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NHS Health Education England

A National Framework

for Continuing Professional Development for Health Visitors - Standards to support professional practice

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Developed by the Institute of Health Visiting on behalf of Health Education England and the Department of Health

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Reader information box

Audience

Health Education England
Local Education & Training Boards (LETBs)
Public Health England
Local Authority Commissioners
Health Visiting provider organisations – professional or service leads
Education and Training providers e.g. Higher Education Institutes, private providers and expert voluntary sector organisations
Health Visitors

Document purpose

Best Practice standards

Title

A National Framework for Continuing Professional Development for Health Visitors

Equality Impact Assessment

Completed December 2014 - assessed by Lucy Hall - RGN RHV MA Equality & Diversity. Lucy currently works as Equality and Diversity Lead for Newcastle upon Tyne Hospitals NHS Foundation Trust.

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A National Framework for Continuing Professional Development for Health Visitors - Standards for the High Impact Areas for Early Years iHV 2015

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The Institute of Health Visiting is a Centre of Excellence:

- supporting the development of universally high quality health visiting practice;
- enabling health visitors to effectively respond to the health needs of all children, families and communities;
- enabling all children, families and communities to achieve their optimum level of health, thereby reducing health inequalities.

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The Framework and Standards were commissioned and supported by Health Education England and the Department of Health.

Foreword

Dear Colleague

In 2010 the Department of Health set out the Health Visitor Implementation Plan (HVIP), which envisaged the health visitor workforce being expanded by 4,200 full time equivalent health visitors. Health Education England was asked to commission training places across the country to help meet this target and focus on the delivery of the service offered to children and families so that health outcomes can be improved. Since 2010 we have all been working hard to increase the numbers of health visitors in post by training, retention and supporting returners. Of course the HVIP was not just about these numbers, it also concerned supporting the transition from student to qualified health visitor, newly qualified staff and returning health visitors to the workforce. This gives us our next challenge: we need to support and retain the newly expanded health visiting workforce because they can provide inspiration for all of us, as individuals and teams, to implement on-going improvements to the health visiting service.

Health Education England and the Department of Health have responded to health visitor views and commissioned the Institute of Health Visiting (iHV) to produce a framework to support post qualification continuing professional development. The framework will contribute to the ongoing development of the workforce as part of the HVIP (DH, 2011) by supporting health visitors entering the service as well as those in the existing workforce.

This framework sets out expectations for the continuing professional development for qualified health visitors. It then provides a set of standards to support the commissioning of education and development for health visitors focusing on key areas for professional development identified from policy and a large survey of practitioners views. This framework complements the earlier standards which were aimed at the High Impact Areas for Early Years (DH,2014a). Its aim is to provide a consistent approach to training and education across the workforce to support high standards of service delivery. Ultimately, this will support health visitors to improve the health and welling of all children, families and communities across the Nation.

I would like to thank everyone who has shared their expertise so generously in the preparation of such a timely and valuable document for health visiting.

It is recommended that all employers benchmark their current continuing professional development provision against these standards with the aim of commissioning training and development to meet any gaps.

Professor Lisa Bayliss-Pratt
Director of Nursing
Health Education England

Contents

1. Executive Summary

Overview

This document, commissioned by Health Education England, provides a framework for Continuing Professional Development (CPD) for Health Visitors.

The framework sets out the importance of CPD and offers a set of guiding principles that should be embedded in all post-qualifying training and development provided for health visitors. It builds on the standards set out in "A National Framework for Continuing Professional Development for Health Visitors - Standards for the High Impact Areas for Early Years (iHV, 2015)". Best practice standards are offered to promote the expected knowledge, skills and attitudes that should be achieved by health visitors to support the development of professional practice in four of the key areas identified from policy, key stakeholders and practitioners.

Health visitor provider organisations, service commissioners and education providers should review the current provision of health visitor CPD against the framework and standards. Consideration then needs to be given to future commissioning and development of high quality post-qualifying training and development to meet these standards. This should be made available for all registered health visitors in England, including those early in their career and returning to practice.

The four standards for Continuing Professional Development included in this document are seen as essential to support the delivery of the Healthy Child Programme (DH, 2009) and the health visitor service specification (NHS England, 2014).

They cover:

- Working therapeutically to effect change with children and families;
- maintaining and developing prescribing practice;
- providing and developing intelligence to inform the Joint Strategic Needs Assessment Process; and
- working in partnership with families and communities to build capacity and resilience.

Focusing CPD on these areas will support health visitors in their professional practice and maximise the impact they will have nationally on public health outcomes for children, families and communities.

Importance of Continuing Professional Development

Continuing Professional Development (CPD) is an essential component of professional practice.

"A Health Visiting Career" (DH, 2012a) highlights that completion of the Specialist Community Public Health Nursing (SCPHN) health visiting qualification is only the start of the journey for continuous learning, growth and profession. All health visitors must be enabled to access and demonstrate achievement of CPD to meet the revalidation requirements for future registration to practice (Nursing and Midwifery Council, 2011).

Contemporary evidence indicates the patient care and retention of staff is compromised if staff are not provided with access to professional education and training (Francis, 2013; Whittaker *et al*, 2013). It is essential to standardise core CPD for health visitors to ensure that children, families and communities are supported by an appropriately equipped and skilled workforce.

The Framework and Standards

This framework focuses on the core knowledge, skills and attitudes that qualified health visitors will need to support service delivery within the context of a complex and changing workplace.

It is envisaged that CPD is delivered through a continuum of levels, starting with awareness and moving to advanced or specialist practice. The standards of professional practice identified in this document focus on the level of core knowledge, skills and attitudes that all post qualified health visitors need to maintain and develop in order to retain their professional registration (NMC, 2011).

The standards have been developed through partnership and consultation with a range of stakeholders including experts in their field, practitioners, Health Education England, Provider Leads, Public Health England and Local Authorities.

Support for Health Visitors

To support health visitors at a local level, an online Directory of CPD opportunities has been developed along with a guide to completing CPD for health visitors – "Lifelong Learning in Health Visiting - Your 3 step guide to personalising your Continuing Professional Development". These two elements are specifically aimed at supporting health visitors to engage in and manage their own personal professional development activity in the same key priority areas identified in this document, in order to remain at the forefront and lead health visiting practice through continuously enhancing their own professional capabilities. These resources are available to all health visitors and can be accessed via www.ihv.org.uk.

2 - Introduction and Purpose

The Institute of Health Visiting was commissioned in 2014 by Health Education England, on behalf of the Department of Health, to develop a framework for the continuing professional development (CPD) for all registered health visitors in England.

This work aims to build on the Health Visitor Implementation Plan (HVIP) (DH, 2011) by ensuring that the workforce continues its journey of transformation, through training and education, to provide a gold standard service to children, families and communities. Following extensive consultation and careful consideration of key policy guidance, we have developed this second document which sets out a framework and a set of professional practice standards to underpin CPD for all health visitors in England.

The Health Visitor Implementation Plan (DH, 2011) has seen a rapid expansion in the health visitor workforce, with an anticipated increase of 4,200 whole time equivalents by 2015. It has been estimated that by mid-2015 around 60-70% of the health visitor workforce will have qualified since 2012. Whilst this is exciting for the profession it has brought challenges to recruitment, training, support and retention of health visitors. Over the last decade it is increasingly common to see Masters level education in health visiting. This factor, combined with the transformation of nurse education nationally, has led to a great deal of heterogeneity within the health visitor workforce. The need for robust and accessible programmes of professional development is therefore paramount.

The transfer of the commissioning of the health visiting service to Local Authorities in 2015 is a significant landmark for health visiting practice at a local level. This has the potential to provide the springboard for future development but also presents challenges in ensuring that the integrity of the universal service is maintained. A national mandate has been provided to the Local Authority commissioners outlining the core health visiting service that must be offered universally, and includes elements of the Healthy Child Programme (DH, 2009). The Department of Health High Impact Areas for Early Years (DH, 2014a) articulate the contribution of health visitors to the 0-5 agenda and describe areas where health visitors have potential for significant impact on health and wellbeing and improving outcomes for children, families and communities.

"A Health Visiting Career" (DH, 2012a) highlights that completing the Specialist Community Public Health Nursing Qualification (Health Visiting) is the starting point in the journey of professional development. It is a statutory requirement of the NMC (2011) that all practising health visitors access CPD in order to validate their continued registration. Within the context of a rapidly changing society, the health visitor needs to be equipped with contemporary knowledge and skills alongside the attitudes to effectively support children, families and communities.

This National Framework for CPD for health visitors provides a set of principles that should be embedded in all CPD - aiming to ensure that health visitors are offered targeted training and development opportunities that will support them to meet the National Health Visiting Core Service Specification (NHS England, 2014). Health visitors must be supported by their employing organisation to continue enhancing their practice in order to remain at the leading edge of their profession, through structured and meaningful personal and professional development opportunities. Any education programme developed or commissioned with the aim of supporting the CPD of health visitors must therefore endeavour to ensure that the content of the programme meets the standards and principles outlined within this framework. The How to Use Guide section of this document offers further guidance on the use of the framework and standards.

The standards for CPD for health visitors included in this document are focused on four key areas that practitioners, service leads and policy have identified as essential for the delivery of the Healthy Child Programme (DH, 2009) and the 2015/16 National Health Visiting Core Service Specification (NHS England, 2014). They cover working therapeutically with children and families to effect change; maintaining and developing prescribing practice; providing and developing intelligence to inform the Joint Strategic Needs Assessment Process; and working in partnership with families and communities to build capacity and resilience. Focusing CPD on these areas will support health visitors in their professional practice and maximise the impact they will have nationally on public health outcomes for children, families and communities. Further standards should be developed in future to continue safeguarding the access to and consistency of standard of post-qualifying education and development opportunities for health visitors nationally.

It is important to emphasise that health visitor CPD can be seen as a continuum of development with practitioners entering training at a range of levels depending on their career pathway and the specific needs of the service area that they are working in - see Figure 1. The focus of the CPD presented in this document is on the core training that all health visitors require to be effective in their roles. It is expected that if this core CPD is addressed then the health visitors will be able to raise awareness of key areas that are core to health visitor practice to other staff and partners, for example the wider health visiting team and early years workers. Reviewing the current pathways for health visitor CPD nationally highlighted that training is provided at each of these levels to varying degrees. The development of standards for these additional levels is outside the scope of this current work but there is the potential to consider expansion of the framework in the future to develop these levels in more depth.

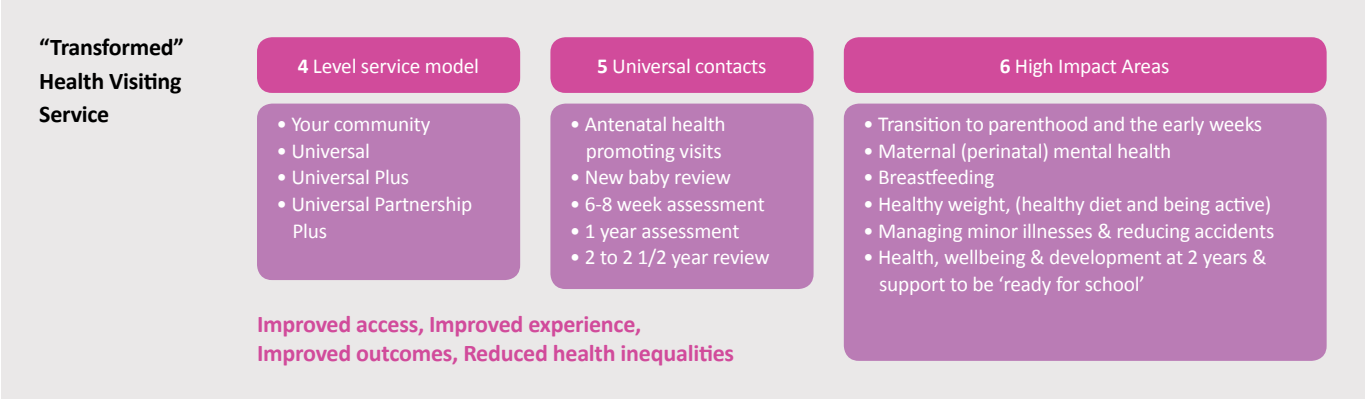
Figure 1: Platform with potential levels of CPD programmes to support the Health Visiting service

This introduction has set out the need to provide a framework of guiding principles for CPD alongside a set of specific standards for health visitor education. It is important to highlight that this builds on the work of the Education Initiative (EI) (DH, 2014b) which provides a report aimed at provider organisations and Health Education Regional Teams and outlines the need to "support workforce development to meet the new and emerging requirements of service transformation and transition of commissioning responsibilities, as well as emerging evidence on effective practice (DH 2014 b; p1). The EI report signposts the reader to a range of training opportunities that will support health visitors in achievement of their CPD and should be considered alongside this document.

It should also be emphasised that as a companion to this and the earlier National Framework for CPD for Health Visitors - Standards for the High Impact Areas for Early Years document, we have also produced an online Directory of CPD opportunities and a guide to completing CPD for health visitors – "Lifelong Learning in Health Visiting - Your 3 step guide to personalising your Continuing Professional Development". These two elements are specifically aimed at supporting health visitors to engage in and manage their own personal professional development activity in the same key priority areas, in order to remain at the forefront and lead health visiting practice through ever enhancing their own professional capabilities. The online directory aims to signpost health visitors to a wide range of CPD materials and opportunities, the provision of which is from a range of providers or freely accessible within the workplace. This includes specific iHV tools to support the development of knowledge and skills for safe prescribing and working effectively to build community capacity. It is important to emphasise that we recognise the valuable contribution of all organisations that are collectively supporting the CPD of health visitors. These resources are available to all health visitors and can be accessed via www.ihv.org.uk.

3 – The Framework for Continuing Professional Development (CPD) for Health Visitors

This section offers an overview of the current health visiting service; the rationale for the development of a national framework for CPD; a conceptual framework for CPD and key principles; and guidance on potential routes to support CPD.



The Health Visiting Service Offer

The national health visiting service in England is central to delivering the Healthy Child Programme, (HCP) (DH, 2009) with a focus on working across services for 0-5 years. Health visitors work with children, families and communities to improve public health outcomes (DH, 2014b). Closely aligned to this work is the Public Health Outcomes Framework (PHOF), the NHS Outcomes Framework and the NHS Mandate (DH, 2014c; 2014d; 2014e) which outline a range of outcomes expected to be achieved by an effective 0-5 years public health nursing team. Meeting the objectives within the PHOF and NHS Outcomes framework requires that health visitors are equipped with the broad knowledge base and contemporary skillset central to delivering the anticipated better outcomes for children and families.

The health visiting service aims to provide family focused provision. The HVIP stated that "The government believe that strong and stable families are the bedrock of a strong and stable society" (DH, 2011:p7) and incorporated a new vision of service provision, based on an ecological framework (that is, it encompasses children, families and the communities in which they live) operating according to the principles of proportionate universalism. Marmot *et al* (2010) explain that, in order to reduce health inequalities and give every child the best start in life, services need to be provided for all (universal) but be delivered in a way that is proportionate to need. Accordingly, the HVIP and the National Health Visiting Core Service Specification for health visitors 2015/16 (NHS England, 2014) have set out a series of four service descriptors: Community (strengthening local resource and cross agency working), Universal Service (for all families), Universal Plus (specific packages, interventions or support for some families according to need), and Universal Partnership Plus (intensive, multi-agency support for the most needy families); with safeguarding/child protection as a cross -cutting theme. Collectively, the descriptors are known as the service levels with a tailored offer that families can expect from their local health visiting team.

