Returning to Health Visiting Practice: Completing the Circle

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Abstract

One response to the Health Visiting 'Call to Action' has been active recruitment of health visitors, who have left health visiting, back into practice. One Strategic Health Authority, NHS London, initiated a pilot Return to Health Visiting/Nursing Practice scheme in London in 2010. This paper reports on the experiences of the first three cohorts of returnees on the City University London programme, one of the London programmes, and the adaptations that have been made to the programme to help provide returnees with the theory base and practice experience to equip them to work in today's health visiting. Written evaluation forms were completed by the returnees and information gathered from their application forms. This information was supplemented for Cohort 1 with some interviews with Practice Teachers and Lecturers and a mid-stage questionnaire to the returnees. Of the 54 students in the three cohorts over half were still on one or both NMC registers which had not been anticipated at the start of the programme and led to modifications to the programme after Cohort 1 with an increase in the health visiting specific content. The returnees had a wide range of experience to bring back to health visiting reflecting the fact that a large number had been out of health visiting for more than 11 years. The evaluation shows that providing support by the university to the practice placement areas; ensuring that the taught element is current and useful to health visiting practice and having a relevant but not too onerous assessment process are critical.

Keywords: education; evaluation; return to practice; workforce development

Introduction

To encourage those who have left nursing and midwifery to return to the profession, Return-to-Practice programmes (RTP) have been in place since the 1990s. Relatively little is known about their extent or success (Gould, 2005), but the idea continues to have intuitive appeal. In addition as Trivedi (2011, NHS London unpublished/internal report) comments: 'They provide value for money by offering a far more efficient way to get Health Visitors into post than any other route.'

In response to national and local shortages of health visitors (Unite/CPHVA, 2009), and to the government's pledge to increase the number of health visitors by 4200 over the next five years (DH, 2010) NHS London launched pilot Return to Practice programmes in 2010. Return to practice health visiting/nursing (RTPHV/N) programmes offer an immediate and cost-effective way of addressing the shortage (Chalmers et al, 2011; Ly, 2011). The London RTPHV/N programmes are currently based at City University London (CUL), Buckinghamshire New University, and at Greenwich University (from 2012) covering the greater London area. The London RTPHV programme was previously described in Community Practitioner (Trivedi et al, 2010) and this paper gives more detail of the CUL programme together with details of the development and progress of the programme over three completed cohorts. Findings from the evaluation are presented based on data gathered during the programme, which has now run three times: September 2010, February 2011 and September 2011 (with a fourth currently in progress). These findings demonstrate the value of Return to Practice programmes whilst also highlighting good teaching practice and the challenges faced by students.

Out of the 54 students recruited to the CUL programme, three dropped out of Cohort 1, one from Cohort 2 and two from the Cohort 3 (see Table 1) so overall 32 have completed the programme with another 12 students aiming to complete by July 2012. However, in the February 2011 cohort 17 out of 22 completed practice but 4 students were still required to complete their personal development plan essay.

Table 1. Recruitment and completion rates

Cohorts (start date)	No. of students starting course (no. dropping out)	No. of students completing practice hours & assignments to date
1 (Sept. 2010)	18 (3)	15
2 (Feb. 2011)	22 (1)	17 (as May 2012)
3 (Sept. 2011)	14 (2)	12 (due to complete July 2012)
Total	**54 (6)**	**44**

The programme consists of ten theory days over a period of ten weeks, combined with placements across greater London. Each student has a variable amount of placement time, depending on individual learning needs, number of years they have been out of practice and NMC requirements (see Table 2).

Table 2. Practice hours required by programme

Years out of Practice	Minimum practice hours required	Equivalent days in practice (7.5 hours per day)
5-10 years	150	20 days
11-20 years	300	40 days
➢ 20 Years	450	60 days

Source: NMC Guidance (2011) and DH 2011a

Consequently, the programme lasts between three and six months. It provides students with the opportunity to refresh and update their skills and knowledge in both theory and practice. The programme is based on the NMC education and learning outcomes identified by NMC Standards of Proficiency, this document outlines the education and learning environments required for Specialist Community Public Health Nursing as directed by (NMC, 2004; Department of Health 2011a, 2011b).

The course was initially designed for those with lapsed registration for both nursing and SCPHN, providing the opportunity to rejoin both registers. However, applications were in addition received and accepted from registrants who had not practised for some time but who were still on one or both registers, so the

programme provides the chance for such students to refresh and update their practice knowledge and skills (see Table 3).

