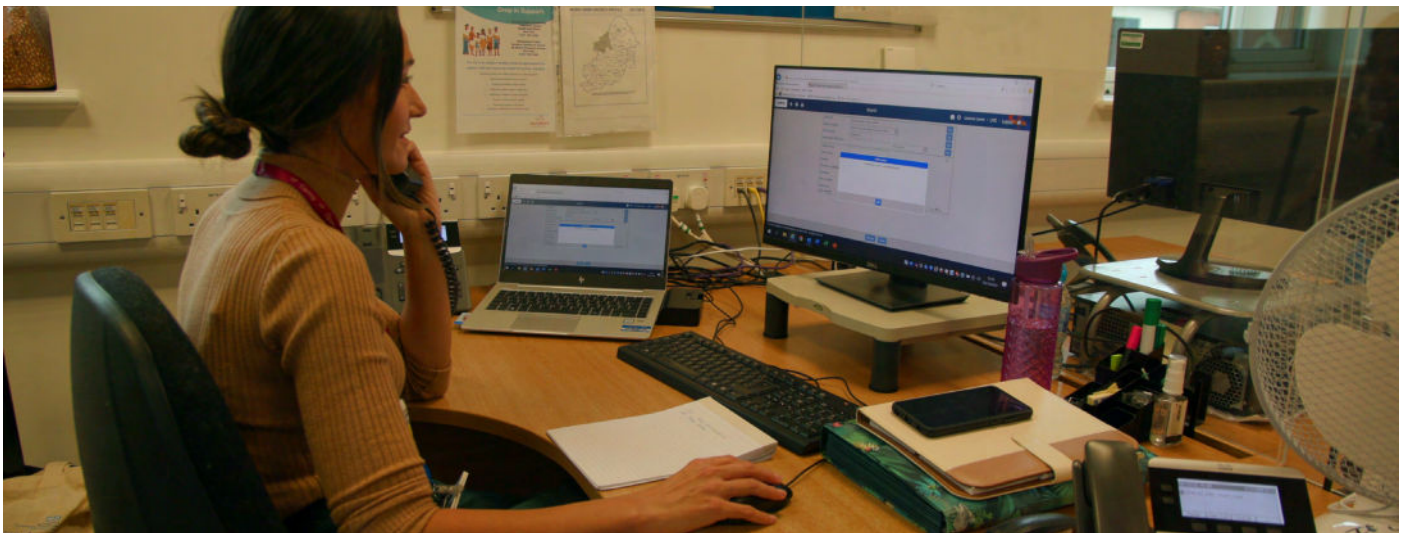
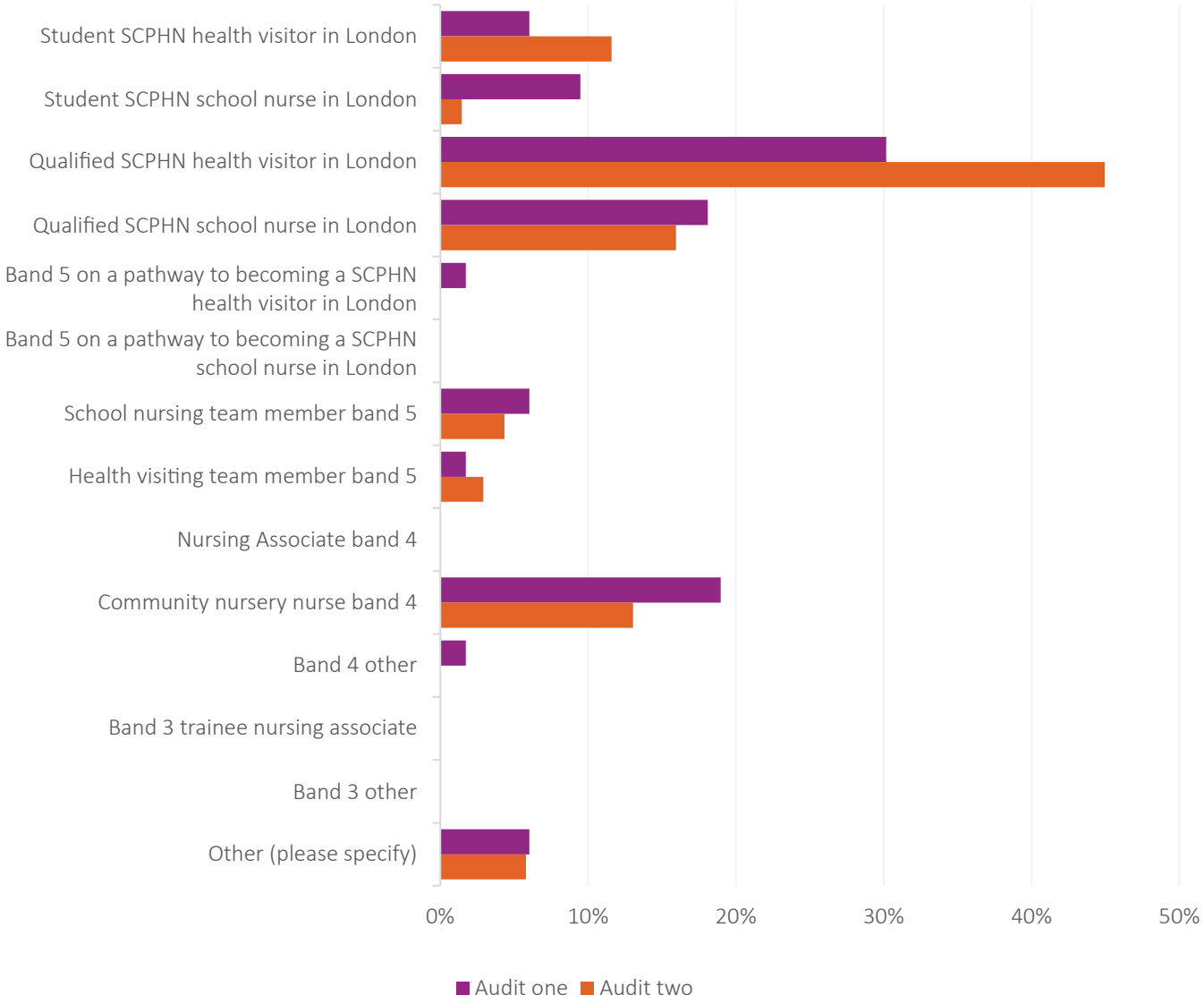