The National Health Visiting Core Service Specification 2015/16 (NHS England, 2014) clearly sets out the level of service that all children, families and communities should expect stating that the full service should be available for "any family" when they may need it. The specification focuses on the key role the health visitor has in supporting the delivery of the Healthy Child Programme (DH, 2009) and achievement of the six High Impact Areas for Early Years (DH, 2014a). To strengthen this, future commissioners of health visiting services have been mandated to ensure that a core offer of a minimum of five universal contacts are provided to all children and families (DH, 2014e). These are focused on the Healthy Child Programme and include:

- Antenatal health promoting reviews
- New baby reviews
- Six to Eight week assessments
- Nine to Twelve month assessments
- Two to Two and a half year reviews

The 4 5 6 model at the top of this page summarises the key components of the transformed health visiting service. To support the health visitor workforce to meet the challenge of further developing and delivering the full service specification, it will be essential that they are supported through access to continuous professional development.

The need for CPD

As stated NHS England (2014) has set out a 'National Heath Visiting Core Service Specification for Health Visitors 2015/16', which requires providers to pay due attention to the mobilisation of the workforce and develop a robust workforce development plan based upon the learning needs analysis of the existing workforce.

This should include:

- Staff development in building community capacity and innovation and creative health visiting practice to meet local needs.
- Access to CPD programmes which support delivery of the service specification; particularly evidenced-based assessments and interventions; as well as multi-agency learning, leadership and supervision.
- Resources allocated for the CPD requirements identified in the workforce plan and access to multi-agency training at every opportunity.
  (NHS England, 2014: p24)

The Nursing and Midwifery Council (NMC) is currently updating its PREP requirements (NMC 2011) to develop a clearer model of revalidation, which will be introduced during 2015 and will, as before, include CPD as a requirement of continued registration. To maintain their registration, health visitors are required to make a commitment to undertake continuing professional development (CPD) and to record it. This guidance is designed to support health visitors to deliver a high standard of practice and care, demonstrating that they have responded to the commitment.

Proposed Revalidation requirements (NMC, 2014)

Future CPD is anticipated to:

- Be outcomes focused (i.e. what learning is taken from the CPD activity).
- Cover at least 40 hours over the 3 year renewal period (with at least 20 hours of participatory learning).
- Incorporate written reflection on practice and CPD activity, based on the requirements of the Code, using practice-related feedback from a minimum of 5 sources (e.g. service users, patients, relatives, colleagues and others).
- Include confirmation from a third party about compliance with the revalidation requirements.

The NMC Standards for Proficiency for SCPHN (2004) set out the requirement for all practising Health Visitors to develop and expand their knowledge post-registration. These standards of proficiency are underpinned by ten key principles of public health practice (see appendix one) grouped into four 'domains' of the principles of health visiting which are: search for health needs; stimulation of awareness of health needs; influence on policies affecting health; facilitation of health-enhancing activities (Cowley & Frost, 2006).

"CPD is a requirement for continuing registration for all clinicians including health visitors (HVs). CPD consists of any educational activity which helps to maintain, develop or increase knowledge, problem-solving, technical skills or professional performance standards all with the goal that professionals can provide better health care. CPD includes 'formal' activities, e.g. courses, conferences and workshops, as well as self-directed activities such as preceptorship and directed reading".

Department of Health - Definition of CPD for Health Visitors (DH, 2014b: p1)

An evidence review by Cowley *et al* (2013) drew attention to the variety and extent of skills needed within current health visiting practice, all of which require development or maintenance through ongoing personal and professional development. A study by Whittaker *et al* (2013) has demonstrated that access to continuing professional development was an important factor in encouraging staff retention. Additionally the Munro Review (Dept of Education, 2011) underlined the importance of developing expertise and specialist knowledge to safeguard children, and placed significance on continuing professional development for all professionals. The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis, 2013) highlighted the need to safeguard the public through adequate training and support for all healthcare staff. Continuing professional development needs to be placed high on the agenda of priorities for provider organisations employing health visitors in order to respond to the findings of these in-depth reviews of healthcare practices and sustain the momentum brought about by the HVIP (DH, 2011).

Health visitors need to deliver high quality, compassionate care to achieve excellent health and wellbeing outcomes. In 2012 the Chief Nursing Officer and Director of Nursing at the Department of Health cemented this further in plans to create a culture of compassionate care (DH 2012b). Creating a vision for nurses, midwives and health visitors, they introduced the concept of the the six Cs: Care, Compassion, Competence, Communication, Courage and Commitment. These values and behaviour should lie at the heart of any health visiting practice and are therefore embedded in the framework and standards created.

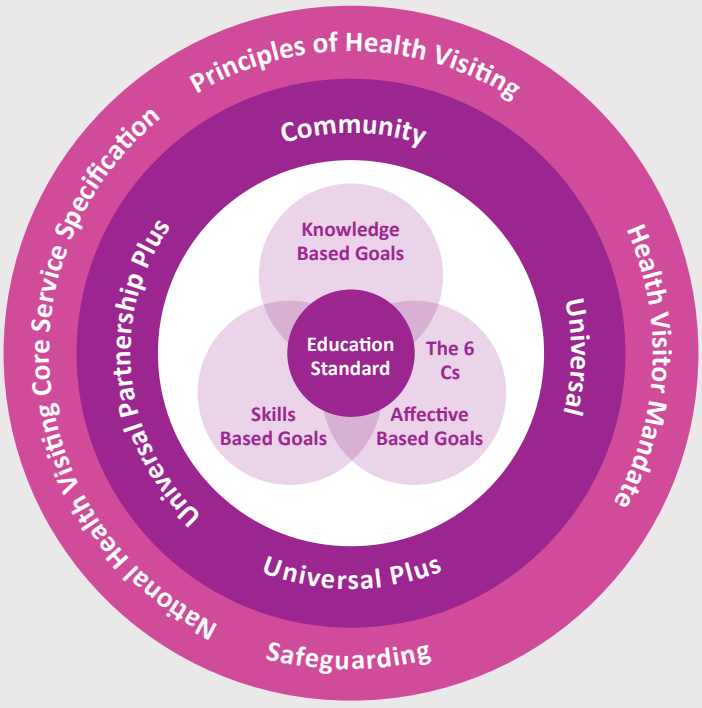
The National Framework for Continuing Professional Development for Health Visitors

This framework has been developed to support the continuing professional development (CPD) needs of all health visitors at all stages of their career.

The framework sets out what is expected to be covered in any CPD programme. The National Framework for Continuing Professional Development for Health Visitors - Standards for the High Impact Areas for Early Years (iHV, 2015) highlighted key priorities for attention. We have developed further standards for professional practice in this second document which aim to further support practice.

The framework sets out the need for all CPD to incorporate three broad categories of intended outcome. These include knowledge-based goals; skills-based goals and affective/ attitude-based goals. These have been adapted from the seminal work of Bloom *et al* (1956). The attitude-based goals have been linked to the six Cs (DH, 2012b) to support health visitors' delivery of high quality compassionate care. Additionally, we have considered these against the mandate for the service (NHS England, 2014) and the principles of health visiting. Combined, these define the standard required by health visitors to achieve competence in their role at all levels of service delivery (DH, 2011) (Community; Universal; Universal Plus; and Universal Partnership Plus). As identified in the National Heath Visiting Core Service Specification for Health Visitors 2015/16 (NHS England, 2014) safeguarding is an essential component of the role of all health visitors and therefore should be included in all CPD. Please see Figure 2 for an illustration of the conceptual framework. We have applied this framework to the development of detailed standards for the High Impact Areas highlighted by the Department of Health as priorities for attention (DH, 2014a).

Figure 2: A Conceptual Framework for CPD for Health Visitors adapted from Bloom *et al* 1956



Key Principles for all CPD

Adoption of the principles below by provider organisations (when developing or commissioning training for health visitors) will ensure that health visitors access high quality programmes of a consistent standard to support practice in order to reduce inconsistencies across England.

CPD for health visitors should:

- Include a clear rationale for the significance of the subject area in relation to current health needs, evidence base, policy agendas and professional contribution of health visiting to improved outcomes for children, families and communities
- Be applicable to nationally mandated health visiting provision. In England this is currently the four layer model of community, universal, universal plus and universal partnership plus
- Support the principles of health visiting and enhance the capabilities of health visitors, building upon the proficiencies achieved in their pre-registration health visitor education
- Indicate the knowledge, skills and attitudes that can be expected to be developed as outcomes of the CPD
- Enhance the impact, professional effectiveness, emotional resilience and career development of health visitors as leaders in practice
- Make use of recognised best practice and / or standards that may be applicable e.g. iHV programmes, UNICEF Baby Friendly
- Supports enhancement of knowledge, skills and attitudes in working inclusively and effectively with key groups at risk of health inequality in their local communities e.g. Black and Minority Ethnic families, Gypsy, Roma and Traveller and socially deprived communities, as well as considering how the service they provide meets the needs of fathers, same sex couples, parents with disabilities and parents of children with disabilities.

Provision of CPD

It is expected that provision of CPD opportunities by organisations employing health visitors will be achieved through a range of formal, informal and planned work-based learning activities which will strengthen the national contribution of health visitors to public health and wellbeing and improve the outcomes for children, families and communities. Formal opportunities for programmed learning can be enhanced and consolidated by health visitors adopting self-directed approaches to their continuing personal professional development (CPD), pursuing a range of work based activities within their practice.

Examples of the range of CPD activity are provided in Figure 3 below:

Figure 3: Range of Potential Personal Continuing Professional Development Activities

Work based learning	Informal learning	Formal learning
In-service training events	Journal reviews	Lectures/ short courses
Case studies/ critical event analysis	Online literature searches	Accredited courses or further education
Reflection on learning	Online forum membership and discussions	Online e-learning packages
Reflection on feedback from colleagues, patients, carers and service users	Accessing websites e.g. iHV	Webinars
Clinical Audit activity	Receiving web alerts e.g. ChiMAT, NICE, DH.	Writing for journals
Receiving coaching / mentoring/ supervision	Membership of virtual professional groups e.g. e-communities of practice	Research activity
Peer review	Membership of e communities of practice	Attending professional conferences
Working groups or project work	Networking at events	
Journal clubs	Reading Serious Case Review reports	
Action Learning set activity	IT skills workshops	
Mentoring/ Teaching		
Professional update meetings		
Shadowing other professionals / visiting other agencies e.g. key partners in early years practice or specialists in child health.		

4 - National Standards

The National Standards cover four key areas for professional practice.

1. Working therapeutically to effect change with children and families
2. Maintaining and developing prescribing practice
3. Providing and developing intelligence to inform the Joint Strategic Needs Assessment Process
4. Working in partnership with families and communities to build capacity and resilience

Each standard offers an introduction to the area and discusses its importance in the context of the current evidence base, national policy drivers, its significance for public health, and consequently the impact upon children, families and communities.

The standards outline the anticipated core knowledge, skills and attitudes that continuing professional development programmes should achieve. It is anticipated that the standards for each high impact area will not be met by a single "training" event. An individually tailored mix of continuing professional development activity will account for the different learning styles and levels of experience of individual health visitors. Health visitors will be able to self-assess their own learning needs against each standard thus enabling them to seek additional personalised development opportunities when gaps in the knowledge, skill or attributes are identified. The "Lifelong Learning in Health Visiting - Your 3 step guide to personalising your Continuing Professional Development" will support this process.

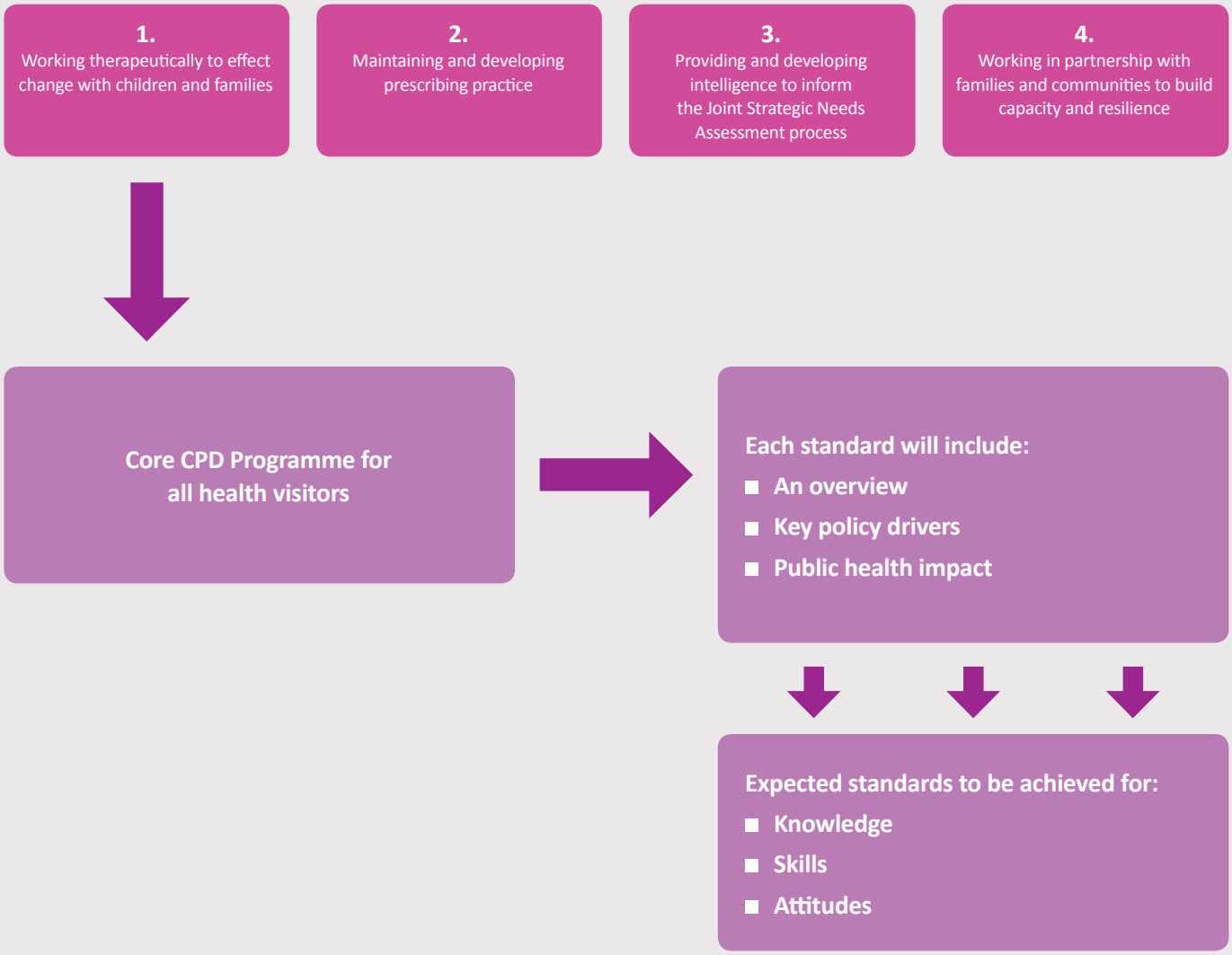
The Standards aim to enable organisations to:

- Benefit the children and families for whom they are commissioned to deliver services through the achievement of better outcomes by health visitors who are equipped and continually refreshed in terms of the knowledge and skills central to tackling health inequality.
- Benchmark their current workforce development plans and continuing professional development provision for health visitors against the standards and identify gaps and areas for development.
- Commission high quality training from appropriate providers using the content of the standards to underpin the content of that training.
- Support and develop-evidence based practice in health visiting through robust workforce development plans and the provision of high quality continuing professional development opportunities, thus contributing to the organisation meeting Care Quality Commission (CQC) standards.
- Retain health visitors and reduce attrition of their newly expanded workforce.

