

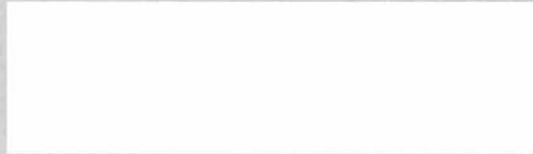
The Council for the Education and Training of  
Health Visitors : a case study of a statutory  
qualifying association in nursing

Elaine Wilkie

Ph.D  
University of Edinburgh  
1980



**I certify that this thesis has been written by me and is entirely  
my own work.**



### Acknowledgments

I should like to express my thanks to the Royal College of Nursing and the Health Visitors Association for granting me access to Minutes of Committees and to Reports of the organisations. My especial thanks are due to the Council for the Education and Training of Health Visitors and to its professional and administrative staff who were untiring in their provision of copies of records and Reports as well as facilitating my search of the Minutes of the Council and its Committees.

The typing of the text has been undertaken by Mrs V. Chuter and Mrs M. Armstrong and Miss Catherine Fraser has given personal assistance in the final stages of the collation of the papers.

I have received personal advice from a number of sources within the University including the late Professor J. Spencer and from Dr A. Patterson, both of the Department of Social Administration. My greatest debt is to Dr Lisbeth Hockey who has been the supervisor throughout the project and without whose constant support and helpful criticism the study could not have been completed.

### Abstract

This study attempts to identify the interplay between the statutory qualifying associations in nursing, the service within which they operate and the climate of opinion in the profession they serve. Using a case study approach one such organisation is chosen as the vehicle for the exploration of the factors influencing the powers and responsibilities of a qualifying association and the significance of its relationship with the central government departments.

The Council operated from 1962 to 1974 with the Council for Training in Social Work. This thesis is concerned with the policies and progress of the Council in that twelve year period. The study is based upon four propositions related to the history of the qualification provided, the effects of current developments in the mainstream of higher and further education, professional attitudes towards health visiting and the nature of employment within the National Health Service.

The implications of the reorganisation of the National Health Service and of the establishment of a new Central Council for Nurses, Midwives and Health Visitors in 1979 are discussed. The significance for the powers and degree of autonomy of a body registering nurses for what will be a monopoly employment situation is discussed and questioned.

Primary and secondary source material is extensively used, Minutes of Council and Committee meetings, correspondence with central and local government and

training institutions as primary sources provide information not previously systematically explored. Published documentation reports and other relevant literature represents the secondary sources.

## Contents

	<u>PAGE</u>
Introduction	1
Chapter 1 : The inception of the Council : policies and progress in the first three years	7
2 : Progress of the Council 1965-1974 : selection of priorities in the changing context of the health and social services	33
3 : Origins of health visiting and the training of health visitors : an overview of developments prior to 1962	63
4 : Implications of the past history of health visiting for the training policies adopted by the Council	87
5 : Qualifying Associations in Nursing : the Council compared with four examples	107
6 : The educational setting 1962-1974	131
7 : The relationship of health visiting to nursing : the implications of professional disunity for the Council as a qualifying association	152
8 : The reorganisation of the health and social services 1970-1974. Consequences for the interplay between the Council, the Council for Training in Social Work and the Government Departments	176
9 : Conclusion : the significance of the reorganisation of the National Health Service for qualifying associations in nursing	205
References	
Additional source material (unreferenced)	
Appendix	

## Appendices

- A. Membership of the First Council 1962-1965
- B. The Health Visitors Training Rules and Guide to the Training Rules
- C. Recruitment of Students 1964-1973
- D. Post registration Students 1968-1973
- E. The Function of the Health Visitor
- F. Examinations organised by the Royal Society of Health 1963
- G. Health Visitor Training Centres, England, Wales and Northern Ireland 1963
- H. The six main groups in the Department of Health and Social Security
- I. Summary of the Council's evidence to the Committee on Nursing

**Abbreviations:** CTHV Council for the Training of Health Visitors  
CETHV Council for the Education and Training of Health Visitors  
after 1971  
"Council" is used to refer to either title above  
HVA Health Visitors Association  
NHS National Health Service  
RCN Royal College of Nursing

The Council for the Education and Training of  
Health Visitors

A Case Study of a Statutory Qualifying Association

Introduction

This study of one of the qualifying associations in nursing arose from the involvement of the writer in the operation of an organisation established by statute to promote and regulate the training of health visitors in the United Kingdom. Interest was further stimulated by legislation which will affect all such bodies in nursing. Like the five organisations; the General Nursing Councils of Scotland and England and Wales; the Central Midwives Boards for Scotland and England and Wales; the Council for Nurses and Midwives for Northern Ireland; the Council for the Education and Training of Health Visitors operated through the medium of an Act, the Health Visiting and Social Work (Training) Act 1962. Although also concerned with registered nurses, the methods by which the Council carried out its responsibilities differed from those of the other Councils. This study is concerned with these differences and the features of the period which may have had a bearing upon the formation of its policies on training for a service which came within the sphere of the Health Ministers.

The Choice of the Case Study Method

The Council\* is unique among the nursing bodies quoted above. There

---

\* In the interests of brevity, the term "Council" is used in this study to refer to the Council for the Education and Training of Health Visitors

are differences in constitution such as the nature of the membership of the bodies; the Council is an appointed, not an elected body. The terms of reference also differ in that the General Nursing Councils are concerned with the registration of nurses following the general training upon which the Council builds its training syllabus. The unique form of the Council has to be borne in mind in determining upon a method of study. The lack of an exact counterpart, coupled with the retrospective form of the study precludes any direct comparison with the other bodies. Case study was therefore chosen as the most appropriate vehicle for the study of this example of a qualifying association.

It is not possible within the limits of the case study method to demonstrate a causal relationship between the policies adopted by the Council and the contemporary events in such areas as education, health and local government. It is, however, possible to identify a number of key trends which appear to have influenced policy in this one example and which, it might be assumed, could be employed in similar studies of the related bodies.

Rose (1969) writing in *Policy Making in Britain*, suggests a case study as one of the simplest methods of observing the policy making process:

"the study of individual cases may lead inductively to the development of new insights into policies and concepts that can be generalised from the aperçus of close observation". (1)

An example of the use of a case study as a means of understanding pressure groups is provided by Eckstein (1960) in his study of the British Medical Association. In his preface he outlines the steps involved in the organisation of such a study and concludes that:

"the data are not intended as any sort of 'proof' of the generalisation. They constitute a case study and nothing more: evidence not validation". (2)

The value of concrete evidence is emphasised again by Rose:

"The concreteness of cases provides an excellent test of the meaningfulness of generalisation that rapidly proliferates in the social sciences today. Examining a general idea in the terms of a relevant case may also lead to a reassessment of empirical assumptions that fail to hold true in the case at hand". (3)

Evidence for the study is obtained from a number of sources.

Adelman, Jenkins and Kemmis (1976) suggest "case study is not the name for a methodological package ... it is eclectic". (4) The sources used are largely documentary, minutes of meetings, annual reports, government circulars, letters to Local Health Authorities from the Council, informative pamphlets and handbooks for students and teaching staff. An additional source is the History of the Council compiled on behalf of that body by Wilkie (1979). (5) In selecting this last work it is recognised that accounts of such a nature will inevitably show some bias. Gottschalk (1945) comments:

"Official histories of recent activities ... have marked weaknesses, in part ... derived from an understandable effort to appeal to large constituencies by making them journalistic and timely ... (but) ... the historian interested in a timely subject often does interview contemporaries or exploit his own experience of contemporary events; and the official historian has exceptionally good facilities for doing so". (6)

Despite the possible bias, the advantages obtained from personal experience appear to be supported by Gottschalk's view. Bias may be demonstrated not only in an account of events but also in the selection of the facts to be included in a study. Carr (1951) distinguishes between facts and "facts of history".

"It is only the decision of the historian to use them (the facts) and the conviction of the historian that they are significant for his purpose which makes them into 'facts of history'. His choice and arrangement of these facts and the juxtaposition of them which indicate his view of cause and effect must be dictated by presuppositions". (7)

An example of such presuppositions is the set of four propositions given below which are used for the organisation of the material contained in this study.

#### Organisation of the Case Study

"Case study data paradoxically is strong in reality but difficult to organise" (Adelman et al. 1976). (8) To organise the material and the arguments in this study, four propositions are made.

- (a) That a newly established qualifying association will be influenced by the history of the qualification concerned and the previous regulations
- (b) That a body with the specific remit of "training" and/or "education" will be influenced by the general educational climate of the period under study
- (c) That the policy of a qualifying association is influenced by the climate of opinion in the professional organisation representative of the workers to whom the qualification is awarded
- (d) That the progress, development and authority of a qualifying association established by statute will be promoted or inhibited as much by the employment available to the trainees on completion of training as by the actual powers of the Act.

In the period 1962-1974, membership of the Council changed four times, members being appointed for terms of three years. The first two chapters of the study give a factual account of the twelve years during which the Council was linked administratively to the Council for Training in Social Work. Chapters 3 and 4 are related to the first proposition and therefore provide an overview of the health visiting service, and the patterns of training prior to the establishment of the

Council. The relevance of that background to the activities of the Council is explored. Chapter 5 considers the qualifying associations in nursing in relation to their powers, responsibilities and authority. The significance of the atypical form of the Council is discussed. The education scene during the period under review is examined in Chapter 6 with particular reference to the emergence of new resources for training. The interplay between the structure of the nursing profession, the health visiting section of that profession and the policies of the Council is explored in Chapter 7.

The period 1962-1974 was one of considerable change in the health, social and education services, all of which had an impact on the Council. In Chapter 8 the relationship of these changes, actual or proposed, to trends in the Council's policies is explored. In the later years of the period under review, a major report on nursing was published. (9) The significance of this report which proposed extensive changes in nurse training and in the qualifying associations in order to achieve a closer integration of the nursing service is discussed in the final chapter along with a reconsideration of the four propositions with which the study began.

There has been relatively little study of the qualifying associations in nursing although Abel-Smith (1960) (10), Hector (1973) (11), Bendall and Raybould (1969) (12), and in a more generally discursive form, Bowman (1967) (13) all include accounts of progress towards a national registering body for nurses earlier this century. Maggs (1978) speaking at the first meeting of the History of Nursing Interest Group of the Royal College of Nursing argued that a new approach to the history of nursing would have wider implications:

"not only can a study of the social history of modern Britain add to our understanding of nursing's past but that a fresh look at nursing will add to our total understanding of British society". (14)

In this claim Maggs relates the study of the development of nursing to the social history of women's work in a particular period:

"by selecting a particular context in which to investigate a particular phenomenon the social historian is attempting to identify what it is that constitutes the 'social point of view' of the period". (15)

To encourage such new thinking on nursing Maggs advocates more "micro history" studies of institutions, hospitals, groups and processes.

In addition to the contribution "micro histories might make to the larger study of nursing in its social context" there is a more immediate need for more knowledge of the actual working of some of the regulatory organisations in the professions. The reorganisation of the NHS has, by the incorporation of services previously administered by the local health authorities, reduced the choice of employer for nurses in the UK. The establishment of one unitary registering body for all forms of pre and post registration training for nurses as a result of the Nurses, Midwives and Health Visitors Act 1979 may have other limiting effects. The desire to achieve common goals in nurse training by reducing the diversity of the participatory training bodies must be balanced against the possible dilution of the expertise such bodies have offered in the past. Such balance requires an understanding of the resources as well as the constraints affecting their operation. The absence of studies of individual qualifying associations in nursing indicates a gap in available knowledge and therefore an important field for further study.

CHAPTER 1

The Inception of the Council : policies  
and progress in the years 1962-1965

The Health Visiting and Social Work (Training) Act 1962 established two organisations, one, as the title of the Act implies, responsible for the training of health visitors and the other responsible for the training of social workers in the health and welfare services. The original titles of the two councils were, Council for Training Health Visitors (CTHV) and Council for Training in Social Work (CTSW). These were amended in 1971 following the Local Authorities Social Services Act of 1969 to those in use at present, that is, Council for the Education and Training of Health Visitors (CETHV) and Central Council for the Education and Training of Social Workers (CCETSW). The two Councils shared a chairman appointed by the Privy Council, a secretariat and accommodation. Of the 31 members of the CTHV and 32 members of the CTSW some served on both Councils.

The Council ended its first term of office in the summer of 1965. The period was characterised by fundamental changes in the nature and method of training. It also saw the beginning of a number of further innovations which developed during the later years of the Council. Because so much of that later work stemmed directly from activities in the first three years, it has seemed appropriate to devote a considerable portion of the study in this first chapter to a catalogue of these activities.

Terms of reference of the Council

Both bodies had the same terms of reference. As set out for the health visitor Council these were:

The Council for the Training of Health Visitors:

- (a) shall promote the training of health visitors by seeking to secure suitable facilities for the training of persons intending to become health visitors, by approving courses as suitable to be attended by such persons and by seeking to attract persons to such courses;
- (b) if it appears to them that adequate provision is not being made for the further training of health visitors, shall provide or secure the provision of courses for this purpose;
- (c) may conduct or make arrangements for the conduct of examinations in connection with such courses as are mentioned in the preceding paragraphs; and
- (d) may carry out or assist other persons in carrying out research into matters relevant to the training of health visitors.

Section (2) (i) An approval under paragraph (a) of subsection (1) of this section shall be given by the Council in accordance with rules made by the Council and approved by the Health Ministers and these rules may specify subjects to be comprised in the course to be approved and shall specify the conditions for admission to the courses and for the award by the Council of certificates of their successful completion. (1)

Under the National Health Service (Qualifications of Health Visitors) Regulations 1964, the health visitor's certificate awarded by the Council became one of the conditions of employment as a health visitor in England and Wales.

Although the terms of reference of the two Councils were essentially the same, there were two differences which did not receive much attention at the time. The first related to the approval of the rules made by either Council in respect to subject matter of courses, student admissions and award of certificates. In the case of the

Social Work Council such rules were to be approved by the Privy Council not the Health Ministers. Although this may appear to be a minor difference and possibly related in a superficial sense only to the prestige of the body concerned, there are other implications. Carr-Saunders and Wilson (1933) point out that professional qualifying associations have some common problems and therefore rather than placing them under different government departments the Privy Council would seem to be the desirable department and in relation to this opinion deprecate the removal of the Central Midwives Board in 1919 from the control of the Privy Council to the Ministry of Health. (2) The second difference was to have a more practical effect following the passage of the Local Authorities and Social Services Act 1970. In section 3(3) of the Health Visiting and Social Work (Training) Act it was laid down that:

Her Majesty may by Order in Council make provision for conferring on the Council for Training in Social Work such functions in relation to other social work as are conferred on it by subsection (1) and (2) of this section in relation to the social work therein mentioned; and, in connection therewith, for the making of such modification in the constitution as She may deem expedient.

The significance for both Councils of this section became obvious in 1970 with the implementation of the Local Authorities Social Services Act (1970). The powers given by this section allowed for a sudden expansion of the Social Work Council to 64 members and led to an imbalance in the needs and resources of the two Councils and eventually to their separation.

The interpretation of the Council's powers and responsibilities and consequently the staff and other resources required to carry out those responsibilities, formed the subject of a continuing debate with the

government departments in the years under review in this study.

Under the Act (Schedule 1 paras 12 and 13), the Chairman was appointed for 5 years and each Council member for three years, although it was possible to be reappointed for a further period. (3) During the period covered by this study, two joint Chairmen held office, the first Sir John Wolfenden (later Lord Wolfenden) for one year, followed by Sir Charles (later Lord) Morris who continued until 1971. The constitution of the two Councils then changed and the office of chairman was divided with one chairman to each Council.

Training for health visitors was already established in 1962 although two different examining bodies were responsible, the Royal Society of Health in England and Wales and the Royal Scottish Sanitary Association in Scotland. Training in Northern Ireland came under the Royal Society of Health. The development of these two systems and their particular relevance to the new Council is discussed in Chapter 3.

The first Council was convened on 25th October 1962 with Lord Wolfenden in the chair, the membership is shown in Appendix A. The meeting was brief; the main business being a statement by the chairman outlining the priorities as he saw them. These were:

- (a) A revision of the syllabus for training health visitors
- (b) A consideration of the part played by the Royal Society of Health and the Royal Scottish Sanitary Association in the examination of health visitors
- (c) A consideration of the supervision of students in practical work
- (d) Discussion to consider the best patterns of relationships to establish with the Standing Conference of Health Visitor Training Centres
- (e) Consideration must be given to improving the recruitment of students to training courses and to means of obtaining candidates of the best quality. (4)

The first meeting was largely introductory but two panels of members were set up, one to consider the syllabus and examination and the second to consider the supervision of students' practical work. In addition, two special groups were convened to consider applications for posts on the staff of the Council.

Willie (1979) has summarised the innovations introduced in the period 1962-1974 as those related to:

- (1) Training
- (2) Recruitment of students
- (3) Establishment of communications with related organisations.

These three headings provide a convenient framework within which to consider the activities of the Council in the first three years.

(1) Training

When the Council was established in 1962, there were 29 health visitor training centres in the United Kingdom. (5) The two bodies responsible for examination had carried out some revision in the preceding years, the Royal Society of Health in 1950 and the Royal Scottish Sanitary Association in 1956. The nature of the courses varied greatly as did the conditions under which the training was carried out. No standards had been laid down respecting classrooms, libraries and common rooms. In some cases universities might provide facilities either within the university proper or through its extra mural department. In few cases were the tutorial staff appointed to the staff of the university; more usually they were seconded from a local health authority. Some colleges of advanced technology provided courses, as did a few technical colleges - usually in co-operation with specific local health authorities. Two professional organisations organised training but the majority of courses were administered entirely by local health

authority staff and housed in local health authority premises.

The two panels referred to above were concerned with:

- (i) Syllabus and Examination
- (ii) Fieldwork and supervision.

(i) The Syllabus and Examination Panel

The panel considered three areas:

- (a) Syllabus content
- (b) The type of institution in which the necessary teaching and learning facilities could be provided
- (c) The nature of the examination

(a) Syllabus content

Wilkie (1979) draws attention to the number of different situations in which health visitors might be employed. (7) The syllabus therefore had to take account of this variety so that the student might have a sound base from which to begin her work after training. Although the student might expect to find employment within the authority organising training, where that local health authority was responsible for the management of the training centre, the course should have prepared her for work in any part of the United Kingdom. It also should have equipped her to operate with a caseload based upon a geographically defined area or upon the caseload based upon the practice list of a general medical practitioner.

The Jameson Committee (8) had identified health education as one of the main functions of the health visitor and the panel had to bear in mind both the targets for health education and the skills required for its effective operation. Changes had taken place in the mortality and morbidity rates related to mothers and young children. In addition the

public had over the years had access to more information on health and disease through the press and media generally. Along with exposure to increasingly skilled advertising techniques this knowledge was producing a sophisticated clientele for whom the simple "talk" on health and hygiene was no longer appropriate.

The second of the functions of the health visitor as described by the Jameson Committee was that of "social advice". (9) Two years after the publication of the Jameson Report, recommendations on the training of the social worker in the Youngusband Report recognised the emergence of an additional source of social advice in the social workers employed in the health and welfare services. (10) The health visitor was no longer the main trained purveyor of such advice. In order to accommodate the above aspects the panel would have to identify a knowledge base upon which the student could begin her work and from which it would be possible to develop new techniques as the patterns of community health and related social services might alter in ensuing years.

The panel decided that there should be five themes in the syllabus of training. These are:

- (1) The development of the individual
- (2) The individual in the group
- (3) The development of community care
- (4) The social aspects of health and disease
- (5) The principles and practice of health visiting. This section defines the component skills involved in health visiting, dividing these into the art of interviewing, the means of assessment, the organisation of work and the forms of health education which may be appropriate. (11)

(b) The type of institution in which the necessary teaching and learning facilities might be provided

The new syllabus made new demands upon training schools, especially those organised totally within the resources of a local health authority. In addition to the administrative resources required for a devolved examination described below, teaching staff able to deal with the behavioural sciences of psychology and sociology which underlay the first three sections of the syllabus were needed. The new concept of shared study presented a further problem. The guidance issued to training schools contained the following advice:

The Council will have regard to the material conditions provided for the tutorial staff and for the students to work and study and for the opportunities offered to study with other student groups. (12)

While efforts might be made to share certain lecture sessions, the most fruitful contact was likely to develop in informal surroundings such as those of refectory and common room. The institutions most able to provide these facilities were those which catered for a variety of disciplines. The solution therefore appeared to lie in the encouragement by the Council of further development of training within educational institutions.

(c) Examinations

It was decided that the arrangements for examination should be devolved to the training institutions. In order to safeguard a national standard for the certificate, each training centre was required to appoint an external examiner from a list prepared by the Council. The explanation given in the first report of the Council indicated that the aim was to provide a more realistic assessment of the student's capacity than might be obtained through hypothetical questions at an oral

examination. The principles were stated as follows:

Features of the new examination will be that questions will be set on subjects, rather than being the general type of questions that have been in use up to date; and, that candidates will produce, as part of their examination, personal case studies which they have prepared over the year; these will be read in advance of the examination and the candidate will discuss them with the external examiner. It is expected that this will give a very much better indication of the candidate's qualities of perception of the factors in family situations with which she has been in contact, her ability to detect trends in a family's development, and her capacity to decide on an appropriate programme of health education for an individual family or the most suitable form of help for a handicapped person or for a specific problem. (13)

(ii) The Fieldwork and Supervision Panel

The nature of the supervision of the students' practical experience was given as one of the priorities to be considered by the new Council. The panel was concerned at the variation of practice throughout the country. The members of the panel therefore had to define what was meant by fieldwork, what proportion of the course should be devoted to this part of training and how the Council could ensure that the criteria it might establish would be accepted by the local health authorities. The various interpretations of practical work which existed in the previous system of training are considered in Chapter 3. The panel recommended that fieldwork instructors should be specially selected to work with students in their practical placement. After giving extensive consideration to the nature of fieldwork experience, the panel came to the conclusion that a satisfactory level of experience for the health visitor students could only be attained if a certain number of practising health visitors were specially selected for its teaching. This nucleus of specially designated health visitors found in those areas providing practical experience for training centres, would be known as

fieldwork instructors. (14)

The proportion of time to be given to fieldwork as distinct from classroom work related to the nature and content of the latter and the establishment of acceptable criteria for practice was part of the whole system of approval of courses which the Council had to design. The two panels having completed preliminary and extensive meetings separately, joined for the last stages to put forward a complete design for training.

The complete design for training

The new form of training was approved by the Council in 1964, published in May of that year and courses based upon it came into operation in 1965. For the first intake the courses could be completed in nine months but all subsequent courses had to extend to a calendar year. (15) In the first Report of the Council 1962-64 the rationale for the new syllabus and plan for fieldwork was set out as:

It is based on the view that the health visitor's task has two main aspects: first the assessment of the health potential of the individual and family group, and provision of appropriate health education and, secondly, the health needs of the handicapped of all age groups, the implication of their care on the family and their continued maintenance and support in the community. The syllabus therefore is designed:

- (a) to sharpen the student's capacity to perceive early deviations from the normal;
- (b) to give her knowledge of various statutory and voluntary agencies which may assist in any particular situation;
- (c) to provide practice in the working out of a programme of help for the individual where this is required;
- (d) to prepare her to select the method of health education likely to be the most successful in any particular instance.

The Council is required to make rules by which approval would be given to courses. The rules which are to be approved by the Health Ministers:

May specify subjects to be comprised in the courses to be approved and shall specify the conditions for admission to the courses and for the award by the Council of certificates of their successful completion.

Two new features of the rules compared with those in force previously were the requirement that candidates should be on the general register of nurses and that they should be in possession of an educational qualification. Where a candidate had not had the opportunity to acquire an appropriate certificate, the organisers of the training school were required to set an educational test of their own devising and approved by the Council.

The implications of the requirement that future candidates should be registered general nurses was not immediately apparent. At the time it appeared simply as a rationalisation of the existing situation described in Chapters 3 and 4 but in Chapters 7 and 8 the effect of the rule on the relationship of health visiting to nursing especially in the light of reorganisation in the National Health Service is explored.

The rules were approved in 1965 and with the guide to the rules issued by the Council appear at Appendix B. A small number of training schools were invited to provide specimen curricula based on the new system and the rules and finally all training centres were invited to submit schemes for approval of courses beginning in 1965.

## (2) Recruitment of students

An improvement in the numbers of students entering training was one of the priority tasks awaiting the Council in 1962. Figures abstracted from official statistics used by the Jameson Committee showed that in the five year period between 1949 and 1954 the number of whole-time equivalent staff rose from 3,745 to 3,885 of general duty health visitors in England and Wales while the number employed by means of a

dispensation, that is without certificate, fell from 1,350 to 815. In Scotland the system of dispensation did not operate at that time and the number of whole-time health visitors rose from 768 to 883 in the same period. (16) The Committee recommended that the work force should be about 11,500 for the whole of Great Britain, basing that figure upon a projected number of visits required. (17) Following this, a target figure in the report for an annual student intake would have been 1,100 to allow for replacement of existing health visitors as these retired, the replacement of "acting" health visitors and for expansion of the service. (18) In 1962 the Ten Year Plan for Local Health Authorities "The Development of Community Care" (19) gave figures of staff which the local health authorities considered as required in 1962 - 5,270, by 1967 - 6,698, and by 1972 - 7,607. It should be noted that these figures referred to England and Wales only and these figures were not the result of any centrally directed plan, they represented the position in individual authorities. The only general figure suggested by the government department was that of .17 health visitors to 1,000 of the population which represented a departure from the dependence upon infant births as a measure of caseloads for health visitors. The discrepancy between the two sets of figures emphasises the problem which the Council faced on arriving at a target figure for the number of training places which should be provided.

The Standing Conference of Health Visitor Training Centres, an independent association composed of delegates from all existing training centres, maintained a record of the number of students entering training each year. The number had not increased in the six

years since 1956 when the Jameson Committee reported an intake of 623. (20) There was therefore urgent need to examine the situation and a small panel of Council members was set up.

In view of the new requirement that all candidates should be registered nurses, care was taken to ensure that the one member of Council nominated by the General Nursing Council should be one of the members of the panel. This panel was reconstituted in 1965 as the Recruitment Committee, one of the standing committees of the Council, the others being an Education Committee and a Finance Committee joint with the Council for Training in Social Work.

There appeared to be three areas which should be examined by the panel:

- (a) the establishment of a central source of information
- (b) standardisation of financial support for intending students
- (c) the relationship between general nurse and health visitor recruitment.

(a) Central source of information

The Jameson Committee suggested that:

More effective and better co-ordinated advertising and publicity directed to the trained nurses generally is clearly needed ... this might be backed by a central advisory centre able to deal with queries and refer inquirers to the most suitable training centre or employer. (21)

That Committee also placed some reliance on an increase in courses which combined nurse and health visitor training in an integrated programme. The development of such courses is discussed further in Chapter 2. The immediate task was to establish a central source of information giving details of training centres and an indication of career prospects. For this the advice of the Ministry of Health was

sought and as a result contact was made with an advertising agency specialising in recruitment techniques. Leaflets were produced and were in considerable demand by local authorities. Staff at headquarters answered personal enquiries concerning financial support, contracts of service and forms of work. (22) Advertisements that this service was available were inserted in the nursing journals. Means of ensuring that information should reach the young student completing general training as well as the qualified nurses had to be explored. Such efforts included participation in the recruitment campaigns for general nursing and the use of stands in large exhibitions such as that organised at that time by one of the nursing journals, The Nursing Mirror.

(b) Standardisation of financial support for intending students

In addition to these general moves there were certain aspects of student support which merited further examination. One such was the nature of the finance for which students might apply. There were three principal sources of help:

- (i) sponsorship
- (ii) education awards
- (iii) competitive scholarships.

(i) The most common form was that of "sponsorship". By this the employing authority would enter into a contract with the intending student that, in return for support during training, she would return to work in that authority on completion for periods which varied from 6 months to three years. The contract did not guarantee the student eventual employment in every case. The relationship between the system and the staffing position which existed in 1962 is explored more

fully in Chapter 3. One of the problems as seen by the Council was the lack of standardisation in conditions in which financial support might be provided. In addition to the diversity of actual grants, additional sums might be given by some, but not all authorities, for books, extra travel and uniform. An approach was made to the Local Authority Associations in England and Wales and in Scotland to seek some agreement on standardisation but there was no simple solution and discussions continued in the later life of the Council.

(ii) Education Awards. A few local authorities were willing to make education awards. Such awards had an advantage in that the student was not restricted to any particular area on completing training. The amount was smaller than that which might be obtained through entering a scheme of sponsorship and this fact, along with the sporadic availability of grants, made this form of support during training less attractive to the majority of students.

(iii) A small number of competitive scholarships were awarded each year. These were available for a range of post-registration courses for nurses and some health visitor students obtained these awards.

(c) The relationship between general nurse and health visitor recruitment

Health visitor recruitment could be seen as part of a general campaign of nurse recruitment. A major problem, however, was that there was no central policy of recruitment to the service as a whole. In the view of the Council the needs of post-registration services such as those in the community should be borne in mind when attracting potential recruits to a career in nursing and targets fixed accordingly. Some of the problems encountered by the Council in its early years are described

by Wilkie (1979). A paper summarising the Council's view on the need for career guidance to the student nurse in training was presented to the National Nursing and Midwifery Recruitment Committee (23) but a unified approach to the problem had to await the reorganisation of the service though some moves were made by a circular issued to health authorities in 1972 in England (13/72). (24)

In general there was little direction given to authorities on staffing standards. Griffith writing in "Central Departments and Local Authorities." (1966) refers generally to the relationship between central department and local authority in relation to the Department of Health. Commenting upon the initiative taken by the Department which resulted in the Ten Year Plan already referred to, he suggested this was a first step in the creation of minimum standards of staffing in the Health and Welfare Services but went on to comment:

The Department seems reluctant to insist. The Department prefer, for a variety of different reasons, to stop short at advice and exhortation ... This philosophy ... is, in its simplest form, that the Department ought not to seek to direct local health and welfare authorities but should, as we have said, advise and exhort. (25)

The Council therefore had to rely on the same methods, that is advice and exhortation, to influence recruitment and in addition to the dissemination of information referred to above, the professional staff visited local health authorities to discuss the relationship between their staffing needs and training facilities in the locality.

The Council considered other sources of recruits to training. Two possible approaches were the encouragement of more courses in which nursing and health visitor training are integrated in one training programme and the provision of training for men.

The Jameson Committee were optimistic that securing courses which would attract the school leaver would do much to remedy the low recruitment to the profession. The Council's attitude towards the courses of which there were five in existence in England in 1962, was one of caution; no systematic evaluation had been carried out of such schemes. It is noticeable that the majority did not give preparation for health visiting as the primary aim of the course. Although O'Connell (1978) states the first objective in the course arranged by Southampton University and St Thomas Hospital as:

To provide a unified course of nursing and community health for girls initially aiming to be health visitors. (26)

Brockington (1964) on the other hand, reporting upon the Manchester University scheme, gives the aim of that course as:

The providing of a basis for clinical practice and administration in any nursing situation in hospital or community. (27)

The number of places in each course was small due to problems associated with appropriate practical experience and although it could be expected that courses offering a more broadly based curriculum than that provided in general nurse training would be attractive to a proportion of sixth form school leavers, they could not in 1962 be considered to make a significant impact on the problem of recruitment.

(3) Establishment of communications with related organisations

The organisations concerned may be grouped under five headings:

- (a) the other statutory qualifying associations in nursing and midwifery
- (b) the Council for Training in Social Work
- (c) professional associations in Nursing and Health Visiting

- (d) Government Departments
  - (e) the Royal Society of Health and the Royal Scottish Sanitary Association.
- (a) Other statutory qualifying associations in nursing and midwifery

The Council was one of a number of organisations established by statute to regulate and certify forms of nurse and midwifery training. In 1962 these were the General Nursing Councils for England and Wales and for Scotland, the Central Midwives Boards for England and Wales and for Scotland, and the Joint Nurses and Midwives Council for Northern Ireland. As the Council's rules required the health visitor student to be a nurse on the general part of the State Register and to be a midwife or to have had specified obstetric experience, some form of communication had to be established by the Council as a newcomer to the group of organisations. Provision existed in the Act by which the General Nursing Councils should be consulted on the appointment of two of the Council's members. (28) There was no reciprocal arrangement by which the Council would be consulted on appointing a member to the General Nursing Councils until 1969. Informal discussion took place between the officers of the organisations and on occasion meetings with members were convened to discuss specific topics. However, in that period of the Council's life there was little development of any more systematic consultation. This fact was noted by the Committee on Nursing and was one of the factors in their recommendation that there should be one central qualifying body for the United Kingdom. (29)

- (b) The Council for Training in Social Work

The other training body with which the Council had obvious relationships since it had been constituted by the same Act was the

Council for Training in Social Work. Wilkie (1979) describes some of the practical problems encountered in the setting up of a completely new organisation. In the early months of 1963 the only staff in the two Councils consisted of two Chief Professional Advisers supported temporarily by officers of the Ministry of Health and accommodated in that establishment. This resulted in a close, informal relationship which generated some understanding of the goals and aspirations of each other. However, as the tasks facing each Chief Professional Adviser became more obvious and while the supporting professional staff remained small there was little opportunity for the development of joint staff activity at more than a friendly and superficial level. (30) Pressure for a clearer definition of the function of the health visitor led to the formation of a Joint Advisory Committee composed of some members of each Council which produced a report in 1966. (31) The recommendations are given in this chapter since the work was largely carried out in the period 1962-65.

The recommendations were:

- (a) The Councils should plan, at least for some time to come, on there being two separate workers, the health visitor and the social worker in the health and welfare services, but that a degree of overlap would be welcomed
- (b) The central function of these two workers should be ... the health visitor is a nurse and not a social worker though her service contains an element of social work; the social worker though not a nurse is involved in her work in the problems of personal health
- (c) The Councils should keep closely in mind development in the relationships in general practice and
- (d) The Councils should examine further the question of common ground for training.

The final recommendation was not pursued. Joint activity of Council members was therefore limited to service on a joint finance committee which dealt with the compilation of a budget, matters of staff establishment and administration. Although there was no further progress in joint activities, the early discussions of the committee were of particular importance to the Council in that they were the precursors of discussions in the Council which led eventually to the Council's statements on the function of the health visitor. An elaboration of the significance of the relationship between the two Councils and consideration of the factors which might be thought to have encouraged or inhibited development is included in Chapter 8.

(c) Professional associations in nursing and health visiting

The Health Visitor and Social Work (Training) Act 1962 requires the Health Ministers to appoint eight members "after consultation with associations appearing ... to represent health visitors". (32) The significance of the constitution of qualifying associations in general is considered more fully in Chapter 5. In this chapter in which the activities of the early years are described, a recommendation of the Jameson Committee in which an advisory body is suggested is relevant.

There are, however, a great many persons and organisations that will have a deep interest in the efficiency of the service and therefore of training ... it will be necessary for the central bodies to consult fairly widely beyond the field of representation. (33)

Consultation implies an understanding of the issues about advice may be sought. If then the associations consulted by the Health Ministers were on the one hand to give informed advice on the suitable nominees for membership of the Council and on the other to advise the Council on the implications for the professions of new policies on

training, there must be some form of communication. In the first three years communication was largely of an informal nature, the more structured arrangements were introduced later and are described in the following chapter.

An important body to be included in the consultative process was the Standing Conference of Health Visitor Training Centres. The contribution of this organisation to the development of health visitor training before 1962 and in particular to the eventual establishment of the Council is developed in Chapter 3. Wilkie (1979) describes the contribution of the Conference as a pressure group before 1962. (34) Following the establishment of the Council its position and objectives were less clear. The Conference was a voluntary organisation composed of representatives from all the training schools. It began in that form in 1945 with the remit:

- (i) to appoint eight representatives of training centres to the Health Visitor Examination Committee of the Royal Society of Health
- (ii) to consider questions related to recruitment and selection of candidates for training
- (iii) to consider from time to time, questions relating to the training of health visitors (other than matters dealt with by the Health Visitors Examination with the agreement of the appointed members of Standing Conference on that committee) and to make recommendations to the Ministers on any such matters on which he may seek their advice or on which they wish to offer representations.

Two aspects of communication could be identified in relation to the Standing Conference. First it could be assumed it would be consulted on membership of the Council:

Members ... shall be appointed after consultation with such universities and other bodies concerned with the training of health visitors as the Health Minister and the Minister of Education think fit. (35)

Secondly, some of the functions of the Conference would no longer be required, for example the appointment of representatives to the examination committee of the Royal Society of Health. Finally, with the responsibility for training vested in the Council under the Act, it could be questioned whether the views of the Conference should be presented to the Minister or to the Council. An exploratory meeting was held in 1964, but the development of a working relationship was not established quickly. (36) Before 1962 the Royal Society of Health and the Royal Scottish Sanitary Association had operated largely as examining bodies only and had no professional staff concerned with visits to training schools. Wilkie (1979) points out:

Although professional organisations may campaign for some regulation of standards, many of their members may fear the introduction of 'inspection'. (37)

Inspection may be thought to imply criticism and interference. The title of professional staff of the Council was that of 'adviser' but it can be assumed that in some training schools the term was interpreted as 'inspector'. A satisfactory structure for consultation was not achieved in the first three years of the Council's life.

(d) Government Departments

The departments involved with the Council were the Ministry of Health (later Department of Health and Social Security), the Scottish Home and Health Department, the Ministry of Education (later the Department of Education and Science), the Scottish Education Department and the Ministry of Health and Local Government of Northern Ireland. Each department sent officers as assessors to the meetings of the Council. These representatives did not have voting rights, they were not named as Council members, nor did they attend any of the panels,

working groups or committees, but although they were not voting members, the assessors could influence the work of the Council in an indirect way. The Act required the Council to gain the approval of the Health Ministers to its training rules, to its staff establishment and salary structure, and to the subsistence and travelling expenses to be paid to members attending meetings. The Council was also required to submit a budget of proposed expenditure each financial year for the approval of the Health Ministers. Such approval would be affected by the advice given to the Minister by his officers as well as upon the case submitted by the Council. The significance of the method of finance for statutory bodies such as the Council is explored in Chapter 5 where the different systems operating in the statutory bodies in nursing can offer some comparison related to their powers and policies. In the following chapter the significance of the financial control becomes clearer as it affected policies the Council might wish to implement.

In the life of the first Council there was a close, informal contact between the Chief Professional Adviser and the appropriate government staff in the nursing divisions while the Joint Secretary established his own contacts with administrative colleagues in the same departments. Later, the nature of the contact between professional staff of the Council and their professional colleagues in the Government Departments was affected by changes in these departments over the years of this study, culminating in the revised deployment of staff in the central government department prior to the reorganisation of the NHS. The implications of these changes are discussed again in Chapter 8 with particular reference to the future of the Council. The size of the staff with which the professional advisers of the Council

had to make contact in Scotland, Wales and Northern Ireland in the early years had implications for speed and efficiency of communication. Each country had, in 1962, and for some years later, only one nursing officer concerned with the nursing services in the community. The number of innovations described by Wilkie (1979) which were effected in Scotland is one illustration of such possible effects on closer contact. (38) Just as the interest and support of the professional associations was necessary to the growth of the Council, so was that of the government departments.

(e) The Royal Society of Health and the Royal Scottish Sanitary Association

The Jameson Committee saw no reason why the two bodies should not continue as the responsible examination bodies with some modification and under the Act it would have been possible for the Council to have used the examination facilities of the two organisations. The opportunity, however, provided by the establishment of a new body to create a new approach to the education of the health visitor, standardising training in the constituent countries of the United Kingdom was stimulating. The interest generated by this new power along with the contribution of a varied membership did not encourage the Council to consider further developments with the two existing bodies. Accordingly meetings were held with the two organisations and agreement was reached on a method whereby examinations (RSH and RSSA) continued on the existing system for the years 1964, and 1965. The Council therefore gave "blanket" approval to all existing training schemes. (39) This period gave time in which training schools could submit schemes for approval based on the new syllabus and professional staff of the Council could visit to discuss plans for practical experience and subsequent

examination.

The first three years of the Council generated much activity and a number of major changes in training were effected. These changes and their accompanying developments may be summarised as:

- Relating to training
- a new syllabus of training
  - the devolution of the examination to the training centres
  - pre-entry requirements for candidates, general state registration and educational certificates
  - extension of the course to a calendar year
  - introduction of fieldwork teachers and courses for their preparation
  - recommended ratios of tutors to students
  - evidence required of "opportunity offered to work with other students"
- Related to recruitment
- establishment of a central information service
  - design of appropriate leaflets
  - participation in general nurse recruitment exhibitions
- Related to establishment of communications with related organisations -
- informal contacts with statutory bodies, professional associations and government departments.

A regular structure within which the business of the Council could be carried out was established. Three standing committees were set up.

- An Education Committee to
- (a) review courses and recommend approval
  - (b) consider modifications and changes in training and examination in the light of experience of the new system
- A Recruitment Committee to
- (a) examine methods of attracting suitable candidates to training
  - (b) discuss appropriate financial support for students and its standardisation.

A Joint Finance Committee with members from both the Council and the Council for Training in Social Work to recommend staff establishment, appropriate salary scales and the administrative resources necessary for the conduct of the affairs of both Councils.

Two advisory committees were established to make recommendations specifically related to Scotland and Northern Ireland by the Secretary of State for Scotland and the Minister of Health and Local Government for Northern Ireland.

An account of the way in which the above activities developed in the succeeding years of the Council is given in the following chapter.

Together, the first two chapters provide the background against which the four propositions upon which this study is based are considered.

- (a) that a newly established qualifying association will be influenced by the history of the qualification concerned and the previous regulations
- (b) that a body with the specific remit of "training" and/or "education" will be influenced by the general educational climate of the period under study
- (c) that the policy of a qualifying association is influenced by the climate of opinion in the professional associations of the representative of the workers to whom the qualification is awarded
- (d) that the progress, development and authority of a qualifying association established by statute will be promoted or inhibited as much by the employment available to employees on completion of training as by the actual powers of the Act.

CHAPTER 2

Progress of the Council 1965-1974 : selection  
of priorities in the changing context  
of the health and social services

The second triennium of the Council began in October 1965.

