Institute of Health Visiting response to the Nursing and Midwifery Council's (NMC) consultation on draft standards for post-registration community and public health nursing

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1. About the Institute of Health Visiting

The Institute of Health Visiting (iHV) is an independent charity, professional body and centre of excellence for health visiting, established to strengthen the quality and consistency of health visiting services for the benefit of all children, families and communities. Our Vision requires health visiting to play its fullest part within an integrated system to reduce health inequalities that arise in childhood and for our children to achieve health outcomes on a par with the best in the world. Education is central to the purpose and vision of the iHV – high quality initial education of health visitors as Specialist Community Public Health Nurses (SCPHNs) and high quality continuing professional development for all health visitors will help ensure quality, consistency and effectiveness in health visiting practice. The Institute works to promote education and lifelong learning in health visiting with other partners and with individual practitioners.

2. The NMC Review of post-registration standards

The iHV welcomes the NMC's review of standards and the opportunities afforded for breadth and depth of participation in the development of the new draft Standards including the Steering Group, standards delivery groups as well as the public webinars, drop-ins and other engagement events facilitated by the NMC under the challenging conditions of Covid restrictions.

We have also engaged informally and formally with other professional organisations in a collegial manner. We have held two networking events with the helpful support of the NMC team for our members focussed on the draft standards: one for students and one for the wider membership with interest in practice education. We published a Voices Blog on 'Future Health Visiting' summarising the key issues emerging from this wide dialogue. We are grateful for the expertise and counsel of our Trustees in the development of our response.

We recognise that the review of the standards takes place within a context that is complex and dynamic requiring careful reflection to come to a balanced judgment that takes account of the range of interlocking issues at stake and the variability of the current state of health visiting across the four nations of the UK and more locally. However, we also believe that the standards provide a timely opportunity to re-envision health visiting and Specialist Community Public Health Nursing. We are committed to build on the strength of evidence in support of the vital contribution that SCPHN health visitors make to improving the health and life chances of people across the life-course from its earliest days in their families, communities where they live, learn and work, and at a time of widening persistent inequalities, as well as new public health challenges.

In what follows we set out our responses to selected questions in the NMC's online survey. As an Institute of Health Visiting we focus our response on those questions with relevance to the field of health visiting, welcoming the development of proficiencies specific to the three SCPHN fields of health visiting, school nursing and occupational health nursing. We believe that this in an important strengthening of the regulatory status of health visiting so that the public can have assurances of what can be expected of a SCPHN health visitor.

We also set out some additional recommendations for enhancements of the draft proficiencies themselves.

We strongly encourage all health visitors and others with an interest in child and family public health to take the opportunity to make their own responses to the NMC consultation. It is vital that health visiting standards are shaped by health visitors. We hope that by publishing our response this will assist health visitors and others to consider their own responses to the survey.

3. NMC Survey questions

B1: Standards of Proficiency

Q17	**Do you agree or disagree that the draft core and field-specific standards of proficiency adequately reflect the specialist knowledge, skills and attributes necessary for all SCPHN registrants?**				
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
		✓			
Q18	**Please give reasons for your answer.**				
	The iHV welcomes the inclusion of both core and field-specific standards. We have some further recommendations to enhance some of the draft standards.				

The following sections focus on each of the fields of SCPHN practice: health visiting, occupational health nursing and school nursing.

Q19	**Do you want to answer questions on health visiting?**					
	Yes		No			
	✓					
Q20	**Do you agree or disagree that the draft core and health visiting field-specific standards?**					
		Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
	will enable future health visitors to practice with a high level of autonomy?		✓			
	reflect the breadth and depth of the evidence-base needed for SCPHN health visiting practice?		✓			
	focus on the health visitor's role in working in partnership with children, parents and families in relation to their mental, physical, emotional, spiritual and social needs?		✓			
	focus on the importance of the health visitor's role in being able to recognise, identify and provide person-centred support and care to meet the needs of women with perinatal mental health needs?		✓			

	focus on the importance of the health visitor's role in being able to recognise, identify and provide person-centred support and care to promote infant mental health and identify infant distress?		✓			
	emphasise the knowledge and skills the health visitor needs to proactively supportand work in partnership with people and families and other agencies to safeguard those in vulnerable circumstances, and those at risk of harm or abuse?		✓			
	state the knowledge, skills and attributes health visitors require to strategically influence and lead change?		✓			
Q21	**Please comment on what is missing from the draft standards.**					
	We provide a detailed response to this separately due to space requirements.					
Q22	**Do you want to answer questions on occupational health nursing?**					
	Yes	**No**				
		✓				
Q25	**Do you want to answer questions on school nursing?**					
	Yes	**No**				
		✓				

B2: Prescribing Practice

There is currently a mixture of approaches with regard to the inclusion of prescribing modules within existing NMC approved SCPHN programmes, with many including the V100 prescribing programme.