The standards are designed to provide robust CPD which will enable health visitors to:

- Recognise their role and responsibilities at each level of the core HV service offer.
- Articulate their contribution to the specific area of practice in terms of Public Health; Health Promotion; Prevention; Early intervention; Protection from harm.
- Enhance their capability through refreshed knowledge and skills in specific (high impact priority) areas and across health visiting practice.
- Recognise and use local data as evidence for their practice.
- Support working in partnership with early years colleagues and partners in their local area.
- Deliver an expert and inclusive service that is designed around and evidenced to meet the complex needs of parents and carers (including those with protected characteristics) in their local community.

Figure 4: Overview of the Standards



Promotion of Equality & Diversity in the standards:

Attention to the promotion of equality and diversity needs to be at the core of the development of all training courses for public sector professionals. There is an expectation that training provided for health visitors as part of their ongoing development will include consideration of the interaction between the 9 protected characteristics (Equality Act, 2010) and the standard - age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation as well as other equality factors such as social class as appropriate. Health visitors work in communities with increasingly diverse demographics and any training provision should take the local composition of the community into account to ensure that it provides the appropriate knowledge, skills and attitudes to equip the workforce to work effectively and inclusively.

Throughout the document the word “inclusive” is used to describe the manner in which health visitors work knowledgeably (through an understanding of the issues) with unconditional positive regard for all individuals, families and communities especially those who may be subject to direct or indirect discrimination or inequality.

5 - How to Use the Standards

The following table highlights how we expect the National Standards for CPD for health visitors to be used by all key stakeholders. To support this we have developed a benchmarking tool which can be found in Appendix two.

Target	Expectation	Actions required
Health Education England	To promote the use of the Standards Framework for CPD nationally and monitor their implementation.	Share standards with LETBs and consider process for organisations to provide assurance that they are meeting the standards.
Local Education and Training Board (LETB)	To work with local providers of health visiting services to benchmark current CPD provision against the standards.	To commission and coordinate CPD training against gaps to ensure local health visitors have access to CPD that meets the standards.
Health Visitor Provider Service Leads	To review current training and development plans and benchmark these against the standards. To support health visitor staff to incorporate the use of the framework and associated guide and online directory of CPD into their personal development planning. To ensure time is available to practitioners to pursue CPD in the workplace.	To produce and deliver learning and development plans that support health visitors to meet the standards. Utilise the iHV online directory of CPD for support. To disseminate the standards to all health visitors and team leads to be used during Personal Development Planning (PDP).
Local Authority Commissioners	To review the standards and ensure they are highlighted in contract negotiations.	To seek assurance from providers that they are meeting the CPD standards and have robust plans in place.
Education and Training Provider e.g. HEI or expert organisation	To review the standards in relation to any CPD programme commissioned for health visitors .	To ensure content of commissioned CPD programmes for health visitors meets the standard identified.
Health Visitors	To review the standards through reflection and self-assessment of their Personal Continuing Professional needs.	To identify gaps in knowledge and potential solutions to their line manager to agree and plan Personal Continuing Professional Development objectives. Utilise the iHV online directory of CPD and associated Guide for support.

The funding and resourcing of CPD for the health visiting workforce is a consideration for all parties and requires agreement between providers, commissioners and LETBs. The Education Initiative guidance (DH, 2014b) contains further information on the position of funding in line with the National Core Service Specification and the possibility of using Service Transformation funding where relevant.

Education Standard 1

Working therapeutically to effect change with children and families

Overview of subject:

Introduction

Making improvements to the health of all children and young people, specifically improving physical and mental health outcomes, predominates key drivers and policy-making in England with the publication of a number of key documents including the cross-party manifesto 'The Critical 1001 days' (Leadsom et al, 2013), also Wave Trust (2013); Department of Health (2010); Lansley (2012). In February 2014 (shaped by national policy), NHS England, Public Health England (PHE), Royal Colleges and Local Government organisations all signed up to an ambitious shared pledge to improve every aspect of health services from pregnancy to adolescence and beyond, furthermore placing children, families and communities at the heart of decision-making (Report of the Children and Young People's Health Forum, 2012).

Health visitors, as part of the public health workforce, need to be confident and effective in engaging and building positive relationships inclusively with all children, families and communities if they are to make a successful contribution. The Healthy Child Programme (HCP) (DH, 2009) and the Health Visitor Implementation Plan 2011-2015 (HVIP)(DH, 2011) highlight the requirement for health visiting teams to have high levels of communication in order to build strong relationships with parents early in pregnancy. Building robust relationships that are mutually respectful and therapeutic is of crucial importance in order to get to know, understand and work effectively to promote behaviour change within families. Equally in the Wave Trust report, vital health visiting skills of "establishing and maintaining a trustworthy relationship" are documented as "absolutely central to effective assessment as well as intervention" (Wave Trust, 2013; p37). This requires excellent interpersonal skills and personal qualities (e.g. emotional literacy and emotional resilience) in order to establish and maintain effective working relationships with parents and carers. Personal qualities (e.g. resilience, trustworthiness, honesty and genuineness) that are often not directly observable can have a significant influence on our professional behaviour, directly influencing our ability to engage and work within a therapeutic relationship that is both meaningful and reciprocal.

The Therapeutic Relationship

A therapeutic relationship is said to be present when the person "feels comfortable being open and honest with the nurse" (Dart, 2011) and where communication encompasses both warmth and empathy (McCabe and Timmons, 2006). Psychologist Carl Rogers (1980) highlighted important attributes of a "therapist" that contribute to a "therapeutic relationship" as genuineness, the acceptance of a person without judgement (unconditional positive regard) and empathy. In a review of the literature, Dziopa and Ahern (2009) recognise nine principles integral to the therapeutic relationship; conveying understanding and empathy, accepting individuality, providing support, being available, being genuine, promoting equality, demonstrating respect, maintaining clear boundaries and having self-awareness. Equally the ethical principles of safeguarding client's freedom of choice and action, doing good and promoting the client's welfare (Daniel and Jenkins, 2000) are fundamental in ensuring all interactions with children and families remain therapeutic.

In order to work therapeutically with children and families, the first contact is fundamental in initiating partnership working. Davis and Day (2010) define partnership working as; working together with active participation and involvement, sharing decision making,

recognising complementary expertise and roles, agreeing aims and objectives together with mutual respect, trust and open communication. Communication and problem-solving skills are also critical in enabling families to be empowered to define the outcomes they want to achieve, in building skills and resilience and in supporting success. Focusing on strengths within families (and areas of need) demands that health visitors work in partnership to identify priorities for the family, set objectives that are realistic, maintain focus in order to effect change, work through obstacles and continually review progress. More specifically to health visiting, health visitor Robyn Pound's (2003) doctoral work around 'alongsideness' (developed through 'Living Theory') distinguishes the significance of the health visiting therapeutic relationship as an essentially collaborative process incorporating connected relationships built around equality and mutual respect, beliefs, hopes, parenting styles and encouragement.

Active Listening

Active listening is often described as the "the bread and butter" of health visiting service, and essential in the development of the relationship and achieving improved health outcomes (Stickley and Freshwater, 2006; Jonas-Simpson, Mitchell *et al*, 2006; Canning *et al*, 2007). The bread and butter description suggests simplicity and disaffirms the complexity of the interaction. Active listening is part of the core foundational skill set for health visitors but is one which is continually explored, developed and finely tuned by health visitors to fit the uniqueness of each client interaction. As the starting point of effective communication, active listening encourages parents and carers to open up, explore and consider their current position, think about possible options or alternative behaviours that may be more helpful and result in change.

Studies highlight that above all, parents and carers want to be listened to by professionals who genuinely try to understand, who recognise their expertise and strengths and make children and families feel valued, respected and comfortable as opposed to judged, ashamed or belittled (Attride-Stirling *et al*, 2001; Family Policy Alliance, 2005). Kagan (2008) maintains that "people desire to be listened to more than anything else during their experiences with professionals" and that being listened to is both "freeing and healing" (Kagan, 2008: p59). Failure to maintain active listening can result in interactions where professionals are not engaged and lack understanding, leaving families "misunderstood and alienated" (Condon, 2008) with a consequent deterioration in the relationship.

Empathy

Empathy is described by Brené Brown (2013) as "feeling WITH people", cultivated by courage, compassion and connectedness, saying "Rarely does a response make something better, what makes something better is a connection". Empathic listening, the ability to listen and understand from the parent's or carer's perspective, is different to sympathy and fundamentally important to building a therapeutic relationship and effective working. The health visitor "aware of and sensitive to the feelings, thoughts and experiences of another" (Shipley, 2010: p129) must convey this understanding to the parent in order for the parent to feel heard, valued, understood and accepted, without judgement.

Demonstration of empathy arises from the ability to attend completely to the parent; focusing attention fully in order to be as receptive as possible, with the direction of gaze and facial expression to indicate concentration along with the ever-moving pattern of the face to signify emotion such as humour, surprise, confusion, anxiety and anger. The parent will recognise nonverbal cues as positive, feel valued, acknowledged and free to carry on. The relationship will continue to develop, building trust, gaining knowledge and through a shared understanding, facilitate problem-solving throughout the helping process (Davis and Day, 2010). Empathy may also be shown more directly, having very powerful and specific effects; for example, verbal statements that encapsulate the parent's and carer's experiences, thoughts and feelings will be a clear indication to them of listening and of understanding. Statements need to be:

"Simple and direct reflections of exactly what parents are saying using the same words… they may also paraphrase what has been said or they may put into words what the helper thinks the parent is showing" (Davis and Day, 2010: p130).

Empathy can be described as moving from a 'single -minded' to a 'double-minded' focus. In single -mindedness we think only of our own mind (or our own thoughts and feelings) or low empathy, whilst in double-minded focus we are keeping in mind someone else's mind at the very same time (Baron Cohen, 2011).

The challenge for health visitors with high caseload numbers, complex workloads and competing priorities is that double-minded focus requires concerted effort. High workloads can result in practitioners being less focused and attentive, and their capacity to concentrate on more difficult issues is reduced. They move from the vantage point in double-minded focus of "seeking to understand" to a single-minded focus of "listening with the intent to reply" and thereby "filtering all information through reading their own autobiography into other people's lives" (Covey, 2004: p239). Behaviours that indicate such to parents or carers will result in a withdrawal in the relationship. Conversely, if health visiting staff are able to remain in "double-minded focus", that is seek first to understand, the "psychological air" given to the parent will reap beneficial rewards in terms of the relationship being cemented (Covey, 2004).

Empathic listening is thus the key to making deposits in parents' "emotional bank accounts" a "fifth level" of listening that reinforces positive relationships (Covey, 2004) and enables a platform to support change. Covey (2004) believes that, next to physical survival, the greatest need of a human being is psychological survival; that is to be understood, affirmed, valued and appreciated. When this occurs you give the person the psychological survival they need; only then can you begin to have an influence and/or begin problem-solving and effect change.

Equality and Diversity

Health visitors are conscious of areas of difference and inequity (between individuals and groups of people) arising through unequal power or access, or through social prejudice and discrimination. However, practitioners may not always be aware that their own thinking and own assumptions can unintentionally contribute to inequalities and that their behaviour may demonstrate subtleties that are observable to parents or carers. The acronym GGRRAAACCEEESSS from the field of systemic family therapy can help practitioners to become intentionally more aware, sensitive and respectful of the differences and inequalities that exist in society (Burnham et al, 2008; Burnham, 2010). GGRRAAACCEEESSS denotes the following categories – Gender (Sexism e.g. identity or orientation), Geography, Race (Racism), Religion, Age (Age-ism), Ability (or disability), Appearance, Class, Culture, Ethnicity, Education, Employment, Sexuality, Sexual Orientation and Spirituality. Being aware of and taking time to explore the impact of such differences on lifestyles contributes to more open, honest and respectful relationships. This will promote therapeutic working and provide a platform to use strengths-based programmes to motivate behaviour change.

Drawing on an anti-discriminatory practice approach developed by Thompson (2012) within social work, combined with a recognition of attributes essential for health visiting practice (DH, 2012a), there is an opportunity to encourage health visitors to explore explicitly individuals' attitudes, actions or prejudices and their impact on behaviour. Thompson (2012) explains how discrimination is 'sewn into the fabric' of society and how the relationships between the personal, cultural and social influence our practice with people we view as different to ourselves and often socially marginalised. Encouraging deeper levels of self-examination and understanding of how beliefs and values are shaped may allow health visitors to develop more self-awareness, emotional literacy and, ultimately, confidence when supporting families in challenging situations.

There is evidence that health professionals need specific knowledge and skills to work with diversity. For example lack of knowledge and insight into people's religious beliefs or negative views about the place of religion in lives of individuals and society can have a negative impact on therapeutic relationships (Coyle and Lochner, 2011). It should not therefore be assumed that health visitors have implicit knowledge and skills to work therapeutically with everyone rather that information; advice and support is sought as required.

Promoting Behaviour Change

Recent therapeutic styles developed in health visiting focus on behaviour change through strengths-based and solution-focused approaches. Models vary in design; however current approaches include the Family Partnership Model (Davies and Day, 2010), Motivational Interviewing (Miller and Rollnick, 2012) and the Solihull Approach model (Douglas et al, 2001) amongst others. In order to work effectively to stimulate change within families, health visitors need to underpin practice with behaviour change theory that focuses on the concerns and perspectives of the client. Motivational interviewing is a client-centred approach, focused on motivation, collaboration and eliciting from individuals their own change talk (i.e. positive statements and reasons for own need to change) (Miller and Rollnick, 2012). Exploring and resolving ambivalence as part of the

change process at both pre-contemplation and contemplation stages (Prochaska and DiClemente, 1983) will enable parents and carers to think about where they want to be and where they are currently. The National Institute of Clinical Excellence (NICE) (2014) provides guidance that includes a set of generic principles that can be used as the basis for planning, delivering and evaluating public health activities, all aimed at changing health-related behaviours. In order for health visitors to be successful in supporting behaviour changes and effect positive outcomes, it is crucial that they have the opportunity to be trained in one of the evidence-based approaches and are continually supported in working to the principles while working with families.

Developing and supporting the health visitor – client relationship in practice

As already underlined, within the therapeutic relationship the focus needs to remain on the parents /carers, their ideas, experiences and feelings. Boundaries within the relationship need to be clearly defined from the outset and reviewed as the relationship develops, with challenges within it explored openly and honestly in a timely manner. Although the health visitor may take on a number of roles (e.g. teacher, health promoter, advisor, advocate, liaison, and referrer), their own needs need to be met outside the relationship. In this way the health visitor is able to work effectively with children and families to influence behaviour change and contribute to improved physical and mental health outcomes.