There was some change in membership but a proportion of the original members were reappointed so some degree of continuity was assured.

The activities in the nine years described in this chapter represent the consolidation of the policies established in the first three years, as well as expansion into some new areas. In general the activities may be considered in five main groups. Those associated with:

- (a) the consolidation of policy related to training, the approval of courses and the form of the examination
- (b) the recruitment of students
- (c) a clearer definition of the function of the health visitor and therefore of the objectives of training
- (d) an expansion into activities which lay within the permissive as distinct from the mandatory responsibilities of the Council
- (e) a consideration of the future of the Council itself.

Consolidation of policy related to training

The Council laid down certain rules and guidelines for training as described in Chapter 1 but the required standards could not be achieved quickly. Wilkie (1979) writing of the early years of the Council refers to the gradual move towards the incorporation of health visitor training within the mainstream of higher and further education:

The Council saw obvious problems in laying down a formal policy in relation to training. It would have been possible, theoretically at least, to have declared a moratorium on any change for a period of some years while an ideal system was designed ... The Council decided, however, not to delay for a number of reasons. It accepted with great seriousness its responsibility for

maintaining a constant flow of effectively trained health visitors into the service. There were advantages in allowing for modification in the light of experience and dangers in creating an inflexible pattern incapable of adaptation and advance. (1)

To achieve the standards of the new training, action was required in five ways:

- (i) educational institutions capable of supplying the necessary features of a health visitor course had to be found both for existing courses and for any new developments
- (ii) sufficient tutorial staff to meet the Council's required ratio
- (iii) fieldwork instructor staff to meet the Council's new requirements
- (iv) a method by which the Council's approval of courses could be carried out had to be designed
- (v) a method of contact between the Council, the training colleges, the local Health Authorities and the professional organisations had to be organised.

(i) Educational institutions

During the period under study there was considerable change and development in the field of education - features discussed more fully in Chapter 6 where their significance for the nature of the Council's training policy is explored. A number of colleges, anxious to diversify the courses they could offer were interested in providing health visitor training; it was necessary to ensure as far as possible that the college was likely to develop the resources required for the training. The Ministry of Education in England and later the Scottish Education Department sent assessors to the Council meetings and the staff were able to obtain guidance from these departments.

Health visitor training had grown on different lines in England and Wales, Scotland and Northern Ireland, although there was considerable

similarity in the work of the health visitor. As a body charged with responsibility for training throughout the United Kingdom, the application of the training policy to the needs in each constituent country required careful planning. The Council had the benefit of advice from two committees set up under the Health Visiting and Social Work (Training) Act (1962) (2) and the siting of courses in Scotland and Northern Ireland was discussed in these committees before proposals were put to the Education Committee of the Council.

In Scotland when the Council was established, there were three training centres in Aberdeen, Edinburgh and Glasgow, all under the direction of the local health authorities, all operating in health department accommodation and not in contact with any other student group. In Northern Ireland the one centre was organised by the Royal College of Nursing (Northern Ireland Committee) and was held in the premises of that body where a small number of other courses related to nursing were also provided. Only one training centre, Aberdeen, was able to meet the staff ratio set out by the Council. The move into the educational setting was slow, due in part to a natural reluctance on the part of the organisers to detach the centres from their long association with the maternity and child welfare departments of the cities concerned. There was also the need to await the development of suitable venues. In general it was thought that the most appropriate college would be a central institution, that is financed directly by the Scottish Education Department but colleges ready to absorb the health visitor courses were not available in every city. Gradually, however, the three courses were established in Aberdeen at Robert Gordon's College, Aberdeen, in Edinburgh at Queen Margaret College and in Glasgow at the College of Technology, all of which catered for a wide range of students

and courses.

(ii) Sufficient tutorial staff to meet the Council's required ratio

Few colleges or centres had the required number of tutorial staff at the beginning of the period under discussion. The situation was particularly acute in Scotland, exacerbated by two factors. First, as the centres remained within the health authorities longer in general than in England, the salary scales applied to the tutors were those laid down by the Whitley Council for local health authority staff. These compared unfavourably at that time with those operating in the education field in England - that is the Burnham Scale. (3) There was little incentive therefore for staff to move from the South to take posts vacant in Scotland. The second factor was the lack of any tutor training course other than London. Not only was there a shortage of tutors for the existing courses, but it was difficult to establish further training centres for which there was an urgent need. The Jameson Report referred to the relative imbalance in Scotland in staffing among the local authorities and in particular to the number of "acting", that is uncertificated, health visitors working in the country areas. In 1953 there were 330 qualified as against 559 unqualified staff in these areas. In the cities and large burghs the figures were 521 and 101 respectively. (4) Other training centres therefore had to be created and this was hampered by the position relating to tutors.

The problem created by the shortage of training courses for tutors and fieldwork teacher courses was increased by the lack of financial support during the training period. The desirability of providing both the Council and the Council for Training in Social Work with finance for training to be disbursed by these bodies was raised unsuccessfully before the Health Visiting and Social Work (Training) Act 1962 was passed. (5)

It was anticipated that the costs would be met by the local authorities responsible for the services. For health visitors there was provision for training and the spreading of costs over all local health authorities by the Pooling system. (6) This system, however, limited resources to health visitors employed in areas where an interest in health visitor courses already existed and authorities were anxious to supplement their own staff. The impact of this lack of centrally administered training awards was recognised by the first members of the Council. The chairman wrote on their behalf to the Government Departments, outlining the position and suggesting the provision of 10 grants to be awarded annually for a period of three years. This was not to establish a permanent scheme but was intended to give the necessary support to the new training in its early stages. (7)

The response from the government departments was another circular designed to encourage the local health authorities to use the pooling system for sponsoring candidates for both tutor and fieldwork teacher courses. (8) The exhortation had little effect, the system of sponsorship was linked to the pattern of local authorities requiring candidates to return to work for the authority after completing training. In the case of the health visitor tutor this was not always possible. Increasingly as the courses moved into colleges, the tutors became employees of the education instead of the health department. Although both departments were part of one county or municipal authority, training a tutor would be a charge on the health department's budget. That department would not reap the benefit of the training except indirectly by a possible increase of student health visitors for the staff. In addition, the sponsored tutor candidate remained on the establishment of the health department during training and the vacancy

caused by her absence could not be filled until the course was completed and the candidate had officially left the staff of the health department. This would be a period of not less than one academic year.

Concern at the apparent failure of the circular to increase the number of tutor students led to a meeting between officers of the Council and officials of the Ministry of Health. (9) The possibility of central funds was raised again and the poor response to the circular was quoted. The representatives of the Government Department pointed out that a moratorium on all staff increases had been adopted one month after the publication of the circular and stated that the schedule to the Local Government Act which dealt with pooling was under review and some clarification could be expected. A further circular giving rather fuller details of the scope of the system was published in 1968. (10) Although the circulars made little impact on the number of tutor candidates they were of assistance to the professional staff of the Council in discussions with officers of health authorities on training.

Before the establishment of the Council, the Royal College of Nursing had organised the only course specifically designed for health visitor tutors at its headquarters in London. The place of a professional organisation as a training and qualifying association is pertinent to this study and is discussed more fully in Chapter 5. Since 1948 when the first College course was held a number of candidates had obtained the certificate of the College and some new health visitor training centres had opened by local health authorities. The Royal College of Nursing therefore decided to establish a roll of holders of the certificate as well as others deemed to have appropriate

qualifications for the training of health visitors. In 1967 following discussions between the Council and the Royal College of Nursing, the roll became the responsibility of the Council, thus providing it with more accurate information on the numbers of tutors available to fill posts created by the opening of more training centres. (11) Not all those whose names appeared on the roll, however, were free to take up posts and others were approaching retirement. There was need therefore to expand the numbers of tutor students.

The problem of the numbers of tutors in training was not solely one of finance. Three other aspects of the tutor training required consideration. These were:

- (a) the siting of training courses
- (b) the administrative structure of the course
- (c) the certificate obtained on completing the course.

(a) The siting of training courses. The fact that there was only one course and that based in London in co-operation with the City of Birmingham Health Department limited potential recruits to those either able to leave home for an academic year or resident within travelling distance of the centre

(b) The administrative structure of the course. The course at the Royal College of Nursing had been established at a time when most health visitor training had been carried out by health authorities. Tutors, moving as a result of the Council's training policy from health to education departments found they had to adjust to different administrative patterns and resources and to co-operate with colleagues from a variety of disciplines.

(c) The certificate obtained on completing the course. There could be value in a teaching certificate more generally recognised, for example, one which was commonly held by other teachers in the further education field.

Four teacher training colleges in England organised courses specifically for teachers in further education, Bolton, Wolverhampton, Huddersfield and Garnett College, London. The General Nursing Council for England and Wales had already negotiated a course for sister tutors in the Bolton College and this seemed to be an appropriate site for a second health visitor tutor course. Candidates prepared for a teaching certificate which was acceptable for inclusion in the roll of sister tutors and in the case of the health visitors for inclusion in the Council's roll. The Bolton course had a number of advantages; geographically it provided for the north of England, it prepared for a qualification recognised in the further education field and as the students were student teachers they were eligible for teacher training grants. Although these grants were small in comparison to those available through sponsorship by an employing authority, and consequently the year's study involved considerable financial outlay, a number of candidates elected to enrol in the course.

(iii) Fieldwork instructor staff to meet the Council's new requirements

As in the case of tutors, the Council had no financial resources with which to provide courses for fieldwork instructors or for the expenses of the trainees. Wilkie (1979) describes the use made by the Council of the established system of short refresher courses for health visitors. A number of two week courses were offered; in the first instance organised by the staff of the Council but later by tutors in the training schools. By 1970 the courses had been extended to 30 days, the system

of acceptance of courses by the Council had been established and all fieldwork instructors (now called teachers) had to possess a letter of recognition issued by the Council. (12)

Consolidation of the Council's training policy required that the fieldwork teacher be recognised in her special role within the staff of a health authority. In practical terms this might be expected to carry some recompense for the additional duties, probably in the form of a tangible financial reward. Achieving this position posed a question of the degree of involvement proper to a statutory training body with no remit for the negotiation of salaries and conditions of service. The ambiguity created by this situation is examined further in Chapters 5 and 7.

The views of the Royal College of Nursing, the Health Visitors Association and the Scottish Association were obtained in one of the early consultative committees established by the Council. The problem was one of the narrow salary differential between the existing grades on the salary scales into which any new grade could be inserted. Eventually it was decided to recommend that a responsibility allowance should be paid to the fieldwork teachers and the Education Committee recommended that there should be a temporary appointment, at first lasting for a period of three years. (13) Although this arrangement did not completely accord with the Council's objectives that the fieldwork teacher should be in post over a sufficiently long period to allow the development of her teaching skills, it represented a compromise which allowed progress to be made.

The position of the fieldwork teacher relative to the first supervisory grade in the local health authority health visiting staff, that of the group adviser, continued to be uncertain. The group adviser

had an agreed grade in the salary scale. In 1970 an allowance was agreed for the fieldwork teacher to be paid while she was concerned in training. Unfortunately, following a revision and streamlining of the numerous grades in the profession carried out by a specially appointed committee under the chairmanship of Lord Halsbury, additional allowances were removed. (14)

(iv) A method by which the Council's approval of courses could be carried out

The new pattern of training for health visitors was launched during the life of the first Council but the implementation of both syllabus and examination was developed after 1965. The establishment of a regular pattern for the approval of courses and the production of guidelines for colleges and examiners was a major part of the work of the Education Committee of the Council. As the members and staff of the Council learned to work together and expand their knowledge of appraisal methods, the pattern of approval was gradually clarified. Wilkie (1979) describes the early moves towards the establishment of a pattern. (15) The main stages remained essentially the same:

1. A college wishing to submit a course for approval notified its intention to the Council
2. A member of the professional staff visited to discuss, plan and advise on the Council's requirements
3. A plan of the curriculum, giving the numbers of lectures, personnel involved, plan of fieldwork, and names of participating local health authorities, proposed examination pattern and a general picture of the college and its activities was provided by the college organisers
4. The education committee considered the plan along with a confidential report on the course prospects by the professional adviser. This report included any comments on consultations with the Inspectorate of the Department of Education and Science as to the choice of college in relation to plans for educational developments in the region

5. A recommendation was made by the committee to the Council on whether or not approval should be granted
6. Approval was granted for two intakes of students in the first instance in order to allow for modification and improvements in the light of experience
7. A second submission was made with any alterations found to be desirable and if successful approval would be recommended for a period of five years
8. Applications were then made for reapproval at five year intervals.

Apart from the visits by the professional adviser in the planning stages the college had no access to the education committee should it be dissatisfied with the decision of that body; no system of appeal against rulings of the Council had been written into the Act. The absence of an appeal system is one of the differences between the Council and the other statutory bodies in nursing which is considered further in Chapter 5.

(v) A method of contact between the Council, training colleges, local health authorities and the professional organisations

Approvals by statutory bodies have certain problems. First, colleges anxious to mount experimental programmes and willing to take part in the expansion of training facilities might feel inhibited. Secondly, the health visitor course was only one of a number of courses each coming under the supervision of different qualifying associations while the college itself came within the sphere of Her Majesty's Inspectors of the Department of Education and Science. Brosan lists five different authorities from which approval must be obtained for courses in polytechnics and concludes that the differing demands made by these bodies and the qualifying associations prevents any single educational philosophy for the institution as a whole. (16)

In order to provide more opportunity for participation by the college in the decisions, one of the first modifications in the procedure was an

invitation to the course organisers to attend the committee meeting at which submission for a five year period was being considered. Towards the end of the term of office of the fourth Council, a further development was under discussion that of a visit by a small group of Council members and staff to colleges as part of the quinquennial review. This system has been adopted by Councils since the period under review in this study. (17)

Colleges were invited to suggest the names of suitable examiners for inclusion in the list compiled by the Council. These examiners were not, however, eligible to examine for the college putting forward their name. (18) Most of the names were those of examiners who had operated under the old system used by the Royal Society of Health and the Scottish Sanitary Association but there were a number of newcomers especially from non-medical and non-nursing fields. In order to achieve a common approach to the new examination, a pattern of annual conferences was established to which examiners and chairmen of examination boards were invited. (19) At these conferences papers were presented on aspects of assessment and appraisal by members of the panel or by visitors with a special expertise. In addition, a report was prepared by the professional staff in which the examination results and comments by examiners on specific aspects of the previous year's experience were given.

In 1969 the education committee set up a sub-committee to consider the examination system and the syllabus. The sub-committee considered that the concept of a devolved examination had been justified but that the degree of latitude allowed to the training schools in the design of examinations had led to considerable variation in interpretation and, accordingly, more precise guidelines were issued. (20) Some research seemed advisable on a more objective assessment of the system and the

views of the sub-committee were passed to the Council's research committee for consideration.

#### Recruitment of Students

Improvement of student numbers was one of the first tasks facing the new Council in 1962 (see Chapter 1). The later Councils carried on this work. Activities in this area had six aspects:

- (a) Target figures for entrants to training were set for each year. These were related to national estimates of staff in England and Wales in the Development of Community Care. Later the circular on Norms of Good Practice suggested a ratio of one health visitor for a population of 3000/4000. (13/72) Appendix C shows the projected figures of entrants required and the targets reached up to 1974
- (b) Index cards were completed in the training schools and returned to the Council for all students each year. These gave age, marital status, educational background and previous professional training. Analysis of these data was used to identify areas to be emphasised in the publicity material produced each year. Appendix D shows the change in marital status and age of students between 1968 and 1975. This trend was reflected in the subject of a second film produced by the Council "Living and Learning" as well as explanatory leaflets designed annually
- (c) The geographical spread of training schools was taken into consideration. Where there appeared to be a lack of facilities, new institutions were approached and special arrangements for older candidates with domestic commitments were explored
- (d) The possible value of a central clearing house for applications was examined in 1968 to determine if there was a substantial number of candidates unable to train because the school of their first choice had no vacancies. (21) The results did not justify the expense of establishing such a system. The Council, however, offered a service each year from May to October by which colleges notified the Council of any unfilled vacancies each month so that candidates unsuccessful in their first application might find from the Council's headquarters where there were still vacancies
- (e) One member of the professional staff was given the responsibility for the oversight of the recruitment programme. She was concerned with the work of the design consultants on suitable leaflets, posters, advertisements, exhibitions and on the making of the two films.

A series of meetings was convened in those areas of the country in which recruitment was poor. Chairmen of Health Committees, Medical Officers of Health and senior nursing personnel met representatives of the Council and staff along with tutors from the adjacent colleges to consider the new training proposals as relevant to the local situation. (22)

The meetings described above were designed to identify problems in individual authorities. Reference is made in the preceding chapter to the variation in both financial support which a student might obtain from an individual local health authority and also in the time she would be required to contract to remain in the area of that authority after training. In the view of the Council such a commitment to a particular area deterred potential recruits. Health visitor candidates would already have completed four years training necessary for nurse training along with the obstetric component required for health visiting training. It was the Council's view that recruits might be more willing to contract to work within the NHS without restriction to a particular area.

Discussions were begun with the Local Authorities Association in 1965. The Council's opinion that the commitment should be to work in the NHS in general rather than in one area was not generally acceptable. Although one of the bodies in Scotland was prepared to agree, the Association of Municipal Corporations did not. The matter continued to be debated at intervals without success. The County Councils Association writing in 1970 expressed the general view of the employers when they said:

If local authorities in the less 'desirable' areas had no contract, newly trained health visitors would tend to move to the more 'desirable' areas whereas if they are encouraged to stay for a year or so, some will put down roots and stay of their own volition.

Despite the disappointment this opinion gave the Council, it was possible to achieve some standardisation of the expenses paid to candidates. The Local Authorities Association agreed to circulate a letter to its members stating the Council's views but without indicating that the Association was in agreement. (23)

The introduction of an educational requirement for candidates entering training was possibly the cause of an initial drop in the numbers of students but this did not continue; the progress in numbers is shown in Appendix C.

Clearer definition of the function of the health visitor

Wilkie (1979) suggests that the impetus to clarify the function of the health visitor came from the Council's responsibility "to promote the training of health visitors ... by seeking to attract persons to such courses". (24) The significance of this responsibility on the part of the Council, which was peculiar to it, is examined further in Chapters 6 and 7. The other qualifying bodies in nursing did not have this remit.

Exploration of the definition of the health visitor function had been stimulated by the formation of a joint committee with the Social Work Council as described in Chapter 1. Following the report referred to in that chapter, a working group of health visitor members of the Council was set up which published a short report in 1967. The report identified the base upon which the health visitor training was built and the area of work for which the student was prepared. The statement is probably one of the most important put out by the Council and appears in Appendix E. The rules established by the Council ensured for the first time that only registration on the general part of the Register

for Nurses would be acceptable for health visitor students. The statement of function confirmed this, placing health visiting within the nursing profession:

The health visitor is a nurse with post registration **qualification who provides a continuing service to families and individuals in the community.**

Wilkie (1979) suggests that this decision is relevant to the Committee on Nursing's views on the training of the health visitor and may have been more significant than it appeared in 1967. (25)

The leaflet had a wide circulation and continued to be in great demand. By 1974 approximately 3000 copies were still being issued each month, to general enquirers, schools preparing for career meetings, professional groups, overseas visitors, health visitor training colleges, nurse training schools, the technical and professional press, organisers of professional conferences and refresher courses. (26) This activity, concerned with the identification of the function of the worker for whom training was designed provided another contrast with that of the other qualifying associations in nursing, and consequently is developed further in Chapter 5. It formed the basis for other publications such as an expanded form on the function in 1969 (27) and as a background to the Council's evidence to the Committee on Nursing. (28)

This initiative, that is, the expanded form of the statement, was the starting point for a series of study groups organised by the Council for health visitor tutors on the teaching of Section V of the syllabus, namely, the Principles and Practice of Health Visiting. These were formalised in 1975 by a Working Group to examine the Principles and Practice of Health Visiting, as distinct from the teaching only, and after the period under study culminated in a publication "An investigation into the Principles of Health Visiting." (29)

### Expansion into Activities

There were three aspects of the expansion of the Council's activities which lay within the permissive as distinct from the mandatory responsibilities of the Council.

- (i) Some special groups required modified or additional training to meet a particular need such as:
  - (a) the triple duty nurses already in post but without a health visitor's certificate
  - (b) men entering health visiting either for the first time or having followed a course before the regulation defining a health visitor as a "woman" was altered

- (ii) In the Act there is provision for powers which the Council may assume:

If it appears to them that adequate provision is not being made for the further training of the health visitor, shall provide or secure the provision of courses for this purpose. (30)

This section had already been invoked by the Council in the provision of courses for fieldwork teachers (Chapter 1)

- (iii) There is provision in the Act for the Council to engage in research related to health visitor training or to assist in such research. A group was convened to consider priorities in 1964 and a research committee was established whose main work took place within the period covered by this chapter. (31)

- (i) Needs of Special Groups - Triple Duty Nurses

Reference is made to "acting" health visitors in Chapter 1. This group was the subject of some recommendations in the Jameson Report, such as "acting staff should cease to be appointed in future except with a view to early training". (32) There was a particular difficulty in Scotland in that the regulation requiring health visitors to possess a health visitor's certificate was not introduced until 1965. (33) In 1963 out of 940 nurses operating as triple duty nurses, responsible for district nursing, district midwifery and health visiting, two thirds did not have the health visitor certificates. (34) Many of the authorities

employing nurses in this capacity relied on district nurse candidates emerging from the Queen's Institute of District Nurse Training in Scotland for nursing staff ~~vacancies~~ and did not attempt to recruit directly. The need to appoint staff able and willing to undertake the further training for the health visitor certificate could thus be overlooked.

In 1968 the Council with the co-operation of the Scottish Home and Health Department convened a meeting with medical and nursing staff of the areas with particular problems and following the recommendations of a small working group of the Scottish Advisory Committee decided on a course of action to deal with the situation. A threefold strategy was designed:

- (a) The Queen's Institute in Scotland would co-operate in the organisation of short updating courses for older nurses for whom it would be unreasonable to expect that they should undertake further training
- (b) Every effort would be made to ensure that young candidates should understand that they would be expected to take training
- (c) For nurses already in post and willing to take a specially designed course, the Council would waive the requirement that fieldwork could only be carried out in areas employing whole-time health visitors, the course would be arranged in two terms - one in each academic year - and would build upon the daily experience of the student. (35)

A course to cover this last group was established in Dundee but did not have the success expected by the senior medical and nursing staff who had pressed for special facilities. (36) The venture did, however, have a number of results. First the number of candidates coming forward for training increased and the willingness of the Council to consider practical solutions gained goodwill in some setting where there had been apathy and finally it indicated that the Council could not operate in a restricted field as far as the nursing services in the

community were concerned, health visiting and district nursing could not be considered quite separately.

Courses for men in health visiting

Two factors had prevented men from training as health visitors. First was the required midwifery or obstetric training. The Midwives Acts 1951 prevented men from attending women in childbirth unless they were registered medical practitioners or medical students. Secondly, the health visitor was defined as a "woman". (37) Nevertheless a small number of men were employed as "male health visiting officers" mainly in those authorities in which the health and welfare services were administered in one department. Few of the men appear to have been engaged in the complete range of health visiting duties. An article in 1965 described a male health visiting officer as:

Employed as a social worker with a nursing background  
(he) co-operates with health visitors in work of a  
specialised nature. (38)

The first health visitor school to offer training to "male health visiting officers" was Aberdeen in 1961. A small number continued to train at other schools although excluded from the statutory certificate by the definition in the regulation and pressure to regularise the training began early in the life of the Council. The Council did not have the power to grant the certificate to other than statutorily defined health visitors, but made its views known to the Government Departments, concluding that "there is a place for men in a good health visiting service". (39) In the early discussions it was thought that an additional professional certificate should be required of the male student in place of the midwifery or obstetric nurse component required of women. Wilkie (1979) comments on the timing of such a recommendation which may have been premature. It was made at a time when the Council



was a relatively new body and was in the midst of a major reconstruction of training.

With more mature examination of the subject and experience of the new syllabus the real significance of the obstetric or midwifery qualification as a prerequisite to the health visitor course emerged. (40)

The full impact of the new syllabus had yet to be experienced.

(1978)  
O'Connell writing of one particular school comments that the pattern was more radical than many schools had expected. (41)

The reliance of the new health visitors syllabus on this previous training became obvious as the courses moved from the incorporation of the necessary obstetric content in the previous training syllabus to the more broadly based curriculum required by the new syllabus. There was no time in the new timetables for major revision on material which students could be expected to have covered in previous courses.

The pressure to include men in the training plans continued and the topic appeared regularly in the minutes of the Scottish Advisory Committee of the Council; it also was the subject of articles in professional journals and conferences such as that of the Royal Society of Health in 1966 when the health visiting section of the annual congress of the Society was given over to a consideration of the topic. The staff of the Council continued to give thought to some form of special training should the government departments decide to make a change in the regulation. When the change was finally made in 1972 advice had already been sought on possible alternatives and two specially planned courses were made available, one in England and one in Scotland. The courses were intended to ensure that the students had an understanding of:

Prenatal factors affecting the growth and development of the child

The emotional, physical factors affecting the mother, baby and family during pregnancy and childbirth

The processes of normal labour and the puerperium

The special problems of the newborn infant and of the neonatal period.

This initiative may be taken as one of the examples of co-operation and advice between the Council and other statutory bodies, in this case the Central Midwives Boards for England and Wales and of Scotland. By selecting appropriate sections of training and by concentrating upon the family aspects of the childbirth period it was possible to provide a sound basis for the health visitor course.

(ii) The further training of the health visitor

The Council had exercised its powers under the Act in relation to the provision of courses for fieldwork teachers as well as for some short courses in Scotland where there had been relatively little provision for senior nursing personnel in the community services. The Council was interested in the development of courses for senior staff in view of their influence on the quality of supervision during practical work by students as well as the working environment which the newly qualified health visitors should enter after completing training.

Some preliminary discussion took place with interested colleges where there was already provision for management training for a variety of occupations. The powers of the Council were, however, limited to courses for health visitors. In many cases the most senior nursing staff in the community services were responsible for all three of the nursing services that is district nursing, district midwifery and health visiting. In 1966 a committee had reported on the senior staff

in hospital (42) and in 1969 a departmental committee reported on the management structure in the local health authority services. (43) As it was expected, that a common approach to a management structure would be made for staff in both parts of the health service, the Council did not pursue its negotiations. The Council did, however, organise a short course for supervisors of the final period of practical work and this served as a prototype for courses put on by some colleges; three such courses appear in the list of special courses issued by the Council for 1974/75. (44)

An important feature of the further training of the health visitor was the organisation of regular refresher courses. The position which obtained in 1962 is outlined in Chapter 3. In 1969 the Council was asked by the government departments to assume the responsibility for this aspect of further training. Immediate moves to fulfil this responsibility were hampered by the very small professional staff at the Council but some increase was achieved and the Council then convened a meeting with those organisations already providing refresher courses as well as a number of colleges interested in entering this area of work on 14th January 1972.

The activity presented a number of problems:

- (i) a total number of places to be made available each year had to be determined
- (ii) suitable venues had to be identified
- (iii) criteria for the assessment of the courses had to be established.

The numbers involved were considerable and health visitors in Wales and Northern Ireland had also to be catered for. In 1943 in England the Rushcliffe Committee had recommended that all health visitors should be entitled to attend a course of two weeks every five years. (45)

Although not universally applied, a large number of employing authorities had endeavoured to send staff on this basis. The Rushcliffe Committee did not apply to Scotland but a small number of authorities in Scotland had sent staff to such courses as were available. If all employers were to accept the recommendation of the Rushcliffe Committee that health visitors should attend refresher courses at 5 year intervals, the number of places required would be very large.

In 1971 a survey was made of available places and in 1972 a working group produced a planned programme based on agreed criteria which provided for a phased increase in places on the courses. The number of places available was 1230 in 1973 and 1400 in 1974. (46) Two new features were incorporated in the Council's plan for future courses. The first of these related to the provision of courses with a specialist interest as well as those covering the general area of the work of the health visitor. These were incorporated in the general list issued by the Council to all employing authorities. (47) In 1975 three special courses organised in co-operation with tutors in clinical fields were offered. The second feature was an annual study day planned by the Council for course organisers. (48) Appraisal forms had been designed as part of the overall plan and the findings from these were reported each year at the study day. There was, in addition, a session on some aspect of this form of adult education. The first was organised in 1973.

#### Multi-disciplinary courses

The concern of the Council that the environment in which health visitor training and practice should take place would be constructive and supporting extended beyond interest in courses for senior staff only. It

included concern for co-operation with allied professions. The activities of the Joint Advisory Committee which considered the relative functions of health visitor and social worker in the first Council are referred to in Chapter 1. In 1971 the Council joined with the Social Work Council and the Royal College of General Practitioners in initiating multi-disciplinary study groups on a regional basis. (49) In 1972 a pilot five day course was promoted jointly with the National Institute for Social Work Training and the Royal College of General Practitioners. This venture proved successful and appeared to have encouraged greater co-operation in the working situations of the participants. Further tentative plans were begun in which health visitor students and general practitioner trainees might be involved in a mutual learning experience.

(iii) Research

The third feature of the expansion of the Council's activities related to its powers of research. (50) The first Council established a research committee to consider priorities and the means for conducting enquiries. The Council had a professional staff establishment of one chief professional adviser and three professional staff. The pressure to increase the number of trainees (Chapter 1) and the implementation of the new training policy presented this small staff with a volume of work which did not allow for further involvement in research. A two part solution was adopted. For studies requiring an expertise which did not exist among the professional staff, along with financial needs which could not be accommodated within the annual budget, the interest of research foundations was sought.

From a long list of possible topics, two projects were identified which seemed to the Council to be germane to health visitor training:

(a) An enquiry should be mounted upon the range and variety of the work of health visitors in the United Kingdom. A report had been completed by the Nuffield Foundation in 1950 in England but was not published and the data collected on behalf of the Jameson Committee had been obtained prior to 1956. The interest of a University department was obtained and a proposal was submitted to the government for support. This was not forthcoming and personal communication with officers of the Department was not encouraging. Through the good offices of a member of Council it was possible to interest the Intelligence and Research Unit of the Greater London Authority in carrying out a study of the work of health visitors in the area of that authority. (51) Although London could not be considered representative of the country as a whole, it was thought that there was sufficient variety among the inner, middle and outer boroughs to indicate the different forms of work required and to stimulate similar studies throughout the country.

(b) The second important area for investigation was that of the health visitor in general medical practice. The association of the health visitor with the family doctor had begun in Oxford in 1956. (52) Abel reported in 1969 that 70% of health visitors were "attached". (53) The interpretation of "attached" was not clear but the term was coming into general use. Reedy comments that in 1964/65 it appeared in five of the leading medical and nursing journals. (54) It could be assumed therefore that the practice of associating staff with general medical practice would increase. Such a development would make demands upon the training pattern and it was not clear that these were being met. District nurses were also being "attached" and bearing in mind the Council's definition of the health visitor as a "nurse", it seemed appropriate to

consider the work of a team of nurses.

The interest of the Nursing Studies Department of the University of Edinburgh was obtained and a proposal for the necessary finance was submitted and after some negotiation accepted by the Department of Health and Social Security. The study required considerable participation by the Council staff as it incorporated a counselling component organised by one of the professional staff. The report was published in 1974 and Wilkie (1979) comments on some of the difficulties encountered in initiating such a study which seem to emphasise the limitations imposed by too small a staff in the Council. (55)

The study was, however, of great importance; it indicated areas where there was insufficient preparation in the health visitor course, it also had features related to the concept of the health visitor as a nurse which are explored further in Chapter 7.

The need for the two studies quoted above was established early in the life of the Council. The need for an objective enquiry into the examination system adopted by the Council is referred to above. The National Foundation for Educational Research was consulted and a proposal was submitted for the necessary finance; once more the project required a substantial input from a member of the professional staff. The enquiry began in 1973 and the report was published in 1976 - that is after the period under study in this thesis. (56)

These major studies represent one part of the dual approach to research by the Council. The second part was the responsibility of professional staff in some small studies of an ad hoc nature which might be contained within the overall budget of the Council. These were:

(a) An evaluation of two courses which integrated nurse and health visitor training. The progress of two intakes of students was followed over the years 1966 to 1974. This was made available to the Council in 1977. (57)

(b) An investigation was carried out into the range of fieldwork experience provided by three different institutions and a report made to Council in 1975. (58)

The lapse of several years between the first proposals on research projects and eventual publication may have been related in part to the resources available to the Council, both in terms of professional staff and administrative support. The position poses questions related to powers and the resources necessary for their realisation which are examined further in Chapter 5.

#### Consideration of the future of the Council

The first Council began with considerable optimism. Sir Charles Morris (later Lord Morris of Gwasmere) in his foreward to the First Report of Council said:

The Council for the Training of Health Visitors is the first body to be given overall responsibility for the training of health visitors throughout the United Kingdom and its establishment is a landmark in the history of a service which is now over 100 years old.

The Report of the Committee on the Local Authority and Allied Personal Social Services which was published in 1968 (59) and the Social Work (Scotland) Act 1968 both had implications for the Social Work Council. There was therefore an awareness in the Council of impending change which increased between 1969 and 1974. The preparation of evidence to committees such as that on Social Work and comments on the "Green Papers" on the reorganisation of the National Health Service

emphasised the probable extent of the change. (60) Wilkie (1979) refers to the effect of these on the Council. "Apart from the ferment of new ideas arising within the Council, the climate within which it had to operate was one of turbulence and change". (61) She then lists several reports or changes in legislation which had an effect directly or indirectly upon the Council and its work.

The most immediate impact was made by the Local Authority Social Services Act (1970) by which the Health Visitor and Social Work (Training) Act 1962 was amended to extend the remit of the Social Work Council to other kinds of social work. (62)

The extension in responsibility for the renamed Central Council for the Education and Training of Social Workers resulted in a considerable increase in the staff of that Council and the earlier balance by which the numbers of professional staff in each Council was very much the same disappeared. The increased staff required more office space and greater administrative support. The Social Work Council now had a clear remit for the foreseeable future.

The position was very different for the Council now renamed the Council for the Education and Training of Health Visitors. In 1970 a committee was set up under the Chairmanship of Professor Asa Briggs (later Lord Briggs):

To review the role of the nurse and the midwife in the hospital and the community and the education and training required for that role so that the best use is made of available manpower to meet present needs and the needs of an integrated health service. (63)

The report of that committee did not appear until 1972 so that there was a period of two years between the implementation of the changes in the Social Work Council and the consideration of the implications for

the Health Visitor Council of the report of the Committee on Nursing.

There had been dissatisfaction among some district nurses with the provisions for their training. One of the professional associations, the Royal College of Nursing, suggested that, as an amendment to the Health Visiting and Social Work (Training) Act 1962 would be made in respect of Social Work Training, a similar amendment might be made to enable the remit of the Health Visitor Council to be extended to responsibility for other nurses in the community. The amendment was put by the opposition in the debate but was negatived. The Secretary of State for Education and Science however stated:

It would be our intention during the next few years to bring the Panel of Assessors and the training coming under it as closely as possible in touch with the Council for the Education and Training of Health Visitors and the Central Council for Training in Social Work with a view to seeing what steps should be taken in the light of the Report of the Briggs Committee. (64)

No further action was taken by the Government Department after the passing of the Local Authority ~~and Social Services~~ Social Services Act 1970.

The Royal College of Nursing reported in 1970 that at a meeting with Sir Alan Marre, the Second Permanent Secretary of the Department of Health and Social Security, the matter had been raised again:

At that meeting the future of state registered and state enrolled district nurse training had been discussed. Mr Mayston (one of the Departmental assessors to the Health Visitor Council) agreed the meeting had shown the implications to the Health Visitor Council and the Panel of Assessors for District Nurse Training in relation to each other would have to be considered. (65)

In March the Panel of Assessors, the body responsible for advising the Health Ministers on district nurse training, decided any approach to the Secretary of State should be delayed until after a meeting of district nurse tutors. No subsequent approach was made by the Panel of Assessors to the Council.

There continued to be growth in training facilities throughout the period under review despite the uncertainties referred to above. The Report of the Committee on Nursing was published in 1972 and the debate about the future of the Council assumed a greater immediacy. The report created considerable anxiety among health visitors. In response to a request for comments from the government department the Council prepared a report in which four areas of concern were identified. (66) Discussions began with the Government departments and with the other statutory bodies on the implications of the report. These implications for a statutory qualifying association in relation to the four propositions discussed in this case study are examined further in Chapter 8.

CHAPTER 3

Origins of health visiting and the training of health visitors : an overview of developments prior to 1962

The content of this chapter is largely descriptive and leads up to the identification of features which can be seen to have had implications for the first of the propositions outlined in the introduction to the study. That proposition was that the policy and progress of a newly constituted qualifying association for a profession will be influenced by the history of both the profession itself and the previous qualification for the practice of the profession. Discussion is based upon:

1. An outline of the origins of health visiting and its development up to 1962
2. An account of developments in health visitor training until 1962. These developments are assumed to have influenced:
  - (a) The Council's approach to its responsibility for attracting suitable persons to training
  - (b) The decision to attempt the definition of the function of the health visitor
  - (c) The formation of new training patterns with emphasis on main areas of study
  - (d) The establishment of needs for practical work
  - (e) The design of an examination incorporating an assessment of the student's appreciation of both the knowledge base and the practice of health visiting
  - (f) The identification of professional groups which affected previous developments either in practice or training and the establishment of working relationships between the Council and the groups concerned.

1. Outline of the origins of health visiting and its development before 1962

This account is arranged in five periods:

- (a) the beginnings in the mid-nineteenth century
  - (b) the health visitor prior to 1918
  - (c) the Maternity and Child Welfare Act 1918
  - (d) health visiting between the wars and related professional developments
  - (e) the post war period.
- (a) Beginnings in the mid-nineteenth century

A considerable number of accounts of the early development exist. Textbooks for students such as the first, McEwan (1951) and the most recent, Owen (1979) all begin with brief histories. Early histories of the maternity and child welfare movement such as McCleary (1935) and Lane-Claypon (1920) give considerable space to health visiting within that context up to and including the first two decades of this century. Reports of official Government Inquiries such as that on Health Visiting (1) contain a preface outlining history as do more general books on the growth of public health services such as Brockington (1956) and of the social services such as Hall (ed. by Forder) (1963). Descriptions of the growth of services in a specific authority such as Tait (1974) give more detail while research reports such as Clark (1973) and Hobbs (1973) include brief accounts. Dowling (1973) contributed a series of articles to the Nursing press based upon an unpublished MSc thesis on the early years of health visiting.

In view of the numerous accounts of the history of health visiting available in the literature, only a broad outline is given in this chapter which identifies, within a brief overview, the stages in the development

of health visiting which appear significant to health visitor employment and training as it existed in 1962 when the Council was established. These stages include the growing association of the health visitor with nursing and the implications of her employment under the direction of the medical officer of health within a maternal and child ~~and~~<sup>health</sup> department of a local health authority.

The institution of health visiting is usually ascribed to the Ladies Sanitary Reform Society of Manchester and Salford in 1862. To begin with visiting was carried out by voluntary workers, the "ladies", but it became obvious that a more practical approach was required and a salaried worker was employed, the "respectable working woman" who would go from house to house to encourage good hygiene and to instruct the mothers of poor families in the care and feeding of infants and young children. In 1890 the service which had begun without assistance from the sanitary authority was put under the direction of the medical officer of health for Manchester, thus beginning the association of the health visiting service with local authorities which continued until the reorganisation of the health service in 1974.

The second half of the nineteenth century, was one in which there was great interest in the possibility of preventing illness by improving the sanitary environment. Sir John Simon (1897) writing of the period refers to:

the old common place that without Health there is no Wealth has been spreading as with the force of a new discovery ... Disease always enough understood to be an evil had gradually come to be seen as an evil which could often be prevented ... Health now began to take rank as an object of practical politics. (2)

Writing more generally of the late Victorian period Thomson (1950) refers to the energy with which some social problems were approached:

Evils felt to be humanly remediable were tackled as promptly, and on the whole, as competently as the means at their disposal allowed. The organised improvement of working class housing, the factory conditions, of public health, of education, came remarkably fast once appropriate development and scientific knowledge became available. (3)

Health visiting then began in a period of optimism, the visitors could direct their efforts towards a clearly defined group in the population, mothers and young children. Brockington (1956) has described the maternal and child welfare movement as the first example of attention to a vulnerable group in our community. He described a vulnerable group as:

a group of individuals which for biological, medical, social or industrial reason is subject to special risk and as such is a liability to society. (4)

In the period under review the risks were clear, evidence was available in the statistics which could now be collected, that the death rates of children in the first year of life was high. McCleary (1935) quotes a figure of 151 for every 1,000 births rising to a peak in 1899 when the figure was 163 per 1,000. (5) Causes of death were being identified, the commonest among young babies being 'epidemic diarrhoea' which was recognised as related to poor personal and domestic hygiene and to bad housing and to overcrowding.

Interest in the provision of health visiting grew. Some authorities appointed women sanitary inspectors, others "health missionaries". Florence Nightingale, convinced of the effects of environment on the care of the sick was anxious to co-operate in a scheme to assist mothers to improve the home environment of the young child. In considering the type of worker most appropriate, she differentiated the task from that of nursing. In a much quoted letter to Mr Frederick Verney she wrote:

it hardly seems necessary to contrast sick nursing with this (health visiting). The needs of home health bringing require different but not lower qualifications and are more varied. She (the health visitor) must create a new work and a new profession for women. (6)

Another of the features of the maternity and child welfare movement was the establishment of welfare centres. Such centres had begun in France in 1892 and developed in Britain as centres where the baby's progress could be measured by regular weighing and where appropriate advice could be given on feeding, clothing and general care. Some centres, the first being St Helens in Lancashire, also provided free milk. (7) The health visitor was associated with the centres as the link between the centre and the home. The provision of milk and of some infant foods at low cost and the systematic weighing of babies continued up to the time at which the Council was established.

