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Postnatal care: the views of first-time mothers

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Date of preparation: June 2010
CET0610781
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Non-member subscription rates:
- Individual (UK) £125
- Individual (rest of world) £145
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Institution online access:
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- Six to 10 users £390
- 11 to 20 users £780
- 21 to 50 users £1560

Subscription enquiries may be made to:
Community Practitionersubscriptions,
Ten Alps Subscriber Services,
Alliance Media Limited,
Bournehall House, Bournehall Road,
Bushey WD23 3YG
Tel: 020 8950 9117
tenalps@alliance-media.co.uk
www.cphvabookshop.com

The journal is published on behalf of Unite/CPHVA by:
Ten Alps Creative,
One New Oxford Street,
London WC1A 1NU
Tel: 020 7878 2300
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Production:
Ten Alps Creative – design and production
Williams Press – printing
© 2010 Community Practitioners’ and Health Visitors’ Association (Unite/CPHVA)
ISSN 1462-2815
The views expressed do not necessarily represent those of the editor nor of Unite/CPHVA. Paid advertisements in the journal do not imply endorsement of the products or services advertised.

COMMUNITY PRACTITIONER

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new

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How it feels to get what you want

The Unite/CPHVA conference is always a busy time for the health sector team, especially those who do more direct work on the CPHVA agenda. It can feel like a rollercoaster from arriving for set up to getting back home on the Friday night. It can also be hectic because not only do we want to take in the messages from sessions and from you our members, but also to feed out messages about the work done and support available for the coming year.

I always try to take time to personally reflect on the event back home, and the main thing that ran through my head this time was how it feels to get what you want. Conference had to contend with a lot of difficult issues – the on-going attack on the NHS from the coalition government, continued low numbers of health visitors and school nurses and the autumn spending review, with its ideologically driven swinging cuts to public services.

However, with all of that (and more) it has to be remembered that all of the successes are even more remarkable. We had a conference that attracted more delegates than last year (though everyone thought the opposite because of the much bigger venue), had greater levels of support (both through stands and sponsorships) and some of the most positive announcements that I’ve witnessed as an attendee.

I’ve worried that the 4200 pledge would be forgotten, as have other pre-election pledges (eg university fees trebling and a top-down reorganisation of the NHS). But no, Anne Milton gave what sounded like further promises in her address on top of the numbers. Most welcome to me, a firm promise to work on school nurses as well.

I came away proud of all the campaigning work that members and colleagues have excelled at, with the hope that continued, it will have the same effect across the other goals that we need to achieve. I also thought about conference pledges. I’m delivering on my 2009 pledge – I hope that Anne has the same intention to deliver on hers!
Early intervention £2billion ‘not enough’

Unite/CPHVA has stated that the £2billion included in the comprehensive spending review for early intervention services is insufficient, with specific concerns about how it may be spent given that it will not be ring-fenced.

Unite/CPHVA professional officer Dave Munday stated: ‘The NHS has been told to make £15billion to £20billion-worth of savings and now only £2billion is going to be put back in – this is nowhere near the amount needed.’

He added: ‘Funds that are not ring-fenced are not always spent appropriately. A good example is when unprotected funds were provided in 2004 in order to help deliver one full-time qualified school nurse to every secondary school and cluster of primary schools in England. The vast majority of organisations frittered that money away.’

Sure Start: real-term cut

Unite also noted that protecting funding for Sure Start in cash terms, as planned by the government, would still result in a real-term cut once inflation is taken into account.

Dave stated: ‘The language that the government is using implies that there could possibly be more cuts. It is dressing up proposals with words that are not specific.’

Dave gave an example of a shift in language relating to Sure Start that has already taken place: ‘Before the Conservative Party was elected into coalition they were very keen to cut Sure Start, but realised that there was immense support for the service. So it changed the language away from “cuts” to “taking it back to its original focus” – this will cut out the middle class.’

Middle class families may be asked to pay for access to Sure Start services, as children’s minister Sarah Teather recently suggested in an Observer interview.

Further privatisation

The spending review is expected to lead to further NHS privatisation, having stated that the government will: ‘Look at setting proportions of appropriate services across the public sector that should be delivered by independent providers, such as the voluntary and community sectors and social and private enterprises.’

This approach is to be explored in adult social care, early years, community health, pathology, youth services, court and tribunal services, and early intervention services for the neediest families.

Unite continues to campaign against public sector cuts and held a demonstration outside the House of Commons on the eve of the spending review.

Unite is also asking members to sign up on the campaign’s online supporters’ UK map. Thousands have declared their support so far, but members are being encouraged to ask colleagues and others to sign up too.

Sign up to Unite 4 Our NHS
www.unitetheunion.org/health

School nurse and health visitor pledges

Public health minister Anne Milton’s promises to improve health visiting and school nursing, made at Unite/CPHVA’s annual professional conference (see page 7), have been welcomed by the association.

Anne said that with a new public health service – expected to be detailed in the public health White Paper this month – school nursing would be at the heart of local plans.

She added that the role of the school nurse needs to be better defined, and that work was underway to develop a school nursing service model similar to that developed for health visiting.

Unite/CPHVA professional officer Ros Godson noted that Anne had identified three important areas for improvement, adding that the definition of the school nurse must include being:
- Qualified to specialist community public health nursing level
- Commissioned to work ‘outward from health across education services’; since too many school nurses are clinic-based
- Tasked to deliver the Healthy Child programme five to 19, as it is not clear what outcomes school nurses are supposed to be delivering and this varies throughout the country.

Ros stressed that in order to put school nurses at the forefront of local plans, numbers must increase: ‘We have about 1000 qualified school nurses and roughly 3500 secondary schools. The government thinks that we have more school nurses because trusts are naming community staff nurses as school nurses.’

Ros stated that it is pivotal that the public health White Paper must include a pledge from the government to market school nursing in order for the right numbers to be achieved.

Unite/CPHVA School Nurse Forum member Sarah Sherwin welcomed the minister’s statement, but was also cautious:

‘The Choosing health White Paper in 2004 set out similar promises, but the policy failed to invest in school health services. The challenge for the government will be to support their words with real action.’

Anne set out plans for 2011 to help deliver 4200 health visitors, including:
- Launch of a national health visiting recruitment campaign
- Launch of a new training programme to ‘refresh and extend’ health visitors’ community health skills
- Improved commissioning.

Unite/CPHVA is continuing its work to improve health visitor numbers in London, where the crisis is particularly acute. As part of this, a health visiting conference took place last month in Holborn, where NHS London chief nurse Trish Morris-Thompson promised to take delegates’ concerns about funding and commissioning to the health secretary Andrew Lansley.
Unite: need for universal early intervention services

Unite has submitted its evidence to the Graham Allen Review of early intervention practices, emphasising the need for universalism. The evidence highlighted the economic savings and health benefits of the Family Nurse Partnership (FNP) programme, but stressed that some members are concerned because it has been seen to ‘asset strip’ the universal health visiting service for a targeted approach, and that this would contribute to health inequalities.

Unite asked: ‘If there is a restriction on the numbers of vulnerable families per FNP, why is this not applied to health visitors?’

It also asserted that one of the best ways to improve children’s wellbeing cost-effectively is to provide: ‘Accessible universal services that engage with parents, children and young people from the antenatal period to secondary school. Health visitors and school nurses are the ideal professionals to work with families in this way.’

Unite’s recommendations included:

* Developing a national delivery unit for health visiting, similar to the one developed for the FNP programme
* Providing incentives to encourage the uptake of breastfeeding
* Promoting no smoking in cars

Meanwhile, the government has announced that it will be extending the FNP programme, and Unite is seeking clarification as to whether health visitors recruited to boost the FNP will be additional to or included in the 4200 additional health visitors promised so far.

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Public health minister Anne Milton announced a raft of promises to improve health visiting and school nursing that were welcomed but also met with sceptical questions from conference delegates.

The first was a reaffirmation of the commitment to provide 4200 more Sure Start health visitors by the end of this parliament. She told delegates that, following the comprehensive spending review, there was money to ‘recruit, pay and train’ these additional health visitors, which she said would increase the workforce by 50% in five years.

In order to deliver this, the minister made three promises for 2011:

- To launch a national recruitment campaign that ‘tells the full story of health visiting, highlighting the value that they bring’
- To launch a new training programme for all health visitors to ‘refresh and extend’ their community health skills
- To improve commissioning, so that commissioners are ‘with no doubt, sure that they need to strengthen health visitor teams’.

The minister also acknowledged that school nursing needed investment and pledged to:

- Better define the role of school nursing
- Develop a service model for school nursing
- Put school nurses at the forefront of local plans regarding child and adolescent health services.

When delegates’ questions were invited, Kathy Walters, a health visitor and school nurse team leader, asked whether assurances about commissioning would mean that commissioners would be told in no uncertain terms that they need to commission specialist community public health nursing services.

Health visitor Elaine Baptiste commended the promises, but noted that in Waltham Forest, each full-time health visitor has a caseload of between 700 to 900. She asked what would be done in the short term.

Bev Shaw, a school nursing team manager, also gave an overview of the dire school nursing situation in her locality, and asked whether funding would be provided to help increase staff numbers.

Anne reinforced that the drive for appropriate commissioning ‘has to come from the centre’, and said the public health White Paper (due to be published by the end of the year) would provide details of commissioning responsibilities.

She also promised that the NHS White Paper and the new public health service would set out a commitment to school nursing, and promised to visit Waltham Forest health visitors.

Unite/CPHVA president Lord Victor Adebowale gave an enthusiastic welcome, stressing that on the same day that the comprehensive spending review (CSR) was due out, delegates would go home ‘enriched and informed’ to meet the challenges ahead.

He gave a frank overview of these challenges – the Liberating the NHS White Paper will move £80billion of public expenditure to GPs, while the public health White Paper will change the relationship between local government and health.

Victor encouraged delegates to work against the ‘inverse care law’, saying: ‘Health visitors and school nurses need to join in and make your connection visible – because if we don’t, the inverse care law will continue to exist.’

Unite assistant general secretary Gail Cartmail focused on the CSR and the NHS reform White Paper in her address.

She said that reforms would affect NHS staff terms and conditions and attack the founding principles of the NHS.

However, she also stressed that the Unite 4 Our NHS campaign has gathered immense support: ‘The campaign goes to the heart of the values of the visionaries of those who created our NHS. It is a campaign that has to be fought and a campaign that has to be won.’
Making the case for health visiting and school nursing services

London School of Economics and Political Science senior research fellow David McDaid and WAVE Trust founder George Hosking gave encouraging presentations reviewing the evidence that universal early intervention services are cost effective.

David stated that the cost-saving argument could be used to provide ammunition when making the case to commissioners and ministers about commissioning health visiting and school nursing services. ‘Health is wealth – invest to gain, not only in health but beyond,’ he stated.

He gave the example of providing universal postnatal screening for new mothers, and cited research that had identified that every £1 spent on this intervention would generate an economic return of £3.

He noted that the same argument could be put forward for school nursing services: ‘If you think about the interventions that school nurses deliver in terms of behavioural problems and obesity, then you can make these long-term economic arguments.’

David ended by stating: ‘It is not just about talking to the ministers of health or ministers of finance – it’s about the impact on all government departments.’

George supported the case for early intervention further. He opened his presentation by saying that health visitors were more than healthcare staff. ‘Health visitors are frontline crime fighters,’ he asserted.

George cited research from New Zealand in which children were followed from birth to adulthood. He said that in the ‘at-risk’ group, there were two-and-a-half times as many convictions as in the normal group, and 55% of those convictions were violent offences, compared to only 18% in the normal group.

Unite 4 Our NHS: getting on the map

Delegates stand together to Unite 4 Our NHS

Speaking to conference about on-going threats to the NHS, Unite national officer for health Karen Reay told delegates that ‘we can’t afford to sit back and not do anything’.

Karen emphasised the role of the Unite 4 Our NHS campaign, stressing that the health service in the UK is ‘our’ NHS and belongs to all who use it. She encouraged all members to sign up to the campaign through its website (www.unitetheunion.org/unite4ournhs) and add themselves to the map of supporters, as well as forwarding a link to the map to all contacts. She also noted that proposed changes would have an impact on the whole of the UK and not only England.

Representing the United Steelworkers’ Union – Unite’s partner in the international union – Workers Uniting – international vice-president at large Carol Landry warned of the dire healthcare service in the US and the threats of increased privatisation in the UK. She told of how insurance companies are allowed to discriminate, describing situations where women pay about a 140% higher premium than men in most states, that pregnancy and miscarriages are considered as ‘existing conditions’ that add further increases to premiums, and that insurance companies in some states are allowed to reject applications from women who have been victims of domestic abuse and rape.

She warned: ‘There are death panels in the US and they are called insurance companies – and some of them are waiting in the wings to pick up business in the UK.’

She encouraged members to fight the reforms and said that Workers Uniting is supporting the campaign by highlighting the damage done to the value and respect of the NHS.
‘I would walk 500 miles’: Nick Robin Memorial Lecture

Olivia Giles

The founder of 500 miles – a charity that helps people with missing limbs in Malawi and Zambia to get up and walking again – gave a deeply moving and inspiring Nick Robin Memorial Lecture.

Having lost both her lower arms and legs following sudden meningococcal septicaemia, Olivia Giles said that she now believes in making the most of the opportunities presented to her. She began her talk by removing one leg prosthesis and showing delegates how it fitted her. She went on to describe how she became an amputee, and how this led to 500 miles.

Eight years ago, when she was a commercial property lawyer aged 36, she said that she felt ‘fluish’ one day, but was unconscious within 24 hours. After being in a coma for four weeks, she was brought around to discover that she no longer had any hands or feet.

‘But,’ she continued, ‘I did have the opportunity to live.’

She began a six-month rehabilitation programme at the Astley Ainslie Hospital, during which her strength and function returned with tiny improvements each day. She recalled the highlight of this time as being when she was fitted with leg prostheses, describing the ‘sheer joy and relief’ of being able to take her first steps again. Returning home brought its own trials, but she was able to make the psychological adjustments.

