Evidence submission template

Shape of Caring - *a review of the education and training of the nurse and care assistant workforce.* [1]

The Shape of Caring Review will recommend evidence-based improvements to education and training. We want to find solutions to our key question:

'How can we ensure the education and training of nurses and care assistants' is fit for purpose to support them in delivering high quality care over the next 10-15 years?'

These are the themes and particular areas where we would like to gather evidence:

Theme 1: Increasing patient/carer voice and service user involvement across education and training
Examples of good practice and evidence where the service user has been involved in the development of education and training.

See example of research under Theme 7

Theme 2: Valuing the role of the care assistant
Examples of good practice and evidence on making care assistants feel valued and opening opportunities for learning and development.

Theme 3: Widening opportunities for care assistants' career progression, which may include entry to nursing education
Examples of good practice and evidence on widening opportunities for existing care assistant staff to develop their career -this may include entry to nursing degrees. In addition, we would also like to seek examples of 'Career Frameworks/ Skills Escalators' for people in a care assistant role.

Health visitors do not usually work with care assistants. Community nursery nurses are valuable members of most health visitor-led teams, who are normally paid on Band 4, but it is hard for them to progress or develop a career ladder, because they are unable to access health visitor education (see Theme 4). The

Institute of Health Visiting believes it is inequitable to deny these workers the opportunity to develop by accessing health visitor education, unless they spend three years preparing to work in a different profession (that of nursing) before being able to access a health visiting programme. A different form of health visitor preparation, such as a three-year direct entry degree in health visiting, would enable this to happen.

Theme 4: Assuring flexibility in nursing and care assistant education and training of the future

Examples of good practice and evidence that supports the development of a future model of education and training for both pre-and post-registration for nurses; which is flexible at all levels and would produce more care assistant and nurses with transferable skills.

At the Institute of Health Visiting, we strive to promote the best available high quality standards in health visiting practice. We are responding to the request for comments on The Shape of Caring Review led by HEE on educational structures of nursing. Having read the whole report we are disappointed to see no reference to Health Visiting education. Health visitors are currently prepared through a year long post - registration programme. By the time the students have qualified as a health visitor they will have spent at least four years in education of which only one year will have been spent on their speciality. Health visitors have a key role in public health education, lead the Healthy Child Programme, work in partnership with local authorities including social workers on high level child protection cases requiring specialised knowledge. Additionally health visitors are the only universal service in the lives of very young children, consistently having a key role in the detection and support of perinatal mental health issues and emotional distress in families including with the essential parent-infant relationship.

Much needed investment has been given to the Health Visiting service over the past 4 years due to the health visitor implementation plan by the Department of Health which end in 2015. A major study led by Professor Dame Sarah Cowley found amongst many salient points that "There also needs to be more investment in education programmes for health visitors, including continuing professional development, and recruitment of students must take account of the values, skills and attitudes that are essential to the role" (Cowley et al 2013). The requirements for nursing do not guarantee these aptitudes are present, but restricting health visitor education to nurses or midwives only, reduces the size of the recruitment pool and the opportunity for many other potentially suitable candidates.

Current Health Visiting training is 45 programmed weeks, 50% of which is practice based and there is a growing consensus that this is not long enough to encompass all the necessary learning. As currently required, student health visitors must first undertake three years as an under graduate student nurse learning how (for example) to bath a patient, treat an open wound or care for the surgical patient and

many other skills that are largely redundant in health visiting practice. Furthermore they can only enter health visiting through a specialist nursing route – childrens, adult, mental health or learning disability or midwifery despite requiring skills in all 5 areas to effectively deliver their role. Health visitors are specialists in public health and are motivational change agents, skilled in empowering families through early intervention to prevent hospital admissions. There are a large number of areas where the necessary underpinning attitudes and beliefs in health visiting differ from those in nursing. To take one example, Willis' first 'key message' stresses 'patient-centred care,' focused upon managing conditions – whereas health visitors would like a first key message to be concerned with a person-centred service, focused upon promoting positive health. Such apparently small differences in terminology mask major differences in the underlying knowledge, aptitudes and skills required.

We believe this would be an appropriate point to re - examine the relationship between nursing and health visiting education. Expanding the entry gate for health visitor education would help to demonstrate both the huge benefits that accrue from nurse education as one possible starting point and the many differences required for the work. There are many graduate students from different disciplines who could access a differently configured health visitor preparation including just the elements of nursing which are relevant, if the entry gates were widened. Transferable skills include: mental health trained practitioners, graduates from a range of social science degrees, early years workers including children centre staff could access directly a public health model of three years training without the need to undertake a pre-registered course before health visiting. We believe this would improve recruitment and lead to a better-prepared workforce, benefiting the health visiting profession and, ultimately, enhancing public health outcomes and services by improving standards in the workplace.