(b) The health visitor prior to 1918

Two developments in the first decade of the present century were of significance to the health visitor. The first was the Notification of Births Act of 1907. Although not mandatory and associated in the first instance with the city of Huddersfield, it demonstrated a means whereby much earlier information could be obtained on new births and consequently help and advice could be available to forestall adverse conditions as far as possible. The Notification of Birth (Extension) Act of 1915 made notification compulsory for the whole country.

The second development was the Education (Administrative Provisions) Act of 1907. This Act required the medical inspection of all children in publically maintained schools. Although at this stage the health visitor was not directly involved in these examinations, as the years progressed it was convenient in a number of areas for her to assume the

responsibilities of the school nurse whose original duties were the supervision of the cleanliness of the school child.

(c) The Maternity and Child Welfare Act 1918

McCleary (1935) quotes the Maternity and Child Welfare Act as one of the most important landmarks in the maternal and child welfare movement. (8) Twelve features of a model scheme were set out in a circular to local authorities and these included a health visiting service on the basis of one health visitor to every 400 births. Other provisions related to services for the expectant mother, recuperative homes, domestic help for home confinements and welfare centres where, if necessary, extra meals could be provided.

With the Act the pattern of health visiting was set for the next twenty years, although there might be additions to the range of work and it might be administratively convenient for the health visitor to assume responsibility for tuberculosis visiting and for Child Life Protection.

Certain features of the service as it had developed from 1918 are of importance to an understanding of later progress and of some of its anomalies. These are:

- (i) Health visiting had grown out of "sanitary" visiting, it was associated with work in areas of poor living conditions and actual poverty. Lane-Clayton (1920) refers to the provision of meals as part of schemes to improve maternal health. (9)
- (ii) The health visitor was primarily concerned with mothers and babies and at the centres where she operated some medical facilities might be provided for families unable to make provision for medical care themselves.
- (iii) The visiting originated from a notification of birth, it was unsolicited and was not associated with a crisis.

(iv) It was part of the local health authority services directed by the medical officer or a member of his medical staff specialising in the service.

(d) Health visiting between the wars and related professional developments

Health visiting was only one facet of the maternity and child welfare movement. Two closely related developments must be considered, these are the development of a midwifery service and the establishment of district nursing.

In the nineteenth century attendance in childbirth for families unable to pay for medical attendance was largely in the hands of women who had not received any formal training. In an effort to achieve an acceptable standard of competence for midwives, the London Obstetrical Society organised an examination and certificate but it was not until the Midwives Act in 1902 that a Central Midwives Board was set up for England and Wales limiting practice to women certified by the Board. A similar Act for Scotland followed in 1915. It was a duty of Local Health Authorities to secure an efficient midwifery service and where the locality was one in which the inhabitants were unable to meet the fees of midwives it was possible for the authority to subsidise midwives by guaranteeing a small salary.

The progress to an effective supervised service was slow. McCleary (1935) points out that the local health authorities carried out their duties with "varying degrees of efficiency" (10) and refers to the report of 1929 which ended by stating "We believe that the remedy can only be found in the application of a State Scheme of Maternity". (11) Unlike the health visitor, the midwife was still a private practitioner and

there was a lack of co-ordination between the work of the midwife and that of the local authority. There was possibility of overlap; health visitors visited expectant mothers and were involved in the ante-natal clinics. By 1925 all health visitor students had to possess a midwifery qualification. (12)

The situation changed after the Midwives Act of 1936 which required local health authorities to provide a domiciliary midwifery service. The majority of midwives joined the service and so became, with the health visitors, employees of local authorities. Another salaried employee therefore entered the local health authority's Maternity and Child Welfare service, in which the health visitor had previously been the sole representative of fieldworkers.

The health visitor was not the only "health missionary" in the period outlined so far. The history of District Nursing has been described by Stocks (1960) and her account emphasises the opportunity for health education which the service offered. Florence Nightingale interested in the provision of district nursing described the nurse she had in mind as "a sanitary missionary, not an almsgiver, and to be a sanitary missionary she must be trained". (13)

One of the plans for the commemoration of the Golden Jubilee of Queen Victoria in 1887 was the gift through the Womens Jubilee Offering of money to be spent as the Queen might wish. It was decided that it should be devoted to the welfare of nursing and of nursing establishments, after considerable negotiation this was further defined as the "achievement and dissemination of nursing standards for the home nursing of the sick poor by an organisation about to be created". (14) The organisation, The Queen Victoria's Jubilee Institute for Nurses, received its Royal Charter in 1889 and later, as the Queens Institute of District Nursing, was the

principal body establishing and maintaining standards for home nursing for many years.

The service was provided by voluntary associations who might apply to be affiliated to the Institute. Affiliation required associations to accept the Institute's training requirements "enforced by inspection". (15) There was therefore another "sanitary missionary" operating in the domiciliary field although not on this occasion employed by the health authority. In some cases the district nurse was also the local midwife and later might also be the health visitor in rural areas.

(e) The post-war period

By 1939 the health visitor was established in the Maternity and Child Welfare Service but might, as shown above, be involved in the school health service, tuberculosis and maternity services, Infant Life Protection and now with two qualified nurse colleagues concerned in the promotion of health, the district nurse and the midwife.

During the war years the service continued despite the disruption caused by enemy action on the large cities, the large scale evacuation of children and the absence of staff on active service with the armed forces. Thought continued to be given to the range of work the health visitor might be expected to cover; a statement published in 1943 by a Joint Consultative Committee, the forerunner of the Standing Conference of Health Visitor Training Centres, outlined her duties as associated with maternity and child welfare, the school medical service, tuberculosis visiting, the control of infectious disease and social work, caring for the family as a unit. (16) An extensive series of legislative changes which have had far reaching implications for the health visiting service

followed the end of the war.

The Education Act (1944) had, through School Health (Handicapped) Pupils regulations, made the health visitor certificate a requirement for school health visiting, the regulation, however, was not implemented by all Local Education Authorities. Although many health visitors were engaged in school work along with their other duties, the variety of worker employed for the school health work prevented a clear function being identified and the Court Committee reporting thirty years later in 1976 recommended a special training for the school nurse. (17) Many of the Acts passed in the period immediately post war affected the health visitor either directly, as in the case of the Children Act 1946 by altering the provisions for child life protection, or indirectly by the whole range of Acts concerned with social security which affected the financial resources of many of the families she visited.

The introduction of new colleagues in the local health authorities is described above but the National Health Service Act of 1946 extended the function of the health visitor to include "advice to persons suffering from illness". (18) McEwan (1951) comments "it is increasingly important that she (the health visitor) should co-operate and not encroach on the province of the home nurse". (19) The Jameson Committee held the view that "the institution of a national qualification for home nurses commonly called district nurses would affect the relation between the district nurse and the health visitor:

We expect that both workers will find little difficulty in working together recognising that health visitors will not be practising nurses and district nurses will not be highly trained health educators and social advisers. Their common participation in the general practitioners team will do much to eliminate possible causes of friction. (20)

Such a statement does not recognise that if there is to be harmonious co-operation there must be an understanding of what each partner is expected to do and that this must be made clear to all members of the team in general medical practice. This clarification is the more important in that as a result of the National Health Service Act every family can have its own general practitioner.

In 1949 a working party on Midwives reported. It outlined an extended role for the midwife emphasising her responsibility in ante natal care and recommending that she be responsible for the supervision of the new baby for one month after delivery and amendments to midwifery training to take account of an extended role were made in 1955. (21) The Jameson Committee although accepting that the revised training of the midwife was expected to equip her to undertake this longer period of supervision, rejected the recommendation:

With her special training the health visitor is likely to be better able to assess social and psychological factors both during pregnancy when sympathy and reassurance are both so necessary and during the first months of the child's life when the establishment of breast feeding for example, may be hindered by factors other than the physical condition of mother and child. (22)

The health visitor's work was therefore changing in the period 1945 to 1962. The midwife had a bigger role to play in the ante natal service, the general practitioner was available to advise mothers and children and, although child welfare centres continued, a number of family doctors organised "well baby" clinics at their own surgeries and on occasion employed their own "Practice Nurses".

The establishment of the Childrens Departments following the Children (1948) Act and the employment of almoners earlier in the Tuberculosis service had further implications for health visiting. Reference is made above

to the deployment of health visitors in services such as Child Life Protection. The Younghusband Committee (1959) report comments:

It has been said that local government like nature abhors a vacuum and if there is a job to be done someone will do it whether or not it is part of his particular function or appropriate to his training ... in particular health visitors perhaps more than others have filled the vacuum especially in relation to mothers and young children. (23)

The introduction of a new worker with specially designed training into a sphere <sup>in</sup> which many health visitors had found considerable satisfaction caused anxiety. This concern was recognised by the Committee:

As a health visitor she develops by training and experience her knowledge of these (medical) factors from the social and psychological point of view. Many find this aspect of their work particular fascination as indeed it is. (24)

The shortage of social workers initially to whom a health visitor might refer a case or with whom she might co-operate exacerbated the health visitor's concern.

The Younghusband Committee recommended the establishment of two levels of social worker - one with a professional training following an academic education and one with a shorter training which would be designed and supervised by a training council. As in other reports, the Committee was optimistic that there would be constructive relationships between the proposed new workers and those already in the local authorities, ending its report with a quote from the evidence submitted by the Royal College of Nursing's Public Health Section:

Social workers, health visitors, doctors and all those working in the community should accept each other as friendly professional colleagues, willing to discuss, defer and refer in order to ensure the best possible service to those whom all serve. (25)

Despite the hope, many health visitors found the advent of yet another worker into a field in which they had operated for some years threatening and the anxiety deepened.

It can be assumed that the lack of definition of the health visitor function increased the uncertainty. The phrase "advice to persons suffering from illness" in particular was not clear. There is little evidence that the health visitor pattern of work changed greatly or that there was any new emphasis given to this new area of work in the programme of refresher courses organised by the professional associations. A survey of ten local health authorities in Scotland in 1962 found that the health visiting service was still largely concentrating on the traditional field of work that is routine maternity and child welfare, tuberculosis and the school health services. Some authorities had developed group education for expectant mothers. In only a few areas were health visitors involved in services for the elderly, or the after care of patients discharged from hospital. (26) The implied criticism did not appear to take account of the lack of a system by which the elderly might be identified. In contrast to the birth notification by which the health visitor was informed of the location of the new baby there is no comparable organisation for the collection of data for the elderly, nor is there any universally acceptable view on what the term "elderly" means. The majority of health visitors were sited within maternity and child welfare departments and in 1948 there might be little contact with general practitioners from whose records it might be possible to identify those patients in need of nursing or social support.

Thus the health visitor in 1962 appeared as a worker from whom there were varied expectations without these having been spelt out and without the necessary administrative machinery by which she could identify her

extended clientele. Her work still was largely directed by the needs of the maternity and child welfare service and direction might be from a medical officer within that service. Clark (1973) refers to the "lack of congruence between the health visitor's own perception of her role and a stereotype which appears to be held by other groups". She goes on to suggest that the stereotype has three elements:

- (i) the clientele is limited to young children and their mothers
- (ii) the health visitor's work is limited to maternity and child welfare and that her chief concern is with physical health and basic hygiene rather than with the psycho/social aspects of health
- (iii) the health visitor's approach in her relations with clients is didactic and authoritarian rather than non-judgemental and discursive. (27)

The study in Scotland quoted above which found in 1962 that the health visiting service still concentrated on traditional work would seem to suggest that there was a kernel of truth in the stereotype. There were, however, studies in the sixties which suggest that the health visitor had a more varied work content than was shown by returns in government reports. Among others, Akester and MacPhail (1963) write of work in Leeds which indicated that the health visitor did not consider that their work depended upon a birth notification:

Of all the visits, 31.4% were "picked" up by the health visitor herself with the help of the public. The bulk of these cases could be dealt with on the spot, by advice; a surprisingly high proportion proved to be of a serious, even grave nature. (28)

Marris (1970) writing of his study on the range of work of health visitors in London in the sixties, identified 34 topics which members of the public might raise with the health visitor, some of which seemed little associated with the health visitor's primary contact with mothers and young children. Clark's study in 1969 concludes that the health visitor:

Is concerned with a wide range of families, that she has frequent contact with the various health and social agencies and that she discusses and advises on a very wide range of subject matter. (29)

2. An account of developments in health visitor training before 1962

This section is arranged under five main headings:

- (a) Training before 1925
- (b) The Statutory Bodies and Government Departments
- (c) The Standing Conference of Representatives of Health Visitor Training Centres approved by the Minister of Health (commonly referred to in this context as Standing Conference)
- (d) Financial considerations in training
- (e) Health Visitor Training Schools.

(a) Training before 1925

The first course specially organised for health missionaries is usually quoted as that in Buckinghamshire in 1892. It was instigated by Florence Nightingale who encouraged her brother-in-law, Sir Harry Verney, and his son Frederick who was then chairman of the North Bucks Technical Education Committee to provide a course. (30) The association of health visitor training with institutions of a technical nature therefore is seen at this early stage. There is no evidence that the course was repeated but it is significant for future developments in that in addition to the training being provided from technical education, the students were not nurses and that the medical officer was the main lecturer; a pattern repeated in various forms until 1962.

In 1919, the newly formed Ministry of Health sent a circular to maternity and child welfare authorities setting out the training requirements laid down by the Board of Education for health visitors in consultation with the Ministry. The courses of study were to be held at

universities which also had to make "due arrangements for practical work". (31) The extent of the involvement in "due arrangements" was not specified. In Scotland some health visitors had attended a course at the Heriot Watt College in Edinburgh and obtained the certificate of the Royal Sanitary Institute of England. Later the Edinburgh School of Social Study and Training organised a two year course for non-nurses. When the Department of Health for Scotland issued conditions for the certification and registration of health visitors, this was modified to one year for trained nurses; the city public health department providing the practical work. With the establishment of a maternity and child welfare scheme in Edinburgh, the Medical Officer of Health insisted that the health visitors must be trained nurses or midwives with added qualifications and Tait (1974) claims this was a view representative of the majority of medical officers of health and of the nursing profession in Scotland. (32) Lane-Clayton (1920) while commenting upon the inadequacies of the nurse training as a background for work with children who are not ill, nevertheless points out:

The trained nurse has acquired habits of order and discipline and of regularity in her work and these qualities are of untold value to all workers. (33)

Forty five years later the CTHV in identifying four skills brought by nurses to training as health visitors gives one as "skills in organisation and planning in their own sphere".

In discussing the implications for training of the statement on the function of the health visitor the Council claims that:

The student brings to work in the community from her nurse training, skills in systematic observation and recording along with skills in organising and planning in her own sphere of work. (34)

Although couched in rather more contemporary terms, the Council's statement seems to agree with the observations on the importance of the nurse background in the early twenties of this century.

The requirement for midwifery experience for the intending student did not appear until 1925 in England and Wales although some employers already expected candidates to have such a qualification. (35) Lane-Clayton suggests there may have been disadvantages in requiring a certificate for workers who would not be practising as midwives as this must limit the amount of practical experience for the midwife looking forward to practice.

She goes on to point out:

it is a wiser policy, however, to look ahead and make provision for better midwifery services than to require all the health visitors to hold a midwifery certificate. (36)

In saying this she looked forward to a greater involvement of the midwife in the ante natal and early post natal care of the mother and child. Clark (1973) writing more than fifty years later describes the decision that midwifery should be a prerequisite training for health visiting as "disastrous in the long term". (37) In her view, such a decision limited health visiting to work in maternity and child welfare and in no way indicated the diversity of the service.

By the mid 1930s 15 schools were recognised by the Ministry of Health for the training of health visitors in England and Wales. The syllabuses of training reflected the current thinking on the contribution expected of the health visiting service. In 1920 in England and Wales the syllabus had four main sections:

- (i) general knowledge of elementary physiology
- (ii) a short course in artisan cookery
- (iii) a full course in general hygiene and infant and child hygiene of all ages
- (iv) lectures on social work, its methods and objectives.

Practical work was included. (38)

(b) Statutory bodies and Government Departments

In 1925 the Ministry of Health appointed the Royal Sanitary Institute to be responsible for the examination of health visitors in England. In Scotland, development of a health visiting service staffed by nurses with a health visiting qualification took place much more slowly. In 1933 the Royal Scottish Sanitary Association was appointed by the Scottish Health Department as the responsible examining body for health visitors in Scotland (39) but there was no accompanying regulation requiring local health authorities to appoint only holders of the health visitors certificate to health visitor posts. As there was considerable similarity in the two bodies, the Royal Sanitary Institute, later the Royal Society of Health, is taken as the example of a statutory qualifying body in this section.

The Royal Sanitary Institute was founded in 1876 to promote health and held its first examination, for Inspectors of Nuisance, in 1877. It was a voluntary agency with a wide membership but in view of its early interest in the group who were later named sanitary inspectors, membership was largely composed of medical officers of health and sanitary inspectors. It was responsible for a number of different examinations, a list of those current at the inception of the Council is given in Appendix F. The Institute was governed by a Council composed largely of medical officers

and sanitary inspectors elected from the membership. No health visitor was elected to serve on the Council of the Institute until 1954. (40)

The main work associated with the health visitor examination was carried out through a training and examination committee which had representatives of the council of the Institute, of the training centres through the Standing Conference, and of the two major professional associations. The committee appointed examiners who were medical officers of health or of Maternity and Child Welfare or health visitors. The committee had no remit to visit training schools, the only control of standards was through the setting of examination papers by a panel of examiners, the marking of the scripts and the oral examinations which followed the written papers. Approval of courses was the responsibility of the Government Department and any guidance or supervision came from two professional officers of the Ministry of Health - one medical and one nursing. Visits to the schools were made by these officers at approximately five year intervals and more frequently to the oral examinations. O'Connell (1978) points out that as a result of the system, individual health visitor training schools had no direct link with the committee unless one of the tutors employed in the school happened to be elected to the committee as one of the representatives of the Standing Conference. (41) With the lack of any direct reports from the examination committee to individual schools, there was little information to guide the organisers of training on the value of their methods.

Apart from subjective estimates, the only measure by which the schools could assess the quality of the course and its teaching was the number of successful candidates at examination. Wilkie (1978) refers to the difficulty of examiners achieving "a perfect standard which will not be

affected by the nature of the group to which it is to be applied". (42) Examination results by themselves were not an entirely reliable means of estimating the general standard of training in the country or of evaluating an individual school.

- (c) The Standing Conference of representatives of Health Visitor Training Centres approved by the Minister of Health (commonly referred to in this context as Standing Conference)

A body which could exercise considerable pressure on both the government department and the Institute which became the Royal Society of Health in 1955, was the Standing Conference. This body developed from an earlier organisation, the Joint Consultative Council of Health Visitor Training Centres and Professional Organisations. In 1944 it was reconstituted and given the title quoted above, and in the new constitution the professional organisations were no longer members. Each training school could send two delegates and the Standing Conference was self financing through affiliation fees paid by training schools.

The first meeting of the new body took place in January 1946 when it had the following remit:

1. to appoint eight representatives of training centres to the Health Visitor Examination Committee of the Royal Sanitary Institute
2. to consider questions related to recruitment and selection of candidates for training
3. to consider from time to time, questions relating to training of health visitors (other than matters dealt with by the health visitor Examination Committee with the agreement of the appointed members of Standing Conference on that Committee), and to make recommendations to the Minister on any such matters on which he may seek their advice or on which they wish to offer representations.

There was no comparable body for Scottish training centres but in the fifties they applied to send delegates and subsequently continued in membership.

The Standing Conference was a body of considerable importance, able to bring some pressure to bear on the examination pattern of which many health visitor tutors were critical. Originally examiners were not given fees, instead hospitality was provided for the two days involved in the examination and travelling and other out of pocket expenses were met. The two days of examination included the marking of the students' written papers in a two and a half hour period following the completion of the third examination paper. Viva voce examinations took place the following morning.

As a result of representations made over a period of time by the Standing Conference, fees were introduced for examiners, students undertook the written part of the examination in their own training schools, and a more reasonable time for marking was allowed.

Other areas in which the Standing Conference exercised influence concerned the training of tutors and encouragement to training centres to consider integrating health visitor and nurse training in one course in co-operation with an adjacent school of nursing. Standing Conference pressed strongly for a working party to consider health visiting and the secretary of the Conference, Miss Mary Davies, was a member of the steering committee of the working party. (43)

(d) Financial considerations in training

When training first became obligatory for health visitors in England and Wales it was feared that the cost of training might prevent suitable candidates from coming forward for training. McEwan (1951) describes two systems of financial support which were introduced:

- (i) an advance of salary
- (ii) employment as a probationer.

The first of these schemes is related to the system of sponsorship which developed widely and is referred to in the first chapter of this thesis. The second scheme was adopted by a few authorities. There can be dangers in schemes in which the trainee is employed as a member of staff. The hours of work dictated by the needs of the service may be long and tiring so that the trainee is limited by the time available for study as well as in the energy she can bring to such an activity at the end of a long day.

Probationer schemes had certain safeguards in that the Minister had to approve the schemes and these had to incorporate some lectures (some of these might be in the evening), practical work and time for study. Edinburgh employed six probationer health visitors from 1948-64. (44) Authorities could design their own form of remuneration and expenses to be claimed by the students and the inequalities and problems generated by both schemes were commented upon by the Jameson Working Party. (45)

(e) Health Visitor Training Schools

The National Health Service Act of 1946 gave a fresh impetus to the provision of health visiting services and there was a considerable expansion of training centres. By 1950, 24 schools were in existence (46) and by 1962 when the Council was instituted this number had risen to 29. (47) Nine of these were organised entirely by local health authorities, others were either within educational establishments or were using facilities made available through the education authorities or universities. Leeds, Liverpool and Hull had links with universities, training in Essex and Middlesex was arranged through the local education authority, Bradford and Durham were examples of courses organised by the health authorities themselves. A complete list of training centres as approved in England and Wales 1962 forms Appendix G. In Scotland, in Edinburgh, there had

originally been co-operation with the university but in 1948 the corporation assumed complete responsibility. (48)

The lack of a consistent pattern presented problems of authority within individual schools. Wilkie (1976) gives a description of the circumstances of some of the schools in 1962. (49) The problems however were more complex than the physical surroundings in which students were trained. Siting courses within universities or colleges did not necessarily mean that the tutors would become members of the staff of the institution nor that the students would become registered students of a university. In general, in both university and college, the tutorial staff were employees of the local health authority and seconded to the institution. The first tutor to be appointed to the staff of a university was in Southampton in 1950 and two years later in the University of Wales the Welsh National School of Medicine appointed the health visitor tutor to the staff. (50)

The anomalous position of the tutors and of the courses in a setting in which the health authority was the employer of tutor and of the sponsored students could lead to three adverse situations:

- (i) As the tutor was not a member of the staff of the department in which the course might be housed, she did not participate in staff meetings in which training policy for the department as a whole might be debated and determined. Not only was she thus denied the stimulation of debate on teaching methods, she was also at a disadvantage in pressing for resources for the health visitor course in competition with the established courses
- (ii) The tutor was a member of the staff of the health authority, frequently of the maternity and child welfare department of the authority, her immediate superior was therefore either the superintendent health

visitor or the maternity and child welfare officer, neither of whom would necessarily have any experience in teaching or the design of curricula.

(iii) The imposition of an examination by an external body and surveillance by a government department was unacceptable to universities. O'Connell (1978) writing of her experience in Southampton comments upon the insistence on freedom in academic matters which may cause difficulties when standards are also governed by outside professional bodies of a statutory nature. (51) This particular problem is explored further in Chapter 6.

From the foregoing account five main features emerge which could be said to have implications for the policies of the Council in 1962. The five features which are explored further in the following chapter are:

1. The image of the health visitor in 1962 which appeared anchored to that of the very early practitioner
2. The impact of new colleagues in nursing and in social work
3. The changes in objectives of the "public health" services
4. The relationship between employment and training
5. The content of the training and its statutory control.

CHAPTER 4

Implications of the past history of health visiting  
for the training policies adopted by the Council

The Health Visiting and Social Work (Training) Act 1962 lays certain responsibilities upon the Council. These include:

1. Training of health visitors
2. Recruitment of students.

Of these, the first had been the responsibility of two organisations previously; the Royal Society of Health and the Royal Scottish Sanitary Association. It can be expected therefore that the patterns developed by these bodies would have an impact upon the policies on training adopted by their successor, The Council. The second responsibility towards recruitment did not have a precedent. Nevertheless the decisions made by the Council in relation to recruitment were influenced by the history of health visiting and by the image the health visitor presented in 1962.

1. Training of health visitors

It might be expected that previous experience of training would lead to an expansion of ongoing policies or conversely a rejection of the existing pattern in favour of a completely new approach. Study of the Council shows both processes. The first of these, the development of ongoing policies included:

- (a) Reliance on pre-course training provided by other statutory associations that is the General Nursing Council; Central Midwives Boards and the Joint Nurses and Midwives Council of Northern Ireland
- (b) Inclusion of two elements in the training programmes, those of theoretical instruction in the classroom and practical work in the community
- (c) Encouragement of training centres to use the facilities of educational institutions.

(a) Reliance upon pre-course training

Pre-course training for health visitors had two components:

- (i) A general nurse component
- (ii) A midwifery component.

(i) A general nurse component. A move to introduce new forms of training might have been expected from a new body. The first three chapters of this study have included some of the criticisms made of the previous training system for health visitors, some of which were directed to the general nursing requirement. Such training was considered to be unnecessarily time consuming and to produce skills which would not be utilised in the subsequent activity of health visiting. The Wood Report <sup>(1947)</sup> recommended a general reduction in the overall nurse training and the incorporation of special components for nurses who would eventually practise in the community. (1) That there should be some alteration in the balance of preparation and the subsequent training was the subject of discussion in conference and in articles. Brookington and Davies (1949) put forward proposals for a new type of training to produce a new form of medico-social worker. The course would incorporate elements of both nursing and social work in a two year training but would not lead to state registration as a nurse. (2) Windmuller (1954) in a paper presented to the annual congress of the Royal Society of Health described the greatest disadvantage of nurse training as:

the hierarchical structure of nursing and life in hospital. The student nurse's attitude tends to be conditioned for all time by habits of submission to authority and dependence on the doctor. (3)

The report of the Jameson Committee (1956) contains four paragraphs in which the possibility of an integrated course incorporating the three elements of general nursing, some midwifery and health visiting is

advocated. The Committee express approval of the courses currently in progress with particular reference to their attraction to young recruits to nursing:

The establishment of integrated courses is essential if an appeal is to be made for direct entrants to health visiting. (4)

In view of the Council's responsibility for attracting students it might be expected that such a development would be among the priorities of the Council. Some courses had been inaugurated and three reports of their operation appeared in the early years of the Council's life, Williams (1962) (5), Brookington (1964) (6) and Bryden (1969). (7)

The Nurses Act of 1949 which reconstituted the General Nursing Council of England and Wales amended the Acts of 1919 and 1943 giving the GNC the power to approve experimental schemes of training subject to the Minister's approval. (8) The existing integrated courses which all adapted in some form the general nursing content of syllabus were approved through this provision. The term "experimental" in this context did not, however, imply systematic and organised evaluation of the schemes thus approved.

No common policy on the design or indeed on the purpose of integrated state registration/health visitor courses had been agreed among the previous statutory bodies concerned in granting approval to the various component parts of the training. The Council therefore did not make the expansion of such training an immediate priority.

A new body such as the Council in 1962 had still to establish relationships and caution in making fundamental changes was exercised. The Council was content to offer approval of the health visitor component of the existing integrated courses in order that the health visitor certificate might be granted to successful candidates.

The reliance of a new statutory body upon a previous training pattern may be compared with that of one of the other qualifying association, the General Nursing Council for England and Wales. The General Nursing Council was established in 1919 amid a certain amount of controversy on its constitution and powers. It differed from the Council in that although it also inherited a pattern of existing schemes there had been no co-ordination of the various forms of training which had evolved in individual hospital schools, principally the teaching hospitals in the large cities and in London. The period is well described by Abel Smith (1960), Bendall and Raybould (1969) and White (1978). Hector (1973) in an account of one of the early leaders in nursing, Mrs Bedford Fenwick, who was associated with St Bartholmews Hospital quotes 1882 as the year in which a three year training was introduced in that institution and points out that the period has been retained ever since as a standard. (9)

The rules laid down by the newly established General Nursing Council in 1921 required that nurses seeking registration must hold a certificate of three years training from a general hospital or infirmary approved by the General Nursing Council. (10) Subsequent revisions in training have all retained this three year period although the time may be distributed differently and reports such as the Wood Report (1947) which proposed a 2 year training to be followed by 1 year under supervision before registration (11) and the Platt Report of the Royal College of Nursing (1964) all propose an overall period of this length. (12) The most recent report, that of the Briggs Committee (1972), continues the pattern although breaking the period into a number of modules of types of experience. (13)

The Council therefore followed what would appear to be a trend in nurse education for the perpetuation of patterns of training. Where the Council departed from the system existing in 1962 was by extending the length of the course to one of not less than a calendar year and by a major revision of the syllabus and examination.

(ii) A midwifery component. The introduction of midwifery in the preparation of the health visitor is described in Chapter 3 and its possible contribution to the lack of clarity in the function of the health visitor is considered. Clark (1973) goes so far as to call its introduction in 1925 as "disastrous":

The health visitor's social and preventative training was weakened by the reduction of the post basic course to six months to balance the extra time in midwifery training. (14)

The Jameson Committee (1956) suggested that reliance upon all or part of midwifery training was no longer appropriate. The first six months of the full midwives training was accepted for entry to the health visitors course but the Committee felt this first part to be unsatisfactory "it should cease to be regarded as a qualification for entry to training". (15) The Standing Conference of Health Visitor Training Centres had considered the design of an alternative maternity nursing course (16) but the expectation that a new training body was to be formed would seem to have removed some of the urgency. There is no evidence in the minutes of the Council meetings or the reports of the meetings of the specialist panels on syllabus and examination that serious consideration was given to discontinuing reliance upon general nurse training and midwifery training. Wilkie (1979) points out that the event which compelled the Council to consider the part played by midwifery in the training of the health visitor lay in the alteration of

the regulation in 1973. (17) In 1948 Statutory Instrument 1415 stated "health visitor means a woman employed by a local health authority for the visiting of persons in their homes ..." In 1973 the word "woman" was replaced by "person" theoretically men thus became eligible for health visitor training. (18) Before, men were precluded from attendance upon women in childbirth under the Midwives Acts so in considering the appropriate pre-course training for men attention was focused upon the significance of midwifery or obstetric nurse training for all health visitor students.

(b) Inclusion of two elements in the training programme, those of theoretical instruction in the classroom and practical work in the community

The syllabus of training current in England and Wales in 1962 did not specify any set period of practical work. Candidates were required to have "completed a course of training approved by the Ministry of Health in public health work lasting at least six months". (19) The examining body therefore relied upon the visits of the officers of the Ministry to scrutinise the nature and amount of fieldwork contained in the curricula of the individual schools. The examination did not have a section directly related to the skill of health visiting.

Possible alternatives to providing both practice and theory in one course were being explored in other fields. The term sandwich course was being used in further education in which periods in college were alternated with blocks of practical experience. Such blocks might be extensive and carried out at some distance from the parent college. In nursing there were experiments such as that in Glasgow in which nurse training was completed in two years with a subsequent year as nurses in the hospital wards. (20) In St George's Hospital in London a scheme known as the "two plus one" was in operation which was designed on the

same principle. Registration as a general nurse was granted at the end of the 3 years. (31)

Applied to the health visitor courses such a design of training would have allowed for greater depth in the teaching in the theoretical part of the course and a longer period in which the student might develop her skills. Such a system could have utilised areas geographically removed from the school for practical work, thereby reducing pressures for practical work places in its immediate vicinity. In considering such a change, however, the Council had to bear in mind that in 1962 the larger number of training schools were operated by local health authorities, accustomed to providing practical work facilities within their own boundaries; an extension to areas further afield might prove costly in terms of time and travel for students and tutors. The existing pattern had proved acceptable to the sponsoring authorities in the past and in view of the considerable changes envisaged in syllabus and examination further innovation was not considered practicable until the Council became more firmly established and had the opportunity to develop further relationships.

(c) Encouragement of training centres to use the facilities of educational institutions

Chapters 2 and 3 of this study outline the variety of institutions in which health visitor training was carried out in 1962. Wilkie (1979) describes some of the conditions in the various establishments. (22) The fact that a course might be sited within the walls of an educational institution did not mean that it enjoyed the same facilities as other courses in a similar setting. In Chapter 6 the educational context within which the Council operated is considered with particular reference to the rapid expansion of facilities in further education in the period under review.

It is suggested above that the Council appears to have favoured a continuance of previous patterns of training and it can be argued that in deciding to exploit the resources available in further education the Council was simply continuing a process already begun in some training schools. The objective of such a development, however, after 1962 was a closer integration of the health visitor courses in the general programme of the institution concerned. Such a setting could be expected to offer a degree of independence to the course. There were two reasons for seeking such independence, first the apparent advantage of providing teaching on the theory and practice of health visiting by staff of the same employing authority gave students a narrow view of their future work. Secondly, the experience of early health visitor training schools in which the tutorial staff were employed directly by the institution concerned, such as the Royal College of Nursing, Battersea Polytechnic, the Welsh School of Medicine and the University of Southampton, appeared to have allowed the tutors in these institutions greater freedom than was available to those tutors working directly under the control of the departments of the medical officer of health.

O'Connell (1976) in a study of health visitor education in Southampton University refers to:

The most important reason for freedom from medical dominance was that the university assumed full responsibility for the health visitor tutor by appointing her to the academic staff. Had she been on permanent secondment from a Local Health Authority ... the influence of the Medical Officer of Health as her immediate superior would have been considerable. (23)

O'Connell claims that the difficulties which arose in Nottingham, the Institute of Education in London University and Bristol arose from the position of the tutor as an employee of the health authority is an

over simplification, other factors, primarily the financial support for the course concerned, and the nature of the department within which the course was housed could be assumed to have affected the issue. Nevertheless, the greater freedom enjoyed by those tutors not employed by any specific authority encouraged them to design curricula to prepare students to operate in a variety of settings. This national rather than local emphasis in course planning was of importance to a body such as the Council which had a national responsibility. Without stating explicitly that no further development in local health authorities schools would be supported, the Council staff discouraged such proposals and pointed out the opportunities available in the colleges of the local education authorities. The policy therefore represented the development of an existing but small sector of training in educational institutions and a rejection of the more usual provision of training by employing authorities.

Of these three features of the training pattern existing in 1962 which were continued by the Council's policy, the first two, that is the requirement that the candidate for training should be a registered nurse and either a state certified midwife or have successfully completed part of midwifery training or a course in obstetric nursing, appeared acceptable to the profession and the employing authorities. A course which would incorporate both classroom and practical experience within a calendar year was also acceptable. The third feature, that is the development of an educational setting for the courses, was less immediately attractive to senior nursing and medical staff. It may be that there was a lack of information on the variety of training patterns in existence. Wilkie (1979) describes the efforts of the Council's staff to ensure that information was readily available. (24) The presence of successful

courses which achieved both a good record of success in examination as well as in the attraction of students to training would appear to have been significant in the progress of the Council's educational policy.

There was general acceptance of a form of training which included practical experience but the Council was not satisfied that the experience currently provided was necessarily appropriate. Wilkie (1979) describes the problems involved in laying down standards particularly those associated with supervision of the student. (25) The Council's decisions on requirements for training represented a departure from the previous pattern. Chapter 3 of this study outlines the expansion of health visiting with its traditional functions and skills in a changing environment and reference is made to the doubts concerning those functions expressed by health visitors and their colleagues in medicine and social work. In the previous chapter it is suggested that prior to 1962 there was a gap between the skills which training schools aimed to develop in students and the experience available for practice. In addition, there was a gap between these skills and the expectations held by employers of the products of training.

The study by Clark (1973) in which the public image of the health visitor is compared with the health visitor's own perception of her role concludes by claiming that one of the reasons for the health visitor's failure to fulfil the role envisaged for her by the Jameson Committee (1956) was due to the large caseloads she carried. (26) The Council had inherited a situation in which training had made substantial progress but which was prevented from further advance by the working situation including the large caseloads. The Council's powers were confined to training which was interpreted as that carried out in the training schools.

This therefore did not allow a direct impact upon the service. The members of Council appointed in 1962 (Appendix A) included 10 health visitor members and two Medical Officers of Health who had been active members of the Standing Conference of Health Visitor Training Centres. There were also three medical representatives who had a particular involvement in the organisation of the health service. Despite the restrictions in the Council's remit these members who formed half the complement of the Council had an effect upon the way in which the Council approached its task, especially in those methods by which the quality of practical experience might be enhanced.

#### The introduction of new concepts in training

This chapter has begun with the suggestion that the influence of previous patterns of training might lead to either the development of the current form of training or to its rejection in favour of a fresh start. The first of these possibilities is examined above, the second involves consideration of the background to the innovations made by the Council in 1965 and the identification of features which might contribute to the success or failure of the new design. Three features which appear significant are:

- (i) an assessment of the contribution of the tutors in post in 1965
  - (ii) the part played by the external examiners in the new system
  - (iii) the introduction of fieldwork teachers.
- (i) An assessment of the contribution of the tutors in post in 1965

Reference is made above to the composition of the Council and the substantial proportion of members with a direct interest in advances in training. It could be expected that some revolutionary proposals would

emerge. Although the ideas were relatively new, especially the new form of examination, each was dependent upon the attitudes and abilities of existing staff. As with any other new organisation developing from an established form, the Council could not write on a "tabula rasa". A system which previously had neither central direction nor a central advisory service allowed considerable development by some training centres but conversely allowed the mediocre to continue with a rigid adherence to outdated methods and ideas. In addition a syllabus which contained a considerable amount of detail could be assumed to foster a fragmented curriculum.

Wilkie (1979) comments on the advantages possessed by the Council in having a professional staff which provided a liaison between the Council and the training centres. (27) The staff could be of assistance in the design of more relevant curricula; the method for the approval of courses is described in Chapter 2 of this study. Despite the service available to training centres from the central body advance and improvement in standards must ultimately be dependent upon local tutorial staff. A number of tutors had trained some time previously, the numbers qualifying each year immediately before the institution of the Council had been small. The new pattern of health visitor training had to be operated by tutors who in many cases had not been fully responsible for course planning, who were single handed and who were therefore relatively unsupported by junior colleagues. Of the 28 tutors in charge of courses when the Council was set up, five had not obtained a teaching certificate related to the training of health visitors, seven had followed the first course organised by the Royal College of Nursing in 1948/49 and there had been little opportunity for refresher courses since the initial teaching course.

To overcome this gap it would have been desirable to provide a large up-dating programme directly related to the new training for health visitors. The problem of providing a training mechanism for tutors is discussed more fully in Chapter 2. One of the main obstacles was the lack of finance, the system of finance itself being a product of history. Historically local health authorities had to provide monies for the training of health visiting and tutorial staff.

In the absence of a systematic up-dating programme in 1962-1965 it is not possible to say that the implementation of the Council's new training policy would have proceeded more quickly and effectively if such courses had been organised. Nor can the degree to which the policy was affected on the one hand by the previous system and how much by the lack of finance for training staff in post be determined.

(ii) The part played by the external examiners in the new system

The form of examination in force in 1962 is described in Chapter 1. Although the question papers were issued from a central source the students' scripts were marked in the individual training schools. Wilkie (1979) refers to the effect of the student group under scrutiny upon the expectations of the examiner concerned and suggests the method did not guarantee a uniform standard. (28)

The new form of assessment required among other features that each school should have an external examiner selected from a list maintained by the Council. (29) The Council sought the help of the training schools in compiling the list by asking for nominations of suitable examiners and recommending that such persons should have had experience either in the training of health visitors or in the conduct of examinations. As a result of this approach the list was largely composed of those who had been involved in the previous system. Fader (1976) in "The Examination

for Qualifying Health Visitors" comments that examiners coming from a variety of disciplines might have different expectations of what constitutes a good answer. This comment made when the examination had been in operation for 10 years would seem to be even more relevant to the situation in 1965 when the new form of examination was introduced. The first lists contained names of tutors, nursing officers and various representatives from medicine with, in addition, a small number of representatives from the disciplines of psychology and social administration. (30) Fader's study, which indicated considerable variation in standards does not relate these differences to the external examiners as such but by recommending an alternative method could be said to criticise the list maintained by the Council. (31)

The system introduced by the Council represents an effort to achieve innovation in examination without the creation of a completely new cadre of examiners. Desirably, short courses or conferences on the new aspects of the training for examiners should have been offered and such short courses would have been of particular value in identifying the special features of the family studies. As in the case of the tutors referred to above, however, courses would require financial support which is not available to the Council, restricted as it is to "returnable" courses, that is those for which a fee is charged to cover costs.

It is not possible to demonstrate that provision of courses would have led to any greater standardisation of results than that achieved. As Fader suggests the variety of disciplines may have been a significant factor in the large variation in the papers set "not only between centres but also within a centre". (

(iii) The introduction of fieldwork teachers

So far it appears that the Council was leaning heavily upon the prevailing patterns but the fieldwork component of training demonstrated a much more fundamental change in policy. A totally new worker with special responsibility for fieldwork instruction was introduced, designated as fieldwork instructor - changed later to fieldwork teacher. The arguments concerning the position of the fieldwork teacher as either a member of staff of the health authority or of the college from which the students were drawn are rehearsed in Chapter 1. In addition to the matter of principle there was the practical problem of finance. If the Council was to gain the collaboration of the health authorities it was necessary to provide an explanation of what the Council saw as the function of practical experience. This in its turn required some clarification of the function of the health visitor. The part played by a body with a statutory responsibility to training in relation to an attempt to define the function of the worker it was hoped to produce is debated in Chapters 5 and 7.

In contrast to the lack of special preparation for tutors and examiners, the Council was able to institute some courses for the health visitors selected to undertake the practical teaching of the students. The selection of appropriate members of staff was, however, at that time in the hands of the employing authority through the agency of its medical and nursing staff. As the examiners would have different expectations of what constituted a good written answer, so the senior health service staff had different expectations of what constituted good health visiting practice. Chapter 3 of this study traces the varying forms of the health visiting service as these evolved in the years before

1962. The contrasting views expressed by the professionals are examined in Chapter 7.

In the Handbook issued to training schools the Council refers to "the need to establish and maintain the relationship between theory taught in the classroom and the practice encountered in the field". (33) The removal of the health visitor courses over a period of time to the setting of an educational institution encouraged tutors to explore facilities for student practice in new areas. Another new concept was introduced as a result, that of a system of communication between the school and the local health authority so that "fieldwork instructors ... be informed on the philosophy behind the training at a special school". To achieve the latter the involvement of the tutors in the selection of the health visitors to be fieldwork teachers would be an advantage.

