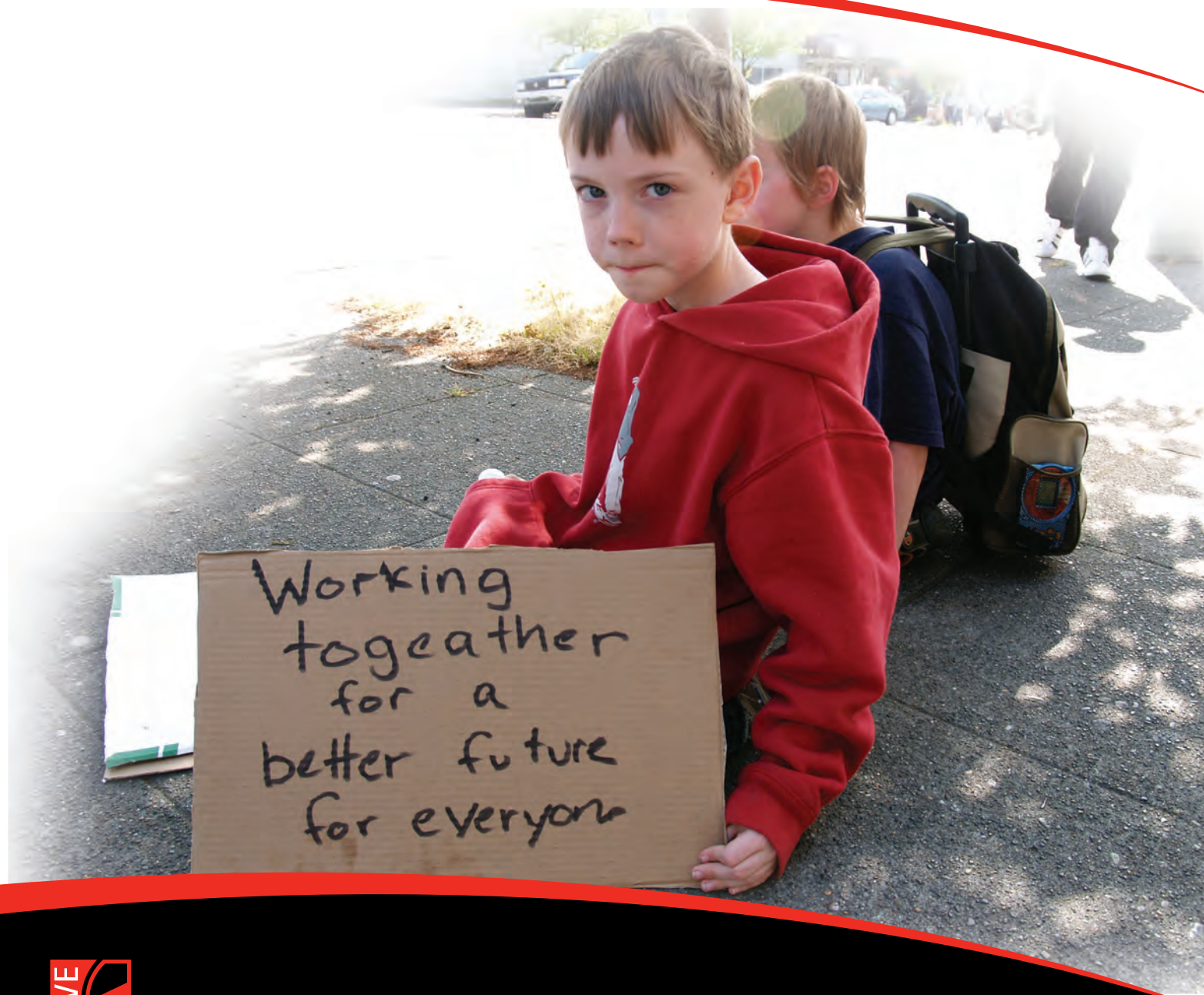


Meeting the challenges of the Health Visitor Implementation Plan at the University of the West of England, Bristol

Judy Brook, Debra Salmon, Richard Kimberlee, Judy Orme and Emma Bird



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An evaluation to assess the extent to which the University of the West of England's Public Health Nursing (SCPHN) programme meets the aims set out in the Government's Health Visitor Implementation Plan

January 2014

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Acknowledgements

We are very grateful to a wide range of people who contributed their knowledge, time and attention to this evaluation. In particular, we would like to thank the Specialist Community Public Health Nursing (SCPHN) students from September 2013 cohort who completed the surveys and took part in focus group interviews.

This evaluation would not have been possible without the commitment of SCPHN service managers across the south west region, thanks also go to those services managers and practice teachers who agreed to take part in the study. The parents who agreed to take part have made a crucial contribution, which we would like to acknowledge, we also recognise this meant giving up precious time in their busy lives, thank you.

We would also like to acknowledge the contribution of the steering group members: Clare Chivers (Deputy Director of Education and Quality Health Education South West); Karen Evans (Deputy Head of Nursing – Child Health, North Bristol NHS Trust, Bristol Community Children’s Health Partnership); Julia Slingsby (Public Health Nurse Lead, Service Manager – Southern, Virgin Care); Joy Murray (SCPHN Programme Manager, UWE) and Louise Condon (SCPHN Senior Lecturer, UWE). In addition big thanks go to our funders, the South West Strategic Health Authority; this support has resulted in the first formal evaluation to take place nationally since the introduction of the HV Implementation Plan (2011) which will contribute to wider national debates around health visiting and service development.

A special thank you goes to Alison Hughes (Senior Lecturer, Community Nursing, UWE), Louise Condon (Senior Lecturer, Specialist Community Public Health, UWE) and Joy Murray (Programme Leader, Specialist Community Public Health, UWE) who have supported this research with their expertise and guidance. Alison also undertook work around the student focus groups.

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ISBN: 978-1-86043-518-8

Published by the University of the West of England, Bristol

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Executive Summary

Background

Health visiting has been at the forefront of public health policy of the Coalition Government since its election in 2010. This has resulted in the regeneration of the health visiting service supported by national policy that called for an additional 4,200 health visitors to be trained by 2015. The Health Visitor Implementation Plan 'A Call to Action' (DH 2011a) sets out three integrated workstreams: growing the workforce, professional mobilisation and aligning delivery systems. These areas for development are intended to collectively strengthen the health visiting service over a four-year period, and all are significant for the delivery of educational programmes in higher education institutes (HEIs). Increased student numbers have impacted on the design and delivery of Specialist Community Public Health Nursing (SCPHN) Programmes, whilst a new vision of service delivery has been developed to clarify and align the expectations of the health visiting service nationally. The University of the West of England was successful in securing an educational contract to deliver health visitor education associated with the Implementation Plan across the South West. Providing the Health Visitor Programme to 11 Health Care Organisations across the region, means UWE, Bristol is the biggest provider of Specialist Community Public Health Nursing education in the UK.

Overview of the evaluation

Drawing on the Health Visitor Implementation Plan (DH, 2011a) and Educating Health Visitors for a Transformed Service (DH, 2011c), this evaluation aimed to assess the extent to which the Specialist Community Public Health Nursing programme meets the vision of the future workforce. Across the 11 Trusts within the South West the evaluation focused on:

- The experience of the student through the SCPHN programme and their preparedness for practice (student journey).
- Stakeholder analysis to assess the degree to which the SCPHN programme is meeting the new service vision as outlined in the Health Visitor Implementation Plan (DH 2011a) and associated public health outcomes.

- Family and community perspectives on the introduction of the new service provision.

The objectives of the evaluation were:

- To assess how the current programmes of education for health visitors maps on to and meet the demands of the new health visiting service model.
- To explore the education and training needs of students from different educational backgrounds at the start of the programme and to ascertain the extent to which these needs were met.
- To explore how the knowledge, attitudes, skills and efficacy of SCPHN students and health visitor students in particular change across the life of the programme.
- To undertake a stakeholder analysis of the extent to which the programme meets the needs of health organisations serving local communities, and in particular the demands on the health visiting service in light of the Implementation Plan.
- To investigate the experience of students at the end of the programme, in particular the extent to which they feel prepared to deliver new models of practice set out within the Implementation Plan.
- To make recommendations to support the progression of newly qualified practitioners during the implementation of the new service model for health visiting.

Methods

This evaluation used a case study approach employing quantitative and qualitative methods. Longitudinal survey data was collected from students (n=140) at two points to assess potential changes in their knowledge and skill development through their study period. Themes highlighted in the survey data were further explored through the use of focus group methodology to gain a more in depth understanding of student experiences. Stakeholder perspectives were an essential element of the evaluation and were established using semi-structured interviews. A range of relevant practice teachers (n=10) and strategic managers (n=7) were included in the sample. Also parents (n=14) were identified through Children's Centres and asked to reflect on their experiences and expectations of the health visiting service in order to understand the impact of the programme in practice.

Findings

Findings from students

- Most SCPHN students had heard about the programme through www.jobs.nhs.uk, although almost one in five through the baby shaped leaflet issued by the Department of Health.
- From this the baseline sample, 3% (n=4) were men, 97% women (n=136).
- Most students defined their ethnicity as White 90%, (n=135); in addition 6% (n=8) reported having a disability. Types of disabilities reported included dyslexia and additional learning needs, though some students did not specify.
- The average age of students on the programme was 37.92 years with a range of 22 - 55 years of age.
- The time since gaining their first nursing/ midwifery qualification ranged from 1 year to 33 years (mean = 11.33 years).
- At baseline students were least confident in dealing with clients with learning difficulties and mental health problems. The follow up questionnaire revealed that students rated their confidence as higher in relation to all the confidence statements.
- Students increased in confidence across the key skills associated with being a successful SCPHN practitioner and reported feeling confident to deliver a new model of service delivery. For example, students were three times more likely to see their role as developing community capacity at follow-up than at baseline (80% at Follow-up, 40% at baseline).
- Students felt a weight of responsibility at being the 'new vanguard' of health visiting. Managers described great expectations of them as newly qualified practitioners and endeavoured to support them with continual innovation and improvement in order to realise the new service vision. However, students expressed concern about the theory practice gap – they were being educated for a role that they were not all observing in their placements and this caused anxiety and frustration.

Findings from managers

- Service managers were asked about what they thought the programme gave SCPHN students. The majority felt that the taught element

of the programme offered opportunities to discover and understand the best evidence based practice and models of health visitor practice.

- There have been tensions between new and existing staff, which have presented a challenge to manage. On the one hand it was noted that the new staff can provide an impetus to service delivery, but there is also some anxiety around the impact that this has on existing staff who have been providing services in the organisation for some time, albeit working to a different service delivery model.
- Service managers' biggest anxiety was what will happen in March 2015 when the initiative to recruit comes to an end. This appeared to raise several issues including concern that there will be sufficient jobs for everyone who qualifies. The managers were also wary of change in other agencies, together with NHS reorganisation, undermining the drive to change health visitor practice.
- In relation to the new model of supervision in practice, which utilises mentors as well as practice teachers, managers mostly commented on how this arrangement enabled the wider workforce to update their skills, fostered enthusiasm and generated learning cultures. Support for mentors was mostly undertaken by practice teachers, and university mentor study days.

Findings from practice teachers

- All ten interviewees discussed the fact that they were now working with more than one student at a time and that mentors were now involved with the day-to-day supervision of the students. This was logistically difficult, involving careful planning and creativity so that students were offered a positive experience and had sufficient contact with the practice teacher as well as the mentor, particularly so that the practice teacher could feel confident in the ability of the student, given the reduced contact time.
- The implementation plan has required a number of new practice teachers to be trained in order to support the larger body of students. One interviewee suggested that this has had the advantage that a number of practitioners have recently attended university, and are subsequently confident with study skills and able to offer students a fresh outlook.

- Unlike managers, practice teachers felt there had been significant personal cost to the process, wrestling with caseload demands, student learning needs and mentors who had not played an educational role in practice for many years.
- Ultimately, the perception of the service managers that morale was improving in the workforce was not universally upheld by all these interviews. However, the commitment from the interviewees was evident, as was a belief that the increase in student numbers was a positive development, despite the challenges it presented.

Findings from parents

- The parents shared both negative and positive experiences of the health visiting service. Positive experiences tended to centre on individual health visitors who were perceived to 'go the extra mile', who genuinely seemed to care, who were knowledgeable and skilled and who were able to give advice and guidance that resulted in a positive outcome. Student health visitors were discussed in this light.
- When negative experiences were reported, these tended to focus on a poor relationship between the parent and the health visitor. In these instances practitioners were perceived to be unprofessional, uncaring or lacking in credibility.
- The parents repeatedly brought up the issue of lack of time and resources and this too was seen to be a major influence on whether a contact was positive or negative. However, here the participants were split – some felt that lack of time was an issue that was inevitable in today's NHS with the inference that it was outside of the control of the health visiting teams. Other parents expressed impatience with the view that the practitioners were too busy to do a good job, indicating that this was down to poor caseload management, and even suggesting ways that the delivery of the service could be changed to make it more effective.

Discussion

Overall, managers felt that this group of student practitioners were 'fit for purpose' and students were excited about putting their new learning into practice. Many students felt confident to work collaboratively across agencies, therapeutically with families, inclusively with

communities and were beginning to understand how their leadership role would develop.

Although there was a general recognition that A Call to Action had offered unprecedented opportunities for the profession, criticisms were levelled by students, practice teachers and managers about the delivery of the implementation plan. The short four-year timescale, the top-down approach and the level at which the policy has been influenced by research activity were all questioned. However, there were also unanticipated benefits of the fast pace of implementation of the Health Visitor Plan. Previously education had been largely the role of the Practice Teacher and while initially there were serious concerns about a lack of practice teachers, health visitor mentors took on an increasing role in supporting students. Stakeholders commented on how this arrangement had helped the wider workforce update their skills, created enthusiasm and generated cultures based on learning, which have the potential to significantly benefit service delivery.

The theory practice gap could be seen as a driver of innovation in practice. In reality there is a policy practice gap where the new service vision is not yet realised in practice due to workforce restraints. The positive partnership arrangements between the University and practice placements may go some way to encouraging shared understanding and shared outcomes to benefit the students. Equally, robust clinical supervision arrangements may help newly qualified practitioners navigate through the political context of their new role and maintain the impetus of innovation for the service.

The service vision falls short of being open and transparent to the families to which it applies. This may in part be explained by the incomplete implementation of the new service model in practice. It would seem that, despite the efforts of the Department of Health to raise the profile of health visiting, at the level of parents and carers, there is still much work to be done to maintain the credibility of the service. As concerning is the perception that partner agencies and commissioners are not aware of the value that SCPHN services offer. Health visitors need to embrace the new service vision, believe that it can succeed and channel that motivation in to revolutionising the service delivery. Raising the profile of the service at local level is an essential first step, and the indication from this research is that now is the time to do this before the window of opportunity closes.

Recommendations

Recommendations for Policy Makers

The Health Visitor Implementation Plan is part of a complex policy landscape that determines the outcomes for children and young people:

- These findings should be considered to ensure the achievements associated with building capacity and capability within the health visiting workforce are maximised to promote early intervention and improved life chances for children.

To maintain a high quality motivated workforce, it is crucial that funding continues for SCPHN education and development:

- This will support the retention of newly qualified practitioners and motivate the established workforce.

Given the dearth of large-scale research specific to health visiting interventions, leadership is key to promoting the development of the profession:

- Research relevant to SCPHN practice, to underpin future policy and practice, should be actively encouraged, financed and prioritised.

Recommendations for SCPHN education

It is important to maintain the wider entry gates to the SCPHN education:

- Students who have recently graduated from nurse or midwifery education have adapted well to the role and achieved well both academically and in practice.

The high levels of student recruitment associated with the health visitor implementation plan have created significant opportunities for learning about selection. Specifically:

- The focus on attributes rather than knowledge at interview.
- The need to undertake local recruitment drives to select students who reflect of the demographic characteristics of the local area, particularly black and minority ethnic students and men.

The pivotal role of practice teachers in successful student education should be recognised and valued:

- The strong links between practice placements and the education provider should be nurtured in order to offer support around individual student issues.

Practice teachers have moved away from the traditional one to one model of supervision of students:

- Further research is needed to evaluate the new way of working with SCPHN students in practice, particularly the continued role of mentors in the education of SCPHN students.

Recommendations for practice

Newly qualified practitioners are the catalyst for change and innovation:

- SCPHN service providers should implement a robust and supportive preceptorship programme for newly qualified practitioners that supports and develops their creative ideas for service improvement.

Clinical supervision models should be embedded in service provision:

- Supervision will nurture and enhance the resilience of both the new and established workforce.
- Practitioners will be enabled to critically review practice and narrow the theory practice gap.

Tensions exist between traditional practice and new service delivery models:

- Continue work to communicate the new service model to the established workforce, recognising the tensions between traditional practice and new service delivery.
- Offer continuing professional development to up skill, update and motivate existing practitioners and work towards narrowing the theory practice gap.

Clients focused on the relationship between client and practitioner as key to an effective intervention. Practitioners were expected to be credible, up to date and flexible:

- Prioritise a model that allows consistency of practitioners for the client. Parents identified lack of time as central to failings in service delivery. Clients particularly disliked practitioners explicitly referring to lack of time as justification for limited service.

Changes in NHS architecture have influenced the commissioning structures:

- It is critical that the profile of the SCPHN service is raised so that commissioners and partners are clear about the role of the health visitor, and are able to make effective decisions about resource allocation.