Q28	**Please tell us if you think that a prescribing element should be a mandatory integrated programme requirement, should be an optional requirement, or is not necessary for the role/s of the SCPHN programmes' fields of practice routes you wish to respond to (leave blank those you don't wish to respond to).**			
		Mandatory integrated	**Optional**	**Not necessary**
	SCPHN - Health visiting route		✓	
	SCPHN - Occupational health nursing route			
	SCPHN - School nursing route			

<table>
<tr><td>Q29</td><td colspan="3">Please tell us which level of prescribing qualification – either the V100 or V300 – you believe is most appropriate for the SCPHN programmes' field of practice routes you wish to respond to (leave blank those you don't wish to respond to).</td></tr>
<tr><td rowspan="4"></td><td></td><td>V100</td><td>V300</td></tr>
<tr><td>SCPHN - Health visiting route</td><td></td><td>✓</td></tr>
<tr><td>SCPHN - Occupational health nursing route</td><td></td><td></td></tr>
<tr><td>SCPHN - School nursing route</td><td></td><td></td></tr>
<tr><td>Q30</td><td colspan="3">Please tell us your rationale in the comments box provided.</td></tr>
<tr><td></td><td colspan="3">We propose that the nurse prescribing qualification remains an additional qualification, rather than a mandatory integral part of the SCPHN programme (although we recognise that historically it has been integrated in some HV-SCPHN programmes). Our recommendation is underpinned by the following reasons:
We believe that prescribing can be a useful capability that is desirable for all health visitors. However, exercising this capability in practice is highly dependent on local service conditions which are very variable.
To align with the 'Future Nurse' (2018) standards which expect registrants to be able to demonstrate 'the ability to progress to a prescribing qualification following registration'. The nurse prescribing qualification represents a 'standalone' qualification which leads to a distinct and separate annotation on the register which is not integrated within the nursing qualification. In the same way, we do not consider that the prescribing qualification should be integrated within the SCPHN programme. We recognise that the 'readiness for prescribing' of potential entrants to SCPHN programmes will be variable for some time to come.
The inclusion of the prescribing qualification takes a disproportionate amount of programmed learning time relative to other essential and distinctive heath visiting knowledge and skill development.
We therefore believe that it should be provided as a stand-alone programme before or after the SCPHN programme or, if integrated, it should not be at the expense of the other proficiencies and that due recognition is given to the length of the overall programme to accommodate the additional time needed to complete the prescribing qualification. This would exemplify positive use of the 'innovation and flexibility' that the NMC standards wishes to support.</td></tr>
</table>

B3: Retaining the RPHN qualification

As well as the existing Specialist Community Public Health Nurse (SCPHN) qualifications, we also have a broader registered public health nurse (RPHN) qualification.

We know that public health nursing roles exist today that the NMC does not regulate and more may emerge, especially as a result of the impact of the Covid-19 pandemic. We therefore wish to test whether we should consider retaining the RPHN qualification for those roles and if so whether the knowledge, skills and attributes described in the draft core SCPHN standards would be applicable.