The lesson for her was that life is ‘so very precious’, and while she is still ‘terrified of failure’, she tries to take opportunities when they come because ‘pushing the boundaries of your potential is what living is about’.

Seeing an amputee in Malawi literally living in the gutter emphasised how much her own legs gave her independence, dignity and hope. This motivated her to set up 500 miles, which supports the local production of prostheses and orthoses in Malawi and Zimbabwe, and funds local people to be able to purchase them.

Referring back to immediately after her first steps, she recalled how important it was to take them again, and how she owed it to her second chance to do this: ‘I’m so deeply grateful to be here to do it, and I can.’

Association update: we’re counting on you

Obi Amadi, Unite/CPHVA lead professional officer, provided an update on the work of the association and the need to address the radical change in government and policy.

Speaking about the previous day’s announcement on the spending review, she stressed ‘the need to use opportunities well’. She also gave an overview of the on-going agendas relating to health visiting, school nursing and community nursery nursing – most notably in the Action on Health Visiting programme, the continued lack of the kind of school nursing workforce described in the 2004 White Paper, and regulation of CNNs.

She noted the importance of the professional team, which is ‘smaller than last year but which has a lot to celebrate in terms of what it has achieved’. She also thanked the wider team, National Professional Committee and the members, who the association ‘can’t make a difference without’.

Referring to the Unite 4 Our NHS campaign, she stressed the importance of members getting colleagues and others to sign up to the campaign online (www.unitetheunion.org/unite4ournhs) to support the future of the health service.

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CNN registration debate and good practice

The community nursery nurse (CNN) agenda was well balanced, providing concurrent sessions that focused on examples of good practice and a professional symposium looking at the future of community nursery nursing.

A debate about possible CNN registration with the Health Professions Council took place during the professional symposium, where delegates discussed what regulation could mean for the protection of the public, future career prospects and training opportunities. The vast majority of delegates supported the notion that this would be a good way forward.

The debate was picked up in the CNN fringe meeting. Delegates explored the logistics of taking this forward, looking at how best to develop an initial voluntary register. It was agreed that although there was initial support from members to pursue this, a definite decision could not be made without consulting the wider membership.

Delegates discussed methods of engaging members’ opinions, including developing a questionnaire and recruiting a core group of volunteers to look at how best to pursue registration.

In other sessions, University of Edinburgh professor emeritus Colwyn Trevarthen explored how music could help baby brain development. An example of good practice was provided by Gill Pearl, development manager of continence product awareness charity PromoCon. She spoke about the use of specially developed headphones that include a bone conductor, and how playing music through this device has helped with the potty training of children with learning disabilities.

A practical masterclass on CNNs’ role in prevention and health promotion was given by Kevin Browne, University of Nottingham professor of forensic psychology and child health.

Progress across all four countries of the UK

Dame Christine Beasley, chief nursing officer (CNO) for England, began by noting that what the details of the spending review will mean and what incentives and levers there will be to increase the workforce were not yet known. The fall in health visitor numbers has slowed but not reversed and morale and energy are low – Christine stated that a lot of local work will be required, but that ‘opportunity is in our hands’.

Wendy Herbert, head of nursing for children and specialist community public health nursing at Cardiff and Vale Local Health Board, described work to build on Flying Start and One Wales, saying it provided the ‘ideal opportunity for health visitors and school nurses to deliver to their fullest potential’.

CNO for Northern Ireland Martin Bradley referred to the review of health visiting and school nursing services, and the ‘move from industrial age medicine to information age health care’. He also made special acknowledgment of the work of health visitors and school nurses throughout the troubles over the years.

Ros Moore, CNO for Scotland, spoke about a range of programmes and initiatives being tested across Scotland, where she emphasised mutuality as being very strong. She also noted the challenging current political climate, with the Scotland Bill, Calman Review recommendations and Scottish elections.
Focus: sustaining positive change

Speakers provided compelling additions to the discussion about sustaining positive change in community health. In her keynote address, University of Lincoln professor of community and public health Laura Serrant-Green gave a historical overview of the challenges that community nurses have faced, and their contributions to improved public health. She stated that positive changes must be sustained during a period in which the NHS is undergoing the biggest reform of its time.

She also spoke about the divisions of professions within community nursing, stating that barriers need to be broken and that different ways of working may need to be identified in future. She said community nurses are entrepreneurs and innovators: ‘These are the names that replace sanitary inspectors and the long list of professional titles that we’ve had in the past.’

Other speakers on the subject of sustaining positive change included University College London senior research associate Mike Grady, who gave his keynote address about sustaining the achievements made so far in reducing health inequalities, and UK Public Health Association chief executive Angela Mawle, who spoke about building community resilience.

This year’s awards

Every year at conference, the outstanding work of members and local accredited representatives (LARs) is awarded and celebrated.

This year, Unite assistant general secretary Gail Cartmail presented the Unite/CPHVA LAR of the Year Award and Lifetime Achievement Award. The lifetime award went to Berni McCrea, who was nominated for her long-term commitment to the work of the trade union.

Jim Torrance won the award for LAR of the Year, having been commended for winning every workplace case. The runner up was Sarah Hughes, who was acknowledged for a local campaign against a threatened service model requiring health visitors to take on local school nurse workloads.

CPHVA Education and Development Trust chair Jane Dauncey also presented this year’s MacQueen Awards. The MacQueen Award for Excellence in Leadership went to Jayne Botham for developing a process to identify children lost from the health visitor or school nurse caseload because they moved houses, and the MacQueen Travel Bursary for Public Health was given to Felister Heeley who will be looking at community health services in Kenya.

Health visitor Ruth Reilly was winner of the poster competition with a poster on epilepsy, and the research poster winner was health visitor Julie Greenway for her poster on health visitors’ views about ethical issues.

And at the same time...

Delegates were spoilt for choice with a number of concurrent sessions, masterclasses and fringe meetings over the three-day conference.

These included a fringe meeting on the health visiting model of practice for delivering the Healthy Child programme presented by Department of Health clinical lead community practice Pauline Watts, who spoke about the aims and benefits of the model. In another session, Unite/CPHVA Education Subcommittee chair Margaret Wade spoke about facilitating learning in practice. She provided an overview of health and social care policies influencing learning in practice and looked closely at the role of the practice teacher.

The masterclasses included a presentation from BT London and South LSP Programme child health clinical lead Amanda Hamilton. She gave an overview of the work to modernise the NHS IT system and how this could help manage electronic record keeping. Elsewhere, Elaine Tabony, Hillingdon Community Health school health team leader, spoke about a local programme to support children to manage feelings associated with change, loss and grief.
The other side to conference

Social networking the old fashioned way
It’s not all work, work, work at the annual conference — delegates get the chance to let their hair down and network at the conference party, wine reception and exhibition.
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Important Notice: Breastfeeding is best for babies. Breastmilk provides babies with the best source of nourishment. Infant formula milks and follow on milks are intended to be used when babies cannot be breastfed. The decision to discontinue breastfeeding may be difficult to reverse and the introduction of partial bottle feeding may reduce breastmilk supply. The financial benefits of breastfeeding should be considered before bottle feeding is initiated. Failure to follow preparation instructions carefully may be harmful to a baby's health. Infant formula and follow on milks should be used only on the advice of a healthcare professional.
Seacole: telling the untold stories

One member is awarded a Mary Seacole Development Award while Obi Amadi steps down as steering group chair

Danny Ratnaike
Editor

Unite/CPHVA lead professional officer Obi Amadi quoted from Maya Angelou while speaking at her last Mary Seacole Awards ceremony as steering group chair: ‘There is no greater agony than bearing an untold story inside you.’

She stated: ‘Mary Seacole scholars all had a story inside them which they have been able to tell. There are many more out there.’

Befriending Breastfeeding
Community Health Oxfordshire health visitor Naomi Douglas said she was delighted to receive her development award for a home-based Befriending Breastfeeding programme for South Asian women.

Naomi commented: ‘I became interested in specifically targeting this population because it was apparent that we were not accessing them for routine antenatal breastfeeding contacts at the children’s centre, nor were they attending our Baby Café.’

She added: ‘I am fortunate that because I work a split role – part-time children’s

Members’ work celebrated at QNI awards ceremony

The Queen’s Nursing Institute (QNI) recognised the achievements of 10 Unite/CPHVA members at its most recent award ceremony.

Central London Community Health school nurse and new Queen’s Nurse Jessica Streeting commented: ‘I hope this will enable me to work with other nurses within the community to develop good practice, and raise the profile of public health practice within educational settings.’

NHS Shropshire County school nurse and QNI Fund for Innovation winner Angela Scull stated: ‘The award has enabled me to have extra time to work on an enuresis care pathway, attend study days, arrange a study day for all Shropshire school nurses, and promote the service.’

The other new Queen’s Nurses were NHS Gloucestershire specialist health visitor Gayle Clay, NHS North Tyneside school nurse Jane Cook, NHS Sheffield health visitor Sue Givans and NHS Harrow health visitor Wendy Sumpton.

NHS South Staffordshire health visitor Janine McKnight was both inducted as a Queen’s Nurse and a QNI Fund for Innovation awardee, the others of whom were Sandwell and West Birmingham Hospitals NHS Trust health visitor Narinder Kular, NHS South Birmingham health visitor Jewant Singh and North West London Hospitals NHS Trust school nurse Elaine Tabony.

(Left) front row from left: Jane Cook QN, Gayle Clay QN, Narinder Kular, Wendy Sumpton QN; back row from left: Jewant Singh, Elaine Tabony, Janine McKnight QN, Sue Givans QN, (above left) NMC chief executive Professor Dickon Weir-Hughes with Angela Scull, (above right) Jessica Streeting QN
ANPF: Open Space

This year’s Annual National Professional Forum (ANPF), delivered using an Open Space format, was well received by those who attended the morning before the annual professional conference.

NHS Hounslow Unite/CPHVA local accredited representative Gerry Haliburn stated: ‘The Open Space session was enabling and helped to promote discussion. It brought out members’ views on grassroots developments, and I prefer this method to the previous one.’

Unite/CPHVA Health Visitor Forum chair Maggie Fisher, who facilitated one of the discussions, also found the process useful because the debates provided useful points for the National Professional Committee (NPC) to consider.

There were five discussion groups, and as part of the Open Space format members were encouraged to move from one debate to another.

Key points from the discussions included a suggestion to provide employment rights training to all so that members could easily spot issues with protocols, and concerns that there will not be enough practice educators to support the promised 4200 additional health visitors.

The themes used were influencing policy at national level, workforce issues, fitness for practice, leading professional practice and demonstrating effectiveness.

Kin Ly, assistant editor

Rays of CPHVA sunshine

The boxes have been packed, the badges put in the drawer with their historical siblings, the last cakes from Betty’s devoured and the tagged pictures on that social networking site removed – conference 2010 is over.

Despite the cloud threatening to drown everything and everyone in an economic deficit downpour, delegates donned their wellies and cagoules and braved the gloomy conditions, bringing little rays of passionate Unite/CPHVA sunshine to Harrogate.

A few new ideas this year kept us on our toes. The cabaret-style seating was a success, with some speakers getting into the conference mood by singing Money Makes the World Go Around.

The ‘where do I put this conference badge?’ game was played alongside ‘hunt the lanyard’, perhaps less fun. The most imaginative response was from a delegate who asked for a duplicate badge and made a pair of earrings. She did suffer for her art, spending more time in Harrogate than planned as a patient in the local ENT ward.

The venue presented a daily aerobic challenge as we collectively followed the circular, flume-like path from the entrance to the main hall. We could have collected the ministerial crocodile tears, given out inner tubes and had a wet water ride at conference! Perhaps next time.

Some delegates obviously thought the hall was set for a comedy act who would pick on those at the front tables. Why else would they continue to hide in the cheap seats shrouded in gloom? Maybe next year we should play the Price is Right to start the day?

The party had a loose James Bond theme, and although no one’s number came up, one lady arrived with nothing but a draping of cats and insisting she was Pussy Galore.

Next year, we venture to the deep south to Brighton and already the suggestions for a party theme are coming in, my favourite so far being Mods & Rockers. Staff in CPHVA Towers have already organised to arrive on a fleet of scooters (well, at least two). I hope to see you there – I’ll be in the tartan parka.

Gavin Fergie, Unite/CPHVA professional officer

Public health travel bursary

The CPHVA Education and Development Trust is inviting applications for next year’s MacQueen Travel Bursary for Public Health.

The travel bursary provides a one-off sum of up to £1000 to cover travel connected with undertaking a public health project abroad. The award will allow the winner to:

- Share expertise gained in this country with others
- Learn from other countries
- Promote partnerships between people from different cultures
- Broaden knowledge and understanding of other cultures
- Broaden knowledge of the working practices of others
- Personally develop as a result of the experience.

The closing date for applications is 28 February 2011.

For further information or to receive an application form, please email: l.kenward@open.ac.uk

Linda Kenwood, Professional Advisory Committee member, CPHVA Education and Development Trust

Unite 4 Our NHS: members act now

Have you signed up yet to show NHS supporters around the country who wants to defend our NHS?

Please see the campaign website at: www.unitetheunion.org/unite4ournhs to add yourself to the Unite 4 Our NHS map, part of Unite’s campaign to fight plans that could destroy the NHS.

Thousands have signed up so far, and Unite is calling on all of its members to join them to send a clear, strong message. It is also encouraging members to contact their MP – please see WriteToThem.com or TheyWorkForYou.com for your MP’s contacts.
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Antibodies

Other

*Small balls represent LCPs at minimum expert recommendations. Large balls represent LCPs at in excess of minimum recommendations.