Theme 5: Assuring high quality practice learning environments which support the development of the future workforce

Examples of good practice and evidence focusing on high quality clinical learning, high quality mentorship, and increased opportunities for students to develop autonomy and confidence within their role.

Theme 6: Assuring predictable and sustainable access to ongoing learning and development for registered nurses

Examples of good practice and evidence relating to: high quality preceptorship, on-going supervision, peer review and opportunities for learning and development linked to the role and revalidation. In addition, we would be grateful for examples of post-graduate career frameworks.

Positioning health visitor education as a post-registration nursing qualification creates difficulties in developing career frameworks and progression for newly-qualified health visitors, who need to be regarded

as novices in their new profession. The Institute of Health Visiting has been commissioned by HEE to produce National Induction and Preceptor Frameworks specifically for newly qualified, new to area and return to practice health visitors. These are scheduled to be with organisations in early September 2014 to benefit the many new staff arriving. The benefits of a robust preceptorship programme are well documented (Whittaker 2013) which include staff satisfaction and staff retention which ultimately should serve to improve outcomes for very young children and their families.

The emphasis of the Preceptor Framework is on self-directed learning supported daily by a mentor alongside regular meetings every 4-6 weeks with a preceptor. In health visiting these points below encompass the meaning of a gold standard preceptorship programme:

What will a successful local preceptorship programme achieve?

- An enhanced ability for the preceptee and the health visiting profession to develop clinical knowledge, skills and strategies to support vulnerable families quickly and to deliver health messages in challenging situations;
- A service that has responded to the new vision for health visiting and the **"Six C's"** by:
- showing care, commitment and compassion in how they look after families;
- finding the courage to do the right thing, even if it means standing up to multi-agency colleagues to act for the child or parent's best interests, in a complex and pressured environment;
- being confident to communicate well at all times;
- able to demonstrate high levels of professional competence.

What will a successful local preceptorship programme include?

- Experiential and active learning methods using strengths based, solution focused strategies and motivational interviewing skills to enable health visitors to work in a consistently safe way utilising the full scope of their authority.
- Opportunities for constructive feedback and challenge using advanced communication skills to facilitate reflective supervision.
- Strategies to equip health visitors to manage strong emotions, sensitive issues and undertake courageous conversations**.**

Every practitioner comes with their own life experiences and previous skills and knowledge. Preceptorship should not be seen as a training course (i.e. is something that follows the education programme).

- The preceptee must be at the centre of developing their own preceptor programme tailored to their own level of need.
- It is based on experiential learning in the context of practice. It is the practical experience and use of expertise in the field that will develop preceptees into expert practitioners.

- To become advanced practitioners, health visitors need to possess the additional personal attributes and professional maturity that will enable them to move the health visiting profession forward (Baldwin 2013).
- Is aimed at the development of skills and the emotional confidence necessary to underpin autonomous practice (Maxwell et al (2011) and Ellis and Chater (2012).

Research tells us that the first 2 years of a new role can be very challenging. Through extensive focus group testing and evaluations we recommend formal preceptorship lasts for one year including regular supervision both child protection (3 monthly) and clinical supervision (4-6 weekly). The end of the first year's flows into the second with the preceptee developing peer supervision groups and support as required from a mentor. From day one of a career in health visiting practitioners are encouraged to keep reflective journals.

Continuous Professional Development

The Institute of Health Visiting has also been commissioned by HEE to develop Continuous Professional Development (CPD) opportunities for every health visitor by March 2015. The National Health Visiting Service Specification (NHS England 2014/15) outlines the requirements for commissioned services in line with the Healthy Child Programme (encompassing Public Health Outcomes framework) and the 6 High Impact Areas.

The team are currently scoping and developing a framework designed to underpin and enhance current practice needs under the umbrella of PHOF and DH 6 High Impact Areas. The whole focus being to improve the lives of young children and their families (Bishop and Gilroy 2014).

The CPD package under development includes:

- Modules of learning for each CPD area.
- Blended Learning combining internet and digital media along with more formal face to face models.
- Training and Development materials and opportunities.

Theme 7: Supporting and enabling research, innovation and evidence based practice

Examples of good practice and evidence relating to the development of a greater practice based research foundation (where the researcher is based in clinical practice) and innovation, including increasing the number of people undertaking clinical academic careers.