Please give us your views on the following:

Q31	**Should the NMC retain the SCPHN RPHN qualification for public health nursing roles other than health visiting, occupational health nursing and school nursing?**		
	Yes	**No**	**Don't know**
		✓	
Q32	**Please explain your rationale.**		
	In terms of public protection, standards are linked to regulated titles that have public recognition and are meaningful to them. SCPHN has low public recognition but the addition of field-specific proficiencies gives substance to the well-established (over a century) statutory recognition of health visiting that, until 2004, included the whole age-span including school age. The title of SPCPN RPHN is a seldom used historical title that is no longer a 'registered' (the R in RPHN) title in its own right, but a field of SCPHN; it is also difficult to regulate as it does not have a specified field of practice. Moving forwards, we are supportive of public health nursing increasing its scope - building on the emphasis of the Future Nurse pre-registration proficiencies (2018) and the proposed core SCPHN standards could likely be applicable to such roles. In principle, additional 'fields' with their own field proficiencies could be added, should demand become evident. However, in practice we believe that such use of the SCPHN part of the register and protected title would more likely serve to further confuse the public understanding of the fields denoted by this title. An alternative approach could be facilitated through advanced clinical practice – public health, as per recent work led by HEE (which may be regulated by NMC in future). We believe that this also offers the prospect for SCPHNs to rapidly progress as advanced practitioners in health visiting, SN or OHN, providing a much-needed career development route not well supported by the status of SCPHN as a 'post-registration' qualification and therefore an end point rather than a progression point.		
Q37	**The next questions are all about Specialist practice qualifications (SPQ). Do you wish to answer these questions?**		
	Yes	**No**	
		✓	

Section D

Standards for post-registration programmes: SCPHN and SPQ programmes

Introduction

Our draft standards for specialist community public health nursing (SCPHN) and community specialist practice qualification (SPQ) programmes cover draft standards on entry requirements and entry routes, curriculum, practice learning, supervision and assessment requirements and information on the award and registration requirements for these post-registration programmes.

These draft post-registration programme standards should be read with our Standards framework for nursing and midwifery education and Standards for student supervision and assessment which apply to all NMC approved programmes.

The NMC propose that Level 1* NMC registered nurses and midwives can be considered for entry to a SCPHN programme as long as the applicant is capable of safe and effective practice at a level of proficiency for the intended field of SCPHN practice.

*The Level 1 registered nurse title is set out in NMC legislation - The Nurses and Midwives (Parts of and Entries in the Register) Order of Council 2004 ("the Parts and Entries Order") SI 2004/1765, Article 7(2).

Q69	**Do you agree or disagree with this proposal?**				
	Strongly agree	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**
		✓			
Q71	**Do you agree or disagree that the design of the programme standards enables education providers and their practice partners to be creative and innovative in the way they develop programmes?**				
	Strongly agree	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**
		✓			
Q72	**Do you agree or disagree that the draft standards will enable Approved Education Institutions (AEIs) together with their practice learning partners to design a curriculum which supports students in meeting programme outcomes for their intended field of SCPHN practice (health visiting, occupational health nursing and school nursing)?**				
	Strongly agree	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**
	✓				
Q73	**Please explain your answer.**				
	Q69 - We agree that registered nurses and midwives are eligible for entry to SCPHN-HV programmes. However, we consider it illogical that entry is restricted to these professions and reflects the NMC's limited mandate to regulate only nurses and midwives and not health visitors. If nurses and midwives are indeed separate and distinct professions, either of which is suitable for entry to SCPHN-HV, then there should be elements of pre-registration nursing or midwifery respectively that should be required for SCPHN-HVs. However, this is not specified. Entry could be open to other health professionals or graduates, and programmes could be developed for such a 'direct route' to nursing combined with SCPHN utilising current APEL arrangements (this would provide a much-needed alternative route into health visiting to address current workforce capacity issues for both nursing and health visiting). Hence, we provide qualified agreement to Q71 (i.e. there is room for more radical innovation). Q72 – we agree that the Standards provide well for a collaborative curriculum design in partnership between AEIs and practice partners.				
Q76	**Do you agree or disagree that AEIs together with their practice learning partners should have flexibility to decide how theory and practice are integrated into the curriculum to support students to meet the SCPHN programme outcomes?**				
	Strongly agree	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**
			✓		

The draft outcome-focused programme standards do not specify the duration of SCPHN and SPQ programmes, giving AEIs, together with their practice learning partners, the flexibility to develop programmes of suitable length that support student achievement of proficiencies, programme outcomes and the qualification to be awarded.