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IMPORTANT NOTICE: Breastfeeding is best for babies. Breast milk provides babies with the best source of nourishment. Infant formula milk and follow on milks are intended to be used when babies cannot be breast fed. The decision to discontinue breast feeding may be difficult to reverse and the introduction of partial bottle-feeding may reduce breast milk supply. The financial benefits of breast feeding should be considered before bottle feeding is initiated. Failure to follow preparation instructions carefully may be harmful to a babies health. Infant formula and follow up milks should be used only on the advice of a healthcare professional.
A vital step in the development of clinical guidelines is the journey from evidence to recommendations. This journey is described in the full National Institute for Health and Clinical Excellence (NICE) guideline for the care of pregnant women with complex social factors.

One recommendation – for commissioners to consider a specialist antenatal service for young women aged under 20, using a flexible model of care tailored to local needs – will be used here to illustrate how this process works.

Available evidence
Evidence of interventions that improve early access to care and that encourage maintained contact with antenatal services was drawn from 30 studies comparing one type of intervention or service with another. This was complemented by a review of quantitative and qualitative evidence of barriers to uptake of antenatal care (10 studies). All were of moderate to low quality evidence.

The majority of studies providing evidence of effectiveness were from North America, and many involved specific populations such as African-American young women in urban areas or young women living in poverty. The absence of UK data was disappointing, and recommendations were made to support and encourage this much-needed research.

Due to the disparity between reported services and the multi-faceted nature of the interventions, it was not always possible to tell which components were driving the benefits seen.

Guideline development group (GDG) members identified common components that seemed to be associated with improved outcomes, adding their own knowledge and expertise in caring for pregnant women with complex social factors.

Two components were most commonly associated with improved access and contact:

- Antenatal education alongside antenatal consultations targeted at young women
- Home visiting with transport to and from antenatal appointments.

After discussing both, it was decided that the former could be provided within the NHS.

Specialist services
The GDG identified evidence that young women are put off attending for care due to embarrassment and perceived poor staff attitudes when attending alongside older women. Since the developed health economics model also showed that a specialist service could be cost effective, the GDG recommended the provision of a specialist service to provide age appropriate care. This should be delivered by staff with an interest in and knowledge of caring for young women.

Accessible settings
Noting that transportation to and from appointments was identified as a barrier to uptake, the GDG recommended that antenatal care should be provided in settings that are familiar and easy to get to, such as GP surgeries, children’s centres or schools.

One-stop shops
The GDG was aware of examples where antenatal services are provided alongside other services, such as housing, social care and benefits advice. It endorsed this, since it can address barriers including a lack of awareness of available services, difficulties getting to appointments, concern over social problems and financial difficulties. It was also felt that the provision of services in one place would improve communication between different agencies – a recurrent theme throughout the guideline.

Bridging the gap
Most practitioners are aware of the gap that often exists between evidence and clinical practice or service provision. The process of interpreting the evidence in light of GDG members’ experience and knowledge is made transparent in the full version of the guideline, and practitioners are encouraged to read it to see how this was done.
Book review: ‘poignant and honest’

Living with learning disabilities, dying with cancer: thirteen personal stories by Irene Tuffrey-Wijne
ISBN: 9781849050272

If you want to sleep soundly, do not read this book before going to bed. It is a moving, poignant, honest and at times exceptionally sad account of the lives of 13 people with learning disabilities who also have cancer. By the end of the book, 10 of them have died.

Written in a narrative style, the reader is fully immersed into the story of the participants’ lives without the distraction of the research methods, which are included in appendices. This leaves no escape from the reality of delayed diagnoses, confusing language and misinformation, lack of truthfulness and help to understand. The loneliness and impact of enforced jollity on the participants, even while very ill, is raw and painful to read.

Although the title implies a focus on dying, in reality this is an account of living with a learning disability and of the challenges felt by the participants and those caring for them. Their illnesses seem to polarise these challenges; when the need for understanding and communication skills is at its greatest, their lack is felt the most. At times, there are hopeful glimpses of wonderful care and genuine understanding and respect, but for the most part the narrative feels much less positive.

It is an essential read for anyone working with people with learning disabilities as a window into the world of those who rely on support to understand their changing world. However, as the mother of a young adult with a severe learning disability, I found it gruelling and hard to read, and to people in a similar situation, I would recommend it with caution, for it confirms many of a parent’s worst fears.

Janet Heywood, aiming high for disabled children lead, Bedford Borough Council

New resources

NHS SAFER tool for children at risk of harm
For efficient, appropriate telephone referrals of children suffering or likely to suffer significant harm: www.unitetheunion.org/pdf/NHS%20Safer%20tools.pdf

Baby Clues online game for new parents
Free One Plus One online game for expectant and new parents, available via thecoupleconnection.net

Good Childhood Index for children’s wellbeing
Children’s Society quarterly measurement tool for professionals and schools: www.childrensociety.org.uk/all_about_us/what_we_do/Well-being/19903.asp

Research evidence

Parental smoking after smoke bans
Millennium Cohort Study analysis of smoking behaviour in England and Scotland. Sherburne Hawkins et al Tob Control doi: 10.1136/tc.2010.037028

Allergies and early growth
Patterns of foetal and infant growth and risk of atopy and wheezing disorders at three years. Pike et al Thorax doi: 10.1136/thx.2010.137028

Correction: October’s Clinical papers summary on Schwarz et al (2010) should have read ‘Risk of type-2 diabetes increases when term pregnancy is followed by less than one month of lactation’ and not ‘more than’.

Teenagers, sex and alcohol

Aqueous cream and skin barrier
Effect of aqueous cream on the skin barrier tested in vivo raises questions over use in eczema. Tsang and Guy British Journal of Dermatology 163(5): 954-8

Identifying late-life depression
Meta-analysis of GPs’ ability to diagnose depression among older compared to younger people. Mitchell et al Psychogeriatrics 79(S): 285-94

Acne, treatment and suicide risk
Retrospective Swedish cohort study of suicide attempts among acne patients treated with isotretinoin. Sundstrom et al BMJ doi: 10.1136/bmj.c5812

Early life and age at first pregnancy

Commuting and physical activity
Study of a ‘natural experiment’ in the provision of new transport infrastructure in Cambridge. Ogilvie et al BMC Public Health 10: 703

Advice for physically disabled parents
New Disability, Pregnancy & Parenthood International guide free to disabled parents or for £15 to professionals, Tel: 0800 018 4730 or email: info@dppi.org.uk

Commissioning guide for looked-after children
Outcomes and efficiency: commissioning for looked after children from the Commissioning Support Programme: commissioningsupport.org.uk

Exemplar: continence and learning difficulties
Care pathway for children with continence issues and learning difficulties or autism: www.dh.gov.uk (‘Publications’)
Letter: Appropriate use of disinfectants in the home setting

I was interested to read September’s home hygiene supplement, as I believe that public health nurses have an important role to play in health protection. However, I was very disappointed that it recommends such extensive use of disinfectants, and cannot help wondering whether this may have been influenced by the sponsorship received from Dettol. Endorsement by the Infection Prevention Society would have been preferable.

I believe the use of disinfectants as recommended is wholly inappropriate in the home setting, and even goes beyond hospital cleaning practice. Rather than recommend extensive disinfectant use, it is far more important to facilitate families in understanding the chain of infection, good hand hygiene (using plain liquid soap) and frequency, and the principles of cross-contamination.

Abhayadevi Tissington,
senior health protection nurse specialist, NHS Highland

Joint response:
The targeted use of appropriate disinfectants outlined in the supplement is the approach recommended by the International Scientific Forum on Home Hygiene (IFH). The IFH is the leading scientific authority on home hygiene and its recommendations were made following a thorough review of the scientific evidence concerning the spread of infections in the home and the efficacy and effectiveness of hygiene procedures in preventing transmission.

The IFH uses a risk-based approach as the basis for making evidence-based decisions. The use of appropriate disinfectants is recommended in situations where detergent-based cleaning is either impractical or inadequate – eg to destroy germs on kitchen work surfaces following contact with raw meat – and where ordinary cleaning and thorough rinsing is not possible.

Infection risks in the home may be lower than in hospitals, but knowledge and understanding of hygiene is often lower too. An understanding of the principles of cross-contamination is helpful, and the supplement lists resources to help teach this, but families also need to know exactly how to protect themselves from infections. This means teaching, demonstrating and explaining the evidence-based practices outlined in the supplement.

Unfortunately, without the financial assistance from industry, Unite/CPHVA would be unable to provide such high quality and much needed educational materials free of charge to its members. However, Unite/CPHVA and the contributors are not influenced by sponsorship and do not endorse any particular brands or products.

Viv Cleary, consultant in health protection,
North East and North Central London Health Protection Unit and Gavin Fergie, Unite/CPHVA professional officer

Letter: Olive oil versus medicinal grade mineral oil for baby massage

October’s skincare supplement, written with support from Johnson & Johnson, suggested that mineral oil is a far better and safer choice than olive oil in the massage of infants. Is this yet another example of a multinational company trying to influence mothers during a most vulnerable period through ‘scare tactics’? A little more worrying when they are known to be or have been closely involved with an international baby massage teachers group.

Mineral oil, ‘medicinal grade’ or otherwise, is a derivative of crude petroleum and not something that I nor any other massage therapist I know would advocate for use on a baby’s skin – it feels gritty and is not readily absorbed.

In my experience, through prolonged and frequent usage as in baby massage, it dries the skin. It’s also known, through oral usage, to coat the intestines and prevent the uptake of certain essential vitamins and nutrients, therefore not something you would want a baby to suck from their hands.

A light non-aromatic olive oil is recommended for baby massage (by many healthcare professionals) because it can improve ‘dry skin’. Unlike a perfumed mineral oil, it will also not inhibit the sense of smell – a prominent feature in mother and baby bonding.

Regarding Jiang and Zhou (2003), this claims that oleic acid might increase the epidermal permeability.

A ‘medicinal’ (a wonderful word to create reassurance among unsuspecting mothers) grade mineral oil – sounds like the start of a publicity campaign for the usage of commercial mineral oils for baby massage.

Peter Wilker, developmental baby massage course director

Joint response:
The supplement is an evidence-based summary with information from published clinical studies. It was authored by an independent journalist and approved by Unite/CPHVA.

Medicinal grade mineral oil is approved for use in many common cosmetic products. It is the basic ingredient of most emollients used to treat atopic dermatitis and has been confirmed as one of the most inert and safest ingredients for topical skin usage. The usage feel is based on personal preference and some might prefer one oil versus the other. Peer-reviewed clinical trials have found mineral oil to have comparable occlusion and penetration profiles with other vegetable oils such as jojoba and sweet almond oils.

Medicinal grade mineral oil is used in many preparations as a laxative to ease intestinal transfer because the amounts absorbed – much more than a baby would suck from their hand – have been approved safe even for oral intake.

Any recommendation to use light non-aromatic olive oil for baby massage needs to be reviewed based on published evidence, as oleic acid disrupts the skin barrier and olive oil contains 55% to 83% oleic acid. Permeability is just one aspect of skin barrier function. Jiang and Zhou (2003) also demonstrate how oleic acid disrupts the stratum corneum, separates corneocytes and removes them completely from the upper stratum corneum. It has been known as one of the most efficient skin penetration enhancers when applying topical active ingredients. See also Mélot et al (2009, J Contr Release 138(1): 32–9) or Naik et al (1995, J Contr Release 37(3): 299-306).

Gavin Fergie, Unite/CPHVA professional officer and Sarah Fleury, HCP communications manager, Johnson’s Baby UK and Ireland
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*Trade Mark **Compared with equivalent products on the market †Alpha-lactalbumin

Important Notice: Breastfeeding is best for babies. You should always seek the advice of a doctor, midwife, health visitor, public health nurse, dietitian or pharmacist on the need for and proper method of use of infant formulae and on all matters of infant feeding. These products must be used under medical supervision. SMA Breast Milk Fortifier is a nutritional supplement designed to be added to expressed breast milk for feeding preterm and low birthweight infants. SMA Gold Prem 1 is a specially formulated product designed for the particular nutritional requirements of preterm and low birthweight infants who are not solely fed breast milk. SMA Gold Prem 2 is a catch-up formula designed for preterm and low birthweight babies who require additional nutrition above breast milk. It is a nutritionally complete formula for use on discharge from hospital or when the low birthweight formula is no longer appropriate. It is suitable for use as the sole source of nutrition for infants up to 6 months. Professional advice must be followed on all matters of infant feeding. SMA Gold Prem 2 is not intended for use with newborn preterm babies for whom fortified breast milk or low birthweight formula is more appropriate. Reference 1. Tsang RC, Uauy RU, Koletzko B, Zlotkin SH, eds. Nutrition of the preterm infant. Cincinnati, OH: Digital Education Publishing, 2005.
Not simply black and white: dignity and respect

Disparities relating to both ethnicity and religion have been identified in patients’ and clients’ reported experiences of health services

Kin Ly
Assistant editor

The recent Equality and Human Rights Commission’s report How fair is Britain? provides evidence of progress and continued challenges in building a fairer society. It notes inequalities not only in levels of health, but also in whether people feel they are treated with respect and dignity when using health services. Disparities in this area tend to relate to ethnicity and religion.

While poor communication is identified as a key issue, it not only applies to interpretation and translation problems for non-English speakers, but to ‘poor listening, dismissiveness, rushed consultations and disrespectful attitudes’ experienced by minority clients and patients.

Many of these may be longstanding problems, but with a backdrop of diminished resources on one hand and increased tensions regarding immigration and religion on the other, what can community practitioners do to address them?

Gaps in understanding

Unite/CPHVA School Nurse Forum member Yasmin Perry teaches pre- and post-registration nursing students. She describes being one of the few black and minority ethnic (BME) people on a post-registration programme as having been ‘frustrating’: ‘In my training, I worked in areas where there were significant populations of BME groups, and I felt that as much as native British people can have an understanding of different cultures, they may not truly understand some of the issues facing these groups.’