By 1973 the Council was able to require that applications for fieldwork teacher courses should include the name of the school with which the health visitor would be associated and the signature of the tutor concerned. Acceptability, however, of the new concept of fieldwork teacher was achieved with difficulty. Wilkie (1979) refers to a parallel development in general nursing of the clinical teacher. (34) Although there are similarities, the situation is not entirely comparable. In the hospital setting, tutor, clinical teacher and ward sister have a common employer. In the new form of health visitor training the tutor, once responsible to the medical officer of health now becomes responsible to the principal of the college concerned. The implications of impending change within the health and social services on the staffs of health departments of local authorities are explored further in Chapter 8. In the context of this chapter, it may be argued that the slow acceptance

of the fieldwork teacher in health visitor training represented more than doubt on the efficacy of practical teaching as conceived by the Council, rather it may have reflected a more general uncertainty on future developments in the structure of the National Health Service. The degree of authority of the medical officer and of the superintendent nursing officer in the future service as seen by these officers may have been of greater significance than past patterns of training.

As well as variety of opinion on the nature of the work of the health visitor, figures in the Report of the Development of Community Care show the variations in staff establishment as well as the average figure suggested at that time by the Ministry of Health. (35) ~~XXXXXX~~e numbers in individual authorities did not necessarily reflect a difficulty in recruiting staff, they also illustrated the wide range of views on what numbers were required to carry out the authority's statutory responsibility to provide a health visiting service. This variation in the staff required was reflected in another aspect of the Council's work, that of seeking to attract suitable recruits.

## 2. Recruitment of students

The recruitment of health visitor students had not been a responsibility of any one organisation prior to 1962. The policies adopted by the Council and the background to them are described in Chapters 1 and 2. The history of health visiting has shown the gradual blurring of the image ~~the~~ presented to nurse colleagues and therefore the lack of attraction to potential students. The gradual erosion of the original function which the health visitor fulfilled in the first two decades of the twentieth century and the accretion of a variety of tasks

as the service developed has already been outlined in the previous chapter. The Council had no authority to direct the deployment of health visitors but by providing a statement of what training aimed to produce, local authorities might be stimulated to couch advertisements for students in more positive terms. Such encouragement was given by the production of leaflets for the use of individual enquirers and for distribution by Local Health Authorities. More important was the publication of the statement on the Function of the Health Visitor. (36)

In its recruitment policy the Council was concerned to counter in an active form the previous picture of the health visitor which appeared to have developed over the years of a worker primarily concerned with the physical health of mothers and young children.

A second feature of the Council's policy on recruitment was an effort to promote training for health visiting at an earlier age. The Jameson Committee had expressed the view that this might be achieved by the establishment of more integrated nurse/health visitor courses to appeal to the school leaver and by encouraging qualified nurses to begin training before the age of 25 years. (37)

A survey carried out by Council staff in 1967 of health visitors in post in the United Kingdom, showed that 2,093 full time and 385 part time health visitors were in the age group 50 to 60 years. The picture presented by the survey was that of health visiting as an occupation for the middle aged and elderly. (38) The Council's policy therefore was to direct the recruitment literature to the newly qualified nurse showing the health visitor as a young woman, a car driver with a wide range of professional activities and with opportunity for a full social life.

In this chapter the relevance of the professional background from which health visiting and training emerged is considered. The effects generated, however, are more subtle than appears from a simple recital of those patterns which were perpetuated and those which were changed. Such an account cannot identify direct causes for some of the successes as well as the failures in the Council's policies. Some features, however, appear relevant. Change will be consequent upon:

- (a) the presence of a large population anxious to achieve change. In the context within which the Council worked the health visiting service was small in relation to the health service as a whole and to the total nursing profession
- (b) a speedy response to recommendations by Government departments made by their own committees of enquiry. Six years elapsed between the publication of the Jameson Report and the passing of the Health Visiting and Social Work (Training) Act in 1962. In that time the interest generated by reports can cool
- (c) adequate financial resources and, more important, a degree of autonomy in the disbursement of money to provide up-dating courses and conferences for existing administrative, medical, training and field staff. This could go some way towards creating the favourable climate to which Wilkie (1979) refers.

It is not suggested that these features are peculiar to the progress of the Council. Hall et al (1975) refer to a similar feature of pressure groups also concerned in achieving change:

Many political issues directly affect only small groups and have limited consequences for the rest of the population. The groups involved may be passionately committed to their demands ... but against a background of lack of interest among the population as a whole they have to be able to control very key resources. (39)

The Council was composed of members much involved in the service and in training but not directly elected by the membership of the profession, a contrast with the other qualifying associations which is discussed in Chapter 5. It could be argued that such a constitution makes for less contact with the wider population of that profession. It is that wider population which must be in tune with the proposed changes and it may be necessary to continue with some known patterns. The financial resources of the Council are outlined in Chapters 1 and 2 and the comment is made there that there was no latitude in the use of money other than in the organisation of the administration and the employment of the professional staff. It is the interplay therefore between the resources of the new body and the past history of the profession that is a significant feature in shaping the policies and the success or failure of these policies.

CHAPTER 5

Qualifying Associations in Nursing : the Council  
compared with four examples

In the account of the Council's activities as set out in the first two chapters of this study certain trends in policy-making emerge. Some of these are related in Chapter 4 to the immediate past history of the qualification of health visitors and the facilities available for training. This chapter considers the possible relationship between the Council's record of successes and failures in promoting a new training programme and its statutory position as a qualifying association. The Council presents some unique features and the aim here is to illustrate the complex and subtle relationship between structure, remit and influence of a qualifying association. In order to identify the Council's unique characteristics and responsibilities the qualifying associations in nursing are arranged in four categories; one example of each is described briefly so as to provide both a comparison with and a contrast to the Council. Although initially the associations might be expected to form a homogenous group since all are concerned with the one profession of nursing, striking differences emerge on examination.

Discussion is directed along two lines; first the degree of congruence between the Council and the other qualifying associations in nursing and second, ways in which they, and the Council, appear to correspond to qualifying associations in general.

Millerson (1964) classifies a qualifying association as one form of professional association describing its aims as: "to examine and qualify individuals wishing to practise in a subject". In doing so he is distinguishing it from three other forms of professional association

which he describes as:

- (a) the prestige society which implies the sense of honour and distinction bestowed on an individual by election to a closed group. This would not necessarily be confined to demonstrated skill, ability or achievement in a specialised branch of knowledge or activity
- (b) the study association consisting of individuals willing to further knowledge of a subject in a narrow field of enquiry
- (c) the occupational group which may be subdivided into those concerned in the co-ordination of sections and those exercising pressure to improve the working conditions and remuneration of their members. (1)

A number of features are selected to form a framework for comparison:

- (i) The background to the formation of the association
- (ii) The powers, constitution and financial resources for the body
- (iii) The form of administration.

The main features of the Council described in the first four chapters are summarised under the headings given above.

- (i) Background to the formation of the Association. The Council was set up in 1962 following the Reports of two working parties, the Jameson Report (1956) (2) and the Younghusband Report (1959) (3). The first report recommended changes in health visitor training while the second recommended the institution of training for social workers in the health and welfare services.
- (ii) Powers, constitution and financial resources. As a result 2 councils were established with certain common features and resources. The Council for the Training of Health Visitors was required to approve courses for the health visitor certificate, arrange for the examination and attract candidates to training. It might provide further courses for health visitors if thought necessary and might carry out or promote

research into aspects of training. (4)

In 1962 the Council was established with 31 members appointed by the Health and Education Ministers and one chairman appointed by the Privy Council. The bodies to be consulted by the Ministers when making the appointments are listed in the first schedule to the Act. Two committees were appointed by the Secretary of State for Scotland and the Minister for Northern Ireland respectively to advise on the relevance of the Council's policies to these countries. (5)

The Council had no income of its own, the costs to the Council of fulfilling its statutory responsibility were estimated annually and the budget was then submitted to the Government Department. Agreement then had to be reached with the Government Department on the sums required. Much of the expenditure on items such as the administration, shared accommodation and general office resources was estimated jointly with that required for the Council for Training in Social Work.

(iii) Form of administration. The Council had its own professional staff which consisted of a Chief Professional Adviser supported by other professional staff, all qualified health visitors. The Chief Professional Adviser and the Joint Secretary were each answerable directly to the Council. The Chairman and some members served both Councils.

The four categories into which the qualifying associations which operate in the nursing profession may be placed are:

1. Organisations established by statute to regulate some part of the nursing profession. Such bodies usually have disciplinary functions in relation to their register or roll. The example chosen for comparison is the General Nursing Council (GNC) for England and Wales
2. Ad hoc bodies established by the Government Departments to meet a special need for the co-ordination and standardisation of training in a specified area of the nursing service. The example selected for comparison is the Joint Board of Clinical Nursing Studies for England and Wales (JBCNS)

3. Professional organisations one of whose functions is that of awarding certificates of competence for practice in a special field following training and examination, the example taken is that of the Royal College of Nursing (RCN) which awards a certificate in occupational health nursing
4. Institutions acting as agents for the award of a statutorily required certificate. Such bodies may not be concerned solely with one profession. The example chosen is the Royal Society of Health for England and Wales.

1. The General Nursing Council (GNC) for England and Wales. In the United Kingdom, the General Nursing Council for England and Wales is one of six bodies set up by statute to regulate nursing; the others being the General Nursing Council for Scotland, the Central Midwives Boards for England and Wales and for Scotland, the Nurses and Midwives Council for Northern Ireland and the Council for the Education and Training of Health Visitors. All these bodies at present operate through separate Acts which regulate their constitution and powers.

(i) Background to formation. The GNC was formed following the Nurses Registration Act of 1919 which required the GNC to form and maintain a register with five sections, thus providing for general nurses, for male nurses, for nurses for sick children, for nurses of mental disease and for a further group which could be prescribed.

(ii) Powers, constitution and financial resources. The GNC makes rules concerning age of entry to training, educational background of students, conditions for the approval of nurse training schools but these rules in their turn are submitted to the Health Ministers for approval. The GNC may remove the names from its register or roll if:

it is brought to their attention by the Courts, employing authorities or individuals that a nurse is guilty of a felony, misdemeanour or of any misconduct which warrants consideration. (6)

The Council consists of both elected and appointed members.

22 members of the GNC are elected by registered and enrolled nurses and 18 appointed by the Health Ministers. The election is organised to ensure that representation is spread over the country without an undue preponderance, for example, from the London region. A member of the GNC is elected Chairman by the Council. Income is mainly from fees for examination, assessments, registration and enrolment; some additional income comes from the sale of publications, investment income rents from property let and payments from the Government Department for the approval and inspection of training schools. The liabilities lie in staff salaries and wages and fees to examiners and assessors.

(iii) The form of administration. The business of the GNC is administered by a Registrar, a registered nurse with supporting administrative and office staff. There is an Education department headed by an Education Officer, a qualified sister tutor supported by a deputy and a team of inspectors.

2. The Joint Board of Clinical Nursing Studies (JBCNS) was established in 1968.

(i) Background to formation. As early as 1945 the Horder report of the Royal College of Nursing (7) had commented upon the variety and lack of standardisation in courses offered at post-basic level for nurses but it was not until 1966 that the Standing Nursing Advisory Committee of the Central Health Services Council commented unfavourably upon the provision of post registration training and discussions began between the Department of Health and Social Security and the medical and nursing professions.

(ii) Powers, constitution and financial resources. The remit of the JBCNS is:

To consider and advise the needs of nurses and midwives for post certificate clinical training in specialist departments of the hospital service in England and Wales and to co-ordinate and supervise courses provided as a result of such advice and to discharge such other functions as the Secretary of State may assign to them.

These powers were extended to provide for courses for nurses in the community three years after inception of the JBCNS. (8)

The Board has 35 members all appointed by the Government Department after consultation with the Royal Colleges of Nursing, Midwives, Physicians, Surgeons, Obstetricians and Gynaecologists. The first Chairman was a well known surgeon but the chair at present is occupied by a nurse, Baroness Macfarlane of Llandaff. In the early years the Chief Nursing Officer of the Department of Health and Social Security was a member.

The administrative costs of the Board are met by the Department of Health and Social Security although initially, in the first three years, the King Edward Hospital Fund for London and The Nuffield Provincial Hospitals Trust made substantial contributions, the balance being met by the Government Department.

(iii) Form of administration. The business of the JBCNS is conducted by a Director, a qualified nurse supported by professional, administrative and office staff.

3. The Royal College of Nursing (RCN) is the largest body catering solely for nurses in the United Kingdom.

(i) Background to formation. The RCN was set up in 1916 with the original objective:

- (a) To promote the better education and training of nurses and the advance of nursing as a profession in all or any of its branches
- (b) To promote uniformity of curricula

- (c) To make and retain a register of persons to whom certificates of proficiency or of training and proficiency had been granted
- (d) To recognise approved nursing schools
- (e) To promote Bills of Parliament for any object connected with the interest of the nursing profession and in particular nurse education, organisation, protection or their recognition by the State. (9)

Although as a result of the establishment of the General Nursing Council the RCN did not become a registering body, it did continue with the provision of education for certain special areas, notably for nurse teachers, and administrators, as one of its activities. One of the qualifications still provided by the College which offers an opportunity for contrast with those already described is that for Occupational Health Nurses. The qualification was first offered in 1934 at a time when the growth of health departments within the major industries was creating a demand for nurses to staff the new departments. (10)

(ii) Powers, constitution and financial resources. The RCN issues a statement on its responsibilities in relation to the granting of certificates:

The Royal College of Nursing of the United Kingdom is empowered by its Royal Charter to be a certificate granting body. Its responsibilities are:

- (a) to set a syllabus for post registration courses;
- (b) to appraise and approve courses in other colleges wishing to prepare for its certificates;
- (c) to advise as required;
- (d) to examine and award certificates. (11)

The RCN is governed by a Council consisting of 44 members who are elected representatives of the membership and with a Chairman elected from among these members.

The income of the RCN is derived mainly from membership subscription? The Department of Education and Science make a grant towards the operation of the Institute of Advanced Nursing Education (IANE)

which is concerned with the educational activities of the RCN.

The Occupational Health Nursing Certificate is administered within the IANE. Students pay fees for courses at the IANE and colleges seeking approval for an external course pay a fee currently (1979) of £150 and a renewal fee of £100.

(iii) Form of administration. The overall business of the RCN is conducted by a General Secretary who is the Chief Executive Officer of the Council and who is a qualified nurse. There are 5 Chief Officers with major functions of which the Director of Education is one. The IANE, of which the Director is head, occupies premises in the headquarters of the RCN and has additional premises in Birmingham. There is a United Kingdom Education Committee covering the work of the IANE and a special committee exists for the approval of External Courses.

#### 4. The Royal Society of Health (RSH)

(i) Background to formation. The RSH, originally called the Royal Sanitary Institute was established in 1876 to promote the health of the people and instituted an examination for health visitors and school nurses in 1908. (12) Following the institution of a new health visitors certificate in 1925 the RSH became the statutory examination body for health visitors in England and Wales, a responsibility which it retained until 1962 when the Council was established.

This body is included in the group of qualifying associations in this context in view of its place in the history of the health visitor qualification outlined in Chapter 3. The formation and early policies of the Council can be seen as a reaction to some aspects of the organisation of health visitor training which existed in 1962.

(ii) Powers, constitution and finance. The RSH acted on behalf of the Minister of Health for the examination of health visitors, by laying down

a syllabus, approving the training syllabus in the first instance submitted by training schools and conducting the examination. Fees were charged for the examination. The main governing body of the RSH was its council composed of elected members of the Society. The membership was diverse, representing a considerable number of forms of work in the health services; it was, however, predominantly representative of medical officers of health and public health inspectors. (13) A sub-committee, the Health Visitors Training and Examination Committee was responsible to the Council for the regulation of the health visitor examination. In addition to the members of the Council on the committee a number of members were co-opted, eight representing training schools and two representing the professional organisations. Two members of the central government department also attended as observers, one medical officer and one nursing officer. (iii) Form of administration. The administrative staff of the Society is headed by a Secretary who conducts the business of the organisation in general. The organisation of the examinations was in the hands of an examination department which was responsible for a number of other qualifications awarded by the RSH. The department did not have a health visitor on its staff.

Some of the similarities illustrated in the above categories raise questions concerning the origins of the qualifying association. For example, why are there so many? Separate organisations for the constituent countries of the United Kingdom may be expected since legislative and administrative provisions may differ, but if by 1962, as indicated in Chapter 3, most health visitors were registered nurses the necessity for another new body may be questioned. Two possible alternatives might have been either the extension of the powers of the GNC

or some revision of the system operated by the RSH. According to the Jameson Committee (1956) the existing body, that is the RSH, was providing what was on the whole an acceptable service. (14) A similar question can be asked concerning the remit of the JBCNS extended in 1971 to include courses for nurses in the community.

The overriding question is why are qualifying associations formed? Millerson (1964) suggests five reasons for the formation of qualifying associations, four of which are pertinent to the discussion:

- (a) a search for status
- (b) generation from existing associations
- (c) to co-ordinate the activities of existing practitioners
- (d) as a response to entirely new developments.

If these reasons are accepted then the dates given for the institution of the four categories are significant. As an example of his first reason, Millerson gives the Chartered Society of Physiotherapy founded in 1894. (15) The circumstances appear to resemble those advanced for the establishment of a GNC, that is the presence in the work force of persons of widely differing ability and therefore the need to establish acceptable standards of competence. The available literature on the origins of registration of nurses in this country is considerable. Bendall and Raybould (1969) have written on the History of the GNC, Abel-Smith (1960) has studied the history of nursing. Biographies of key figures such as those of Florence Nightingale and Mrs Bedfore Fenwick and occasional papers and articles in which the development of nursing is set in its social context such as Pomeranz (1973) (16) and the series by Maggs (1978) (17) and Davies (1978) (18) in the Nursing Times among many others. Abel-Smith suggests that the search for status was related to the entry of the "lady pupils" and was an expression of the search for

status of that group. This, however, can be an over simplification and the legislation which established registration of nurses should be seen as the outcome of what Maggs describes as the general debate between 1890 and 1920 on women "their social roles, their biological and psychological nature and their work roles". This debate reached a proportion not attained again until the late 1960s. (19)

The climate in 1919 can be said to be ripe for the establishment of a registering body for what was at that time primarily a woman's occupation, which raises the question, was the climate ripe for the establishment of the Council in 1962? There are some parallels. The contribution of the health visitor to the community health services was being affected by the development of other workers whose function impinged on that traditionally undertaken by the health visitor. The boundaries of her specific function were blurred and the employment of other nurses without qualification as health visitors added to the lack of clarity. The Jameson Committee referred to the numbers of nurses so employed in their report. (20) As well as the need to reduce the number of unqualified health visitors there was the pressure to reduce the number of unqualified social workers in the health and welfare services. The Younghusband Committee (1959) had recommended the establishment of a national qualification. (21) The institution of a joint Council to regulate and promote training for both workers could be seen as an administratively convenient answer to both reports. Linking the health visitors with the social workers in training avoided the need to embark upon a debate on the relationship of health visiting to nursing which would have followed any proposal to place health visitor training within the ambit of the GNC. The impact of conflicting views held by the Royal College of Nursing and the Health Visitors Association are

discussed at greater length in Chapter 7. Progress on a closer relationship was unlikely in 1962.

The establishment of the Council in 1962 was therefore associated in part with the health visitors effort to establish an identity but was in part also a response to the need to standardise training for a separate profession - that of social work. This association with another discipline is one of the unique features of the Council when compared with the other qualifying associations in nursing. The two new Councils in 1962, the Council for the Training of Health Visitors and the Council for Training in Social Work are examples of the third of the causes for the formation of a qualifying association as set out by Millerson - that is to co-ordinate the activities of existing practitioners.

The remit of the JBCNS indicates another example of co-ordination of existing practitioners. What is not at first clear is why a new body should have been thought necessary - the GNC is responsible for the registration and enrolment of nurses and for setting standards for training. Increasing specialisation in medicine has led, however, to an increasing number of short courses of a practical nature in the nursing of conditions for which new techniques are needed. The immediate purpose of the JBCNS therefore is clear; to provide some common standards to which post registration courses are expected to conform. What is not clear is why the powers of the GNC were not extended in 1968 to meet the need and why in 1971 with a committee in process of discussing future plans for the nursing service and training, the Briggs Committee, the remit of the JBCNS was extended to include courses for nurses in the community. For the latter, two bodies were already in

existence, the Council and the Panel of Assessors, a body which advises the Secretary of State for Health and Social Services on district nurse training. The latter body is also responsible for examination and the national qualification. In Chapter 8 reference is made to the failure to reach agreement on a common approach to the training of health visitor and district nurse.

That the division between health visitors and district nurses was serious is indicated in the decision in the main professional organisation, the RCN, to provide separate sections within the membership structure for health visitors and district nurses in 1972. Davies (1978) suggests that early problems in establishing the authority of the GNC arose from disagreements within the profession on the criteria for registration so that the GNC was overridden by the Ministry of Health and "nurses had paid the price for their disunity". (22) A similar explanation of the decision to use the JBCNS for certain aspects of work in the community nursing services may be the answer to the extension of the responsibilities of the JBCNS.

Disagreements among the professional organisations are time wasting even if eventually resolved by the intervention of a Minister. A body more directly linked with the Government Department in the first place may seem to offer more prospects for speedy action. The constitution and powers of the JBCNS offer a contrast to both the Council and the GNC. The JBCNS has no statutory duty, and is the creation of a Government Department although as described above it was financed in part from non-governmental funds in its first three years. The Department appoints the members, one of whom in the first three years was the Chief Nursing Officer of the Department. The Department still have a nurse representative as a member. In contrast, the Council does not have

direct membership from the professional staff of the nursing division. In the absence of strong pressure from the profession for a separate body concerned with all aspects of training for nursing in the community and with the growing concern that all aspects of the provision of health care should be covered in training programmes the use of the JBCNS is not unreasonable.

There is no available evidence that the creation of the JBCNS was a conscious rejection of an extension of powers of the GNC. The latter would have required new legislation which can take considerable time to achieve. The official history of the GNC does not record any discussions on the possibility although the JBCNS was formed during the period covered by the history. Nor is there any evidence that the extension of remit in 1971 was directly associated with the failure to make progress on associating the Council more closely with the Panel of Assessors as promised in 1969. (24) It is only possible to make assumptions.

Comment on the formation of the JBCNS and its remit raises questions on the degree of actual authority exercised by the various bodies. Both the Council and the GNC make rules regarding the approval of training schools and on the qualifications required of candidates for training. The distinction between the two bodies is that there is an appeal system built into the legislation concerning the GNC.

Any person aggrieved by the refusal of the Council to approve an institution ... may appeal to the permanent secretary of the Lord Chancellor ... two persons will be nominated (who) shall give such direction therein to the Council as they think proper and the Council shall comply with them. (25)

Examples exist of successful appeals against the GNC. (26) There is no similar provision in the Health Visitor and Social Work (Training) Act 1962. The rules made by both bodies have to be approved by the

Health Ministers. Since the student nurses are part of the staff establishment of the hospital and the Ministers are responsible for the maintenance of the hospitals they can be expected to look critically on any rule which might appear to reduce the numbers of students entering training. An example is the effort of the GNC to introduce educational entrance requirements. Bendall and Raybould (1969) quote a period of 16 years during which the GNC attempted to get agreement to the introduction of a minimum entry requirement. It was not until 1961 that such agreement was finally achieved. (27)

In considering the difference between the two bodies, GNC and Council, two factors are significant, in 1962, health visitor students were freer of service responsibilities than the nurse in training and the Council has the responsibility not shared by the GNC of attracting candidates to training. If therefore the Council produced rules which might be thought to reduce the number of applicants, this could be balanced by vigorous recruitment campaigns. The graph at Appendix C shows the initial fall in recruitment following the introduction of the Council's new training programme and, the rise in numbers as the recruitment schemes got under way.

Another factor possibly contributing to the Council's freedom of action is the presence of another government department in the training scene, the Department of Education and Science. Although it is to be expected that expansion of training in the public sector of education must conform to overall plans for a particular area, the relationship between student members and staff requirements will be only one factor in making decisions on the provision of educational facilities.

An example of a qualifying association not constrained by service requirements either during or after training is the RCN. This body

makes its own rules, selects its own students who may, or may not, be members of the RCN and determines the content of the syllabus and the form of the examination. It therefore appears to exercise considerable power. Such authority, however, must be set against the field in which it operates. At present there is no national occupational health service. The RCN in their document setting out the case for such a service quote figures from "The Way Ahead" which show that in manufacturing industry, non manufacturing industry and all industry the percentage of firms with medical and/or nursing staff are 12.2%, 4.5% and 5.7% respectively. (28) One of the propositions upon which this study is based is:

That the progress, development and authority of a qualification established by statute will be promoted or inhibited as much by the employment available to the trainees on completion of training as by the actual powers of the Act.

If a national occupational health service is established as the responsibility of a government department it can be assumed that the service will conform to patterns laid down by that department and the degree of freedom at present exercised by the RCN could diminish.

In deciding upon a framework of discussion, the powers, constitution and financial resources of a qualifying association are linked together. The powers possessed by the body will be affected by the composition of the body exercising these powers and by the financial resources available for the implementation of its policy. Millerson (1964) in his discussion of the structure of qualifying associations concentrates on bodies governed by a Council of elected members. Of the four examples chosen here for comparison with the Council, the two which would come within such a category are the RCN and RSH. The GNC is composed of elected and appointed members and the JBCNS is entirely appointed as is the Council.

Two questions arise. Does a Council composed of elected members give greater autonomy to the association concerned and does election produce a governing body more representative of the profession concerned? The Briggs Committee (1972) considering the creation of a new qualifying association for nursing considered the advantages and disadvantages of an elected body pointing out that the advantages of involving the rank and file of nurses more closely in the government of their profession may be more apparent than real when the candidates are unknown to the majority of the voters. (29) The Committee decided that there were advantages in an elected element with safeguards to ensure representation of small groups. The Merrison Committee (1975) considering the future of the General Medical Council recommended a tripartite membership, part elected, part nominated and part appointed. The Committee comment further on the place of representatives of the government department:

The general principle to which we are attached ... postulates an over-riding need for the separation of the setting of standards from the provision of services. We regard the latter as sufficiently important to require that the participation of Departmental representatives should be on an assessor or observer basis. (30)

Both the committees are agreed that there should be some elected element. When the Council was established in 1962 there was no register of health visitors so election would have been difficult but there is no evidence that election was considered. A similar position obtains for the JBCNS. It is suggested in Chapter 7 that a subtle change in the emphasis in the policies adopted by the Council is associated with changes in the composition of the Council following one of the periodic reappointments of members. The RSH although an independent body with an elected Council acted as an agent in the award of a statutorily required certificate and was therefore subject to

influence by the Government Department.

The second question relates to the extent to which an elected body may or may not be representative of the profession concerned. The possible disadvantages of election as seen by the Briggs Committee are quoted above. The Health Visitor and Social Work (Training) Act 1962 sets out in the first schedule the types of organisation to be consulted by the Health Ministers in making appointments to the Council but phrases can be imprecise and "associations appearing to the Health Ministers as representing health visitors" is subject to different interpretations. The degree then of authority which the Council possesses by means of its powers of approval of courses which appears to offer a greater degree of autonomy than that possessed by the GNC is in reality also susceptible to influence from without the Council. It can be argued that the RCN appears the body with the greatest degree of independence but this is to some extent attributed to the qualification which is not one for a national service at present nor are employers required to appoint only staff with the RCN's certificate.

The chairmanship of the governing body is also of importance in the constitution of a qualifying association. The GNC, RCN and RSH all have chairmen elected by the governing body of the organisation. Under the Health Visitor and Social Work (Training) Act 1962 the chairman is appointed by the Privy Council, that of the Joint Board is appointed by the Health Ministers. Writing of chairmen in advisory committees in education, Kogan and Packwood (1975) refer to the chairmen of public bodies suggesting that if appointed they are likely to exercise more initiative and authority since:

They are accountable for ensuring that recommendations or decisions are made and also for representing those statements to the appointee. (31)

The Merrison Committee consider the chairman should be elected, the Briggs Committee made no specific recommendation. The Chairmen of the Council of the JBCNS have not necessarily been members of the profession though the present holder of that office in the JBCNS is a nurse as described above. The comments by Kogan and Packwood (1975) are pertinent when they refer to the need for the chairman of a committee on which they are commenting to:

Be a public figure near enough to education to know its problems and not frighten its practitioners but distanced enough ... to be authoratative about dealing with government and witnesses. (32)

The three chairmen of the Council in the period under study can all be described as public figures, Lord Wolfenden, Lord Morris and Sir John Butterfield and all were vice-chancellors of universities at the time of their appointment. The significance of the Council's relationship to the Council for Training in Social Work should be noted respecting these appointments. First, as indicated in Chapter 3, health visitors had become uneasy about the development of social workers and their impact on the sphere of work of the health visitor, the linking of the two training bodies could be expected to be more harmonious if the joint chairman was not directly associated with either field of work. Secondly, the choice of the first two chairmen represented a departure for health visitors from the influence of medicine on nursing. That the choice was relevant to the association with the Council for Training in Social Work appears to be borne out by the choice of the third chairman who, although a vice-chancellor, was also a well known physician. This appointment was made in 1971 when each Council was given its own chairman, and can be assumed to relate to a closer association with nursing in general in the reorganisation of the National Health Service

proposed for 1974.

Reference is made to the effect of reorganisation on the activities of the Council in Chapter 2 and this will be discussed at greater length in Chapter 8 when the relationship of a qualifying body to the employment available to the holders of the qualification is considered. An account of the Council's activities indicates the problems encountered by a qualifying association charged with a responsibility for establishing and maintaining standards but without resources to provide training for the trainees. In considering the contrast between the examples chosen in this chapter a distinction must be made between the finance required for the provision of courses and support for students and that required for the day-to-day running of the organisation concerned.

All the students preparing for qualifications awarded by the organisations given as examples receive support in some measure from current or future employers during training. The degree to which such support depends upon service either during or after training varies. In pre registration training the training is carried out within an employment situation and attention is drawn above to the constraints this can place upon the qualifying association and its policies on standards. The Council appears to have been less inhibited in the demands it was able to make for a pre entry educational standard. On the other hand Wilkie (1979) draws attention to the difficulties encountered when the Council tried to obtain more tutors and fieldwork teachers in implementing its new training programme. (38)

In the resources for day-to-day running of the bodies, there is considerable variation, the RCN and RSH have income through membership fees apart from examination and, in the case of the RCN, tuition fees.

The JBCNS and the Council are dependent upon funds agreed with the central government department. The GNC has some independent income from registration fees and other sources as set out above.

An illustration of the different approaches to bodies charged with training responsibilities is that of the resources granted for research. The Health Visitor and Social Work (Training) Act 1962 Section 2 (1)(d) gives the Council power to carry out research or to promote it in other bodies.

Despite this section in the Act, some entered in the proposed budget were not approved and the Council therefore developed a policy of stimulating projects in other organisations and supporting their submission for funds rather than of directly embarking on research. An example of such a project is the study of the Nursing Team in General Practice. (39) In the case of the GNC, the Minister of Health in 1967 agreed to consider the setting up of a research unit and this has been achieved. The JBCNS also has a research officer and a small unit. Wilkie (1979) suggests that a joint unit established jointly with the Council for Training in Social Work might have been successful but there is no evidence that such co-operation would have been possible in the early years of the life of the two Councils. (40)

Control therefore is exercised by the central government departments upon qualifying associations. What is not always clear is the basis for the decision, as, for example, in the case of research when two bodies, one with and one without statutory power, are granted research facilities and another body with statutory responsibilities is not given the same facilities.

A point of contrast between the RSH and its successor, the Council, was the nature of the staff. Millerson (1964) refers to the:

Most important element in the birth and growth of any association is the presence or absence of suitable enthusiastic organisers. (41)

With the coming of the Council, health visitors for the first time had organisers from their own ranks in the central organisation. Whole time professional staff can have considerable power in the shaping of policies. This is particularly so where the governing body is composed of representatives of different interests, all in whole time employment. Commenting upon the Council for Training in Social Work, Forder and Kay refer to an aspect of this topic; that qualified whole time staff accountable to a body of part time members are in a position of considerable strength. (42)

The importance of professionally qualified staff is indicated above but when the Council is compared with the other nursing organisations it will be seen that the GNC, RCN and JBCNS all have a nurse as chief officer. The fact that the Council was established with the Council for Training in Social Work could result in a problem if a chief officer was appointed to serve both Councils and who came from either discipline. Accordingly a layman was appointed as Joint Secretary. Such a situation in which Joint Secretary and Chief Professional Adviser were each responsible to the Council but neither was in authority over the other could create tension and when the Council separated in 1974 a professionally qualified Director was appointed as the chief executive officer.

The qualifying associations in nursing with which the Council is compared have all been established at different periods and show the effect of that period on their terms of reference. All exist to provide a certificate of competence to practice in a general or special area. No association is completely independent financially and this

has a bearing on the powers the body can exercise despite the responsibilities set out in terms of reference or by statute. The body with the greatest apparent independence seems to be the RCN and it could be argued therefore that professional organisations are in the most favourable position to forward progress in nursing education. It should be noted, however, that the RCN is pressing at present that the qualification of Occupational Health Nurse should become required by statute. Carr-Saunders and Wilson (1938) point out:

The intervention of the State and the setting up of a register have profound effects ... when a professional association is employed in the mechanism of regulation it becomes an organ of the State and however powerful it may be it loses freedom. (43)

Comparing the Council with the other examples of qualifying associations in nursing the Council is seen to have considerable powers according to the Act but these were not accompanied by financial provision other than for the administration of the Council's business; it was expected to utilise existing resources. This expectation has had advantages by encouraging the use of facilities in the mainstream of further and higher education.

The constitution of the Council consisting as it does of appointed rather than elected members should ensure that a variety of expertise from different regions of the UK is available for the determination of Council policy. In practice the system has left the Council vulnerable when on occasion, as shown in Chapter 2, selection of members within the government department has resulted in a disproportionate representation of some interests. The Council appears to have derived considerable advantage from its association with the Council for Training in Social Work in its early stages. Reference is made above to the significance of the chairman as independent of medicine and a feature of the Council

has been the co-operation between colleagues from medicine and education in the design of the new training rather than the domination by one discipline.

CHAPTER 6

The Educational Setting 1962-1974

The statement is made in Education and the Professions of the very strong link between education and the professions:

The educational system affects the professions in turn the professions affect the educational system. (1)

The Council is required by the Health Visitor and Social Work (Training) Act 1962 to:

Secure suitable facilities for ... the training of health visitors by approving courses ... to make provision for further training for health visitors; if necessary and to conduct or arrange for the conduct of examinations.

The Council is not provided with funds for the provision of courses and therefore uses the resources already available in the mainstream of education. In this chapter the relationship between resources and the policies of the Council, an organisation providing a professional qualification, is explored.

The year 1956 was significant to health visitors because of the publication of the Jameson Report (2) was also a year of considerable significance in the field of technical education with the publication of a White Paper "Technical Education". (3) There were a number of reasons for the growing concern for provision of further education. There had been an increase in the numbers of children leaving school with certificates appropriate for further education, e.g. in 1938 only about 3% of those aged 19 were having full time education as compared with 1962 when the figure had risen to 7% nearly all in higher education. (4) The recent war had emphasised the need for a higher degree of technical education in the population, a feature not confined to the UK (Vaisey). (5) There was also a climate of opinion in some political groups that

educational opportunity might be one means of achieving equality, e.g. Kogan writing in the Politics of Education comments on the views of Anthony Crosland, later Minister of Education. (6)

The White Paper, Technical Education (1956), surveyed the provision of technical education in terms of national need and as a result increased expenditure was advocated and the establishment of Colleges of Advanced Technology. Perhaps most significant for the context in which the Council would operate was the attention drawn to the need to avoid a narrow approach to technical education by including such subjects as economics, business management, wage systems and human relations. Emphasis was also given to the need to develop liberal studies in technical courses, in other words, the courses were to provide a general as well as a specialist education. The effects therefore, particularly important to this study, were considerable increases in accommodation and the expansion of teaching staff equipped to deal with the wider aspects of education.

By 1962 when the Council was established there was therefore a considerable variety of facilities available including Colleges of Advanced Technology, regional colleges offering full and part time courses at advanced level, area colleges, colleges of commerce in which some advanced level courses were being offered and local colleges largely concerned in training junior technicians and in providing general education. In addition to the material resources there was in 1962 a favourable climate in which to explore the possibility of developing health visitor training. Writing in the Politics of Education, Kogan refers to the economic atmosphere of 1962 as "one of most remarkable buoyancy which prevailed over most of 1962, 63 and part of 1964. Whatever the difficulties encountered by the Chancellor, the Minister of

Education was able to benefit from the general policies of expansion! (7) Revision of health visitor training therefore began in 1962 at a period of growth and optimism.

Two features of the educational context which were to have significance for the policies adopted by the Council were the (1) challenge being made to existing systems of accreditation and the (2) development of new institutions such as the Open University and the Council for National Academic Awards.

1. The Challenge to systems of accreditation

The Council as a body charged with a responsibility to establish standards of professional competence for health visitors was concerned with two forms of accreditation. First a system of assessment of student competence had to be devised to replace the original examination pattern which differed in England and Scotland. Secondly, criteria had to be established upon which to grant approval to educational institutions as suitable for the provision of health visitor courses.

(a) The Assessment of student competence. In many cases there was a lack of definition of what the practitioner should be able "to do" as a result of his course. Beard (1970) suggests that:

No professional body in England has yet systematically analysed the skills, information and attitudes it requires. (8)

Carter (1972) comments:

Some kinds of examinations and assessments test the ability to analyse a problem, originality in devising solutions, ability to see what is important, endurance, stamina and other mental qualities. It is seldom, however, just what connexion is perceived between the qualities tested and those thought desirable in later life. (9)

Brosan (1972) on the same topic writes:

Few syllabuses state in any form what a student should be able to do at the end of the course. They state what he should know, they state in some cases what he must understand but fail to specify what he must do to demonstrate that understanding. (10)

While these demands for greater precision were being made during the period under review, relating both to the University (Beard) and the Polytechnic (Brosan), there was questioning by students and some lecturers mainly in the departments in which the behavioural sciences were taught, of the whole system of periodic and final examinations. Burgess comments, "students very often scorn the examination commonly met with in post school education and question their validity. But none of these criticisms can alter the need for the student to be accountable for what he has done." (11) The problem therefore is how to assess professional competence in a specific case which implies examination of skill as well as factual knowledge.

A traditional method of examination includes papers written in answer to questions, essays and viva voce examinations. Two other options were being debated during the early life of the Council and used in some instances. The first was a system of continuous assessment throughout the course, the marks being accumulated to form the final assessment along with reports of progress in any practical work. In complete contrast was the system which was gaining acceptance in medicine in which the candidate was presented with a range of possible answers to a question and was required to identify the correct response. This system of multiple choice questions was favoured in the United States of America, and was under discussion in the General Nursing Council in England. (12) Claims were made that a wide variety of topics, including those which required a quality of judgement as well as purely factual

knowledge, could be incorporated in the question papers. The advantage of the system was that it would appear to eliminate bias upon the part of the examiner who would mark the numbers of correct responses according to a scheme agreed in advance.

The Council considered the advantages and disadvantages of the system at some of the annual meetings of its external examiners. An example is that of the meeting in 1968 when Mr MacFarlane Smith, then head of the Inner London Education Authority Research Unit in Further Education, presented a paper on the topic. (13) Two aspects of the system appeared to militate against its adoption by the Council. First compilation of the questions is complex and time consuming, secondly the amount of money and effort devoted to such compilation would only be economic if the questions could be used by all training schools over the country. The introduction of a "bank" of questions to be obtained from the Council headquarters which would render the scheme more economic, would infringe the autonomy of the individual training schools to which responsibility was delegated by the Council's examination procedure.

A scheme of continuous assessment by which the student is assessed at intervals throughout the course and appropriate grades given would seem to lessen the tension associated with a major final examination and assist the student to monitor her own progress during the year of the course. For the Council as a qualifying body with a statutory responsibility to award a national certificate, the system presents problems. In some colleges, however, the system was already in operation in other disciplines and late in the period studied in this thesis the Council accepted some examination schemes which incorporated continuous assessment for part of the Examination and since 1974 has

issued guidance to external examiners accordingly. (14)

The pattern of examination in use in 1962 was affected by contact with other methods of assessment in the field of education in which courses were being established. Bloom's (1956) taxonomy offers a classification of features which should be demonstrated in any assessment system: (15)

- (a) Knowledge, terminology, facts, methods and principles
- (b) Comprehension, interpreting, extrapolating, determining consequences
- (c) Application, general ideas, rules, procedures
- (d) Analysis, reducing the parts and understanding their relationships, detecting unstated assumptions, distinguishing fact from opinion, recognising form and pattern
- (e) Synthesis, communicating and planning, testing and deduction
- (f) Evaluation, judgement of values and methods.

If it is accepted that these features should be present then a variety of assessment procedures are required.

In Education Strategies for the Health Professions (16), a series of steps are given by which a pattern of examination may be worked out.

These are to:

Consider the purpose of the examination

Determine what is to be examined

Determine the formal options, i.e. free or fixed responses

Develop a scoring system

Set standards for either (i) a normative standard in which the individual is assessed in comparison with all the others taking the exam or (ii) a standard of criteria adequacy in relation to an absolute standard set before the examination is administered.

The first step, that of considering the purpose of the examination, appears obvious but is nevertheless one of the most difficult. The Council with a responsibility for establishing a national standard which all certificate holders could be expected to have attained had to decide if the certificate simply represented a licence to practise or if it implied that the candidate had demonstrated the capacities listed by Bloom in his taxonomy.