Q78	Do you agree or disagree with this above approach for SCPHN programmes?				
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
				✓	
Q79	**Please explain your answer.**				
	Q76 - We are fully supportive of AEIs, together with their practice learning partners, having flexibility to decide how theory and practice are integrated into the curriculum to support students to meet the SCPHN programme outcomes. However, we believe that the word 'balance' is too weak in the proposed standards. We are aware that a strict 50:50 split between theory and practice can be unnecessarily prescriptive, but 'balance' is too loose to be meaningfully quality-assured in a transparent manner. We propose that alternative wording be found, such as 'ensure that the curriculum provides an approximately equal balance of theory and practice learning opportunities, using a range of learning and teaching strategies'. Q78 - We understand that programmes should indeed be of suitable length to achieve the outcomes for any given student. However, there is strong emerging evidence in England that the costs necessitated by longer programmes, such as the Apprenticeship programme, are a severe deterrent to uptake by employers and potential applicants, unless underpinned by reliable funding. While this is not a direct issue for the NMC, the introduction of variability in the length of programmes (as exemplified by apprenticeship in England) has the unintended consequence of skewing decisions to meet market pressures without regard to educational or professional rationale. The removal of a minimum programme length can be expected to facilitate disparities both within England and between the four UK nations, calling into question the validity of UK-wide regulatory standards. There is also substantive evidence that the present one-year programme is insufficient for preparation for the full range of professional practice supported by the burgeoning evidence base for health visiting. The present standard sets a minimum of 52 weeks of which 45 are programmed learning, and this minimum is, in practice, the norm. There is no reason that suggests that removing this would lead to decisions to maintain one year or increase the length of the programme – rather there are more likely to be pressures to shorten programmes. We therefore suggest that a minimum should be specified to maintain the current benchmark of 52 weeks, fulltime or equivalent, with provision for Recognition of Prior Learning in keeping with the 'Part 1: Standards framework for nursing and midwifery education' (2018).				

The draft outcome-focused programme standards do not stipulate the requirement for SCPHN and SPQ programmes to have a specified period of consolidated practice.* This gives AEIs and their practice learning partners the flexibility to develop programmes that support continuous student achievement of proficiencies, programme outcomes and the qualification to be awarded.

* Previous standards indicated a timeframe for undertaking practice in a defined area of practice.

Q82	Do you agree or disagree with this above approach for SCPHN programmes?				
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
				✓	
Q83	**Please explain your answer.**				
	The statement in Q82 that the draft new programme standards 'support continuous student achievement of proficiencies, programme outcomes and the qualification to be awarded' implies that the reverse is true of the present requirement for the provision of a period of consolidation of practice, but this is not the case. On the contrary, a period of consolidation,				

	relatively free of academic pressures towards the end of the programme, provides for further integration of theory and practice and the opportunity to practise leadership and the exercise of autonomy in the ways given enhanced prominence by the new draft proficiencies. It also smooths transition to preceptorship following entry to the SCPHN part of the register. In the period of time when health visiting education was based on the model of SPQ before the 2004 proficiencies, there was pressure to reduce or eliminate consolidation of practice in the shortened programme. This had a deleterious impact on the confidence of newly-qualified health visitors that the reinstatement of the 52-week SCPHN Standards (including consolidation of practice) was intended to rectify.

Supervision and assessment of post-registration SCPHN and SPQ students must comply with the NMC standards for student supervision and assessment in ensuring that practice supervisors and practice and academic assessors are suitably prepared, and receive ongoing support to fulfil their roles when supervising and assessing these post-registration students.

Q86	**Do you agree or disagree with this above approach for the supervision and assessment of SCPHN post-registration students?**				
	Strongly agree	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**
		✓			
Q87	**Please explain your answer.**				
	NB. Alternative wording suggested for text in the proposed draft standards is provided in *red italics.*				

We agree with the above statement. However, we believe this requires significant qualification in respect of the draft programme standards. The standards for Practice Learning state:

3.3 'provide practice learning opportunities that allow students to develop, progress and meet the Standards'

This needs to be strengthened to 'Ensure practice learning opportunities are provided which *enable* students…

3.5 'take into account students' individual learning needs…' and the SSSA states: 1.10 'learning experiences are tailored to the student's stage of learning, proficiencies and programme outcomes'.

These statements strongly imply responsibility for assessing learning needs on an individualised basis and planning of learning experiences.

This point links to 'Supervision and Assessment', the Standards for which were agreed for *all* NMC programmes at the time of the review of pre-registration nursing and midwifery programmes ('Future Nurse' and 'Future Midwife') and *well before* the present review of post-registration standards.