Yasmin gives two examples: ‘When people from BME groups pass away, nurses do not always understand the mourning process that other cultures follow. And in this day and age, nurses still complain that BME patients receive a large number of relatives visiting them in hospital, not understanding that very often these families live in the same house so of course would want to visit.’

Meeting community needs

Yasmin says that in areas with high BME populations, some professionals make little effort to learn a few basic words of the most commonly spoken languages within that community: ‘I was recently teaching a few qualified health visitors, one of whom stated that she could speak a little of a couple of Indian languages. But a fellow colleague commented that there was absolutely no need for this and that people living in that area should be able to speak English.’

She adds: ‘I of course challenged this – the reality is that many of them do not speak English so by not being able to communicate with these clients effectively, we are excluding them from a lot of services and placing them at a disadvantage.’

Joan Myers, a community nurse who is also professional officer for diversity at the Department of Health (DH), says there is often evidence of unconscious bias: ‘The

\[\text{Despite there being some positive efforts within community nursing, BME clients and patients can still feel as though they are at a disadvantage}\]
Media does have a huge role in developing people's perceptions of a given minority group, and negative portrayals often feed into people's minds. They may then express those views, but may not consciously be aware of how they are behaving.

Unite/CPHVA professional officer Dave Munday notes that, in some cases where BME people feel they have not been treated with respect, there may be additional factors that affect how the service is delivered.

Referring to an example highlighted in the commission's report, regarding Muslim women 'suffering severe humiliation' when having to accept care from a male member of staff, he says: 'Did she feel like this because the member of staff wanted to cause harm because they were racist? In the vast majority of cases I would guess not. Was it because that person was culturally insensitive? Maybe. Was that person the only one on shift that day? Perhaps so. We need to look at similar situations and identify exactly why the patient had a negative experience. In addition to appearing culturally insensitive, there will be a huge raft of reasons, such as capacity constraints, to explain why the service did not meet the patient's needs.'

Diverse workforce benefits

A lack of BME staff in specific roles or taking on post-registration courses to progress their career remains an issue that could improve services for BME clients and patients if addressed.

Yasmin states: 'I was probably the last BME person to be trained at this institution in 2002. In a school of nursing that employs about 200 people, there are only two lecturers from BME backgrounds. More needs to be done to attract BME students.'

She adds: 'BME women are not encouraged to go into higher education per se and higher education institutions could do more to try to address this.'

Joan says: 'I am Caribbean and I can quite openly speak to patients of a similar background. For example, I run an eczema clinic and can explicitly advise African and Caribbean patients that because they have black skin, they need to apply more oily emollients than a white patient. A white colleague however may not feel comfortable saying this or may not even realise that it needs to be said.'

Dave agrees that the NHS would be improved with an increase in BME staff, and gives examples of approaches that could be adopted: 'When I was health visiting, I used to work in an area where there was a high population of Bangladesh families. So what we did was encourage individuals from this background to become health service volunteers. What we found was that they were so encouraged that they undertook training and became qualified support workers. The hope was that they would go off and develop a career within the health service.'

He adds: 'There are countries where doctors are trained to a very high level, and they can come directly to the UK and get jobs that are more senior. But this has not been adopted within nursing and could potentially be a good way of increasing BME representation in executive roles.'

Working for change

Unite/CPHVA Equalities Sub-Committee chair Neisha Fielder says that in some areas of Manchester, staff are provided with cultural, equality and diversity training to help counter cultural bias. She notes that there have been fewer complaints from clients and patients regarding racial inequality in these areas, and believes that this type of training should be mandatory for all staff.

As a diversity adviser, Joan works with the chief nursing officer (CNO) for England to bring to the surface issues relating to inequality, and look at ways to improve diversity within the NHS. She has already undertaken work to ensure that BME views are represented within community nursing: 'With the launch of the Action on Health Visiting programme, I was asked to recommend health visitors from BME backgrounds to be members of the stakeholder group. Additionally, with reports such as the Midwifery 2020 policy report, the DH proactively asked us to provide evidence from a BME perspective.'

She plans to meet with the CNO and senior management team about the findings of How fair is Britain?

Birmingham health visitor Mel Richards says improvements have been made in her trust: 'The vast majority of the community are Muslim and every effort is made by the primary care trust (PCT) to reflect the ethnic make-up of the community – interpreters are available and often healthcare professionals speak the community languages.'

Dave has also noted progress with the push to provide single-sex wards in hospitals, which is 'not just sensitive to the needs of one community, but of all service users.'

However, he stresses: 'Sadly, not everyone's needs can be met, and there needs to be guidance to advise staff who may be in a situation where a patient's preference cannot be delivered.'

Looking ahead at the restructuring proposed in the Liberating the NHS White Paper, Joan said: 'We recognise that we have more senior BME staff in PCTs compared to acute or foundation trusts, therefore cuts are more likely to adversely affect them, particularly with the abolition of PCTs and strategic health authorities, so this needs to be taken into consideration.'

What can be done?

Overall, progress to improve equality and diversity within the NHS has often been slow, and despite there being some positive efforts within community nursing, BME clients and patients can still feel as though they are at a disadvantage.

Dave emphasises that it is the responsibility of everyone to bring about change, and provides key pointers to how staff can help:

- Treat each client as an individual independent of their ethnicity or religion, and work with them to ensure care is the best that it can be
- Ensure that all negative language and behaviour among colleagues is challenged
- Implement a system in which clients, patients and staff can provide their views, and address problems promptly.

Get involved

If you are interested in getting involved with the Unite/CPHVA Equalities Sub-Committee, please contact Neisha Fielder for more information, email: neisha.fielder@manchester.nhs.uk

December 2010 Volume 83 Number 12 Community Practitioner 23
Inspiration to action

Engaging with the annual conference results in enjoying it and learning more, and is a reminder of how important it is to be actively involved with Unite/CPHVA

Louise Hales
Teaching fellow, School of Nursing and Midwifery, Queen’s University Belfast

I returned from the Unite/CPHVA annual professional conference in Harrogate feeling really inspired. I did a presentation on childhood obesity in a concurrent session called ‘Discussing the taboos’.

I have been so busy at work recently that I only finished my PowerPoint on the Monday morning, and I realise now that I was a wee bit stressed to say the least prior to actually delivering it on the Thursday. I was nervous because I really wanted to provide a presentation that practitioners would find useful in some way. I know how busy everyone is, juggling many different roles. However, once I’d actually got my presentation ready, I started to get excited about going to the conference and it was with mixed emotions that I set off from Belfast International Airport on the Wednesday morning. Conference is such a great chance to network with colleagues from all over the UK, and for me and many others it’s also a chance to get away with some of your friends who you have worked with over the years.

Choosing to engage
I’ve been to conference only once before, but I enjoyed this one more. I know why, as well – it’s because I engaged with it.

I learnt a lot and feel invigorated about my personal and professional development. I’ve had a chance to influence health care through my presentation. I’m more knowledgeable about public health, and that will be passed on to the future generation of students. I haven’t worked as a health visitor since 2002, but have kept up to date with as much as I can through being active in Unite/CPHVA, sometimes more than others due to competing demands. I’ve been a chair and a treasurer in my local centre and represented Northern Ireland on the Education Sub-Committee. It’s been really good for maintaining a handle on how health visitors are getting on in practice and for informing my teaching role.

Value of conference
The value of the annual conference for both personal and professional development cannot be downplayed. Where else can health visitors, school nurses, community practitioners and those from education and research with an interest in public health nursing go to meet like-minded people with similar interests but from so many different fields? Who else could do it better? Who else would carry the torch for the wider public health agenda?

I am happy to be professionally aligned with Unite/CPHVA and its philosophy of care as well as cure. Health visitors and school nurses are the leading professions to co-ordinate and deliver services that aim to educate, empower, support and guide parents to improve and safeguard children’s lives.

Unite/CPHVA offers a collective voice that promotes public health nursing from a model of health that takes in the wider determinants of health. This holistic perspective is synonymous with good nursing care. Anything less from my professional organisation and I would feel cheated. This year’s conference enriched my respect for and dedication to the profession I am proud to belong to.

Olivia Giles, the founder of 500 miles who gave the memorial lecture, was just the required tonic to toast the end of the conference and to set me up to face the challenges of our time. If you haven’t heard this amazing woman speak, you should take the time to listen to her on the podcast from the conference. Her words echo in my ears: ‘it’s the challenges in our lives which unlock our potential’, ‘it’s the opportunities that trigger the deepest sense of obligation in your conscience, the ones where you just know, even fleetingly, that this is something that you can do and something where you can achieve or make a difference’.

A perfect time
Work for all of us is harder than it’s ever been, but few would want to exchange places with the growing numbers of unemployed. The importance of the work done with children and families needs to be marketed in terms of its economic impact as well as health impact. With cuts to every sector occurring, our interventions need to be promoted in terms that mean something to those holding the purse strings. This will be increasingly important as every profession extols the virtues of their service.

Health visitors and school nurses cannot waste this opportunity. This is the perfect time to become actively involved in your Unite/CPHVA to make a difference.
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Postnatal care: exploring the views of first-time mothers

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Abstract
Government policy has highlighted the provision of a postnatal service that responds to women's physical, psychological, emotional and social needs. This paper presents the results of a small in-depth qualitative study that aimed to explore the views of first-time mothers with regard to the level of support they would have liked to receive from health visitors during the postnatal period, focusing on the theme of health visitor contact. Homogenous sampling was used to identify seven first-time mothers. Data was collected from semi-structured interviews and analysed using a thematic network approach. Four organising themes were identified – health visitor contact, emotional adjustment to motherhood, infant feeding and other support. Although the first-time mothers valued the postnatal support provided by the health visitor highly, there were varying levels of satisfaction with the frequency and pattern of health visitor contacts. The findings also raise issues about the perception of need and the value of home visiting contacts. The findings also raise issues about the variation to permit a focused enquiry' (Polit and Beck, 2006), while homogenous sampling was used to identify potential first-time mothers want from health visitors during the postnatal period?

Aim of the study
The study aimed to explore and clarify the views of first-time new mothers by addressing the question: 'What level of support do first-time mothers want from health visitors during the postnatal period?'

Design and methodology
In order to address participants' perceptions, views and 'lived experiences' meaningfully and promote a deeper understanding of their views, a qualitative approach was adopted.

Sampling method
Purposeful sampling involves researchers 'hand picking' cases, which will most likely contribute positively to the needs of the study (Polit and Beck, 2006), while homogenous sampling involves 'a deliberate reduction of variation to permit a focused enquiry' (Polit and Beck, 2006:271). In an attempt to promote a more focused enquiry, purposeful, homogenous sampling was used to identify potential research participants who were all first-time mothers. The health visitors were asked to give out study information and a recruitment pack to the mothers of babies born during a specific time period. All mothers who met inclusion and exclusion criteria (first-time mothers with babies aged three to six months within the locality, excluding those on the researcher's caseload) were invited to take part.

Data collection
First-time mothers were interviewed (n=7) between three and six months after childbirth at a time and place convenient to them, in every case this was at home. In order to keep the interview focused on postnatal health visitor support, semi-structured interviews based on a flexible list of questions were used.
It was envisaged that this would enable the development of pertinent questions while allowing the woman time to discuss and explore things that were relevant and meaningful to her. The interviews were recorded and transcribed verbatim, and all research data were anonymised.

Ethical considerations
The study was approved by the appropriate NHS research ethics committee and local research and development consortium.

Prior to interviews, participants were asked for permission to record them, reminded that they were free to withdraw from the study at any time and gave informed, written consent.

Data analysis
In order to demonstrate the credibility of interpretations of qualitative data and promote thorough and rigorous analysis, it is important to present the analysis of research data in a transparent way (Green and Thorogood, 2004), and the use of a tool or strategy can assist this. Interview transcripts were subjected to thematic analysis utilising a ‘thematic network’ technique to facilitate a more systematic and robust data analysis (Attride-Stirling, 2001). This facilitates a process by which text is broken down into analytical categories, explored and grouped into categories, searching for emerging themes, and putting themes back together to describe the findings as a complete picture.

Discussion of findings
In addition to clarifying the level of support they required from the health visiting service. The basic themes provided the underlying story of what the participants were saying, identifying some of the factors that the women felt affected the level of support they required (see Figure 1).

These were grouped into four main ‘organising themes’ – health visitor contacts, emotional adjustment to motherhood, other support systems and feeding issues. Having summarised and interpreted the main themes, it was possible to describe the level of postnatal support the participants would have liked to receive from health visitors, consider the implications for service development and examine how this fitted within current policy. This paper focuses on the organising theme of health visitor contacts.

Value of health visitor contacts
Although this study reported the views of only a small sample of women from a single area, its findings correlated with other larger studies in identifying that, while for many women becoming a mother is a positive thing, the realisation of becoming a mother can be an ‘overwhelming process’ (Barclay et al, 1997), particularly for first-time mothers, with many finding the transition to motherhood a fearful and anxious time (Forster et al, 2008). All of the mothers commented that they felt unprepared for the reality of caring for a baby and for the extreme levels of tiredness that they experienced during the postnatal period:

‘I knew it was going to be, you know, hard work. But it’s all so much more’ (mother 3).

One of the strongest themes to emerge was the new mothers valued the knowledge and support provided by the health visitor during the postnatal period highly:

‘Having lots of support at the beginning was really valuable... I mean, to come to your house, give you the support you need at that time and available on the phone or to drop in to clinic, I’m not sure what else could be done’ (mother 5).

The participants consistently commented that health visitor support was a positive factor in building their confidence as a mother and easing and supporting their transition to motherhood. The findings suggest that emotional support and reassurance from the health visitor was as valuable to first-time mothers as specific practical advice. These findings reflect those of previous studies, in which appraisal support has been identified as particularly valuable when given by health professionals (Tarkka et al, 1999; Warren, 2005).

‘I was feeding and the health visitor said, “oh you could be a case study for breastfeeding you’re doing it so well”. And for somebody to say that at that point was just fantastic. So all day I was, you know, oh they said I was doing it perfectly! And that was brilliant because that just boosted my confidence no end, which I really needed at that stage’ (mother 1).