(b) Criteria upon which to grant approval of training institutions.

The problems encountered in establishing criteria for the approval of institutions as suitable for a specific professional qualification differ from those applied to the assessment of the individual student. Some of the objectives applied to students may, however, indicate some of the measures against which to consider a particular college and the following questions need to be asked. Does the College have a teaching staff equipped with the necessary knowledge of the subject? Is it possible to provide field experience closely linked to the college so as to encourage the practical application of principles learned in the classroom? Is the curriculum planning such as to provide opportunities for classes of mixed disciplines? Does the environment encourage students to see their profession in relation to others in the health and social services and is there a range of extra-curricular activities which would help students to widen their interests?

Establishing criteria to be applied to the approval of educational institutions also introduces problems concerning the authority of the approving body and the effect its demands may have on the college as a whole.

Brosan quotes 5 hurdles to be cleared by a polytechnic when setting up a new course:

- (i) Administrative approval from the governing body of the college
- (ii) Academic approval - there are about 150 joint committees, examining bodies, institutions, universities (for external degrees) and the Council for Academic Awards
- (iii) Approval of buildings by the governing body and its sub committees, the local education authority and its sub committees, and several branches of the Department of Education and Science
- (iv) Approval of equipment by the same bodies as for buildings except for items over £1,000 for which separate approval had to be sought
- (v) Approval of staff establishments by the governing body and its sub committees, the local education authority and its sub committees, and for non-teaching staff, the local authority and its sub committees and in some cases the Department of Education and Science.

Such demands do not merely cause additional costs in administration and delay, they also raise questions concerning the degree of autonomy which might be appropriate to an educational institution. Brosan argues that demands made by the various qualifying associations, each with its own objectives, prevent any single philosophy developing for the institution as a whole. (17)

In considering the degree of autonomy exercised by an institution such as a polytechnic, it is pertinent to ask if the problems arise from the competing demands of a multiplicity of qualifying associations or if the varied financial resources which can be commanded are also a factor. It is also necessary to ask if the problem only arises in the public sector of education. Although the extent of university involvement in professional nursing courses is small, courses are available at certificate and degree level in a few universities and provide a useful comparison.

O'Connell (1978) describes the relationship between local health authorities and the University of Southampton in the establishment of

health visitor courses in that university in 1948. (18) Later, expansion of courses to provide for integrated nurse/health visitor courses as well as courses at degree level, proved more complex, a problem experienced by a number of course organisers. She refers to the unpublished study by the Association of Degree and Integrated Courses which found that all the early schemes had been supported by what might be described as "hidden" finances, that is that all were dependent upon association with other programmes. (19)

The greater part of the financial resources for the universities comes from public funds channelled through the University Grants Committee. Although the universities have certain freedom of decision, that freedom is affected by the decisions of the University Grants Committee. Burgess (1977) quotes as an example from a memorandum of guidance in 1967 from the University Grants Committee in which universities are urged to exercise restraint in adding to the "considerable variety of existing offerings" in the management field and also to contain the increase in social studies to those universities in which the subject was already established. (20)

Qualifying associations and educational institutions alike may have difficulty in establishing new courses due to limited independence in the deployment of financial resources. The comment of Brosan (1972) introduces another aspect of the problem of relationships between qualifying bodies and educational institutions - that there may be too many qualifying associations. That such a situation has been reached in nursing is recognised by the Committee on Nursing in their report and the consequent legislation reducing the existing nine statutory or quasi statutory associations to one body in the Nurses, Midwives and Health Visitors Act (1979). Reducing the actual numbers of

organisations involved does not necessarily diminish what can be construed as interference in the management of an institution, that is "inspection". Qualifying associations required by statute to issue a certificate of competence require assurance that comparable training standards obtain throughout the country. Such assurance may be obtained by a variety of means, one of the most common being that of inspection of the course.

Wilkie (1979) refers to the title applied to the professional staff of the Council and the interpretation put upon that title by the Chief Professional Adviser and the Council. (21) Despite the avoidance of the actual term "inspection", however, visits made by staff of a statutory body are likely to be construed as inspection and as a duplication in some cases of inspection already carried out by the Department of Education and Science. Although the universities are not subject in such a direct manner to inspection from a government department, the problem of scrutinising standards still exists. Examples may be taken from medicine and from teaching.

The McNair report (1944) recommended that the powers and duties of the then Board of Education as regards inspection should extend to the professional courses for graduates however provided, i.e. even within the universities. Niblett et al (1975) commenting on the recommendation point out that a great many principles are involved of which the first is public accountability:

It is a strongly established rule that institutions in receipt of government grant shall be open to the same kind of inspection since government is responsible to the House of Commons. (22)

The Merrison report (1975) referring to powers over institutions states:

Registration is founded on a certain standard of competence. The General Medical Council must specify this standard of competence and ensure that only the competent are placed on the register and must be able to refuse to accept that an educational body has inculcated the necessary competence. (23)

Despite the apparent autonomy of the universities, a number of checks and controls are exercised by various agencies. The Council as a qualifying association therefore has to resolve the problem of respecting the independence of the universities while ensuring that certain standards are adhered to. In the case of colleges in the public sector, the Council must recognise that an undue amount of "inspection" can be disruptive to the college concerned both in time and in the development of a coherent pattern, the colleges in the public sector being already subject to inspection by the DES and SED.

## 2. New institutions

The second feature of the period 1962-74 which was of significance to the policy of the Council on health visitor education was the institution of new bodies which offered a new route to educational achievement. These are the Council for National Academic Awards (the CNAA) and the Open University. The early professional experience of most nurses and health visitors had not included university teaching and the opportunity of achieving graduate status was particularly attractive to tutors. A further effect of the new bodies was their fresh approach to methods of teaching and assessment which influenced the thinking of the Council. An example is that of the extended courses for the health visitor certificate and the experimental course for unqualified health visitors in post in Scotland.

The CNAA was established in 1964 as a replacement for the National Council for Technological Awards following a recommendation by the

Robbins Committee. (24) In a sense the CNAA can be viewed as a further example of the move towards a broader concept of technical education begun in the fifties described above.

In 1964 there was already a well established series of external degrees offered by the University of London. Students worked for these degrees either through correspondence courses or by enrolling in one of the colleges of further education in which courses in preparation for specific degrees were offered. Such preparation, however, particularly that by correspondence had some disadvantage. Niblett et al (1975) quote the Vice Chancellor of Birmingham in his report of 1966 referring to:

The traditional meaning of a degree is that its holder has not merely passed certain examinations but has shared in the full intellectual and community life of the institution that grants it. (25)

The opportunities implicit in the system by which colleges designed the degree syllabus themselves for approval by the CNAA and the provision in the Open University system of tutorial teaching and the use of summer schools present an advance towards a more stimulating atmosphere in which to study.

By 1972 the pressure on the external degree system of London University was such that taking into consideration the new resources for obtaining degrees it was decided that external degrees should no longer be available to students in further education. The Robbins Report comments that the system of external degrees had provided for students otherwise deprived of opportunity for educational advance but suggested that it lacks flexibility referring to "the disadvantage both for teachers and students of courses of study prescribed by Boards of Studies that have no connection with the institution in which they are to be pursued ... there can be no satisfactory substitute for examinations set

by teachers acquainted with the way in which students to be examined have been taught". (26)

The existence of the external degrees of the University of London had demonstrated over the years that it is possible to prepare for degrees outside the walls of a university and that the technical colleges in further education can in certain cases provide the necessary facilities. In doing so the colleges had gained experience in courses at this level. Such colleges embraced the opportunity of the CNAAB with enthusiasm and to do so it was necessary that they should demonstrate to the CNAAB that they were equipped in terms of staff and material resources to operate at this higher level. The CNAAB was concerned to ensure the standards were no lower than those imposed within universities. As the original widening of technical education influenced the teaching within the colleges, so the involvement of the colleges in the planning of courses to be validated by the CNAAB extended the interest and enthusiasm of the staff. This movement could be seen in a practical way. Commenting on the academic background of staff in polytechnics, Whitburn, Mealing and Cox (1976) found it noticeable that 85% of the staff teaching in degree courses had a first degree as compared with 56% of those teaching non degree courses and that staff with more than 10 years service were less likely to have a higher degree. (27) The staff entering the polytechnics therefore after the advent of the CNAAB came in with a more traditional academic background.

The introduction of the CNAAB created an enthusiasm for new development since this could be a joint exercise between college and validating body. It encouraged a greater proportion of graduate teaching staff and possibly contributed to what Burgess and Pratt (1977) describe as "academic drift", that is the tendency of institutions in the

established service tradition to seek freedom from public control and from the discipline of external validation. (28) The problems which external validation can produce for colleges are outlined by Brosan (1972) above. These problems along with the growing confidence on the part of the colleges in the design of new type courses have implications for bodies such as the Council, responsible for the award of a national certificate. The decision to delegate the examination to the colleges in the new training introduced by the Council in 1964 was in part a recognition of the new resources in education which could be deployed in health visitor training and in part a recognition of the need to ensure participation by teachers in the examination of their students referred to by the Robbins Committee above.

The Open University had a later start, i.e. 1969, and its impact from the point of view of this study is less immediate. The impact of the degree courses developing in the educational institutions and the increase in the numbers of academic staff with a growing interest in research drew the attention of existing health visitor tutors to the possibility of increasing not only their paper qualifications but also their competence to participate in academic teaching. The Open University provided a means of private study which also had the advantage of the tutorial system referred to above.

Much of the foregoing comment relates to polytechnics since they present the most dramatic and easily identified progress through the amalgamation of a group of colleges. The term "Polytechnic" is an official designation. Similar developments can be traced in other colleges in the further education system during the period under review.

The CTHV was established in 1962 at a time of considerable optimism in education. The Council's progress in the succeeding years took place in a ferment of new ideas and the development of new institutions and its policy could not be untouched by these events. The development of health visitor training has been described in Chapters 2 and 3 and a fuller account is given by Wilkie (1979). In 1962 the 29 schools exhibited a variety of organisation, universities, extra-mural departments of universities, colleges of advanced technology, technical colleges and professional associations were all represented. Several different forms of co-operation between these institutions and the local health authorities existed while in some cases the local health authority was the sole organiser.

The Council was committed to increase the number of trainees and this could only be achieved by an increase in the number of training places and a wider geographical distribution of centres for training. The existing system placed a burden upon some health authorities especially in view of the absence of any clear indication of the actual cost of mounting a course. The expenses incurred were not necessarily expressed as a separate item in the budget of the health department. The tutors were usually part of the health visitor establishment and in some cases had responsibilities for duties in the health visiting service in addition to their teaching duties. As lectures were largely provided by the staff of the authority, fees for lecture sessions were absorbed into the budget for their salaries. Local health authority premises were used to house the course. Such accommodation varied greatly in size and quality. (29) An increase in training places could be an embarrassment where accommodation was limited and the

introduction of a new syllabus which required a substantial input from the social and behavioural sciences could create problems for a staff primarily geared to the provision of a service.

The development within technical education noted above as significant in the formation of the Council's policy appeared to present possible solutions to difficulties encountered by the health authorities. Some colleges already had staff able to undertake the teaching. Some of the facilities in further education in the early years of the Council might not seem ideal. The formation of new institutions by the grouping of existing colleges which might be distributed over a wide geographical area presented problems in the development of a sense of common purpose in the new institutions. The premises of the component colleges might require up-grading to their new use but the spirit of optimism to which Kogan refers above encouraged the Council to pursue the establishment of more health visitor training in the sphere of further education.

The polytechnics and the further education colleges had a particularly strong claim for consideration by the Council in that they could meet local needs and were orientated practically. Burgess (1977) comparing higher education in university with that in further education points out:

British Further Education has not traditionally been concerned with knowledge for its own sake or the pursuit of truth. It has been concerned with professional and vocational education, with the transmission of clearly defined skills. (30)

He goes on to comment that one major innovation in this century has been that a locally relevant course could be given national validity by

external validation. A training scheme which allows considerable flexibility to meet local needs and resources with external assessment led the Council to design a syllabus in sufficiently broad terms to ensure that not only would it be able to accommodate new developments in succeeding years, but that a straitjacket of detail might be avoided. The incorporation of new elements in the syllabus was made more readily in 1965 in that resources for teaching the behavioural sciences and facilities for course organisation were beginning to develop rapidly.

The setting of health visitor training within general education presented the Council with a conflict of goals. The prime objective was the creation of a professional training geared to current needs and pruned of extraneous material so producing a high concentration of professional expertise. In the general education setting, however, the courses would be in an environment of mixed disciplines so that the impact of "professional training" as distinct from general education would of necessity be more dilute.

In the view of the Council the advantages of placing health visitor within general education outweigh the difficulty of developing the professional skills in the new setting. The solution lies in the improving the quality of the fieldwork teaching and the introduction of fieldwork teachers. The advantages to the student of a multi-disciplinary setting are considerable. The nurse has undergone her pre registration training in a relatively closed environment in a school of nursing. With the exception of the few in the university programmes the teaching is by the nurse tutors of the school and the consultant medical staff in the area. The teaching is geared largely towards the nursing of the sick although there is provision in the GNC syllabus in

England and Scotland for observation of services in the community. In a few nurse training schools there may be some shared lectures with other groups such as students of physiotherapy, but there is little opportunity for an interdisciplinary approach to the whole training period. Theoretically the setting offered by the educational development outlined in this chapter would allow the student to enlarge the horizons of the earlier nurse training by sharing both in and out of the classroom with students from other disciplines.

Three factors require consideration if the concept of training the health visitor in an educational environment was to be successful. First there has to be sufficient common ground upon which to build a curriculum. In the change taking place in the period covered by this study, some colleges still had a high proportion of young students under 18 years and a considerable number of these were following craft rather than professional or technical courses. There was therefore little common interest between two groups so divided in age as the health visitor and the teenagers. Conversely, the interest in ever higher education levels outlined above led to the possibility in the eyes of some Directors that the polytechnics would become more akin to universities. Such a development could lead to a situation in which courses which did not demand university entrance qualifications of their students were suspect. The Council therefore had to resolve the problem of ensuring that the courses would be acceptable to that level of college which could provide the setting in which the nurse candidate could mature. Such a college was likely to offer a number of courses leading to qualifications particularly for work in the social and public services. The student body of the college would contain a proportion of adult students and there would be a range of extra-

curricular activities in which the health visitor students could meet with fellow students in common social events.

The second factor concerned the tutors. Like their students they had to be able to meet with teaching colleagues from other disciplines on common ground yet these colleagues had a different and in some cases a much more academic background. Although the Council might insist that courses could only be approved with a specified complement of tutors whose names appeared on a list maintained by the Council, the qualification required for entry on this list was a teaching certificate, usually of a professional nature. Before 1962 few tutors had had the opportunity of a more academic preparation. This lack created some insecurity in a number of the tutors who consequently did not feel able to mix freely with new colleagues who had a different background. The institution of the Open University was of particular interest at this time and many of the tutors registered as undergraduates when these facilities became available. This widening of their academic background led to their participation in the teaching in other related courses in the colleges and consequently a considerable increase in the numbers of tutors was required. There is a danger of thus diluting the "professional" as distinct from the "educational" contribution of the tutor to health visitor training. This shift in professional direction had the additional effect of possibly detaching this group of nurses yet further from nursing in general, a feature explored in Chapter 7.

Thirdly, groups of teachers and students must be prepared to work with each other if there is to be a practical outcome of the common sharing of college resources. There is little to be expected from simply putting groups together and relying on the students to find the

answers. The fact that the Council was established along with the Council for Training in Social Work with shared resources and using the same educational facilities in the colleges, would, in theory, have provided for a joint approach. There were certain obvious difficulties, e.g. the courses were of different length, that for health visitors covering a calendar year and that for social workers lasting for two years. The health visitor students in the early years were a little older than those in social work as they had already acquired a professional qualification and, in addition, many had considerable post registration experience. More important, however, than these practical difficulties was the failure to identify the common ground between workers preparing for the health and welfare services albeit from different origins.

The setting up of a Joint Advisory Committee described in Chapter 2 served to illuminate the differing philosophy behind the two trainings but did not succeed in resolving the differences. The objectives of the two Councils were not the same. The Social Work Council had to set about creating a new training ~~body~~ and in their efforts to identify the knowledge and skills to be developed in the new workers had to concentrate their thinking on social work. Any sharing of concepts with another training body at that early stage could have been interpreted as a dilution of the concentration required to identify the essential features of training the social worker. The Council on the other hand had to achieve a break with a long established and inflexible system of training at one and the same time extending the number of training places and encouraging a larger recruitment. The problems thus generated were the outward signs of a deeper unease with its roots in the reports of the two committees which were the genesis of the Council, the Jameson

Report (31) and the Younghusband Report. (32)

The educational setting within which health visitor training was to be carried out increasingly after 1964 had four major effects:

- (i) The Council, pursuing the policy of a more broadly based training for the health visitor saw the possibilities in the developing colleges of further education and accelerated the move from a purely professional setting to the mainstream of higher and further education
- (ii) The design of syllabus and examination was influenced by the need to allow more scope to individual colleges
- (iii) The relationship between a body charged with statutory responsibility for a specific professional qualification and the institutions in which training is provided was brought into focus
- (iv) The teachers of health visitors were faced with a comparison of their academic preparation with that of new colleagues. They also had to consider their possible involvement with other disciplines.

The following chapter discusses the relevance of health visiting to nursing in general and questions the apparent tacit assumption that health visitors are nurses in the accepted sense. It can be argued that the change of venue for health visitor courses from that of the local health authorities to educational institutions contributed to a widening of the gap between the two sections of the profession.

CHAPTER 7

The relationship of health visiting to nursing : the implications of professional disunity for the Council as a qualifying association

This case study of the CEHV examines four propositions, the third of which concerns health visiting as part of the nursing profession and the relevance of that position to the activities and policies of the Council. Two features are discussed in this context:

- A. The classification of the health visitor as a nurse
- B. The changing structure of the nursing profession within the period under consideration.

A. The classification of the health visitor as a nurse

The inclusion of health visiting within nursing raises problems. Apart from a statement made by the Council in 1965, there is no official definition of the health visitor as a nurse. The statutory instrument (1) which defined the health visitor in 1948 incorporated the earlier statutory rules and orders (1930 No.69) passed following the Local Government Act of 1929. In these the only descriptive term was that of "a woman", the word nurse was not used. The only alteration to this early definition was made in 1972 when the word "woman" was replaced by "person". This was the change which allowed the Council to award the health visitor certificate to men. (2)

Despite the omission of the term nurse from the definition there appears to have been a tacit assumption that health visitors were part of the nursing services provided by local health authorities prior to 1974. (3) Two committees established to consider nursing, the Woods Committee (1947) (4) and the Briggs Committee (1972) (5) included health visiting in their deliberations. A further instance of this tacit

assumption that nursing included health visiting is found in the remit of the Briggs Committee which reads:

To review the role of the nurse and the midwife in the hospital and the community and the training required for that role, so that the best use is made of available manpower to meet present needs and the needs of an integrated service. (6)

The title health visitor and the training required by statute are not mentioned, although later in the Report in the chapter on nurses midwives and the public, health visitors are included among the workers in the community services who are regarded as "nurses". (7)

Two principal organisations are recognised in negotiations on salaries and conditions of service for health visitors although a few health visitors might have belonged to the National Association of Local Government Officers when the service was administered by local health authorities. The main organisations are the Health Visitors Association, formerly the Women Public Health Officers Association established in 1895. (8) The Association is largely concerned with health visitors in England, Wales and Northern Ireland although there are links with a Scottish Health Visitors Association. The other organisation is the Royal College of Nursing established as the College of Nursing in 1916. A public health section which represented the interests of health visitors and other nurses employed in the community was set up in 1923. (9)

Fredson suggests that:

The broadest and most general use of the word profession is built upon the distinction between profession and amateur ... performing market related labour for one's living is one's professional vocation while professional labour unconnected with a market is one's amateur avocation. (10)

The change from amateur to professional in the sense of Freidson's distinction was taking place in health visiting in the last half of the 19th century. Owen (1977) quotes MacQueen's view that the employment of "sanitary visitors" by the public health department of the corporation of Manchester can be interpreted as the origin of health visiting. (11) There is therefore an indication that a group of new workers was growing and that the formation of an association for their mutual benefit and support could be expected. What is significant in the present context is that the early members of the Association were probably not nurses and that the Association has maintained doubts over the nurse content of health visiting ever since. In a Manifesto published in 1970, the Health Visitors Association describes health visiting as an independent profession by which they implied one with its own particular contribution to make:

Health visiting is an independent profession, linked both to nursing and to social work but separate and essentially different from both. (12)

The Royal College of Nursing, although more committed to the health visitor as nurse, since all College members are registered or enrolled nurses, also emphasises this separation and describes the health visitor as a "practitioner in her own right" when operating in a general practice setting. (13) These statements would appear to show a measure of agreement between the two bodies but the Health Visitors Association continued to express concern over setting the health visitor too firmly within nursing. In the Manifesto quoted above they challenge the assumption of the Royal College of Nursing that health visiting is merely "an extension of, or advancement of, public health nursing".

The reservations of health visitors concerning their description as nurses may have three aspects:

- (i) The connotation of the word "nurse" for the general public
- (ii) The health visitor's own experience as a nurse
- (iii) The position of the nurse vis a vis the doctor.

(i) The connotation of the word "nurse" for the general public

In presenting evidence to the Committee on Nursing the CETHV devoted some space to a consideration of "nurse" including the term "community nurse". (14) Attention was drawn to the use of such a category in some other countries where it may refer to a field worker with "no formal preparation or professional standing".

Owen (1977) enlarges upon the difficulty of establishing a concept of nursing apart from one "in the context of hospitals" and quotes similar problems in the United States of America and Canada. (15) In an effort to clarify the particular contribution of nursing to the establishment and maintenance of health as distinct from the care of illness alone, an expert committee of the World Health Organisation using the term "public health nurse" defined this field of nursing as:

Public Health Nursing is a special field of nursing which combines the skills of nursing public health and some phases of social assistance. It functions as part of a total health programme for the promotion of health, the improvement of conditions in the social and physical environment, rehabilitation and the prevention of illness and disability. (16)

As with other attempts to arrive at a definition appropriate to work settings as diverse as those of highly developed countries, those with emergent services and those now commonly referred to as in the Third World, as a definition, it is paradoxically diffuse.

The World Health Organisation description quoted above refers to the skills of nursing but there is no specification of what these skills are

or what their especial contribution is to health visiting. The Jameson Committee commenting on the evidence presented by witnesses concerning the nursing background summarises these by suggesting that it contributes to professional experience, prestige with the public, nurses, midwives, social workers and that it enables the health visitor to seek other employment if health visiting fails her. (17) The latter gives a somewhat negative view of the significance of the nurse component of the health visitor's preparation.

The function of the nurse is susceptible to a number of different interpretations depending upon the setting within which nursing is to be practised. Some clarification is required if objectives for training are to be determined. From that clarification it should be possible to identify those elements which are important to the health visitor.

In 1962, the Royal College of Nursing published a report set up under the chairmanship of Sir Harry Platt to:

Consider the whole field of nurse education and training in the light of developments ... in reference to the part which the nurse is called upon to play in the various spheres of nursing service ... (18)

The Committee stated:

The professional preparation of the nurse must equip her to assume the responsibilities of leadership at a level appropriate to her qualifications and experience. She must be able to adopt a critical approach to her work and to adjust to changing conditions. Complex and exacting techniques have become an established part of the treatment of patients. Nurses must be capable of carrying them out and also of teaching others to do so. (19)

Statements such as that quoted above tend to concentrate upon the personal qualities which training is to develop rather than to define the actual theoretical basis upon which such training must draw.

Nursing is not alone in the use of such generalisations. Forder (1969)

states "social work is easier to describe than to define" (20) and Kogan (1971) defines the work of a general duties social worker as:

To investigate, assess and plan action to help the individual client within his family to cope with social, emotional, economic and environmental problems. (21)

While this is rather more specific than the description of the nurse it does not set out the methods by which work is actually carried out.

A much quoted definition of nursing is that produced by Henderson (1960):

The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. (22)

Neither this description nor that of the International Council of Nurses (1973) that a nurse:

... is qualified ... to provide responsible and competent professional service for the promotion of health, the prevention of illness, the care of sickness and rehabilitation" (23)

are sufficiently specific although the latter comes a little nearer to the health visitor's function if certain sections of the statement are selected. Neither description gives the underlying skills to be deployed and on which specialist training can be based.

The report of the Joint Advisory Committee of the Council and the Social Work Council is described in Chapter 2. In that document the Council states that the health visitor is a nurse. There was no common agreement between the two Councils on further action and the Health Visitor Council decided to proceed to define its own training objectives. To do so the Council had to identify the skills rather

than the generalised attributes of the nurse from which the skills of the health visitor could be developed.

It appears that an acceptable definition of the nurse as a member of a profession in which health visitors are also placed could not be found and such a lack leads to some want of clarity. The Council felt impelled to proceed to a definition of nursing skills, although not itself responsible for nurse training, in order to gain a clearer picture of the goals to be set for health visitor training. Their definition is as follows:

The health visitor is a nurse with post registration qualification who provides a continuing service to families and individuals in the community. The work has five main aspects:

1. the prevention of mental, physical and emotional ill health
2. early detection of ill health and the surveillance of high risk groups
3. recognition and identification of need and mobilisation of appropriate resources where necessary
4. health teaching
5. provision of care; this will include support during periods of stress, and advice and guidance in cases of illness as well as in the care and management of children. The health visitor is not, however, actively engaged in technical nursing procedures. (24)

(ii) The health visitor's own experience as a nurse during and after training

The health visitor's view of herself as a nurse may be coloured either by the actual work with which she was involved during her pre registration training or by the conditions under which she was expected to train. The young student may have entered training with unrealistic expectations. The Briggs Committee considering the image of the profession presented by books, magazines, television and films comments

"it is the drama and the romance which predominate", (25) but in contrast reality as Abel-Smith points out:

What is exceptional in nursing is the nature of the work : the continuous and intimate association with pain and not infrequent contact with death. (26)

The emotional stress thus engendered may be such as to encourage an escape from the hospital setting and in doing so to escape from the classification as a nurse.

Dingwall (1976) studied the progress of a health visitor course by means of participant observation. When considering the reasons given by the students for leaving hospital nursing he quotes the elaborate bureaucracy, authoritarian attitudes in senior staff, and nurse training as having constricted their personal development rather than enlarging it. Any changes which might have been made over the years were "not thought to run very deep". (27)

In addition to doubts about inter-staff relationships suggested by the above views, the material surroundings in which the nurses lived and worked may have a bearing upon the attitudes of health visitors towards their initial experience in the profession. Abel-Smith (1960) writes of the effect of inadequate resources which limited buildings and equipment as well as the "unwillingness of some senior nurses to delegate tasks which had once been done by nurses" and draws attention to the conditions in some hospitals in the post-war years. (28) Examining the position ten years later, the Briggs Committee members found similar criticisms in evidence submitted to them. (29) In addition the Committee found, when considering a greater degree of integration between the hospital and community services, that when asked about a possible return to work in hospital only 9% of nurses and midwives working in the community were prepared to contemplate doing so with a further 25% probably prepared to consider the proposal. (30)

These observations relate to the health visitor's possible view of nursing in hospital; it is also necessary to examine the view of nursing in the community as illustrated by the district nursing service. Chapter 3 of this study draws attention to the significance of the development of other nursing groups in the community such as that of domiciliary midwifery in the thirties and and of the inclusion of the provision of district nursing (called home nursing in the National Health Service Act) in the duties of local health authorities. In some areas the policy of the health authority was the use of triple duty nurses, able to carry out domiciliary midwifery, district nursing and health visiting. As there was no requirement that health visitors must be qualified in Scotland before 1965 (31) and the use of dispensations for triple duty nurses in parts of England and Wales had continued, some of these nurses were not trained as health visitors. (32) This could give health visitors the sense that the health visitor certificate was not related to the other two forms of nursing and that health visiting was only a minor branch of the profession. It can be assumed that such a situation could lead to dissension and a further repudiation of the nurse content of the health visitor's preparation.

Two features have demonstrated this dissension in the activities of the two professional associations. In 1972 the Royal College of Nursing took the decision to divide the community health section (formerly Public Health Section) into a Community Health Section and to establish a separate section for district nurses. This action was taken at a time when the moves towards an integrated health service were advanced. The reason given was the concern of district nurses that their bargaining power in national negotiations over salary was weakened by

the absence of a group identifiable as district nurses by name. (33) A direct comparison with this view may be seen in the reaction of health visitors to the report of the Committee on Nursing which replaced the designation "health visitor" with that of "family health sister" and the omission of a component in the proposed new registering body, identifiable by name. Health visitors contrasted this decision with the proposal in the same report to retain a midwifery identity.

Like the district nurse therefore the health visitor might be thought to fear the loss of her particular knowledge and skills if too closely associated with nursing. This fear was demonstrated by the Health Visitor Association in 1973 when a proposal that there should be a change in the rules of the Association so as to admit to full membership those other workers in the community services (including district nurses) at present eligible for associate membership only was not passed as the majority in favour was inadequate, that is less than two-thirds of the votes cast. (34) It appeared that members feared that the powers of the Association to represent health visitors would be diluted.

The two trends illustrated above, on the one hand that of the Royal College of Nursing in dividing a section originally concerned with all aspects of nursing in the community and on the other the decision to maintain a separate existence as shown by the Health Visitor Association, can be assumed to have added to the ambivalent attitude of health visitors to membership of the nursing profession.

(iii) The position of the nurse vis a vis the doctor

Baly's (1975) use of the term "adjunct to the doctor in affecting a cure" is relevant to the health visitor's view of herself as a nurse. Baly points out it was the association of the nurse with the doctor in

achieving a cure that had led nurses to regard nursing as a career. (35)

In contrast to this, the health visitor regards herself as independent, a view supported by the two professional associations. Although it can be accepted that, as described in Chapter 3, the health visitor worked within the department of the medical officer of health, she did not work to a prescribed regime for individual families or persons. Rather the assessment of health needs and the means of providing appropriate health education had to be determined by the individual health visitor. The gradual absorption of the health visitor into the nursing department of the local health authority and, following the reorganisation of the health service, into an even larger setting, is examined later in this chapter.

Before moving to such a consideration the effect of the association of the health visitor with the family doctor is reviewed. The development of deployment into general practice was received with mixed feelings by health visitors and doctors alike. Gilmore, Bruce and Hunt (1974) found:

The health visitor was regarded by many doctors as ambiguous. A high proportion of health visitors were of the opinion that their functions were not well understood or appreciated by general practitioners. (36)

The Health Visitors Association in its Manifesto (1970) examined the concept of health visiting as an independent profession, stating:

No one profession exercised for the benefit of other people can function independently ... In the pursuit of that state of physical, mental and social well being which is the modern concept of health, the doctor, nurse, midwife, health visitor and social worker are equally interdependent. (37)

Later, despite the claim for interdependence the Association notes the tendency to regard the health visitor as the adjunct to specialists:

Medical consultants and voluntary organisations engrossed in their particular interests would like the health visitor to specialise with them and there are regular calls for health visitors to concentrate on paediatrics, geriatrics, diabetes and various forms of handicap. (38)

It could be assumed that such pressure to adopt the place of "adjunct to the doctor" in this sense might generate doubts of the degree of independence possible and to fears that it is the nurse connotation which contributes to the development of such working situations. A contrast in the views of health visitors and district nurses in the setting of the general practice team is shown in the study by Gilmore et al (1974):

Doctors in all teams perceived themselves as carrying out co-ordinating roles. The doctors were in agreement with their medical colleagues and expressed little dissatisfaction ... A high proportion of health visitors regarded their team as lacking in co-ordination and only a third considered that this responsibility should be assumed by a doctor. (39)

This would seem to support the view that nurses as a group are more compliant in accepting direction from a medical colleague than those nurses who have moved into health visiting. This concern over dependence upon another discipline might be thought to be another aspect of the health visitor's unwillingness to accept the designation of nurse which in such a context might imply subservience.

The association with nursing as contributing to a loss of independence may be misconceived. There are indications that nurses are examining their degree of professional independence. The term "nurse practitioner" has been used. Ferguson (1976) comments on the transatlantic experience where the nurse practitioner is seen as associate rather than assistant "capable of a high degree of decision making and practising with considerable independence". (40) Examples in the

United Kingdom are of the use of a staff nurse as the primary contact in general practice, screening requests for medical attention and organising these into a scale of urgency possibly by personal visits where a domiciliary visit has been requested. Similar uses of nurses in general medical practice are as the "practice nurse". Those observed in the study by Gilmore et al (1974) were mainly involved in the treatment rooms and did not undertake any domiciliary visits. They chaperoned patients and assisted them to dress and undress. (41)

Efforts by the professional associations to specify what is meant by "nurse practitioner" in primary care exhibit the same tendency towards generalisation which gives little indication of ways in which the independence may have advanced. The latest definition from the Royal College of Nursing in its evidence to the Department of Health and Social Security Working Party on observation and Assessment in Local Authority Childrens Services describes her as:

A nurse who has been educated to function in an expanded role in the primary care setting, who is capable of maintaining a nursing case load, of working effectively within a multidisciplinary team and of relating to individuals on a long term basis. (42)

Ward has described the family nurse practitioner as:

A registered nurse who makes initial and/or continuing assessments independently or in collaboration with others of the health status of a person of any age group. This nurse is prepared to take health histories, perform physical examination; diagnose, treat and manage common health problems; and depending on the need or problem, provide care alone or jointly with other health workers or initiate referral for care beyond her scope of practice. (43)

The description if the words "physical examination" are excluded, or more narrowly defined, resembles that of the health visitor in this country. The Council in setting out its views on the function of the

health visitor was careful to state that the health visitor is not engaged in technical nursing procedures.

Apart from the generalisation in the definition given by the Royal College of Nursing and the definition from the United States of America of the family nurse practitioner, the views quoted above seem to indicate that the contribution of the nurse, at present, is that of adjunct to the doctor. The three aspects that of the popular concept of the nurse, the health visitor's experience in hospital and her observation of the use of nurses in general practice can be assumed to add to her reservations on her inclusion in nursing. The Council, in attempting to establish standards for entry to health visitor training and concerned with relationships within the service, was involved in the interplay between the opposing views of the two professional organisations. Wilkie (1979) comments that by establishing for the first time the rule that health visitor students must be registered nurses the Council may have contributed to the later uncertainty which led to the omission of the Council as a separate entity in the report of the Committee on Nursing. (14)

B. The changing structure of the nursing profession

After the initial employment of the "respectable working woman" by voluntary agencies, health visitors were deployed by medical officers of health. Chapter 3 describes the gradual assumption of responsibility for a service by the health authorities and the incorporation of the health visitors into the staff of the local health authorities. With the few exceptions where a senior health visitor had been appointed, the development of health visiting was therefore in the hands of the medical officer of health.

The situation of the health visitor may be contrasted with that of her contemporary in hospital. Abel-Smith (1960) describes the impact

of the Florence Nightingale's trainees in the control of hospital nursing. Miss Nightingale's view of their function was:

To take all power over the nursing out of the hands of men and put it into the hands of one female trained head and make her responsible for everything (regarding internal management and discipline) being carried out. (45)

Although there was opposition to the appointments and to the degree of authority vested in the Matron there was a steady increase in the number of matrons and two organisations were formed for their particular interests, the Hospital Matrons Association and the Poor Law Matrons Association.

There was no comparable development for nurses in the community. There was, however, a parallel development in midwifery. The supervision of midwifery was laid down in the first Midwives Act of 1902 and altered by the Local Government Act of 1929 to extend the powers of supervision to the district councils where there was a full time medical officer of health. The Midwives Act of 1936 allowed the Central Midwives Board to make regulations regarding supervisors who might be non-medical. McEwan (1951) points out that a Ministry of Health circular in 1937 showed a change in attitude to supervision suggesting that the supervisor might be regarded as a "counsellor and friend" by the midwives. (46)

In district nursing, early developments had included a system of paid superintendants as, for example, in Mrs Ranyards Bible Womens Scheme. (47) Similar schemes to that for the first health visitors in which the field workers were supervised by "ladies" were in existence, but in 1876 a further advance was the appointment of "district matrons" responsible for supervising the nursing of a group of districts. In distinction to the supervision of midwifery it is significant that this

development was associated with the growth of the Queens Institute of District Nursing, the major organisation concerned with training and regulating district nursing in many parts of the country. The Institute was a voluntary organisation although at a later stage it received grants from local health authorities in respect of services carried out on their behalf. The place of a professional or voluntary organisation as a qualifying association is explored in Chapter 5. It is possible that in such a setting nurses are more likely to assume positions of responsibility. In the Queens Institute the first Inspector-General, Miss R. Paget, was appointed as early as 1890. (48)

In health visiting the supervision was exercised to a varying extent by the medical officer of the particular service for example, for those health visitors in the maternity and child welfare service it would be the maternity and child welfare officer and for school health visitors, the school medical officer. As in a number of authorities the health visitors might be engaged in both maternity and child welfare and school health service, for part of their time the supervision was divided and the possibility of developing clear objectives in the health visiting was consequently reduced. Some local authorities appointed a superintendant to co-ordinate the health visiting services and in some cities where a number of health visitors operated from one centre, the most senior might be designated "superintendant".

If "supervision" is interpreted as "control", health visiting is probably less susceptible to direction except in the most general terms. The work is carried out in individual homes and the introduction of a third party in the shape of a supervisor during a visit could be thought

to prejudice the relationship the health visitor is trying to establish. Direction tends to be related to periods "on duty" and staff might be required to sign a time sheet in the same way as other employees of the local authorities. Some authorities might set standards in the number of visits to be accomplished each day and health visitors required to complete a number of different returns showing attendances at various clinics, welfare centres and the proportion of their time spent on listed activities. A study carried out shortly after the introduction of the National Health Service emphasised the large proportion of time spent in the clerical duties associated with the recording of such minutiae. (49) The emphasis was therefore on time keeping and maintenance of records rather than encouragement of professional expertise as such.

The establishment of the National Health Service might have been expected to encourage the exchange of views on the significance of supervision in the sense of professional development. The Ministry of Health issued a circular in 1947 which contained among its recommendations that of the appointment of a superintendant nursing officer to co-ordinate the midwifery, district nursing and health visiting services. (50) There was no formal training available for such a management position. The only higher professional certificate which health visitors could take was that of the Diploma in Nursing, an extra mural diploma offered by the University of London. The Diploma had a section especially designed for nurses in the public health services.

For the nurse in hospital there was more opportunity. Bowman (1967) describes the College of Nursing's contribution in 1924 when it co-operated with Bedford College for Women and the League of Red Cross

Societies in the organisation of a course known later as the International course. It was designed for administrators and teachers in schools of nursing and continued until 1939. In 1944 the Royal College of Nursing organised the first full time certificate course for nurse administrators. (51) In 1948 the Royal College of Nursing arranged a comparable course for nurse administrators in the public health nursing service. The certificate was the Nursing Administration (Public Health) Certificate.

Despite the availability of training the response by candidates was slow. Two causes may be identified; first there was no requirement that nurses occupying the position of superintendent nursing officer should have any specific qualification although it was expected that supervisors of midwifery should have obtained the midwife teachers certificate. Secondly, and associated with the first, there was no financial provision other than competitive scholarships and no guarantee that a post would be available on completion of the course.

In addition to the lack of training for senior posts there was no specific forum in which the nurse administrators in the public health field might discuss their problems. In 1960 a nurse administrators section was formed within the Royal College of Nursing, but as members at that time could only belong to one section membership would have required the public health nurses to leave the public health section to which they also had allegiance. The public health section of the Royal College of Nursing formed a sub group and a similar small group formed within the Health Visitors Association but the small number of members involved made it difficult to exercise the degree of pressure required to influence the policy of the organisations and consequently

to contribute to any pressure being exerted by the organisations on central or local government.

The hospital nurse administrator therefore seemed to be at some advantage from the historical development of the matron's position over many years. The health visitor not only lacked a strong senior supporting staff, in addition she was an employee of individual health authorities who had considerable autonomy in the direction of their services. Griffiths (1966) compares the attitude of the Ministry of Health towards its local authorities with that of other departments of central government:

In comparison with the relationship between some other departments and their local authorities, the Ministry of Health shows a marked reluctance to be even strongly persuasive. (52)

The Jameson Committee (1956) took note of the lack of senior posts and recommended the creation of a higher grade of field worker but their proposals for advanced training appeared imprecise and did not meet with approval either by employers or health visitors. (53)

The situation which existed as a result of the history of supervision, or the lack of it, in health visiting had implications for the Council. The new training required standards of supervision for students both in the first three terms of the course and in the later short period of supervised practice which was expected to be undertaken in a position as nearly that of employment as possible. In the Second Report of the Council attention is drawn to the lack of facilities for the further education of health visitors in particular in the skills of supervision. (54)

In view of the Council's powers under the Act (55) in relation to further courses for health visitors, it might have been expected that

the organisation of suitable courses might be carried out by the Council. Two factors inhibited this progress:

- (i) decisions on training for management in the hospital field
- (ii) the appointment of superintendant nursing officers in the community field.

(i) The training for management in the hospital field

The Salmon Committee reported in 1966. (56) This Committee had as its remit:

To advise on the senior nursing staff structure in hospital service (ward sister and above) the administrative function of the respective grades and the methods of preparation for them.

Following the report, the National Nursing Staff Committee was set up to organise management training for nurses in hospital. This body was not related to the statutory registering organisation for nurses, the General Nursing Council, so a precedent was set for the creation of a specialist committee concerned with one aspect of post registration management training. When the Mayston Committee reported in 1968 on the structure of nursing management in the local authority services, this precedent was followed and authorities were encouraged to send staff to the many courses organised by the National Nursing Staff Committee. (57)

(ii) The appointment of superintendant nursing officers in the community field

Reference is made above to the circular (118/47) in the appointment of nursing officers to co-ordinate the three nursing services in the community. By 1968, 42 County Councils, 34 County Boroughs and 17 London Boroughs had appointed chief nursing officers to carry out this function. (58) In many cases the appointment was given to the non-medical supervisor of midwives who was already in post, in other

cases the appointment might be that of a district nurse although she would have a health visitor certificate. It could not be claimed that a co-ordinating nursing officer of whatever background was acting as a health visitor but the Council's powers were limited to courses for health visitors as such and did not extend to other branches of the profession.