**Figure 2 - Current role of participants**




## 3.3 Formal responsibility for training and education

Findings from audit one showed that less than half (44%) of NMC-registered practitioners stated they have a formal responsibility for training and education. At audit two, the proportion of respondents who were NMC-registered practitioners and stated they had a formal responsibility for training and education increased to 63%. This could be indicative of an upward trend in proportions of SCPHN practitioners supporting learners and thereby contributing to the learning environment. This is not surprising given that the concurrent programmes of education for SCPHN workforce were in operation.

We specifically asked in audit two, if practitioners had completed an assessor programme at university and 43% (n=56) said yes. Of those who responded yes, just under half of the sample did not have a formal teaching qualification (45%).

The updated NMC (2023) standards for education in practice have superseded the requirement for supervisors or assessors of SCPHN students to hold an NMC-approved practice education qualification[8]. It is not surprising, therefore, that only 7% of practitioners completing audit two reported that they had a postgraduate Practice Teacher qualification. The changes to professional body requirements means there is no longer the imperative for practitioners to complete postgraduate courses leading to a teaching qualification. Nevertheless, the NMC does require educators and practice assessors to be "appropriately qualified and experienced professionals with necessary expertise for

their educational and assessor roles"[9]. Further, they recommend that to support education in practice, registrants are required to "undertake preparation or evidence prior learning and experience that enables them to demonstrate achievement of the following minimum outcomes"[10]. These minimum outcomes concern skills in: interpersonal communication to support learning and assessment, objective evidence-based assessment and constructive feedback, and could be included within single study days or short courses.

**This next section of findings set out the key themes from the audit aligned to the Kirkpatrick framework.**

# 3.4 Level One: Reaction summary

**Level one: Initial reactions to the taught sessions** – did they find it engaging and was it relevant to their needs?

**Box 1 – Summary of initial reactions to the training and educational programmes**

- ✓ There was good engagement in the training and educational programmes provided, with over 80% of NMC-registered practitioners participating.
- ✓ Most practitioners found the training and educational programmes relevant. However, the way the training was introduced was important to them and impacted on engagement.
- ✓ The mode of delivery needs to be considered. A blended approach (mix of face-to-face and online) is preferred.

## 3.4.1 Participation in training and education

For NMC-registered staff, there was good engagement across both audits with over 80% participating in training/ educational programmes.

For non-NMC-registered practitioners, audit two showed a small increase in staff participating in training and education (56%; n=9) compared to audit one (54%; n=24). However, it is important to note that the sample sizes were small for this group as the education and training programme was primarily aimed at NMC registrants.

## 3.4.2 How do practitioners like to learn?

Across both audits, virtual and e-learning formats were the least favoured options. Short training which lasted one to two hours was also least favourable. Across all practitioners, blended learning (a mix of face-to-face and online) was the most preferred format for training or education.

NMC-registered practitioners had a higher preference for face-to-face training than non-NMC-registered practitioners. The COVID-19 pandemic accelerated the use of digital platforms for SCPHN services. This too was reflected within SCPHN education. A recent report highlighted how SCPHN students had more virtual contact with supervisors and assessors, compared to face-to-face contact. This negatively impacted on opportunities for informal support derived from contact with peers and other practitioners in office spaces[3].

## 3.4.3 What factors are considered important when deciding to enrol onto a training/educational programme?

Practitioners across both audits reported that it was important that the training or education programme was relevant to their role (94% of practitioners in audit one and 97% of practitioners in audit two – see Figure 3). Time and personal commitments were also considered important. Cost was still a key consideration, alongside whether the course was delivered face-to-face or virtually.

**Figure 3 - Important factors for deciding to enrol onto a training/educational programme**


## 3.4.4 How training needs are identified

Thirty-five percent of staff across both audits rated personal interest as the top area for identifying their training needs. Personal Development Reviews (PDR) were also areas where staff said their training needs were identified (28% for audit one; 30% for audit two). A quarter of staff in both audits stated that their training needs were identified through a request to attend training through their manager. Only 3% of staff in audit one and 4% of staff in audit two said that a recommendation for training had come from one of their colleagues, showing that "word of mouth" as a method of engagement is very low.