Table 3. Registration status of RTPHV students at start of programme

Cohorts (start date)	On Nursing but ***not*** on SCPHN register	On neither register	***On*** both	Total
1 (Sept. 2010)	8	9	1	18
2 (Feb. 2011)	4	7	11	22
3 (Sept. 2011)	2	8	4	14
All 3	14	24	16	54

NHS London has provided a bursary of £2000 for each student, and additional funding for travel and child care may be applied for. All course fees are fully paid by NHS London and NHS Trusts receive a payment for each RTPHV student for whom they provide a placement.

Cohort 1 was taught together with students on a concurrent RTP nursing programme, in order to facilitate dual re-registration. However, RTPHV students reported that sessions that focused on nursing skills were not relevant to their health visiting role, and the programmes have run separately since. The RTPHV programme still covers core topics that are needed for re-registration as a nurse such as record keeping and accountability but contains more content reflecting the principles of health visiting (Cowley and Frost, 2006).

The academic programme includes, for example, sessions on public health policy, the early intervention agenda, infant and maternal nutrition, working with vulnerable families and safeguarding issues (DH, 2011). Guest speakers with specialist expertise are invited to the theory days: for example, a speaker from the Tavistock Centre for Couple Relationships has helped equip the RTPHVs for supporting families to improve relationships and thereby to promote family health (Rhodes (no date).

Students completing the programme have to be signed off in practice and complete academic assignments at Level 5 with the award of 30 credits. Given the different registration status of the students, and following comments from Cohort 1, it was decided that students should be given different academic options for completing the course in accordance with their NMC registration status and these changes were implemented with Cohort 2 (see Figure 1).