The Royal College of Nursing, Public Health Section, produced a report in 1968 which recommended a Salmon type structure of management in the community nursing service.<sup>(59)</sup> This was followed quickly by the Mayston report quoted above. In contrast to the laissez-faire attitude criticised by Griffiths above, on this occasion, the Department embarked on an energetic plan to implement the proposals. It can be assumed that some of this energy was engendered by the expected reorganisation of the National Health Service, first proposed in 1968.

The result of the implementation of the Mayston report was an approximation of the management structure of the nursing service in the community to that of the hospital. Davies (1978) draws attention to the emphasis apparently given by the government departments to nursing management rather than a more fundamental reconsideration of the education required for the nursing service, as recommended by the Royal College of Nursing's Platt Committee. She compares the situation with that of the reception of two reports later from the public health section of the College. <sup>(60)</sup> The first, quoted above, supported the introduction of a Salmon type structure in the community service, the second the following year sought to specify community needs upon which administration would depend, was not followed up as such. <sup>(61)</sup> It may have been thought that the subject might form part of the consideration

of the whole field of nursing, an expectation to be realised by the establishment of the Committee on Nursing the following year.

This interest in the management aspect of the nursing service in the community rather than the preparation for senior posts did not only inhibit the Council in its efforts to establish courses for nurse managers, particularly those associated with the supervision of students and the newly trained, it was also reflected in the composition of the Council. The proportions of health visitor members with teaching as distinct from managerial responsibilities altered. In 1962, of the twelve members who were health visitors, eight were engaged in teaching, the remaining four in management.<sup>(62)</sup> The membership appointed in 1968 almost exactly reversed this proportion; of the 13 health visitor members, nine were engaged in the administration of the service and only four in the teaching of health visitors, two in England, two in Scotland and none from Northern Ireland or Wales. <sup>(63)</sup> To what extent this change reflected the interests of the professional officers in the central government departments it is not possible to determine without access to DESS files which are not available. As, however, the members of the Council are appointed by the Health Ministers it can be assumed that the composition of the Council which served from 1969 to 1971 reflected some of the views of the staff within the department from whom the Ministers obtained advice. The balance remained the same for the next triennium, that is 1971 to 1974. <sup>(64)</sup>

It is not possible to measure the effect of the features outlined above but a review of the activities of the Council in the years 1968 to 1974 indicates two trends. The first was the continuing effort described in Chapter 2 to establish a system of regular consultation with the professional organisations and the second the organisation of

a series of conferences and residential seminars for nurse managers and tutors in which there could be an exchange of views on the objectives to be set for training. A second series was arranged for the newly appointed nursing officers in the reorganised health service in 1974.

The consultation with the professional associations was particularly important in view of the Council's statement on the function of the health visitor. The action of the Council in making such a statement poses questions concerning the right of a statutorily appointed body with no members directly elected by the profession to make pronouncements likely to have implications for the deployment of health visitors. The lack of agreement between the two professional organisations on the place of health visiting within nursing may be considered to have encouraged the Council to have taken on the role of a professional association in respect of statements of policy on the function of the health visitor and the organisation of professional conferences.

A second aspect of the Council's decision on health visiting as part of nursing which was not foreseen in any of the Council's statements on function relates to the report of the Committee on Nursing. There was the apparent expectation by Council members and staff that there would be an acceptance that the health visitor deploys skills which develop from nursing but which differ from it. Far from clarifying these skills it would seem that the "diffusion of health visiting management" to which the Health Visitor Association referred in 1975 (65) has led to some blurring of the contribution of the health visitor. It is noticeable that in the seminars arranged for the regional and area nursing officers in the reorganised service, the

response initially was poor, a number of the officers seeking to second the member of staff with a health visitor certificate although such a member could be assumed to be already knowledgeable.

Health visiting has been assumed to be a part of nursing but this chapter questions the validity of the belief. The conflicting views held by the professional associations indicate considerable doubt among health visitors about their professional affiliation. The development of a management structure for the nursing service in the community in which the health visiting contribution is inevitably diluted by the amalgamation of related disciplines has reduced the clarification of the objectives of health visiting rather than enhanced the opportunity such co-ordination could be expected to provide.

Wilkie (1979) lists a number of reports or major legislative changes occurring in the period 1962 - 1974 which affected health visiting and consequently the progress of the Council.(66) Of these probably the most disturbing for health visiting was the reorganisation of the National Health Service and it is that change which is examined in the following chapter.

CHAPTER 8

The reorganisation of the health and social services 1970-1974. Consequences for the interplay between the Council, the Council for Training in Social Work and the Government Departments

The preceding chapter contains an examination of the interplay between the Council's policies, the structure of nursing management and the relationship between health visiting and nursing as a whole. The changes in nurse management were related to the pattern of the current health services and could therefore be expected to have considerable significance for an organisation required by statute to provide a qualification for workers in the health services.

The reorganisation of the NHS was only one of a number of changes affecting the Council in the period under review. In the History of the CETHV, Wilkie (1979) lists a number of features of the period, such as government reports or legislative changes which directly affected the Council, in its powers, constitution or administrative support. (1) The seven most pertinent to the discussion in this chapter are:

Ministry of Health, Scottish Home and Health Department (1966)  
Report of the committee on senior nursing staff structure  
(Chairman Brian Salmon) HMSO

Department of Health and Social Security, Scottish Home and Health Department and Welsh Office (1969) Report of Working Party on Management Structure in the Local Authority Nursing Services (Chairman E.L. Mayston)

Establishment of the Joint Board of Clinical Nursing Studies 1970

Parliament Report of the Committee on Local Authority and Allied Personal Social Services 1968 (Chairman F. Seebohm) Cmnd 3703

Local Authority Social Services Act 1970

Parliament Report of the Committee on Nursing 1972  
(Chairman Asa Briggs) Cmnd 5115

National Health Service Reorganisation Act 1973.

The relevance of such events to the fourth proposition made in this study, that is that the policies of a statutory qualifying association will be directly affected by the service into which the holder of the qualification will enter after training, are examined in this chapter.

The actual or proposed changes in the period 1962-1974 which are of particular importance to the Council's progress may be considered under two headings:

1. Those concerned with the interplay between the Council and
  - (a) The Council for Training in Social Work
  - (b) The Health Authorities
  - (c) The Government Departments and their professional staff
  - (d) The rank and file of health visitors
2. Those concerned with the reorganisation of nurse training proposed by the Committee on Nursing.

1. Interplay between the Council and the Council
  - (a) for Training in Social Work

- (i) Common goals in training

At the time of the Council's inception health services under Part III of the NHS Act 1946 which referred to personal services including health visiting were administered by County Council and County Borough Councils, (2) as were some of those in the National Assistance Act. (3) The staff in these personal services, health visitors and social workers, were employed by the same authorities, sometimes in the same departments, headed by a medical officer of health. Griffiths (1966) quotes 39

medical officers of health as having complete responsibility for health and welfare services in 1964 while others had partial responsibility, mainly for Sections 29 and 30 of the National Health Service Act. The Guillebaud Committee (4) in the fifties had favoured placing welfare under the health committees of the local authorities and this view was supported by a number of medical officers. In the light of this proposed provision of health and welfare services by the same authorities and, in some cases by the same departments, the association of the Social Work and Health Visitor Councils under one Act could be expected.

The period 1962 to 1969 was, however, one of reassessment of local government and of the health and welfare responsibilities of the local authorities. A Royal Commission reported on Local Government in England (5) and proposals were also made for a reorganisation of the personal social services by a committee under the chairmanship of Lord Seebohm. (6) The Seebohm Report called for a standardisation of the training of all social workers including those in the health and welfare services which implied the formation of a new training body to replace the existing Council for Training in Social Work. (7)

Comment is made in Chapters 1 and 2 on the failure to develop a common policy on training between the Council for Training Health Visitors and the Council for Training in Social Work. Both bodies had been concerned with the need to improve existing training to meet the current problems and, in the case of the health visitor Council, to increase the student intake. It can be argued that the delays experienced in the ten years before the Council's establishment first in the setting up of an inquiry (8) and subsequently in the implementation of the Jameson Report contributed to the pressure to

achieve change once the Act (9) came into effect. The five areas outlined by the chairman at the first meeting of the Council were:

- (a) A revision of the syllabus for training health visitors
- (b) A consideration of the part played by the Royal Society of Health and the Royal Scottish Sanitary Association of Scotland in the examination of the health visitor
- (c) A consideration of the supervision of students in practical work
- (d) Discussion to consider the best pattern of relationships to establish with the Standing Conference of Representatives of Health Visitor Training Centres
- (e) Consideration must be given to improving recruitment of students to training courses and to the best means of obtaining candidates of the best quality. (10)

The list does not include any reference to direct co-operation with the Council for Training in Social Work although the chairman served both Councils. The first, second and third Reports of the Council in 1964, 1965 and 1967 all concentrate on business related to improvement in recruitment, examination and further training as well as progress in the implementation of the new syllabus.

Following representations by the Council, a Joint Advisory Committee was formed with the Council for Training in Social Work which considered the relative contributions of health visitor and social worker to the health and welfare services. The progress of this committee which reported in 1966 (11) and is described in Chapter 1 indicated a willingness to co-operate but the second stage which would have included a consideration of joint goals did not follow. By 1966 the trends which led to the publication of the first Green Paper (12) and the setting up of the Seebohm Committee were obvious. It can be argued that the resources designed to achieve the "forging of links" (13) were too

limited and came too late.

Wilkie (1979) describing some of the problems associated with the setting up of a totally new organisation suggests that the diverse group of members forming the first Council in 1962-1965 took time to make a coherent whole and to develop a sense of common purpose. (14) Time was also required to fill posts in the staff establishment; the Council did not have full time senior administrative and professional staff until July 1963. The Council and the Council for Training in Social Work had to find an identifiable base from which to operate. The first meeting of the Council in its own premises was not held until July 1964. (15) The limited resources available to the Council in terms of staff, the Council had one Chief Professional Adviser and three professional advisers, could be expected to lead to a concentration of effort on the five areas listed above. By the time the Joint Advisory Committee reported in 1966 changes in the health and social services were being discussed.

Levitt (1976) outlining the background to the reorganisation of the NHS in 1974 refers to the contribution made by the reports of a number of committees such as the Porritt Committee (1962) and the Gillie Committee (1963), in drawing attention to flaws in the administrative structure of the NHS. The initial statement was made by the Minister of Health in the House of Commons on 6th November 1967 that the administrative structure of the NHS would be reviewed with a view to its future for the next twenty years. (16)

It is not possible to prove that earlier decisions would necessarily have succeeded in defining common goals for the two Councils. Wilkie (1979) points out that the principle of cross membership between the Councils placed an intolerable burden of attendance for members as

committees proliferated. (17) Brown (1975) comments on the value of the principle in general as contributing to integration:

We tend to place too much emphasis on cross-membership of committees even as instruments of co-ordination, and co-ordination is much less demanding than integrative policy making. (18)

It may be regretted that opportunities of developing a close working relationship with colleagues on the Council for Training in Social Work were lost by the professional staff of the Council. Such relationship could be expected to illuminate thinking by both staffs on new approaches to training and education. Aiken and Haug suggest:

The involvement of staff in interorganisational relationships introduces them to new perspectives and new techniques for solving organisational problems. The establishment of collegial relationships with comparable staff members of other organisations provides them with a comparative framework for understanding their own organisation. (19)

In the case of the Council, the pressure to expand training facilities and to achieve an increase in candidates for training placed on a small staff appears to have inhibited any such interorganisational activity.

(ii) Administrative provision for the two Councils

In 1962 the two Councils had similar staff establishments and both were to provide training for workers in the health and welfare services of the local authorities. Reference is made above to the recommendation of the Seeborn Committee on the integration of the personal social services and to the repercussions of such a move on the body providing training.

Two options were available to meet the needed change, either the existing Social Work Council might have its powers extended by an order

in Council giving it:

Such functions in relation to other social workers ...  
and make such modifications in the constitution of  
that Council as She may deem expedient". (20)

or, alternatively, a completely new organisation might be created. The first solution was adopted, the existing Council for Training in Social Work was renamed "Central Council for Education and Training in Social Work" and its membership extended from 32 to 64. As a result of the increased responsibilities the professional staff of the revised Council was enlarged, additional office space therefore had to be found and administrative support had to be strengthened.

In 1962 the two Councils had shared a chairman, some members and a secretariat. In 1971 the office of chairman was divided; Sir John Butterfield, at that time Vice-Chancellor of Nottingham University, was appointed chairman of the Health Visitor Council (21) and Sir Derman Christopherson, Vice Chancellor of Durham University, to the Social Work Council. The growth of further links between the professional staff of the two Councils became less likely and joint activities impossible. A priority for the newly recruited staff to the Central Council for the Education and Training in Social Work was the establishment of common policies on training for the different forms of social work now within the remit of that body.

It can be argued that personal doubts about further co-operation between the two Councils among both members of Council and members of staff may have contributed to the growing distance between the two Councils. The changes, however, in the social work service resulting from the Local Authorities Social Services Act (1969) and the amendment of the Health Visitor and Social Work (Training) Act 1962 were more important factors in impeding further joint activity. Referring to

the effect of professional aspirations on policy formation, Brown (1975) points out that although these have tended to:

Coincide with national objectives ... they have influenced the development of administrative structures in ways that may or may not turn out to be beneficial". (22)

Forder (1973) quotes the problems faced by the new CCETSU in attempting to "work out new policies from an inheritance of disparate traditions". (23)

1. Interplay between the Council and the Health Authorities  
(b)

Proposals for reorganisation of the NHS in the first Green Paper coincided with recommendations from the Royal Commission on Local Government in England which suggested a series of unitary authorities. These authorities might have appeared to be suitable for the administration of a newly organised health service as envisaged by the first Green Paper. (24) Such a change presented problems in that it could impose an excessive burden upon rates and that the control of a health service by local government was not acceptable to the medical profession as a whole, although favoured by some Medical Officers of Health. It could be interpreted as threatening an independent professional status. Levitt (1976) points out that a <sup>such</sup> move might be claimed to introduce a political force in what should be a non-political activity. (25) Such a belief is frequently quoted but Hume (1964) who reviewed the relationship between professions and the state as part of an international study emphasises that any subject requiring government action is "automatically part of the context of politics". (26)

Some of the doubts about the capacity of local government to organise the NHS may have stemmed from experience in individual cases. Mackintosh (1951) in the Heath Clark lectures admitted that a number of

authorities had a poor record in the provision of health services but argued that this indicated a need to reform local government rather than the health service. (27) Griffiths (1966) describes the different relationships achieved by the various central government departments and in the case of the health authorities comments upon the 'laissez-faire' attitude of the then Ministry of Health towards the local health authorities. (28)

In the period under study more positive guidance was given, however, from the central government departments in the publication of a Ten Year Plan. (29) In these plans information on both health and welfare services as organised in the individual authorities was given and planning for health and welfare services were seen to be complementary. At that stage the plans did not indicate that any part of the personal health services would be removed from local government. The then Minister of Health, Enoch Powell, appeared committed to local as against central control, making the point that in local control there is a closer connection between decisions on services and their efficiency and financial implications. With central control he says:

All discontents, all deficiencies, all inadequacies can be externalised and rationalised by a single anthropomorphic explanation: it is the fault of a miserly Minister, or Treasury, or Cabinet. (30)

The publication of two Plans, one for the hospital services and the other quoted above for the community services assisted authorities in forward planning and that on the community services was of particular help to the Council in setting targets for the recruitment of students.

In the first years of the Council's life it appeared that the policy of preparing a health visitor to work in a service complementary to that of social work would seem to have been in line with the current planning and this is reflected in the joint committee considering the function of the two workers which reported in 1966. (31)

There had been shortcomings in the system which was operating when the Council was set up but some improvement was achieved as indicated above. The decision to administer all sections of the NHS through a centralised system rather than through a reorganised form of local government represented a major change in employment for health visitors. They would become employees of a national system rather than of County Councils or County Boroughs. Attention is drawn to the significance of this change in the 5th Report of the Council where it is suggested that its effect has tended to be overlooked in the consideration of the future nursing service. (32)

The expected separation of the health and welfare services had an effect upon the direction of the Council's policies and priorities. More evidence begins to appear in the periodic reports of the Council of efforts to clarify the contribution of the health visitor within the NHS with particular reference to her relationship to general medical practice. The 4th Report of the Council covering the years 1967-1969 contains an extended statement on the function of the health visitor which was subsequently published as a separate pamphlet. (33) It is significant that the first research project sponsored by the Council was concerned with general practice. The pilot study was carried out in 1966/67 thus coinciding with what appears some change in direction in the deployment of health visitors, a change recorded and studied by Abel (1969) (34) The particular significance of the study sponsored by the

Council is that it concerns the health visitor as part of a nursing team. (35)

Further indications of the Council's growing concern for relationships with medical rather than social services is found in the Fourth Report of Council in which it is reported that evidence had been submitted to the sub committee of the Standing Medical Advisory Committee which was considering general practice. The Council in evidence had drawn attention to the new training syllabus for health visitors and the preparation it could provide for their participation on general practice. (36)

In the Fifth Report of the Council this trend continued with reports of the institution of multidisciplinary discussion groups and courses. (37) The policy of co-operation with other professional groups was not confined to the central activities of the Council and a liaison committee was established between the Scottish Council of the Royal College of General Practitioners and the Scottish Advisory Committee of the CETHV which published a report in 1973. (38)

Further evidence of the Council's change of emphasis as the probable reorganisation of the NHS came closer is seen in the study days which were organised for health visitor tutors. The syllabus designed in 1964 identifies main subjects of study which should be appropriate to the practice of health visiting regardless of the pattern of the service, but it was recognised that there would be a difference in the colleagues with whom the health visitor would be associated. Up to 1968 a typical theme for the study day was "The teaching of sociology as a background to family studies". (39) The study days were designed to help health visitor tutors prepare students for work in the contemporary setting and as the setting changed so the

topics were adapted. In 1969 the theme had changed to health visiting in general practice (40), a topic continued in the study days in 1970. In 1972 the theme changed again to meet the challenge of the reorganisation when the group work included "Coping with Change", a discussion led by a team from the Tavistock Institute of Human Relations. (41)

In 1974 it was becoming clear that the new setting in which health visitors would operate would be that of a large nursing service dominated numerically by colleagues engaged in curative work in hospital. In 1971 the numbers of registered nursing staff at field level (that is below senior nursing grade Salmon or Mayston 7) were 67,476 hospital staff as against 16,585 in the community services, that is in England and Wales. (42) The community nursing service includes health visitors, home nurses and others with state registration.

In such a setting in which the majority of nurse colleagues could be expected to have no experience of the training or work of the health visitor, clarification of the contribution of the health visitor was as necessary as it had been in the early discussions with the Social Work Council. The Council therefore took as the theme for the 1974 tutors study days consideration of the fifth section of the syllabus "The Principles and Practice of Health Visiting". In this consideration an important aspect was to be its relationship to other areas of nursing. The need for study of this subject had been emphasised by recommendations of the Committee on Nursing that there should be a more integrated form of training for all types of nursing. The topic was developed as a workshop rather than as formal study sessions and was the precursor of a major exercise which culminated in the publication in 1977 of an extensive report of the conclusions of the working groups. (43) As the

Report was published after the period covered in this study further analysis of the findings is not included in the present thesis.

The Council is a training and educational body responsible for the award of a national certificate but that does not imply that its policies are immutable. It is possible to trace an alteration in the priorities in its policies. The early concern for teaching method and the substance of a syllabus as indicated by the choice of topics for the tutors study days changes to an increasing concern for the setting in which the health visitor will eventually work. Chapter 7 contains consideration of the relationship of the professional associations, the Royal College of Nursing and the Health Visitors Association to the statutory qualifying association and the suggestion is made that in identifying the function of the health visitor the Council is usurping the function of those professional bodies. It is also suggested that such an activity was to some extent associated with the lack of a common goal agreed by the professional associations. The effect of proposed changes in the services provides another example of pressures external to the Council which shaped policies particularly those associated with the further training of health visitors.

1. Interplay between the Council and the  
(c) Government Departments and their professional staff

In Chapter 5 attention is drawn to the difference between the General Nursing Council for England and Wales and the Health Visitor Council in that in the latter members of the government department do not count as full members and therefore do not have voting rights when policy is determined. The system, however, by which certain members of the Department staff are classified as "assessors" and attend Council meetings at which they may be asked to explain government decisions or

to offer advice on proposed Council policy established useful co-operation in the early years of the Council. In 1962 the professional staff of the nursing division in the Ministry of Health in England was headed by a chief nursing officer and two deputies, one of whom had special responsibility for nursing services in the community. A number of nursing officers each with special interests and with a responsibility for a particular area of the country were grouped under the direction of the two deputies.

Before the reorganisation of the NHS in 1974 it was the practice of the Deputy Chief Nursing Officer responsible for the nursing service in the community to attend the Council meetings as one of the assessors. In addition to professional staff from the government departments a number of civil servants were present at Council meetings. In the case of the Department of Health the representative was usually an assistant secretary or principal. Comparable representatives of similar status attended from the departments in the other countries, that is from the Home and Health Department for Scotland, the Ministry of Health (later Department of Health and Social Services) in Ulster and from the Welsh Board of Health. The Department of Education and Science sent a medical officer and one of Her Majesty's Inspectors of Schools, no civil servant attended. Although there was a nominated representative for the Scottish Education Department it was not until the training in Scotland moved into the education sphere that there was more regular attendance from that department. Apart from attendance at Council meetings there was informal and regular contact between the staff of the Council and the government departments which is discussed in Chapter 2.

Changes in the NHS were preceded by changes in the internal structure of the <sup>Central</sup> health departments. In 1972 six main groups were created with the following main functions. A diagram giving fuller details of the remit of each group is given in Appendix H

1. Top of the office - to help the Secretary of State provide central leadership in the health and social services
2. Service development - to help the Secretary of State decide national objectives, priorities and standards for the health and social services
3. Regional - to guide the health and local authorities on national objectives and priorities
4. NHS personnel - to help the Secretary of State decide fair and economic pay and conditions of service for all NHS personnel and to see agreement is reached with staff concerned. To help the NHS recruit, train, retain and employ wisely sufficient staff of the required calibre and experience
5. Department support - to support the Top of the office on manpower and organisation and efficiency matters and negotiate with CSD and Treasury
6. Finance - to represent the Department with the Treasury and the rest of the government on financial matters. (14)

The three of these which affected the Council most closely were Service development, the Regional and the NHS personnel groups. The formation of the first meant that there was no longer a section concentrating and therefore especially knowledgeable about community services. The former Deputy Chief Nursing Officer now became the head of the nursing officers in the group considering developments across

the whole spectrum of the provision of care. The regional group was responsible for advice and guidance to health and local authorities on national objectives and priorities while the personnel included within its remit consideration related to training "to help the NHS recruit, train and retain and employ wisely".

The nursing officers, previously grouped according to their main professional experience, were distributed among the three new groups. The comment was made by the HVA on the effect of the implementation of the Mayston structure in the local health authorities nursing service that between 1970 and 1973 "the diffusion of health visiting management was complete". (45) In the government departments similar diffusion was taking place. In England two of the nursing officers formerly concerned with the nursing services in the community moved to the personnel and training group and one became an assessor attending Council meetings. This move had two effects. First the new assessor did not occupy a position of such authority as her predecessor. Such a situation can create a lack of confidence between a body such as the Council and the Government Department. Griffiths (1966) points out that communication problems can be created when:

The chief officer of a local authority is not always satisfied that the person to whom he has official access is sufficiently senior or has sufficient power of decision. (46)

The second effect was that the Deputy Chief Nursing Officer heading the group responsible for training did not have an opportunity of gaining first hand knowledge of the operation of one of the statutory qualifying associations of which she had not had previous experience. A similar situation is described in Chapter 7 in which the newly appointed regional and area nursing officers of the new health authorities tended to refer to seminars on training arranged by the

Council candidates who were already qualified as health visitors. The regular meetings described in Chapter 2 between the staff of the Council and the professional staff of the department were discontinued. The pressures generated by the reorganisation of the NHS and the reorganisation of nurse training following the report of the Briggs Committee meant that such contact did not have a high priority for the staff of either the Council or the Department.

Although the departmental assessors did not have voting powers at Council meetings their influence on Council policy could be considerable. The most obvious area of influence lies in the composition of the Council itself. Attention is drawn in Chapter 7 to the change in the Council's work when the balance of interests between teaching and administration was altered. No direct evidence is available of the extent or nature of the advice given by professional staff within the government departments on the functions of the Council. Brown (1970) writing on the contribution of professional staff in the government departments comments:

The true measure of influence on policy and day-to-day administration will become apparent if and when the department files become available for research. (47)

1. The interplay between the Council and the rank and file of health visitors
- (d)

The Council's professional staff had pursued a course of frequent visits to Local Health Authorities involved in health visitor training. In Chapter 2 the lack of provision for systematic updating for health visitors is discussed. Refresher courses might be arranged by some employing authorities to which staff from adjacent authorities might also be invited. Apart from such facilities, the two professional bodies, the Royal College of Nursing and the Health Visitor Association,

arranged courses primarily for their members but open to non-members as well. The Council had the power to provide further training for health visitors if necessary. (48) The moves which followed the request from the Department of Health that the Council exercise this option and assume responsibility for the provision of courses to cover the UK is described in Chapter 2. The system designed by the Council required that professional staff should visit all courses. In addition therefore to the contact which existed between Council staff through fieldwork teaching courses there was now a contact with the main body of health visitors.

The Council staff found that as independent observers, that is, neither employees of the health authorities nor of the professional associations, they were frequently the recipients of the concern expressed by health visitors over their relationship to the new Social Work Departments and to the reorganised NHS. This experience contributed to the comments made by the Council on the reorganisation of the NHS. (49) Two areas of concern emerged in the informal discussions with health visitors:

- (i) uncertainty over the responsibilities to be assumed by the social work departments to be set up by the Local Authorities Social Services Act (1969)
- (ii) uncertainties over the management structure within which health visitors would work following reorganisation of the NHS.

(i) The responsibilities of social work departments which were set out in the first schedule to the Act appeared to indicate some involvement by the new departments in aspects of maternity and child welfare which were traditionally within the remit of health visitors. Paragraph 36 of the second Green Paper on the future structure of the NHS, however, makes specific mention of the responsibility of area health authorities

for maternal and child health. (50) The Council welcomed the clarification in its observations made to the government department on the Green Paper stating:

The latter reference does much to clear up the anomalous situation arising from the list of functions listed in the First Schedule of the Local Authorities Bill which conveyed the impression that responsibility for this service was to be transferred to the new Social Services Committee of local authorities. (51)

(ii) The nature of the management structure within which health visitors would work once the office of medical officer of health was discontinued was the second area of concern.

Comparison is made in Chapter 7 between the existence of a nurse leader in the form of the Matron in hospital and the absence of a similar position in the nursing service in general in the community and especially in the health visiting section of the service. Chapter 3 indicates the reliance historically of the health visitor upon the Medical Officer of Health and on the medical officer responsible for the maternity and child welfare service. Proposals therefore for reorganisation which would entail the disappearance of the local health authority and of the medical officer had serious implications for health visitors.

In addition therefore to the representations made to the government departments by the professional associations the views expressed to the Council staff in the closer contact following the organisation of the refresher courses is reflected in the comments the Council made on the proposed legislation. Reference is also made in the Fifth Report of the Council to the implications of the change from work in local government. (52) The views on the possible dangers to the service were widespread and in the comments prepared for the Scottish Home and Health Department on the changes in that service concern was expressed that:

The preventative and promotive aspects of the health service should not be engulfed by the demand for curative services for the acutely ill when limited financial resources are available. (53)

2. Proposed changes in the training of nurses and the Report of the Committee on Nursing

It could be assumed that the reorganisation of the NHS as proposed in the various Green Papers would have repercussions on the nursing staff who are:

The largest group of the NHS staff, the success of integration policies will depend substantially on their effective education and deployment. (54)

Reference is made above to the gradual change in the Council's policy on the links to be formed with other bodies. It was gradually appreciated by Council members and staff alike that these links should be developed with other sections of the health rather than the social services. The announcement therefore by Richard Crossman in 1970 that a committee was being established to consider all aspects of nursing was not unforeseen. The Council had devoted considerable thought to the place of health visiting in a nursing service.

Such concern is demonstrated by the Council's sponsorship of the research project on the nursing team in general practice quoted above, and in the efforts made to achieve a consensus of views on training for nurses in the community with the Panel of Assessors for District Nurse Training. This body created following the report of a working party in 1957 (55) was appointed to advise the Minister of Health on matters related to district nurse training. The Panel which had an independent chairman had staff and resources provided by the government department. The circular sent to local authorities in 1967 (56) contained much that could be said to be common ground between the

training of district nurses and health visitors. The Council, which had expressed the view that the training of the health visitor should be related to that of other nurses in the community services, convened a meeting with the Panel. It was apparent, however, in a meeting held in 1971 that the Panel did not have confidence in a closer link with health visitor training. (57) To what extent the view reflects that of the staff of the Ministry of Health, involved by then with the deliberations of the Briggs Committee, it is not possible to estimate without access to the records of the Government Department.

Further indication of the Council's concern to establish the relationship of health visiting to nursing is seen in the evidence the Council submitted to the Briggs Committee. (58) In that evidence the Council made eight recommendations of which seven relate to the nursing profession as a whole. The recommendations are summarised in Appendix J. Evidence of the Council's change in direction from links with the social services to links with the health services can be traced in the Reports of the Council. The Council publishes periodic rather than annual reports and five such reports were published between 1962 and 1974. If the topics covered in each report are examined it is possible to detect a change in the importance which the Council appears to place upon its various activities. The first two reports devote most space to decisions on syllabus, fieldwork and examination and the shortage of tutors and student recruitment. By the Third Report an item appears on the Function of the Health Visitor and in the Fourth Report this item is expanded to take up half the report. Finally, in the Fifth Report there is evidence of action on the Council's policy on relating the training of the health visitor to the contemporary scene in the NHS. A major section is headed "The Context of Education and Training" in which

progress on multi-disciplinary groups is described and mention made of the contacts with the Joint Board of Clinical Nursing Studies following the extension by the DHSS of the remit of that body to include courses for work in the community.

The activity of the Council in seeking links with the medical and nursing professions is recognised in reports such as "Nurses in an integrated service", one of a series prepared by the Scottish Home and Health Department.

In some respects health visitors have led the profession in critically examining their own function and adapting their role to current needs ... The CETHV has been instrumental in making health visiting a growth point of the nursing profession because it has recognised the value of post-basic education specially designed for the job. (59)

The report of the Committee on Nursing was published in 1972 and received with disappointment by most health visitors. (60) The report contains 75 recommendations relating to:

The statutory framework

Education

Manpower

Conditions of work

Organisation of nurses and midwives work and career structure

Assimilation (to a new structure)

Of the 75 recommendations, 5 are concerned with the statutory framework of a qualifying body and 31 with education and training. The committee therefore concentrated much of its efforts upon the content and design of training.

To achieve integration of the various aspects of nursing to match the integration of the NHS in which the nurse would work, the Committee

recommended the creation of a single statutory qualifying body "responsible for professional standards, education and discipline in Nursing and Midwifery in Great Britain". (61) In setting out the case for a unified body, the Council emphasise the greater degree of authority a body speaking for nursing "with one voice" could have both within the United Kingdom, outside the profession and abroad. What is not clear in the Report is the degree of independence such a body might possess. New legislation has now been enacted, the Nurses Midwives and Health Visitors Act 1979. In the final chapter of this thesis some of the features of the new qualifying body are related to the propositions examined and the implications for future development of nurse training are discussed.

Following the publication of the Report the views of interested bodies were sought by the Government Departments in October 1973. The Council saw profound effects should the Report be implemented as it stood and in commenting quoted four areas of considerable concern:

Which could affect the future of not only the health visiting section of the nursing profession but also the contribution health visiting is making and can make in the future to the effective work of the health service. (62)

The main tenor of the Briggs Report as stated above is the need to achieve closely integrated nurse training and service. The tacit assumption already referred to in this study that health visiting is an aspect of nursing akin to clinical nursing and therefore amenable to the same forms of training appears to have been completely accepted by the Committee. There is no reference in the summary of recommendations to health visitors by name. One new national body was recommended for nurses and midwives with three boards to organise training in the constituent countries of the UK. Ulster was not included in the initial Report.

It is not intended to discuss the report in detail in this thesis. The Nurses Midwives and Health Visitors Act 1979 contains considerable revision of the original proposals.

Wilkie (1979) comments on the reception of the report as "one of mixed feelings", (63) while in general the establishment of a single statutory, registering body was welcomed the omission of health visiting from the title of the new body was deprecated by institutions and journals related to health visiting as well as by individuals. Examples may be found in comments made by the Society of Medical Officers of Health (64), the Royal College of Nursing (65) and the Society of Chief Nursing Officers (a body composed of nurses engaged in the management of the community nursing services). (66) In view of the gradual disengagement of the Health Visitor and Social Work Councils which was taking place during the period 1970-1974 it is notable that a degree of common policy on the context of training had developed between the two bodies and is demonstrated in the comments made by the CCETSW on the Briggs Report. The Social Work Council expressed itself as:

Disappointed with the approach which the Briggs Report takes towards the organisational context of nursing education and refers to the 'over emphasis which appears to have been given to the service aspects of nursing at the expense of its educational development in a world of rapidly increasing knowledge and continuously changing medical and nursing techniques'. (67)

Similar views were expressed in some journals, (68) for example, the British Hospital Journal and Social Service Review and in letters sent by some health visitors to their members of parliament. (69)

The Council in its comments on the Report concentrates upon four areas as follows:

- (i) the omission of a health visiting component from the overall statutory framework of the proposed statutory body
- (ii) the present proposal for establishing Colleges of Nursing which appear to be monotechnic institutions
- (iii) the attenuated nature of training proposed for health visitors
- (iv) the consequent loss of professional identity for health visitors implicit in the whole Report. (70)

The recommendation by the Committee that Colleges of Nursing and Midwifery should be established within which all aspects of nurse and midwife training could be organised (71) conflicted with the Council's policy of placing health visitor training within the mainstream of higher and further education. In making the recommendation the Committee recognised that to provide health visitor training in such a setting would draw back staff based in general educational establishments into the NHS framework. In Chapter 6 the advantages to health visitor training of the resources available in general education are discussed and the Council's concern is expressed in (ii) above. The Council held the view based on previous experience of training in educational establishments to which the tutorial staff had been seconded from the health departments that opportunities for the effective use of the institution were much diminished in such a case.

The Council refer to what they call the "attenuated" nature of the proposed training for health visitors. The Committee recommend that there should be a higher certificate to be completed in 6 months after registration. This certificate would replace that for health visitors whom the Committee call "family health sisters". (72) The Council in its evidence to the Committee had expressed the view that the course currently extending over a year could only be contained within such a

period if there were to be considerable changes in the basic training of the nurse. The Council had not envisaged any reduction in time.

The loss of identity to which the fourth area quoted above refers would seem to be epitomised in the change of name. The term "family health sister" would seem to represent an effort on the part of the Committee to achieve greater uniformity in the staff structure of the NHS. There would be two "sisters" in the community services, an odd anachronism in 1972 when titles such as nursing officer or charge nurse were being used, titles which took account of the presence of men.

Reference is made above to the impact of a change of employer for health visitors. Should such a change imply efforts to fit the health visitor into a mould which had been formed for the hospital service there would be consequences for health visitor and Council alike. The danger of attempting to produce uniformity among nurses at field level is emphasised in the Council's comments:

By reason of historical development and present work the health visitor cannot be regarded as a complete counterpart of either the ward sister or the district nurse. There are grave dangers that any attempt to achieve such an analogy in the search for an orderly administration can only result in the loss of the unique and very important contribution the health visitor can make to a reorganised health service. (73)

The early years of the Council's life were characterised by the need to identify the function of the health visitor for her place in the health and welfare services administered by the local authorities and for the encouragement of recruits to the local health authority services. By the end of the period the Council was still involved in such clarification but for a new employer of health visitors this is a national rather than a local authority.

The Council's policy in 1972-1974 had three goals as shown in its activities, all related to the reorganisation of the NHS.

- (i) to safeguard the Council and its work while discussions took place on the implementation of the Briggs Report. The Council had to "operate with dignity and efficiency for an interim period". (74)
- (ii) to participate in discussion on the future organisation of training at officer level and prepare for consultation with the government departments and the other statutory qualifying associations. Such preparation included the convening of a residential conference for Council members and some guests and was addressed by the then Secretary of State for Health and Social Services, Sir Keith Joseph
- (iii) to clarify further the subject matter of the 5th section of the syllabus The Principles and Practice of Health Visiting.

This chapter has indicated the significance of reorganisation of the NHS on one statutory association and on the products of its training, the health visitors. During the period under study the influence of the government department upon the health visitor's employers, that is the local health authorities, which Griffiths suggests was less positive than that exerted by other central departments gradually became firmer, first in the recommendations in The Development of Community Care and later in circulars concerned with the financing of tutor and fieldwork teacher training and in 1972 recommendations on the ratio of health visitors to population required to provide an effective health visiting service. (75) With the reorganisation of the NHS and the centralisation of its direction, the power of the Departments was increased in an overt form as distinct from the more subtle form discussed earlier in relation to influence upon the membership of the Council. The gradual move towards a monopoly employer may seem to be of great significance to the

health visitors in that they had previously been employed by local authorities but the move raises issues concerning the future of registering bodies in the nursing profession as a whole. Questions arise such as:

(i) what degree of actual authority should be vested in a statutory qualifying association? In Chapter 5 of this study it has been suggested that such power may be more apparent than real

(ii) arising from the question of authority, what should be the relationships between the central government departments directing a national service and the body appointed by statute to prepare its employees?

(iii) to what extent has nursing become a homogeneous profession and what is the contribution of the qualifying bodies to such development either in the present or the future?

Four propositions have been used as a framework for a case study of one qualifying body, that is the Council for the Education and Training of the Health Visitor. These are set out in the Introduction as:

(a) that a newly established qualifying association will be influenced by the history of the qualification concerned and the previous regulations

(b) that an association with the specific remit of "training" and/or "education" will be influenced by the general educational climate of the period under study

(c) that the policy of a qualifying association is influenced by the climate of opinion in the professional organisations representative of the workers to whom the

qualification is awarded

(d) that the progress, development and authority of a qualifying association established by statute will be promoted or inhibited as much by the employment available to the trainees as by the powers of the Act.

The final chapter of this thesis offers a consideration of the relevance of the three questions posed above to the four propositions with which the study began.

CHAPTER 9

Conclusion : the significance of the reorganisation  
of the National Health Service for qualifying  
associations in nursing

The introduction to this study sets out four propositions:

- (a) that a newly established qualifying association will be influenced by the history of the qualification concerned and the previous regulations
- (b) that an association with the specific remit of "training" and/or "education" will be influenced by the general educational climate of the period under study
- (c) that the policy of a qualifying association is influenced by the climate of opinion in the professional organisations representative of the workers to whom the qualification is awarded
- (d) that the progress, development and authority of a qualifying association established by statute will be promoted or inhibited as much by the employment available to the trainees as by the powers of the Act.

The four propositions are related to a study of the progress and development of one specific qualifying association, one which presents some unusual features. In the five years which have elapsed since the end of the period studied, discussion has taken place on the future of the national registering body recommended by the Committee on Nursing. The outcome is the Nurses, Midwives and Health Visitors Act 1979. It is pertinent to such a development to consider again the propositions round which the case study is assembled and to formulate questions which such consideration raises. Applying the above four propositions to the specific qualifying association they relate to:

- (i) the significance of the previous history of the health visitor certificate
- (ii) the educational climate

- (iii) the debate on the place of the health visitor within the nursing profession
- (iv) the connection between a statutory qualifying association and the National Health Service which the trainees will enter on qualification.

(i) The significance of the history of the health visitor's certificate before 1962

The Council continued some features of the previous training pattern, that is it continued to rely upon pre-course training in general and obstetric nursing. It can be said to have gone further in that for the first time the training rules required that health visitor students should be state registered nurses. It can be argued that by making full general nurse training obligatory the Council was creating a conflict by extending the health visitor training within the mainstream of higher and further education. Although a small number of nurses qualify in schemes which include teaching in university, the great majority train in the traditional hospital school of nursing. The situation which existed before 1962 was one in which the health visitor was the only nurse occupying a first level post in the National Health Service following full time education extending over one year. The distinction this created between her and her colleagues was made the more explicit by the nature of the institution in which such education was to be provided.

In contrast to the Council's acceptance of the previous for students entering health visitor training, it rejected the design of training which obtained in 1962 and the examining bodies, the Royal

Society of Health and the Royal Scottish Sanitary Association.

Although the Jameson Committee (1956) had expressed confidence in the two organisations (1) there is no evidence that the Council considered a continuing role for them in the training of the health visitor. The consensus of opinion as demonstrated in the record of the Council in the first three years of its existence was that there should be a new start. Such a new start had, however, to be grafted on to the existing system of financial support for training and to a lack of consistency of opinion on the function of the health visitor.

(ii) The educational climate 1962-1974

The availability of resources in the mainstream of education and the optimistic spirit in the early sixties encouraged the Council to extend training facilities in educational institutions. It can be assumed that the number of members of the first Council who held appointments in University, College of Advanced Technology or other educational establishments had a bearing upon the Council's policy on the appropriate setting for the training courses.

The combination of developing facilities in colleges and the presence on the Council of informed members with experience of opportunities for the "new start" referred to above contributed both to the policy on the siting of courses within the mainstream of education and to the new thinking which lay behind the Council's plans for the syllabus and fieldwork training.

(iii) The debate on the place of the health visitor in the nursing profession

It can be argued that demanding that the health visitor student should be a registered nurse on the one hand and on the other by designing a training which differed completely from that of a nurse, the distance between the health visitor and her counterpart in the hospital

service, the ward sister, or her colleague in the community service, the district nurse, was increased. Yet, if the Council's view is right, that training for a worker in the community working in day-to-day contact with colleagues from other disciplines required a multi-disciplinary setting such a result was inevitable. The Council may even be thought to have contributed to the uncertainty of the health visitor; she does not "fit" the image of nursing in the National Health Service although she is assumed to be part of the one profession of nursing. While the health visitor remained in local health authority employment, the lack of "fit" was less apparent but the reorganisation of the National Health Service draws attention to this body of workers who differ from other nurses both in preparation for, and objectives to work.