1 Introduction and Policy Context

1.1 Introduction

Health Visiting has been central to the Coalition Government since its election in 2010. Not only has David Cameron demonstrated a personal interest in the regeneration of the health visiting service, but has supported this with national policy. The Health Visitor Implementation Plan 'A Call to Action' (DH 2011a) sets out three integrated workstreams: growing the workforce, professional mobilisation and aligning delivery systems. These areas for development are intended to collectively strengthen the health visiting service over a four-year period, and all are significant for the delivery of educational programmes in higher education institutes (HEIs). Increased student numbers have impacted on the design and delivery of Specialist Community Public Health Nursing (SCPHN) Programmes, whilst a new vision of service delivery has been developed to clarify and align the expectations of the health visiting service nationally.

In line with the Health Visitor Implementation Plan (DH, 2011a) and Educating Health Visitors for a Transformed Service (DH, 2011c), this evaluation aimed to assess the extent to which the SCPHN programme meets the vision of the future workforce. The Health Visiting Implementation Plan identifies four levels of provision of health visiting that will enable the Healthy Child Programme [HCP] (DH, 2009) to be met across communities. This research enabled one of the first evaluations of this large policy initiative. The fact that the evaluation was conducted in an HEI setting was important, as it remained constant at a time of significant organisation change for health commissioning bodies and service providers during 2013 and 2014 and leading in to the next general election. This changing NHS architecture was influential for service delivery and practitioners nationally.

The evaluation identified the benefits and achievements to date associated with the implementation of the Health Visitor Implementation Plan within both an HEI and practice settings. Lessons learnt from the evaluation will be utilized to inform future strategy and ways of working across England. In addition, the tools developed to evaluate this large programme will be made available for other providers to assess the fit of their programmes against current policy development and best practice. The staged reporting of findings

enabled an 'evidence into practice' cycle to be realised against a backdrop of complex NHS reforms.

Across the 11 health visiting service providers within the South West the evaluation focused on:

- The experience of the student through the SCPHN programme and their preparedness for practice (student journey).
- Stakeholder analysis to assess the degree to which the SCPHN programme is meeting the new service vision as outlined in the Health Visitor Implementation Plan (DH 2011a) and associated public health outcomes.
- Family and community perspectives on the introduction of the new service provision.

The objectives of the evaluation were:

- To assess how the current programme of education for health visitors maps on to and meet the demands of the new health visiting service model.
- To explore the education and training needs of students from different educational backgrounds at the start of the programme and to ascertain the extent to which these needs were met.
- To explore how the knowledge, attitudes, skills and efficacy of SCPHN students and health visitor students in particular change across the life of the programme.
- To undertake a stakeholder analysis of the extent to which the programme meets the needs of health organisations serving local communities, and in particular the demands on the health visiting service in light of the Implementation Plan.
- To investigate the experience of students at the end of the programme, in particular the extent to which they feel prepared to deliver new models of practice set out within the Implementation Plan.
- To make recommendations to support the progression of newly qualified practitioners during the implementation of the new service model for health visiting.

1.2 Policy Context

The publication of the Health Visitor Implementation Plan (DH 2011a) demonstrated a clear move by the Government towards developing the health visiting service. Soon after election in 2010, David Cameron declared a personal commitment to the expansion of the health visitor workforce in England (DH 2011b).

He has since reiterated that health visitors are 'hugely valued' and are 'vital' to improving the wellbeing of children (Institute of Health Visiting 2012) and once again emphasised the Government commitment to increasing the number of health visitors.

This focus on the health visiting profession is timely, as the past decade has seen a steady decline in the number of health visitors in England (DH 2011a, RCN 2011). The introduction of skill mix and corporate health visiting teams, together with investment in Sure Start Children's Centres has helped to maintain the headcount in the children's workforce. However, the reduced capacity of qualified health visitors has narrowed their role to one of leadership, delegation and specialised work with families with complex needs or child protection issues. This has resulted in a workforce frustrated by the gap between the role that their training prepares them for and the work that they can do in practice (DH 2012a).

The Public Health Outcomes Framework (DH 2012c) is focused on two high level outcomes: the need to reduce health inequalities between communities and to increase life expectancy in England. In order to achieve this, services need to be planned and delivered in the context of the broader determinants of health. Health visitors are central to this agenda in that they are ideally placed to assess the health needs of families as they visit all new parents. They have expert knowledge of the health needs of the communities in which they work and have the skills to build community capacity in line with the Government's concept of social capital (DH 2012c).

In its 2010 coalition agreement, the Government pledged to increase the workforce by 4,200 extra health visitors by 2015, to bring the total number from a baseline of 8,092 in May 2010, up to 12,292 in April 2015 (DH 2012a). In order to account for natural loss of practitioners leaving the profession over the four-year period, 6000 new health visitors need to be trained to meet this commitment. This has had a major impact on Higher Education Institutions (HEIs) where education programmes have been expanded and adapted to meet the needs of almost four times the historical annual number of students (DH 2013). The February 2013 figures indicate that plans to increase the workforce by this extent are almost on track (DH 2013), with 1000 more health visitors in practice than in 2010. This has been achieved through a combination of bringing in new recruits and encouraging health visitors to return to practice. Some organisations, including

early implementer sites, also offered additional development opportunities to established practitioners to encourage retention. However, this initiative has been inconsistent across the region with some practitioners highlighting that they felt 'left behind', leading to an accentuation of the theory practice gap.

In line with the increase in workforce numbers, the Health Visitor Implementation Plan (2011a) describes a new model of service delivery, a service that will be available through both home visits and through convenient local settings such as Children's Centres in order to provide more comprehensive local health visiting service. The growing body of evidence to support early intervention and the importance of joined-up support for children and families early in life (Field 2010, Allen 2011, Tickell 2011, Munro 2011) has influenced the service model, not least in terms of the potential economic benefits to the welfare budget that preventing poor health, underachievement or antisocial behaviour may return. Health visitors are centrally placed to provide early intervention and support for those families that need it. The new service vision for health visiting (DH 2011a) augments the tradition of partnership working with enhanced practitioner skills and embeds the wider public health role that they have been trained to perform, but which has been eroded over recent years. Hall and Elliman were commissioned by the government in 2003 to report on universal child health provision. Arguably, their report had a significant influence on the health visiting service, particularly around the wider public health aspects of the role and the provision of universal health reviews such as those at 2 and 3.5 years, which were subsequently removed from national provision. Their recommendations for a service that offered fewer universal contacts together with an emphasis on targeting need has had the (perhaps unintended) consequence of slimming down the workforce to an unprecedented level.

The new model outlines four levels of service, from interactions at community level, a universal service for all families and higher levels of additional input for families where need has been identified. The health visitor assesses the level of service provision to be offered to each family using the family health needs assessment. Arguably, a model which targets high risk families with additional resources whilst offering a lower level of basic universal health promotion and screening universally does in fact play in to the hands of the inverse care law (Bellman and

Vijeratnam 2011). Service providers will need to be confident that the targeting 'safety net' is sufficiently effective at identifying vulnerable children and the families with the most need. These are the clients who are least likely to access services either because they aren't available locally or the families do not see the services as relevant to their needs. Perhaps to counter this potential pitfall, the Government has funded Early Implementer Sites across the country to develop new and innovative ways of working to deliver the service within this model, sharing good practice and enhancing the skills base of the workforce in order to maximise the effectiveness of the vision.

To add to the complex picture, investment in the health visiting service is set against a backdrop of NHS transformation and economic reform. The Health and Social Care Act (DH 2012) set out radical changes to the structure of the NHS, which will have a major impact on public health services. GP commissioning, the abolishment of the Strategic Health Authorities and Primary Care Trusts and the plan to move public health services under the commissioning auspices of the local authorities have the potential to influence the direction of travel for the health visiting profession. Indeed, Snow (2012) reports fears that the current financial pressures local authorities are facing will impact on their ability to support the full public health agenda, with potential ramifications for the health visitor workforce in 2015. A service model based on universal and targeted services is a compromise that requires a large investment of resource and, given the current politically driven change in the NHS, Bellman and Vijeratnam (2011) raise concerns that the need to address inequality in this area will get lost.

The new service model relies heavily on a strong relationship between the service provider and the commissioning body, which is why it is a positive step that the Government has retained its intention that health visiting should remain with the NHS England until 2015. The Strategic Health Authorities previously managed the workforce component of the Health Visitor Implementation Plan (DH 2011). Currently, the Local Education and Training Boards, overseen by Health Education England, commission the training. It is hoped that the government initiated health visitor taskforce (DH 2011a) will be sufficiently influential to maintain strategic challenge at the highest level to ensure the current trajectory of recruitment, retention and training once funding

for health visitor education is in direct local competition with medical, nursing and allied health professional workforce development and supply, especially given the likelihood that there will be no new money and a larger workforce to maintain.

1.3 The University of the West of England

The University of the West of England (UWE) was successful in securing an education contract to deliver health visitor education associated with the Health Visitor Implementation Plan from 2011 – 2015. UWE now provides the health visitor education programme to 11 Health Organisations across the south west and as such is the biggest provider of Specialist Community Public Health Nursing (SCPHN) education in the UK. The programme has been designed to accommodate the large numbers of students and to develop practitioners who can meet the health needs of local populations across the South West, both now and in the future. The content of the programme is mapped closely against the framework outlined by the Department of Health in Educating health visitors for a transformed service (DH 2011c) in order to meet the new model for the health visiting service (DH 2011a).

As the largest provider of SCPHN education in the UK UWE is ideally placed to evaluate the impact of the policy initiatives focusing on health visitor workforce development. Given the current level of organisational change within health services, an evaluation that is embedded in the relative stability of an HEI will go some way to mitigate the loss of organisational memory sometimes associated with transitions in health service arrangements. UWE has the opportunity to work closely with NHS Trusts (n = 8), Community Interest Companies (n = 2) and Local Authorities (n = 1) across the region, which offers a valuable oversight to both the variables and similarities of health visiting service delivery.

2 Methodology

2.1 Overview of methodology

The aim of the evaluation was to assess the extent to which the University of the West of England's Public Health Nursing (SCPHN) programme supported the ambitions of the Government's Health Visitor Implementation Plan. The objectives of the evaluation were:

- To assess how the current programmes of education for health visitors maps on to and meet the demands of the new health visiting service model.
- To explore the education and training needs of students from different educational backgrounds at the start of the programme and to ascertain the extent to which these needs were met.
- To explore how the knowledge, attitudes, skills and efficacy of SCPHN students and health visitor students in particular change across the life of the programme.
- To undertake a stakeholder analysis of the extent to which the programme meets the needs of health organisations serving local communities, and in particular the demands on the health visiting service in light of the Implementation Plan.
- To investigate the experience of students at the end of the programme, in particular the extent to which they feel prepared to deliver new models of practice set out within the Implementation Plan.
- To make recommendations to support the progression of newly qualified practitioners during the implementation of the new service model for health visiting.

The purpose of the evaluation was to inform future practice and contribute to the national debate surrounding the introduction of the implementation plan. Undertaking the evaluation in a relatively short time scale allowed for timely reporting to ensure the findings from this study contribute to on going national debate as we come to the next phase of service development.

Pilot work to develop data collection tools took place up until July 2012. UWE has good access to SCPHN students at different stages of their study, which allowed for prospective and retrospective accounts of student journeys, experience and orientation to the new service delivery model in health visiting practice. It was possible to involve

students completing the one-year programme starting in September 2012. This evaluation used a mixed methods approach; data were collected using quantitative and qualitative methods, namely longitudinal survey data from students, semi-structured interviews and focus groups with a range of relevant professionals and strategic managers. Participating stakeholders included students, health organisation and voluntary service organisation managers, expert professionals, users and their families.

2.2 Sampling and data collection

2.2.1 Students

Quantitative data were collected from students using a longitudinal survey technique. The students were asked to complete a questionnaire during the induction week of the programme (the 'Journey Questionnaire'), in September 2012 and a follow-up questionnaire just prior to finishing the programme (the 'Stepping in to Practice Questionnaire') in August 2013.

The rapid change initiated by the focus on SCPHN workforce development presented an unprecedented context in which to embed this research. Concurrently, a dearth of existing, validated frameworks with which to collect the data, specifically from SCPHN students, enforced the need to develop a unique approach. The questionnaires were subsequently developed drawing themes from the Implementation Plan, the framework for educating health visitors (DH 2011c) and the health visitor attributes, identified by the Department of Health (2012d) to aid recruitment of health visitor students. Inspiration was also taken from the Evidence-Based Practice Self-Efficacy Scale, which was tested for reliability and validity by Tucker et al (2009). The questionnaire was piloted with a cohort of students who were not participants in the evaluation and was subsequently amended to add clarity and eliminate ambiguous statements.

A total of 140 students were recruited from the September 2013 cohort to take part in the longitudinal survey. These students represented a wide range of experience, backgrounds and qualifications outlined in tables 1, 2, 6, 7 and 8. The initial survey focused on assessing students' motivations, expectations, confidence levels, attitudes and values at their entrance onto the programme, in addition to biographical information about past experiences and knowledge of the public health nursing field. As students completed the programme a follow-up survey assessed possible changes in attitudes,

knowledge, skills and confidence that had emerged during their time on the programme. The degree to which students felt prepared to meet the demands of the new service delivery model was also assessed. Data were also collected from school nursing students to allow the possibility of comparing and contrasting the data between the two groups. This was particularly important as, unlike school nurses, many of the student health visitors had no previous experience in the public health field. In many instances health visitor students had come to the programme from adult acute and intensive care settings and so potentially had a steeper learning curve than school nurses who usually had experience from within their field.

The qualitative aspect of exploring student experience came from discussions with eleven students who were recruited to take part in the focus group interviews. These were conducted shortly before the students finished the programme and qualified as SCPHN practitioners. The facilitator of these discussions encouraged the students to focus on their learning experiences during the programme, including the influence of previous experience and professional background on those experiences. Other aspects of the discussions included looking ahead to the future in terms of progression from students to qualified practitioner and recommendations for the future to ensure programme delivery enables students to be prepared for their new role. The focus of the discussions was influenced by the evaluation objectives and the contact was used to explore the findings from the initial questionnaire in more depth. However, the focus groups were essentially an opportunity for students to raise ideas and issues that they felt were relevant to the remit of the evaluation.

2.2.2 Managers and Practice Teachers

Stakeholder perspectives were an essential element of the evaluation, and were established through semi-structured interviews. Service managers and practice teachers were recruited to the evaluation by using an opt-in approach. All participation was voluntary and participants were fully informed about the research process. Six service managers were recruited from a range of health organisations across the region, with one children's centre manager. In addition, ten practice teachers also volunteered to take part in the interviews. The interviews took place between March and September 2013.

The interview schedule was developed by drawing on the themes from the Health Visitor

Implementation Plan, together with the criteria outlined in Educating health visitors for a transformed service (DH 2012c) as essential for SCPHN programme content. Interviewers established stakeholders' roles and level of contact with SCPHN students. They also explored the professional values that stakeholders perceived to underpin student learning and ultimately the SCPHN service ethos. Stakeholders were asked to assess the degree to which learning (both in theory and practice) was appropriate in meeting the needs of the new service delivery model, potential opportunities and barriers for students on entry into the workforce including the most challenging aspects of SCPHN service delivery in the future. Managers were also encouraged to discuss the implications for SCPHN practitioners in light of the recent NHS reforms, The Health & Social Care Act 2012 (HM Government) and the impact that the new arrangements from April 2013 on commissioning of the HV service and subsequent employment of new Health Visitors.

2.2.3 Parents

Fourteen parents were identified through children's centres within two separate Health Visiting Service Providers; all those interviewed had experience of the health visiting service and most with health visiting students specifically. The focus groups and individual interviews took place between March and May 2013. Parents were asked to reflect on their experiences to date of the health visiting service, personal expectations of service delivery and potential areas for improvement. Parents' understanding of the introduction of the recent implementation plan and their views on these developments were also sought.

2.3 Ethics

The evaluation was informed by guidance cited in the British Educational Research Association's Ethical Guidelines for Educational Research (2011). Ethical issues addressed throughout the research included: voluntary informed consent, right to withdraw, confidentiality and all the issues associated with good researcher conduct set out in the guidance. Particular attention was paid to issues of confidentiality and anonymity for those stakeholders who were in more unique roles, as their comments were identifiable. In these instances stakeholders were asked to consider their contributions before publication. Prior to commencement of the study ethical approval was obtained from the UWE

Bristol Research Ethics University and Faculty Committees. In accordance with ethical principles all the data collected was anonymised and pseudonyms used to protect the identity of those who took part.

2.4 Data analysis

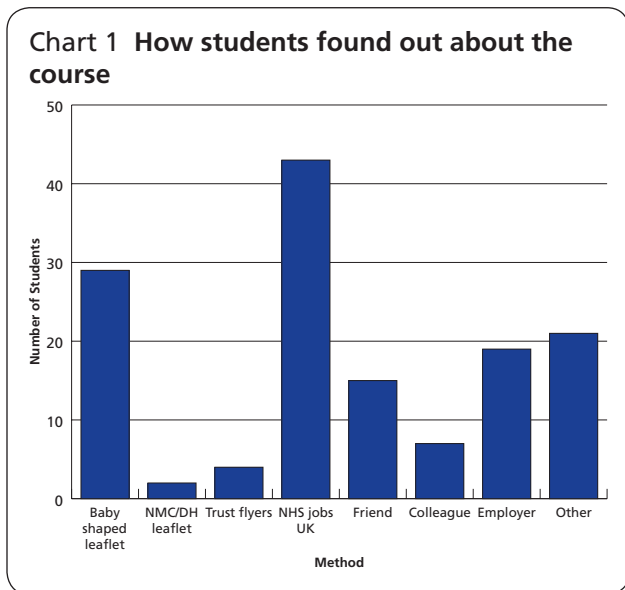
The questionnaires were anonymised using a unique identifier so that data could be analysed both on entry to the programme and at follow up as post intervention comparison at the end of the programme. Baseline and follow-up questionnaire data were entered into SPSS version 20.0. Descriptive statistics and frequencies were used to examine the characteristics of the study population. Frequency distributions for participant responses at baseline and follow-up were compared and a statistical assessment of differences was performed using χ^2 test of association. Fisher's Exact Probability test was used to overcome the violation of minimum cell frequency, where appropriate. Odds ratios were calculated to assess the size of the differences between participant responses at baseline and follow-up. Qualitative data collected from the interviews and through open-ended responses from the survey were analysed to identify key emergent themes (Strauss and Corbin 1990) to assist in exploring the research questions posed.