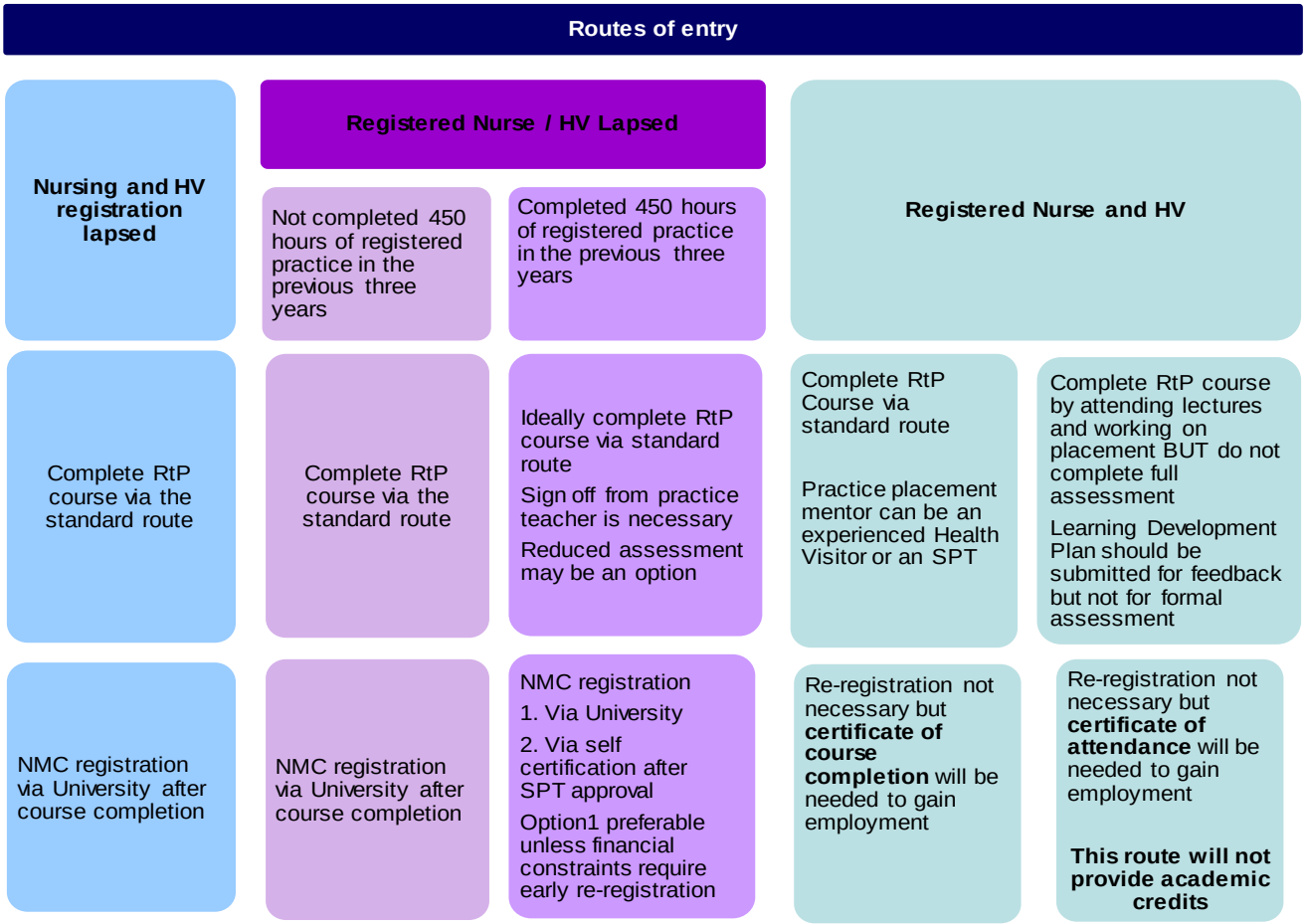

Figure 1 Options for completing the RTPHV Programme at City University London (from Trivedi, 2011, NHS London unpublished/internal report Figure 7).

Students who return to practice do so with different combinations of qualifications that have lapsed. The RTPHV programme enables NMC re-registration in Nursing and Health Visiting (SCPHN). Therefore the first purple column (Figure 1) indicates students who maintained their nursing qualification but their health visitor registration had lapsed.

Students are supported in practice by Practice Teachers (PT), or, for those on both registers, an Experienced Practitioner (EP) who is supported by a sign off PT. All students in Cohort 1 received at least one visit from the link lecturer during their practice placement. For Cohort 2, the commissioners suggested that such visits, which are time-consuming, be made only to those students off both NMC registers. However, given the range of practice, academic and pastoral issues experienced this was found to be insufficient. Visits to all students were reinstated for Cohort 3 onwards with visits being made within the first four to six weeks of practice. These visits allow lecturers, students and PTs/EPs to discuss the student's progress, and to identify as early as possible any concerns about their development in practice. The PTs/EPs are invited to attend a half day induction held with the RTPHV students from Cohort 3 onwards, and a half day study afternoon midway in the programme as well as having an open invitation to the RTPHV programme sessions and the student presentations on the last day.

Each cohort has had a diverse student population. Some students have been working at strategic level across health and social services, some have worked outside health care, and others have been out of the working environment, caring for family members or children.

Evaluation of the RTPHV Programme

This paper considers the RTPHV students experience in detail by drawing on a range of evaluation material:

- replies by students in all three cohorts to a questionnaire on the first day of academic teaching, asking about their expectations of the course;
- replies by students in all cohorts to a questionnaire about what they had learnt, completed on the last day of academic teaching; and
- NHS London data (background information about students).

Additional data were gathered during and shortly after the first programme:

- students' midway impressions of 'the story so far';

- brief (face-to-face or telephone) interviews or e-mail exchanges with academic teachers; and
- brief telephone interviews with practice teachers.

Although these methods of data-gathering have not been repeated, they are included here because those running the programme confirm that they reflect what later cohorts have expressed informally.

From these data, a coherent picture emerges of the hopes and experiences of the students and how these affected learning and teaching in both academic and practice settings.

Findings

Not all numbers sum to 54 because of missing data (failure to answer particular questions, or absence when the questionnaire was distributed). All percentages are calculated out of 54.

Of the fifty-four students joining the programme, fifteen (27.8%) were aged between 36 and 50; twelve (22.2%) between 51 and 55; fourteen (25.9%) between 56 and 60; and seven (13.0%) between 61 and 70. Thus, nearly two thirds were over 50. These older students brought with them considerable expertise from other fields to inform their return to health visiting, although even with the current policy push for later retirement, they are unlikely to have very long working lives in health visiting.

There was considerable past health visiting experience among students. Fifteen (27.8%) had been a health visitor for up to 5 years, sixteen (29.6%) for 6 to 10 years, and thirteen (24.1%) for 11 or more years. However, this was generally not very recent experience: for two (3.7%), it was five years or fewer since they had practised as a health visitor; for fifteen (27.8%), between 6 and 10; for twelve (22.2%), between 11 and 15; and for fifteen (27.8%), 16 or more.