Every mother was able to give an example of something the health visitor had done or said that had been valuable to them:

‘When they come round and say she’s growing well and she’s doing well you think, oh maybe I am doing something right’ (mother 6).

‘I was going through a difficult stage... and it was fantastic to talk to her about my emotions’ (mother 5).

Pattern and frequency of contacts
Although every participant commented on the value of the postnatal support they received from the health visitor, varying levels of satisfaction with the frequency of health visiting...
contacts were expressed. Mothers who had received weekly contact were extremely satisfied with this, and valued the therapeutic relationship that they had built up with the health visitor during these contacts:

'I think the amount of contact I had was just right' (mother 5).

Although the remaining mothers valued the postnatal contact and support they had received, they consistently commented on the need for more contact with the health visitor:

'I think once a week for the first three or four weeks would be good' (mother 1).

'I could have done with the health visitor coming to visit me a bit more, definitely' (mother 7).

Two participants compared the level of antenatal support and care they had received to that in the first six weeks following childbirth, commenting that they felt they needed support and contact from a health professional more during the latter period:

'Very close, very careful and I felt comfortable and it was almost like, well baby's been born, now it's over to you and it was a real shock because I'd had such good care antenatally. It was postnatally I felt that I needed it more' (mother 7).

The mothers perceived that if they had received more postnatal contact with the health visitor, this may have helped them to deal with periods of transient low mood during the weeks following childbirth more easily, and to establish breastfeeding and overcome associated feeding problems. The need to assess maternal mental health and provide support for breastfeeding have been identified as two of the core universal postnatal recommendations in the Child Health Promotion Programme (DH, 2008).

There was a notable variation in the pattern, content and settings of local service health visitor contacts offered to the mothers during the six weeks following childbirth. This appears to reflect the disparity in postnatal health visiting service provision provided in other areas. Haughery (2008) proposes that the NHS is operating within a framework of 'finite resources', with escalating financial pressures, and in many areas it could be argued that a lack or stretching of resources may be the cause of this disparity. However, another reason could be that despite NICE guidance highlighting the need to provide new mothers with a postnatal service that places the mother-infant dyad at the centre of care and responds to their individual needs (Demott et al, 2006), service providers and/or individual health visitors are placing a different emphasis on needs assessment. As such, the mother's needs are interpreted in different ways.

This apparent focus on health needs assessment within policy and practice has led to many primary care trusts introducing health need assessment tools and questionnaires to assist health visitors in assessing need and prioritising caseloads (Appleton, 2008). There is debate on how needs should be assessed and measured; the term 'need' is a subjective one and as a concept its definition is loose (Carver et al, 2008). Bradshaw (1972) acknowledges that the concept of need is complex and imprecise, but offers a framework to classify 'social need' – normative need is determined by experts or professionals, felt need describes what people say they want or desire, expressed need is demand or felt need turned into action and comparative need is concerned with equity. Bradshaw (1972) emphasises that need is relative, and those identified by professionals often differ to those felt by the individual. Cowley and Appleton (2000) argue that the adoption of a problem-focused approach has led to a change in the 'philosophy of universal concern' that has characterised health visiting practice, replaced by professionally defined need.

The findings of this study suggest that the content and pattern of health visiting contacts during the postnatal period is often dominated by what health professionals perceive as need. The mothers frequently expressed concerns that the health visitor had not assessed their needs accurately or taken their 'felt' needs into account:

'The thing was, I think we were probably coping quite well. That's probably why we didn't see anyone, they didn't think we needed anyone' (mother 6).

Instead, the mothers perceived that the service they received was based on the normative need of health visiting service provision, often alluding to the fact that they knew the health visitors were busy with families with greater needs than them:

'But I don't feel it was because the health visitor didn't care. I just feel they didn't have the time' (mother 7).

All of the mothers who expressed these concerns could be considered 'well', with no obvious demonstrable physical, emotional or social needs. However, they all articulated a felt need that they would have preferred more regular postnatal contact and support from the health visitor. This is consistent with previous studies, which have highlighted how some families are excluded from accessing support from health visitors because they were deemed not to be 'in need' (Roche et al, 2005). If health visiting service provision during the postnatal period is based on a targeted approach and more regular contacts are only offered to mothers with demonstrable needs, then the support needs of many 'well' mothers who do not meet the criteria for targeted contacts will be neglected.

Perhaps one of the most important implications of this study is the identification of a real demand from first-time mothers for regular postnatal support contacts from the health visitor. This reflects national larger scale research (Netmums, 2008; Scottish Government, 2008) and supporting publications (DH, 2008), which emphasise the need to support the transition to parenthood, especially for first-time parents.

**Home versus clinic contacts**

New mothers are increasingly encouraged to attend child health clinics in the postnatal period. With the exception of one, the participants consistently commented that during the first few weeks after the birth they preferred the health visitor to visit them at home:

'So, I think at home you are a lot more relaxed... I think you're probably a bit more open. So I think more visits at home would have been good' (mother 5).

The mothers referred frequently to feeling the health visitor had more time for them when they visited at home. This was important to them, and they appeared to value this opportunity to ask questions in an unhurried manner. Although the reason mothers preferred home visits may be in part due to the practicalities of attending clinic, the overriding theme was that they perceived child health clinics to be too busy and 'conveyor belt'-like:

'...and it tends to be because they are rushed, they are usually very rushed... basically you take her in, get her weighed, have a quick conversation about two or three things and then that's it, it's on to the next person' (mother 7).

The postnatal period is often an exhausting and anxious time for new mothers, when they are faced with learning to care for themselves in their new role as a mother and for their new baby (Warren, 2005), leading to many questions. It was important to the mothers to have time to ask the health visitor all of the questions they wanted, and they felt pressured and at times unable to ask all of their questions in a short clinic appointment.

Despite some anxieties about attending clinic, many appeared to enjoy the social side of being there, acknowledging the importance of getting out of the house, meeting other new mothers and forging friendships:

'It gets me out and gives me a purpose... it was really nice in the waiting room because there were all these other ladies -- it was clinic so everybody's got babies and there for a reason and it's very social' (mother 4).
It is acknowledged that many health visitors may prefer to offer mothers home visits during the postnatal period, but due to time constraints, increasingly busier and challenging caseloads, pressure from managers or service providers and a general lack of resources, they are instead forced to encourage new mothers to attend baby or child health clinics. However, Facing the future (DH, 2007) identified home visiting as a core element of health visiting and one that should remain intact. The findings of this study suggest that there should be a refocusing on the felt needs of first-time mothers, who have identified that during the first few weeks of motherhood they found home visits from the health visitor more helpful and supportive than clinic visits. This may encourage health visitors and service providers to consider their priorities and reorganise work patterns so that first-time new mothers can be offered postnatal domiciliary visiting. There is scope for further research in this area, since although large-scale reviews have examined the effectiveness of domiciliary health visiting in general (Elkan et al, 2000), further studies could explore maternal satisfaction with this specifically during the postnatal period.

Limitations
This study involved a small sample. However, Holloway and Wheeler (2002) suggest that six to eight participants should be sufficient when a sample consists of a homogenous group. This study is not seeking to generalise from participants’ experiences, but anticipates that the reliability and validity of its findings will be judged in terms of their transferability and credibility. Every effort was made to reduce bias in the sampling process. Despite this, all of the participants came from a similar socio-economic group, and a different sample may have identified different needs. It was not within the boundaries of this study to explore the role of team or nursery nurses in providing postnatal care and advice. However, this is an area where there is scope for further research.

Conclusion
This study provided evidence that first-time mothers value the knowledge and support provided by the health visitor during the postnatal period highly, and also established that there is a genuine demand for this provision of health visiting care. However, the findings also suggest that mothers would prefer increased levels of contact, domiciliary visiting and support from health visitors during this period to help them deal with the adaptation to motherhood.

Ostensibly, it appears that – usually because of a stretching or lack of resources – postnatal health visiting service provision is often based upon the normative needs of the health visiting services. Furthermore, it could be argued that a change in the philosophy of universal concern that has previously characterised health visiting practice has been transformed into a more targeted approach, whereby only those with provable needs are offered regular support contact during the postnatal period.

This study suggests a need to refocus postnatal care onto the felt needs of the mother-infant dyad. Recent publications (DH, 2006; Demott et al, 2006) provide the context within which to do this, and Facing the future (DH, 2007) identifies that antenatal and postnatal contacts provide the starting point for engaging with families and assessing needs, and gives health visitors the opportunity to grasp the notion of ‘progressive universality’, whereby a universal health visiting service that is systematically planned and delivered according to individual need should be offered to all.

Acknowledgments
The author thanks and acknowledges the support, encouragement and guidance of Karen Rees, senior lecturer in public health and health visiting, Bournemouth University and Sandy Werrey-Easterbrook, health visitor. Thanks also to health visiting colleagues in Wiltshire Primary Care Trust for their time and support and the new mothers who agreed to participate in this study.

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KEY POINTS
- First-time mothers highly value the practical, emotional and social support offered by health visitors during the postnatal period, seeing health visitor support as an important factor in building their confidence as a mother.
- There is variation in pattern, content and settings of postnatal health visitor contacts.
- Health visiting service providers need to refocus postnatal care onto the felt needs of the mother-infant dyad rather than professionally defined need.

December 2010 Volume 83 Number 12 Community Practitioner 29
Diversity training: a DVD resource showcasing BME role models

Background
There is evidence that, despite legislation and initiatives to encourage black and minority ethnic (BME) staff into positions of leadership, progress has been very slow. Duffin (2008) remarks that this is linked to the 'glass ceiling effect' that prevents BME staff from entering into senior positions, and points to the NHS race equality action plan (Department of Health, 2007) as a way forward to tackle discrimination and encourage fairness of opportunities. The main features of this plan include building race equality into performance management systems and tracking the career progression of BME staff.

According to Harris and Dutt (2005), having a diverse workforce that brings in additional experiences and skills to improve patient experience and care has an impact upon making organisations more attractive to potential recruits. However, they point out that advantages can only be realised if BME staff are in senior positions and motivated to challenge discrimination.

This paper reports on a Mary Seacole Development Award project to develop a DVD to showcase BME role models in the NHS.

Rationale for making a DVD
The DVD was produced in order to portray the positive contributions and value that BME people over the generations have made to the NHS, including recent migrants. It was also to highlight the important role that recruitment, mentoring and coaching can play in encouraging and managing the career progression and personal development of BME staff.

The DVD was intended to portray senior staff from BME backgrounds who have overcome barriers and achieved success. It would be used in different arenas to explore and reflect on diversity issues.

A DVD was chosen because, as a visual medium, it is a powerful way to depict real-life stories that can be used to support change in others. This is based on the concept that learning is enhanced through listening to stories that resonate with an intended audience. In some BME cultures, role models and storytelling could play a key role in raising aspirations and achievements (Linde, 2001; Poletta and Lee, 2006). The DVD intention was to promote participants as BME role models who can explore problems, identify needs, and promote solutions and aspirations.

Role models can play a crucial part in leadership development by sharing on the ground experiences and skills (Coughill, 2007; Ishmeal, 2009; Ling, 2003; Poletta and Lee, 2006). There is specific evidence that role models from BME backgrounds can enable other BME professionals to overcome barriers to career progression, reduce feelings of alienation and isolation and attain success (Duffin, 2008; Ling, 2003; Poletta and Lee, 2006).

Aim and objectives of the project
The aim of the project was to promote the positive contributions of BME professionals to the NHS to enhance leadership development among BME staff. The objectives were to:

- Develop a DVD using cameos of BME NHS professionals who are leaders with successful careers – in positions of influence and with moderate to high levels of autonomy
- Identify the factors that have enabled these BME professionals to be successful in their careers
- Use the DVD content to promote learning within NHS and other organisations.

Method
Semi-structured interviews of BME NHS professionals were filmed and content was selected for inclusion in the DVD.

For participants who wanted to contribute to the project but who did not wish to be filmed, audiotaped face-to-face and telephone interviews were offered as a substitute, as was the option to complete an electronic questionnaire.

The videotaped interviews were conducted in order to be used within the DVD resource, while data from the audiotaped interviews and questionnaire were to be used to inform the project as a whole.
Selection of participants
A total of 13 participants were recruited to be interviewed on film, three each for audio-taped face-to-face interviews and electronic questionnaires, and two for telephone interviews. They were primarily from NHS organisations in West Yorkshire, and two were from the London area. The participants were a mix of both males and females.

Recruitment methods included identification from human resources department databases, self-selection and word of mouth. The following criteria were used in order to select participants:
- Felt able to inspire others
- Believed they were positive role models
- Wanted to share their career successes
- Represented diverse occupational backgrounds and diverse cultural and ethnic backgrounds
- Represented male and female, different age groups and different occupations.

Ethical considerations
To ensure that participants were as fully informed as possible, a letter was given explaining the voluntary nature of the recording of the interviews and their right to decline to take part.

Prior written consent was obtained from all participants. All potential participants were informed about the purpose of the DVD and how their contribution through interviews would support this. Participants were given time and opportunities to raise any queries about the use of the DVD locally and nationally before making a final decision about their involvement. During the making of the DVD, participants were kept informed about progress and encouraged to provide feedback on the content before it was finalised.

A code of conduct was drawn up and shared with participants to ensure their right to privacy and maintain the voluntary nature of the interviews. Participants were provided with a copy of the DVD to thank them for their time and contributions.

Data collection and analysis
Individual interviews were conducted using a semi-structured interview guide to gather information on the following four themes:
- Career progression – any barriers to career progression and how these were overcome
- Role models and how they inspired the participants’ career progression
- Equality and diversity training, and ways in which it can be improved from the perspective of the participants
- The value of having a diverse workforce and encouraging BME leadership.