We welcome the following statements in the draft standards:

4.3 'provide constructive feedback to students throughout the programme to support their learning and development for meeting the standards of proficiency and programme learning outcomes for their:

4.3.1 intended field of SCPHN practice..'

4.4 'ensure all SCPHN proficiencies and SPQ proficiencies are recorded in an ongoing record of achievement which confirms proficiencies have been met'

4.5 'assess the student's suitability for award and confirm overall proficiency based on the successful completion of a period of practice learning…

	The above imply a very substantial on-going role for the Practice Assessor for assessing each individual student's learning needs *from the commencement of their programme* – taking into account: • variability of prior training – midwifery and nursing are not the same profession; • there are substantive differences between the four fields of pre-registration nursing; • the level, duration, relevance and recency of prior experience on entry can be extremely variable. The Draft Standards therefore need to *explicitly* support the following: • Continuous formative assessment, feedback and planning of learning experiences is needed in addition to summative assessment; • Selection, planning and quality assurance of practice learning in conjunction with one or more practice supervisors and settings; • Ensuring and assuring valid and reliable recording of progression (or otherwise); • Summative valid and reliable assessment of proficiency based on evidence. We address how practice assessors are prepared and supported in our response to Q90 and Q91.

To facilitate effective supervision and assessment for SCPHN and SPQ post-registration students, we propose that practice supervisors and practice assessors for SCPHN and SPQ programmes must be able to evidence relevant prior learning and experience necessary for the practice supervisor and assessor roles. For example, undertaking a period of preceptorship in line with the NMC principles for preceptorship and/or in line with local and national preceptorship policies for SCPHNs or SPQs prior to assuming a practice supervisor and/or assessor roles of post-registration SCPHN and SPQ students.

Q90	**Do you agree or disagree with this approach for SCPHN programmes?**				
	Strongly agree	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**
			✓		
Q91	**Please explain your answer.**				
	NB. Alternative wording suggested for text in the proposed draft standards is provided in *red italics.* In addition to our response to Q87 we make the following points: We agree that Practice Supervisors and Assessors should be suitably prepared for their roles and responsibilities but believe that the draft standards do not specify this sufficiently. The draft standards state: 4.6 'ensure that practice supervisors have undertaken a period of preceptorship…' We agree with this requirement but add that preceptorship should be applicable to the new SCPHN Standards once published. The new standards raise the bar on what is expected of the SCPHN at the point of registration. The ambitions of the proficiencies lie in the level of autonomy, level of strategic thinking, action and leadership, and commitment to justice, human rights and health equity. Of all these, the level of autonomy is most critical. There is evidence, at least in England, that health visitors acting as Practice Assessors and Supervisors are often restricted in their capacity to function at the level of autonomy and leadership for which the new standards provide a vision. It therefore follows that *the preparation and support that they will need to implement the SSSA standards in a manner that is fit for purpose will need to be tailored to the SCPHN programme and to exceed that required for supporting and assessing pre-registration nursing students.* **Practice learning** must provide a vision for what 'autonomy' can look like. This				

relates to the overarching issue of the SCPHN as **leader**, a cross-cutting theme for all the proposed proficiencies. Therefore we propose that 4.6. should be enhanced, for example, as

> 4.6 Ensure practice supervisors have undertaken a period of preceptorship *in respect of the NMC Standards for SCPHN and SPQ 2022* in line with the NMC principles for preceptorship as SCPHNs or SPQs or can evidence prior learning and relevant practice supervisor experience that enables them to facilitate effective evidence-based learning opportunities for post-registration students *to meet these standards*.