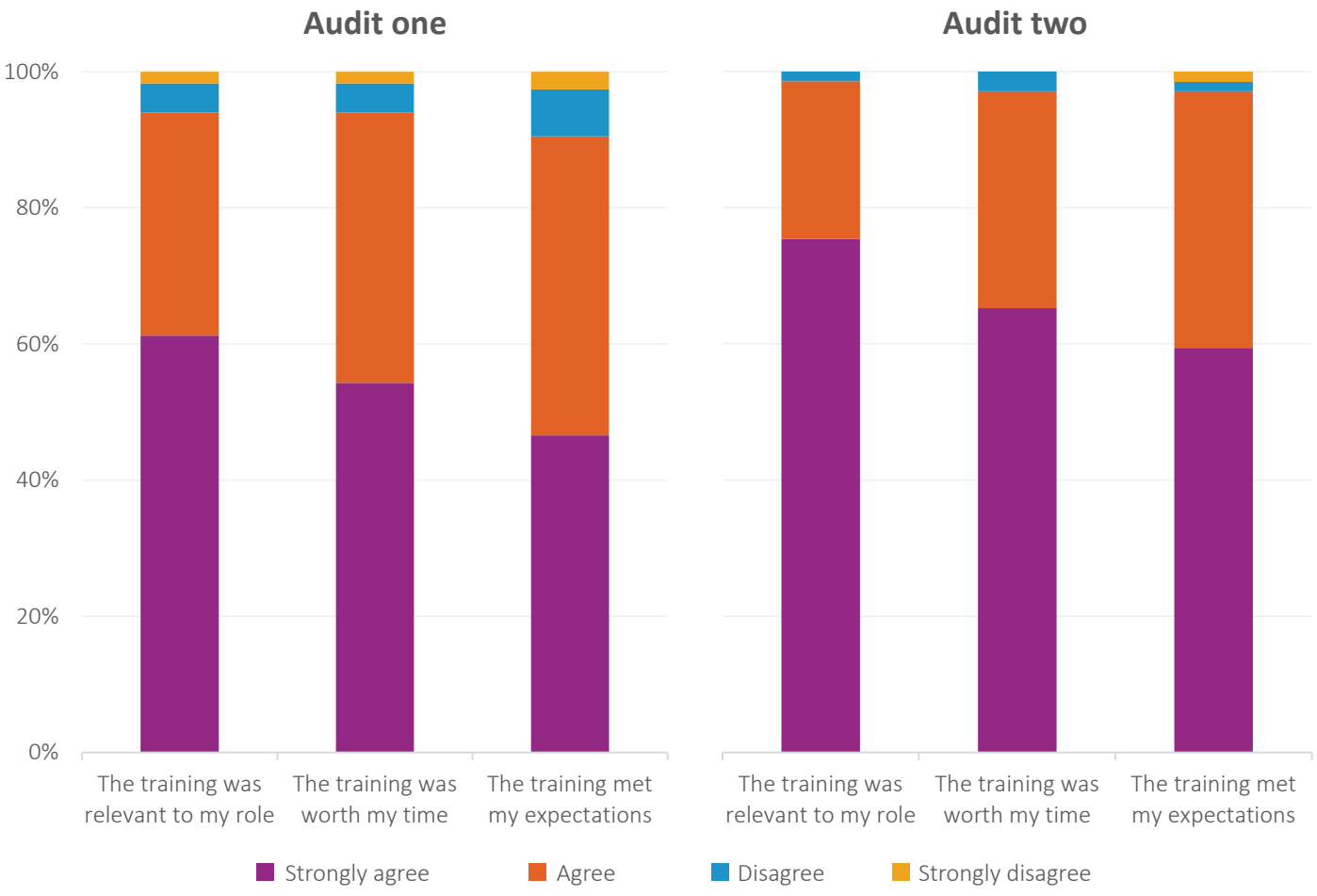
## 3.4.5 How practitioners felt about their training/educational programme

Practitioners were asked in both audits whether they agreed or disagreed with the following statements:

1. The training was relevant to my role.
2. The training was worth my time.
3. The training met my expectations.

A comparison between perceived benefits at the two audit time points was completed, with reported improvements in the learning environment (in all areas questioned) across the duration of the project (see Figure 4). In particular, the data show more participants **strongly agreeing** with the statements, with evidence of less disagreement with statements in audit two.