(iv) The relationship between a statutory qualifying association and the service which the trainee will enter on qualification

The powers and degree of autonomy of the existing statutory bodies in nursing differ according to the Act within which each operates. The record of the Council which appears to illustrate the possession of considerable power in the design and control of training nevertheless also demonstrates ways by which power may be circumscribed by the central government. Despite, however, frustration in some of the projects which the Council considered appropriate for the improvement of training, there was considerable autonomy when the Council is compared with other statutory qualifying associations in nursing. This difference may be attributed to the student health visitor's exemption from service obligations during training, to her subsequent employment in local government and to the presence of other interested bodies, the Department of Education and Science and the Scottish Education Department in the

provision of training facilities.

The Nurses, Midwives and Health Visitor Act 1979 will replace all existing qualifying associations in nursing by one central Council responsible for the qualification of all forms of nursing with, at present, the exception of occupational health nursing, in the four constituent countries of the United Kingdom. (2) One of the first questions raised by the creation of the new registering body relates to its purpose. Millerson (1964) describes the aims of a qualifying association as:

To examine and qualify individuals wishing to practise in the subject. (3)

Is this the only objective to certify the nurse as "safe to practise" or is there an educational function? The Committee on Nursing recognised the need for continuing growth and education if the profession is to meet future demands and stressed the part to be played by the new statutory bodies to "exercise a guiding influence on the reformulation of nurse education". (4) The Committee therefore saw the new Central Council as having an education function. The question is from what source the Central Council is to obtain the input of educational concepts? The educational policies of the Council for the Education and Training of Health Visitors have received approval in such reports as Nurses in an Integrated Health Service (1972):

The Council for the Education and Training of Health Visitors has been instrumental in making health visiting a growth point of the nursing profession because it has recognised the value of post-basic education specially designed for the job. (5)

and the Report of the Royal Commission on the National Health Service (1979):

In particular we welcome the work of the Council for Education and Training of Health Visitors since its inauguration. (6)

It is suggested in this study that the policies of the Council were the outcome of a concatenation of circumstances, the presence of a substantial number of members on the Council with a background of general education, available resources in higher and further education and the opportunity for a new start. The new Central Council will have the opportunity of a new start; what is not clear at this stage is what proportion of its members will be drawn from the field of general education.

The creation of the United Kingdom Central Council for Nurses, Midwives and Health Visitors follows the report of the Committee on Nursing. (7) The Committee was set up in 1970 when discussions on ways in which the tripartite nature of the National Health Service might be altered to provide a more truly integrated health service were well advanced. The problem which the Committee confronted therefore was how the diverse elements of nursing might be brought together in a reorganised service. In the view of the Committee:

What the branches of a united profession have to give each other is more significant than the respects in which they differ. (8)

The Committee also expressed the desire that education in nursing and midwifery:

Become more systematic and be given a far greater degree of independence from the service sector while retaining a realistic relationship with the service needs. (9)

It is the relationship quoted above which poses questions for the qualifying associations. The experience of the Council was that freedom from service requirements during training was a major factor in encouraging the development of a new form of training. What is the relationship between the government department, <sup>responsibility</sup> for the service and the qualifying association to be? The Committee confirmed the close

relationship between service and training:

We believe that it is only within the Health Departments which are concerned with manpower forecasting and manpower deployment that educational policies can be properly related to long term manpower needs. (10)

What degree of freedom does such a relationship give the qualifying body to lay down conditions of entry to training or the standards to be attained? Examples exist in which the General Nursing Council in England and Wales has been overruled in the standards it considered necessary for adequate training or in the educational standard required of trainees in order to ensure benefit from the training programme. (11) In the case of the Council for Training Health Visitors, the constraints of finance upon the full development of training introduced in 1965 are described in Chapters 1 and 2 of this study.

The problems of relationship are not peculiar to nursing. The Merrison Committee (1975) reporting upon regulation in medicine state of the registering body:

It must be independent of the providers of the country's health services and it ought not to be the creature of the government. (12)

The position of the Central Council will be particular difficult in that the trainees will, for the most part, be in the service of the health authorities. Hume in a study of such relationship concludes:

Conceivably a government which is in the position of monopoly ought in certain circumstances to consider they should also exercise general powers of control and discipline which are ... in Great Britain exercised over the medical profession by the General Medical Profession. (13)

Such an observation draws attention to the danger that a registering body might become an agent of the State. The Committee on Nursing obviously did not see the qualifying body in such a light:

We believe the leadership function of the Council will be of crucial importance. It must not be a figurehead committee but a real and active force in reshaping the profession within an integrated National Health Service. (14)

How realistic is the hope of the Committee? While pointing out that representation of all interests is not practicable for the membership of the new registering body, the Committee attach:

More importance to the quality of its leadership than to the mathematics of representation. (15)

Yet comparative study of the composition of the existing bodies in relation to the way in which their policies develop might shed some light on the significance of the membership and constitution of qualifying associations in nursing which could be of value in future development.

The importance of the education element in the progress of the Council is emphasised in this thesis and the Committee on Nursing also laid stress on the importance of links between nursing education and other branches of education at every stage from pre-nursing to post-registration courses. (16)

We believe too that universities and other institutions of higher education should have opportunities to arrange courses. (17)

O'Connell (1978) draws attention to the problems encountered in the establishment of courses for nurses within universities when there is a lack of experience of education in such a setting among the members of the statutory body. (18) Another aspect of the problems of a body related to service but with a remit for education emerges. Can one body provide for both registration and further education? The Council in its evidence to the Committee on Nursing recommended the creation of a second organisation for Advanced Nursing and Research "for the exploration of methods of deepening and extending professional

knowledge". (19) The idea which was apparently put forward by a number of bodies was rejected by the Committee, (20) as was a similar proposal in medicine considered by the Merrison Committee. (21)

The decision to rely upon one body for registration and development, for what the Merrison Committee referred to as the "promotion of excellence" (22) raises questions as to what other resources may exist in nursing to support such excellence. In medicine there are bodies such as the Royal Colleges and the Royal Society of Medicine. There is no comparable body which might be said to fill the role of a learned society in nursing at present. The elements of such an organisation exist in the Research Society of the Royal College of Nursing and more recently in the decision of that body to create a number of Fellows. The Association Degree and Integrated Courses in Nursing also fills a gap in the resources for discussion and debate on developments at a higher level than that within the powers of a body entirely funded by the central government departments.

The final question raised by the case study of the Council for the Education and Training of Health Visitors concerns the degree of homogeneity existing in nursing. Is health visiting compatible with ~~the~~ nursing in general? The Council was satisfied that it had so identified the knowledge base of health visiting that the training could be readily applied to work in the many different settings in which the health visitor of the future might find herself. To do so the Council used different resources to those operating for general nurse training. In its efforts to achieve some standardisation, the Committee on Nursing sought to incorporate training for the health visitor within its main scheme. What is not clear is to what extent the Committee were able to

relate what had been achieved in the education of the health visitor to the nature of its qualifying body since 1962.

The relevance of the composition of a committee such as that on Nursing to its eventual report has parallels with the relevance of the membership of a qualifying association to its policies. The question of constitution is brought into focus once more. Kogan and Packman (1974) refer to the membership of advisory and consultative committees in education, pointing out that in the establishment of such bodies professional interests will predominate but "even within education there are distinctions to be drawn". (23) The distinction between health visiting and nursing is shown in this study to be sharp in terms of philosophy on training, resources used and the eventual field of work. In the absence of a member with experience of health visitor training or the provision of courses for nurses within further education the Committee's conclusions are predictable. The goal the members were set was the design of a unified nursing service and training. The tacit assumption appears to have been accepted that health visitors are nurses, members of a homogeneous profession, working in homogeneous service for a monopoly employer. While such a situation may result from the integration of the National Health Service, this case study suggests the need for further study of the relationship of a profession to a monopoly employer and of the relationship between the profession, the registering bodies and the central government departments.

The Act replacing the existing statutory framework of the nursing, midwifery and health visiting professions has been passed. The views of the present qualifying associations on the implementation of the Act have been sought. (24) The Committee on Nursing expressed the view

that nursing must become a research based profession. (25) The Royal Commission on the National Health Service refers to the progress made to date in nursing research in certain fields. (26) An area which appears to have been neglected so far is that of the <sup>nature</sup> ~~character~~ of the statutory framework of a registering body which will inhibit or facilitate the development of the nursing profession in what is a new setting of predominantly monopoly employment.

The differences and divisions which exist in nursing are emphasised in this thesis and it may be argued that study such as that advocated above will rest upon the value judgements which are peculiar to individuals or specific groups. Nevertheless acceptance that the employment position of the nurse has changed since 1974 and the postulation of a number of different options for future qualifying associations could be a fruitful source of study. Burgess writing of post-school education claims:

Value judgements are of great importance, objectivity rests not in denying their existence (which is dishonest) and in seeking to eliminate them (which is impossible) but in making explicit what they are and testing them. Value judgements are the hypotheses of social science: we cannot make progress without them. (27)

## References

## Introduction

All publications are London unless otherwise stated.

1. Rose, R. edits, (1969) Policy Making in Britain, Macmillan, p.168.
2. Eckstein, H. (1960) Pressure Group Politics, Allen and Unwin Preface.
3. Rose, R. (1969) op cit, p.168.
4. Adelman, C. Jenkins, D. and Kenmis, S. (1976) Rethinking case study, Cambridge Journal of Education, pp.137-150, Vol.6, Part 3.
5. Wilkie, E. (1969) History of the Council for the Education and Training of Health Visitors, Allen and Unwin.
6. Gottschalk, D. Kluckhohn, C. and Angell, R. (1945) The Use of Personal Documents in History, Anthropology and Sociology, Social Science Research Council Bulletin 53, pp.16-22, New York.
7. Carr, E.H. (1951) The New Society, Macmillan, p.9.
8. Adelman, C. et al (1976) op cit.
9. Secretary of State for Social Services, Secretary of State for Scotland and Secretary of State for Wales (1972) Report of the Committee on Nursing, (Chairman Asa Briggs) HMSO., Cmd. 5115.
10. Abel-Smith, B. (1960) A history of the nursing profession, Heinemann.
11. Hector, W. (1973) The Work of Mrs Bedford Fenwick, Royal College of Nursing.
12. Bendall, E. and Raybould, E. (1969) The General Nursing Council for England and Wales 1919-1969, H.K. Lewis.
13. Bowman, G. (1967) The Lamp and the Book, Queen Anne Press.
14. Maggs, C.J. (1978) Towards a social history of nursing, Nursing Times, 18th May, Occasional Paper, p.53, Vol.74, No.3.
15. Ibid.

## Chapter 1.

All publications are London unless stated otherwise.  
CTHV = Council for the Training of Health Visitors.  
CETHV = Council for the Education and Training of Health  
Visitors from 1971.

1. Health Visiting and Social Work (Training) Act, 1962, Section 2(1) and 2(2).
2. Carr Saunders, A. and Wilson, P. (1935) The Profession, Oxford University Press, p.390.
3. Health Visiting and Social Work (Training) Act, 1962, 1st Schedule, paras 12 and 13.
4. CTHV (1962) Proceedings of Council, HV/M/1, 26th October.
5. CTHV (1964) Report of Council 1962-64.
6. Wilkie, E. (1979) The History of the Council for the Education and Training of Health Visitors, Allen and Unwin, pp.17-19.
7. Ibid p.23.
8. Ministry of Health, Department of Health for Scotland, Ministry of Education (1956) An Inquiry into Health Visiting, Report of the Committee (Chairman Sir Wilson Jameson) HMSO., para 293.
9. Ibid.
10. Ministry of Health, Department of Health for Scotland (1959) Report of the Working Party on Social Workers in the local health authority, Health and Welfare Services (Chairman Eileen Younghusband) HMSO.
11. CTHV (1964) First Report of the Council for the Training of Health Visitors.
12. CTHV (1965) Guide to Training Rules, Rule 3(1)(c) p.58, Second Edition.
13. CTHV (1964) First Report of the Council for the Training of Health Visitors.
14. CTHV (1964) First Report of the Council for the Training of Health Visitors.
15. CTHV (1965) The Training of Health Visitors Handbook for Tutors and Examiners, 1971 edition, p.58.
16. Inquiry into Health Visiting (1956) op cit. pp.158-159.

17. Ibid para 394.
18. Ibid para 399.
19. The Ministry of Health (1963) The Development of Community Care, HMSO., Cmd. 1973.
20. Inquiry into Health Visiting (1956) para 256.
21. Inquiry into Health Visiting (1956) para 403.
22. CTHV (1964) First Report of the Council for Training of Health Visitors.
23. CTHV Council Memoranda HV/66/6.
24. Department of Health and Social Security (1972) Local Authority Nursing Staff, Circ. 13/72.
25. Griffith, J.A.G. (1966) Central Departments and Local Government, Allen and Unwin, p.488.
26. O'Connell, P.E. (1978) Health Visitor Education at University, Royal College of Nursing, p.71.
27. Brockington, C.F. (1964) A University Course in Nursing, North Manchester Hospital Management Committee.
28. Health Visiting and Social Work (Training) Act (1962) First Schedule, para 5(c).
29. Parliament Report of the Committee on Nursing (1972) (Chairman Asa Briggs) HMSO., Cmd. 5115, para 622.
30. Wilkie, E. (1979) op cit. pp.11-16.
31. Council for the Training of Health Visitors, Proceedings of Council, HV/M/24 19.5.66.
32. Health Visiting and Social Work (Training) Act (1962) First Schedule, Para 5(a).
33. Ministry of Health, Department of Health for Scotland, Ministry of Education (1956) An Inquiry into Health Visiting (Chairman Sir Wilson Jameson), HMSO., para 374.
34. Wilkie, E. (1979) op cit. pp.4 and 5.
35. Health Visiting and Social Work (Training) Act (1962) First Schedule, para 6.
36. Council for the Training of Health Visitors, Report of Joint Meeting with Standing Conference of Health Visitor Training Centre 17.4.64.
37. Wilkie, E. (1979) op cit. p.40.

38. Ibid, Appendix V.

39. Council for the Training of Health Visitors (1964)  
First Report.

## Chapter 2.

All publications are London unless stated otherwise.  
CTHV = Council for the Training of Health Visitors.  
CETHV = Council for the Education and Training of Health  
Visitors from 1971.

1. Wilkie, E. (1979) The History of the Council for the Education and Training of Health Visitors, Allen and Unwin, p.22.
2. Health Visiting and Social Work (Training) Act (1962) Second Schedule.
3. CTHV Correspondence with Scottish Advisory Committee 5.10.65.
4. Ministry of Health, Department of Health for Scotland, Ministry of Education (1956) An Inquiry into Health Visiting, Report of the Committee (Chairman Sir Wilson Jameson) HMSO.
5. Hansard, House of Commons Debate, Vol.649, c.1697, 24.11.61.
6. Ministry of Health General Grants (Health Authorities) Pooling Arrangement, Reg. 1960 (SI 1960 No.222) and circular 4/60.
7. CTHV., Letter from Chairman to Ministry of Health, Scottish Home and Health Department, Ministry of Health and Local Government Northern Ireland, 23.3.64.
8. Ministry of Health (1965) Circular 8/65 to Local Health Authorities.
9. CTHV., Report of Meeting between Staff of Council and Ministry of Health, 10.2.66.
10. Ministry of Health England and Wales Rate Support Grant (Health Authorities) Pooling Arrangements 1968, 444.
11. CTHV (1965) Second Report.
12. Wilkie, E. (1979) op cit. p.44.
13. CTHV Proceedings of Council HV/EC/M/9.
14. Department of Health and Social Security (1974) Report of the Committee into Pay and Related Conditions of Service of Nurses and Midwives (Chairman Earl of Halsbury) HMSO. para.68.
15. Wilkie, E. (1979) op cit. p.45.

16. Bresson, Carlo, Layard, Venables and Williams (1972) Patterns and Policies in Higher Education, Penguin, pp.123 and 124.
17. CETHV (1977) Sixth Report.
18. CTHV (1965) The Training of Health Visitors 1971 Edition, p.20. A handbook for Tutors and Examiners, CETHV.
19. CETHV (1977) Sixth Report p.9.
20. Wilkie, E. (1979) op cit. p.84.
21. Ibid p.67.
22. Ibid pp.72 and 73.
23. CTHV Correspondence with Local Authorities File 2016.
24. Wilkie, E. (1979) op cit. p.49.
25. Ibid p.25.
26. CETHV (1974) Fifth Report.
27. Parliament Report of the Committee on Nursing (1972) Chairman Asa Briggs) HMSO. Cmd 5115.
28. ~~CTHV~~ (1970) Evidence to the Committee on Nursing.
29. CETHV (1977) An Investigation into the Principles of Health Visiting, CETHV.
30. The Health Visiting and Social Work (Training) Act (1962) Section 2(1)(b).
31. CTHV (1965) Second Report p.4.
32. Ministry of Health, Department of Health for Scotland, Ministry of Education (1956) An Inquiry into Health Visiting, para 396.
33. The National Health Service Scotland SI 1965 No.1490.
34. CTHV Proceedings of Scottish Advisory Committee CTHV (SAC) M 3 10.6.63.
35. Wilkie, E. (1979) op cit. pp.98-99.
36. CTHV Proceedings of Scottish Advisory Committee SAC/M/47 12.12.74.
37. The National Health Service (Qualifications of Health Visitor and Tuberculosis Visitor) SI 1948 No.1415.

38. Campbell, K. and Spalding, W.J. The Male Health Visitor, Nursing Mirror, 26.1.65.
39. CTHV (1964) First Report.
40. Wilkie, E. (1979) op cit. p.95.
41. O'Connell, P.E. (1978) Health Visitor Education at University, Royal College of Nursing, p.61.
42. Ministry of Health, Scottish Home and Health Department (1966) Report of the Committee on Senior Nursing Staff Structure (Chairman Brian Salmon) HMSO.
43. Department of Health and Social Security, Scottish Home and Health Department, Welsh Office (1969) Report of the Working Party on Management Structure in the Local Authority Nursing Service (Chairman E.L. Mayston).
44. CETHV List of Refresher and other Special Courses 1974/75 HV 105/74.
45. McEwan, M. (1951) Health Visiting, Faber, p.27.
46. CETHV (1974) Fifth Report, p.4.
47. CETHV List of Refresher and other Special Courses 1974/75 HV/105/74.
48. CETHV (1973) Report of Study Day, 25.10.73.
49. CETHV (1974) Fifth Report, p.3.
50. Health Visiting and Social Work (Training) Act (1962) Section 2(1)(d).
51. Marris, T. (1971) The Work of the Health Visitor in London, The Greater London Development and Planning Department, Report 12, Greater London Council.
52. Warin, J. (1962) Letter in The Medical Officer, 7.12.63 p.359.
53. Abel, R.A. (1969) Nursing Attachment to General Practice, HMSO.
54. Reedy, L.E.C. (1977) The Health Team in
55. Wilkie, E. (1979) op cit. pp.80 and 81.
56. Fader, W. (1977) A Comparison of Examination Standards for Qualifying Health Visitors, National Foundation for Educational Research.

57. CETHV (1977) An Evaluation of Integrated Nurse/Health Visitor Schemes of Training, CETHV.
58. CETHV (1975) A Small Investigation on Field Work Range of Experience File Reference 1460.
59. Parliament (1968) Report of the Committee on Local Authority Social Services (Chairman F. Seebohm) HMSO. Cmd. 3703.
60. CTHV (1968) Comments on the Administrative Structure of the Medical and Related Services HV/68/32.
61. Wilkie, E. (1979) op cit. pp.100-101.
62. Central Council for Education and Training in Social Work Order (1974) SI No. 1265.
63. Parliament (1972) Report of the Committee on Nursing.
64. Hansard House of Commons Debate, Vol.801, cc.976 and 977, 11.5.70.
65. CETHV Proceedings of Council HV/M/42 16.4.70.
66. CETHV Comments on the Report of the Committee on Nursing, February 1973, CETHV.

### Chapter 3.

All publications are London unless stated otherwise.  
CTHV = Council for the Training of Health Visitors.  
CETHV = Council for the Education and Training of Health  
Visitors from 1971.

1. Ministry of Health, Department of Health for Scotland  
Ministry of Education (1956) An Inquiry into Health  
Visiting, Report of the Committee (Chairman  
Sir Wilson Jameson) HMSO.
2. Simon, J. (1897) English Sanitary Institutions,  
Murray, p.115.
3. Thomson, D. (1950) England in the Nineteenth Century,  
Penguin, p.115.
4. Brockington, C.F. (1956) A Short History of Public  
Health, 1966 Edition, Churchill, p.107.
5. McCleary, G.F. (1935) The Maternity and Child  
Welfare Movement, King, p.177.
6. Woodham-Smith, C. (1950) Florence Nightingale,  
Constable, p.569.
7. Lane-Claypen, J. (1920) The Child Welfare Movement,  
Bell & Sons, p.3.
8. McCleary, G.F. (1935) op cit. p.20.
9. Lane-Claypen, J. (1920) op cit, p.20.
10. McCleary, G.F. (1935) op cit. p.153.
11. Ibid p.160.
12. McEwan, M. (1951) Health Visiting, Faber, p.24.
13. Woodham-Smith, C. (1950) op cit. p.567.
14. Stocks, M. (1960) A Hundred Years of District Nursing,  
Allen and Unwin, p.72.
15. Ibid p.93.
16. Joint Consultative Committee of Institutions approved  
by the Minister of Health for the Training of Health  
Visitors and Organisations of Health Visiting (1943)  
The Duties of the Health Visitor in the Present and  
Future Health Service, The Committee.
17. Department of Health and Social Security (1976) Fit  
for the Future, Report of the Committee on Child Health  
Services (Chairman Professor Court) Vol.1, HMSO.  
Cmnd. 6684 p.109.

18. National Health Service Act (1946) Section 24.
19. McEwan, M. (1951) op cit. p.128.
20. Ministry of Health, Department of Health for Scotland, Ministry of Education (1956) An Inquiry into Health Visiting, para 326.
21. The Midwives Rules, Approval Instrument SI 1955 No.120.
22. Ministry of Health, Department of Health for Scotland, Ministry of Education (1956) An Inquiry into Health Visiting, para 328.
23. Ministry of Health, Department of Health for Scotland (1959) Report of a Working Party on Social Workers (Chairman Miss E. Younghusband) HMSO. para 959.
24. Ibid para 983.
25. Ibid para 1102.
26. Department of Health for Scotland (1982) Report on the Health and Welfare Services, HMSO. Cmd. 1996 para 17.
27. Clark, J. (1973) A Family Visitor, Royal College of Nursing, p.3.
28. Akester, J.M. and MacPhail, A.N. (1963) Health Visiting in the Sixties, Macmillan, p.37.
29. Clark, J. (1973) op cit. p.105.
30. McEwan, M. (1951) op cit. p.21.
31. Lane-Claypen, J. (1920) op cit. p.105.
32. Tait, H.P. (1974) A Doctor and Two Policemen, Edinburgh Health Department, p.246.
33. Lane-Claypen, J. (1920) op cit. p.103.
34. CTHV (1967) Third Report.
35. McCleary, G.F. (1935) op cit. p.33.
36. Lane-Claypen, J. (1920) op cit. p.105.
37. Clark, J. (1973) op cit. p.14.
38. Lane-Claypen, J. (1920) op cit.p.106.
39. Tait, H.P. (1974) op cit. p.242.
40. O'Connell, P.E. (1978) Health Visitor Education at University, Royal College of Nursing, p.57.

41. Ibid, p.58.
42. Wilkie, E. (1979) The History of the Council for the Education and Training of Health Visitors, Allen and Unwin, p.28.
43. Ministry of Health, Department of Health for Scotland, Ministry of Education, An Inquiry into Health Visiting, p.ii, (1956).
44. Tait, H.P. (1974) op cit. p.247.
45. Ministry of Health, Department of Health for Scotland, Ministry of Education (1956) An Inquiry into Health Visiting, para 378.
46. O'Connell, P.E. (1978) op cit. p.44.
47. CTHV (1964) First Report.
48. Tait, H.P. (1974) op cit. p.247.
49. Wilkie, E. (1979) op cit. pp.17-19.
50. O'Connell, P.E. (1978) op cit. p.46.
51. Ibid p.17.

#### Chapter 4.

All publications are London unless stated otherwise.  
CTHV = Council for the Training of Health Visitors.  
CETHV = Council for the Education and Training of Health  
Visitors from 1971.

1. Ministry of Health, Department of Health for Scotland, Ministry of Labour and National Service (1947) Report of the Working Party on the Recruitment and Training of Nurses (Chairman Sir Robert Wood) HMSO. para 136.
2. Brockington, F. and Davies, I.G. (1949) The Need for a Revision in the Training of the Health Visitor, Public Health, April 1949.
3. Windmuller, I. (1954) The Health Visitor in the Social Work Field, Paper presented at 63rd Annual Congress of the Royal Society of Health, Report of Congress, p.166.
4. Ministry of Health, Department of Health for Scotland, Ministry of Education (1956) An Inquiry into Health Visiting, Report of the Committee (Chairman Sir Wilson Jameson) para 361-364.
5. Williams, H. (1962) The Integrated Nurse/Health Course: a report of the first 5 years of the experimental course organised by the University of Southampton and the Nightingale Training School of St. Thomas' Hospital, St. Thomas' Hospital Limited Edition.
6. Brockington, F. (1964) A University Course in Nursing, Report of the first 4 years of the Manchester University Experimental Course, Crumpsall Hospital School of Nursing, Manchester.
7. Bryden, E.G.M. (1969) Integrated Course in Nurse Education, A study of an experiment, Queen's Institute of District Nursing.
8. Bendall, E. and Raybould, E. (1969) The General Nursing Council for England and Wales, 1919-1969, Lewis.
9. Hector, W. (1973) The Work of Mrs Bedford Fenwick, Royal College of Nursing, p.307.
10. Bendall, E. and Raybould, E. (1969) op cit. p.51.
11. Ministry of Health, Department of Health for Scotland, Ministry of Labour and National Service (1947) Report of the Working Party on the Recruitment and Training of Nurses (Chairman Sir Robert Wood) HMSO. para 140.

12. The Royal College of Nursing (1964) A Reform of Nursing Education, First Report of a special committee on nurse education (Chairman Sir Harry Platt) Royal College of Nursing.
13. Parliament (1972) Report of the Committee on Nursing op cit. paras 270-284 and 285-300.
14. Clark, J. (1973) A Family Visitor, Royal College of Nursing, p.14.
15. Ministry of Health, Department of Health for Scotland, Ministry of Education (1956) An Inquiry into Health Visiting, op cit. para 345.
16. O'Connell, P.E. (1978) Health Visitor Education at University, Royal College of Nursing, p.60.
17. Wilkie, E. (1979) op cit. p.97.
18. National Health Service (Qualifications of Health Visitors) Regulation 1972 SI 1972 no. 1822.  
National Health Service (Qualifications of Health Visitors)(Scotland) Regulations 1973 SI 1973 No.63.
19. Royal Society of Health (1963) Regulations and Syllabus for the Examinations for Health Visitors in England and Wales Form E 21.
20. Scottish Home and Health Department (1963) Experimental Training at Glasgow Infirmary, HMSO.
21. General Nursing Council for England and Wales, Annual Report, 1972-1973.
22. Wilkie, E. (1979) op cit. p.18.
23. O'Connell, P.E. (1976) Community and Hospital in University Nurse Education: the Southampton Experience, unpublished PhD. thesis, University of Southampton, p.374.
24. Wilkie, E. (1979) op cit. pp.40-41.
25. Ibid pp.28-31.
26. Clark, J. (1973) op cit. p.106.
27. Wilkie, E. (1979) op cit. p.39.
28. Ibid p.28.
29. CETHV (1971) Training of Health Visitors, CETHV p.20, Handbook for Tutors and Examiners.
30. CTHV (1965) Proceedings of Education Committee HV/EC/MG 21.1.65.

31. Fader, W. (1976) The Examination for Qualifying Health Visitors, National Foundation for Educational Research, p.96.
32. Ibid p.96.
33. CETHV (1971) The Training of Health Visitors, CETHV p.12.
34. Wilkie, E. (1979) op cit. p.29.
35. Ministry of Health (1983) The Development of Community Care, HMSO. Cmd. 1973.
36. CTHV (1967) Third Report.
37. Ministry of Health, Department of Health for Scotland. Ministry of Education (1956) An Inquiry into Health Visiting, op cit. para 409.
38. CTHV (1967) Proceedings of Recruitment Committee HV/RC/67/2.
39. Hall, Land, Parker and Webb (1975) Change, Choice and Conflict in Social Policy, Heinemann Paperback p.28.

## Chapter 5

All publications are London unless stated otherwise.  
CTHV = Council for the Training of Health Visitors.  
CETHV = Council for the Education and Training of Health  
Visitors from 1971.

1. Millersop G. (1964) The Qualifying Associations,  
Routledge & Kegan Paul, pp.32-40.
2. Ministry of Health, Department of Health for Scotland,  
Ministry of Education (1956) An Inquiry into Health  
Visiting, Report of the Committee (Chairman Sir  
Wilson Jameson) HMSO.
3. Ministry of Health, Department of Health for Scotland,  
Report of a Working Party on Social Workers (Chairman  
Miss Eileen Younghusband) HMSO.
4. Health Visitors and Social Work (Training) Act (1962)  
Sec.2.
5. Ibid Second schedule.
6. Bendall, E. and Raybould, E. (1969) A History of the  
General Nursing Council for England and Wales 1919-1969.
7. Royal College of Nursing (1943) Report of the Nursing  
Reconstruction Committee (Chairman Lord Horder)  
Supplement B Post Registration Nursing Education (1945)  
Royal College of Nursing.
8. Gardener, M.G. (1977) The Joint Board of Clinical  
Nursing Studies, Journal of Advanced Nursing, p.622  
Vol.2, No.6.
9. Bowman, G. (1967) The Lamp and the Book, Queen Anne  
Press, p.34.
10. Ibid p.99.
11. Royal College of Nursing, Approval of Course,  
Information circular for Colleges.
12. McEwan, M. (1951) Health Visiting, Fa ter, p.23.
13. O'Connell, P. (1978) Health Visitor Education at  
University, Royal College of Nursing, p.57.
14. Ministry of Health, Department of Health for Scotland,  
Ministry of Education (1956) An Inquiry into Health  
Visiting, op cit. para 375.
15. Millerson, G. (1964) op cit. p.54.

16. Pomeranz, R. (1973) The Lady Apprentices, Occasional Papers on Social Administration, No.51, Bell.
17. Maggs, C.J. (1978) Towards a Social History of Nursing (1) Nursing Times, 18 May Occasional Paper pp.53-56, Vol.74 No.14.  
(2) Nursing Times, 25 May Occasional Paper pp.57-58, Vol.74, No.15.
18. Davies, C. (1978) Four Events in Nursing History: a new look.  
(1) Nursing Times, 22 June Occasional Paper pp.65-68, Vol.74, No.17.  
(2) Nursing Times, 29 June Occasional Paper pp.69-71, Vol.74, No.18.
19. Maggs, C.U. (1978) op cit. p.53.
20. Ministry of Health, Department of Health for Scotland, Ministry of Education (1956) An Inquiry into Health Visiting op cit. para 396.
21. Ministry of Health, Department of Health for Scotland (1959) Report of the Working Party on Social Workers (Chairman Miss E. Younghusband) HMSO., paras 875 and 903.
22. Davies, C. (1978) op cit. p.67.
23. Wilkie, E. (1979) The History of the Council for the Education and Training of Health Visitors, Allen and Unwin.
24. Hansard (1969) House of Commons Debate 801 cc 974 976.
25. Nurses Act (1949) Section 12(2).
26. Bendall, E. and Raybould, E. (1969) op cit. pp.87 and 88, 151 and 152.
27. Ibid p.188.
28. The Health and Safety Commission (1977) Occupational Health Services, The Way Ahead, HMSO. Table 3, p.11.
29. Parliament (1972) The Report of the Committee on Nursing (Chairman Asa Briggs) HMSO. Cmdnd 5115, paras 638 and 639.
30. Parliament (1975) The Report of the Committee of Inquiry into the Regulation of the Medical Profession (Chairman A. Merrison, FRS) HMSO., Cmdnd. 6018, para 404.
31. Kogan, A. and Parwood, T. (1974) Advisory Councils and Committees in Education, Routledge and Kegan Paul, p.27.

32. Ibid p.25.
33. Wilkie, E. (1979) op cit. pp.41-45.
34. Gilmore, M. Bruce, N. Hunt, M. (1974) The Work of the Nursing Team in General Practice, CETHV.7
35. Wilkie, E. (1979) op cit. p.79.
36. Millerson, G. (1964) op cit. p.50.
37. Forder, A. and Kay, S. (1973) Social Work in Social Policy, ed M.H. Cooper, Blackwell, Oxford, p.26.
38. Carr Saunders, A. & Wilson, P.A. (1933) The Professions, 1963 Edition, Clarendon Press, p.307.

## Chapter 6.

All publications are London unless stated otherwise.  
CTHV = Council for the Training of Health Visitors.  
CETHV = Council for the Education and Training of Health  
Visitors from 1971.

1. Cook, T.G. (1973) Education and the Professions, ed. T.G. Cook, History of Education Society, Methuen, Preface.
2. Ministry of Health, Department of Health for Scotland, Ministry of Education (1956) An Inquiry into Health Visiting (Chairman Sir W. Jameson) HMSO.
3. Ministry of Education (1956) Technical Education, Cmd. 9703.
4. Parliament (1963) Higher Education Report of the Committee (Chairman Lord Robbins) HMSO. Cmd 2154 para 42.
5. Vaisey (1971) Studies in Contemporary Europe, Harmondsworth.
6. Kogan, M. (1971) Politics of Education, Penguin Books, p.19.
7. Ibid p.66.
8. Beard, R. (1970) Teaching and Learning in Higher Education, Penguin Books, p.193.
9. Broson, Carter, Layard, Venables and Williams, (1972) Patterns and Policies in Higher Education, Penguin Books, p.85.
10. Ibid p.126.
11. Burgess, T. (1977) Education after School, Gollancz p.172.
12. Bendall, E. and Raybould, E. (1969) A history of the General Nursing Council for England and Wales 1919-1969, H.K. Lewis, p.263.
13. Macfarlane Smith (1968) The use of multiple choice questions. Paper presented to External Examiners' meeting of Council for Training of Health Visitors HV/EC/68/16.
14. CETHV (1976) Regulations for the Appointment, Briefing, Role and Responsibilities of External Examiner, Amended June 1978.
15. Bloom, B.S. (ed) (1956) Taxonomy of Educational Objectives: The Classification of Educational Goals Handbook 1, Longmans.

16. World Health Organisation (1974) Education Strategies for the Health Professions, Public Health Paper, no.61.
17. Broson (1972) in Policies and Patterns in Higher Education, op cit. pp.123-124.
18. O'Connell, P.E. (1978) Health Visitor Education at University, Royal College of Nursing.
19. Ibid p.77.
20. Burgess, T. (1977) op cit. pp.198-199.
21. Wilkie, E. (1979) The History of the Council for Education and Training of Health Visitors, Allen & Unwin, p.40.
22. Niblett, Humphries and Fairhurst (1975) The University Connection, National Foundation for Educational Research, pp.175-176.
23. Parliament, Report of a Committee of Inquiry into the Regulation of the Medical Profession (1975) (Chairman A. Merrison, FRS.) HMSO. para 6.
24. Parliament (1963) Higher Education op cit. para 433.
25. Niblett, et al (1975) op cit. p.259.
26. Parliament (1963) Higher Education op cit. para 427.
27. Whitburn, Mealing and Cox (1976) People in Polytechnics, Research in Higher Education Monograph, University of Surrey.
28. Burgess, T. (1977) op cit. p.31.
29. Wilkie, E. (1979) op cit. pp.18 and 19.
30. Burgess, T. (1977) op cit. p.28.
31. Ministry of Health, Department of Health for Scotland, Ministry of Education (1956) On Inquiry into Health Visiting.
32. Ministry of Health, Department of Health for Scotland (1959) Report of the Working Party on Social Workers (Chairman Miss E. Younghusband) HMSO.

## Chapter 7

All publications are London unless stated otherwise.  
CTHV = Council for the Training of Health Visitors.  
CETHV = Council for the Education and Training of Health  
Visitors from 1971.

1. National Health Service (Qualifications of Health Visitors and Tuberculosis Visitors) Regulation SI 1415 1948.
2. Wilkie, E. (1979) The History of the Council for Training and Education of Health Visitors, Allen & Unwin, p.99.
3. National Health Service Act (1946) Section 24.
4. Ministry of Health, Department of Health for Scotland, Ministry of Labour and National Service (1947) Report of the Working Party on the Training and Recruitment of Nurses (Chairman Sir Robert Wood) HMSO.
5. Parliament (1972) Report of the Committee on Nursing (Chairman Asa Briggs), HMSO. Cmd. 5115.
6. Ibid p.1.
7. Ibid paras 85 and 86.
8. Health Visitors Association (1970) Health Visiting, a Manifesto HVA.
9. Bowman, G. (1967) The Lamp and the Book, Queen Anne Press, p.90.
10. Freidson, E. (1976) The Future of Professionalisation in Stacey, M. Heath, C. Reid, M. Dingwall, R. eds. in Health and the Division of Labour, Croom Helm 1977.
11. Owen, G. (1977) Health Visiting, Bailliere Tindall.
12. Health Visitors Association (1970) op cit.
13. Royal College of Nursing (1971) The Role of the Health Visitor, Royal College of Nursing.
14. CTHV (1970) Evidence to the Committee on Nursing, paras 19 and 20, CTHV.
15. Owen, G. (1977) op cit. p.18.
16. World Health Organisation (1959) 4th Report of the Committee on Nursing Technical Report 147, Geneva.
17. Ministry of Health, Department of Health for Scotland, Ministry of Education (1956) An Inquiry into Health Visiting, Report of a Working Party (Chairman Sir Wilson Jameson) HMSO.

18. Royal College of Nursing (1964) A Reform of Nursing Education, Report of a special committee (Chairman Sir Harry Platt), Royal College of Nursing.
19. Ibid para 27.
20. Forder, A. (1969) Penelope Hall's Social Services of England and Wales, Routledge and Kegan Paul, p.182.
21. Kogan, M. and Terry, J. (1971) The Organisation of a Social Services Department, a Blue Print, Bookstall Publications, p.57.
22. Henderson, V. (1968) Basic Principles of Nursing Care, International Council of Nurses, Geneva.
23. International Council of Nurses (1973) International Nursing Review, 5, 131.
24. CTHV (1966) The Function of the Health Visitor, CTHV.
25. Parliament (1972) Report of the Committee on Nursing, op cit. para 91(b).
26. Abel-Smith, B. (1960) History of the Nursing Profession, Heinemann, p.241.
27. Dingwall, R. (1976) The Social Organisation of Health Visitor Training, Nursing Times, 4th March Occasional Paper, Vol
28. Abel-Smith, B. (1960) op cit. p.247.
29. Parliament (1972) Report of a Committee on Nursing, op cit. paras 107-109.
30. Ibid para 454.
31. National Health Service Scotland, SI No.1490, 580 1965.
32. Wilkie, E. (1979) op cit. p.98.
33. Royal College of Nursing (1972) Annual Report.
34. Health Visitors Association, Letter from General Secretary, 4.12.79.
35. Baly, M. (1975) Professional Responsibility in the Community Health Service, HM+M Publishers, p.34.
36. Gilmore, M. Bruce, N. and Hunt, M. (1974) The Work of the Nursing Team in General Practice, CETHV.
37. Health Visitors Association (1970) Health Visiting, A Manifesto HVA.

38. Health Visitors Association (1975) Health Visiting in the Seventies, HVA p.3.
39. Gilmore, M. et al (1974) op cit. pp.50 and 51.
40. Ferguson, M. (1976) Development of the Nurse Practitioner, Journal of Advanced Nursing, Vol.3, p.240.
41. Gilmore, et al (1974) op cit, p.74.
42. The Nursing Standard, Official organ of the Royal College of Nursing, 29.11.79, p.6.
43. Ward, M.J. (1979) The Nurse Practitioner: Perceived Competence, Nursing Research, Vol.28, no. 6, p.344.
44. Wilkie, E. (1979) op cit. p.25.
45. Abel-Smith, B. (1980) op cit. p.25.
46. McEwan, M. (1951) Health Visiting, Faber, p.138.
47. Stocks, M.L. (1960) A Hundred Years of District Nursing, Allen & Unwin, p.34.
48. Ibid p.81.
49. Nuffield Provincial Hospitals Trust, The 1953 Survey of the work of the Health Visitors (circulated privately in 1953).
50. National Health Service 1947 - Circular 118/47 para 27.
51. Bowman, G. op cit. pp.100-101.
52. Griffiths, J.A.G. (1966) Central Departments and Local Authorities, Allen & Unwin, p.499.
53. Ministry of Health, Department of Health for Scotland, Ministry of Education (1958) An Inquiry into Health Visiting op cit. paras 367 and 368.
54. CTHV (1965) Second Report p.4.
55. Health Visitors and Social Work (Training) Act 1982 Section 2(1)(b).
56. Ministry of Health, Scottish Home and Health Department (1966) Report of the Committee on senior nursing staff structure (Chairman Brian Salmon) HMSO.
57. Department of Health and Social Security, Scottish Home and Health Department, Welsh Office (1969) Report of the Working Party on Management Structures in the Local Authority Nursing Services (Chairman E.L. Mayston).