How health visitors needs are met and their personal resilience will vary dependent on each health visitor's autobiography and health visiting experience; but continuing professional development and restorative supervision (Wallbank, 2012; Wallbank and Hatton, 2011) has been evidenced as central to keeping health visitors resilient and preventing them from being overwhelmed by the complexity and sensitivity of the situations they are immersed in whilst working therapeutically with families. Evidence demonstrates that organisations that prioritise staff in terms of support and development have been found to perform better, patient satisfaction is improved, quality scores are stronger and outcomes improved (Boorman, 2009). Restorative clinical supervision has also demonstrated a positive impact in supporting health visitors to remain resilient, maintain focus, think more clearly and stay solution-focused in working with families (Wallbank, 2012; Wallbank and Hatton, 2011). The restorative function is one of three functions of clinical supervision (Proctor, 1986) and is distinct from broader clinical supervision, in that it gives attention to the emotional needs of the practitioner, how they have been affected by their work with families, and how to deal with them constructively. The commitment to the restorative element of supervision is underlined in the Core Service Specification to ensure that supervision is provided to health visitors "using emotionally restorative supervision techniques" (NHS England, 2014: p17).

In summary, the complexity of health visiting practice and the need to develop safe, sound therapeutic working relationships across diverse families and communities in order to effect change and improve outcomes for children demands that health visitors are equipped with specific personal attributes and continually enhanced capabilities around relationship building.

Provision of continuing professional development opportunities to further enhance their capabilities is central to supporting and developing the health visitor workforce. Further development should focus on ensuring that health visitors can access an evidence-based model of practice, alongside opportunities to refine their active and empathic listening skills, and practise strengths-based and anti -discriminatory approaches to working in partnership to effect lasting change.

Education Standard 1 - Working therapeutically to effect change with children and families

AIM:

To ensure health visitors are equipped to engage, build and develop relationships in order to work therapeutically and inclusively with children and families to achieve positive outcomes.

KEY OUTCOMES:

Health visitors:

- Have received refreshed knowledge, skills (and awareness of attitudes) that underpin development or sustain therapeutic relationships with children and families.
- Report confidence in working therapeutically with children and families to effect change.
- Know how to access information and support to work with diverse people and communities.
- Report increased job satisfaction - associated with feelings of competence in practice.
- Receive positive feedback from service users in relation to the quality of the therapeutic relationship experienced or outcomes achieved.

Education Standard 1 - Working therapeutically to effect change with children and families

KNOWLEDGE

The delivery of a continuing professional development programme must ensure that health visitors have core knowledge to be able to understand:

1. What is a therapeutic relationship and what are the essential characteristics (skills and attributes) in working therapeutically.
2. How each of the characteristics are translated and portrayed through health visitor's own behaviours with children and families.
3. The importance of empathy, genuineness and respect in building and sustaining a therapeutic relationship and in working therapeutically.
4. The value of self-reflexivity (or critical reflection upon their own assumptions and attitudes; and how these may be illustrated in their behaviours).
5. Awareness of equality and diversity issues including the interaction of the health visitor's and the client's gender, race, religion, age, ability, culture, class, ethnicity, education, sexuality, spirituality on the therapeutic relationship especially around issues of power (GRRAACCEESS).
6. How to gain knowledge and understanding of the beliefs and values of diverse clients.
7. When and if to undertake self-disclosure; sharing life experiences may facilitate the therapeutic relationship as sharing experiences enables mothers/fathers to see the health visitor as a real person and equalises the power in the relationship.
8. Theories and models of behaviour change to facilitate effective health promotion messages and changes in behaviour.
9. The evidence base for strength-based approaches e.g. Solihull and Motivational Interviewing.
10. The importance of the restorative element of clinical supervision in maintaining focus, remaining solution focused and identifying own learning needs through the processing of feelings and emotions (related to work) that potentially overshadow the development of the therapeutic relationship.
11. Methods of measuring outcomes achieved and gain user feedback whilst building the therapeutic relationship, using validated tools.

Education Standard 1 - Working therapeutically to effect change with children and families

SKILLS

The delivery of a continuing professional development programme must ensure that health visitors have core skills enabling them to:

1. Build a robust therapeutic relationship with all children and families and work in partnership towards agreed and explicit goals to effect change.
2. Recognise behaviours and factors that may positively or negatively impact the therapeutic relationship, including the impact of equality and diversity elements within the relationship (GRRAACCEESS).
3. Actively listen to parents/carers reflecting their thoughts and feelings as well as summarising important events and feelings conveyed in the interaction.
4. Demonstrate the ability to understand and identify with another person's experiences – empathy without judgement.
5. Demonstrate a questioning style that maximises the amount of relevant information that is gathered in an assessment undertaken in partnership with the parents or carers.
6. Facilitate effective behaviour change through well-evidenced strength-based approaches such as Solihull and Motivational Interviewing.
7. Challenge parental resistance to positive ideas and solutions whilst recognising strengths and areas of progress.
8. Accurately self-assess their own interpersonal skills and seek feedback regarding own development.
9. Continually refine and review the critical elements of the therapeutic relationship in order to ensure partnership and a continuing effective working relationship, using restorative supervision to explore feelings about working therapeutically with families.
10. Measure the effectiveness of their interventions, the outcomes achieved and gain user feedback whilst building the therapeutic relationship using recognised tools, e.g Patient Reported Outcome Measures (PROM's), Recorded Outcome Measures (ROM's), paying attention to equality data and outcomes achieved with seldom heard populations.

Education Standard 1 - Working therapeutically to effect change with children and families

ATTITUDES

The delivery of a continuing professional development programme must ensure that health visitors work in and promote a culture of compassionate care (DH, 2012b), enabling them to demonstrate:

1. **Care** that conveys observable behaviours of openness, respect and genuineness to support the development of the therapeutic relationship.

2. **Compassion** that is embedded in the promotion of equality and diversity through understanding of individuality in all children, families and communities, including (but not exclusively) those with protected characteristics.

3. **Competence** in remaining focused and purposeful in problem solving throughout the helping process, building upon children and parents/carers skills and resilience to meet agreed outcomes.

4. **Communication** skills to engage and build inclusive therapeutic relationships with all parents and carers, including those with communication support needs e.g. those arising through language difference, sensory impairment or learning disability.

5. **Courage** to refine their self-reflexivity, questioning what they know or believe about the interaction of their own gender, race, religion, age, ability, culture, class, ethnicity, education, sexuality, spirituality on the therapeutic relationship.

6. **Commitment** to own personal continuing professional development, seeking and using feedback from clients, peers and managers to inform their practice, and using clinical supervision to explore attributes and feelings that enhance or interrupt the development of the therapeutic relationship.

RECOMMENDED LEARNING ACTIVITY:

The completion of formal programmes underpinned by evidence-based models that address in-depth communication and the skills and attributes required to work therapeutically with children and families. This training should incorporate therapeutic working with diverse families.

Workshop-style participative group training programmes (e.g. videoing and peer review/feedback mechanisms) are particularly valuable for this subject as they are likely to be effective in reviewing attributes and delivering the skills required. Participants benefit from a richer experience when learning is undertaken with colleagues as a result of sharing of valuable practice experience and insights.

Action learning sets and opportunities to practise key skills with colleagues on an ongoing basis (e.g. using motivational interviewing techniques) are central to embedding, practising and refining communication skills.

Development of therapeutic working techniques should be combined with the provision of restorative supervision (to review the resourcing of the professional and process the emotions attached) when undertaking complex client work in order to maintain safe therapeutic relationships.

PERSONAL CONTINUING PROFESSIONAL DEVELOPMENT:

As well as attending CPD opportunities provided by the employing organisation, health visitors are encouraged to further enhance their development, personalising it through completion of additional self-directed informal learning activities.

Examples are given below, however the opportunities are endless and should be explored individually by health visitors:

- Shadow a Family Nurse during a contact with young parents to explore communication and observe skills and attributes when working therapeutically with children and families. Note in detail the recognition of complementary expertise and strengths-based approaches.
- Seek opportunities in local statutory and 3rd sector organisations to observe experienced and skilled professionals working with children and families where change is apparent and evidenced. Reflect upon the skills observed and create a plan for your own development to explore further.
- Seek regular and sustained clinical supervision to ensure the opportunity and time to reflect and critically explore the quality of therapeutic relationships with families in practice and how this impacts upon achieving better outcomes.

For further information see www.ihv.org.uk to access the Online CPD Directory and guide to CPD "Lifelong Learning in Health Visiting - Your 3 step guide to personalising your Continuing Professional Development".

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References for Education Standard 1

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Attride-Stirling, J., Davis, H., Markless, G., Sclare, I., Day, C. (2001) "Someone to talk to who'll listen": Addressing the psychosocial needs of children and families. *Journal of Community and Applied Social Psychology*. Vol. 11, 179-191.

Baron-Cohen, S. (2011) *Zero Degrees of Empathy: A new theory of human cruelty*. London: Allen Lane.

Boorman, S. (2009) *NHS Health and Well-being: final report.* London: Department of Health.

Brown, B. (2013) *The Power of Empathy* video, RSA shorts. Available at: **bit.ly/1zTBkL4** (accessed 19.1.15).

Burnham, J., Alvis Palma, D., Whitehouse, L. (2008) Learning as a context for differences and differences as a context for learning. *Journal of Family Therapy*. Vol. 30, 529–542.

Burnham, J. (2011) Developments in Social GRRRAAACCEEESSS: visible-invisible and voiced-unvoiced. In: Krause, I.B., ed. *Culture and Reflexivity in Systemic Psychotherapy: Mutual Perspectives*. London: Karnac, 139-160.

Canning, D., Rosenberg, J.P., Yates, P. (2007) Therapeutic relationships in specialist palliative care. *International Journal of Palliative Nursing*. 13 (5), 222–9.

Condon, B. (2008) Feeling Misunderstood: A Concept Analysis. *Nursing Forum*. 43 (4), 177-190.

Covey, S. (2004) *The Seven Habits of Highly Effective People*. New York: Free Press.

Coyle, A., Lochner, J. (2011) Religion, spirituality and therapeutic practice. *The Psychologist*. Vol 24, 264-266. Available from: **bit.ly/1A9I6j5** (accessed 4.2.15)

Dart, A.M., (2011) *Motivational Interviewing in Nursing Practice: Empowering the Patient*. London: Jones and Bartlett.

Daniels, D., Jenkins, P. (2000) *Therapy with Children: Children's Rights, Confidentiality and the Law.* London: Sage.

Davis, H., Day, C. (2010) *Working in Partnership with Parents: The Family Partnership Model.* London: Pearson Education.

Department of Health (2012a) *Personal and professional attributes for consideration as part of the recruitment and selection process into health visiting programmes*. Available from: **bit.ly/1EWexTe**. (accessed 9.1.15).

Department of Health (2012b) *Developing the Culture of Compassionate Care: Creating a New Vision for Nurses Midwives and Health Care Staff*. Available from: **bit.ly/1r7BZCy** (accessed 15.11.14).

Department of Health (2011) *Health Visitor implementation plan*. Available from: **bit.ly/1vhgpNS** (accessed 9.1.15).

Department of Health (2010) *Healthy Lives Healthy People: Our Strategy for Public Health England*. Available from: **bit.ly/1z5fim1** (accessed 10.1.15).

Department of Health (2009) *Healthy Child Programme – Pregnancy and the first five years of life*. Available from: **bit.ly/1uD55hQ** (accessed 10.1.15).

Douglas, H. and Ginty, M. (2001) The Solihull Approach: changes in health visiting practice. *Community Practitioner*. (74) 6, 222-224.

Dziopa, F., Ahern, K. (2009) What makes a quality therapeutic relationship in psychiatric/mental health nursing: a review of the research literature. *Journal of Advanced Nursing Practice*. Vol.10, 1–19.

Family Policy Alliance (2005) *Parent Participation: Improving Services for Children and Families*. London: Parentline Plus.

Jonas-Simpson, C.M., Mitchell, G.J., Fischer, A., Jones, G., Linscott, J. (2006) The experience of being listened to: a qualitative study of older adults in long term care settings: *Journal of Gerontological Nursing*. (32) 1, 46-53.

Kagan, P. (2008) Feeling Listened to: A Lived Experience of Human - becoming. *Nursing Science Quarterly: January 2008*. (21) 1, 59-67.

Lansley, A. (2012) Making mental health services more effective and accessible, In: *Giving all children a healthy start in life, National Health Service and Public Health*. London: Department of Health.

Leadsom, A., Field, F., Burstow, P., Lucas, C. (2013) *The Critical 1001 Days: The Importance of the Conception to Age Two Period – A Cross Party Manifesto*. Available from: **bit.ly/1vCPZMo** (accessed 19.1.15).

McCabe, C., Timmons, F. (2006) *Communication Skills for Nursing Practice*. Basingstoke: Palgrave Macmillan.

Miller, W., Rollnick, S. (2012) *Motivational Interviewing: Helping people change* (3rd ed). New York: Guilford Press.

National institute for Health and Clinical Excellence (2014) Behaviour Change: individual approaches. Available from: **bit.ly/16NBPvQ** (accessed 10.1.15).

NHS England (2014) 2015-2016 National Health Visiting Core Service Specification. Available from: **bit.ly/1qDcEWe** (accessed 10.1.15).

Pound, R. (2003) How can I improve my health visiting support of parenting? The creation of an alongside epistemology through action enquiry. PhD Thesis (unpublished), University of the West of England, Bristol. Available from: **bit.ly/1CeFpKH** (accessed 19.1.15).

Prochaska, J., DiClemente, C. (1983) Stages and Processes of Self-Change in Smoking: Towards an Integrative Model of Change. [online] *Journal of Consulting and Clinical Psychology.* Vol. 5, 390-395.

Proctor, B. (1986) Supervision: A co-operative exercise in accountability in Marken, A. and Payne, M. (eds) *Enabling and Ensuring: Supervision in Practice*. Leicester: National Youth Bureau/Council for Education and Training in Youth and Community Work.

Rogers, C. R. (1959) A theory of therapy, personality and interpersonal relationships, as developed in the client -centered framework. In S. Koch (Ed.), *Psychology: A study of science*. Vol. 3, 210-211; 184-256). New York: McGraw Hill.

Report of the Children and Young Peoples Outcomes Forum (2012) Children and Young People's Health Outcomes Strategy (online) Available from: **bit.ly/1DfCCSX** (accessed 09/01/15).

Shipley, S. (2010) Listening: A Concept Analysis. *Nursing Forum*. (45) 2, 125-134.

Stickley, T., Freshwater, D. (2006) The Art of Listening in the Therapeutic Relationship. *Mental Health Practice*. (9) 5, 12-18.

Thompson, N. (2012) Anti-Discriminatory Practice. *Equality, Diversity and Social Justice*. Basingstoke: Palgrave Macmillan.

Wallbank, S., Hatton, S. (2011) Reducing burnout and stress: the effectiveness of clinical supervision. *Community Practitioner.* (84) 7, 31-35.

Wallbank, S. (2012) Health visitors' needs – national perspectives from the Restorative Clinical Supervision Programme. *Community Practitioner*. (85) 4, 29-32.

Wave Trust (2013) *Conception to age 2: the age of opportunity*. Available from: **bit.ly/1DN99hS** (accessed 19.1.15).

Education Standard 2
Maintaining and developing prescribing practice.

Overview of subject:

The importance of Non-Medical Prescribing for Health Visiting

The health visiting profession has a key role in improving healthcare choices, childhood health promotion, and self-efficacy in relation to minor illnesses. The 2015/16 National Core Service Specification for Health Visiting (NHS England, 2014) highlights the importance of health visitor prescribing practice. The ability to prescribe will support the health visitor to deliver the high impact area of 'Managing Minor Illness and Reducing Accidents' (DH, 2014) not only from the point of view of managing symptoms but also from knowledge of medication that enhances advice and support. It is essential for the health visitor to be equipped to support parents and carers to know what to do when their child is ill, but also to understand when this may be linked to unintentional injury.