As previously mentioned, there is evidence, at least in some local authorities in England, that health visitors acting as Practice Assessors and Supervisors are restricted in their capacity to function at the level of autonomy and leadership for which the new standards provide a vision. It therefore follows that *the preparation and support that they will need to implement the SSSA standards in a manner that is fit for purpose will need to be tailored to the SCPHN programme and to exceed that required for supporting and assessing pre-registration nursing students***.**

The draft standards state:

> 4.7 Ensure practice and academic assessors have undertaken a period of preceptorship in line with the NMC principles for preceptorship as SCPHNs or SPQs or can evidence prior learning and relevant practice assessor experience that enables them to engage in fair, reliable and valid assessment processes in the context of SCPHN and / or community SPQ, and
>
> 4.8 Ensure practice and academic assessors have undertaken a period of preceptorship in line with the NMC principles for preceptorship as SCPHNs or SPQs or can evidence prior learning and relevant practice assessor experience that enables them to engage in fair, reliable and valid assessment processes in the context of SCPHN

The requirement for preceptorship should be strengthened as for Practice Supervisors as in our recommendation for 4.6;

and 'engage' is too weak a verb – '*to be responsible for and adopt fair, reliable and valid assessment processes in the context of SCPHN*…' is what is needed.

The SSSA do make some stipulations (section 8) on the preparation of Practice Assessors. However, feedback from former Practice Teachers indicates very wide variability in preparation, often being little or no more than that for pre-registration students and insufficient for the role with SCPHN students for current standards. Practice Teachers raise a number of points of concern:

- The SSSA standards need to be applied in ways that give full recognition to the high level of <u>autonomy</u> expected of registered SCPHNs and the need for students to be assessed for their capability in functioning with increasing autonomy in unregulated environments, highly indeterminate practice situations, without supervision or direct access to support.
- Students have to deal with multiple clinical, social, interpersonal and interagency issues simultaneously. Practice Assessors need to be prepared and supported to facilitate students to recognise and analyse complexity and the judgments, decisions and actions required for practice at increasingly high levels. This makes more demands on the Practice Assessor's own level of practice as they combine their teaching and assessing roles with their own clinical and leadership commitments.
- At the same time, for SCPHN-HV students, there is substantial new knowledge and practical skill acquisition and this will vary depending on the student's prior experience and route into health visiting (e.g. many will be unskilled in supporting breastfeeding and promoting its duration well beyond initiation; similarly for SCPHN-HV students from child branch

	registered nurse programmes, assessing and supporting parental mental health problems will present a whole new field of learning and skills acquisition; conversely students from a mental health branch registered nurse programme will often feel less confident in supporting parents to manage minor childhood illnesses or identify atypical patterns of development). Addressing this requires active enabling of new learning in the practice setting not covered by the 'theory' taught by university partners or well described by the terms 'supervision' of 'learning experiences'. • The *lack of differentiation between the expectations of Practice Assessors for SCPHN programmes and pre-registration students* does not match the higher demands of working with a SCPHN student. Many Practice Teachers / Practice Assessors express the view that this effectively devalues the Practice Assessor for SCPHN and that this is reflected in employers' lack of readiness to recognise this by adjusting workload and / or providing additional financial recognition. As a consequence, many will elect to limit themselves to pre-registration students, *threatening the viability of the implementation of the proposed new post-registration standards*.

The NMC has set a minimum degree level requirement for pre-registration qualifications. In order to surpass this, the draft programme standards indicate that the minimum academic level for specialist community public health nursing and specialist practice qualifications is to be postgraduate level. This also gives flexibility for AEIs across the UK to determine the academic credits for their curricula and programme outcomes

Q94	**Do you agree or disagree with this position for SCPHN programmes?**				
	Strongly agree	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly disagree**
		✓			
Q95	**Please explain your answer.**				
	We agree that the level should be postgraduate level. We would 'agree strongly' if we were assured of a minimum programme length OR the volume of academic credit to be awarded. In the absence of *both,* there would be insufficient safeguards to ensure the standards will be met. We believe that programme duration (combined with equal balance of theory and practice) is the more effective and important safeguard (because it includes practice learning) than the volume of credit for the academic award, provided the level of the award is postgraduate (as proposed).				

4. Supplementary iHV Response on the Draft Standards for Proficiency for SCPHN

In what follows we make our suggested enhancements to the Draft Standards:

NB. Alternative wording suggested for text in the proposed draft standards is provided in red.

Across the proficiencies we have added explicit reference to 'infants' in addition to children and young people as a corrective to the tendency in policy and practice for the earliest years to be omitted or overlooked when the term 'children and young people' is used, i.e. there is a 'baby blind spot[1]'.