3 Findings from students

3.1 Quantitative Findings

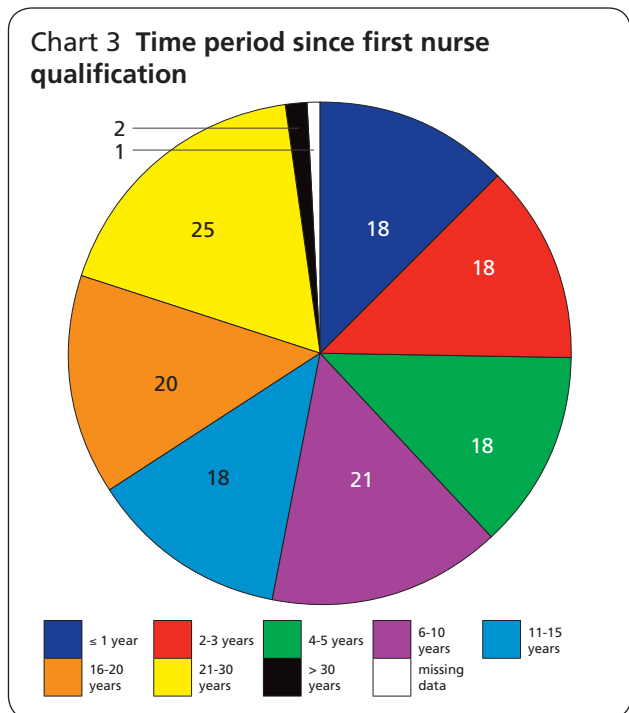
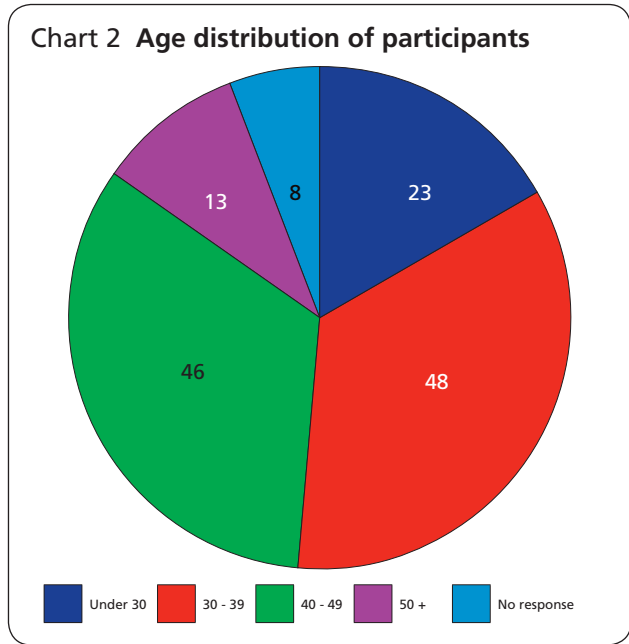
3.1.1 Biographical details of students at the start of the programme

Immediately previous to the period of evaluation students were subjected to a national recruitment drive initiated by the Department of Health, supported by the Nursing and Midwifery Council and delivered through health organisations across England. Most SCPHN students had heard about the programme through www.jobs.nhs.uk, although almost one in five through the baby shaped leaflet issued by the Department of Health. This leaflet was sent to all nurses and midwives through the NMC. Chart 1 describes the range of communications that had informed participants about the SCPHN programme and in particular health visiting.



Initially 140 students were recruited to take part, 25 from school nurses and 115 from health visitors, 60 were from Plymouth, 80 from Bristol. From this the baseline sample, 3% (n=4) were men, 97% women (n=136), most students defined their ethnicity as White 95.4% (n=135); in addition 6% (n=8) reported having a disability. Types of disabilities reported included dyslexia, and additional learning needs, though some students did not specify. The low numbers of BME students recruited can be partly explained by the Office of National Statistics (ONS) (2011) census characteristics of the South West's population that demonstrates that 94.8% of residents in the South West define themselves as white. However, a significant minority of

participants had moved from other parts of the UK to join the programme, which increased the overall ethnic diversity of students on previous years. The average age of students on the programme was 37.92 years with a range of 22 – 55 years of age. The time since gaining their first nursing/midwifery qualification ranged from 1 year to 33 years (mean = 11.33 years). Amongst the health visitors the mean was 10.13 years and for school nurses the mean was 16.84 years. This recruitment drive aimed to encourage a wider range of applicants and move away from



the perception that there was a requirement to complete several years in practice prior to entry on the programme. Chart 3 represents the time period since qualification.

Within the sample, six arrived with a master's degree (4%), sixty five were graduates (47%), sixty eight had a diploma (49%) and one did not respond (1%). Students also arrived on the programme from a wide range of backgrounds, clinical experience and motivations. Chart 4 describes the work location of students prior to entry onto the programme.

3.1.2 Survey sample

At baseline 140 Journey Questionnaires were completed and at follow-up we received 89 Stepping into Practice completed questionnaires. This represented 64% of the SCPHN students who completed the baseline questionnaire. The Stepping into Practice questionnaire was administered on the students' final session at UWE and attendance was lower than usual. In addition, one student declined to complete the follow-up questionnaire and two students did not provide adequate postcode identification. Despite the lower completion rate there is very little difference between the student compositions of the follow-up sample compared to the baseline sample. An independent-samples t-test revealed no difference in the age of those participants who completed baseline and follow-up questionnaires and those who only completed baseline questionnaires ($t=0.08$, $df=128$, $p=0.94$; Completers $M=37.87$, $SD=8.53$; Control $M=38.00$, $SD=8.26$). The Chi-square test of association revealed no differences in gender ($\chi^2(1, n=133) = 0.01$, $p=1.00$), disability ($\chi^2(3, n=133)=3.49$, $p=0.32$), ethnicity ($\chi^2(2, n=133)=0.59$, $p=0.74$), or place of study ($\chi^2(1, n=140)=0.58$, $p=0.45$), among those who completed baseline and follow-up questionnaires and those who only completed baseline questionnaires. This is important in terms of the conclusions drawn.

3.2 Findings from students

3.2.1 Motivations and expectations

Given the rapid recruitment of large numbers of students as a result of the HV Implementation Plan, it was important to understand participants' motivations for joining the programme. This was to provide the context for understanding student expectations, their learning needs and possible outcomes. Participants were asked to indicate all their motivations for joining the programme by ticking options that applied, summarised in Table 1.

Chart 4 Work location prior to entry on the programme

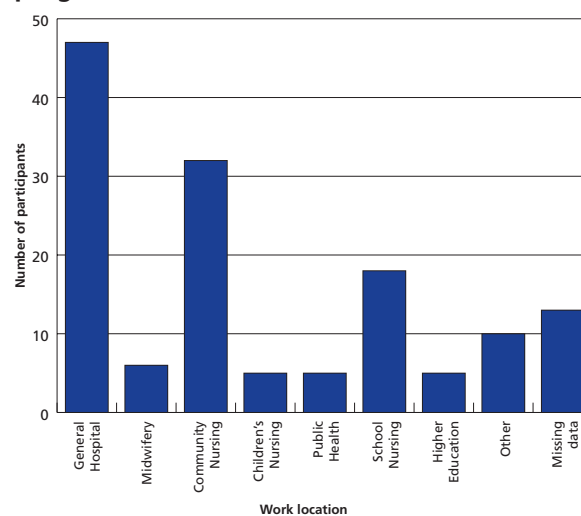


Table 1 Motivations for undertaking the SCPHN Programme at baseline (n=140)*

Statement	Number responding yes	%
I wanted a change from current role in community nursing	39	28
I wanted a change from current role in acute nursing	46	33
I wanted to work in preventative health	106	75
I wanted to work with disadvantaged groups	93	66
I wanted to work 9-5 and no weekends	69	49
I am interested in supporting and developing resources in communities	95	67
I wanted a higher paid job than I had before	46	32
I wanted to lead a team	31	22
I feel that the job will fit in with family life and children	70	50
I wanted to work with children and young people	128	91
I wanted to develop my professional skills/knowledge	128	91

* percentages do not add up to 100% as students were able to tick more than one box.

In addition to the statements described above, participants were encouraged to express additional motivations through an open-ended question. All those participating (n=140)

responded to this question, dominant themes included career progression, personal and academic development and feeling passionate about working in prevention, health promotion and public health. Some responses suggested political motivations, focusing on working with disadvantaged groups, improving outcomes for families and children, and building community capacity. One participant commented that she felt ‘strongly about poor health in disadvantaged groups’, and also thought that ‘health visitors were ideally placed in the community to guide families (parents) through preventative health for a better outcome in the future’.

Participants talked about how the programme would give them the opportunity to either formalise previous practice experience through a professional qualification, or to build on previous practice to ‘bring their career together’. This is well illustrated in the following extract: ‘I wanted to move into early intervention work after a long time in a recovery based career in mental health, domestic abuse and substance misuse.’ Inspirational experiences on HV placements as under graduate nurses or personal experience of using the health visiting service generated a great deal of enthusiasm for some. The data suggested a strong sense of excitement and opportunity

influenced by the HV Implementation Plan, high levels of investment and the possibility of improving services for children and families within the community. On a less positive note participants also reported feeling disheartened by working in parts of the NHS; midwives in particular discussed a lack of job satisfaction and poor job opportunities in the South West as a motivation for a change of career.

3.2.2 Changes in attitudes

An important aspect of the evaluation was to assess possible attitudinal changes in students as they progressed through the programme. This was measured by using a set of practice related statements connected to issues of disadvantage, stigma, normative values around gender, violence and more general aspects of public health and health promotion advice. Over the duration of the programme there was very little change in SCPHN students’ attitudes to practice scenarios.

3.2.3 Changes in Confidence

Students were also asked to rate their confidence relating to key aspects of their SCPHN role.

Examples included confidence in visiting families in their own home, working with parents with drug and alcohol problems, working with

Table 2 Training confidence

	n	Time	%					p
			Very confident	Confident	Neither confident or not confident	Not confident	Not at all confident	
Visiting families by myself	140	Baseline	41.4	20.0	18.6	11.4	8.6	0.001***
	88	Follow-up	60.3	38.6	0.0	1.1	0.0	
Working with families who misuse drugs and/or alcohol	140	Baseline	20.0	21.4	31.4	22.9	4.3	0.001***
	89	Follow-up	21.4	49.4	23.6	5.6	0.0	
Working with families with child protection issues	140	Baseline	13.5	38.6	35.7	8.6	3.6	0.001***
	89	Follow-up	19.1	66.3	11.2	3.4	0.0	
Working with families where health professional advice is ignored	140	Baseline	22.8	40.7	27.9	7.9	0.7	0.008**
	89	Follow-up	21.4	57.3	21.3	0.0	0.0	
Working with families with parental learning difficulties	140	Baseline	6.5	12.9	32.1	27.1	21.4	0.001***
	89	Follow-up	14.6	20.2	34.8	27.0	3.4	
Advising parents about family diet	140	Baseline	17.2	47.1	24.3	0.7	0.7	0.001***
	89	Follow-up	41.6	48.3	7.9	1.1	1.1	
Working with families with mental health problems	140	Baseline	8.6	25.7	30.7	26.4	8.6	0.001***
	89	Follow-up	22.5	51.7	20.2	5.6	0.0	
Completing Health Needs Assessment	140	Baseline	14.3	24.3	29.3	20.0	12.1	0.001***
	89	Follow-up	52.8	41.6	4.5	1.1	0.0	

** = p<0.01; *** = p<0.001

Table 3 Signposting to health prevention and health promotion services

	n	Time	%					p
			Very confident	Confident	Neither confident or not confident	Not confident	Not at all confident	
Smoking	140	Baseline	36.4	32.9	20.0	8.6	2.1	0.001***
	89	Follow-up	79.7	16.9	3.4	0.0	0.0	
Obesity	140	Baseline	24.3	30.7	25.7	15.0	4.3	0.001***
	89	Follow-up	57.3	31.5	10.1	1.1	0.0	
Drugs	140	Baseline	22.1	29.3	22.9	20.0	5.7	0.001***
	89	Follow-up	61.8	32.6	5.6	0.0	0.0	
Alcohol	140	Baseline	22.2	30.7	22.1	19.3	5.7	0.008**
	89	Follow-up	62.9	30.4	6.7	0.0	0.0	
Relationship issues	140	Baseline	17.1	28.7	25.7	21.4	7.1	0.001***
	88	Follow-up	50.6	34.8	14.6	0.0	0.0	
Domestic abuse	140	Baseline	18.6	34.3	25.7	14.3	7.1	0.001***
	89	Follow-up	71.9	22.5	5.6	0.0	0.0	
Mental Health	140	Baseline	21.4	23.6	30.0	17.1	7.9	0.001***
	88	Follow-up	62.9	28.1	9.0	0.0	0.0	
Child illness	139	Baseline	29.3	35.7	21.4	10.7	2.9	0.001***
	88	Follow-up	75.3	19.2	5.5	0.0	0.0	
Sexual health	139	Baseline	19.5	27.9	31.7	16.6	4.3	0.001***
	88	Follow-up	55.1	29.1	14.7	1.1	0.0	
Long term conditions management	139	Baseline	17.6	28.9	32.1	15.0	6.4	0.001***
	88	Follow-up	41.6	41.6	9.0	7.8	0.0	

*** = p<0.001

families where there were child protection issues and dealing with postnatal depression. These statements were scored from 1 – 5 (1=confident; 5=not at all confident). At baseline students were least confident in dealing with clients with learning difficulties and mental health problems. The follow up questionnaire revealed that students rated their confidence as higher in relation to all the confidence statements.

In particular students indicated that at follow-up they were twice as confident when visiting clients in their own homes (odds ratio = 2.14, 95% CI = 1.24-3.69), three times as confident when working with parents who have mental health problems (odds ratio = 3.09, 95% CI = 1.43-6.70), and twice as confident when working with parents with learning difficulties (odds ratio = 2.59, 95% CI = 1.06-6.36). They were six times more confident at follow-up around completing health needs assessments (odds ratio = 6.66, 95% CI = 3.54-12.51) and three times more confident when advising on family diet (odds ratio = 3.51, 95% CI = 1.91-6.46). Students also gained in confidence when working with families who may

misuse drugs or alcohol, with child protection issues and where health professional advice is ignored, but to a lesser extent.

3.2.4 Confidence in signposting

An integral aspect of the SCPHN role is to identify and assess need, offer appropriate advice and guidance and refer clients to relevant sources of information. In some instances this includes making referrals to specialist services. Students were specifically asked about signposting to other services, their changes in confidence around signposting on health issues from baseline to follow-up are outlined in Table 3.

Confidence levels were assessed by a 5-point Likert scale (1 = very confident; 5 = not at all confident). There was a significant difference in reported confidence in signposting to other services at baseline and follow-up across all services (p=<0.05). Of particular note is that students were 11 times more confident to refer to domestic abuse services at follow-up (odds ratio = 11.23, 95% CI = 5.99-21.05), seven times more confident when referring to child illness services

(odds ratio = 7.35, 95% CI = 4.02-13.45) and six times more confident when referring to mental health or smoking services (odds ratio = 6.88, 95% CI = 3.70-12.81). All students at follow up consider themselves confident with signposting for a wide range of issues.

Students were asked specifically about their confidence around safeguarding. As shown in Table 4, reported confidence in safeguarding children and young people increased significantly from baseline to follow-up (p<0.05).

Participants were four times more likely to report that they were 'very confident' in safeguarding children and young people at follow-up than at baseline (odds ratio = 4.79, 95% CI = 2.44-9.40).

3.2.5 Changes in skills

At follow-up, participants were asked what key skills and knowledge they had gained from the programme (Table 5). 87 participants (61%) responded, reporting on wide range of practical skills and knowledge obtained including:

Table 4 Safeguarding children and young people

	Safeguarding	
	Baseline	Follow-up
n	140	89
Time	Baseline	Follow-up
%		
Very confident	11.4	38.2
Confident	35.0	44.9
Neither confident or not confident	40.0	15.8
Not confident	9.3	1.1
Not at all confident	4.3	0.0
p	0.001***	

*** = p<0.001

evidence based knowledge, public health policy, communication skills, health needs assessment and safeguarding.