We do not have any examples of clinical academic careers in health visiting. The Department of Health Policy Research Programme invested in a large programme of research to support the 'Call to Action,' based at King's College London. The first of three projects was a large scoping review and narrative review

of the literature, which identified a very dispersed research literature and sparse academic infrastructure. As a result, **research about health visiting practice has not kept pace with the dramatic expansion in research about children, families, communities and public health**. It also became clear, particularly in the two empirical studies (one about recruitment and retention and one focused on learning from service users) that there was almost no cross-over with the academic literature available from nursing research. A key recommendation was that ***'the academic infrastructure for health visiting needs specific support and action to enable it to develop from its current very low base.'***

The Institute of Health Visiting is committed to improving the availability of evidence for practice, and works to achieve this in three main ways. First, the iHV has commissioned experts in the field to prepare readily accessible resources focusing on the research underpinning key aspects of practice, such as sleep and infant allergy. The iHV has established a robust quality assurance process to ensure the accuracy of these documents. Second, supported by a grant from the Department, the iHV has published (40) peer-reviewed but accessible 'Good Practice Points' focused in improving practice in areas such as ethnicity and working with families that find services hard to reach. These complement a series of information sheets for parents (35), which can be downloaded by parents and printed as resources for health visitors to offer parents. The third approach is to promote online learning, hosting the Health for All Children e-learning platform, jointly with the RCPCH. As well as these direct approaches to learning, the iHV hosts an online Community of Practice, which enables practitioners to contact peers with queries and to discuss issues relating to practice.

Making the Most of health visiting programme

The Department of Health has funded a four-year transformational programme of recruitment and retention, professional development and improved commissioning linked to public health improvement. This explicitly aims at a future health visiting service that is universal, energised and fit for long-term growth. The Health Visitor Implementation Plan 2011-2015 published in February 2011, sets out how the ambition will be delivered. The Prime Minister has personally endorsed the initiative and the linked creation of an Institute of Health Visiting (iHV) in November 2012.

The unprecedented expansion of the Health Visitor (HV) workforce associated with the policy presents a once-in-a-lifetime opportunity to re-imagine the contribution that this highly trained community-orientated workforce can make to the future of a revitalized NHS properly focused on improving health and well-being of families and communities. At the same time, there is a need for ***intensive*** post-qualification training and development of HVs to tailor their skills more specifically to the current and any new evidence base with respect to the Healthy Child Programme and to the public health objectives of local authorities. This will

help sustain the long-term future of the workforce as responsibility for commissioning passes to local authorities in 2015.

This initiative will lead the development of the workforce to improve access, experience and outcomes. In addition, it will sustain and motivate HVs themselves, giving them confidence in the future of their profession. It will provide crucial support to the Implementation Plan by improving recruitment and retention.

The objectives of the programme are to develop an intensive and sustainable process which will support health visitors to deliver high quality and consistent practice contributing to integrated system transformation across agencies and the achievement of national public health outcomes. The objectives will be delivered by running three projects concurrently:

Providing access to effective post qualification training and support for every Health Visitor

Four regional (North, Midlands, London, South) professional support networks will be set up, linked to the NHS, Academic Health Science Networks (AHSNs) and Universities in each region to promote the development of communities of practice and support linked to the iHV. A framework and curricula for evidence based Continuous Professional Development (CPD) and an inventory of high quality training/development materials will be developed. Specific cascade training on infant mental health (IMH) and learning from Serious Case Reviews (SCR) will be provided. We have already rolled out Perinatal Mental Health Training (PMH) and Domestic Violence and Abuse (DVA) training to over 700 senior health visitors who are now cascading this training throughout their organisations to ensure every health visitor is on message. The training is supported by an evidence based training pack and e-learning to help maintain its fidelity. We know that the PMH training has already been cascaded on to around 4000 health visitors. The cascade approach is a really good example of the type cost-effective development/CPD, which can be adapted for many scenarios and which the iHV is well placed to deliver.

Practice based upon theory and evidence

A nationally agreed standardised induction pack for newly qualified Health Visitors has been produced (theme 6).

Supporting Health Visitors and fostering resilience

The iHV supports the implementation of Positive Practice Environments, as supported by the International Council of Nursing and WHO. This is an approach to supporting staff and recruiting and retaining the best possible workforce (Bryar, Kendall and Mogotlane 2012).

Theme 8: Funding and commissioning levers that can support education and training for the future

Examples of good practice and evidence on how resources and commissioning can be used innovatively within education and training to achieve high quality workforce and outcomes.

There were longstanding difficulties in funding health visitor education prior to the advent of the Health Visitor Implementation Plan: A Call to Action (HVIP). These difficulties stemmed from the ambiguous position of health visitor education as a post-qualification qualification, which means that it lay outside standard mechanisms for initial preparation, being bundled instead with post-registration learning/continuing professional development. The HVIP has provided an excellent example of how central funding can successfully drive forward an incredibly ambitious programme of recruitment and education. By May 2015, nearly 7000 new health visitors will have been prepared in the preceding five years – an outstanding achievement, which has required enormous innovation and dedication across the entire education infrastructure, including in practice placements. We believe there is much to learn from this approach, even though education on such a large scale will (hopefully) not be needed in future.