[1] https://parentinfantfoundation.org.uk/the-baby-blind-spot-first-1001-days-report-shows-babies-needs-overlooked-in-covid-response/

Page 3:
"They (health visitors) build trusting relationships with individuals, ~~and~~ families and vulnerable groups, understanding their needs and strengths to empower them to positively influence their health outcomes." (addition in red)
For **'The role of the SCPHN health visitor in the 21st century'** we propose inserting as a second paragraph "Health visitors, as a distinct group of public health professionals, approach their practice with a distinctive orientation to practice, based in salutogenesis (health creation), human valuing and social ecology. They focus on creating health, through activities to build resilience, self-efficacy and capabilities and enable health-enhancing activities. They expand the features of unconditional acceptance and human valuing, which are embedded within person-centred practice, to communities and populations. Relating to people within their situation and personal environment, health visitors understand cultural and social learning, assets and barriers to health." [2]
For the penultimate paragraph we propose: "Health visitors are advocates for fairness, equity and social justice and will use their influence to challenge discriminatory practices and behaviours. They understand the impact of the wider determinants of health and are committed to reducing health inequalities across the life course through prevention…"
Page 5: About these draft standards
We propose to add mental health to the sentence: "Public health challenges exist across all of society, from the pandemic of obesity to the significant increase in people of all ages at risk of living with type two diabetes, and the global upsurge in mental health problems."
Page 10: Sphere of Influence A
Stem sentence should read: **At the point of registration, the registered SCPHN HV, OHN and SN will be able to:**
Page 12: Sphere of Influence B
Point 9 added in red: "use public health and nursing science with people and in practice at community and population levels and support innovative approaches including social prescribing to influence people's motivation, lifestyle choices and behaviours"
Page 11:
Add (**between points 5 and 6?**) for core: "Use knowledge of implementation science to identify and implement health programmes to meet identified health concerns in people, communities, work settings and populations, adopting quality measures and adapting to local circumstances as required for acceptability and sustainability."

[2] Cowley, S., Whittaker K., Malone M., Donetto S., Grigulis A., Maben J., (2015) Why health visiting? Examining the potential public health benefits from health visiting practice within a universal service: A narrative review of the literature. International Journal of Nursing Studies 52: 465–480

Page 12, Sphere of influence C:

Add to description:

"Health visitors are ideally placed to identify, highlight and tackle health inequalities due to their unique reach into every family and their deep understanding of the broader determinants that affect the physical, social, mental, spiritual and emotional health and wellbeing of children, parents, carers and families. Health visitors understand that family life is complex, often unpredictable and may be both the source of strengths, support and resilience, and of potential risks and dangers. They actively seek to uphold the human rights of all of those they engage with, and advocate on behalf of those who are vulnerable or unable to speak up for themselves."

Point 3: added in red

"appreciate the practical, material, legal, ethical, moral and spiritual needs and challenges that may be faced when promoting population health, helping to remove barriers to enable people and families to live to their full potential"

Page 13:

Point 6: (core)

"conduct, interpret and evaluate health assessment and screening, surveillance and profiling checks, and immunisation and vaccination programmes for people, communities and populations"

Immunisation and vaccination programmes don't sit well together within the preceding text focussed on health assessment. It could be divided with an additional outcome framed, such as

"conduct, interpret and evaluate health assessment and screening, surveillance and profiling checks for people, communities and populations"

and

"Lead the promotion, support and delivery of immunisation and vaccination programmes for people, communities and populations"

Point 11:

….timely emergency care and other urgent support when needed

Page 14:

Point 6:

use their professional skills and judgement to observe, inquire, recognise and respond to signs of abuse and neglect in infants, children, young people or adults maintaining a focus on their respective needs, ensuring the lived experience of the infant or child is heard within potentially complex home situations where the parents also have wide-ranging needs.

Adding:

Recognise infants' and children's vulnerability to neglect and abuse or exploitation in many different forms within the family or in the community.

Maintain professional curiosity and objectivity to name and act on concerns with parents or others with responsibility for infant and child health and welfare.

communicate concerns clearly to other health, social and justice system professionals orally and in writing and participate in child protection proceedings with relevant agencies.

Recognise and act on potential indicators and trends across the local population and contribute, for example through case reviews, to system-learning that enhances community safety for infants, children and vulnerable adults.