3.2.6 Delivering on the Implementation Plan and recommendations for programme developers

As previously indicated the Health Visitor Implementation Plan (2011a) describes a new model of service delivery, that outlines four levels of service, from interactions at community level, a universal service for all families and higher levels of additional input for families where need has been identified. A significant aspect of the SCPHN programme has been to prepare the students for this new service vision with specific attention given to leadership, building community capacity, developing therapeutic relationships and public health practice. On comparing baseline and follow-up responses, there was a significant difference in the number of participants who felt that developing community capacity was part of their role, Fisher's Exact Probability Test (3, n=229)=24.21, p=0.001. Participants were three times more likely to report that community capacity was part of their role at follow-up than at baseline (odds ratio = 3.58, 95% CI = 1.95-6.56). In addition to increasing levels of awareness that developing community capacity was part of their role, reported skills in working with and for communities to improve health and wellbeing was shown to be higher at follow-up when compared with baseline. As shown in Table 6, Fisher's Exact Probability Test indicated that all changes were statistically significant (p<0.05). At follow-up participants were five times more likely to report that they were 'very confident' in their ability to create positive relationships with

Table 5 Follow-up skill-set

	n	%				
		Very confident	Confident	Neither confident or not confident	Not confident	Not at all confident
Assessing health and wellbeing	87	19.5	57.5	20.7	2.3	0.0
Improving health and wellbeing	87	33.3	54.1	11.5	1.1	0.0
Developing health programmes	87	15.3	61.2	23.5	0.0	0.0
Developing programmes to reduce health inequalities	87	17.2	55.2	27.6	0.0	0.0
Applying leadership skills	87	19.8	66.5	13.7	0.0	0.0
Managing people	87	19.6	58.6	21.8	0.0	0.0
Partnership working	87	34.4	56.3	8.2	1.1	0.0

Table 6 Delivery of the Health Visiting service

	n	Time	%					p
			Very confident	Confident	Neither confident or not confident	Not confident	Not at all confident	
Do you have the confidence in your skills to do the following?								
Create positive family relationships	140	Baseline	44.3	38.6	13.5	2.9	0.7	0.001***
	89	Follow-up	80.9	19.1	0.0	0.0	0.0	
Create positive community relationships	140	Baseline	30.0	35.0	24.3	10.0	0.7	0.001***
	88	Follow-up	59.1	34.1	6.8	0.0	0.0	
Address local health inequalities	140	Baseline	7.1	34.3	36.4	14.3	7.9	0.001***
	89	Follow-up	41.6	46.1	11.2	1.1	0.0	
Work with other health professionals	140	Baseline	37.1	39.3	18.6	4.3	0.7	0.008**
	89	Follow-up	69.7	23.6	5.6	1.1	0.0	
Work with Early Years professionals	140	Baseline	24.6	40.8	27.4	6.5	0.7	0.001***
	89	Follow-up	61.8	31.5	5.6	1.1	0.0	
Work with community leaders	140	Baseline	14.3	25.7	38.6	20.7	0.7	0.001***
	89	Follow-up	31.3	33.7	30.5	4.5	0.0	
Work with public health professionals	140	Baseline	35.7	42.9	15.7	5.0	0.7	0.001***
	89	Follow-up	69.7	24.7	4.5	1.1	0.0	
Engage with e-learning	140	Baseline	37.1	37.2	20.7	5.0	0.0	0.001***
	89	Follow-up	66.3	32.6	1.1	0.0	0.0	

*** = p<0.001

local families than at baseline (odds ratio = 5.33, 95% CI = 2.85-9.95). When assessing changes in skills confidence in other areas, similar findings were revealed: in particular, participants at follow-up were nine times more likely to report that they were 'very confident' in their ability to address local health inequalities at follow-up than at baseline (odds ratio = 9.25, 95% CI = 4.29-19.26); were almost four times more likely to report that they were 'very confident' in their ability to work with other health professionals at follow-up than at baseline (odds ratio = 3.89, 95% CI = 2.20-6.85) and were five times more likely to report that they were 'very confident' in their ability to work with Early Years professionals at follow-up than at baseline (odds ratio = 5.00, 95% CI = 2.81-8.89). They also reported increases in confidence in their ability to create positive relationships with local community groups, to work with community leaders and to work with public health professionals at follow-up than at baseline. These are important findings if this work is to be proactively promoted by a newly qualified workforce.

At baseline students were also asked to outline the skills their intended role would entail. Predominantly students highlighted the

importance of child protection, safeguarding and communication. The statements in response to open items below are typical:

Child protection, education, preventative and health promotion, communication skills, open minded however having scepticism skills. (SCPHN, 17)

Child protection, safeguarding, baby clinics, home visits, attending meetings and conferences and helping children and families to live happy, healthy lives. (SCPHN, 140)

However, by the end of the programme students had an increased awareness of the importance of their role in terms of leadership and their role leading the Healthy Child Programme. Whilst students understood that a huge range of topics are covered within a 52 week programme, of the 50% of students who did identify potential areas where more time could be allocated for study, 33% reported wanting more information around child development. This is worth noting as the programme adopted a blended learning approach and students were asked to complete identified sections of the Healthy Child Programme e-learning resource (DH) to supplement their practice learning around child development. The programme tended to focus

on more complex demanding areas eg. brain development, attachment, development of social capital as highlighted within the framework Educating Health Visitors for a Transformed Service (DH, 2011c).

3.3 Qualitative Findings from Students

Two focus groups were undertaken by two researchers across both Plymouth and Bristol sites and included both health visitors and school nurses. In total, eleven students took part. Data were analysed around three core themes these included: experiences on the programme, looking to the future in practice and recommendations for the programme. Tables 7 and 8 highlight the biographical characteristics of those who took part.

3.3.1 Experiencing the programme

Students articulated having developed a wide range of skills and knowledge whilst on the programme. In particular, they reported developing an appreciation of the wider determinants of health and taking a more 'public health' approach to practice. This meant developing a holistic approach to families using a social model of health needs assessment and analysing need both in terms of health and inequalities.

"I would go for the public health modules I thought was very good for me because that's what did join up my thinking ... public health and building community capacity – looking at profile of communities and ... its had an impact on my practice ... looking at ... what would be beneficial for the whole school as opposed to an individual child" (Student 6, Bristol)

"I see myself as a specialist community public health nurse ... I don't see myself as a health visitor because the programme has made me more aware of those wider determinants of health and particularly the health promotion module and the alternative public health practice days that we did really influenced my thinking around health. I spent 2 days with local housing agencies – it really opened my eyes." (Student 1, Plymouth)

Those who had completed a 'working therapeutically with families' module during their programme felt this was highly relevant and important in terms of skills development and building relationships with families. Learning about motivational interviewing, improving communication skills and developing partnership working, was viewed as having had the most direct impact on practice with families.

Table 7 Biological backgrounds of focus group participants, Plymouth

Student 1	10 years midwifery. 1 year Community Public Health Nurse (HV)
Student 2	1 year RNMH Learning Disabilities, 16 years RMH, numerous inpatient and community roles in mental health (HV)
Student 3	7 years general nursing including agency working, 3 years mental health, 3 years school nursing (SN)
Student 4	13 years nursing. Mix of acute, Paediatric, Oncology and health visiting (HV)
Student 5	3 years general adult, 3 years mental health (HV)

Table 8 Biological backgrounds of focus group participants, Bristol

Student 6	4 years children's nurse: 3 years in hospital, children's oncology and 1 year school nursing (SN)
Student 7	12 years HCA children's ward. 3 years as children's nurse on paediatric ward and 4 years in school nursing (SN)
Student 8	15 years adult nurse, 3 years in the community with immunisation team, 6 months school nurse (prior to starting SCPHN programme) (SN)
Student 9	14 years paediatric nurse in hospital. 2 years as community health nurse (HV)
Student 10	16 years paediatric nurse – most in acute setting, 3 years in community as school nurse (SN)
Student 11	12 years as mental health nurse (acute and community). 4 years working for LA working with families with MH problems (HV)

Importantly, this learning appeared to have created a shift in students' thinking, away from professional led to more client or community centred approaches. These aspects students found fundamental in terms of building their confidence and working effectively, both with individuals and communities. These points are well articulated in the following extracts:

*"Rather than trying to **give them solutions** to things, because I think when you are from a **nursing background**, you are just trying to do it, do it, do it, get it done, help, help, help to actually **put it back to them a little bit** and say well how do you think you can do this ... this has just given me maybe a different perspective ... an alternative way to get families to come up with things, rather than it being all about what we can offer." (Student 3, Plymouth)*

“You would notice the family setting the agenda, more in control’ – power more with the family – more at ease with this shift in power dynamic. ‘Systemic look’.” (Student 2, Plymouth)

Learning about children particularly around child development and child protection were viewed as essential to meet the demands of the role, including exposure to the theories underpinning effective interprofessional working and collaboration. Students reported having started on the programme with varying degrees of safeguarding experience, therefore learning about the policy context and the evidence underpinning interventions helped build confidence, allay their anxieties and equip them to deal with perceived challenges that lay ahead. Universally, child protection was viewed as a core skill to be achieved during their time on the programme:

“It’s always something in my previous role that I was quite scared of ... I avoided it if I could, but I am not [afraid] now, I feel with that knowledge I can confidently sort of go into that child protection arena, and know what I am talking about.” (Student 7, Bristol)

The development of broader critical thinking skills, such as analysis, synthesis and service development was perceived in more complex and contradictory ways. For most it was crucial, making the learning powerful and interesting while for others, there was a sense that the health visiting role was less demanding and required less analysis than the programme team/ or professional bodies demanded. A minority of students suggested many of the subjects could be taught to less depth and breadth. The following two quotes highlight these contradictory views:

“It has made me look at the theory behind everything and how ... theory relates to what we do, ... it’s changed my thinking in relation to looking at how I practice ... Evidence Based Practice was words before the course whereas now actually when I am doing stuff, I am questioning it and I am making other people question.” (Student 8, Bristol)

*“I do actually think that the intensity and how much is in the course is **unnecessary for the job**, and I really think that is, um, is a real thing, you don’t need it, you just don’t need it all.” (Student 2, Plymouth)*

There was general agreement that the programme was ‘full on and intense’ and for some the realities of the job were much more limited than the scope inferred by the teaching both in the practice and academic setting. This intensity was sometimes likened to a notion

of ‘specialness’, a view further reinforced by qualified SCPHN practitioners they came into contact with. However, students reported that in reality what was required in practice, did not mirror or justify this reified view, particularly in terms of the health visiting role. This contradiction was also evident in how students felt others perceived them:

“People don’t perceive that though, families don’t perceive that [HVs as special]. Our children’s centre manager was really, really surprised that I was here doing a Masters level qualification just to be a health visitor, because she couldn’t see how I was ... how it was such a special job, and how actually, it was worth more than working with sick children in a hospital.” (Student 2, Plymouth)

3.3.2 Looking to the future in practice

Participants were looking forward to the opportunity to have more scope, practice autonomously and begin to make an impact on the health and well being of children and families. There was some consensus that the programme had been inspiring, but concern that they might struggle to implement all they had learnt in practice:

“It sounds like we have been really inspired and if there is access to build community capacity, and we are supported by managers in practice, definitely, I think the one thing that I have got from this course is a lot of inspiration, so I think yeah, the possibilities are there as long as it’s not quashed when we get into practice.” (Student 9, Bristol)

Participants also raised concerns about the implications of losing their students status, particularly in terms of increased workloads that would limit their ability to put into practice the more developmental aspects of their role:

*“We have achieved a lot for our service in the last 12 months, but there is that danger that we will go back to practice, and we will have a caseload and that’s where our responsibility will be, and **having your wings clipped** ... with the developmental stuff.” (Student 11, Bristol)*

*“I am **not as inspired by the reality of the workplace** ... I go back to practice and I feel sometimes that, um, because people are under pressure to deliver the healthy child programme ... it focuses on quite a small micro area of that public health role.” (Student 5, Plymouth)*

Both school nurses and health visitors within the focus groups saw the issue of delivering on the public health aspect of the role as problematic. Participants consistently made reference to the theory practice gap, articulated by their

frustrations of taking back enthusiastic learning and new ideas to practice teachers and mentors, who responded in ways that dampened their enthusiasm. There was an increasing resignation that to meet the demands of the core service particularly around the Healthy Child Programme meant that there would be little time to develop broader aspects of the role. The most common illustration of this was in discussions about building community capacity, which was seen as something highly relevant and important, that there would be little opportunity to deliver on. These fears were further compounded by a sense that existing staff had not always been afforded the same level of exposure to new ways of working so were not invested in the delivery of the new vision, or trying new ways of working:

*"You get back to your work place and think you are just kind of going back and feeling a little bit full of it really, we did this, we did that ... its going to be brilliant and I am going to start this project, and I am going to do this, this, this and this, **and then your mentor says, actually that's great, but** you have got this and until we can deliver the basic core service, and until we have got staffing numbers up, none of this is going to happen ... it's trying to get everything in place in order for those things to happen, but that brings with it its own sort of frustrations and there is nothing really that you could have included extra on the programme to allow for that, that's a workplace issue." (Student 9, Bristol)*

*I don't think the programme needs to include any extra knowledge ... but ... there has been a definite sense of students being both **fragmented** from what they are learning academically and practice, and in an ideal world, it would be lovely if the education that's been given to us, and the amazing things that we have all learned, could somehow be **passed on to the people who are currently in practice** who have been practising for many years and have lots of experience, but its kind of I felt very fragmented ... coming in as the new wave of health visitors that the university obviously wants us to be, and I think that the sense from other students is that hasn't matched up, you know, its almost like **we are speaking a foreign language** or we have got rocky ideas ... I think maybe we wouldn't be perceived as this new wacky, new breed of health visitor, if a bit more people were exposed to the programme content." (Student 1, Plymouth).*

3.3.3 Recommendations for the programme

Students came up with suggestions of how the programme could be further improved these

included: reducing the numbers in groups; lengthening the programme; more focused teaching on inter-professional working; didactic teaching on child development and improvements within IT particularly blackboard. In addition students felt being prepared for the intensity and demands of the programme by the academic team was helpful, and several mentioned that expectations needed to be clear and set at the beginning on the programme:

"Things have to go to the side because you have to focus on this ... a strict talking to at the beginning when everybody is here on their first day." (Student 4, Plymouth)

For some students the large cohorts had detracted from opportunities to have a more personal relationship with their lecturers within the academic setting, the school nurses in particular felt there should be opportunities for student led sessions which acknowledged, and drew upon their experiences and skills. Also more opportunity for students to feedback from practice, one student suggested 'we don't do enough of that'. However, the most significant area was bridging the theory practice gap, while students recognised it was important to be aspirational, there needed to be more recognition of the difficulties students faced in putting theory into practice. Students discussed the tensions between the commissioned agenda, which practitioners had to deliver versus what was viewed as uncommissioned work such as community capacity building:

"I think in practice from my perspective the staff are so concerned with delivering the core commissioned business, a lot of the stuff that we talk about academically isn't commissioned – the building community capacity, we need to look at how we can build that in to our commissioned working ... I suppose the academic programme needs to marry up with what services are commissioned locally." (Student 4, Plymouth)

"The academic teaching has been fantastic' but 'I have been frustrated with the lack of link between practice and that alienation." (Student 2, Plymouth)

There was a suggestion that involving practice teachers to a greater extent within the University may help this. An interesting point as several practice teachers had been recruited to the University as secondments to work alongside the academic team and several of the academic staff continue to practice on a sessional basis or are undertaking primary research focused on practice issues related to specialist community public health nursing.

4 Findings from stakeholders

4.1 Service Managers' perceptions of SCPHN students

Seven service managers were interviewed using a semi-structured interview technique, either face to face or by telephone. Six of the managers were leading services in health organisations from a range of geographical areas in the South West, and one interviewee was the manager of a children's centre and voluntary services organisation.

The service managers interviewed expressed a deep enthusiasm for tracking and monitoring the progress of SCPHN students both within their own organization and at the university. Service managers had various means of meeting and communicating with their SCPHN students. All said they had an 'open door' policy and most communicated through a range of methods. Out of necessity, they have a less intense relationship with the SCPHN students than practice teachers but all felt they grew to understand the SCPHN students on their journey into practice, including gaining insight in to their motivation for becoming SCPHN practitioners.

4.1.2 The SCPHN programme

The managers identified diligent selection and recruitment as a key factor in the success of the students, and universally felt that the process of recruitment was becoming more refined as each successive cohort of students was selected. One interviewee suggested that previous cohorts may have been more technically able but found the implementation of the new service model (at that stage) into actual practice more frustrating.

The programme was amended to meet the requirements of large student numbers as part of the Implementation Plan, and this was also highlighted as posing broad and numerous challenges. There was sympathy expressed for those delivering the programme; in particular that the training had to be delivered with a limited run-in time making the first run of the programme an *uphill* struggle.

Some service managers also suggested that the ability to survive in a community setting is an important capability to consider at the recruitment stage. Whilst empathy and a desire to engage with families was recognised as an important motivator in potential SCPHN students, experience of community settings was seen as increasingly important by service managers.

"... quite a few of this years' students we had employed as community staff nurses in our community teams so they had a bit more experience about community development."
(Manager 6)

Service managers were asked about what they thought the programme gave SCPHN students. One felt it covered: all the vision requirements. The majority felt that the taught element of the programme offered opportunities to discover and understand the best evidence based practice and models of health visitor practice. An example of this is that one service manager reported on an extensive discussion with a SCPHN student around the latest practice on working therapeutically with children. However, managers also felt the programme, including the practice elements, provided opportunities to gain non-academic, non-curricular skills and experiences, which were harder to define and not formally accredited, such as communication skills, personal development and a greater understanding of diversity. The opportunity to share practice experience with others, leading to cross fertilisation of ideas was also seen as an integral benefit of the programme.

Some managers reported particular apprehension about the extent SCPHN students had experienced client diversity in their clinical and practice careers. Thus service managers hoped that the programme would provide more insight into the challenges that could be posed by diversity.