Nurse prescribing has a number of benefits from increased compliance to reduced hospital and GP attendances. Health visitors' contact with families enables them to respond to common health concerns, discuss treatment options and the wider management of conditions, and then potentially to prescribe as part of a holistic approach (NHS England, 2014). All health visitors are expected to have completed a prescribing qualification within the first two years of practice if this has not been achieved during their training (NHS, England, 2014).

Non-Medical Prescribing

The inclusive term of Non-Medical Prescribing (NMP) is now widely used to represent all Nurse, Pharmacist, and Allied Health Professional (AHP) undertaking prescribing activity despite professional bodies still referring to specific named titles relating to NMP (Nursing and Midwifery Council (NMC), 2006; Royal Pharmaceutical Society of Great Britain (RPSGB), 2006; Health and Care Professions Council (HCPC), 2013). Furthermore the Department of Health (DH) continues to differentiate between prescribers (DH, 2006a; 2006b; Department of Health, Social Services and Public Safety (DHSSPS), 2006; Scottish Executive Health Department (SEHD), 2006; Welsh Assembly Government, 2007; NHS Scotland, 2009). The individual titles offered to prescribers are part of the broader context of prescribing by health professionals who are not doctors or dentists and it is essential that all NMPs understand this merging of terms.

Considerable consultation was undertaken to develop NMP but it was the demands of Primary Care which resulted in the initial prescribing legislation following the Cumberlege Report (Department of Health and Social Security, 1986) with the ultimate development, of the

Crown Report in 1989, recommending that district nurses and health visitors were to be authorised, following appropriate training, to prescribe from the NPF (DH, 1989). Health visitors have embraced NMP development, which remains a core element for the majority of SCPHN courses in England and a recordable qualification recognised by the NMC.

There are five key principles relating to NMP from the Crown Report (1989) and, when comparing these to current policy and guidance, they remain the backbone of safe prescribing;

- Patient safety
- Effective use of resources
- Skills and competencies of the health professional
- Changes in clinical practice
- Public expectations

The complex nature of prescribing was articulated by the National Prescribing Centre (NPC) offering seven principles of good prescribing as a framework (NPC, 1999). Regardless of not being updated since, they remain a foundation of safe prescribing in the context of evolving demands of practice. Prescribers can utilise the principles to build, develop and maintain competency and continued professional development (CPD) (DH, 2006a; DH, 2006b; DHSSPS, 2006; NMC, 2006; NPC, 2006).

The public health focus of current healthcare provision clearly reflects the demand to meet the needs of the population, and the role of the health visitor is integral (Nuttall, 2008). On an individual level, the prescriber's responsibilities lie within the process and strategy of the prescribing decision. Key aspects for consideration are;

- Informed consent
- Capacity
- Assessment
- Diagnosis
- Concordance
- Pharmacological knowledge
- Record keeping
- Review

Safety is of paramount importance and, within each aspect identified, the ability to maintain and develop practice is an essential component for the health visitor role. Communication is the key to any consultation but within the health visitor role this is more complex given the age range and diversity of individuals consulting, the parental/ carer influence, consideration of the capacity to understand, confidentiality, and the influence of social implications. Working together is a fundamental aspect of safeguarding (The Department for Children, Schools and Families, 2010) and in the role of prescriber; the health visitor is in an exceptional position to consider vigilance, action and above all safe practice.

Importance of CPD for safe prescribing practice

Maintaining competence within NMP demands a mix of knowledge, skills and attitude. Enabling a health visitor to assess and review their prescribing performance is key to long-term prescribing development. The development of competencies relating to prescribing enables individuals to improve their effectiveness and is seen as a significant development within NMP (NPC, 2007b).

There are several aspects which frequently raise concerns relating to the professional development of NMP:

- Numeracy skills
- Prescribing errors
- Lack of demand for prescribing
- Support for NMP
- Support for sign-off mentor
- Prescribing CPD

Clinical supervision enables practitioners to develop and expand their knowledge base. This enhances clinical decision-making coupled with growing confidence relating to prescribing decisions. Hacking and Taylor (2010) suggest that work place support and clinical supervision are paramount in maintaining prescribing competence but care needs to be taken to ensure that supervision reflects best practice.

Within the prescribing role, appraisal can be rewarding and thought provoking. McKay (2007) suggests that 78% of prescribers would value appraisal of their prescribing ability, and that this process could improve and develop practice. A recent survey by the iHV in 2015 of over seven hundred health visitors in England revealed that whilst 95% of respondents were recorded nurse prescribers only 65% are actively prescribing. Respondents reported a lack of confidence, and when asked, 65% respondents said they would value tools and resources to support their prescribing practice. This is a fundamental consideration for practice and one which has the potential to enable development of prescribing skills whilst also ensuring adequate support and educational pathways.

The development of this education standard for health visitors aims to support providers to consider the CPD needs of their health visitors at their annual updates and develop programmes that meet their specific knowledge skills and attitudes required for safe prescribing practice. This presents an ideal opportunity to re-energise health visitors' interest and confidence in their prescribing practice; recognising their unique contribution to the High Impact Area for Managing Minor Illness and Reducing Accidents (DH, 2014) and to reducing health inequalities and improving outcomes for children and families through the use of their prescribing skills.

Education Standard 2 - Maintaining and developing prescribing practice

AIM:

To ensure health visitors refresh and enhance the knowledge base and skills necessary to evidence the adherence to NMC (2006) Standards; and recognise the significance of their prescribing competence in supporting the Early Years High Impact Areas (DH, 2014) and the delivery of holistic care to improve health outcomes for children and families.

KEY OUTCOMES:

Health visitors:

- Report confidence in their prescribing practice knowledge and skills.
- Can articulate how their prescribing activity contributes to reducing health inequalities and improving health outcomes for children and families in their community.
- Can draw on and use the latest policy and evidence to support their prescribing assessment.
- Can overcome structural barriers to community prescribing practice in health visiting locally through solution-focused thinking.

Education Standard 2 - Maintaining and developing prescribing practice

KNOWLEDGE

The delivery of a continuing professional development programme must ensure that health visitors have core knowledge to be able to understand:

1. The legislation (including any subsequent legislative changes) underpinning prescribing rights, and the professional frameworks (NMC, 2006) impacting on prescribing activity.
2. The legal and professional perspective of capacity and consent and its influence on the prescribing process.
3. The significance of the prescribing assessment process for the quality of clinical advice-giving and how community prescribing supports the delivery of the Early Years High Impact Areas (DH, 2014a).
4. The pathophysiology, signs and symptoms of common minor illness and the evidence base supporting management of common conditions being prescribed for (e.g. current NICE guidance – including management of fever, constipation, eczema).
5. The pharmacological actions of products within their prescribing sphere of practice (NPF) and risks of over or under-prescribing, as well as issues relating to poly-morbidity and polypharmacy (including the effects of products on other medication that the patient may be taking and vice-versa).
6. How to access up-to-date information about relevant products in the NPF (e.g. formulations, pack sizes, storage conditions, costs) and their prescribing responsibilities with regard to license and off license drugs within their prescribing sphere of practice.
7. The impact of religious and personal beliefs on product choice (e.g. the inclusion of alcohol and animal products in some preparations).
8. The use and risks of over-the-counter medicines, herbal and home remedies including any allergies and the potential for misuse of medicines by patients and carers.
9. The risk of adverse drug events and how to detect and report suspected adverse drug reactions.
10. Numeracy and its significance for dosage calculations.
11. Prescribing as part of a multidisciplinary team and the common barriers to health visitor prescribing (including ways of overcoming these).
12. How to write a prescription in accordance with legal requirements, including subsequent documentation requirements to satisfy NMC (2009) Recordkeeping and organisational guidelines.

Education Standard 2 - Maintaining and developing prescribing practice

SKILLS

The delivery of a continuing professional development programme must ensure that health visitors have core skills enabling them to:

1. Take a history to ensure an accurate diagnosis is achieved (including a comprehensive prescribed and over-the -counter medication history and any allergies.); acknowledging the impact of religious or personal preferences in choice of medicines and respecting the patient's values, beliefs and expectations about medicines.
2. Use a consistent decision-making strategy covering assessment, diagnosis, and accurate selection of an appropriate prescribing strategy or referral.
3. Select (following assessment and diagnosis) an appropriate product and dosing regimen from the Nurse Prescribing Formulary (NPF).
4. Explain the rationale behind and the potential risks and benefits of management options.
5. Achieve patient concordance in relation to the prescribed product through understanding the range of barriers to concordance (including ways of trying to overcome them) and routinely assessing adherence in a non-judgemental way.
6. Ensure that the effectiveness of treatment and potential unwanted effects are monitored.
7. Prioritise and undertake appropriate and timely review of the individual for whom prescribing was undertaken.
8. Makes changes to the treatment plan in light of ongoing monitoring of the patient's condition and preferences.
9. Communicate efficiently and effectively in relation to the prescribing decision with necessary health care professionals, including information about any medicines and what they are being used for when sharing or transferring prescribing responsibilities/information.
10. Use numeracy skills to calculate safe, efficient dosage and quantity of medicine when prescribing.
11. Value their prescribing knowledge and assessment skills, being aware of how they contribute to improving health outcomes and to delivering the Early Years High Impact Areas (DH,2014a).

Education Standard 2 - Maintaining and developing prescribing practice

ATTITUDES

The delivery of a continuing professional development programme must ensure that health visitors work in and promote a culture of compassionate care (DH, 2012), enabling them to demonstrate:

1. **Care** that contributes to the delivery of the Healthy Child Programme and the reduction of health inequalities, improving access to treatment for vulnerable groups (e.g. families living in temporary accommodation) through assessment and prescribing in the community.

2. **Compassion** that ensures families engaging with the health visiting service are supported sensitively in relation to concordance issues and management of medicines.

3. **Competence** to offer safe prescribing within the health visitor's scope of professional practice, through robust prescribing assessment and review processes that reflect evidence-based practice.

4. **Communication** skills which enable an effective consultation leading to partnership, choices, and above all safe prescribing. This applies to both verbal and written information and particularly those with communication disabilities and people with little or no English language.

5. **Courage** to identify the limitation of their practice, prescribing knowledge and experience and when to refer to another clinician.

6. **Commitment** to maintain and develop prescribing practice, the drive to use skills effectively and appropriately to improve health outcomes for children, families and carers, and direct the use of healthcare services by parents.

RECOMMENDED LEARNING ACTIVITY:

An interactive e-learning programme would potentially address many of the knowledge aspects of the specification or reinforce key messages after a workshop/training event. This could include numeracy, pathophysiology and signs and symptoms of common childhood illness and some of the legislation.

Participative face-to-face and group training programmes (workshop style) are likely to be more effective in delivering the skills required. Participants benefit from a richer experience when learning is undertaken with colleagues as a result of sharing of valuable practice experience and insights.

Annual action learning sets would offer a constructive way of embedding of knowledge and principles of prescribing, affording opportunities to review changes to NPF and discuss common assessment issues and prescribing experiences.

PERSONAL CONTINUING PROFESSIONAL DEVELOPMENT:

As well as attending CPD opportunities provided by the employing organisation, health visitors are encouraged to further enhance their development, personalising it through completion of additional self-directed informal learning activities.

Examples are given below however the opportunities are endless and should be explored individually by health visitors:

- Read the article below - consider the potential for health visitor prescribing to contribute to the care of children with the most common presenting illnesses and record your reflections.

  Sands, R., Shanmugavadivel D, Stephenson T, Wood D (2012) Medical problems presenting to paediatric emergency departments: 10 years on. *Emerg Med J.* 29 (5): 379-82.

- Choose a product that you currently commonly recommend for use, e.g. Ibuprofen or Nystatin. Refer to the Nurse Prescribing Formulary and Clinical Knowledge Summaries (NICE) to review the indications for use, side effects, cautions and contra-indications in infants and children. Record new insights, how it may change your prescribing practice and any alternatives available.
- Shadow other prescribers in your local community e.g. pharmacist, specialist nurses, general practitioners.
- Observe a specialist nurse-led paediatric Dermatology clinic. Discuss the latest evidence supporting advice around skin care of infants, over-the-counter and prescribable products. Record your new insights and the implications for your practice as a non-medical prescriber in health visiting practice.

For further information see www.ihv.org.uk to access the Online CPD Directory and guide to CPD "Lifelong Learning in Health Visiting - Your 3 step guide to personalising your Continuing Professional Development".

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- **Gillian Maw** - Programme Leader (Non-Medical Prescribing), Northumbria University.
- **Penny Franklin** - Associate Professor (Senior Lecturer) in Health Studies (Prescribing), University of Plymouth.
- **Peter Gibson** – Pharmacist, Bolton.

References for Education Standard 2
Maintaining and developing prescribing practice

Department of Health (2006a), *Improving Patients' Access to medicines: A guide to implementing nurse and pharmacist independent prescribing within the NHS in England*. London: The Stationary Office.

Department of Health (2006b) *Medicines Matters*. London: The Stationary Office.

Department of Health, Social Services and Public Safety (2006) *Improving Patients' Access to Medicine: A guide to implementing nurse and pharmacist independent prescribing within the HPSS in Northern Ireland*. London: The Stationary Office.

Department of Health (2012) *Developing the Culture of Compassionate Care: Creating a new vision for nurses, Midwives, and health Care staff*. London: The Stationary Office.

Department of Health (2014a) *Overview of the six early year's high impact areas*. Available from: **bit.ly/1BWLxui** (accessed 15.11.14)

Hacking, S., Taylor, J. (2010) *An Evaluation of the Scope and practice of the Non-Medical Prescribing in the North West*. University of Central Lancashire.

Health and Care Professional Council (2013) *Standards of Conduct. Performance, and Ethics*. London: HCPC.

McKay, C. (2007) Supporting and developing non-medical prescribing. *Nurse Prescriber*. Vol. 5, 263-267.

National Prescribing Centre (2006) *Maintaining Competency in Prescribing: an outline framework to help pharmacist prescribers*. Liverpool: NPC.

National Prescribing Centre (2007) *Scoping Study of Supplementary Prescribing*. Liverpool: NPC.

NHS England (2014) *National Health Visiting Core Service Specification 2015/2016*. Available from: **bit.ly/1qDcEWe** (accessed 15.11.14).

Nursing and Midwifery Council (2009) *Record keeping: Guidance for nurses and midwives*. Available from: **bit.ly/1BZeTbH** (last accessed 6.3.15).

Nursing and Midwifery Council (2006) *Standards of Proficiency for Nurses and Midwife Prescribers*. London: NMC.

Nuttall, D. (2008) Introducing Public Health to Prescribing Practice. *Nurse Prescribing*. Vol 6, 299-305.

Royal Pharmaceutical Society of Great Britain (2006) *Outline Curriculum for Training Programmes to Prepare Pharmacist Prescribers*. London: RPSGB.

Scottish Executive Health Department (2006) *Guidance for Nurse Independent Prescribers and for Community Practitioner Nurse Prescribers in Scotland*. Edinburgh: SEHD.

Welsh Assembly Government (2007) *Non-Medical Prescribing in Wales: A guide for implementation*. Cardiff: Welsh Assembly Government.