Reliability was maintained by checking the content of the interviews with each other to ensure that there was some degree of homogeneity and evenness. Plausibility was addressed by looking for recurrent themes in the raw data across all data sources.

Pilot
Two pilot interviews were undertaken off camera with two people who wanted to participate in the project. These reviewed the interview schedule for its format, structure and sensitivity. As a result, small changes were made to refine the tool.

Limitations
The use of filming meant that some participants may have felt exposed and could have been guarded while being interviewed.

Selecting materials for the DVD
The process of editing the outcomes of the interviews to develop a DVD that was logical and fulfilled the purpose of the project involved a number of steps.

During this period, close liaison with the Mary Seacole Steering Group was maintained. The footage obtained from filming the interviews was looked at with the film production manager in its entirety, in order to choose the information that would have the desired impact for illustrating the following themes on the DVD within the given timeframe.

Joint decisions were made about how to order the themes in a sequence that was logical and also told a story, and which also reflected the analysis. The content of the DVD covered:
- Introduction of participants
- Factors affecting career progression and success
- Benefits of working for the NHS
- Perception of being a role model
- The role of the employer in relation to legislation and staff development
- Importance of equality and diversity in improving health care.

Findings
The key themes that emerged from the interviews and formed the basis for the content of the DVD were:
- Factors supporting career progression
- Barriers to career progression
- Maintaining success
- Inspiring others
- Encouragement to consider NHS careers
- Value of individual contributions
- Role of the employing organisation
- Role of equality and diversity agenda.

Factors supporting career progression
The possession of inner strength, commitment and confidence was cited by over 40% of participants as a supporting factor, and parental and family influences were identified as important by 33%. Other factors included access to training and development and support from colleagues. These participants believed that their success was due to sheer hard work and proving their abilities.

The majority stated that the needs of patients and wanting to make a positive difference to patient care were paramount for maintaining focus and strength.

One participant felt that the use of equality legislation was a supportive factor to bring about change. However, the majority of participants stated that hard work and determination had helped them.

Barriers to career progression
Poor work-life balance was identified as the main barrier to career progression, particularly for women participants.

In all, 14% of participants stated racism at senior level prevented them from progressing due to difficulties in gaining access to development opportunities such as shadowing and secondment experiences, or by suggesting lower status activities or training. In other words, skin colour was not identified as a barrier to progression by a large majority.

A small minority (4.8%) – mainly female nurses – highlighted communication as a barrier to career progression. This ranged from lack of information on opportunities available to receiving information too late to apply for promotion. Lack of encouragement and support was also seen as a barrier to enable or sustain progress.

Poor access to training and development was highlighted by 9.5% participants. It was perceived that being refused permission to attend training was a manifestation of prejudice in the work setting that led to a lack of career progression. Access to training was particularly highlighted by those with childcare needs.

Of those interviewed, 42.9% said that they had experienced no barriers at all. Possible reasons for this ranged from being an extrovert to feeling unable to admit to perceived failure on film. Working for an organisation that embraced equality of opportunity was stated as another reason.

It was noted that it is difficult to provide evidence when discrimination is subtle:

"Proving discrimination has taken place is difficult, as other reasons can be given to mask true reasons for denying BME staff access to further training and development, and it often..."
goes unchallenged, as I don’t think data is being kept on the ethnicity of staff being denied access to courses or training.

Maintaining success
Participants maintained that having a vision and the ability to have consistent career plans linked to appraisals was helpful. For others, seizing opportunities and being ‘ahead of the game’ were instrumental. Being a team player was reported by 9.5% as crucial for maintaining focus and therefore success.

Participants’ self-belief played a role in maintaining success. This was evidenced by having a motto such as ‘never give up, no matter what’ and having well-known leader models as a point of reference, for example Nelson Mandela and Mary Seacole. A minority stated that having faith and religious beliefs were important contributors.

Parents, family, colleagues and work mentors were also identified by over a third (38.1%) as inspirational role models:

‘My parents have done far more for me than anyone else I can think of... where I am today is an example of this.’

Inspiring others
All participants thought that BME professionals as role models had an important responsibility to give other BME staff something to aspire to:

‘We have to encourage and remind others that it is not the wishing that takes you there — it is the action, the learning, the studying that are important, and the application of the wisdom that you have.’

Participants described how they were able to be a role model within a work setting, with 33.3% expressing the importance of being professional at all times and leading by example to maintain best practice. Some stated that providing a high standard of care portrayed a caring, sensitive professional to be emulated by other workers.

Encouragement to consider NHS careers
More than a third (38.1%) of participants said they would encourage others to consider a career in the NHS because it offers many career opportunities and is a good organisation to work for.

At the same time, 23.8% suggested that organisations could be more proactive in recruiting from BME communities. Suggestions for ways to do this included holding recruitment forums and open days to raise public awareness of the range of career opportunities available. Targeting schools was also proposed in order to plant the seeds of available opportunities:

‘There is a vast amount of career opportunities that can take you anywhere in the world.’

Value of individual contributions
A large number of participants (81.0%) reported that their contributions were recognised by feedback and appreciation from clients. Some stated that their work was acknowledged by being accorded greater responsibility and autonomy. A small minority (4.8%) highlighted that undertaking personal appraisal processes helped with recognising their contributions.

Role of the employing organisation
Over half of participants (57.1%) stated that their organisation was supportive and could not do anything further. However, a minority (19.0%) felt that having more opportunities for continuing professional development would help. A small minority (4.8%) said that the organisation could have been more supportive when dealing with concerns relating to discriminatory behaviour and bullying.

In terms of career development, a small number (4.8%) expressed that the organisation could provide more information on how to develop a structured career plan. Again, 4.8% suggested that more support from their line manager and better work-life balance were organisational issues. In addition, 4.8% felt that if good networking and career structures had existed, these would have provided a useful support system.

A minority of participants also felt that it was important for organisations to have systems in place to monitor the career progression of BME professionals, since this would encourage fairer opportunities and prevent indirect or direct racism, which would affect their career progression.

Role of equality and diversity agenda
Just over 75% of participants reported that they had been on an equality and diversity training course. Equality and diversity training was seen as essential for raising and addressing issues of discrimination.

All participants emphasised the importance of equality and diversity training being embedded in NHS organisations to ensure fair and best practice. Participants pointed out the need for innovative approaches to equality and diversity training. These included access to a range of teaching methods, such as group work, audiovisual presentation using the project’s DVD, BME guest speakers, role play and scenarios. These should be linked to legislation and national data on race, ethnicity and discrimination.

Some participants felt that, unlike face-to-face training, e-learning was too general and could be easily forgotten. Others commented that e-learning suited their way of work, as it can be completed at a time and venue suitable to them. It was noted that non-clinical participants appreciated e-learning more than clinical participants, who considered ‘classroom’ training with key speakers and group activities to be more effective and meaningful. One participant stated:

‘Training needs to capture all the strands of diversity, to deny this would be like burying your head in the sand. The alternative is not worth thinking about. The NHS cannot afford to let this happen — staff must speak out if this is the case, and put in place scheme to monitor this. I’ll go as far as to say diversity training should be in everyone’s joint development review or performance review on a yearly basis.’

In terms of having a diverse workforce, all participants felt that this should represent the population in order to ensure a sensitive approach to patient care:

‘Boards and senior clinicians or managers in organisations should reflect the diverse workforce and the populations they serve. Actively promoting leadership development amongst members of the workforce from BME communities is a must.’

Those participants who were aware of equality legislation felt that this is a fundamental tool for helping to prevent and deal with discriminatory behaviour:

‘The legal framework has put almost a responsibility on public bodies to put in place certain schemes to improve the extent to which they reflect the diversity within the community.’

Discussion
The findings from the interviews suggest that the possession of inner strength, through commitment, confidence and family influences, were the most important factors that led to success and overcoming barriers. Participants were largely driven by their own determination, desire to achieve and self-belief rather than organisational forces, such as being part of team and equality legislation. It is therefore not surprising that all participants saw themselves as role models with responsibility for giving other BME staff something to aspire to.

The role of discrimination is worthy of comment, since only a small minority cited this as a barrier. This could be related to the high level of confidence and desire to achieve that most participants seemed to possess. However, it could be that some
participants were reluctant to discuss their experiences of discrimination due to the fact that they were being filmed to provide content for a DVD. It was also noted that it is difficult to provide evidence of subtle forms of discrimination.

Being able to raise the issue of discrimination and bullying sensitively requires assurances of confidentiality and anonymity. This was difficult to achieve due to the use of filming for the DVD, but was possibly captured by the other methods.

Although a large proportion felt that their organisation was supportive of their efforts, there was overwhelming support for having equality and diversity training in place to ensure a culture and environment that encourages the recruitment and promotion of BME staff, and that prevents and deals with discrimination.

Conclusions
The aim of this project was to create a DVD to demonstrate the contributions of BME professionals to the health service and show how their career successes can inspire others. The project explored the factors that have enabled their career progression and the challenges that may have hindered their progress. It also examined the strategies they employed to achieve their goals.

The findings indicate that participants were characterised by a high sense of self-belief and self-esteem, working hard and being determined to succeed. The role of family and fostering good peer and organisational support were also important elements. However some participants, particularly those with childcare needs, felt that it was difficult to access training opportunities due to the attitude of managers.

The majority of participants felt that having role models and mentoring were crucial for encouraging progress. The majority felt that success was due to those parents and family members who possessed the qualities of a good role model.

Even though the vast majority of participants had an individualistic approach to achieving success, the results also highlighted the importance of monitoring the career progression of BME professionals. Having a monitoring system is an important way for identifying discrimination on the basis of race and/or ethnicity.

Acknowledgments
The project was funded by the Mary Seacole Development Award of £6250, following the submission of a business proposal.

Further information
The project DVD is available for purchase (overall cost £10). To find out more, email: pamela.shaw@wdpct.nhs.uk

References

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Dr Maria Robinson

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Can higher education improve the professional identity of CNNs?

Introduction and background
The community nursery nurse (CNN) is an important integral member of the multidisciplinary team in today’s healthcare settings (Department of Health, 2009). However, the nature and ambiguity of the role leads to it often being accorded a lesser status than other team members such as health visitors, social workers and teachers. This is despite there being an acknowledgment that these practitioners have a crucial role to play within the team.

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No potential competing interests declared.

Higher education and identity
The word ‘identity’ is often used with little real understanding of the complexity of its meaning. In seeking a definition, an overwhelming range of views were discovered. ‘In its widest possible sense... a man’s self is the sum total of all that he can call his, not only his body and his psychic powers, but his clothes and his house, his wife and children, his ancestors and friends, his reputation and works... If they wax and prosper, he feels triumphant, if they dwindle and die away, he feels cast down’ (James, 1999:69).

The above quotation suggests that identity is contingent on more than just ‘Who am I?’ but also ‘Where do I belong?’ and ‘How do I fit in?’ This includes recognising not only what individuals share in common with others, but also how they differ (Kidd, 2002). The study of identity formation can be traced back to Erik Erikson’s 1950 work titled Childhood and society (Shwartz, 2009). He based much of his thinking on the work of Cooley, Freud, James and Mead (Shwartz, 2009).

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prosper, he feels triumphant, if they dwindle and die away, he feels cast down’ (James, 1999:69).

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In relation to CNNs, there is evident ambiguity about how their role fits with the wider multiprofessional team. As a consequence, they are often delegated tasks with little understanding of their skills and expertise in the area of children’s learning and development. McGillivray (2008) suggests that in professions such as nursing and teaching, there is a clear understanding of the associated roles, whereas a number of vague job titles involved in early years practice (nanny, nursery nurse, childcare practitioner) potentially create ambiguity and confusion about professional identity. Lack of status may also be linked to the prevalence of women in this area of work. Social constructs dictate that childcare is predominantly undertaken by women, and therefore demands lower pay and status (McGillivray, 2008).

It is conventionally suggested that there are many benefits arising from participation in higher education. This may include benefits to the economy and labour market, as well as enhancing individual knowledge, skills and earning potential (Yair, 2008). However, the advantages this may have at a more personal
level, though less quantifiable, may have equally positive effects on people in terms of their enhanced self-perception. This is felt to be of particular significance to CNNs, who are often viewed negatively in terms of status within multidisciplinary teams.

The widening participation agenda introduced by the previous New Labour government aimed not only to develop the social and economic capital of the UK, but also placed significance upon the development of individuals in terms of ‘empowerment’, therefore contributing to personal growth and development (Britton and Baxter, 1999). According to Bourdieu (1984), such growth may positively influence cultural capital, and break down some of the traditional views of the social class system responsible for many divisions within contemporary society. Being empowered in this way may offer women in particular opportunities to break away from traditional domestic roles, increasing their independence and opportunities for better paid work (Britton and Baxter, 1999).

In relation to CNNs, the desire for recognised qualifications could be associated with the low status ascribed to childcare practitioners. The ‘nursery nurse’ has always been viewed as one who cares for rather than educates young children, and pay and conditions have mirrored this perception (Pervin and Cervone, 2010). It is therefore understandable that many early years practitioners are struggling with the idea of professionalisation, and require assistance in developing the self-belief and confidence associated with adopting the ‘habitus’ of a professional.

It should be noted that proposals for change have recently been made regarding the funding of higher education, resulting in increased fees for part-time students (Browne, 2010). Consequently, this may negatively affect the ability of students, including early years practitioners and CNNs, to access higher education courses.

**Life history approach**

This paper is based on in-depth discussions with two foundation degree students, which considered issues of social class and family background, and how the widening participation agenda had supported these individuals in accessing university – something that would not previously have been possible. These discussions explored the elements of the student experience that influenced their changing identities, and what role the tutors, course content and external factors played.