**Figure 4 – Comparison of responses between audit one and audit two - How practitioners felt about their training/ educational programme.**



## 3.5 Level Two: Learning summary

**Level two: Learning summary - Have the learners acquired the intended knowledge and skills through the programme?**

To address this question, participants were invited to identify and comment on a training programme which was "significant" to them (relevant to their role). Participants were then asked several sets of questions concerning the "significant training" they had previously identified. Box 2 summarises these findings:

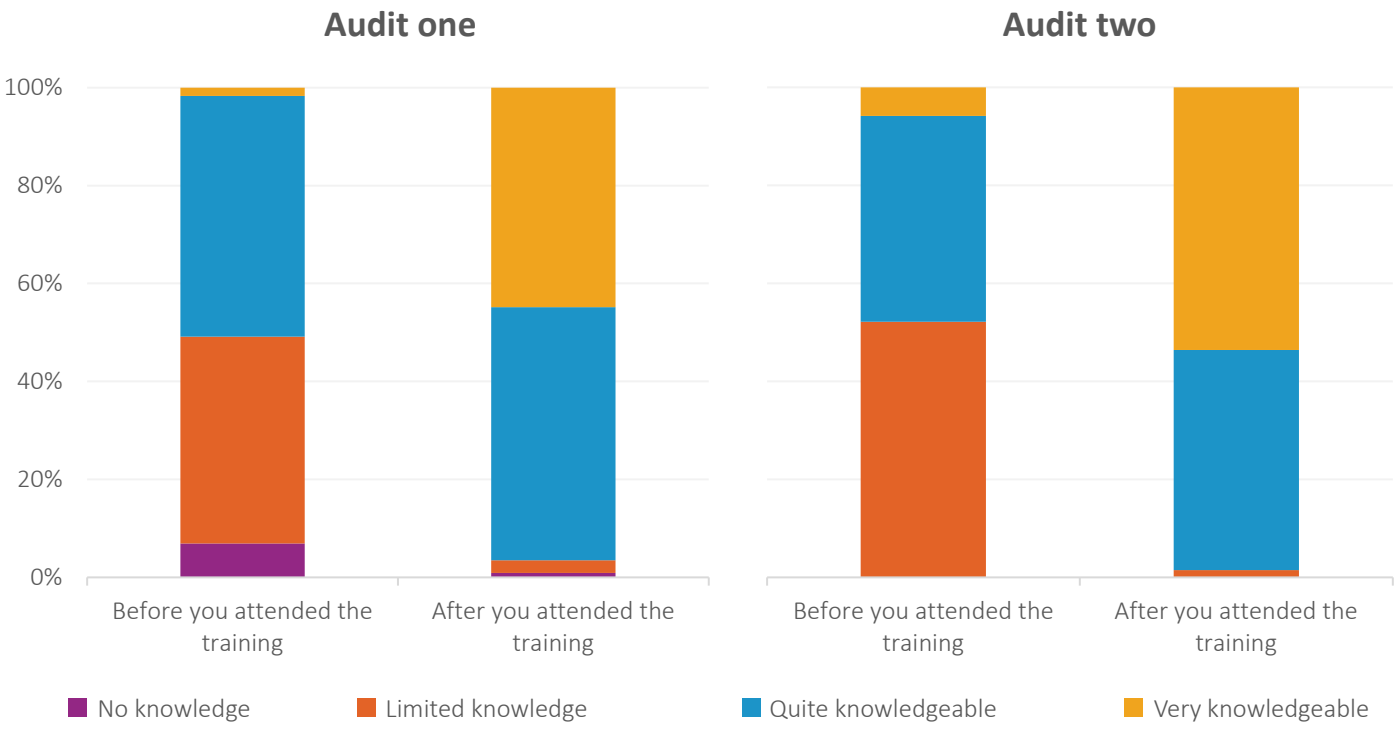
**Box 2 – Learning**

- ✓ Knowledge improved following training.
- ✓ Confidence to apply learning improved between audits.
- ✓ Evidence of increased use of learning and reflection in practice.
- ✓ The importance of reflection was emphasised by practitioners.

### 3.5.1 Rating of knowledge

Participants were asked to rate their level of knowledge before and after they attended their "significant training". Both audits show an improved knowledge post "significant training", and showed "limited" and "quite knowledgeable" prior to the training. More practitioners rated themselves as "very knowledgeable" post "significant training" in audit two, suggesting improvement over time (see Figure 5).