Education Standard 3

Providing and developing intelligence to inform the Joint Strategic Needs Assessment process

Overview of subject:

Why it is important for health visiting

Joint Strategic Needs Assessments (JSNA) were introduced in 2007, with the aim to provide a comprehensive analysis of local current and future needs for adults and children to inform the commissioning process. The purpose of the JSNA is to lead to better health and wellbeing outcomes and help address persistent health inequalities. Data collated includes a wide range of quantitative and qualitative data, including user and community views. More recently, the focus for the JSNA has shifted to include and build upon the assets identified within a population, as well as needs, to inform commissioning (DH, 2013).

The National Health Visiting Core Service Specification 2015/16 recognises the role of health visitors in:

"Providing and developing intelligence about communities' assets in partnership with communities to support the health and wellbeing of 0-5 year olds, to inform the Joint Strategic Needs Assessment (JSNA)" (NHS England, 2014: p13).

The service specification identifies that, in their role as Specialist Community Public Health Nurses, health visitors should use the benchmarked child health outcome framework indicators for 0-5s to form a basis for setting shared priorities for action and contributing to the JSNA.

Health visitors now need to enhance their capabilities, engaging with and establishing pathways in their provider organisations to inform the JSNA's and commissioning picture via agreed routes as part of the collaborative approach to meeting health need at a local level. There are opportunities to community asset map and to collate, aggregate and analyse the individual identified health needs in the population they serve to identify health inequalities and improve health outcomes. The analysis of data is supported by various tools provided by Public Health England (available from: bit.ly/1zMz3Td).

What data should a JSNA include?

Gathering data in one place is just one part of the overall JSNA process; analysing it to build intelligence, inform priorities and drive change is essential. The JSNA process may include the following data:

- Population-level data – e.g. total growth, migration, birth, gender, age and ethnicity.
- Social and place data – e.g. housing quality, environment, employment, educational attainment, benefit uptake, vulnerable groups, crime and disorder and community cohesion.
- Lifestyle determinants of health – e.g. rates of exercise, smoking, diet, alcohol use and drug abuse.
- Health inequalities data
- Epidemiology – e.g. morbidity, mortality, life expectancy, long-term conditions, disease prevalence, immunisation uptake rates, service access and utilisation – for example emergency admissions, vulnerable groups receiving care, primary care data, discharge information, screening uptake, transport, children's centres and welfare rights.
- Evidence of effectiveness – e.g. commentary on good practice, literature reviews and National Institute for Health and Clinical Excellence (NICE) guidelines and quality standards.
- Community perspectives – e.g. the views, expectations, perceptions and experiences of service users and local communities about what contributes to good health. A range of methods should be available to gather community perspectives.

Information from health visitors, along with the voluntary sector, qualitative sources (such as user feedback via local Healthwatch), service providers, and the private sector is crucial to the ability of a JSNA to provide an objective assessment of needs and priorities.

Governance of the JSNA process
Health and Wellbeing Boards

Health and Wellbeing Boards are statutory bodies present in each local authority. The Board evaluates priorities in order to maximise investment across a locality through the review of a Joint Strategic Needs Assessment (JSNA), which provides single needs assessment for all services. The Board consists of the major commissioners of public services (including local government, Public Health, the NHS (commissioners and providers) and local Healthwatch) working together to secure the health and wellbeing services which best meet needs, improve outcomes and are most important to local people.

Joint Health and Wellbeing Strategy

Priorities are defined within a local Health and Wellbeing Strategy, outlining the key areas for collective action. The JSNA is used as the basis upon which to negotiate and agree these overarching priorities on health and wellbeing, helping to determine which services should be invested in or disinvested for the best value to the public purse.

Central to the development of the Health and Wellbeing Strategy is the principle that demand is not the same as need. Data on the use of services is helpful, but building an objective picture of needs rather than demand is fundamental to ensuring that the right people get the right services, at the right time and in the right place. Health visiting knowledge of the public health of communities can contribute to this objective picture of need through the aggregation and analysis of data that they collect through their interventions with families.

The health visiting role in needs assessment

Although the role of the health visitor has evolved from improving sanitation and reducing the spread of infectious diseases, their fundamental role continues to improve child and family health, build family resilience and support parents ensuring their children have improved health and wellbeing outcomes. To address the determinants of health, the identification of health need at an individual and community level has always been a core element of the health visitor role. The four contemporary principles of health visiting were first published in 1977 (CETHV, 1977) and although they have been revisited several times since (Cowley & Frost, 2006) they continue to underpin health visiting training and practice. These principles remain:

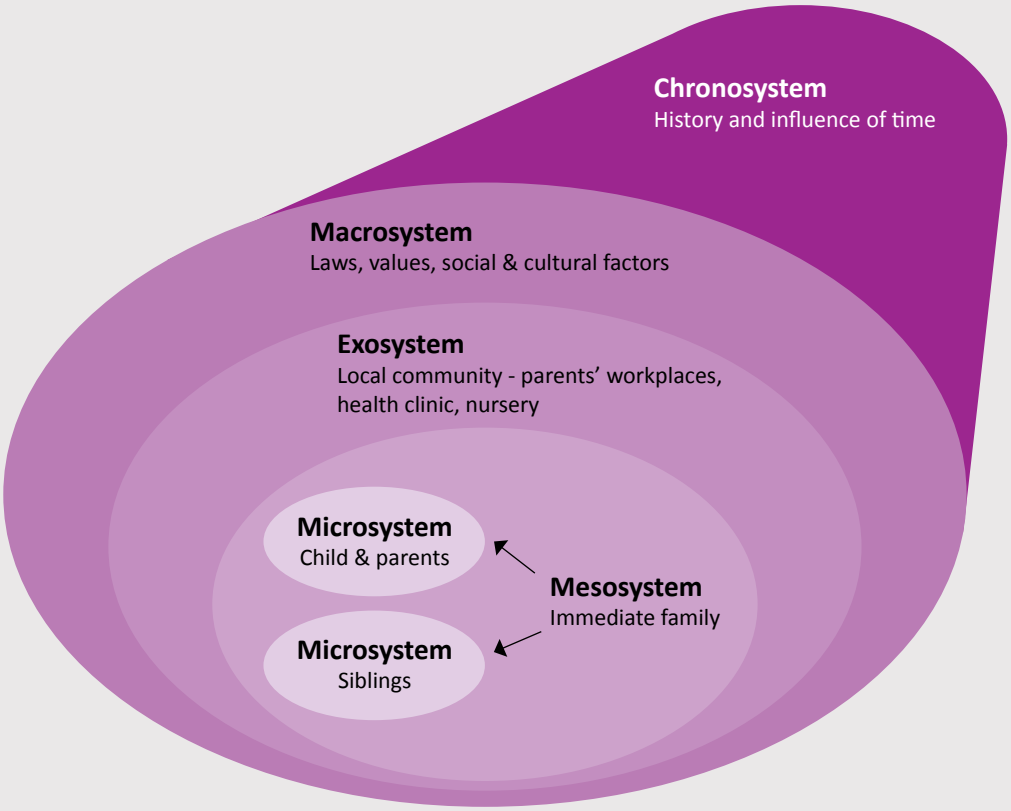
- Search for health needs.
- Stimulation of an awareness of health needs.
- Influence policies affecting health.
- Facilitate health-enhancing activities.

Today, health visiting continues its public health preventative role, focused on improving health outcomes and reducing inequalities in children, families and communities through partnerships and integrated working. The ability to carry out local health needs assessment is a core element of all health visitors' pre-registration training (NMC, 2004). It supports the development of a picture of the local needs and allows the health visitor to consider service provision that is responsive.

The Marmot Review (2010) highlights the need for all professionals to consider the wider determinants of health using local data and intelligence to inform service delivery and development across the life course. As the priority of Marmot to address health inequalities across the life course, health visitors can contribute to this important agenda by informing the JNSA and carrying out a local health needs assessment.

Bronfenbrenner's (1979) ecological model of health is frequently used within the clinical field of child and family health as a means of understanding how influences from each of these spheres have an impact on a family's health experience and health expectations.

Diagram of Bronfenbrenner's theory of ecological development



Reproduced with permission (Underdown, A. (2007) Young Children's Health & Wellbeing. Maidenhead: OU Press.

Within Bronfenbrenner's model the child and parents are at the centre of several concentric circles, which – moving from the inner to the outer circle – represent the immediate family home, the extended family, the neighbourhood or community, and the greater social world (Underdown, 2006). Health visitors enjoy a privileged position in their access to families and communities, directly witnessing their health needs and challenges. They are skilled public health practitioners and able to consider each of the layers within the ecological model and synthesise the intelligence gathered to support collective assessment of need in its broadest sense.

Brigham (2012), in a study to understand how health visitors situated their practice in the context of national policy drivers, highlights the crucial role of health visitors in supporting co-ordinated and integrated services for children and families that is tailored to local needs. She compares their knowledge of the local community to that of a taxi driver's knowledge of streets. This knowledge of the intricacies of a population is essential for effective working with the local communities to meet needs. Health visitors can use the information that they identify in assessing need in each family, aggregating these individual health needs to form a picture of health need at population level. The challenge is how to support health visitors to value and share this local intelligence and to seek formalised agreed routes to inform the JSNA.

How health visitors can support delivery of high quality health care

Husselbee (2014) identified five key messages to ensure the quality of commissioned services. Health visitors can support the commissioning of quality services through embedding the messages in their practice and communicating the findings:

- **Listen to voice of patient/service user** - The service user's voice is crucial to commissioning. The wealth of qualitative data health visitors collect in the delivery of care to clients is immense but lacks a reporting structure. Health visitors are in the unique position to work with every family with a child under five years within a given population and act as advocates for their families. They can support raising awareness of health need in populations e.g. the seldom-heard populations such as Gypsy, Roma and traveller families, learning disabled or disabled parents and fathers as primary carers of children.
- **Triangulate data and intelligence** - Health visitors have knowledge of epidemiology and can triangulate data and intelligence at population level to inform the commissioning process. There is a wealth of statistical data available to public health but 'soft' qualitative data is less readily available. Health visitors are in a unique position of knowing every family within a given population, as well as working in partnership with statutory and voluntary services locally. They can therefore provide qualitative evidence (in relation to reducing health inequalities) as intelligence via routes agreed within their provider organisations.
- **Make use of levers available** – Working with communities and identifying the strengths and contribution that the community can make allows health visitors to identify levers that remain hidden to others. This asset-based approach can empower the communities within which they work and support individual and community aspirations.
- **Walk the service and look and see** – Commissioners need to understand the communities and populations for whom they commission services. Health visitors are in an excellent position to assist commissioners to 'walk the service' and to improve their understanding of the reality of data for some diverse groups within a population e.g homeless families, Black, Asian and Minority Ethnic families, and children and families living in poverty.
- **Share concerns and take action** – Health visitors not only share the concerns of families and communities but can also empower them to voice and address these. They are also able to highlight the resilience that communities own to find solutions and can also seek to ensure that solutions-based programmes are supported and commissioned to help families and communities.

In summary, health visitors have a significant contribution to make in providing local intelligence to inform the JSNA about population health need, in ensuring their activity delivers on outcomes to meet that need, and in influencing future investment decisions by building and communicating proposals for delivery of services designed to reduce health inequalities at individual, family and community level. Robust continuing professional development will ensure that health visitors recognise the value of their public health skills and knowledge and have the confidence to engage in the JSNA to support commissioning of current and future services, raising awareness and marketing the unique contribution of health visiting to improving outcomes for children, families and communities.

Education Standard 3 – Providing and developing intelligence to inform the Joint Strategic Needs Assessment process

Key policy drivers

- NHS England (2014) 2015/2016 National Health Visiting Core Service Specification. Available from: bit.ly/1qDcEWe (accessed 12.1.15).
- Department of Health (2014) Early Years High Impact Areas. Available from: bit.ly/1vBT7Gf (accessed 12.1.15).
- Early Years Profiles – Available from: bit.ly/1ApDILr (accessed 12.1.15).
- Department of Health (2014) Guide to the Early Years Profiles. Available from: bit.ly/1tnfZDA (accessed 12.1.15).
- Department of Health (2014) Public Health Outcomes Framework: improving outcomes and supporting transparency 2013-2016. Available from: bit.ly/1E31iwF (accessed 12.1.15).
- Department of Health (2014) NHS Outcomes Framework 2015/16. Available from: bit.ly/1Cjv25U (accessed 12.1.15).
- NHS England (2014) NHS Public Health functions agreement 2015-16. Available from: bit.ly/1KLHQbG (accessed 12.1.15).
- Department of Health (2013) Healthy Lives, Healthy People: our strategy for public health in England. Available from: bit.ly/1z5fim1 (accessed 12.1.15).

Education Standard 3 – Providing and developing intelligence to inform the Joint Strategic Needs Assessment process

AIM:

To ensure that health visitors are equipped with the knowledge, skills and attitudes that will promote collaborative working in identifying health needs, evidencing outcomes and influencing commissioning decisions with the aim of reducing health inequalities.

KEY OUTCOMES:

Health visitors are:

- Aware of any agreed local routes for engagement and sharing key information with their commissioners or explore these with relevant personnel within their provider organisation.
- Seen to contribute key information on health needs analysis to the local Joint Strategic Needs Assessment (JSNA) through advocacy of their clients' needs by representing the voice of the service user.
- Able to provide and develop intelligence on community assets for in order to support an asset-based approach to needs assessment for the JSNA.
- Observed to demonstrate visionary public health leadership through identifying hidden health needs and working partnership to address these.
- Able to respond to and support delivery of the Joint Health and Wellbeing Strategy working collaboratively with a range of key stakeholders e.g. Early Years services, 5-19 services, Family Nurse Partnership services, GPs, 3rd sector and voluntary sector providers to ensure outcomes are delivered.

The JSNA is valued by health visitors as an opportunity:

- To base their practice on local health inequalities in collaboration with other agencies and partners.
- To provide structured local intelligence to inform the commissioning of services to improve public health outcomes.

Education Standard 3 – Providing and developing intelligence to inform the Joint Strategic Needs Assessment process

KNOWLEDGE

The delivery of a continuing professional development programme must ensure that health visitors have core knowledge to be able to understand:

1. The distribution and determinants of health-related states (epidemiology) and its function to support identification of health need at individual and population level.
2. The wider determinants of health and the impact on health inequalities within their community of practice.
3. Health and social inequalities related to people and communities who have protected characteristics, experience socio-economic deprivation and children in care.
4. The evidence base underpinning better health outcomes.
5. The importance of data collection (including equality data) and service user feedback in measuring outcomes and informing the development of inclusive services for all parents and carers.
6. The policy drivers that underpin the JSNA process and how it informs the Joint Health and Wellbeing Strategy.
7. Current policy drivers that inform health visiting practice and other public health related and children's services at a national level.
8. The structures and systems to support the provision of information to the Local Authorities to inform the JSNA process.
9. How to access local data using Public Health tools, accurate analysis of data and its application to practice.
10. The significance of the tacit knowledge that health visitors have about communities and local health needs and the value of this knowledge to inform the JSNA.

Education Standard 3 – Providing and developing intelligence to inform the Joint Strategic Needs Assessment process

SKILLS

The delivery of a continuing professional development programme must ensure that health visitors have core skills enabling them to:

1. Collect and collate routine surveillance data, alongside epidemiological information and intelligence from their health visiting community of practice.

2. Analyse the data to provide a comprehensive picture of the local health needs including unmet health needs and persistence of health inequality; including those in seldom-heard populations and those experiencing health inequalities.