"I think it's about allowing them the time to explore those things that maybe you've never really thought of or you've kind of thought of in passing because it's been on the news or you've read about it but you thought; oh I don't agree with that, but you've never really looked at or maybe why you don't agree with that. Is it [perhaps] about your religious beliefs? Is it about, you know, how you were brought up and therefore you've never come across that situation ... you know a lot of people I find ... which I do find quite strange ... is they've never had any ... they've never known anybody who has say been in a same sex relationship." (Manager 7)

Not only did managers emphasise the practical skills that the students gained, but also attributed value to the changes in perception that were essential to SCPHN practice, particularly if a student came from a role where they had been immersed in a medical model:

"... coming from a medical model perspective you just think one way ... and that's what the training has to do ... help you to think in more than one way." (Manager 3)

So service managers felt that it was vital that the programme helped to mature SCPHN student attitudes. However, this should be achieved through partnership between the university and practice, with service managers anticipating that this might not be possible to achieve during the programme and extended experiences in practice may be necessary to build on any new ideas or values discussed on the programme:

"Is it enough time to mature people's values and their behaviour? Many were in very directive roles before but now they are being asked to be more facilitative." (Manager 6)

"So I think that people do understand what the values of health visiting and school nursing are and I think the students coming through understand that on the whole. They might not be able to do it but they understand what it is. I think that they don't necessarily have enough time within the course to develop that level of thinking." (Manager 5)

"Values you can't teach ... well you know if you put enough evidence their way hopefully you will but it might take a lot longer." (Manager 3)

Managers articulated a range of skills they felt were essential for SCPHN students to acquire in order for them to be successful in future practice. Acquisition of these skills by a student would indicate that the programme had been a success. These included the following:

- Good communication skills
- Good IT skills
- An ability to think out of the box
- Leadership skills
- Being responsive to change
- Emotional intelligence
- Practitioners who were enablers
- The ability to wear more than one hat
- Good at relationship building
- Assertiveness

"We need practitioners that can be responsive to change because this is a change environment isn't it?" (Manager 3)

"... assertiveness, not aggressiveness ... because we have some health visitors who confuse assertiveness with aggressiveness and they come over to other people as being overly forceful and that causes challenges." (Manager 5)

4.1.3 The SCPHN programme and the crucial leadership role

All service managers felt that the training and practice experienced on the programme provided

real opportunities for the SCPHN students to develop leadership skills. The opportunity in practice varied depending on the locale, caseload and the support provided to the student, however, the managers anticipated that opportunity to utilise leadership skills would expand as pressures on caseloads ease and the culture of change within the organization evolves. Leadership skills were seen as particularly important for SCPHN students returning to practice.

"And that's something that we were starting to look at and explore. I think the leadership role of health visitors generally prior to this expansion plan, I think a lot of them weren't stepping up to the mark from a leadership perspective. It is something that we will do as caseloads reduce." (Manager 7)

"Showing leadership in building community capacity is quite minimal at the moment. Perhaps after 2015!" (Manager 7)

"I think in some areas they're starting to but I think it's quite limited." (Manager 2)

Managers were aware that students demonstrated a range of competence in leadership, and attributed this to prior experience. In particular, students who were previously on a higher-level pay grade on entry onto the SCPHN programme were seen as more capable, with nurses previously based on a ward having insufficient breadth of experience to show as much initiative as those on higher grades from a community background.

"It's about leading the work, leading the community, being accountable for your practice. If we're looking at things like building community capacity, which is the first level of the health visitor implementation plan ... that's a very different way of working for somebody who has come from a hospital based service and it needs a degree of leadership and awareness to be going out and working in a community development capacity and that's quite a trick isn't it?" (Manager 5)

Conversely, service managers were beginning to see examples of SCPHN students demonstrating leadership skills, which are helping to foster a culture of change within their organisation.

"... sometimes the students and the younger ones in particular spot opportunities that perhaps the older ones may just take for granted or not see the potential." (Manager 1)

"I think having the new people come in is changing how people perceive things and having more students, because more staff have been exposed to the students actually, I think is making them a

little bit more politically aware and that's what's changing and that's how things are moving on." (Manager 7)

"... .. they've seen opportunities for leadership and put themselves forward and what that's done is made other people think right ... oh well they're doing that, maybe I should be doing that. Some people have said oh ... how come they're being offered that opportunity and I'm saying ... well they asked." (Manager 6)

"In some of the bases ... they're having the new students, they're exposed to these students and the students are asking questions. It's making people rethink and focus about where they are and where they're going." (Manager 7)

Clearly, the SCPHN students can be a catalyst for change and there is a sense that this will only increase and expand as more newly qualified practitioners enter the service.

"I think at the moment it's stronger than it's ever been but it's not as strong as it's going to have to get." (Manager 2)

Service managers recognised the challenge for newly qualified practitioners as they step into practice. This was seen as a time when they begin to consolidate their knowledge. All managers acknowledged that preceptorship programmes in the form of professional support and development are essential to support the safe transition into their new professional career.

"People need time to consolidate and we don't expect them to run before they can walk because then we're setting them up to fail." (Manager 7)

4.1.4 The SCPHN programme: achievements and additions

Service managers were invited to comment on the delivery of the programme and suggest things that might enhance the learning experience of the students. All accepted that it had been a challenge to get the programme up and running in time when specifications were minimal and timescales were short. The contrasts in service delivery models and the size of service organizations in the region were seen as adding to the complexity of the challenge of running a SCPHN training programme.

"Yes, I think ... I think it's been very difficult for UWE because they've had ... they had to implement a syllabus for the health visitor implementation plan without being told what it was going to look like. So they had to look at what they'd done before because there was a very tight turn around and they weren't getting any learning

from the DH from the early implementer sites, they were just having to put out a programme together. The programme was fine if you were talking about the old health visiting but we've got to do the new health visiting, so for this ... the September 2012 cohort, I hope that my students who come out of that, come out telling me [more] about the healthy child programme and the health visitor plan ..." (Manager 5)

The relationship between the practice placements and the university was seen to be crucial to the success of the students on the programme, and this relationship at the time of interviewing was generally perceived to be positive and productive. A central tenet of this relationship is the tripartite meeting between organisations, students and the Academic in Practice from the university. The managers valued these meetings to address day-to-day administration issues as they arose.

*"We do have quite a good working relationship so we can go back to ***** (a member of the Programme team) or we can go back to the team and say look we're having this real issue or we've interviewed and this bit really seems to be missing, what can we do about ... how can we work together to put those things in?" (Manager 7)*

There was no broad consensus on what could be done to enhance the delivery of the programme. The programme is currently delivered on a 50:50 theory: practice basis. Considerable reflection and deliberation was given to the balance between the academic element of the programme and student's practice experience but modifications to this to improve the programme were not clearly articulated. Ultimately the managers felt that students needed to develop the clinical skills necessary to deliver the SCPHN service, together with critical enquiry skills, which would lead to effective practice, which was seen as a joint responsibility:

"All of this is about up skilling themselves and questioning themselves so maybe we should be doing that altogether." (Manager 2)

4.1.5 Potential future challenges for health visiting service delivery

The service managers were asked to discuss the challenges they envisaged for SCPHN students.

"Clearly learning doesn't stop at end of the SCPHN programme and service managers anticipate continuous training in the future." (Manager 7)

This expectation applies to all newly trained staff and existing staff who have not enjoyed the benefits that accrue from the programme.

There have been tensions between new and existing staff, which have presented a challenge to manage. On the one hand it was noted that the new staff can provide an impetus to service delivery, but there is also some anxiety around the impact that this has on existing staff who have been providing services in the organization for some time, albeit working to a different service delivery model:

"... yes because obviously we still have our collection of laggards who don't want to change and with the changes that are coming, like a train down a track at the moment and with so much training coming on board ... we are already hearing mutterings that the laggards are seriously considering their options so, you know ... in some ways that might be a good thing to have fresh blood etc, ..." (Manager 3)

"... we lose some of the old school health visitors who are resistant to change and so I can see that strengthening our service." (Manager 2)

Unsurprisingly, service managers remain committed to supporting their new health visitors in order to ensure that the culture of change is sustained.

Service managers' biggest anxiety was what will happen in March 2015 when the initiative to recruit comes to an end. This appeared to raise several issues including concern that there will be sufficient jobs for everyone who qualifies. The managers were also wary of change in other agencies, together with NHS reorganisation, undermining the drive to change health visitor practice.

"What will happen post March 2015 ... will there be any jobs in the local authority sector?" (Manager 6)

"What happens post 2015 and especially in the any willing provider approach ... Health visiting always has been an easy mark for cutting money?" (Manager 4)

The changes around the future commissioning of services will be challenging. Service managers are already finding that they have many masters to please. In reality the implications of the recent NHS forms have not yet been sufficiently gauged. In some locales competing for service provision is well understood and an experience already endured so that future requirements to tender for services will not come as a particular surprise to those providing services through a social enterprise approach. Some service managers are thinking ahead and have become very focused on collecting data and ensuring they demonstrate

future performance against key performance indicators.

"... we need to ensure that we have such a fantastic evidence based service that there is no way that they would want to cut that service. Part of that is also ensuring that primary care understand how important health visiting is so that if Public Health England do decide to do some kind of cuts the clinical commissioning group will campaign on our behalf and say well don't do that because this will have a direct impact on outcomes for children and families." (Manager 5)

But service managers are also mindful that local authorities are likely to be looking to cut service provision rather than expand, which may put pressure on the SCPHN service to meet the needs that evolve, particularly in more disadvantaged communities.

"I think that the economic pressures or fiscal pressures on other services will mean that health visitors and school nurses will feel they have to step into the gap where other services are currently operating and I think it's very important that health visitors and school nurses know what their role is and actually don't stray into other stuff." (Manager 5)

Services managers were very aware that newly qualified SCPHN practitioners will need to avoid being coerced into covering work traditionally completed by other agencies but where services have been withdrawn. Whereas this will be difficult, it could be an opportunity, given the changes to commissioning arrangements for SCPHN services. A key to success may be educating stakeholders and commissioners about the new service model and so ensuring the service is sustained. Commissioners were perceived to have an outdated concept of the SCPHN role and hence its value.

"Commissioners are ... people who have an expectation of the service as it was five to ten years ago and its very, very difficult to have that dialogue with the commissioner who believes that our communication with midwives was as it was ten years ago where they all sit having lunch together ... and they can't possibly see how we don't have that sort of relationship with the midwife the same with GPs, they don't really get the complexities of working with Children's Centres so that's another challenge." (Interviewee 5)

"Service users will not know anything about the new service vision or necessarily their entitlements." (Manager 5)

4.1.6 Meeting the challenges of the future

All service managers welcomed the Call for Action and the significance of the times in which local service managers found themselves was a common theme in the stakeholder interviews. All were aware that the next couple of years offered a real opportunity for promoting the role of the health visitor and school nurse in their local area. On the whole the service was seen as experiencing increased morale because of the expansion in resources and the increase in attention from policy makers. All were aware to various degrees of the changing commissioning structure that was evolving around them and the opportunities that this would offer the service to develop to meet contemporary demands.

"... worst storm for us or maybe the best storm for us because we will have had to transform quite a lot in quite a short period of time." (Manager 2)

Ultimately the significance of the change and the implications for local service delivery amongst practitioners in their organization is now filtering through as more SCPHN students enter into practice. This understanding of the new service vision continues to be fostered but it still requires increased advocacy from all practitioners:

"The Call for Action came in 2011 it really didn't hit us until two or three months after publication in any great way and that was at a strategic level. So then you know you filter that down to staff and it's still very new we have been asked to jump through quite a lot of hoops, quite rapidly and so to implement the Call for Action on an already critical staff workforce that's got quite a lot of staff shortage it has been quite a big ask and strategically to understand what Call to Action really means I think every month that happens and we pass through people are more aware of what the new service actually looks like I think there is a better buy in with every month that passes so I do believe we will get there. I also believe that there is a hard core number of the workforce that will never be there they will never be there and you know we mustn't under estimate the influence that they have on the existing workforce, they plant a seed of doubt or anxiety in their colleagues about the reliability of the way forward and that can upset the apple cart." (Manager 5)

4.2 Stakeholder Interviews with Practice Teachers

Ten practice teachers were interviewed, using a semi structured interview technique either face to face or by telephone. Nine of the practice

teachers were women and one was a man and all ten worked as health visitors. Their experience as health visitors ranged from six to twenty-one years. One interviewee was currently completing the module in order to qualify as a practice teacher and the most experienced had been in the role for fifteen years. The practice teachers were based in a variety of rural and urban settings, in both the north and the south of the geographical area covered by the UWE programme. The participants were self-selecting, having responded to an invitation to take part. It is acknowledged therefore that the findings are situated within the context of the individual work environment and as such their particular views may not be representative of the entire practice teacher workforce.

4.2.1 New ways of working with students

The health visitor implementation plan has had a marked impact on the way practice teachers work with students. All ten interviewees discussed the fact that they were now working with more than one student at a time and that mentors were now involved with the day-to-day supervision of the students. This was logistically difficult, involving careful planning and creativity so that students were offered a positive experience and had sufficient contact with the practice teacher as well as the mentor, particularly so that the practice teacher could feel confident in the ability of the student, given the reduced contact time. The practice teachers felt that they were learning all the time about how best to manage the new ways of working, and this learning was especially important if a student was not finding the practice element easy.

"I think that we have learnt a lot from it in terms of the need to include the mentors much more in one to one and you know get some reasonable feedback from them really and so that's one of the things that I think wasn't so helpful it was difficult at times to meet with mentors and get some reliable feedback particularly if there were issues." (Practice Teacher 6)

One practice teacher felt strongly that the change in the way she was working with the students was contributing to her personal stress levels. The change was not universally seen as a positive development for students, and underlined the need for a robust preceptorship programme once students qualified.

"That actually is such a challenge I think that's going to weaken the training I think we are going to get differently trained health visitors and I

think the importance then is to make sure that a preceptor programme is in place when they qualify to support them within practice.” (Practice Teacher 2)

“... and then you have to offset that against the needs of the mentors and in these times of very constrained staffing that takes a lot of careful thought as well and the balance of the team, the office space, the learning environment, the caseload profile um all those things are thought about and that goes for consolidation as well so its not an easy process to get it as good as it can be.” (Practice Teacher 3)

One positive aspect of working with mentors was that it allowed students to work with a variety of practitioners and experience a wider view of practice. However the importance of preparation for mentors was highlighted in order to prevent confusion about the scope of SCPHN student practice.

“I said we cant do that we have to the student can't go there as an independent person because she can't take responsibility for any decisions that are made and so we basically sorted that out but the student bless her she was in consolidated practice and thought oh well this is part of my development I will just do it and we did a bit of conversation around why it wasn't appropriate and so forth so I think you know we will have these issues cropping up.” (Practice Teacher 4)

“The other thing that I found is I think it can be very open to lack of consistency when we as practice teachers look at say evidence from students and that's something that we have discussed in our group several times about how can we be sure that we all have the same guidelines you know we are doing the same thing.” (Practice Teacher 9)

A solution to misunderstanding was to have a practitioner to coordinate the SCPHN education in the organisation. In health organisations where this was in place, the role was seen as central to the student experience as the post holder could act as a conduit for ideas, disseminate information and hold an overview of placement activity.

One practice teacher discussed the impact of reduced health visitor resource on their ability to keep updated, due to time restraints. Conversely, the implementation plan has required a number of new practice teachers to be trained in order to support the larger body of students. One practice teacher expressed concern that the successful use of mentors may allow the NMC to rescind the requirement for SCPHN students to work with practice teachers, making these

newly qualified practice teachers surplus to requirement. Another interviewee suggested that this has had the advantage that a number of practitioners have recently attended university, and are subsequently confident with study skills and able to offer students a fresh outlook. Two practice teachers felt that the Call to Action had opened doors across the profession, particularly for practice teachers.

“Can I just say its been a marvellous opportunity for the practice teachers because we have been able to develop opportunities and also lead and develop innovative practice which perhaps wouldn't have happened if we hadn't have had this drive.” (Practice Teacher 7)

4.2.2 Student diversity

The practice teachers identified that the students they were working with had entered the programme from a variety of different previous roles, which had an impact on the learning needs of the students. Practice teachers discussed students from acute backgrounds, community roles, and those who were newly qualified as nurses. There was no consensus as to which background was beneficial to becoming a SCPHN, but a feeling that the prior experience of the students was more diverse than before the Implementation Plan.

Although diversity was seen as an advantage where students were in a position to learn from each other, equally entrenched ideas and learned behaviours could be difficult to change. Newly qualified nurses were seen to adjust more comfortably to the demands of study but nursing experience was seen as valuable in order to develop communication, lateral thinking and analytical skills.

I: “What sort of social skills do you think we're missing in that first cohort?”

R: “Communication ... The ability to think outside the box. Some of the staff nurses had come from an area where ... where they were task orientated, they were given tasks to do and so that's [what] they did and therefore couldn't independently think on their feet to kind of ... what does this mean? Analyse it, how do I evaluate it? How do I take this forward?” (Practice Teacher 5)

One practice teacher expressed the opinion that students were entering the SCPHN programme with less experience than had traditionally been the case, but that attitude and aptitude are just as important as experience.

R: “before you know people coming through with 10 to 12 years of experience with nursing now you

have got young people who are newly qualified two years qualified and its quite rare to actually find anybody who has been qualified more than five or six years coming into it ..."

I: "... and do you think that's a good or bad thing?"

R: "I think you need a mix and really it should be on you know attitude, aptitude rather than sort of you know how long you have been qualified I have always felt that anyway."

I: "OK so you are saying that it's the attributes of the individual that are important rather than the amount of experience they've had?"

R: "Yes." (Practice Teacher 2)

4.2.3 Programme structure and curriculum

Students are timetabled to spend some of their time each week out in practice, and some time completing academic study. They compile a portfolio to demonstrate competence in practice and are assessed academically by written assignment and exam at UWE. The practice teachers were asked about the 50:50 split of academic and practice work during the programme. Whilst they felt students did spend 50% of their time in practice, they felt students often perceived the academic work to be more imperative, perhaps because of the assessment deadlines. Conversely, most seemed to enjoy the practice element of the programme to a greater extent.

"I think they perceive it [the programme] more academic I think the students and I think that's probably because they have got finite cut off dates you know that assignment has to be in on that date and that sort of exams would be on that date I think that is just the nature of the beast isn't it?" (Practice Teacher 1)

One practice teacher felt that a theory-practice gap was inevitable, but that the relationship between the university and the practice placements was helpful to minimise the impact on the student. Practice teachers specifically mentioned the role of the Academic in Practice, tripartite meetings and practice teacher forums as beneficial to reinforce partnership working and support students.