Students' learning priorities

On the first day of academic teaching, students were asked to complete a questionnaire which simply asked: *Please identify up to 10 priorities for your personal learning during the Return to Practice (Health Visiting) programme.* 17 were received from the first cohort, and 9 from the second cohort. Box 1 illustrates the responses using categories that emerged from the results. The third cohort was given a list of categories, in order to make comparisons between future cohorts easier, and these results are also included in Box 1. Given how long many had been out of health visiting practice, it is not surprising that many specified among their priorities the updating of their knowledge of legislation, policies and guidance, and practice skills and knowledge. A significant minority were also very concerned about the academic demands of the course.

Box 1. Learning priorities for personal learning

Numbers in brackets are of students mentioning each topic as a learning priority.

Cohorts 1 and 2 (N = 26):

Underpinning knowledge/background
Legislation, policies, guidelines (15)
Multi-disciplinary / multi-agency working (10)
Structure of NHS (8)
Practice skills and knowledge
Updating and amplifying knowledge in general (19)
Safeguarding children (15)
Childcare (including feeding) and child development (12)
Parenting (8)
Immunisations (5)
Processes and procedures
Data – collecting, recording, reporting (9)
Corporate caseloads (5)
Learning
Placements (6)
Academic writing / assignments (5)
Accessing information (4)

Cohort 3 (N=12):

Working with families (10)
Identifying those at risk (8)
Health promotion (8)
Child safeguarding (8)
Data collection and analysis (7)

Health protection (6) Screening individuals and populations (5) Working with groups/communities (5) Project planning and implementation (5) Community development (5)

Students' experiences

Were these aspirations met? In the second questionnaire, which students completed on the last day of academic teaching, they were asked to say whether they had learnt a lot, a little or not much about each of the topics listed in Table 4. 'A lot' was scored as 2, 'a little' as 1, and 'not much' as 0. Average scores have been calculated for each question. Where no reply was made, this has been adjusted for. Table 4 shows that the academic component of the course was seen as reasonably successful in helping students achieve their learning priorities. The categories were drawn from Cohort 1's replies to questionnaire 1. The lowest scores relate to aspects of health visiting that are best learnt on placement, and in some cases placements were not completed when the questionnaire was completed.

Table 4. What was learnt

Topic	*Score, cohort 1 (N = 15)*	*Score, cohort 2 (N = 20)*	*Score, cohort 3 (N=8)*
Updating knowledge about child care and child development	1.6	1.9	1.3
Updating knowledge about parents' needs and parenting	1.6	1.7	2.0
Updating knowledge about safeguarding children	1.5	1.4	1.6
Putting learning into practice on placement	1.4	1.4	1.9
Understanding the NHS	1.4	1.3	1.1
Understanding multi-disciplinary and inter-agency working	1.3	1.2	1.4
Health promotion	1.2	1.5	1.4
Study skills	1.1	1.0	1.4
Writing to an academic standard	1.1	1.1	1.4
Learning how to collect, record, report data	1.1	1.1	1.4
Learning how to manage corporate caseloads	0.5	0.8	1.1

By averaging each student's scores for all topics, we can construct a score for the course to date as a whole. Whereas seven of the first cohort (46.7% of the 15

completing) gave average scores of 1.5 or more, four (26.7%) gave less than 1. The equivalent figures for the second cohort are 8/20 (40%) and 5 (25%), and for the third, 5/8 (62.5%) and none. These figures, like those in Table 4, suggest that the lecturers have used student feedback and their own experience with the programme to make the programme more fit for purpose, as perceived by students.

Students were also invited to make any other comments, particularly about placements, and these are summarised in Boxes 2-5. Questionnaire data are supplemented here by the results of an exercise with Cohort 1 conducted about half way through the academic part of the course: students attended an event at NHS London where they were invited to write comments on post-it stickers and place them on a number of posters. These have been analysed together with the free text content of the questionnaires.

Many students felt positive about their placement experiences, although there were some mixed experiences (see Box 2). Box 3 illustrates in particular the strong awareness of changes in health visiting practice; these were viewed as challenging, and, by a minority, as predominantly negative (this was most noticeable in Cohort 1). The quotations in Box 4 indicate that a didactic 'talk and chalk' style of teaching is probably not appropriate for these experienced adult learners. Box 5 illustrates how a minority of students were not familiar with modern electronic-based study techniques, and that the academic workload was felt to be high.