3. Translate this data into a format for use by the JSNA as agreed locally and to inform their local service delivery.

4. Articulate the tacit knowledge of communities and local health needs and to be able to communicate this in a meaningful way to inform the JSNA.

5. Advocate the health needs of disadvantaged populations; exploiting available communication channels to raise awareness of unmet needs and those seldom-heard communities at increased risk of disadvantage.

6. Market the unique contribution of health visitors as Specialist Community Public Health Nurses, voicing the value of their interventions in terms of cost/ benefits and universal reach to improve health outcomes.

Education Standard 3 – Providing and developing intelligence to inform the Joint Strategic Needs Assessment process

ATTITUDES

The delivery of a continuing professional development programme must ensure that health visitors work in and promote a culture of compassionate care (DH, 2012), enabling them to demonstrate:

1. **Care** that is uniquely tailored to the needs of each child and family, available to all children and families universally through the Healthy Child Programme, and gathers data that can inform the JSNA, reduce inequalities and promote health and wellbeing in a population.

2. **Compassion** that recognises and advocates the needs of those most vulnerable to poor health and wellbeing outcomes e.g. those with protected characteristics and those living in poverty.

3. **Competence** to collect, analyse and contribute data that will influence the allocation of local resources to meet health needs identified in their community.

4. **Communication** that confidently and effectively presents information about unmet health needs based on factual information unhindered by emotion.

5. **Courage** to reflect on practice and consider areas of development to support the service to meet identified or hidden health needs.

6. **Commitment** to developing collaborative working, forming robust partnerships with other relevant local services; influencing other agencies to improve and protect the health and wellbeing of children, families and communities.

RECOMMENDED LEARNING ACTIVITY:

An interactive e-learning programme could address many of the knowledge aspects of the standard specified or reinforce key messages after a workshop/training event.

Participative group training programmes (workshop style) are likely to be more effective in delivering the skills required. Participants benefit from a richer experience when learning is undertaken alongside colleagues from partner agencies e.g. 3rd sector organisations supporting seldom-heard populations in the community - sharing valuable practice experience and insights.

Action learning sets are helpful in embedding new knowledge, skills or attitudes into practice; giving time to participants to develop skills in thinking about and influencing commissioning issues e.g. Completing local needs assessment activities in collaboration with other relevant services e.g. children's centres, to jointly analyse health priorities and highlight prioritisation for service provision.

PERSONAL CONTINUING PROFESSIONAL DEVELOPMENT:

As well as attending CPD opportunities provided by the employing organisation health visitors are encouraged to further enhance their development, personalising it through completion of additional self-directed informal learning activities. Examples are given below however the opportunities are endless and should be explored individually by health visitors:

1. Read the "Preparing a needs assessment" guidance (PHE, 2014) and plan to undertake a local needs assessment for your community:
   - Create an action plan listing activities to undertake and resources to access with a timeline for completion.
   - Consider the small area data you need and how you may be able to access this. Note what data you already have access to.
   - Reflect upon whose support or collaboration may enhance completion of the needs assessment. How do you plan to engage their support and by when?
2. Identify your Local Authority commissioner; ask to shadow them (with necessary consents from your organisation so as to avoid duplication) in order to understand the breadth, complexity and demands of their role and market the health visiting service and how it contributes improvements in outcomes for children and families.
3. Visit the Public Health England Data Gateway (bit.ly/1zMz3Td) and access the range of tools and information available online:
   - Review the Children and Young People's Health Benchmarking Tool and reflect on the significance of the data available at Local Authority and CCG level for the Public Health Outcomes Framework and the NHS Outcomes Framework respectively.
   - Consider how you will use the information you have gathered to inform your practice and work with the local community. Whose support do you need and what actions are required of you as a public health leader?

For further information see www.ihv.org.uk to access the Online CPD Directory and guide to CPD "Lifelong Learning in Health Visiting - Your 3 step guide to personalising your Continuing Professional Development".

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- **Jane Johnson** – Public Health Commissioning Manager, NHS England Cumbria Northumberland Tyne and Wear
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References for Education Standard 3

Providing and developing intelligence to inform the Joint Strategic Needs Assessment process

Brigham, L. (2012) Leading in practice: a case study of how health visitors share and develop good practice. Community Practitioner, (85) 5, 25-29.

Bronfenbrenner, U. (1979) The Ecology of Human Development: Experiments by Nature and Design. Cambridge, MA: Harvard University Press.

Council for the Education and Training of Health Visitors (1977) An investigation into the principles of health visiting. London: CETHV.

Cowley, S., Frost, M. (2006) The Principles of Health Visiting: opening the doors to public health practice in the 21st century. London: Amicus.

Department of Health/ Department of Education (2014) Giving all children a healthy start in life. Available from: **bit.ly/1AsQo4s** (accessed 12.1.15).

Department of Health (2013) Guidance-on-Joint-Strategic-Needs-Assessments-and-Joint-Health-and-Wellbeing -Strategies- Available from **bit.ly/16Whftz** (accessed 1.2. 15)

Department of Health (2011) Health Visitor Implementation Plan 2011-15: A Call to Action. Available from: **bit.ly/16WhhBR** (accessed 12.1.15).

Department of Health (2013) The functions of clinical commissioning groups. Available from: **bit.ly/1Ed9Fpc** (accessed 12.1.15).

Department of Health (2013) Healthy Lives, Healthy People: our strategy for public health in England. Available from: **bit.ly/1z5fim1** (accessed 12.1.15)

Department of Health (2014) Guide to the Early Years Profiles. Available from: **bit.ly/1tnfZDA** (accessed 12.1.15).

Department of Health (2014) Early Years High Impact Areas. Available from: **bit.ly/1vBT7Gf** (accessed 12.1.15).

Dowling, B. (2000) GP's and Purchasing in the NHS : the internal market and beyond. Aldershot: Ashgate.

Hussellbee P (2014) Commissioning for Quality: Views from Commissioners NHS England website. Available from: **bit.ly/1IYqdYA** (accessed 10.1.15).

Le Grand, J., Mays, N., Mulligan, J.A. eds. (1998) Learning from the NHS Internal market: A Review of the Evidence. London: Kings Fund.

NAPC (2010) The Essential guide to GP Commissioning. United Health UK. Available from: **bit.ly/1F0oTlg** (accessed 10.1.15).

NHS England (2014) 2015/2016 National Health Visiting Core Service Specification. Available from: **bit.ly/1qDcEWe** (accessed 12.1.15).

NHS England NHS Commissioning Website **www.england.nhs.uk**

Nursing and Midwifery Council (2004) Standards and Proficiently for Specialist Community Public Health Nurses. Available from:: **bit.ly/16VQuFk** (accessed on 10.2.15).

NICE (2014) Health Visiting. LGB22. Available from: **bit.ly/166M4eZ** (accessed 12.1.15).

Marmot, M (2013) Fair Society, Healthy Life's. Available from : **bit.ly/11NaPer** (accessed 13.2.15).

Public Health England (20 14) Preparing a needs assessment: guidance for health visiting students. Available from: **bit.ly/1z9Jqg0** (accessed 12.1.15).

Public Health England gateway tools available from: **bit.ly/1zMz3Td** (accessed 29.1.15).

Yorkshire and the Humber Joint Improvement Partnership: Developing intelligent commissioning. Available from: **bit.ly/1EdbnXq** (accessed 4.1.15). www.healthwatch.co.uk

Education Standard 4

Working in partnership with families and communities to build capacity and resilience

Introduction

Over the last decade the focus of health visiting practice has moved increasingly away from community development to individual work with children and families due to capacity and the different models of commissioning NHS services.

An important element of the Health Visitor Implementation Plan 2011-15 (DH, 2011) and the refreshed service model is the development of the Community level of the family offer, reaffirming health visitors as key professionals in public health delivery with a plan to "update and develop community public health and Big Society competencies" (DH, 2011: p30). The intention of the plan was that, with increased capacity in the service, there would be the prospect of health visitors accessing the Building Community Capacity web-based module to refresh their skills and promote capacity building to enable families and communities to build on their strengths in the development of new ways for providing services. The module sees health visitors work with individuals, groups and the wider community to use their own skills and strengths to enhance health and wellbeing through a specific piece of project work. The National Health Visiting Core Service Specification 2015/16 recognises the role of health visitors in:

"Leading, with local partners, in developing, empowering and sustaining families and communities' resilience to support the health and wellbeing of their 0-5 year olds by working with local communities and agencies to improve family and community capacity". (NHS England, 2014: p12)

The principles that health visitors have espoused for more than three decades are:

- Search for health needs
- Stimulation of awareness of health needs
- Influence on policies affecting health
- Facilitation of health-enhancing activities

(CETHV, 1977; Twinn and Cowley, 1992; Cowley and Frost, 2006)

These principles are central to Community level practice for their potential to reduce health inequalities by advocating, building self-efficacy and promoting community resilience. Health visitors work with groups and specific populations and bridge across or steer the complex networks of people who support children, families and communities in order to achieve the best possible health outcomes through two competences. Firstly, using their public health expertise, they are able to identify health needs at a community level and use this intelligence to support partnership working at a strategic level with commissioners (see Education Standard – Providing and developing intelligence to inform the Joint Strategic Needs Assessment Process (JSNA). Furthermore, their universal presence in communities offers them the opportunity to engage and work in partnership with individuals, groups and organisations at community level; both aspects seeking the same improved outcomes for children, families and communities.

Community development

Community development work has a longer history overseas than in UK settings. Eade (1997) looks at examples in developing countries and makes it clear that building community capacity is more than just delivering competences or weight of investment but is also linked to impacting upon social and economic outcomes. Communities will be motivated to work with professional's when their perceived needs are addressed. Some community development work was based upon the professional's assessment of need rather than that expressed by the population. This was therefore professionally led, with a focus on the imparting of health knowledge around a specific topic, with the community as the medium or setting for the intervention. Many of the interventions may have aligned with communities' perceived needs but some undoubtedly did not. There is a risk that experienced health visitors make assumptions about their skillset in community development work and continue to consider development of the Community level of the service from

a "top down" perspective. Refreshing and updating of knowledge, skills and attitudes is essential to ensure that the workforce is consistently equipped to meet communities where they are.

Florin and Wandersman (1990) discuss models of citizen participation and empowerment, and examine how these affect who participates, why some organisations are more successful in community development, and the overall effects of development. Additionally, Foster-Fishman *et al* (2001) suggest that collaborative capacity is built around four levels – individual (member), relational, organisational (effective leadership and management of a coalition) and programme (the capacity to design and implement programmes impacting upon the community). Health visitors need to enhance their capabilities through understanding the difference in models of community development. This will develop the Community level of the service and maintain a "bottom up" agenda aligning with aspirations of the community members in line with capacity-building approaches, as this will influence both success and sustainability. It will also ensure that seldom -heard populations and those at risk of health inequality e.g. placed asylum seekers or refugee's needs are advocated and are offered an opportunity to build their own resilience and self-efficacy, with health visitors working in partnership, as enablers and facilitators, in a coalition with other community partners.

Building Community Capacity

Building Community Capacity (BCC) is essentially a health assets model reflecting the aspirations of 'Big Society' thinking. Skinner (2006) defines community capacity building as:

'Activities, resources and support that strengthen the skills, abilities and confidence of people and community groups to take effective action and leading roles in the development of communities.'

Building Community Capacity can be seen as a broad process taking many forms "from working with individuals to working with a large number of individuals within the community" bit.ly/1zxi3vn.

Building Community Capacity projects focus upon drawing out and strengthening the skills and knowledge of people to not only influence their health and wellbeing needs but that of others as well. This requires a different kind of leadership from practitioners. In order for schemes to remain community-led the health visitor role is one of enabler or connector and a catalyst in the process. Key skills include the health visitor's recognition and enlistment of 'social capital' in families and communities. Social capital (Putnam, 2000) is usually understood as built upon networks and relationships, defined as "the good-will that is engendered by the fabric of social relations and that can be mobilized to facilitate action" (Adler and Kwon 2002). Gilchrist (2009) describes networking and relationships as essential components for effective community development.

Engagement of health visitors in Building Community Capacity

In an analysis of the outcomes of the nationally commissioned Building Community Capacity programme (bit.ly/1zxi3vn), Pearson (2013) highlighted some of the success factors for successful projects arising through the web-supported programme, including organisational leadership, clear commitment and investment. Some of the issues faced included the relatively restricted timescale placed on the projects within the programme and organisational demands, which meant some projects were building staff or organisational capacity rather than community capacity. Pearson (2013) reinforces that a key consideration for the future is to ensure that projects retain the right focus; i.e. that they aim and are evidenced to make a difference to health and wellbeing outcomes in their local communities.

A survey of practising health visitors by the Institute of Health Visiting completed in January 2015 offers a snapshot of current practice and confidence. Responses indicated that, whilst 71% of those who took part had completed Building Community Capacity (BCC) development (either as part of the SCPHN, the e-learning module or a masterclass delivered locally), only 35% reported that they were actively engaged in BCC projects in their community. Approximately half of the respondents reported feeling uncertain about their skills and knowledge around BCC. Other reasons given for the lack of engagement was lack of time and capacity in the service.

Many of the findings of this survey are underpinned by findings in a review of the literature by Cowley *et al* (2013), who cited discussion papers around engagement of health visitors in community development work. Although many of the studies cited pre-date the Call to Action and the focus on Building Community Capacity, it is interesting to see that many of the issues and attitudes highlighted still persist. Carr (2005), cited in Cowley *et al* (2013), underlined the view that the delivery of community-based activities is perceived as peripheral to core practice, with health visitors prioritising individual casework. Additionally Forester (2004), cited in Cowley

et al (2013), highlighted the challenge of simultaneously managing a caseload and community development responsibilities. The transition of caseloads to reflect communities around Children's Centre reach areas rather than GP practice lists could have eased this view of conflicting or separate responsibilities but the Community level of the service offer remains the least well developed aspect.

It is clear that, whilst the health visiting workforce has the potential to undertake this role, many have continued to be overwhelmed by large workloads due to caseload sizes and mentoring of students during the Call to Action period. Few have therefore been able to sustain the necessary skills or maintain or update their knowledge. There also appears to be an issue with confidence levels and capacity in the workforce as well as commitment from organisations to activity which may not be clearly reportable with Key Performance Indicators identified.

In summary health visitors require confidence to extend or renew their capabilities around building community capacity, taking advantage of social capital and resilience present in families and communities, and using the model for the development of the Community level of the service. Development is also needed to enable health visitors to frame and market community-based activity in terms of cost and benefits (i.e. how it will reduce demand at other levels of the health visiting service or contribute additional value to the Healthy Child Programme and other key objectives). Work -based approaches to developing capacity-building knowledge and skills that are embedded across a whole service are desirable, along with a clear commitment in organisations to prioritise the development of this level of the service.

Examples of successful Building Community Capacity examples that have been published include:

- Grant, R. (2005) 'Micro' public health - the reality. *Community Practitioner*.78 (5), 178-182.
- Harrison, C., Parker, P. et al. (2005) Stepping Stones: parenting skills in the community. *Community Practitioner*. 78 (2), 58-61.
- Stuteley, H. (2002) The Beacon Project - a community-based health improvement project. *British Journal of General Practice*. H52, 44-45.

Education Standard 4 – Working in partnership with families and communities to build capacity and resilience

AIM:

To ensure that health visitors are equipped with the knowledge, skills and attitudes that will promote capacity building and collaborative working alongside families and communities with the aim of reducing health inequalities.