"There is always going to be a little bit of a practice theory gap I think the academic in practice idea is a good way of bridging that and I think certainly there are other developments over the last 20 years particularly the internet that actually makes it a lot easier." (Practice Teacher 2)

One concern was that it was not always possible to offer the student the range of experience in practice that would support their academic

learning, due to the restrictions presented by caseload. However, supporting students to access alternative practice experiences that would fill the gaps may mitigate this. Conversely several of the interviewees suggested that traditional choices for alternative practice were harder to access due to the large number of students and that the time spent away from the core role may impact on the speed of their learning and confidence levels.

4.2.4 Preparation for practice

Practice teachers were asked what they thought the core values are that underpin the SCPHN role. Personal attributes such as openness, honesty, trust, compassion and empathy were a common response, but also the ability to be assertive, challenging and professional. Communication skills, including the ability to listen, were seen as central to the role, as was the ability to make holistic assessments and remain professional.

"They should be acting with integrity, they should be ethical, they should be impartial not judgemental and uphold their reputation and their profession." (Practice Teacher 9)

The interviewees were asked if they thought the programme prepared the students for practice as SCPHNs, particularly in the areas of leadership and partnership working. Whilst the general consensus was that students were well prepared, a preceptorship programme was seen as essential to boost confidence and support newly qualified practitioners who may feel vulnerable without a 'student safety net', especially in the area of child protection and leadership.

"Yes I think that is a risk we do have quite a thorough preceptorship programme which requires leadership skills within it so for the first year there should be opportunities to have a go." (Practice Teacher 10)

Here again the prior experience of the student was seen to affect the extent to which they could demonstrate leadership during their time in placements. Some students with leadership roles prior to starting the programme were confident with their skills, others less so. However there was some debate as to whether this was influenced by the academic element of the programme, the personal attributes of the student or their opportunity for experience in practice. Where students did demonstrate leadership ability during their placements, there was a degree of cynicism as to whether they would be able to maintain momentum with service improvement once qualified, given

the current situation with capacity and NHS reorganisation:

"I think it's because they are in such a new learning environment I think there are the components of leadership and I think because we are taking students from such a diverse base um at some or less experienced with working with other ... they have never been in a role where they have had to be a leader as such and you know a number of them do find that quite hard delegating stuff um within the skill mix." (Practice Teacher 1)

"No matter how you try and maintain a freshness about what you do you know you don't want to impact on them coming in and wanting to lead but there is a certain amount of experience, professionalism and also cynicism you know when people come in and want to do things and somebody will always say wow you have done that before and I think the needs for the training is that they have the confidence to actually address that but also to know how to address it you know different skills not confrontational, confrontational you know facilitative non facilitative they need those skills to be able to come and do it and when you are 12 years qualified when you come into the course it's easy to do than when you are 1 year qualified or 2 year qualified." (Practice Teacher 2)

Partnership working skills were seen as integral to the programme, however the ability of students to contribute to community capacity building projects was seen by some to be limited by the duration of their placement. One practice teacher questioned the ethics of starting something that may not be supported once the student had completed their placement. However, students were enthusiastic to develop projects and prepared effectively by the academic element of the programme.

"Now again is that ... is the university teaching enabling them to do that or is the fact that they're out in the community with us developing observing has developed those partnership working and them being part of the process of that partnership work is something I can't answer. You know which is doing it mostly? They're coming out very enthusiastic and very committed to the partnership working and I'm assuming that the university are really pushing ... pushing that or enabling that." (Practice Teacher 5)

4.2.5 Challenges for the future

The practice teachers were unanimous in that their biggest concern was around what would happen after the Implementation Plan in 2015. They felt unclear about funding and how the increased workforce would be maintained and

regenerated. To some extent the Implementation Plan was criticised as being ill thought out and implemented too quickly, without responding to the concerns and needs of the service.

"What is the commitment going to be to maintain this because the money is there and the issue with the way that the whole programme was implemented was that here is your money but there is nobody to train you, now there are some people to train you there is no money and the timescale is too short you know if you did this over 8 years then you could have trained the practice teachers and then year 3, year 4, year 5, year 6 you could hit the numbers and then wind down in year 7 and year 8 and actually make a very valid judgement to what the needs are." (Practice Teacher 2)

Linked to maintaining the workforce was the ability for the service to meet key performance indicators – if this was not achieved at a local level there was concern that funding would be withdrawn by commissioners. In order to influence commissioner decision making, the practice teachers recognised the need to establish and maintain the high profile of the SCPHN service both nationally and locally, ensuring that there was a clear understanding of what SCPHNs do. Students and newly qualified health visitors were seen as integral to this 'marketing'. One practice teacher added that this also meant remaining valid for clients – offering a service that was seen to be relevant, utilising technology and remaining flexible.

"I still meet a lot of people who say oh health visitors are rubbish you know and they don't appreciate us so that's an area where the students can sort of really help market us." (Practice Teacher 9)

The reorganisation of the NHS was also raised as a significant challenge. Whilst strategic changes were anticipated to take a while to impact on service delivery, it was recognised that they may present exciting opportunities such as enhanced partnerships and public health work with the community. However, the rate of change and the perceived fragmentation of the NHS was seen as a potential threat to best practice, should the impact of a 'market place' model serve to lower rather than raise standards of practice. In addition, the variety of organisations offering SCPHN services may encourage local diversity of practice to a greater extent than is already the case. UWE was seen to be a protective factor in this scenario as the training of practitioners across the whole region should encourage standardisation.

"I think actually we have got to be I think you know ... I think we have to be quite resilient I think we have to be adaptable to the change but I think that actually when you think of all the organisations that are going to be involved you know be it social enterprise, be it foundation status you know as you say I think actually it in some ways could fragment the service ... I think there are uncertain times and I feel that can be unsettling." (Practice Teacher 8)

"I think the danger is that you end up with students who are trained just to work in one place rather than to be able to work nationally."

I: "Yes that's an interesting thought ... do you think that applies to UWE as well? Do you think that's a regional approach?"

R: "I think to be fair the UWE is actually because you have got such a big region there is a really, really good chance that actually there is going to be a standardisation." (Practice Teacher 2)

A further concern was that changes to partner agencies, including the withdrawal of funding would influence their capacity, which may in turn impact on the work of the SCPHN service due to the universal nature of the role.

"I think the challenge that we are seeing currently is that partner agencies are not managing to cope with the workload and we are not either so I think that at the moment multi-agency working because of capacity issues is really struggling not for want of trying but for the capacity and I would say it's the worse I have ever seen it at the moment." (Practice Teacher 3)

The practice teachers are immersed in both the challenges of the implementation plan and the challenges of the modernisation agenda for the NHS. Alongside these national agendas, they are working to deliver a SCPHN service and educate new practitioners at a time where new resource has not yet impacted on the capacity of the workforce to deliver the new service vision. Ultimately, the perception of the service managers that morale was improving in the workforce was not universally upheld by these interviews, although some commented that there had been improvements since the start of the Implementation Plan. However, the commitment and passion from the interviewees was evident, as was a belief that the increase in student numbers was a positive development, despite the challenges it presented. Practice teachers are pivotal to the success of the Implementation Plan, and the contribution that they have made to date is immense.

"So we will have to see it is a bit unknown isn't it but I think we have just got to maintain our

enthusiasm, support for the newly qualified, optimism for the students that are here with us now and hope that we can produce really robust, flexible health visitors." (Practice Teacher 10)

4.3 Stakeholder interviews with parents

Focus groups with parents and one to one interviews were held in two children's Centres on three separate occasions. The participants were all attending organised groups and activities, including a multiple births group, a new babies group and a breastfeeding support group. Some of the participants were first-time parents and some had more than one child. The participants were asked to share their experience so far with the health visiting service, their experience of working with health visitor students and their views on the health visitor implementation plan. A total of 14 parents took part in the discussions, 13 mothers and one father.

4.3.1 Overall impression of the health visiting service

The participants shared both negative and positive experiences of the health visiting service. Positive experiences tended to centre on individual health visitors who were perceived to 'go the extra mile', who genuinely seemed to care, who were knowledgeable and skilled and who were able to give advice and guidance that resulted in a positive outcome. Student health visitors were discussed in this light. Similarly, a large proportion of the negative experiences reported were perceived to be due to poor relationships between the parent and the health visitor, practitioners seeming to be unprofessional, uncaring or lacking in credibility. The way that information was imparted to clients was given as much priority as the content of the conversation – parents were very influenced by the communication skills and personal attributes of the individual health visitor or student.

The participants repeatedly brought up the issue of lack of time and resources and this too was seen to be a major influence on whether a contact was positive or negative. However, here the participants were split – some felt that lack of time was an issue that was inevitable in today's NHS with the inference that it was outside of the control of the health visiting teams. Other parents expressed impatience with the view that the practitioners were too busy to do a good job, indicating that this was down to poor caseload management, and even suggesting ways that the delivery of the service could be changed to make it more effective.

4.3.2 Service delivery

The parents were asked about the model of current service delivery and their responses focused on two main areas – the venue for health visitor contacts, and the frequency of contacts.

The majority of the parents stated a preference for health visitor contacts at home rather than at clinic. Clinics were described as busy, hectic places with very little privacy. The parents were aware that there were generally other parents waiting to see the health visitor so they were reluctant to take up much of their time. There was a reluctance to 'bother' the health visitor with minor issues and the fact that the clinic may be in a doctor's surgery where they would have to wait alongside ill patients was a deterrent.

"I preferred the home visit because the clinics are always a bit hectic always lots going on and so rushed as well."

I: "OK so the hectic means ... does that mean you don't get to say what you want to?"

R: "It just feels like you have got a short time period and you are kind of aware of all the mums outside waiting to come in I just feel like you have got a couple of minutes to get it out and get the answer." (Parent 2)

Conversely, co-locating health visitors within a Children's Centre brought added value. Two of the parents commented that they could catch health visitors in a corridor or pop in to see them if they were attending a group or event with their child. The fact that the health visitors were accessible was important to the parents.

"... yeah they are always in the hall somewhere around you'll see somebody floating past asking if you are OK." (Parent 4)

One parent did say that she preferred to come to the Children's Centre to see a health visitor because it meant that she and her daughter had a reason to get out of the house and meet other children.

The parents particularly valued the personal contact of the health visitor, and the majority would have welcomed more home visits during the first year of their child's life, although there was a wide range in the number of home visits the parents received. One parent had received 'a dozen or so' visits in the first three months, but still became indignant when this was reduced to once a month. This raises the question of whether clients can ever receive enough visits as an increased frequency of contact may foster dependence.

Only one parent had experienced an antenatal

visit, which she described as 'brilliant' and several mothers cited friends who had received no visits at all and had 'slipped through the net'. There was an underlying theme in the comments that the service they received was not as good as it might have been elsewhere, in that in other areas they may have received more home visits as standard.

There was a sense that visits were more valuable if the health visitor initiated the contact, rather than the parent having to request a visit, especially if the client had found the parenting role challenging. This was particularly salient if the health visitor had referred the parent to another agency, and then decreased their contacts given that another professional was now involved.

"Kind of they haven't really checked to see if I am OK for a long time now which is fine but at the time I was in a bad place and they kind of said oh you know have you seen the specialist and I said yeah and that's it I have not heard from them again and that was in January I see her around and she knows who I am she says hello and everything but that's it." (Parent 6)

Parents identified that to see the same health visitor was very important. Ideally they would have liked to meet their health visitor antenatally and then consistently see the same practitioner thereafter. This enabled the parents to feel comfortable talking to the health visitor and avoided having to repeat their history to new practitioners, which was particularly important if they had been experiencing difficulties. On the other hand, one parent did suggest that if she had a specific concern, it might be beneficial to see the health visitor who had specialist knowledge or expertise in that area, rather than see one that she had met before.

"Yeah definitely and then you feel more comfortable talking to them about it um its like everything really you know because I really was struggling at the time but you know you don't know whether ... you don't want to go into the whole story again every time ... " (Parent 6)

The parents were all asked if they knew about the Government drive to increase the number of health visitors. Only three said that they did – two were nurses and had received a promotional leaflet through the post, and one had read a recent article in the local paper. The majority felt that this would be a good idea given how pared down the service seemed to be. They were also asked to comment on the new service vision and how they felt about the universal, universal plus

and universal partnership plus categories. None of the participants were aware of the service model. Their concerns were around the ability of health visitors to assess whether a family required more support than a universal service would offer. They also raised the point that family life isn't constant so they would have different needs at different times. Several parents were anxious about how easy it would be to move from universal service to universal plus or universal partnership plus, and the potential stigma that may be attached to this.

"It makes me feel quite anxious because I think there is a stigma with moving out of a category I think and ..." (Parent 9)

"... yeah and also I think you would constantly move in and out of those categories ..." (Parent 8)

"I think it would be very easy for everyone to say well you're a universal second child um you know or no complications first time mum so we will just keep a kind of little eye on you because someone else is telling us they need more when actually the person over here is just not telling you how bad they are finding it. I think so the fact that people don't have enough time to tell you what category they think they are in but also the fact you would move in and out so much I think that would be quite interesting." (Parent 8)

4.3.3 Knowledge and attributes

Parents felt strongly that health visitors should give advice that is linked to the current evidence base and their ability to do this was in turn was linked to their credibility as a practitioner. Those parents who had been involved with health visitor students discussed them in positive terms related to the fact they were up to date and confident with their knowledge.

"I think it was wonderful I think she was really fresh, really knowledgeable." (Parent 10)

"Just very up-to-date on everything, which is what I needed." (Parent 11)

However, some parents also expressed concern about being seen by a student rather than a qualified health visitor because they weren't sure about their level of competence or expertise. All parents who had contact with students spoke highly of them once they go to know them and were confident with their ability.

Whilst some of the participants felt that they were able to distinguish inappropriate advice, there was concern that this could have a real impact on parents who were unable to do so. Maintaining up to date knowledge was the responsibility of the individual practitioner in

that they should avoid slipping in to complacent practice and 'up their game'. Parents did not respect health visitors who used personal experience with their own family as a basis on which to advise.

"I think it could be that she is not up-to-date because she was talking about what she did when she was a mum and her boys are now at university so she was giving me advice from that long ago and I much rather she respected the up-to-date views." (Parent 3)

On the other hand, when asked about the balance between personal experience and evidence based advice, one parent raised the point that she felt health visitors were restrained by the parameters of evidence based advice and this disabled them in situations that didn't quite fit with the mainstream. This in turn made the parents feel anxious about making alternative choices to those recommended by the health visitor.

"... just you know like feeling more comfortable in giving advice away from this specific current guidelines if you know what I mean? Yeah because at the end of the day obviously its our decision whether to do it or not you know and I would never put that on a health visitor but it just seems at times that they don't want to advise because they are too worried of any like repercussions or anything you know what its like ... or like I feel myself like oh no I can't do that because otherwise the health visitor might go oh no you can't do this, you can't do that ..." (Parent 6)

It was equally important to the parents that the content of the advice was consistent between different health visitors. Parents were frustrated if they were given different messages from different practitioners on the same subject and this influenced the credibility of the individual and the service as a whole. However, there was also some recognition that individual situations may require an individual approach.

"... completely opposite information which I think for an intelligent group of ladies I think we are you know we are all professionals we find it really difficult when we are sat talking to one another that we have been given such different messages ... for me I would envisage that health visitors would discuss amongst themselves and have some kind of meeting where they discuss these things and they go out with the same message but ... they are clearly not doing that." (Parent 8)

"They don't understand why the information is that way and therefore why its different to the person that's sat next to them that has got a baby

that's the same age, similar weight so why is that different." (Parent 9)

The parents also identified that it was essential for a health visitor to be enthusiastic, supportive, approachable, proactive and friendly. They valued the listening skills of their health visitor and their ability to identify the cause of the problem but also the ability of the practitioner to empathise and to be able to advise without making them feel uncomfortable or embarrassed. These were skills particularly highlighted in student health visitors. Parents valued open mindedness and a non-judgemental attitude and highlighted a strong link between credibility and integrity. If a health visitor or student didn't know the answer or felt that an issue was outside their area of expertise, the parents respected their decision to refer on or to go away and find out – as long as they came back to the parent with the answer.

"Credible, know what they are talking about, not to be patronised, open minded different rather than saying there is a set way of doing things and this is the way it needs to be done and be flexible and needs to be able to give us advice and be approachable as well." (Parent 2)

"Like I said if she [student health visitor] didn't know things she would find out from somewhere else or she was easy to talk to very easy to talk to like I said she listened ..." (Parent 7)

4.3.4 Relationships

Many of the parents indicated that a good relationship between the client and the health visitor was integral to an effective contact. The relationship was based on trust. If the trust between the client and the health visitor was lost then the parents were reluctant to engage with the service. The fact that the health visitors had so few home contact with clients impacted on their ability to build a relationship, as did the lack of consistency around who they saw at home or in clinic. There was a strong feeling that unless a relationship was established, parents would not be able to discuss their concerns and admit that they were struggling.

"Yeah definitely some people don't feel they want to talk to a health visitor if they don't really feel comfortable with them they think that the information is going to get misled or next minute you feel a bad parent or something yeah ..." (Parent 4)

Central to developing a relationship was credibility, honesty and the health visitor respecting the views of the parent. Critically,

parents did not want to feel intimidated or that they were a bad parent, especially if they were not naturally confident people. Indeed, one parent said that she would rather research her issues on the internet because she found meeting the health visitor difficult.

I: "OK so you got information from the internet?"

R: "Yeah."

I: "Yeah instead of the health visitor really?"

R: "Yeah."

I: "... and is that what you do generally anyway?"