(NB Similar outcomes may be needed for School Nursing)

Page 17, Sphere of influence D (Core):

Add:

Point 5: "expertly apply knowledge of behavioural, psychological and social sciences to the health of people from conception through the life-course, populations, communities and specialist public health practice that enhances collaborative, strength-based therapeutic relationships"

HV specific:

Point 1:

"apply expert knowledge, professional judgement and the skilled use of validated tools to deliver holistic health and development assessments and programmed reviews, ..."

Point 2:

"identify and assess the early signs of atypical patterns of development or significant anomalies likely to result in diagnosis of illness, or in disability, and /or of emotional or health needs or risks, ..."

Point 6:

" critically apply specialist knowledge of the anatomy, neurodevelopment, physiology and epigenetics of infant feeding, weaning and early food behaviour, including the implications of infant feeding and sleep for child and maternal health, child physical and socio-emotional development and later behaviour patterns

Point 8:

"work in partnership with families to support nurturing care from the start of life, promoting the benefits of children learning life skills in the home environment"

Point 13 for school nurses is:

"signpost and support children and young people, parents, carers and families to local grants, financial support and other services and resources to develop self-advocacy, capability, opportunity and motivation to influence and use facilities/assets in their community."

This could be framed inclusively and more generically as a core outcome for SN, HV and OHN.

Page 23: Sphere of Influence E

Point 2 could be more comprehensive:

"respect parents' and carers' need for autonomy and control with sensitivity to a wide range of attitudes, values, beliefs, expectations and influence of faith and culture upon health practices and parenting, while at all times safeguarding the welfare of the infant and child."

Some additional outcomes for 'E' are:

"design and lead on health campaigns aligned to key public health priorities for people across the life-course, communities and the local population"

"raise awareness of the impact of socio-economic disadvantage and poverty, including digital poverty, working with others to facilitate policy changes that support people in achieving their potential"

"explore the lived experiences that influence people's behaviour, health and wellbeing, taking them into account when working in partnership with others and planning interventions to improve health and wellbeing for people, communities and the population"

These three suggested additions are all similar to ones stated for SNs only: they might be general, rather than either HV or SN specific proficiencies within a 0-19 service context.

Page 24: Sphere of Influence F

Description of health visitors' work:

"They promote collaborative working, not only in terms of leading and working within multidisciplinary and multi-agency teams and ensuring smooth transition between services, but also by working in partnership with families, communities and populations to provide a safe, effective and person-centred proportionately universal health visiting service that addresses the physical, social, mental, spiritual and emotional health needs of all."

Point 1:

"apply high-level communication and interpersonal skills to establish trusting relationships with all families that are respectful of their capabilities, priorities and values"

Grammar query – shouldn't this be:

"apply high-level communication and interpersonal skills to establish trusting relationships with all families, which are respectful of their capabilities, priorities and values" ??

or possibly:

"apply high-level communication and interpersonal skills to establish trusting relationships with all, which are respectful of families' capabilities, priorities and values"

The latter is inclusive of direct work with clients but also includes how HVs communicate with other agencies about their clients.

Point 2:

lead teams that are effective in supporting the delivery of public health services, both on their own and in collaboration with others.

And add:

"base any decisions on delegation of tasks and responsibilities to other health or early years practitioners on assessment of risk, complexity, and competence with due regard to professional accountability and clinical governance."

[NB This may seem obvious, but many health visitors are systematically required to 'delegate' without such due regard).

Page 25:
Between points 2 and 3, add: Lead and contribute to development of care pathways, resources and services for specific high impact health needs, conditions or marginalised groups and workforce readiness for implementation.
Point 3: Lead discussions and make decisions in conjunction with other professionals at the interface of primary and secondary healthcare, social services, education and other agencies regarding the referral, support and management of infants and children and families where there are concerns around the wellbeing of the child, based on an assessment of complex situations and on knowledge of the child and family [This addition may seem an over-elaboration, but many health visitors have become structurally distanced from GPs and paediatric services to the detriment of families where HVs broker continuity of care and referral pathways crossing these interfaces. This is a key leadership function for HVs].
Point 4: work in partnership with midwives and other primary and secondary health and social care professionals, services and agencies during the antenatal period and first days of the baby's life and beyond to ensure consistency and continuity of care for parents and carers, and a smooth transition between midwifery and health visiting services.