Box 2. Placement experiences

Placement experiences

- My practice area was supportive and all the health staff that I came in contact with were helpful, enthusiastic, eager to help and guide me in my clinical practice. I was given access to a wide range of experience, and I enjoyed the overall placement very much. (questionnaire)
- Very mixed. There is a lot of support and genuine concern but workers are very stretched and … it has been difficult to plan and structure my learning experiences. (questionnaire)
- I have very little contact with my clinical practice teacher, because she is a team leader. However, I have worked with other HVs in the team. Staff shortages and high staff sickness rates. (post-it)

Box 3. The reality of practice

The reality of practice

- How can team caseloads deliver on trusting relationship. Can you identify need/risk if you don't see families regularly in own home? Is practice safe with very high case loads? Huge practice concern about lack of home visiting to families. No comparison with 20 years ago. (post-it)
- Sometimes I think it requires one to be superwoman health visitor and can give a rather negative feel to the role – always suspicion instead of emphasising the caring role. (questionnaire)
- A lot of the lectures didn't bear much relation to what is happening in practice (questionnaire)

Box 4. The student group

The student group

- We are a challenging group to teach and support. Lots of different experience, different needs. (post-it)
- Lots of experience in the group – would like the opportunity to share this more. (post-it)
- Group work would mean we could learn more from each other. (post-it)
- Would prefer more group work, more student-led sessions, more participation by students; and less lecturing and discussion. (post-it)

Box 5. Learning needs

Learning needs

- For people who have been away from nursing and university for some time, there is a need to include IT skills and presentation skills during the course or before the course starts. (post-it)
- Assignments – anxieties about libraries, databases, and use of IT could be solved by a specific longer induction on these topics alone. (post-it)
- A lot of studying over a short period. (questionnaire)

Teachers' views

After academic teaching to the first cohort was complete, nine academic teachers gave their impressions to SA, either face-to-face, by telephone, or by e-mail. Quotations are taken from e-mails or from notes made during the interviews by the evaluator and typed up immediately afterwards. Teachers responding are coded AT1 – AT9.

Academic teachers agreed with the comments in Box 3, noting the experience and maturity of the student group.

> *'a range of backgrounds and experiences; high calibre; a lot of rich relevant experience. They were highly motivated, wanting to make a difference, and to improve health visiting practice. They brought insights from other perspectives. They were a delight to teach, they wanted to get the most out of it.' (AT4)*

> *'strong, self-assured and focused on their individual and group needs … they knew what they wanted, and were focused on achieving their learning requirements.' (AT7)*

There was also agreement that group work was the best way to promote learning:

> *'It was good to get them talking, sharing their broad and rich experience.' (AT5)*

While a group work approach allowed students to share experiences and learn from each other, it also legitimised the need that some had to ventilate feelings about some of the conflicts they were experiencing: between theory and practice, and between what they remembered from the past and what they were experiencing on placement in the present.

AT8 drew a clear contrast between their previous experience and current practice. She characterised the former as consisting of

> *'making relationships with families; frequent home visits; groups (breast-feeding, post-natal, weaning, etc.)',*

and the latter as:

> *'skill-mix, whereby the lower grades do all the enjoyable work and all health visitors do is the first assessment and safe-guarding'.*

Academic teachers were also aware that the

'course expectations and required work were felt to be demanding and time consuming'. (AT7)

This partly reflected the reality of the course, and partly a certain lack of confidence among the students in undertaking academic work after a long break:

'They were visibly twitched about assignments, they felt them a burden, they felt unnerved. There was fear of the unknown: 'can we cope?' (AT5)

One teacher confirmed the evidence in Box 5 that some students were under-equipped for the use of IT in an academic setting.

In general, academic teachers enjoyed teaching the group, and appreciated their willingness to engage and debate.

Practice teachers

Three PTs were interviewed by telephone (PT1-PT3). Quotations are taken from notes that were made during the conversations and typed up immediately afterwards. Their students had been out of health visiting for 25, 12 and 7 years respectively. Not surprisingly, the PT supporting the first needed to provide plenty of input:

'discussing basic detail of what health visiting is about; discussion, reflection, debate about practice.' (PT1)

PT1 also reported having to support her student with the academic work. All three PTs emphasised that they thought the quantity of academic work was too large, and the number of learning outcomes excessive. All three likened the work-load to that expected of students undergoing the one-year health-visiting course, even though this programme was much shorter. PT3 believed that the academic load was particularly inappropriate for her student, who had been out of practice for only seven years. Nonetheless, all three PTs regarded the placements as very successful and enjoyable.