58. Levitt, R. (1975) The Reorganised National Health Service, 1977 edition, Croom Helm, p.132.
59. Royal College of Nursing (1968) Administering the Local Authority Nursing Service, Royal College of Nursing.
60. Davies, C. (1978) Four Events in Nursing History, Nursing Times, 29 June Occasional Paper Vol.74, No.18, p.70.
61. Royal College of Nursing (1969) The Future of Nursing in Relation to the Needs of the Community. Royal College of Nursing.
62. CTHV (1964) First Report, CTHV.
63. CETHV (1974) Membership of Council 1968-71. Fifth Report.
64. Ibid Membership of Council 1971-74.
65. Health Visitors Association (1975) op cit. p.6. HVA.
66. Wilkie, E. (1979) op cit. p. 100 and 101
67. Ibid pp.100-101.

## Chapter 8

All publications in London unless stated otherwise.  
CTHV = Council for the Training of Health Visitors.  
CETHV = Council for the Education and Training of Health  
Visitors from 1971.

1. Wilkie, E. (1979) The History of the Council for the Education and Training of Health Visitors, Allen & Unwin, p.100.
2. National Health Service Act (1946) Part III.
3. National Assistance Act (1948) Section 47.
4. Ministry of Health (1956) Report of the Committee of Enquiry into the cost of the National Health Service (Chairman C.W. Guillebaud) HMSO., Cmd. 9663.
5. Parliament (1969) Report of the Royal Commission on Local Government in England (Chairman Lord Redcliffe-Maud) HMSO., Cmd. 4040.
6. Parliament (1969) Report of the Committee on the Local Authority and Allied Personal Social Services (Chairman F. Seeborn) HMSO., Cmd. 3703.
7. Ibid, para
8. Ministry of Health, Department of Health for Scotland, Ministry of Education (1956) An Inquiry into Health Visiting (Chairman Sir Wilson Jameson) HMSO.
9. Health Visiting and Social Work (Training) Act 1962.
10. CTHV Proceedings of Council HV/M/1 25.10.62.
11. CTHV Proceedings of Council HV/M/24 19.5.66.
12. Ministry of Health (1968) The Administrative Structure of Medical and Related Services in England and Wales, HMSO.
13. Hansard, House of Lords Debates, Vol.240, C.1123.
14. Wilkie, E. (1979) op cit. p.11.
15. Ibid, p.12.
16. Levitt, R. (1976) The Reorganised National Health Service, 1977 Edition, pp.20 and 21.
17. Wilkie, E. (1979) op cit. p.103.
18. Brown, R.G.S. (1975) The Management of Welfare, Fontana, p.117.

19. Aiken, M. and Haug, J.H. (1968) Organisational Interdependence and Intra-Organisational Structure in Inter-organisational relations, ed W.M. Evans, Penguin Education 1976.
20. Health Visiting and Social Work (Training) Act (1962).
21. CETHV (1974) Fifth Report.
22. Brown, R.G.S. (1975) op cit. p.137.
23. Forder, A. and Kay, S. (1973) Social Work in Social Policy, ed M.H. Cooper, Blackwell, Oxford, pp.26-27.
24. Ministry of Health (1968) The Administrative Structure of Medical and Related Services in England and Wales, HMSO.
25. Levitt, R. (1976) op cit. p.213.
26. Hume, J.B. (1964) The Professions and the State, Scottish Home and Health Department, p.109.
27. Mackintosh, J. (1951) Trends of Opinion about Public Health, Oxford University Press, p.185.
28. Griffiths, J.A.G. (1966) Central Departments and Local Authorities, Allen & Unwin, p.499.
29. Ministry of Health (1963) The Development of Community Care, HMSO., Cmd. 1973.
30. Powell, E. (1966) Medicine and Politics, Pitman Medical, p.15.
31. CTHV Proceedings of Council HV/M/24 19.5.66.
32. CETHV (1974) Fifth Report.
33. CTHV (1969) The Function of the Health Visitor: implications for training.
34. Abel, R.A. (1969) Nursing Attachments to General Practice, HMSO.
35. Gilmore, M. Bruce, N. and Hunt, M. (1974) The Work of the Nursing Team in General Practice, CETHV.
36. CTHV (1969) Fourth Report.
37. CETHV (1974) Fifth Report.
38. CETHV (1973) Joint Report of Scottish Advisory Committee and Scottish Council of Royal College of General Practitioners.

39. CTHV (1968) Programme for Tutors' Study Day, January.
40. CTHV (1969) Programme for Tutors' Study Day, February.
41. CETHV (1972) Programme for Tutors' Conference, September.
42. Parliament (1972) Report of the Committee on Nursing (Chairman Asa Briggs) HMSO. Cmd. 5115, Table 23.
43. CETHV (1977) An Investigation into the Principles of Health Visiting, CETHV.
44. Levitt, R. (1976) op cit. p.33, Fig.4.
45. Health Visitors Association (1975) Health Visiting in the Seventies, HVA.
46. Griffiths, J.A.G. (1966) op cit. p.525.
47. Brown, R.G.S. (1970) The Administrative Process in Britain, Methuen, p.82.
48. Health Visiting and Social Work (Training) Act, (1962) Section 2(1)(b).
49. CTHV (1968) Comments on the Administrative Structure of the Medical and Related Services in England and Wales HV/68/32.
50. The Department of Health and Social Security (1970) The Future Structure of the National Health Service, HMSO.
51. CTHV (1970) Comments on the future structure of the National Health Service in England HV/70/18.
52. CETHV (1974) Fifth Report.
53. CTHV (1969) Comments on the Administrative Reorganisation of the Scottish Health Services, HV/69/23.
54. Parliament (1972) Report of the Committee on Nursing op cit. Para 3.
55. Ministry of Health, Department of Health for Scotland (1955) Report of the Working Party on the Training of District Nurses (Chairman Sir Frederick Armer) HMSO.
56. Ministry of Health (1959) Training of District Nurses, Report of Advisory Committee (Chairman D.H. Ingall) HMSO.
57. CTHV (1971) Joint Working Group of the Panel of Assessors and the Council for the Training of Health Visitors, Report of meeting 11.1.71.

58. CTHV (1970) Evidence to the Committee on Nursing, CTHV.
59. Scottish Home and Health Department (1972) Nurses in an Integrated Health Service, HMSO., p.23.
60. CETHV (1974) Fifth Report.
61. Parliament (1972) Report of the Committee on Nursing, op cit. paras 618-623.
62. CETHV (1973) Comments on the Report of the Committee on Nursing, para 3, CETHV.
63. Wilkie, E. (1979) op cit. p.107.
64. Society of Medical Officers of Health (1973) Comments on the Report of the Committee on Nursing.
65. Royal College of Nursing (1973) Comments on the Report of the Committee on Nursing.
66. Society of Chief Nursing Officers (Public Health) (1973) Comments on the Report of the Committee on Nursing.
67. Central Council for the Education and Training of Social Workers (1973) Comments on the Report of the Committee on Nursing, para 14.
68. British Hospital Journal and Social Service Review (1972) Editorial, 11th Nov. Vol. LXXXII, No. 4308.
69. City of Leeds Health Visitors (1973) Letters to 6 Members of Parliament for the City of Leeds, 2.5.73.
70. CETHV (1973) Comments on the Report of the Committee on Nursing, para 4.
71. Parliament (1972) Report of the Committee on Nursing, op cit. para 346.
72. Ibid, para 548(b).
73. CETHV (1973) Comments on the Report of the Committee on Nursing, para 24.
74. Wilkie, E. (1979) op cit. p.108.

## Chapter 9.

All publications in London unless stated otherwise.  
CTHV = Council for the Training of Health Visitors.  
CETHV = Council for the Education and Training of Health  
Visitors from 1971.

1. Ministry of Health, Department of Health for Scotland.  
Ministry of Education (1956) An Inquiry into Health  
Visiting (Chairman Sir Wilson Jameson) HMSO, Para 375.
2. Nurses, Midwives and Health Visitors Act (1979)  
Section 1(1).
3. Millerson, G. (1964) The Qualifying Associations,  
Routledge and Kegan Paul, p.37.
4. Parliament (1972) Report of the Committee on Nursing  
(Chairman Asa Briggs) HMSO., Cmnd.5115, para 719.
5. Scottish Home and Health Department (1972) Nurses in  
an Integrated Health Service, HMSO., Edinburgh, p.23.
6. Parliament (1979) Report of the Royal Commission on  
National Health Service, HMSO., Cmnd. 7615, para.13.51.
7. Parliament (1972) Report of the Committee on Nursing,  
op cit, para 618.
8. Ibid para 621.
9. Ibid para 622.
10. Ibid para 649.
11. Bendall, E. and Raybould, E. (1969) A History of the  
General Nursing Council for England and Wales 1919-1969,  
H.K. Lewis, p.151 and pp.186-188.
12. Parliament (1975) Report of a Committee of Inquiry  
into the Regulation of the Medical Profession  
(Chairman Sir Alec Merrison) HMSO., Cmnd.6018, para 9.
13. Hume, U.B. (1964) The Professions and the State, The  
Scottish Home and Health Department.
14. Parliament (1972) Report of the Committee on Nursing,  
op cit, para 633.
15. Ibid, para 634.
16. Ibid, para 362.
17. Ibid, para 368.
18. O'Connell, P.E. (1978) Health Visitor Education at  
University, Royal College of Nursing, pp.18 and 19.

19. CTHV (1970) Evidence to the Committee on Nursing, paras 57,58,59.
20. Parliament (1972) Report of the Committee on Nursing, op cit. para
21. Parliament (1975) Report of a Committee on Inquiry into the Regulation of the Medical Profession, op cit. para 385.
22. Ibid, para 18.
23. Kogan, M. and Packman, T. (1974) Advisory Councils and Committees in Education, Routledge and Kegan Paul, p.28.
24. Department of Health and Social Security (1974) Correspondence with Council for Education and Training of Health Visitors, November.
25. Parliament (1972) Report of the Committee on Nursing, op cit. para 370.
26. Parliament (1979) Report of the Royal Commission on the National Health Service, op cit. paras 13.56 and 13.57.
27. Burgess, T. (1977) Education after School, Gollancz, p.230.

Additional Sources Consulted (Unreferenced)

1. Barnard, K. and Lee, K. (1977) Conflicts in the National Health Service, Croom Helm.
2. Brown, R.G.S. and Stones, R.W.H. (1973) The Male Nurse, Occasional Papers in Social Administration No.52, G. Bell.
3. Bulmer, M. (ed) (1977) Sociological Research Methods, Macmillan.
4. Cochrane, A.L. (1972) Effectiveness and Efficiency, Random Reflections on Health Services, The Nuffield Provincial Hospitals Trust.
5. Catgrove, B. (1967) The Science of Society, Allen & Unwin.
6. Eldridge, J.E.T. and Crombie, A.D. (1974) A Sociology of Organisations, Allen & Unwin.
7. Etzioni, A. (ed) (1969) The Semi-professions and their Organization: Teachers, Nurses and Social Workers, New York.
8. Halmes, P. (1970) The Personal Service Society, Constable.
9. Holcombe, L. (1973) Victorian Ladies at Work, David and Charles, Newton Abbot.
10. Kimber, R. and Richardson, J.J. (eds) Pressure Groups in Britain: a reader, Dent 1974.
11. Mackintosh, J.P. (1977) The Government and Politics of Britain, 4th edition, Hutchinson.
12. McLachlan, G. (ed) (1972) Problems and Progress in Medical Care, Seventh Series, Nuffield Provincial Hospitals Trust, Oxford University Press.
13. Madge, J. (1953) The Tools of Social Science, Longman's Green.
14. Marsh, G. and Kaim Candle, P. (1976) Team Care in General Practice, Croom Helm.
15. White, R. (1978) Social Change and the Nursing Profession, Henry Kimpton.
16. Willcocks, A.J. (1967) The Creation of the National Health Service.

**Appendix A**

**Membership of the First Council 1962-1965**

**Source:**

**Wilkie (1979) The History of  
the Council for the Education  
and Training of Health  
Visitors, Allen and Unwin.**

*Appendix II*

COUNCIL FOR THE TRAINING OF  
HEALTH VISITORS  
MEMBERS OF THE FIRST COUNCIL 1962-1965  
(APPOINTED IN SEPTEMBER 1962)

Chairman : Sir John Wolfenden, CBE (resigned July 1963)  
Sir Charles Morris, KCMG, later Lord Morris of  
Grasmere, appointed 1 August 1963

(1) The original members of Council appointed in  
September 1962 :

Miss J. Armstrong, RGN, SCM, HV

Dr J. C. Arthur, OBE, MB, BS, MRCS, LRCP

Miss N. B. Batley, SRN, HV (resigned 18 February 1963)

Councillor Mrs F. E. Cayford, JP (resigned 24 February  
1964)

Professor T. E. Chester, MA

Councillor A. Cunningham, JP

Miss M. E. Davies, SRN, SCM, HV

Miss J. Ewart, RGN, SCM, QN, HV

Miss G. M. Francis, SRN, SCM, HV

Alderman N. Garrow, OBE (resigned 5 March 1964)

Miss A. A. Graham, OBE, SRN, SCM, HV (resigned 11  
March 1965)

Miss R. Hale, SRN, SCM, HV Dip. Sec.Sc (London), RFN

Miss D. T. Hogg, SRN, SCM, HV

Miss R. A. Hone, BA, SRN, SCM, DN

Dr J. G. Howells, MD, MRCS, LRCP, DPH

Miss D. J. Lamont, SRN, SCM, HV

Dr B. R. Nisbet, OBE, MD, FRCP, DPH

Miss P. E. O'Connell, SRN, HV

Professor J. Pemberton, MD, FRCP, DPH

Mr A. M. Rule, MBE, MA, LL.B

Alderman Mrs Ryder Runtou, CBE (resigned 20 March  
1963)

*A History of the CETHV*

Alderman Mrs P. Sheard, BA, JP (resigned 18 November 1963)

Miss J. A. Surr, SRN, SCM, HV

Dr H. P. Tait, MD, DPH, FRCP (resigned 5 May 1965)

Dr E. Thomas, BSC, PhD (resigned 5 September 1963)

Dr W. E. Thomas, BSC, MB, BCH, DPH, MRCS, LRCP

Dr G. W. H. Townsend, CBE, BA, MB, BCH, DPE

Dr J. F. Warin, MB, DPH (resigned 1 March 1963)

Councillor J. R. Watson

Miss E. E. Wilkie, BA, SRN, HV (resigned 16 April 1963)

Professor R. C. Wofinden, MD, DPH, MRCS, LRCP

(2) Changes in membership 1962-64 :

Dr E. L. Millar, MD, DPH, MSc, appointed vice Dr Warin  
1 March 1963

Alderman A. H. Davies, appointed vice Mrs Ryder  
Runton 20 March 1963

Miss A. L. Adair, SRN, SCM, HV, appointed 26 August  
1963 vice Miss Batley and Miss Wilkie

Mrs E. Beith, SRN, HV, appointed 26 August 1963 vice  
Miss Batley and Miss Wilkie

Mr R. E. Hodd, BSC (Econ), appointed 16 January 1964  
vice Dr E. Thomas

Mr C. Berridge, appointed 4 March 1964 vice Alderman  
Garrow

Councillor K. C. Collis, appointed 3 December 1964  
vice Mrs Sheard

**Appendix B**

**The Health Visitors Training Rules and Guide  
to the Training Rules**

**Source:**

**The Training of Health Visitors,  
A Handbook for Tutors and  
Examiners 1971 edition, CETHV.**

## **The Health Visitors Training Rules 1972**

The Council for the Education and Training of Health Visitors in the exercise of the powers conferred upon them by section 2 of the Health Visiting and Social Work (Training) Act, 1962, hereby make the following Rules :

### **Citation, Commencement and Interpretation**

**1(1)** These rules may be cited as the Health Visitors Training Rules 1972 and shall come into operation on 1st January, 1973.

**(2)** In these rules, unless the context otherwise requires : 'the Act' means the Health Visiting and Social Work (Training) Act, 1962 (as amended) ;

'approved course' means a course approved by the Council for the purposes of section 2(1)(a) of the Act ;

'certified midwife' means a woman who is, or who is deemed to be, for the time being, certified under the Midwives Act, 1951, the Midwives (Scotland) Act, 1951, or the Nurses and Midwives Act (Northern Ireland), 1970, or under any subsequent enactment extending, amending or replacing those Acts ;

'the Council' means the Council for the Education and Training of Health Visitors ;

'Health Visitors Certificate' means the certificate awarded by the Council under rule 5 of these rules ;

'integrated course' means an approved course which also provides instruction for the examinations of the General Nursing Councils (for England and Wales or for Scotland) or of the Northern Ireland Council for Nurses and Midwives, and in obstetric nursing or midwifery ;

'registered general nurse' means a nurse who is registered in the general parts of the register maintained by the General Nursing Councils for England and Wales or for Scotland or under the equivalent registration provisions in Northern Ireland ;

'training institution' means an institution providing an approved course, and other expressions have the same meaning as in the Act.

**(3)** The Interpretation Act, 1889, shall apply to the interpretation of these rules as it applies to the interpretation of an Act of Parliament.

**Revocation**

**2** The Health Visiting Training Rules, 1965, are hereby revoked : Provided that :—

**(a)** such revocation shall not affect any right, privilege, obligation or liability acquired, accrued or incurred, or anything duly done or suffered under those rules ; and

**(b)** such revocation shall not affect any approval, admission, certificate or decision given, approved, awarded or made under the rules so revoked, and every such approval, admission, certificate or decision shall, so far as it could have been given, approved, awarded or made under these rules, have effect as if it had been so given, approved awarded or made.

**Approved Courses**

**3(1)** For the purposes of section 2(1) (a) of the Act, the Council may approve a course giving instruction in the matters specified in the schedule to these rules conducted by an institution which, in the opinion of the Council, is capable of providing a complete training and an examination for the award of the Health Visitors Certificate.

**(2)** For persons who have obtained a qualification in public health nursing outside the United Kingdom or for persons who have successfully followed a degree or diploma course, which the Council deems suitable, at a University within the United Kingdom, the Council may approve a course for the purposes of section 2 (1) (a) of the Act which though not giving instruction in all the matters specified in the schedule of these rules will provide training which will complete the candidate's

knowledge of the syllabus and will provide an examination of the same standard as that for a course mentioned in paragraph (1) of this rule.

**(3)** The Council shall prepare and keep a list of approved courses and of the training institutions providing them.

**Admission to Approved Courses**

**4(1)** No person shall be admitted to an approved course other than an integrated course unless such person :

**(a)** is a registered general nurse or has such other general nursing qualification as the Council may in any particular case approve ; and

**(b)** either

**(i)** is a certified midwife ; or

**(ii)** has passed the first examination of the Central Midwives Board for England and Wales, of the Central Midwives Board for Scotland, of the Northern Ireland Council for Nurses and Midwives, or of the Central Midwives Board for Eire ; or

**(iii)** has completed a course of instruction in obstetric nursing in accordance with rule 5 of the Midwives (Amendment) Rules 1961 (a) as part of general nursing training ; or

**(iv)** has such other midwifery qualification or obstetric training as the Council may in any particular case approve ; or

**(v)** if a man, undertakes to complete such other obstetric training as the Council may in any particular case approve ; and

**(c)** holds one of the following qualifications, including as a subject English or Welsh or History :

**(i)** The General Certificate of Education of England and Wales at Ordinary level or the Certificate of Secondary Education Grade 1 in either case in a minimum of five subjects ; or

Social Aspects of Health and Disease  
Principles and Practice of Health Visiting

These Rules, made by the Council on the 20th July, 1972, are forwarded to the Secretary of State for approval in accordance with section 2(2) of the Act. IN WITNESS WHEREOF the Common Seal of the Council is hereunto affixed the day above stated.

F. E. FRAYN  
Secretary and Registrar to the Council.

**Explanatory Note**

(This Note is not part of the Rules, but is intended to indicate their general purport.)

These Rules replace the Health Visitors Training Rules, 1965, and set out matters appertaining to training courses and examinations for the award of the Health Visitors Certificate and to conditions of entry to such courses and examinations for both men and women. The Secretary of State for Health and Social Services; the Secretary of State for Scotland; the Secretary of State for Wales; the Secretary of State for Northern Ireland hereby approve the foregoing Rules.

Given under the Official Seal of the Secretary of State for Health and Social Services this 18th day of November, 1972.

KEITH JOSEPH  
Secretary of State.

Given under the Seal of the Secretary of State for Scotland this 27th day of November, 1972.

GORDON CAMPBELL  
Secretary of State for Scotland.

Given under the Seal of the Secretary of State for Wales this 1st day of December, 1972.

PETER THOMAS  
Secretary of State for Wales.

Given under the Seal of the Secretary of State for Northern Ireland this 6th day of December, 1972.

WILLIAM WHITELAW  
Secretary of State for Northern Ireland.

The Council for the Training of Health Visitors under the Health Visiting and Social Work (Training) Act, 1962, Section 2 (2) present new Rules for the training of health visitors. These rules have been approved by the Health Ministers. They specify subjects to be included in the courses to be approved, the conditions for admission to the courses, and for the award by the Council of certificates of their successful completion.

The following explanatory notes are prepared for the guidance of training institutions, and replace the interim rules and the draft advance information circulated prior to the issue of these rules.

***Approved Courses Rule 3 (1)***

Approval is for a 'complete training and an examination and an award for the Health Visitors Certificate'.

**1** When considering courses for approval, the Council will note the following aspects:

**a** For the 1966 intake, and thereafter, the Council will not normally approve any course shorter than a calendar year less one week. This period will include a total of six weeks' vacation, spread throughout the year, and will include a continuous period of supervised practical work, in an area deemed appropriate by the Council, which will extend over approximately three months following the examination and will be in addition to the practical work undertaken during the academic year.

**b** The Council will have in mind that the ratio of tutors to students will be one health visitor tutor to fifteen students, that normally no school will have fewer than two tutors, and that fieldwork instructors will not be responsible during the academic year for the practical training of more than three students.

**c** The Council will have regard to the material conditions provided for tutorial staff and for students

to work and study, and the opportunity offered to work with other student groups.

**2** When considering the health visitor content of an integrated course the Council will note the following :

**a** That from the 1965 intake of students the programme will be adapted to the Syllabus of Training issued by the Council in 1964.

***Approved Courses Rule 3 (2)***

Training institutions which propose to offer special facilities for the following categories of student :

**a** Holders of a Public Health Nursing Qualification obtained outside the United Kingdom.

**b** Holders of a Degree or Diploma from a University within the United Kingdom and which covers one or more parts of the Schedule and is deemed suitable by the Council

should send their proposals for a course to complete the candidate's training as a health visitor to the Council for approval, before accepting the candidate for training.

***Admission to Approved Courses Rule 4***

Professional and educational pre-requisite qualifications are given for both post-registration and integrated courses. It will be noted that :

**a** The qualification of a Registered Sick Children's Nurse (R.S.C.N.) is no longer included in the list.

**b** That English, Welsh or History may be accepted as proof of the candidate's proficiency to express herself. One of these subjects, therefore, should be included in the minimum of five subjects required at Ordinary Level in Certificates of Education.

**c** For the purpose of Rule 4 (c) (i) and sub-paragraph (b) above, a mixture of GCE 'O' level and CSE Grade 1

passes is acceptable provided that the subjects do not overlap.

**d** For the time being, provision is made for mature students without the pre-requisite educational qualification to take an entrance test approved by the Council. This provision will be regarded as a temporary expedient only, as the need for it should disappear when the pre-requisite educational qualifications are generally held.

**e** Training institutions in future will have the responsibility of examination procedure and also the responsibility for verifying that candidates do in fact hold the necessary professional and educational qualifications as listed in Rule 4 (1).

***Award of the Health Visitors Certificate Rule 5***

The Certificate of the Council will be awarded if in the opinion of the Council, on the recommendation of the appropriate internal and external examiners of the training institution, the student has been successful in the examination, and that the report of the appropriate nursing officer sent to the training institution, shows that the candidate has satisfactorily completed a continuous period of practical work of approximately three months. For sponsored or seconded students this practical work could be undertaken in the area of the sponsoring or seconding authority, if this is suitable to the training institution. For students not bound by an agreement with a local authority, an arrangement should be made at the time of acceptance for supervised practical work to be undertaken in a suitable area. The continuous period of fieldwork will be undertaken by all students entering under Rule 4 (1) in 1966.

Rev. January, 1966

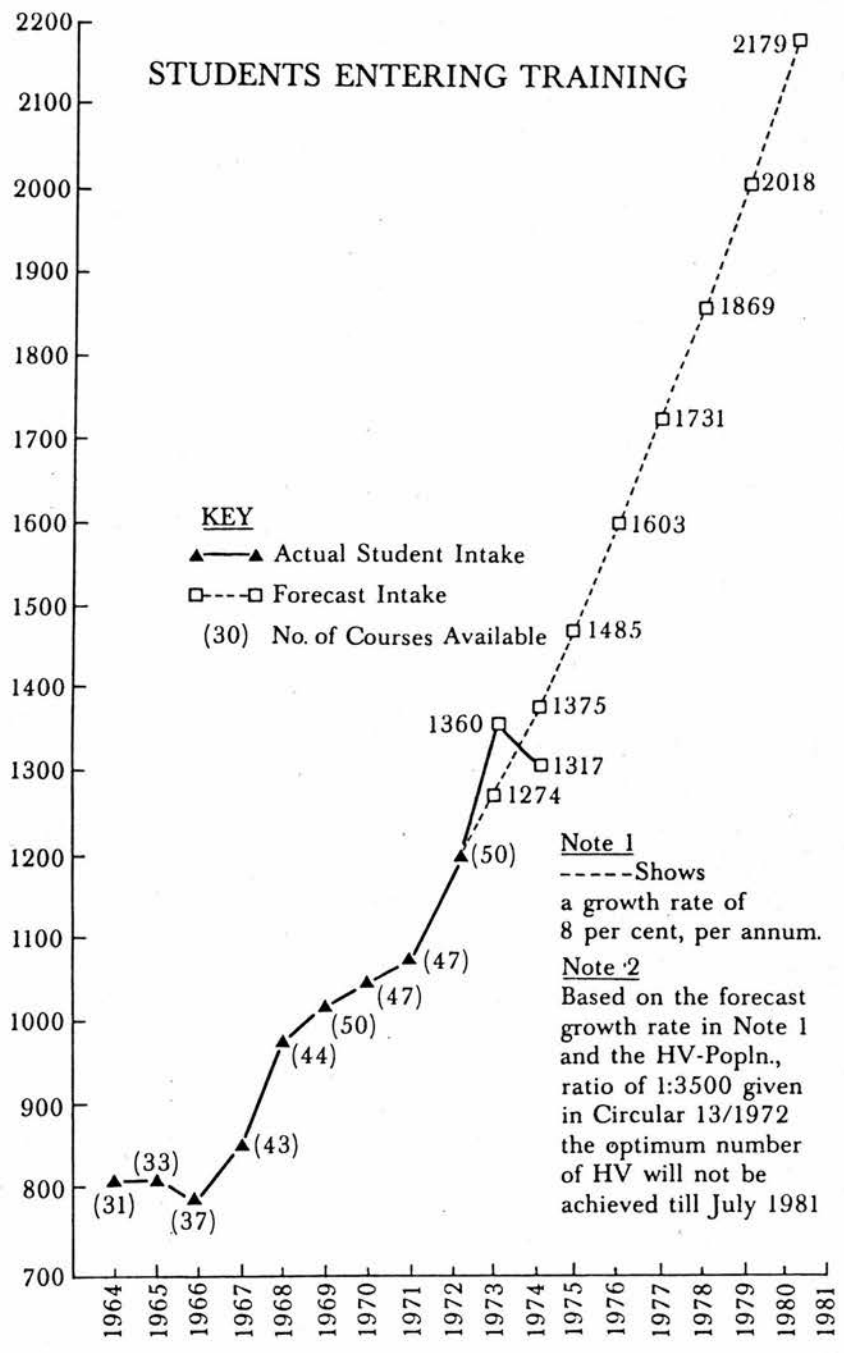
**Appendix C**

**Recruitment of Students 1964-1973**

**Source:**

**Council for the Education and  
Training of Health Visitors,  
Fifth Report.**

Appendix III



Appendix D

Post registration Students 1968-1973

---

**AGE RANGES (POST REGISTRATION STUDENTS ONLY)**

---

	<b>-25</b>	<b>25 - 40</b>	<b>40+</b>
1968	234	549	107
1969	200	674	153
1970	268	560	131
1971	220	616	136
1972	322	578	166
1973	208	800	234

---

---

**MARITAL STATUS  
(POST REGISTRATION STUDENTS ONLY)**

---

	<b>Married</b>	<b>Single</b>
1968	429	463
1969	491	436
1970	515	444
1971	553	419
1972	609	457
1973	799	443

---

Appendix E

The Function of the Health Visitor

## THE FUNCTION OF THE HEALTH VISITOR

### International Definition

The problem of defining the role of the health visitor and the public health nurse is not peculiar to the United Kingdom, and expert Committees of the World Health Organisation have given attention to this. An international definition\* states that public health nursing is a special field of nursing which combines the skills of nursing, public health and some phases of social assistance. It functions as part of the total public health programme for the promotion of health, the improvement of conditions in the social and physical environment, rehabilitation and the prevention of illness and disability.

### Definition of Function in U.K.

By relating this statement to the health visitor in the United Kingdom the work here can be defined as follows:-

The health visitor is a nurse with post-registration qualification who provides a continuing service to families and individuals in the community. The work has five main aspects -

1. The prevention of mental, physical and emotional ill health and its consequences;
2. Early detection of ill health and the surveillance of high risk groups;
3. Recognition and identification of need and mobilisation of appropriate resources where necessary;
4. Health teaching;
5. Provision of care; this will include support during periods of stress, and advice and guidance in cases of illness as well as in the care and management of children. The health visitor is not, however, actively engaged in technical nursing procedures.

\*World Health Organisation Technical Report No. 167

### Knowledge and Skills

Health Visitors are practitioners in their own right, detecting cases of need on personal initiative as well as acting upon referrals. The skills and knowledge particular to the work are drawn from the nursing background and from the additional preparation in the health visitor course. They bring to their work in the community:-

- i) Observational skills
- ii) Skills in developing inter-personal relationships
- iii) Skills in teaching individuals and groups
- iv) Skills in organisation and planning in their own sphere

The knowledge brought to the service is obtained:-

- i) from the nursing background -
  - (a) Human biology
  - (b) Principles of bacteriology
  - (c) Processes of disease
  - (d) Therapeutic methods
- ii) from obstetric nurse or midwifery training -
  - (a) Pre-natal development
  - (b) Factors influencing the subsequent health of the child
  - (c) Care of mother and baby during and following delivery
  - (d) Emotional factors associated with pregnancy and childbirth
- iii) from the health visiting course -
  - (a) The development of the individual at all stages in the life cycle
  - (b) The development of individuals in relation to their social and cultural groups
  - (c) The development of social policy
  - (d) The changing pattern of health and disease and the methods used to determine priorities in the services
  - (e) The principles and practice of health visiting

## Principles and Practice of Health Visiting

This area of the health visitor's training is designed:-

- (a) to sharpen the student's capacity to perceive early deviation from the normal;
- (b) to provide practice in the working out of a programme of help for the individual where it is required, which may include the use of other statutory and voluntary agencies;
- (c) to prepare the student to select the method of health education most likely to be successful in any particular instance;
- (d) to give an understanding of the principles of learning and teaching.

Through supervised practice students are able to develop these skills and learn to help families and individuals and to establish the priority needs among their clientele.

The quality of Health Visiting is affected by the philosophy of the employing authority to some extent, some hindering development and others encouraging professional growth. Since, however, the skills and knowledge outlined above are basic it follows that they are used in any situation in which the Health Visitor operates and in any combination of duties. The group within the population to which they are applied and the problems brought to light may vary but there is no essential difference between the Health Visitor in a rural or industrial setting, based on a geographically defined area or the list of a general medical practice. In the latter they are in a favourable position to compile a more comprehensive list of high risk groups and consequently to maintain contact with those individuals and families likely to require assistance at some stage from medical or social agencies.

### Conclusion

No other worker at present combines the type of knowledge and skills outlined, and the service the health visitor offers is essential if medico/social problems are to be contained within manageable proportions in relation to available resources in money and personnel, quite apart from the promotion of the health of the community in its widest sense.

**Appendix F**

**Examinations organised by the Royal Society of Health  
1963**

**Source:**

**Form E 21, Royal Society of  
Health, 1963.**

# THE ROYAL SOCIETY FOR THE PROMOTION OF HEALTH

## EXAMINATIONS—BRITISH ISLES

The following examinations are held by the Society in the British Isles:

Food Hygiene	Nutrition in Relation to Catering and
Health Engineering	Cooking
Health Visitors	Public Health Inspection for General
Health Visitors and School Nurses	Overseas Appointments
Health and Welfare Administration	School Hygiene
Hygiene of Food Retailing and Catering	Smoke Inspectors
Inspectors of Meat and Other Foods	Tropical Hygiene for Public Health
Meat Inspection	Inspectors
Nursery Nurses	

## EXAMINATIONS—OVERSEAS

Certain of the above examinations can be taken at the following overseas centres: Malta, Cyprus, Israel, Bombay, Sind, Ceylon, Hong Kong, Malaya and Singapore, New South Wales, Queensland, South Australia, Tasmania, Victoria, Western Australia, New Zealand, Fiji, South Africa, West Africa, East Africa, Sudan, Mauritius, West Indies, British Honduras, and Jamaica.

**Appendix G**

**Health Visitor Training Centres, England, Wales and  
Northern Ireland 1963**

**Source:**

**Form E 21, Royal Society of  
Health, 1963.**

## COURSES OF TRAINING

List of Institutions recognized by the Minister of Health for the training of Health Visitors under Memorandum 101/M.C.W., and person to whom enquiries should be addressed.

- Belfast, Secretary, Committee of the Royal College of Nursing for Northern Ireland, 6, College Gardens.
- Birmingham, Medical Officer of Health, Trafalgar House, Paradise Street.
- Bolton, Organizing Tutor, Queen's Institute of District Nursing, Health Visitors Course, Technical College.
- Bradford, Medical Officer of Health, Town Hall.
- Brighton, Organizing Tutor, Queen's Institute of District Nursing, Health Visitors Course, Technical College Building, 237 Preston Road.
- Bristol, Registrar, University of Bristol, Department of Public Health, 21-23, Prince Street.
- Cardiff, Director, Department of Social and Occupational Medicine, Welsh National School of Medicine, The Parade.
- Dagenham, Principal, South-East Essex Technical College, Longbridge Road.
- Durham, Secretary, County of Durham Board for the Training of Health Visitors, 48, Old Elvet.
- Gloucester, County Medical Officer of Health, Health Department, Berkeley House, Berkeley Street.
- Hull, Registrar, The University.
- Leeds, Registrar, The University.
- Leicester, Medical Officer of Health, Greyfriars.
- Liverpool, Secretary, School of Hygiene, Mount Pleasant.
- London, Head of Department of Health Education, Battersea College of Technology, S.W.11.
- London, Education Officer, Royal College of Nursing, Henrietta Place, Cavendish Square, W.1.
- London, Registrar, University Institute of Education, Malet Street, W.C.1.
- Manchester, Principal, Domestic and Trades College, Old Hall Lane, Wilmslow Road.
- Middlesex, Principal, Chiswick Polytechnic, Bath Road, Bedford Park, London W.4.
- Newcastle upon Tyne, Maternity and Child Welfare Medical Officer, Town Hall.
- Nottingham, Secretary, Joint Course for the Training of Health Visitors, Adult Education Centre, Shakespeare Street.
- Oxford, Organizing Secretary of the Health Visitors Course, Health Department, Park End Street.
- St. Helens, Medical Officer of Health, Town Hall.
- Southampton, Secretary, Joint Board for Health Visitors, The University.
- Surrey, County Medical Officer of Health, County Hall, Kingston-on-Thames.

Appendix H

The six main groups in the Department of Health and  
Social Security

**Source:**

**Management Arrangements for  
the Reorganised National  
Health Service, HMSO 1972.**

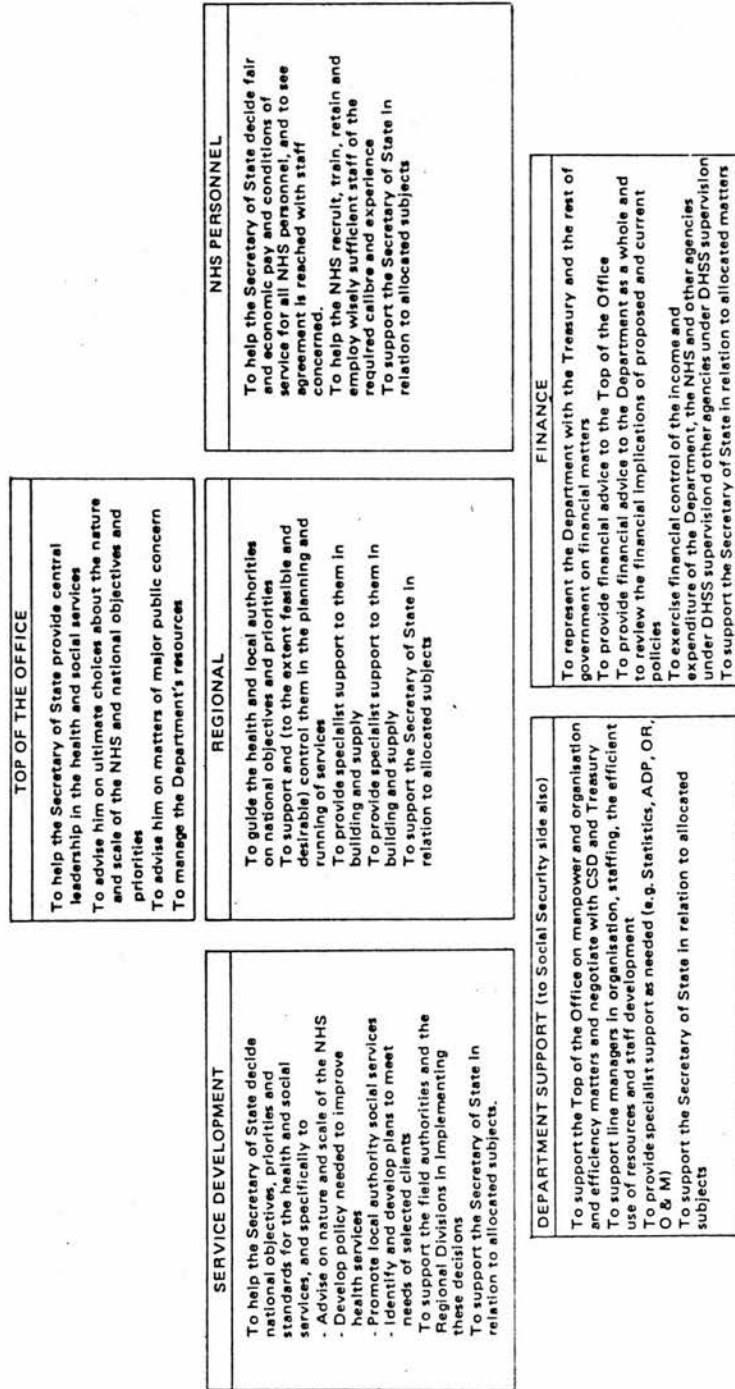


Figure 4 *The Six Main Groups in the DHSS and Their Primary Objectives*  
 Source: Management Arrangements for the Reorganised National Health Service, HMSO, 1977

**Appendix I**

**Summary of the Council's evidence to the Committee  
on Nursing**

## Recommendations

**10** The Council makes the following recommendations which begin with the basic training of the nurse since health visiting is an aspect of nursing :

- a** basic training should aim to prepare a nurse able to take her first post in either the hospital or community service and should be contained within the mainstream of further education in the United Kingdom *see para 31*
- b** two types of basic training should be offered. The candidates would be differentiated as student and trainee both by the nature of the course and the mode and source of financial support *see para 31*
- i* for those seeking a professional career – a course covering not less than two years' full time study in an educational institution with the associated practical work and followed by one intern year for consolidation of skills. The present system of options should be discontinued. Some would follow undergraduate courses in preparation for degrees *see para 32*
- ii* for the larger number seeking immediate involvement in caring for the sick – a two-year course as a trainee in hospital and the community with study periods in an educational institution *see para 36*
- c** advanced nursing education built upon the basic comprehensive student course should be within the mainstream of higher education. Opportunity should be sought for participation in some courses in post-graduate medical centres. The area of education would include training in special fields, e.g. paediatric, obstetric and psychiatric nursing as well as preparation for work in the community *see Section III*
- d** the present pattern of health visitor training should be continued and an improvement made in the provision of fieldwork facilities *see para 90*
- e** the trend towards shared teaching with students of like disciplines should be fostered. The possibility of establishing a common foundation core of study for all members of the caring professions e.g. nursing, medicine, social work and teaching should be explored and development of experimental courses of this nature encouraged *see para 31*
- f** the organisation of recruitment should be on a national basis. The principle of recruitment of trainees by a Council *see para 70*

for Advanced Nursing Education is essential and could well have advantages for a Registering Council in relation to basic training. The needs of the whole service should be taken into account in estimating staff requirements both for hospital and community services

**g** the service should be open in all its branches to both sexes. It will continue to attract young people seeking a career but less reliance should be placed on the young single woman and additional modes of entry, e.g. as a second career, should be developed *see paras 38 and 68*

**h** two new statutory bodies should be created for nurse training in Great Britain : *see paras 41 42*

**i** a Registering Council controlling entry to all branches of the profession and responsible for the professional standards of the members. It would approve courses of training, maintain appropriate registers and have a disciplinary function in relation to the profession. While it should have varied representation from the fields of education and the medical profession, the majority should be nurses elected by the profession and the chairman should be a nurse *see para 45*

**ii** a Statutory and Independent Council for Advanced Nursing Education and Research, responsible for developing policy in general for the further education of the nurse and its relationship to the mainstream of higher education. A major area of its function would be the exploration of methods of deepening and extending professional knowledge. It would be concerned in the accreditation of courses of further study and this would include the award of qualifications, e.g. those related to health visiting. It would be composed of nominated members representing a variety of interests and should have an independent chairman appointed by the Privy Council *see paras 57 58 59*

**iii** Both organisations should have an establishment of highly qualified professional staff drawn from all fields of nursing, their own administrative staff and should have adequate financial support provided in such a way as to safeguard their independence. *see para 60*