R: "Yeah I Google it. Ashleigh is going to be a Google baby."

R: "Yeah and I am on a Mummy Page that I can ask other mums and that."

I: "OK so rather than having somebody face to face that's what works for you?"

R: "Yeah."

I: "Why do you think that is?"

R: "I don't know because I don't really like meeting new people ..." (Parent 1)

Two parents discussed the positive relationship that they had with their midwife and the difficulty that the transition to health visitor care presented. They described feeling emotionally bereft and that the health visitor service didn't quite fill the gap. However, when a good relationship was formed between practitioner and parent, it was very beneficial.

"Well she [student health visitor] knew her stuff she listened to me and she um I don't know she helped me as much as she could she was really supportive I found she was really, really good I haven't really had much support from my mum and she was really OK right OK we can do this for you we can make sure you go to these kind of groups she would phone me up to make sure I was OK how I was ..." (Parent 7)

4.3.5 Lack of time or resource

Underpinning all other areas of discussion was the key theme around lack of time and resource. Lack of resource was seen to be due to both local issues such as increased birth rate, and national issues such as government cuts. The majority of the participants were of the view that this impacted on the ability of the health visitors to provide a satisfactory service. When asked what made them feel that this was the case, the response was overwhelmingly that this was the explanation the health visitors were giving clients for the reason why they could only have a limited number of visits at home or why they needed to come to clinic. This was met with understanding, but also frustration.

R: "I am not sure I think their workload is ... I think they are really overstretched and I think if you seem to be doing OK then you are sort of left alone to your own devices unless you need anything. But I do think it's just the fact that they are overstretched."

I: "So how do you know they are overstretched?"

R: "They are always telling us, they are always telling us." (Parent 10)

"... yes and from a not so great point of view especially for first time mums that's not a helpful message to give anybody because actually all you care about is you and your baby and your situation and not the fact that they are understaffed, overstretched and everything else ..." (Parent 8)

Lack of time was cited as a reason why health visitors did not always call back when they had said they would, did not visit at home and why the clinics were so busy. It also impacted on the development of relationships between the parent and the health visitor and in turn the probability that the parent would use the health visitor as a resource, or turn to other agencies instead for help.

"Whilst I was doing the forms with the Children's Centre worker the health visitor was due to come and visit and I was like you know what in a week and a half the Children's Centre worker managed to put the forms and get in time for ... and I know her caseload is slightly different but you know ..." (Parent 5)

Also, one parent was concerned that gaps in health visitor service were being filled by other organisations, which wasn't necessarily appropriate.

"So for example [name of organisation] have done a weaning workshop that I was sat in but I thought was really they weren't qualified ..." (Parent 8)

"... ill informed ..." (Parent 9)

"... yeah and I don't think they were qualified to do that and I think the reason they have done that though is there is this gap where nobody else is doing it." (Parent 8)

However, when parents felt that they were given enough time this made them feel valued, listened to (and crucially, felt 'heard') and they reflected positively on the service. Health visitor students seemed well placed to offer the parents more time, and this was appreciated. It was the view of one mother too that students were in a good position to take on some of the qualified health visitor workload under supervision.

"Some of them they did mention to me the health visitors workload is extremely high when it comes to paperwork but the students were frustrated

because they couldn't help with the paperwork because they weren't fully qualified and if it had to go to a court of law then you have to be fully qualified. I thought that was rubbish ... it's either a power struggle ..." (Parent 3)

Other parents suggested ways that the service could be delivered in a more effective way that would free up health visitor time including recruiting more nursery nurses in to the teams, delivering group sessions on specific parenting issues and self-weight sessions so that the health visitors are available for advice. Whilst there was some resignation that the current national climate would not support aspirations of a better resourced service, other parents felt that individuals in the profession could change the way they worked to protect themselves against the high workload.

"No not in the current NHS climate they think idealistically definitely I don't think ... I am not sure it's going to happen." (Parent 3)

"She said actually I won't give you a next date but I will contact you and she didn't and I found out that actually what had happened was she is off sick with stress now so I think her approach might be backfiring on her as well because if you always do the tell them, tell them, tell them that's a lot of effort on your part if you part of the moving to mentoring and coaching is so that you can step back as well as developing the person so I think part of the stress is self-generated." (Parent 3)

Ultimately the parents' perspectives on the health visiting service were a spread of positive and more challenging experiences. The perceptions of the parents will of course have been influenced by their personal experiences, not least the presence of family support, perinatal mental health and individual personality. Potentially, difficult personal circumstances influenced a negative view of the service, which may have been underpinned by low mood and subsequent low tolerance levels. Conversely it could be argued that when a client needs the service most, health visitors are least likely to be able to support them at the level the clients expect. Taking either position, it is clear that the resource issues in the health visiting service are having a major impact on the service that parents receive. SCPHN students, given that they have more time in their supernumary status during the programme, were able to offer a service that was well received and appreciated by parents, even though they were developing their knowledge base and skills.

5 Discussion

In terms of student outcomes, the low attrition rates, high numbers of successful programme completions and impressive levels of confidence in delivering new models of working is testimony to the hard work and commitment of the students themselves. It also reflects the enormous amount of support and guidance from a wide range of staff from both within practice and education. Sometimes, stakeholders in particular practice teachers felt there had been significant personal cost to the process, wrestling with caseload demands, students learning needs and mentors who had not played an educational role in practice for many years.

There appeared to be a clear message from the managers that this group of new practitioners were 'fit for purpose' and students were excited about putting their new learning into practice. Many students felt confident to work collaboratively across agencies, therapeutically with families, inclusively with communities and were beginning to understand how their leadership role would develop. Of particular note was the 11 fold increase in confidence in signposting to domestic abuse services. However, the majority of students remained low in confidence in working with parents with learning disabilities. This is perhaps a result of low level exposure in practice but could also indicate a lack of awareness in dealing with marginalised groups. Exposing students to diversity within their own student group can be another opportunity, to extend beliefs and challenge assumptions. However, white women in their late thirties dominated this large cohort, just like previous cohorts in the South West. While, there was a significant improvement in attracting students from black and ethnic minority groups on previous years, very few men applied to do health visiting.

Traditionally, students entered into health visiting having substantial experiences in other fields of nursing. Within this cohort there were significant numbers of students who had entered the profession early in their nursing career, it will be interesting to observe the implications for service delivery and career progression as they become experienced. The majority of students came from a wide range of backgrounds and life experiences, though for the first time six students joined the programme on graduation from undergraduate nursing. These students achieved well, and had no concerns identified within

practice. While on arrival most students had positive motivations for joining the programme, on a less positive note, a small number of students reported feeling disheartened by working in other parts of the NHS; midwives in particular discussed a lack of job satisfaction and poor job opportunities in the South West as a motivation for a change of career. There was also a dominant sense that students were motivated by the belief that their new role would be 9am – 5pm and weekdays. This does raise questions about the implications for service redesign to meet parents and families needs that includes visiting in evenings or weekends, or indeed whether those who believe this role is less pressured or offers more career opportunities will have their expectations realised.

A key area for discussion must be the implementation of A Call to Action. Although there was a general recognition that the policy had offered unprecedented opportunities for the profession, criticisms were levelled by students, practice teachers and managers about the implementation of the plan. The short four-year timescale, the top-down approach, and the level at which the policy has been influenced by research activity were all questioned.

In reality, as Bunn and Kendal (2011) suggest, policy-making is a complex activity that is influenced by a range of factors. Political imperatives, such as the duration of the coalition Government, the availability of funding at a time of austerity and the powerful lobbying of organisations such as the Community Practitioners and Health Visitors Association, will have shaped the policy to as great a degree as the underpinning evidence base. In fact, Bunn and Kendal (2011) argue that there is a dearth of high quality, relevant research in to SCPHN practice on which to base policy. This is a situation that, ironically, has been perpetuated by the decline in health visitor numbers and lack of visibility of the profession in recent years, but will hopefully be reversed as the workforce increases.

Clancy et al (2012) reiterate the importance of research-based policy, but stress that knowledge about the context is imperative for successful policy implementation. Given the depleted workforce immediately prior to A Call to Action, the implementation plan has placed additional pressure on already stretched resources. It has been easier to recruit students than to accommodate them in appropriate placements or ensure that practice teachers or mentors are available to facilitate their learning. Practitioners who are already feeling tested within their

role have been asked to expand their remit further with the promise of a larger workforce at some point in the future. The lack of workforce infrastructure to support the plan has undoubtedly influenced morale in practice and impacted on the ease at which policy has been realised. Add in to the mix the fact that health visiting services are perceived by practitioners to be commissioned and subsequently managed under regimes that emphasise productivity and minimise autonomy (Condon 2011) and the complexity of the policy implementation is evident.

However, there were also unanticipated benefits of the fast pace of implementation of the Health Visitor Plan. Previously education had been largely the role of the Practice Teacher and while initially there were serious concerns about a lack of practice teachers, health visitor mentors took on an increasing role in supporting students. This raised debates about the degree to which mentors were prepared and able to undertake this role. A minority of concerns were articulated about the quality of mentorship, however, stakeholders mostly commented on how this arrangement had helped the wider workforce update their skills, created enthusiasm and generated cultures based on learning, which have the potential to significantly benefit service delivery. Support for mentors was mostly undertaken by practice teachers, and university mentor study days. Rejuvenating the skills of mentors has been reported to have the additional benefit of enlivening the workforce. If this is widely the case, it could be argued that to return to the traditional deployment of practice teachers in to one to one relationships with students has the potential to deskill the rest of the workforce. Consideration of a best practice model for future education of SCPHN students in practice must therefore be open to national debate.

Students felt a weight of responsibility at being the 'new vanguard' of health visiting. Managers described great expectations of them as newly qualified practitioners and endeavoured to support them with continual innovation and improvement in order to realise the new service vision. However, students expressed concern about the theory practice gap – they were being educated for a role that they were not all observing in their placements and this caused anxiety and frustration. Mentors and practice teachers are the role models responsible for socialising the students constructively in to practice (Scully 2011). Successful socialisation enables students to implement the theories they

have learned in university without the negativity often related to change in practice. Mentors immersed in a challenging practice context may have become gatekeepers to learning rather than facilitators (Allen et al 2011). Whilst this may not always be negative as students could be protected from unhelpful influence, Allen et al (2011) describe a 'hidden curriculum', relating to the processes, pressures and constraints in practice, which runs in parallel to the overt curriculum of the university, and which may ultimately perpetuate the theory practice gap. In turn, Swain et al. (2003) suggest that students often collude with this gap, in order to make the 'right' impression with those that are assessing them in practice. This explains, in part, how the gap continues to survive.

However, this gap could also be a driver of innovation in practice. Haigh (2008) argues that there is an inevitable lag between the theory of practice and the day-to-day implementation and this should be celebrated as a sign of impetus for progress. In the case of SCPHN services, in reality there is a policy practice gap where the new service vision is not yet realised in practice due to workforce restraints. The positive partnership arrangements between the university and practice placements may go some way to encouraging shared understanding and shared outcomes to benefit the students. Equally, robust clinical supervision arrangements may help newly qualified practitioners navigate through the political context of their new role and maintain the impetus of innovation for the service.

The service vision falls short of being open and transparent to the families to which it applies. This may in part be explained by the incomplete implementation of the new service model in practice, however Hogg et al (2012) encountered a similar pattern when evaluating a new assessment process in Scotland. Health visitors had difficulty explaining the process to parents and the families that they worked with were unclear about the health visiting role and its limitations.

Parents involved in this evaluation felt that health visitors were too busy to provide the service that they expected or wanted and practitioners did not take the time to develop a partnership with their clients and explain the service model. It would seem that, despite the efforts of the Department of Health to raise the profile of health visiting, at the level of parents and carers, there is still much work to be done to maintain the credibility of the service. As concerning is the perception that partner agencies and

commissioners are not aware of the value that SCPHN services offer. Health visitors need to embrace the new service vision, believe that it can succeed and channel that motivation in to revolutionising the service delivery. Raising the profile of the service at local level is an essential first step, and the indication from this research is that now is the time to do this before the window of opportunity closes.

6 Recommendations

Recommendations for Policy Makers

The Health Visitor Implementation Plan is part of a complex policy landscape that determines the outcomes for children and young people:

- These findings should be considered to ensure the achievements associated with building capacity and capability within the health visiting workforce are maximised to promote early intervention and improved life chances for children.

To maintain a high quality motivated workforce, it is crucial that funding continues for SCPHN education and development:

- This will support the retention of newly qualified practitioners and motivate the established workforce.

Given the dearth of large-scale research specific to health visiting interventions, leadership is key to promoting the development of the profession:

- Research relevant to SCPHN practice, to underpin future policy and practice, should be actively encouraged, financed and prioritised.

Recommendations for SCPHN education

It is important to maintain the wider entry gates to the SCPHN education:

- Students who have recently graduated from nurse or midwifery education have adapted well to the role and achieved well both academically and in practice.

The high levels of student recruitment associated with the health visitor implementation plan have created significant opportunities for learning about selection. Specifically:

- The focus on attributes rather than knowledge at interview.
- The need to undertake local recruitment drives to select students who reflect of the demographic characteristics of the local area, particularly black and minority ethnic students and men.

The pivotal role of practice teachers in successful student education should be recognised and valued:

- The strong links between practice placements and the education provider should be nurtured in order to offer support around individual student issues.

Practice teachers have moved away from the traditional one to one model of supervision of students:

- Further research is needed to evaluate the new way of working with SCPHN students in practice, particularly the continued role of mentors in the education of SCPHN students.

Recommendations for practice

Newly qualified practitioners are the catalyst for change and innovation:

- SCPHN service providers should implement a robust and supportive preceptorship programme for newly qualified practitioners that supports and develops their creative ideas for service improvement.

Clinical supervision models should be embedded in service provision:

- Supervision will nurture and enhance the resilience of both the new and established workforce.
- Practitioners will be enabled to critically review practice and narrow the theory practice gap.

Tensions exist between traditional practice and new service delivery models:

- Continue work to communicate the new service model to the established workforce, recognising the tensions between traditional practice and new service delivery.
- Offer continuing professional development to up skill, update and motivate existing practitioners and work towards narrowing the theory practice gap.

Clients focused on the relationship between client and practitioner as key to an effective intervention. Practitioners were expected to be credible, up to date and flexible:

- Prioritise a model that allows consistency of practitioners for the client. Parents identified lack of time as central to failings in service delivery. Clients particularly disliked practitioners explicitly referring to lack of time as justification for limited service.

Changes in NHS architecture have influenced the commissioning structures:

- It is critical that the profile of the SCPHN service is raised so that commissioners and partners are clear about the role of the health visitor, and are able to make effective decisions about resource allocation.

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Appendix 1 Stakeholder Information Letter



University of the
West of England

Evaluation of the University of the West of England's Specialist Community Public Health Nursing programme meets the aims set out in the Government's Health Visitor Implementation Plan.

We have been asked by the NHS South West Strategic Health Authority to evaluate the Specialist Community Public Health Nursing (SCPHN) programme. The aim of this research is to assess how the current programme of education for health visitors meets the demands of the new Service Model. As part of this evaluation we have been asked to explore the expectations of students on the programme and stakeholders to ascertain whether these were met.

Who is conducting the research?

The research team includes Dr Richard Kimberlee and Judy Brook from the Faculty of Health and Life Sciences. The research is being funded by the NHS South West Strategic Health Authority.

Why have I been asked to take part in this research?

The delivery team on the SCPHN programme have identified you as a key stakeholder to their programme. As a stakeholder we would welcome your observations on the programme's delivery and development.

If I take part what will it involve?

You will be interviewed either by telephone or face to face about your connections with SCPHNs. You will be asked questions about your experiences, understanding and expectations about the delivery of the programme. The discussions will be tape recorded, and should last around 30 minutes, depending on how much you have to say. Only the researchers listed here will hear the recording. In any reports resulting from this research, your name and any other identifying information will not be included.

Confidentiality of information

Your interview will be transcribed by the researchers. The recording will be stored on a password protected computer and any typed up notes from the discussion will be kept in a locked filing cabinet. You will remain anonymous; any identifiable information, such as your name, age, role or where you live will be removed from the typed up notes and also from any reports or publications that are produced using these data.

Withdrawal of data

You are free to withdraw from the research at any time. We will explain this in more detail at the start of the interview. If you wish to withdraw your contribution after the interview, please contact the researchers (contact details below). However, please note that, due to the nature of typing up interviews, once this data has been done, and your contribution anonymised, this will no longer be possible. So if you wish to withdraw your data, you will need to do so within 2 weeks of the interview taking place.

What happens if I decide not to take part or to withdraw the data

Nothing! Participation in the interview is entirely voluntary. This research is undertaken independently of the delivery of the SCPHN programme. Failure to be involved will not be reported to the delivery team

Please keep this information in a safe place.



Dr Richard Kimberlee
Senior Research Fellow

If you have any questions about this research, please contact:

Dr Richard Kimberlee
Faculty of Health and Life Sciences,
University of the West of England,
Glenside,
Bristol,
BS16 1DD.
Tel: 0117 32 81124
Email: Richard.Kimberlee@uwe.ac.uk

If you have any further comments please contact:

Professor Judy Orme
Faculty of Health and Life Sciences,
University of the West of England,
Glenside,
Bristol,
BS16 1DD.
Tel: 0117 32 88836
Email: Judy.Orme@uwe.ac.uk

The purpose of this form is to ensure that you have received all the necessary information concerning the research project and wish to take part. Please read the following statements carefully. If you agree that all points of information have been covered please sign and date the sheet in the space provided below. If you are unclear on any point please contact us using the details provided.