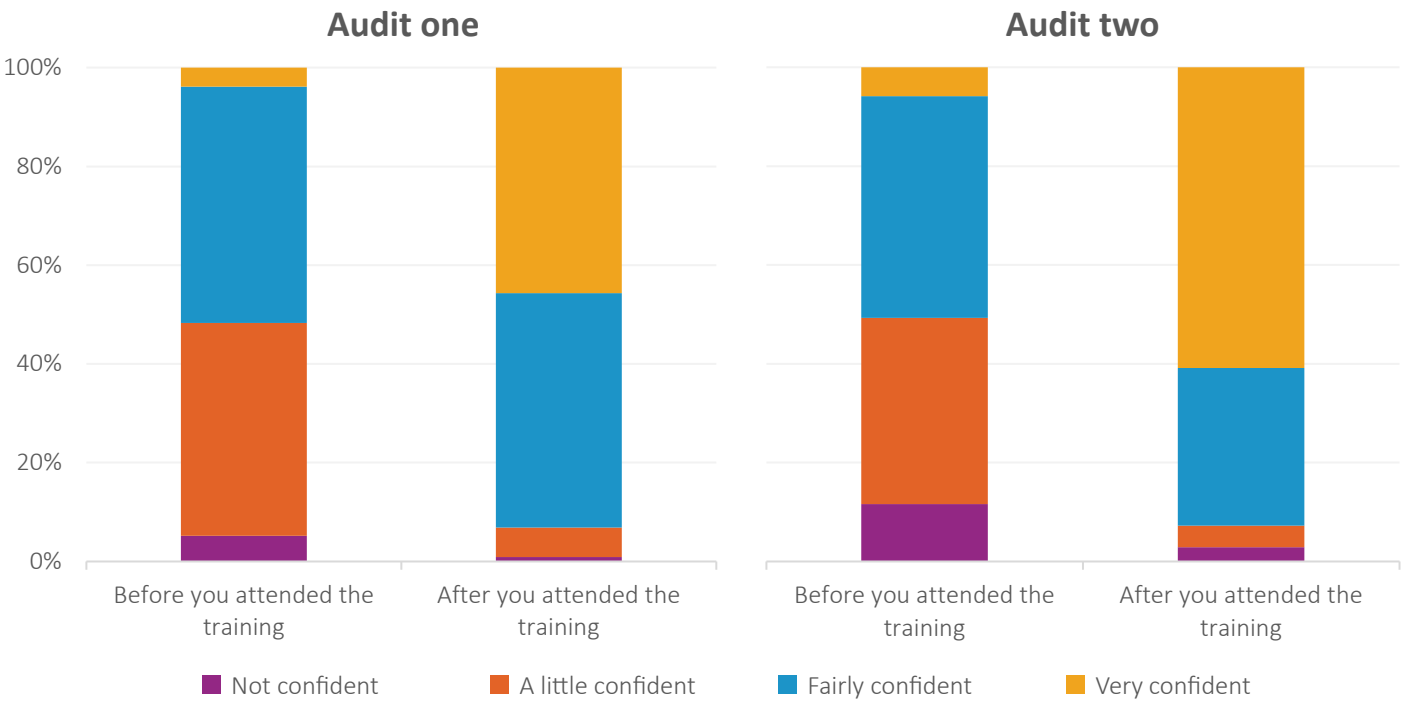
**Figure 5 - Comparison of data between audit one and audit two – level of knowledge pre and post "significant training".**



## 3.5.2 Confidence rating

Participants were asked to rate their confidence in their ability to apply knowledge on the topic covered by the "significant training" (see Figure 6). 93% percent of participants were fairly or very confident in their ability to apply knowledge on the topic after they had attended their "significant training", which increased slightly to 94% in audit two. More importantly, "very confident" increased to 61% from 46% in audit two, suggesting confidence in learning had improved over time.

**Figure 6 - Comparison of audit one and audit two – levels of confidence to apply knowledge.**




## 3.5.3 Learning in practice

Audit one showed that 69% of practitioners reported using the learning from their "significant training" in their practice "often or all the time". By audit two, this proportion had increased to 79%. This improved application of learning over time points towards a strengthening of the learning environment and learning culture.

Research shows that reflection is critical for learning[11]. In addressing further questions about the "significant training", participants stated that the content had helped them to reflect and think about their practice "a lot", increasing proportionally from 51% to 61% across the two audits. This suggests that practitioners are more accepting of reflection being a valid part of learning over time. Written comments supported this point within both audits:

> *"There was a lot of experiential learning and encouragement to reflect and share via discussion and to hear other participants' reflections and insights."*
>
> *"I reflected on how I could use the teaching in my practice to develop others."*
>
> Audit one participant

> *"The training made me reflect on my practice and how to implement it."*
>
> *"The training was delivered in a way that encouraged learners to reflect and apply to practice."*
>
> Audit two participant

### 3.5.4 Gaps in learning

Only 5% of practitioners reported having any gaps after training in audit one compared to just 3% in audit two, which suggests that the majority of learning needs are being met by the level of training offered. Where gaps had been identified, these were in relation to them wanting to learn more:

> *"This was an introductory course so lots of knowledge and skills to be further developed."*
>
> *"It was a vast topic…., so I was left wanting to learn more."*
>
> Audit one participant

> *"No gaps but the training left me wanting to further explore."*
>
> *"Practical experience to consolidate training."*
>
> Audit two participant

## 3.6 Level Three and Level Four: Behaviour and Results – Summary

The final areas of enquiry explored what happened after the training and educational programmes (using the Kirkpatrick Model). The findings indicate that there have been positive impacts following the training and educational programmes, with examples of learning being embedded in practice.

Embedding and using learning and seeing impact.

**Box 3 Summary of behaviour and results**

- ✓ The audit exercises have shown an improved 'state of learning' across London 0-19 provider organisations.
- ✓ There is evidence to suggest that the education infrastructure and learning culture within London has been strengthened with practitioners reporting:
  - Greater use of learning in practice over time
  - Examples of better care provision
  - Improved professional development
  - Improved job satisfaction
  - An improved learning environment.
- ✓ Factors considered important to support embedding learning in practice included:
  - Supervision and a supportive learning environment
  - Embedding learning for impact
  - Improved time and capacity for practitioners.