A ‘life history approach’ was chosen in order to do this. This approach has been used since the beginning of the 20th Century, and was commonly used by anthropologists and sociologists to consider autobiographical accounts. The intention was to understand and interpret the experiences of two students to consider small-scale individual issues in depth (Sikes and Everington, 2001). Detailed analysis was required to take into consideration other external influencing factors, which may not be revealed through other approaches (Cohen et al, 2007). Life history adopts an interpretivist approach, as ‘our interest in the social world tends to focus on exactly those aspects that are unique, individual and qualitative’ (Crotty, 1998:68). While discussions with two students could not be representative, their consideration can provide useful and interesting insights.

The life history approach has many critics who raise concern regarding lack of reliability and validity. Issues about bias, truthfulness of respondents, and interpretation of data lead to the findings being difficult to generalise, and ethical considerations such as inappropriate disclosure can be problematic (Goodson and Sikes, 2001). Confidentiality of the students was assured, as was their right to withdraw at any stage, and they provided written consent (British Educational Research Association, 2004).

The campus in which the students studied was opened because its location was identified as an area of poor academic achievement with a low number of individuals entering higher education (Higher Education Funding Council for England/HEFCE, 2009). Goodson and Sikes (2001:24) claim that ‘life stories taken from the same set of socio constructural relations support each other and make up a strong body of evidence’.

A narrative analysis was undertaken, which according to Cohen et al (2007:64) ‘uses the interplay between interviewer and interviewee to actively construct the life history.’ Life histories differ from ‘life stories’, since they are contextualised within a particular framework, therefore giving them a definite focus. Interaction between the individual and their social, educational and political environment can then be analysed by gathering life history data, consequently making connections around how each influences the other (Goodson and Sikes, 2001). The particular focus was on educational experience and social class or background, and the form of analysis sought to ‘discover commonalities, differences and similarities’ and to ‘generate themes’ (O’Keefe and Tait, 2004:461).

**Personal and professional identity**

The two students had, for different reasons, entered higher education without formal qualifications in the context of a major initiative within the university’s ‘widening participation’ agenda. One was mature, while the other held non-advanced vocational qualifications. Both were female, and neither would have attended university had the campus not been opened in their home town.

Several themes emerged, but this paper focuses on how the higher education experience had an impact on personal and professional identity.

Embracing the higher education experience was described by both students as being ‘life changing’. The idea that education can create a feeling of empowerment can be linked with enhanced personal growth and development which positively affects personal and professional identity (Crotty, 1998). However, this is not without its disadvantages. Breakwell (1986) highlighted that fear of not fitting in or not being able to cope with the level of work can threaten individual identity and be an extremely traumatic experience. It is also suggested that being able to cope with the level of work may impact on self esteem and feelings of self-efficacy (Breakwell, 1986). This needs to be taken into consideration by tutors and colleagues when supporting these students.

Another feature that appears to have had an enormous influence on the way the students viewed themselves within the team is their increasing awareness of the broader social and political picture, including a sense that government agendas are often implemented...
Conclusions

This paper has discussed how the foundation degree in early years can support CNNS in developing a greater sense of professional identity. A life history approach enabled the in-depth critical evaluation of the two students’ experiences and how this affected their personal and professional identity. Acknowledgement has to be given, however, to the subjective nature of material from only two individuals, and research should be conducted to explore this further. To improve validity and reliability of these findings and enable generalisations to be made, research should be undertaken to provide a more robust body of evidence to support the possible benefits of higher education for this group of individuals.

Instilling a greater sense of professional identity within these individuals can result in CNNS utilising their skills and abilities more appropriately, using a reflective and reflexive approach. Empowering CNNS in this way could result in a better use of their skills, thus benefiting the entire team and the families with whom they work. More fundamentally, the students are likely to develop strong professional identities that work symbiotically with their sense of personal worth.

A number of factors are of prime importance in supporting practitioners to access such courses, including the continuation of widening participation drives, financial support from employers and supportive colleagues. Since this work was undertaken, radical changes have been announced by the Department of Health. (2009) Revised ethical guidelines for educational research (11th edition). Available from: www.hefce.ac.uk/widen/challenge/evidence (accessed 15 Nov 2010).


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Acknowledgments

The author thanks the two students involved, and also her colleagues Jonathan Glazzard and Roy Fisher for their support and comments in the preparation of this paper.
Nocturnal enuresis: assessing and treating children and young people

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Abstract
Bedwetting (nocturnal enuresis) is a common and distressing condition, both for children and young people and their families, and the National Institute for Health and Clinical Excellence (NICE) has produced its first guidelines for its assessment and treatment in those aged up to 19 years. This paper, by two NICE guideline development group members, provides an update on the new guidance.

Treatment options include the provision of advice, use of a reward system and/or alarm, and desmopressin medication. These should be considered carefully depending on individual needs. Treatment for most children is effective and successful. Where necessary, referrals may be made to a specialist enuresis practitioner.

Key words
Bedwetting, nocturnal enuresis, children and young people, daytime symptoms

Community Practitioner, 2010; 83(12): 37–9.

No potential competing interests declared.

Introduction
Bedwetting, sometimes referred to as nocturnal enuresis, is a common and distressing condition. There are many different definitions, but for the purpose of the new National Institute for Health and Clinical Excellence (NICE) clinical guideline (2010a) it is described as involuntary wetting during sleep. It not only has an impact on the child but on the whole family. The emotional wellbeing of the child is affected with possible loss of self-esteem. Children feel different from their peers and in fear of these peers knowing about their condition. They may decline social activities, such as ‘sleepovers’ and school residential trips, in case they wet the bed. Bedwetting can be stressful for families to deal with. They may struggle to find support for their child but also face ongoing financial implications.

Prevalence decreases with age – bedwetting less than two nights a week has a prevalence of 21% at about 4.5 years of age and 8% at 9.5 years. More frequent bedwetting is less common and has a prevalence of 8% at 4.5 years and 1.5% at 9.5 years (Butler and Heron, 2008). If children have severe wetting – defined as bedwetting every night – it is less likely to resolve spontaneously.

Children with bedwetting are often seen by a variety of practitioners, such as school health nurses, specialist enuresis nurses, continence advisors, health visitors and GPs. The first ever NICE clinical guideline on this condition (2010a) aims to help practitioners in assessments and management plans, and applies to children and young people up to the age of 19 years of age. Importantly, it does not specify a minimum age limit, thus allowing practitioners to use their professional judgement when considering treatments for children under the age of seven years where deemed appropriate (NICE, 2010a).

Assessment
Although the causes of bedwetting are not fully understood, identified predisposing factors are sleep arousal difficulties, polyuria and bladder dysfunction. Accurate assessment is key to identifying whether the bedwetting is a presentation of a systemic illness, such as:

- Urinary tract infection (UTI) (NICE, 2007)
- Constipation and/or soiling (NICE, 2010b)
- Diabetes mellitus (NICE, 2004)
- Medical, emotional or physical triggers
- History of recurrent urinary infections
- Known or suspected physical or neurological problems
- Developmental, attention or learning difficulties
- Family problems or vulnerable child, young person or family

- Behavioural or emotional problems
- Maltreatment (NICE, 2009).

All children with bedwetting should be offered an assessment that is suitable to their circumstance and needs.

It is important to assess the family’s needs and ability to cope with treatment options. Support should be offered if the family is finding it difficult to cope with the burden of bedwetting.

Consider assessment, investigations and/or referral for children with severe daytime symptoms, a history of UTIs or previous comorbidities (see Table 1 and Figure 1).

Do not perform urinalysis routinely in bedwetting unless any of the following apply:

- Recent onset
- Daytime symptoms
- Signs of ill health
- History or symptoms of UTI
- History suggestive of diabetes mellitus

Management: general principles
There are some general principles that the healthcare professional can go through with the parent or carer to help their child achieve dryness at night. For younger children (aged under seven years) these can be suggested independently, but they can also run alongside any other treatment options.

An adequate daily fluid intake is important. Parents and carers should be advised that this can vary according to ambient temperature, dietary intake and physical activity (see Table 2). Caffeine-based drinks should be avoided.
A healthy balanced diet is also advisable, and there is no need to restrict diet as a form of treatment.

Advise on the importance of using the toilet to pass urine at regular intervals throughout the day. This is typically four to seven times a day, including before sleep.

It may be necessary to liaise with the school to ensure access to drinks and the toilet during the school day.

If the child or young person wears pull-ups or nappies at night but is toilet trained during the day, a trial of at least two nights in a row can be suggested. This can be done at regular intervals to see if it promotes dry nights. It is not worth suggesting that these should be removed permanently if the child remains wet and the parents or carers are against this, as they can still be used with any treatment option.

There is no evidence to suggest that lifting or waking a child helps to promote long-term dryness. Lifting (carrying the child to the toilet while they are still asleep) means that no effort is made to ensure the child is fully woken. Waking (waking a child from sleep to take them to the toilet) at regular times or randomly during the night will promote dryness, but may be used as a practical measure in the short term only. Some young people who have not responded to treatment may find self-instigated waking a useful management strategy.

Reward systems with positive rewards for agreed behaviour, rather than dry nights, should be used either alone or alongside other treatments. The agreed behaviour could be for drinking recommended levels of fluid during the day, using the toilet before sleep or engaging in treatment. Systems that penalise or remove previously gained rewards should not be used.

Planning management
It is important that practitioners involve the family and child in the discussion about treatment options. The child's views should also be explored, as should the ability of the family to cope with an alarm as a treatment option. It is essential to know what the family hopes to achieve from treatment – long-term success or whether in the first instance they require rapid-onset, short-term improvement for the child to go on a residential trip or holiday (see Figure 1).

If the family chooses to use an alarm, it is important that their specific circumstances and needs are considered, such as the child's sleeping arrangements. For a child sharing a bedroom with a sibling, a body-worn alarm that vibrates may be more appropriate. A child with a hearing impairment will also find the vibrating alarm appropriate. A child with a hearing impairment may find the vibrating alarm more appropriate. A child with a hearing impairment may find the vibrating alarm more appropriate.

If rapid-onset or short-term improvement is required or the family cannot use an alarm at this moment in time, they may want to consider desmopressin medication. It is important that the family is given accurate written information with regard to fluid restriction and contraindications.

### Table 1. History taking (NICE, 2010a)

<table>
<thead>
<tr>
<th>Patterns and symptoms</th>
<th>Interpretation or action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pattern of bedwetting</strong></td>
<td></td>
</tr>
<tr>
<td>● How many nights a week does it occur?</td>
<td></td>
</tr>
<tr>
<td>● How many times a night does it occur?</td>
<td></td>
</tr>
<tr>
<td>● Does there seem to be a large amount of urine?</td>
<td></td>
</tr>
<tr>
<td>● At what times of night does it occur?</td>
<td></td>
</tr>
<tr>
<td>● Does the child or young person wake up after bedwetting?</td>
<td></td>
</tr>
<tr>
<td><strong>Daytime symptoms</strong></td>
<td></td>
</tr>
<tr>
<td>● Does the child or young person need to pass urine frequently (more than seven times) or infrequently (less than four times) during the day?</td>
<td></td>
</tr>
<tr>
<td>● Do they need to pass urine urgently during the day?</td>
<td></td>
</tr>
<tr>
<td>● Are they wetting during the day?</td>
<td></td>
</tr>
<tr>
<td>● Do they have abdominal straining when passing urine or a poor urinary stream?</td>
<td></td>
</tr>
<tr>
<td>● Do they have pain passing urine?</td>
<td></td>
</tr>
<tr>
<td><strong>Toileting patterns</strong></td>
<td></td>
</tr>
<tr>
<td>● Does the child or young person avoid using certain toilets, such as school toilets?</td>
<td></td>
</tr>
<tr>
<td>● Do they go to the toilet more or less often than their peers?</td>
<td></td>
</tr>
<tr>
<td>● Do daytime symptoms happen only in certain situations?</td>
<td></td>
</tr>
<tr>
<td><strong>Pattern of bedwetting</strong></td>
<td></td>
</tr>
<tr>
<td>● How much does the child or young person drink during the day?</td>
<td></td>
</tr>
<tr>
<td>● Are they drinking less because of the bedwetting?</td>
<td></td>
</tr>
<tr>
<td>● Are the parents or carers restricting drinks because of the bedwetting?</td>
<td></td>
</tr>
</tbody>
</table>

Bedwetting that occurs every night is severe bedwetting, which is less likely to resolve spontaneously than infrequent bedwetting.

A large volume of urine in the first few hours of the night is typical of bedwetting only.

A variable volume of urine, often more than once a night, is typical of bedwetting and daytime symptoms with possible underlying overactive bladder.

Daytime symptoms may indicate a bladder disorder such as overactive bladder.

Pain passing urine may indicate a UTI.

Perform urinalysis

If daytime symptoms are severe:

● Consider assessment, investigation and/or referral

● Consider investigating and treating daytime symptoms before bedwetting

This may rarely indicate an underlying urological disease.

Give advice about encouraging normal toileting patterns

Inadequate fluid intake may mask an underlying bladder problem and may impede development of adequate bladder capacity.

Give advice on fluid intake

### Table 2. Suggested daily intake of drinks for children and young people (NICE, 2010a)

<table>
<thead>
<tr>
<th>Age</th>
<th>Sex</th>
<th>Total drinks per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Four to eight years</td>
<td>Female</td>
<td>1000ml to 1400ml</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>1000ml to 1400ml</td>
</tr>
<tr>
<td>Nine to 13 years</td>
<td>Female</td>
<td>1200ml to 2100ml</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>1400ml to 2300ml</td>
</tr>
<tr>
<td>14 to 18 years</td>
<td>Female</td>
<td>1400ml to 2500ml</td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>2100ml to 3200ml</td>
</tr>
</tbody>
</table>
For children and young people being treated with desmopressin, the following should not be measured routinely:
- Weight
- Serum electrolytes
- Blood pressure
- Urine osmolality.

With all treatment options, it is necessary for the family and child to feel well supported. Regular evaluation – at a minimum of every four weeks – is required in order to assess progress. This may improve compliance and eventual outcomes. Phone contact should also be available for advice and support between appointments.