Consent statement

I have read and understand the information presented in the Information Sheet. I have had the opportunity to discuss it with the researchers and to ask any questions. I understand that:

- My participation is entirely voluntary
- I am free to refuse to answer any question asked in the interview
- I agree that this interview may be recorded
- I am free to withdraw from the research project at anytime

I agree to take part in the above project and I give my permission for anonymised data from the interview to be used to evaluate the programme.

Participant information

Name

Signed

Date

Appendix 2 Information Sheet for Families



University of the
West of England

Looking at the role of Health Visitors in our Community

We are doing some research on Health Visitors. We have been asked to do this by the NHS, South West, Strategic Health Authority. Our aim is to learn about your experience of Health Visitors in your local area.

Who is conducting the research?

The research team includes: Dr Richard Kimberlee and Judy Brook from the Faculty of Health and Life Sciences at the University of the West of England, Bristol.

If I take part what will it involve?

Richard or Judy will visit you on a day you normally meet. You will be asked some questions about your experiences, understanding and expectations of Health Visitors in your local area. You may be sharing your views with other people in your group. Our discussions will be recorded, and the experience should last around 20 minutes, depending on how much you have to say. Only the researchers listed here will hear the recordings. In any reports resulting from this research, your name and any other identifying information will not be included. You will remain anonymous; and any identifiable information, such as your name, age, role or where you live will be removed from any notes we make of our discussions.

Withdrawal

You are free to withdraw from our discussions at any time. We will explain this in more detail at the start of the discussion groups. After the discussion you can withdraw your contribution by contacting us (details below).

What happens if I decide not to take part or to withdraw the data

Nothing! Participation in the discussion groups is entirely voluntary. This research is undertaken independently of the Children's Centre you visit.

A handwritten signature in blue ink, appearing to read 'Richard Kimberlee'.

Dr Richard Kimberlee
Senior Research Fellow

If you have any questions about this research, please contact:

Dr Richard Kimberlee

Tel: 0117 32 81124

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Judy Brook

Tel: 0117 32 88697

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Professor Judy Orme

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E-mail: judy.orme@uwe.ac.uk

Faculty of Health and Life Sciences, University of the West of England, Glenside, Bristol, BS16 1DD.

The purpose of this form is to ensure that you have received all the necessary information concerning the research project and wish to take part. Please read the following statements carefully. If you agree that all points of information have been covered please sign and date the sheet in the space provided below. If you are unclear on any point please contact us using the details provided.

Consent statement

I have read and understand the information presented in the Information Sheet. I have had the opportunity to discuss it with the researchers and to ask any questions. I understand that:

- My participation is entirely voluntary
- I am free to refuse to answer any question asked in the discussion group
- I agree that this discussion may be recorded
- I am free to withdraw from the research project at anytime

I agree to take part in the above project and I give my permission for anonymised data from the focus group to be used to evaluate the programme.

Participant information

Name

Signed

Date

Appendix 3 Student Focus Group Interview Schedule

1. What would you say are the most important skills that you have learned?
(students said that they felt they had the key skills already but 'reawakened' them during the programme)
2. What do we need to do to ensure that the programme enables you as a practitioner?
3. How has your professional background influenced how you have experienced the programme? (prompt – maybe working in the community, in people's homes)
4. Do you feel more equipped to address health inequalities?
5. How important is Leadership to you?
6. What messages would you like to give us about your programme experience?
7. In the first 3 – 6 months after qualifying, what do you think will be the key challenges?
8. Do you anticipate practice as a qualified health visitor being different to practice as a student?
9. What are your expectations of preceptorship? What do you hope to get out of your preceptorship?
10. To what extent has the programme prepared you for your role?
11. What is your perception of the new service vision and how does this relate to your experience of service delivery?

Appendix 4 SCPHN Stakeholder Interview Schedule

AIM: to assess the degree to which the SCPHN programme is meeting the new service vision and associated public health outcomes.

- Explanation of the study
- Written consent (if not already obtained)
- Right to withdraw
- Confidentiality
- Right to stop interview at any time
- Contact information

Background

- Name of stakeholder's Local Authority
- Name of trust

Role

- Title of role
- How long have you been in this role?
- How long have you been a health visitor (if appropriate)

What types of contact do you have with new SCPHN students in your professional practice?

- When
- In what capacity
- Practice skills are appropriate to meet the needs of the new service vision
- Impression

Curriculum

On reflection are there any additional areas that need to be covered on the SCPHN programme?

- What should be included
- Do you perceive that the students have a 50:50 theory practice split – is this appropriate?

There is considerable talk about SCPHNs taking a leadership role.

- Do you agree that this is important?
- Can students use leadership skills during the programme?
- In what ways/format would you anticipate this happening?
- What would be a marker of success?
- What are the barriers to success?

Do you think that SCPHN students are ready to:

- Challenge the status quo?
- Take a leadership role in the community?

Partnership roles are important. Do you think that SCPHNs are prepared well to:

- Take the lead
- Face challenges
- What would you like to see SCPHNs doing in partnership?
- Do you feel SCPHNs can do this locally?

Values

What values do you feel should underpin the new SCPHN role?

- 6Cs: care, compassion, competence, communication, courage and commitment.
- Attributes of a SCPHN Practitioner

Is the education that they are receiving preparing them for this?

What challenges do you feel SCPHNs face in the light of recent reforms in the NHS? Could you describe your views of the impact that the new arrangements from April 13 will have on commissioning of the HV service and subsequent employment of new HVs?

- GP Commissioning
- Movement of Public Health
- Children Centres

Comparing to student responses

What do you feel are the most important outcomes for students applying for the SCPHN course today?

The demands and needs of clients are changing ... are there any issues you feel that SCPHN students will find more challenging when they start working in the community?

Future

What do you see as the three most challenging aspects of SCPHN service delivery in the future?

What advice do you have for the professionals training new SCPHNs?

Is there anything else that you would like to say?

Appendix 5 **SCPHN Focus Group Schedule for Parents**

- Explanation of the study
- Written consent (if not already obtained) and consent for use of tape recorder
- Right to withdraw
- Confidentiality
- Right to stop interview at any time
- Contact information

Personal experience

- What experience have you had with health visitors?
- What did you think of the contacts that you had?
- How many contacts did you have?
- What do you think makes a good HV contact?
- What could be better about the contacts that you had?
- What do you think the role of the HV should be?

HV students

- Have any of you met the HV students?
- What did you think of the experience?
- Did the student have the knowledge that you needed them to have?
- Did the student have the communication skills to help you?
- Was there anything that you would have liked the student to know or do that they didn't demonstrate?

Service model

- Have you heard about the government drive to increase the number of HVs?
- Do any of you know about changes to the way the HV service is delivered?

Appendix 4 **SCPHN Stakeholder Interview Schedule**

Appendix 6 SCPHN Stepping into Practice Questionnaire

STRICTLY CONFIDENTIAL

Specialist Community Public Health Nursing

Stepping into Practice Questionnaire

When you started the SCPHN course we asked you some questions to find out about your views on working with families and people; and your ambitions and expectations about this programme. In this questionnaire we would like to revisit some of those questions and also ask you some new ones about: Stepping into Practice.

Your answers will be treated as confidential. We do not need your name.

The information you provide will help us to advise and shape the programme for future students. Some of the questions you may feel do not apply to you. Where this is the case please use the option that says 'not applicable' or leave blank.

To help us link your answers anonymously we would like to use your home postcode to match your answers with the answers you gave on the *Journey Questionnaire*.

Thank you.

What is your home postcode? _____



University of the
West of England

bettertogether

Section A

2. What do you feel are the most important outcomes for you in doing this course?

	Agree strongly	Agree	Neither agree or disagree	Disagree	Disagree strongly
Getting a job as a health visitor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting another kind of job (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting a pass degree	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting a post graduate diploma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going on to complete a Master's degree	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting a Band 6 post	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enhanced understanding from academic knowledge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developing skills for the Health Visiting team	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Returning to previous job (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Can you tell us what duties/skills you anticipate your future work role will demand?

4. Below are a list of statements about people you may be working with in your future roles. Can you tell us to what extent you agree with these statements?

	Agree strongly	Agree	Neither agree or disagree	Disagree	Disagree strongly
Families from lower socioeconomic groups tend to have children with more behavioural difficulties.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If mothers return to work full time after having a baby it often has a negative impact on bonding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People who misuse drugs or alcohol always make poor parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There is strong evidence that breast milk is best for babies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunisation is one of the most effective public health strategies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If a family experiences problems that mean a child can no longer live in the family home, then it is better to place a child with relations rather than in a foster placement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If a father has harmed a child physically social workers should ensure that he never has further contact with the child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gypsies and travellers experience severe health inequalities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Domestic Violence tends to happen more often in Black Minority Ethnic groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. How confident do you feel at the end of your training about the following statements?

	Agree strongly	Agree	Neither agree or disagree	Disagree	Disagree strongly
I feel confident to visit families in their own homes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel confident to visit families in their own homes by myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel confident in working with parents who misuse drugs and/or alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I think I will be effective in working with families where there are child protection issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I think I can work well with families who do not always follow health professional advice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working with parents with learning difficulties is within my area of expertise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Advising parents about family diet is within my area of expertise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Advising parents about infant feeding and weaning is within my area of expertise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel confident in working with parents experiencing post-natal depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel confident in working with parents with mental health problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel confident completing a Health Needs Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel confident in advising groups of parents on sexual health needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section B - working with families, children and other professionals

6. Have you seen your local Joint Strategic Needs Assessment?

Yes, and I have read it	<input type="checkbox"/>
Yes, I have read a summary	<input type="checkbox"/>
Yes, I am aware of it	<input type="checkbox"/>
No I haven't heard of it	<input type="checkbox"/>
No it is not applicable to my profession.	<input type="checkbox"/>

7. Do you feel when connecting with families you can help them to understand the impact of the community on children's growth and development?

Yes	<input type="checkbox"/>
To some extent	<input type="checkbox"/>
No	<input type="checkbox"/>
Don't know	<input type="checkbox"/>
Not applicable	<input type="checkbox"/>

Question continued overleaf...

Do you feel it is part of your role to develop community capacity?

- Yes
- To some extent
- No
- Don't know
- Not applicable

If you answered yes, please tell us how

8. As you step into practice do you have the confidence in your skills to do the following?

	<i>Confident</i>				<i>Not at all confident</i>
	1	2	3	4	5
Create positive relationships with local families	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Create positive relationships with community groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work to address local health inequalities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understand the principles of universal health visiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work with other health professionals such as GPs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work with Early Years professionals such as Children's Centre Managers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work with community leaders such as religious leaders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work with public health professionals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Engage in e-learning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. How confident do you feel as you step into practice about giving families evidence based information on the following health and health promotion issues?

	<i>Confident</i>				<i>Not at all confident</i>
	1	2	3	4	5
Infant feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationship issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Domestic abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Continued...

	<i>Confident</i>				<i>Not at all confident</i>
	1	2	3	4	5
Mental health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Long term conditions management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. How confident do you feel as you step into practice about signposting families on the following health prevention and health promotion issues?

	<i>Confident</i>				<i>Not at all confident</i>
	1	2	3	4	5
Infant feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationship issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Domestic abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Long term conditions management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. How confident do you feel in safeguarding children and young people?

I feel...	<i>Confident</i>				<i>Not at all confident</i>
	1	2	3	4	5
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. In your practice how important do you feel these issues will be?

	Very important	Important	Neither important or unimportant	Unimportant	Very unimportant
Engaging in the transition to parenthood and positive parenting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Safeguarding children and young people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Promoting strong family relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Promoting attachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Promoting care which promotes health and safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Early recognition of growth disorders and risk factors for obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Early detection of deviations from normal physical and neuro-developmental pathways	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Engaging children in decision making	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Engaging families in decision making	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section C - looking forward

13. As you step into practice what key skills do you feel you have gained from the SCPHN programme?

14. As you step into practice what key knowledge do you feel you have gained from the SCPHN programme?

15. Are there any additional issues/skills/knowledge you feel the programme should have covered?

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Appendix 7 SCPHN Journey Questionnaire

strictly confidential



Faculty of Health
and Social Care

Specialist Community Public Health Nursing

Journey Questionnaire

We would like to find out some information about your views on working with families and people; and your ambitions and expectations about this programme. We do not need your name. Your answers will be treated as confidential.

This information will help us to advise and shape the programme for yourselves and future students. Some of the questions you may feel do not apply to you. Where this is the case please use the option that says 'not applicable' or leave blank. We will visit you again and ask you some questions a year later.

To help us link your answers we would like to use your postcode to match both questionnaires. Thank you.

What is your home postcode?

.....

Section A

Please tell us about yourself

1. About you...

What is the year of first nursing or midwifery qualification?

.....

What professional qualifications do you have?

.....

.....

.....

Where were you working/studying before you came to study on this course?

.....

What is your highest level of qualification? (e.g. diploma, degree, masters degree)

.....

2. Which of the following statements describes your motivation for applying for the SCPHN course?

> please tick ALL that apply

- I wanted a change from current role in community nursing
- I wanted a change from current role in acute nursing
- I wanted to work in preventative health
- I wanted to work with families and children under five
- I wanted to work with disadvantaged groups.....
- I wanted to work 9-5 and no weekends.....
- I am interested in supporting and developing resources in communities
- I wanted a higher paid job than I had before
- I wanted to lead a team
- I feel that the job will fit in with family life and children
- I wanted to develop my professional skills/knowledge

Do you have any other comments about your motivation for wishing to train on the SCPHN programme?

.....

.....

.....

3. How did you hear about the SCPHN programme at UWE?

- Baby shaped leaflet.....
- NMC/ DH leaflet
- Trust flyers
- NHS Jobs UK.....
- Through a friend.....
- Through a colleague.....
- Through your employer.....
- Other > *please specify*

.....

4. What do you feel are the most important outcomes for you in doing this course?

	Agree strongly	Agree	Neither Agree or Disagree	Disagree	Disagree strongly
Getting a job as a health visitor.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting another kind of job, > <i>please specify</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
.....					
Getting a pass degree	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting a post graduate diploma.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going on to complete a Masters degree.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting a Band 6 post.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enhanced understanding from academic knowledge.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developing skills for the Health Visiting team.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Returning to previous job > <i>please specify</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

.....

5. Can you tell us what duties/skills you anticipate your future work role will demand?

.....

.....

.....

6. Below are a list of statements about people you may be working with in your future roles. Can you tell us to what extent you agree with these statements?

	Agree strongly	Agree	Neither Agree or Disagree	Disagree	Disagree strongly
Families from lower socioeconomic groups tend to have children with more behavioural difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If mothers return to work full time after having a baby it often has a negative impact on bonding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People who misuse drugs or alcohol always make poor parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There is strong evidence that breast milk is best for babies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunisation is one of the most effective public health strategies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If a family experiences problems that mean a child can no longer live in the family home, then it is better to place a child with relations rather than in a foster placement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If a father has harmed a child physically social workers should ensure that he never has further contact with the child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gypsies and travellers experience severe health inequalities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Domestic Violence tends to happen more often in Black Minority Ethnic groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. How confident do you feel at this point in your training about the following statements?

	1 Confident	2	3	4	5 Not at all confident
I feel confident to visit families in their own homes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel confident to visit families in their own homes by myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel confident in working with parents who misuse drugs and/or alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I think I will be effective in working with families where there are child protection issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I think I can work well with families who do not always follow health professional advice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working with parents with learning difficulties is within my area of expertise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Advising parents about family diet is within my area of expertise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Advising parents about infant feeding and weaning is within my area of expertise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel confident in working with parents experiencing post-natal depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel confident in working with parents with mental health problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel confident completing a Health Needs Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel confident in advising groups of parents on sexual health needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section B

Working with families, children and other professionals

8. Have you seen your local Joint Strategic Needs Assessment?

Yes, and I have read it

Yes, I have read a summary

Yes, I am aware of it

No I haven't heard of it

No it is not applicable to my profession

9. Do you feel when connecting with families you can help them to understand the impact of the community on children's growth and development?

Yes

To some extent

No

Don't know

Not applicable

Do you feel it is part of your role to develop community capacity?

Yes

To some extent

No

Don't know

Not applicable

If you answered yes, please tell us how >

10. *At this stage in your training do you have confidence in your skills to do the following?*

	1 Confident	2	3	4	5 Not at all confident
Create positive relationships with local families	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Create positive relationships with community groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work to address local health inequalities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understand the principles of universal health visiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work with other health professionals such as GPs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work with Early Years professionals such as Children's Centre Managers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work with community leaders such as religious leaders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work with public health professionals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Engage in e-learning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. **How confident do you feel at this point in your training about giving families evidence based information on the following health and health promotion issues?**

	1 Confident	2	3	4	5 Not at all confident
Infant feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationship issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Domestic abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Long term conditions management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. How confident do you feel at this point in your training about signposting families on the following health prevention and health promotion issues?

	1 Confident	2	3	4	5 Not at all confident
Infant feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationship issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Domestic abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Long term conditions management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. How confident do you feel in safeguarding children and young people?

	1 Confident	2	3	4	5 Not at all confident
I feel...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. In your practice how important do you feel these issues are/will be?

	Very important	Important	Neither important or unimportant	Unimportant	Very unimportant
Engaging in the transition to parenthood and positive parenting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Safeguarding children and young people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Promoting strong family relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Promoting attachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Promoting care which promotes health and safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Early recognition of growth disorders and risk factors for obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Early detection of deviations from normal physical and neuro-developmental pathways	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Engaging children in decision making	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Engaging families in decision making	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section C

Looking forward

15. What skills/knowledge are you aiming to gain from the programme?

16. Is there anything you think the module team could do to support/help you on the programme?

17. Do you want to tell us anything else?

Thank you for taking the time to complete this questionnaire. This will be a great help.



ISBN: 978-1-86043-518-8

January 2014

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