Discussion

These evaluation data are limited in a number of ways. Because the academic timetable was very crowded, tools for gathering data were deliberately kept brief and simple, so that rich data could not be gathered. Conversations with academic and practice teachers were also deliberately kept short, because of the pressures those staff are under in their daily work.

Nevertheless, these data make it clear that RTPHV is not an easy option for students, partly because of the academic requirements and partly because of 'culture shocks' as students adapt to contemporary health visiting practice. The realities of Returning to Practice in Health Visiting are highlighted by Miller (2011), a student from the first cohort at City University. After 12 years out of practice she explains some things never change; for instance 'clients were anxious about the same topics: breastfeeding, sleep and child development' (Miller, 2011p.19). Yet, the culture and pace of the modern health visiting profession and services have changed drastically, with Children Centres, skill mix teams and changing patterns working with families. The realities of these challenges in turn require sensitivity and support from academic and practice teachers.

Some of our findings reflect those of a recent evaluation of a return to practice scheme for health visitors (Amin et al, 2010), which noted, as we did, anxieties about academic assignments, and the importance of peer support.

The diversity of students is also an important finding, echoing that of another study of a RTP programme for nurses (Barriball et al, 2007). Previous experience and expectations varied considerably, as did students' responses to placement experiences in general and to changes in health visiting over time. It seems from this evaluation that such diversity is best handled by trusting the students to use their differences to inform debating and exploration in groups. Although students hoped to acquire plenty of information, they wished to do so interactively rather than passively: their preference was for andragogic learning, where the learner takes responsibility for learning rather than leave it with the teacher (Knowles, 1970).

Practice teachers have a different role, being better placed to assess and respond to each student's individual needs.

Student feedback, given both formally via this evaluation and informally during classes and practice visits, has identified throughout the programmes to date a number of areas where adjustments to the programme could improve their learning. As a result, changes have been made in three areas: support for students on placement; getting the teaching 'mix' right; and making the academic requirements more manageable.

First, as the Introduction points out, the initial plan to visit all students on placement was modified in cohort 2 but has been restored for all subsequent cohorts as a means to support the student and practice teacher. Second, it has been a challenge to provide classroom education that meets the diverse needs of all students. The aim has been to foster learning that is informed by practical experience, strategic understanding and sound academic knowledge. Changes have been made from cohort to cohort to ensure a range of teachers from academia and practice who together can provide such a range. The most important change was that following cohort 1 when the RTPHV/N programme was separated from the Return to Nursing programme and the revised programme led by and focused on health visiting.

Third, the NMC (2004) requires SCPHN students to demonstrate their level of competence across 25 SCPHN learning outcomes in theory and practice. Students from first cohorts who (were off the register) were expected to undertake 2 key assignments: a short 1,000 word reflection on their journey of learning across theory and practice and to write a series of reflections across 25 learning outcomes - which often felt bewildering and unwieldy for students and practitioners. A revision has been made to this assignment so that students reflect across 5 themed 'mini' essays which are: a community profile of practice, health promotion, safeguarding children at risk, identifying unmet need and The Healthy Child Programme. This recent development enables student's to be focused on topical areas in practice. The

assignment for students 'on' the register remains unchanged – the short 1,000 word reflection essay.

Conclusion

Although the RTPHV programme was described as 'straightforward' on paper from CUP, Miller (2011) did not anticipate the 'blood, sweat and tears' of sheer hard work she experienced at a practical level. Students rarely anticipate the 'culture shock' experienced from returning back to practice (Miller 2011p.19). The fast pace of health visiting work is determined by new IT systems, skill mix teams with a range of expertise and backgrounds and the expectations of interventions in preventative work has changed the level of face to face client contact. The programme at CUL attempts to support students to cushion the culture shock experience. For instance we ask students from previous cohorts to communicate their advice and support on how to successfully complete the programme. We offer seminars to support the assignments; these sessions are particularly useful for students who have not undertaken any academic work for some time. Changes have also recently been made in the financial support for students making the RTPHV/N a viable option for more people.

Support, flexibility in completing the programme and encouragement is available for all those interested in undertaking the programme. What prospective students require is the determination, focus and support to return to health visiting practice. As many of the RTPHVs have told us: returning to health visiting practice feels like completing the circle of their professional careers: returning to what motivated them in the first place. The uptake of RTPHV is making a significant contribution in bringing returnees back into the clinical field. In order to continue this trend we encourage potential returnees to find out more about their local programmes and consider it a serious option to boost the public health workforce and contribute to the health and wellbeing of children and families.

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