## 3.6.1 Embedding learning in practice

Practitioners reported that their ability to use learning from their training in practice "often" or "all of the time" had increased from 69% in audit one, to 78% in audit two - indicating an improvement in embedding learning in practice. When asked about factors that had supported their learning in practice, the majority of practitioners (77% for audit one and 75% for audit two) highlighted the importance of having opportunities to put new learning into practice in order to consolidate their skills. This was also reflected in participants' feedback:

> *"It's really important that it's very clear the expectation of our role after completing training otherwise it is wasting our skills."*
>
> *"Embedding the theory into practice in order to consolidate my learning."*
>
> Participants' feedback from audit one and audit two

Supervision is well known for supporting CPD and also maintaining professional registration[12]. We asked participants if supervision was available to support practitioners to use new knowledge and skills in practice – 73% said "yes" in audit one which increased to 77% in audit two. Participants who answered "no" stated that the supervision available was "not for this purpose" and that supervision in their organisation related purely to "safeguarding children".

To explore this further, in audit two we specifically asked participants to tell us which type of supervision was available for them to access. The findings from audit one were echoed in audit two, with safeguarding supervision having the highest number of responses (81%), followed by management (54%), and clinical (52%), supervision. The following quote from a participant reflects how beneficial supervision is to support learners to consolidate and embed new knowledge and skills in practice:

> *"The training I implement within my role to the teams is discussed during supervision so we can jointly reflect on the impact".*
>
> Audit two participant

## 3.6.2 Barriers to applying new learning

The findings from both audits were similar. Practitioners reported that limited time and capacity and insufficient support were the main barriers to applying new learning in practice (see Table 2).

**Table 2 - Barriers that impact on applying new learning**

| Theme | Evidence – example practitioner quotes |
|---|---|
| **Limited time and capacity** | *"Only 1 candidate per team allowed to attend."*<br>*"Work overload and no time to reflect."* |
| **Insufficient support** | *"Not enough staff to supervise students. Some staff not willing to take students. Some staff not willing to change from old ways of practising."*<br>*"Lack of acknowledgement or interest from management."* |

The themes in Table 2 were also identified as barriers for the SCPHN training programme in the recent pan-London report "Roadmap to Success"[3]. Other similar findings included lack of opportunities to prescribe and a lack of opportunity for career progression being highlighted as barriers to learning. Both of these were identified in the audit for education thematic analysis:

- **Prescribing**

  The "Roadmap to Success" report acknowledged that workforce shortages, and the introduction of skill mix, had impacted on prescribing opportunities in practice[3]. This was echoed in the audit of education findings, with practitioners stating there are no longer opportunities for prescribing in practice:

> *"We have not been able to prescribe for over a year. This is deskilling us."*

  Our findings highlight the importance of being able to practise new skills learnt. If practitioners are not able to practise prescribing once they have been taught, then they are at risk of becoming deskilled in this area.

- **Career progression**

  The "Roadmap to Success" report highlighted the importance of establishing a clear career pathway for individuals aspiring to become qualified Specialist Community Public Health Nurses (SCPHNs). The report emphasised the necessity of outlining the steps and requirements needed to advance in this profession.

  From the audit's education analysis, it seems that practitioners, both those registered with the NMC and those not registered, expressed concerns about the lack of opportunities for career progression. This perception of limited advancement prospects can act as a hindrance to both professional development and learning.

> *"There is limited learning and development opportunities for staff below band 4 that would potentially allow them to progress within the service/organisation."*
>
> Audit one - non-registered participant

> *"No other training available to help further career. This further training I have attended does not lead to career progression."*
>
> Audit two – NMC-registered participant

**Equality and anti-discriminatory practice**

The experience of bullying and harassment is identified as a significant concern in the NHS, with results from a national NHS staff survey showing that 28.5% of NHS staff reported to have experienced bullying[13]. A toxic working environment for minority groups is also a widely publicised concern[14].

In both audits, a small number of individuals made comments about bullying and a toxic working environment for minority groups. These were also identified by the practitioners as being a barrier to their learning. Whilst the anonymity of practitioners completing the audits was preserved, these specific comments were brought to the attention of project sponsors. The national data highlight that London is not an outlier, and it is imperative that equality and anti-discriminatory practice are at the heart of all SCPHN practice.