What counts as evidence?

Items such as:

- research (quantitative and qualitative)
- good practice examples from education and training practices of registered nurses and care assistants
- organisation or policy initiatives based on the review's themes
- surveys or collated group feedback from groups e.g. public health, community, hospitals etc.
- examples from across the UK and international research are welcome

Please do not supply patient identifiable information or information which does not have the explicit consent of the individual(s) involved (this would not include for example case studies of patient experience in published material already in the public domain).

Form submission

To submit evidence please complete the form below. Please make your submissions relevant to the categories provided in the boxes overleaf. If there is extensive information you wish to submit we would be grateful for a succinct summary. In due course evidence received may be published.

You can include extracts of reports into the free text boxes, or submit a whole report along with this form. For each step please supply the relevant theme heading (as outlined above) which your evidence sits under. Please mark clearly in the email which of the below steps the report/evidence

relates to, including any relevant page numbers. Where an extract is provided, please reference the source.

Before completing the form below please submit your contact details here:

Name: Elaine McInnes
Job title: Lead Professional Development Officer / Project Lead
Organisation: Institute of Health Visiting
Contact email: Elaine.McInnes@iHV.org.uk
Contact number 07825 167486

We are not expecting you to commission new work to answer these questions, but we would welcome sight of any intelligence and evidence you already have on these issues. Please submit and share any existing documents by Wednesday 17th September 2014.

Once completed please submit the form via email to HEE.ShapeofCaringevidence@nhs.net making sure all supporting documents are embedded in the document. Please make the subject of the email: ***HEE Shape of Caring call for evidence - [Insert your organisation's name]***

Data Protection and Freedom of Information

The information you send us may be made available to wider partners, referred to in future published workforce returns or other reports and will be stored on our internal evidence database. We may need to contact you to seek further information on your submission.

Any information contained in your response may be subject to publication or disclosure if requested under the Freedom of Information Act 2000. By providing personal information for this review it is understood that you consent to its disclosure and publication. If this is not the case, you should limit any personal information provided or remove it completely. If you want the information in your response to be kept within HEE's executive processes, you should make this clear in your submission, although we cannot guarantee to be able to do this.

Step 1 – the future nursing and care assistant workforce

HEE recognises that due to demographic changes, disease prevalence, and innovation it is highly likely we will see an increase in people seeking access to health care services. Together with the financial challenges we are facing, there will be changes to the way we deliver services in the future.

To continue to deliver a high quality service to patients we need to future proof the workforce so we have a workforce with the right skills, in the right number, in the right place, with the right behaviours and values to deliver health services for the 21st century.

Using assumptions made in the HEE Strategic Framework ('Framework 15') on the future workforce (see background briefing), what kind of nursing and care assistant workforce will be required if we are to meet the needs of future patients in 10-15 years' time?

It would be helpful to include in your response reference to the following implications: the type of skills, behaviour and values we will need our workforce to have e.g. specialist v. transferable, settings they will need to work in e.g. primary, community or hospital; and in what numbers.

Review theme: …….. *Insert evidence here*

Step 2- identifying evidence-based solutions to meet the future workforce challenges

Once the future workforce is clearer we will need to understand how we can meet these challenges in terms of numbers, skills and ensuring high quality education and training for both nurses (pre and post registration) and care assistants.

How can we meet these challenges?

Using the review themes (identified on page 1-2) please supply examples of good practice in education, training, or workforce planning that could future-proof our workforce in order that it might deliver high quality care in 10-15 years' time.

We would be particularly grateful for evidence regarding whether such good practice has been evaluated. If so, we request that any formal evaluation/outcomes are shared along with a summary of the criteria against which this good practice was measured.

Although this call for evidence is focusing primarily upon examples of good practice, we understand that valuable evidence may have been obtained from less successful experiences, e.g. lessons learnt.

If you have more than one area of good practice to share please expand in this box with theme as a title.

Review theme …… *Insert evidence here*

Evaluation: Yes/No

Step 3 – identifying solutions

There may be ideas which have not yet been tested or implemented but might better enable our workforce to deliver high care quality care in 10-15 years' time.

Please provide any solutions that might be useful for the review to consider; if you have more than one solution to share please expand this box.)

Insert evidence here Review theme ……

General/other evidence not included elsewhere

Insert evidence here

Thank you for taking the time to complete this form and for contributing to the Shape of Caring Review.

Reminder

Please email your completed form to: HEE.ShapeofCaringevidence@nhs.net by 5.00pm Wednesday 17th September 2014.