KEY OUTCOMES:

Health visitors:

- Have received refreshed capabilities to support capacity-building work with families and communities and report confidence in working in the Building Community Capacity model.
- Are skilled and confident in working effectively to reduce health inequality through Community level work in partnership with 3rd sector groups and other partner agencies.
- Know how to access information and support to work effectively with diverse people and communities.
- Can frame their Community level activity in terms of how it contributes to key elements of the Healthy Child Programme.
- Can market their capacity-building interventions in the community as contributing to specific key organisational objectives.

Education Standard 4 – Working in partnership with families and communities to build capacity and resilience

KNOWLEDGE

The delivery of a continuing professional development programme must ensure that health visitors have core knowledge to be able to understand:

1. How to identify the aspirations of groups and communities through involvement in or links with regular sustained engagement.
2. How to easily access and interpret local and national data and information about local populations and priorities including diverse people and community.
3. How to consider and meet the needs of people with protected characteristics, within each development.
4. How to demonstrate the connection between capacity building in communities and specific organisational objectives.
5. How to identify the internal and external systems and people of influence in the success of community capacity building.
6. How to find out about other community empowerment initiatives and their effectiveness in a community.
7. The potential inputs of people, groups and communities and voluntary and statutory organisations present within a community (i.e. Social capital).
8. How capacity building is impacted by the nature of the community, its population and the presence or absence of other voluntary or 3rd sector agencies.
9. The role of enabler or facilitator (rather than leader) as a key element of capacity building.
10. The importance of strategic thinking and collaboration in order to ensure approaches are joined up to avoid confusion and duplication.
11. The components of a business case and their value in highlighting the costs/ benefits of anticipated outcomes and any additional outcomes.
12. The elements of project planning and management (i.e. timelines or Gantt charts) and their value in ensuring that momentum is sustained and objectives achieved.
13. The presence of funding sources locally and the underpinning bidding processes to support communities in accessing project funds.
14. The importance of data collection (including equality data) and service user feedback in measuring outcomes and informing the development of inclusive services for all parents and carers.

Education Standard 4 – Working in partnership with families and communities to build capacity and resilience

SKILLS

The delivery of a continuing professional development programme must ensure that health visitors have core skills enabling them to:

1. Work with and engage groups and communities (including those seldom-heard populations e.g. homeless families) about their aspirations; seeking information and support from people who work with those who have protected characteristics as required.

2. Scope the aspirations and needs of a community and convert these to deliverable objectives, assisting in the planning of steps required.

3. Recognise 'social capital'; the potential inputs (to delivering initiatives that will improve health outcomes) of people, groups and communities within a population, acting as a bridge or guide to develop, empower and sustain their engagement.

4. Seek out opportunities to collaborate with any individuals, groups and communities on projects that may already have been initiated.

5. Select, in collaboration with the community, what their role as a health visitor should be in the project (e.g. enabler, facilitator); on which aspects and for how long.

6. Work in partnership with community members to support the bidding process to access project funds.

7. Enable the development of identified objectives for BCC initiatives by facilitating or securing other inputs required (i.e. financial investment or expert support).

8. Identify in partnership with the community what success will look like to them e.g. what are their success criteria or social value benefits?

9. Identify suitable outcome measures to demonstrate improvements in health and wellbeing outcomes resulting from the BCC initiative and how these link to the Healthy Child Programme or key organisational objectives.

10. Sustain community relationships and partnerships over the medium to longer term i.e. longer than the time-limited scope of an identified project or initiative.

11. Collect, collate and analyse data that demonstrates unmet health needs and persistence of health inequality, especially those in seldom-heard populations and vulnerable groups e.g. homeless families.

12. Market the unique contribution of health visitors as Specialist Community Public Health Nurses, voicing their capabilities to engage in and support capacity building or community-led initiatives.

Education Standard 4 – Working in partnership with families and communities to build capacity and resilience

ATTITUDES

The delivery of a continuing professional development programme must ensure that health visitors work in and promote a culture of compassionate care (DH, 2012), enabling them to demonstrate:

1. **Care** that is community-led; evidenced in terms of positive outcome measures (e.g. micro-population health gain in some communities), and in positive feedback from families, groups and communities.

2. **Compassion** to seek out and engage individuals, families, groups and communities considered to be harder to engage or traditionally seldom heard (e.g. Gypsy, Roma or Traveller families), being sympathetic to and respectful of attitudes, views and ways of living that are different from their own.

3. **Competence** to utilise social capital; to enable individuals to be empowered; to influence, improve and protect the health and wellbeing of children, families and communities.

4. **Communication** that supports robust networking and relationships as essential components for effective community development; and the championing of communities and reduction in inequalities.

5. **Courage** to develop own capabilities in capacity building with families and communities, seeking and using feedback from clients, peers and managers to inform their practice, and utilise clinical supervision opportunities to explore areas for further development.

6. **Commitment** to developing community working and the Community level of the health visiting service in their area, forming robust partnerships with individuals, families, groups and communities in their population.

RECOMMENDED LEARNING ACTIVITY:

An interactive e-learning programme could address many of the knowledge aspects of the standard specified or reinforce key messages after a workshop/training event.

Participative group training programmes (workshop style) are likely to be more effective in delivering the skills required. Participants benefit from a richer experience when learning is undertaken alongside colleagues from partner agencies e.g. 3rd sector organisations supporting seldom-heard populations in the community - sharing valuable practice experience and insights.

Work-based approaches embedded across organisations are desirable. Action learning sets are helpful in embedding new knowledge, skills or attitudes into practice; giving time to participants to develop skills in working as enablers and facilitators rather than leaders in communities.

PERSONAL CONTINUING PROFESSIONAL DEVELOPMENT:

As well as attending CPD opportunities provided by the employing organisation, health visitors are encouraged to further enhance their development, personalising it through completion of additional self-directed informal learning activities. Examples are given below however the opportunities are endless and should be explored individually by health visitors:

- Visit a local community project and explore how it was initiated, who was involved and what outcomes have been achieved. Reflect upon any learning shared and on how this may influence your practice in approaching community-based initiatives.
- Find your local council for voluntary services and arrange a visit to learn more about the community development sector and the current challenges they face. Consider and record what this means for your health visiting practice and how you can work with your local community or voluntary organisations.
- Reflect upon some of the social determinants of health prevalent in the community in which you work e.g quality of housing stock, access to work and income, levels of social cohesion and exposure to crime and violence. Identify and record how a capacity-building approach could be shown to contribute to aspects of the Healthy Child Programme or other organisational objectives. What might be a first step to initiating a capacity-building approach to working with the population to address these issues?
- Review Joint Service Needs Assessments and key websites for people with protected characteristics. For example Stonewall in relation to lesbian gay and bisexual people; IHAL for people with a learning disability.

For further information see www.ihv.org.uk to access the Online CPD Directory and guide to CPD “Lifelong Learning in Health Visiting - Your 3 step guide to personalising your Continuing Professional Development”.

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References for Education Standard 4

Working in partnership with families and communities to build capacity and resilience

Adler, P., Kwon, S.W., (2002) Social Capital: Prospects for a New Concept. *Academy of management review*. 27 (1), 17-40.

Council for the Education and Training of Health Visitors (CETHV) (1977) *An Investigation Into The Principles Of Health Visiting*. London: CETHV.

Cowley, S., Whittaker, K., Grigulis, A., Malone, M. et al (2013) *Why Health Visiting? A review of the literature about the key HV interventions, processes and outcomes for children and families*. London: National Nursing Research Unit.

Cowley, S., Frost, M. (2006) *The Principles of Health Visiting: Opening the Door to Public Health Practice in the 21st Century*. London: CPHVA.

Department of Health (2012) *Developing the Culture of Compassionate Care: Creating a New Vision for Nurses Midwives and Health Care Staff*. Available from: **bit.ly/1r7BZCy** (accessed 15.11.14).

Department of Health (2011) Health Visitor implementation plan. Available from: **bit.ly/1vhgpNS** (accessed 9.1.15).

Eade, D. (1997) Capacity Building. *An approach to people-centred development*. Oxford: Oxfam.

Florin, P., Wandersman, A. (1990) An introduction to citizen participation, voluntary organisations and community development: insights for empowerment through research. *American Journal of Community Psychology*. Vol 18, 41-54.

Foster-Fishman, P.G., Berkowitz, S.L., Lounsbury, D.W., Jacobsen, S., Allen, N.A. (2001) Building collaborative capacity in community coalitions: a review and integrative framework. *American Journal of Community Psychology*. 29 (2), 241-261.

Gilchrist, A. (2009) *The well-connected community: a networking approach to community development*, 2nd ed. Bristol: Policy Press.

Pearson, P. (2013) Working with communities to improve health: The Building Community Capacity programme. *Journal of Health Visiting*. 1 (12), 704-709.

Putnam, R. (2000) *Bowling alone: The collapse and revival of American Community*. New York: Simon and Schuster.

Skinner, S. (2006) *Strengthening Communities: A Guide to Capacity Building for Communities and the Public Sector*. London: Community Development Foundation.

Twinn, S., Cowley, S. (1992) *The principles of health visiting: a re-examination*. London: HVA.

Indicative reading:

Reed, J. (2007) Appreciative Inquiry: Research for Change. London: Sage.

Bell, J. (2005) Doing your research project - a guide for first time researchers in education, health and social science. Maidenhead: Open University Press.

Appleton, J. V., Cowley, S. (2000) The Search for Health Needs: Research for Health Visiting Practice, Basingstoke: Palgrave Macmillan.

Freeman, R., Gillam, S., Shearin, C., Pratt, J. (1997) Community development and involvement in primary care : a guide to involving the community in COPC. London: King's Fund Publishing.

Hothi, M., Woodcraft, S., Cordes, C., Muskett, D. (2010) The End of Regeneration? Improving what matters on small housing estates. The Young Foundation.

Knapp, M., Bauer, A., Perkins, M., Snell, T. (2010) Building community capacity: making an economic case.

Marmot, M. (2010) Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post 2010, The Marmot Review. Available from: **bit.ly/11NaPer** (accessed 13.2.15).

Skidmore, P., Bound, K., Lownsbrough, H. (2006) Community participation: Who benefits? Joseph Rowntree Foundation.

Williams, G., Popay, J. (1994) Researching the people's health. London: Routledge.

Overarching References

Bloom, B.S. Engelhart, M.D. Furst, E.J. Hill, W.H., & Krathwohl, D.R. (Eds.) (1956) *Taxonomy of Educational Objectives – The Classification of Educational Goals – Handbook 1: Cognitive Domain*. London: Longmans, Green & Co. Ltd.

Cowley, S. Frost, M. (2006) *The Principles of Health Visiting: opening the doors to public health practice in the 21st century*. London: Amicus.

Cowley, S. Whittaker, K. Grigulis, A., *et al* (2013) *Why Health Visiting? A review of the literature about key health visitor interventions, processes and outcomes for children and families*. National Nursing Research Unit, King's College: London.

Department of Education (2011) *Munro review of child protection: final report - a child-centred system*. Available from: **bit.ly/1vypGpU** (accessed 15.11.14).

Department of Health (2014a) *Overview of the six early year's high impact areas*. Available from: **bit.ly/1BWLxui** (accessed 15.11.14)

Department of Health (2014b) *Health Visiting Programme: Guidance and FAQs for the Education Initiative – Continuing Professional Development for Health Visitors*. Available from: **bit.ly/1v6aLBr** (accessed 15.11.14).

Department of Health (2014c) *The Public Health Outcomes Framework 2013-16*. Available from: **bit.ly/1z6JXjI** (accessed 15.11.14).

Department of Health (2014d) *The NHS outcomes framework 2014-15*. Available from: **bit.ly/1qd0CAE** (accessed 15.11.14).

Department of Health (2014e) *Factsheet: Commissioning the national Healthy Child Programme - mandation to ensure universal prevention, protection and health promotion services.* Available from **bit.ly/1s6ePlL**. (accessed 8.12.2014)

Department of Health (2012a) *A Health Visiting Career*. Available from: **bit.ly/1z6Jo9m** (accessed 15.11.14).

Department of Health (2012b) *Developing the Culture of Compassionate Care: Creating a New Vision for Nurses Midwives and Health Care Staff*. Available from: **bit.ly/1r7BZCy** (accessed 15.11.14).

Department of Health (2011) *Health Visitor Implementation Plan 2011-2015: A Call to Action*. Available from: **bit.ly/1Fbh3ks** (accessed 15.11.14).

Department of Health (2009) *Healthy Child Programme: Pregnancy and the First 5 Years of Life*. Available from: **bit.ly/1uD55hQ** (accessed 15.11.14).

Francis Report (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. Available from: **bit.ly/1tbnlLd** (accessed 15.11.14).

Marmot Review (2010) *Fair Society Healthy Lives*. Available from: **bit.ly/11NaPer** (accessed 15.11.14).

NHS England (2014) *National Health Visiting Core Service Specification 2015/2016*. Available at: **bit.ly/1qDcEWe** (accessed 11.1.15).

Nursing & Midwifery Council (2014) *Revalidation Evidence Report*. Available from: **bit.ly/1Chaj7s**. Accessed 27.11.14.

Nursing and Midwifery Council (2011) *The Prep handbook*. Available from: **bit.ly/1sX6Sdz** (accessed 15.11.14).

Nursing and Midwifery Council (2008) *The Code: Standards of conduct, performance and ethics for nurses and midwives*. Available from: **bit.ly/1xMfcU3** (accessed 15.11.14).

Nursing and Midwifery Council (2004) *Standards of proficiency for specialist community public health*. Available from: **bit.ly/150PzDa** (accessed 15.11.14).

Public Health England (2014) *A Guide to Early Years Profile Data*. Available from: **bit.ly/1tnfZDA** (accessed 15.11.14).

Whittaker, K. Grigulis, A. Hughes, J., *et al*. (2013) S*tart and stay: The Recruitment and Retention of Health Visitors*. National Nursing Research Unit, London.

Proficiency standards to qualify as a health visitor NMC (2004)
Search for Health Needs
Surveillance and assessment of the population's health and wellbeing
Stimulation of Awareness of Health Needs
Working for health and wellbeing
Working with, and for, communities to improve health and wellbeing
Influence on Policies Affecting Health
Developing health programmes and services and reducing inequalities
Policy and strategy development and implementation to improve health and wellbeing
Research and development to improve health and wellbeing
Facilitation of Health Enhancing Activities
Promoting and protecting the population's health and wellbeing
Developing quality and risk management within an evaluative culture
Strategic leadership for health and wellbeing
Ethically managing self, people and resources to improve health and wellbeing

This tool can be used as evidence of CPD provision for assurance and review by HEE and commissioners.

Standard to be Achieved for Each High Impact Area	Current Training in Place to Support Achievement (please detail)	Future Training/ Support Planned (please detail)	Can you provide assurance that training is in place for next 12 months to support HVs to meet standard? YES / NO If no, please detail why not	% (n) of health visitors achieved standard at time of completion of audit
1. Working therapeutically to effect change with children and families				
2.Maintaining and developing prescribing practice				
3. Providing and developing intelligence to inform the Joint Strategic Needs Assessment Process				
4. Working in partnership with families and communities to build capacity and resilience				

The Institute of Health Visiting is a Centre of Excellence

- Supporting the development of universally high quality health visiting practice
- So that health visitors can effectively respond to the health needs of all children, families and communities
- Enabling them to achieve their optimum level of health, thereby reducing health inequalities.

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