## 3.6.3 Impact of training/education programme

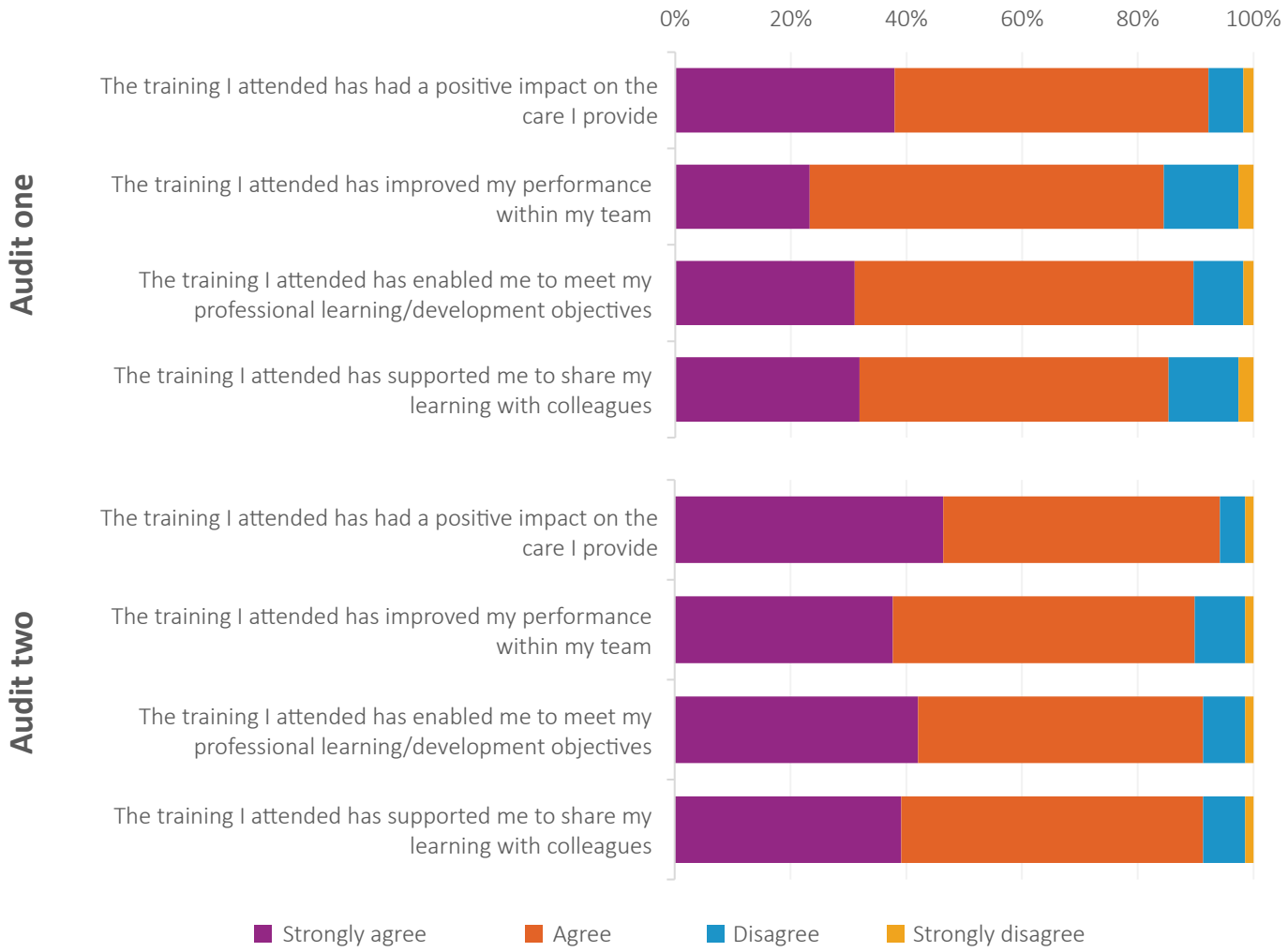
In audit two, practitioners were asked whether they had continued to use the new knowledge and skills that they had learnt after their training programme. Nearly three-quarters of practitioners (74%) said that they continue to use skills and knowledge learnt "a lot" (every month) and just less than a quarter (24%) stated that they continue to use their skills and knowledge "somewhat", suggesting that learning is being embedded into routine practice. There was also evidence of an upturn in practitioners strongly agreeing that the lessons from their training will be useful for their role, increasing from 52% in audit one to 62% in audit two, suggesting an improved learning culture.

We asked practitioners to think about the impact that their "significant training" had by rating the following statements:

1. The training I attended has had a positive impact on the care I provide.
2. The training I attended has improved my performance within my team.
3. The training I attended has enabled me to meet my professional learning/development objectives.
4. The training I attended has supported me to share my learning with colleagues.

The data show an increase in practitioners strongly agreeing across all four statements in the second audit (see Figure 7), indicating an upturn over time in practitioners using their learning in their practice. There was also a reduction in the percentage who disagreed across all four statements, reinforcing that learning is more embedded. The data also indicate that the training and educational programmes accessed were perceived to have had a positive impact on the care that practitioners provide as well as their performance and professional development.

**Figure 7 - Comparison of data between audit one and audit two – Impact of training**



## 3.6.4 Feedback from participants

Participants of both audits were asked to identify impacts from attending their "significant training". Themes emerged from the qualitative data, represented in Table 3.

**Table 3 - Individual experiences relating to training opportunities from audit one and audit two**

| Theme | Evidence |
|---|---|
| **Improved performance** | *"Able to do my job better."*<br>*"Ability to lead team better."* |
| **Increased knowledge** | *"Becoming familiar with a very current issue within HV, an issue I had very little knowledge and experience of previously."*<br>*"Increasing my knowledge to be better equipped a practitioner."* |
| **Increased confidence** | *"Feeling more confident about my practice."* |
| **Increased understanding** | *"It allowed me to learn what works and what doesn't, it helped me to identify and aid with key issues and struggles within the local area. It helped me to become more confident and competent and built my understanding in a lot of areas of the SCPHN profession."* |
| **Improved job satisfaction** | *"The training I attended has increased job satisfaction in a way as when you are well equipped in what you do, you enjoy the job more."*<br>*"Increased job satisfaction, increased confidence, happier in my work."* |
| **Supporting better care for babies, children and families** | *"Confidence to assess and support clients presenting with mental health challenges."*<br>*"The training and knowledge has enhanced my practice especially in safeguarding."*<br>*"How I now share information with clients has changed, as instead of me finding solutions for potential problems they discuss, we explore how they can solution solve and come to decisions for themselves. Using the information learnt from the course material."* |
| **Practitioner capacity** | *"Training often highlights the restrictions on our service, where we don't have time to implement it."*<br>*"Positive was the blended learning. Negative not up to date on my day-to-day work."*<br>*"It's positive in a sense that it is transferable to practice however at times the stretched capacity and workload can interfere with the quality of our consultations due to limited time."* |
| **Embedding learning** | *"Embedding the theory into practice in order to consolidate my learning."*<br>*"Would be useful to have a meeting where colleagues can feedback their learning to others."* |
| **Supportive learning environment to apply new knowledge in practice** | *"I would go over the training I have learnt from training days with my supervisor and see what is relevant to include in my job role."*<br>*"My team - there is a cultural resistance to change, so any new ideas on how to improve how we meet the needs of the service users would not be welcomed."*<br>*"…I felt disrespected, devalued… [which did not help my learning]."* |
| **Leadership** | *"It's really important that it's very clear the expectation of our role after completing training otherwise it is wasting our skill."*<br>*"I felt that my learning needs were prioritised by the organisation I work for."*<br>*"Need time to reflect on learning… Felt unsupported - professional development not prioritised… resulting in giving up protected time that you have organised."* |
| **Career Progression** | *"There is limited learning and development opportunities for staff below band 4 that would potentially allow them to progress within the service/organisation."*<br>*"No other training available to help further career. This further training I have attended does not lead to career progression."* |

# 4. Conclusion and recommendations for practice

**Conclusion**

The audit exercise, using the Kirkpatrick Evaluation Model as a theoretical guide, provides evidence of an improved 'state of learning' for SCPHN practitioners across London 0-19 provider organisations during a period of educational investment. The investment included the introduction of a wide range of training and educational programmes directed at practitioner professional development and growth of a learning culture. During this period, the willingness of practitioners to engage in training increased across the London Boroughs – and is particularly highlighted by the improved engagement rate of NMC-registered practitioners in supporting and participating in training or educational programmes.

There is evidence that the education infrastructure and learning culture across London 0-19 provider organisations has been strengthened, suggesting an improved learning environment. This is indicated by the audit evidence showing:

- Improved practitioner's confidence, knowledge and skills in practice.
- Perceived positive impacts on care for babies, children and families.
- Greater practitioner acceptance that reflection is a valid part of learning.
- An improvement over time of practitioners using the learning from their "significant training" in their practice.

Practitioners felt the way that training and educational programmes were introduced was important to them (they were more likely to enroll on training if they had a personal interest in the topic, rather than being asked to attend by their manager). The data also suggest that a more blended approach to training should be taken, as virtual and e-learning were rated least favourable as formats for learning.

A perceived lack of time and capacity were identified as barriers to embedding learning in practice. Further improvement across London 0-19 provider organisations is needed to ensure that all practitioners have access to a supportive learning environment which includes systems and processes for:

- Listening to practitioners
- Embedding and sharing learning
- Improving capacity to support learning activities
- Equality and anti-discriminatory practice.

The audit findings identified the need for short courses and structured support to prepare and equip registrants who are required to fulfil supervisory and assessors roles. This is necessary for maintaining quality in practice-based education and currency with regulatory body requirements as detailed by the NMC within their published standards for student supervision and assessment also known as the SSSA framework[9,10].

Practitioners highlighted how training for both NMC and non-NMC practitioners need to link to a career pathway and demonstrate how training or educational programmes can support their career progression and development.

Overall, the audit for education has shown that investment, in training and education programmes across London 0-19 provider organisations, has matched an upturn in organisational learning culture and overall infrastructure to support learning across the London Boroughs. To achieve maximum impact, these efforts need to be augmented with actions to continue to strengthen and sustain the education infrastructure across London.

A clear and long-term commitment to health visiting and school nursing, as valued professions, is also needed from national government alongside continued investment in the education infrastructure for all London 0-19 provider organisations. This will provide confidence in the long-term future of these professions and help support the London Boroughs to reverse the workforce shortages they are currently experiencing. Investing in health visiting and school nursing in this way will enable the effective delivery of the Healthy Child Programme, so every child can have the best start in life.

**Recommendations for practice:**

1. Continue to invest in the education infrastructure for all SCPHN teams.
2. Ensure there are mechanisms for embedding and sharing learning.
3. Continue to build a supportive learning environment through:
    - Supervision to support learning activities.
    - Systems and processes to listen to practitioners to understand their needs.
    - Equality and anti-discriminatory practice.
4. Increase the number of NMC-registered practitioners who hold a teaching and learning qualification to enable leadership or high-quality practice learning and the ongoing development of supportive supervision and assessment.
5. Provide short course training in practice education to enable supervisors and assessors to meet the learning and assessment needs of students in line with regulatory requirements.
6. Develop a career pathway with further training and development to support career progression and retention.

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