Lack of response to initial treatments
If there is a lack of response to first-line treatments or if children relapse, it may be necessary to refer the child and family to an enuresis specialist for further review. Factors associated with poor response include an overactive bladder, underlying disease and social and emotional factors. Treatment options for these children may include combination therapy of desmopressin and alarm, desmopressin and an anticholinergic, or the use of tricyclic antidepressants.

Alongside the clinical guideline, NICE has provided a costing tool to help NHS organisations in England, Wales and Northern Ireland plan for the financial implications of implementation. It is not thought that the guideline will have a significant impact on the use of NHS resources at a national level. However, due to variations in practice, some may incur costs or savings depending on their circumstances (NICE, 2010a).

The most significant change for many organisations may be the provision of service for five- to seven-year-olds. Additional costs may be related to patient referrals, but also for alarms and pharmacological treatments. However, the actual number of children aged five to six years who might be eligible for an alarm or desmopressin is likely to be low. Treating people when they are younger may also resolve issues earlier and remove the need for them to be treated when they reach seven years. Staff training may be an issue for some authorities if in-house training is not available. In these cases, ERIC (the Education and Resources for Improving Childhood Continence charity) may be able to provide training days (see: www.eric.org.uk).

Conclusion
Treatment of nocturnal enuresis has a positive effect on the self-esteem of children. For most children, bedwetting treatment is effective and successful.

Healthcare professionals should persist with treatment options if these are not successful at first. Referrals should be made to a specialist enuresis practitioner when there are comorbidities or if first-line treatments do not work.

Support should be available when relapse occurs so that reassessment and treatment can be started again. Practitioners should take into account the family’s circumstances and they should explain all the treatment and management options clearly so that the child and young person with their family can make an informed decision. Written information should be made available to families that is evidence based.

Further information
For all guideline documents – including a quick reference guide for professionals and guidance written for patients and carers – see: www.nice.org.uk/CN111

References
NICE. (2010b) Diagnosis and management of idiopathic childhood constipation in primary and secondary care. London: NICE.
Coming back for the future

Some initial progress and case studies from NHS London’s Return to Practice programme

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Helen Mansfield
Lizzie Smith
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This year comes to an end with the beginning of what could be a new era for health visitors. In October’s spending review, the government has reconfirmed its pledge to increase the number of health visitors by 4200 over the next five years (Department of Health/DH, 2010).

Two strategic health authorities – NHS London and NHS East Midlands – are implementing a DH-led pilot project aiming to address workforce shortages by enabling health visitors to return to practice. This project also aims to assess the real value of return to practice and investigates mechanisms for establishing effective return to practice programmes. Progress made by the London project to date shows much promise.

Health visitor shortage
The importance of health visitors to our society is well understood. Increasing evidence shows that health and wellbeing in pregnancy and childhood affects health in later life (DH, 2007). Despite this, over the past decade there has been a decline in the number of practising health visitors while the national birth rate continues to rise (Unite/CPHVA, 2009). The number of health visitors being trained nationally has also reduced. The NMC revealed that in 2005 there were 715 new registrations of health visitors, but this has steadily declined with only 253 initial registrations being made in 2008 (Ly, 2009).

A multifaceted approach will be required to reverse this trend. As part of this endeavour, it may be important to attract those who have left health visiting to now return to practice. This provides the quickest method of replenishing the workforce. NHS London is campaigning for health visitors to ‘Come Back for the Future’. London faces a shortfall of around 300 health visitors, despite the fact that education commissions for health visitors have consistently increased over the past three years. With birth rates in London having risen by 14% over the past five years while retirement and retention of health visitors remain an issue, NHS London launched a plea for health visitors to return to practice (NHS London, 2010a and b).

Return to practice in London
During the summer of 2010, NHS London initiated its first recruitment campaign to attract health visitors back to practice. Those who had let their health visiting registration lapse or had been out of practice for five years or more were eligible for entry onto a fully funded return to practice course at City University or at Bucks New University. Completion leads to re-registration with the NMC and eligibility to rejoin the workforce as a fully qualified health visitor.

The campaign resulted in 49 expressions of interest, from which 24 were shortlisted for interview. On this occasion, spreading the message via word of mouth through professional networks was found to be the most effective way of recruiting students. Now, 18 people have started the return to practice course at City University, with others deferring entry until February 2011. They will be undertaking practice placements at various NHS trusts across London.

Bringing back a wealth of experience
The pilot project led by NHS London is in its early stages. However, there is much to be learnt from the current cohort of students, and some initial views are presented here.

Candidates had left health visiting for varying periods ranging from seven to over 20 years. In this time, they gained knowledge and experience through parenting, further education and the pursuit of differing career paths. Many had undertaken master’s degrees in disciplines related to public health, while some had undertaken research and attained a doctorate. Opportunities for promotion and the desire to embark upon different career paths were common reasons for leaving health visiting. People are returning from careers in management, education and research, to name but a few.
The case studies (see Box 1) demonstrate some reasons why people leave and why they then return to health visiting. Their future plans vary – some look to either full- or part-time work as a health visitor, while others would like a dual role combining health visiting with management or nursing.

Future plans
The case studies allow some reflection on the background and thoughts of those who are returning to practice. The project to date demonstrates that there are talented and experienced individuals who are keen to return to health visiting, bringing a wealth of experience and transferable skills with them.

NHS London strives to support this cohort through their education and in finding employment thereafter. At the same time, recruitment for more health visitors wanting to return to practice continues for courses starting in February 2011. The current campaign aims to raise broad awareness using web-based social media as well as local and mainstream press. Findings from this project will be fully evaluated and analysed at the end of the academic year in order to assess the value of this type of return to practice programme. However, workforce shortages combined with a real appetite for the London programme indicate that return to practice may prove to be an essential lever in reversing the decline in health visitor numbers and in returning valuable experience to the NHS.

Acknowledgments
NHS London acknowledges the support of the DH and collaboration with NHS East Midlands. NHS London has worked in conjunction with City University and Bucks New University, and thanks Ros Bryar and Rita Newland at City University and Kate Potter at Bucks New University.

The authors thank Daniel Pople and Stephen Lightbown in the NHS London Communications Team. NHS London also thanks the NHS trusts that have supported placement students, and of course the excellent group of students who have committed to return to practice.

Box 1. Return to practice case studies

Jo Lansdown qualified and worked as a health visitor in the 1980s. After completing a master’s degree in the sociology of health and illness, she took up the opportunity to work in management. Following a recent South West London Cancer Network role, Jo was seconded to the Department of Health to support national projects focused on cancer and referral to treatment waiting times.

Throughout her career, Jo has drawn upon the skills and experience gained while working as a health visitor. Jo says: ‘I have always seen the individual — client, patient, child, carer — as being at the centre of whatever service I have been responsible for managing or delivering.’

Jo is committed to helping the most needy families in London and is enthusiastic about returning to health visiting.

Ruth Newson spent eight years working in Africa with malnourished children, educating people about HIV and AIDS and healthy lifestyles. On return to the UK, Ruth began working as a practice nurse in London. She has found that her knowledge of the different languages and cultures she experienced in Africa proves useful when caring for patients in her diverse community.

Ruth says: ‘I am really looking forward to returning to work as a health visitor, spending more time in the community with my patients and working with people in their own homes.’

Ermin Bryce left health visiting to work in the Armed Forces Hospital in Riyadh, Saudi Arabia. While abroad, Ermin, a UK-qualified midwife and health visitor, was able to utilise the breadth of her skills. She ran child health clinics, provided support for mothers and worked on health promotion campaigns.

Ermin says: ‘I feel I have never really left health visiting. I feel passionate about my profession and would like to continue to work in this field.’

The determination to work as a health visitor once again can also come from experiences in a new line of work. Gloria Thomas was working in North London supporting children in care, and is now returning to her health visiting roots.

She says: ‘My main driver for returning to health visiting is to try and prevent even one child from going into care.

I believe that intervening at community level provides an opportunity to change lives for the better, in particular for those in vulnerable groups.’

In her previous job, Gloria provided in-depth support to ensure that the best outcomes were achieved for children and families going through care proceedings. She worked in partnership with schools and other agencies to develop plans for effective assessment, education and rehabilitation.

As well as all this, Gloria has worked for many years in nursing and health visiting as both a practitioner and a manager.

‘Return to practice may prove to be an essential lever in reversing the decline’

Further information
See: www.london.nhs.uk/hvreturntopractice or email: seema.trivedi@london.nhs.uk

References
Celebrations marking 2010 as the 125th anniversary of the Soldiers, Sailors, Airmen and Families Association (SSAFA) Forces Help are drawing to a close, and this article looks at the charity’s history and the work that it continues to do in the UK and around the world.

**Founded on need**

The charity now known as SSAFA was founded by Major (later Colonel Sir James) Gildea, a true visionary who recognised the need to support the wives and children of serving soldiers and sailors when the second expeditionary force set sail for Egypt in 1885.

Major Gildea – known as ‘the soldier’s friend’ – appealed for funds and volunteers in a forceful letter to *The Times* (Gildea, 1885) and the charity was born.

The then Princess of Wales (the future Queen Alexandra) became the first president of the Soldiers’ and Sailors’ Family Association (SSFA), with Queen Victoria as patron.

After the First World War, the title changed as the families of airmen were included, and the charity became known as the Soldiers’, Sailors’ and Airmen’s Families Association (SSAFA). Much later, SSAFA amalgamated with the Forces Help Society and the title changed to SSAFA Forces Help, as it remains today.

Branches were set up in Britain and overseas. The first foreign branches – the forerunners of the SSAFA Voluntary Overseas Committees – were established in 1887 in Bombay, Bengal, Madras, Hong Kong and Malta.

**SSAFA nurses**

Appointed in 1892, Lady Diamond was the association’s first nurse, providing domiciliary care for serving men’s families.

SSAFA nurses visited the sick and provided information on health and hygiene resulting in reduced incidence of epidemics and illness. These nurses were the antecedants of the health visitors of today.

Throughout numerous conflicts and times of great hardship, SSAFA staff and volunteers have been stalwart in providing help and support to the most vulnerable families. As recently as 2004, SSAFA staff in Cyprus assisted in the evacuation of refugees from Lebanon. SSAFA health visitors, social work staff and a band of formidable SSAFA volunteers combined forces with their military counterparts and many other agencies to ensure that families were rescued and forwarded safely to the appropriate destinations.

**Unique needs**

It is recognised that life in the armed forces provides many opportunities and challenges. Postings to interesting parts of the world and opportunities for travel are interlaced with particular difficulties. The third joint chief inspectors’ report on arrangements to safeguard children (Ofsted, 2008) identified children and young people from forces families as vulnerable.

Overseas families and their children have to cope with
frequent upheaval and displacement from their culture and community. Increasing military deployments, trauma arising from action and domestic violence and alcohol abuse are some of the difficulties families may experience. Therefore, the support offered should be responsive to the community’s unique needs.

In 1944, Field Marshall Montgomery stated: ‘In the knowledge that his family at home are being well cared for by SSAFA, the soldier fighting overseas may wholeheartedly devote himself to his duty’ (SSAFA Forces Help, undated).

This remains relevant today, and SSAFA Forces Help provides health and social care for forces families in a number of overseas locations.

Primary and community care
Primary healthcare teams and provision vary according to the needs of the population and location. Teams include health visitors, midwives, practice nurses, community psychiatric nurses, community children’s nurses, school nurses and many others. The services that are provided include child and adolescent mental health services, speech and language therapy, dietitians and health promotion services.

Health visitors are based in Canada, Gibraltar, Naples, Brunei, Nepal, Belgium (SHAPE), Cyprus and Germany. We work in partnership with the military, social work services, service children’s education and a prestigious band of SSAFA volunteers.

Health visiting offered to forces families overseas mirrors that provided in the UK. The services offered reflect the needs of the specific communities we serve. We strive to deliver the Healthy Child programme and wholly embrace our public health role. We adhere to the guidance in Working together to safeguard children (HM Government, 2006) and have robust policies and structures to ensure that children from forces families receive the care that they deserve, including local safeguarding children’s boards (LSCBs) in each location.

Keeping in touch
As health visitors overseas, we are conscious of the need to keep updated and use all methods of media to ensure we remain informed. We are in close contact with our counterparts in the UK, and SSAFA health visitors were well represented at the Unite/CPHVA annual professional conference. The Health Visitor Forum in Germany enables practitioners to share best practice, discuss issues affecting practice and provide valuable peer support.

A quality training programme reflects the needs of practitioners to ensure continuing professional development.

Great opportunities
Health visitors working overseas acknowledge the great opportunities provided. We embrace the challenges presented, working in a military environment, with a diverse, mobile population with specific healthcare needs, and strive to provide a quality health visiting service, working in partnership with other agencies.

After 125 years, it is clear that Major Gildea’s vision to provide support to the families of service personnel is as necessary today as it was in 1885. We look forward to the next 125 years of SSAFA Forces Help.

Further information
For more information about SSAFA Forces Help, please see: www.ssafa.org.uk

References
The case for fair pay

Unite’s evidence to the NHS Pay Review Body this year stresses the importance of providing a fair uplift in pay

Siân Errington
Unite research officer

Unite submitted its evidence to the NHS Pay Review Body (PRB) last month, emphasising the need for a fair uplift in pay for NHS workers in the coming years. This article summarises the case made by the union.

Public sector pay

Unite began by focusing on the impact of the government’s policy of a two-year public sector pay freeze from 2011, except for those earning £21 000 or less (who will receive an annual increase of at least £250).

Unite continues to support the NHS PRB and its independent role, and believes the government’s announcement of a real-term pay cut for public sector workers rides roughshod over the role of the NHS PRB.

This pay policy is part of wider deep and damaging spending cuts that Unite, the TUC and many leading economists believe are economically wrong-headed. Cuts do not lead to economic growth and create jobs, but threaten to ruin public services and push the economy back into recession.

Limiting public sector pay increases to 2% at a time of record-high inflation led to many public sector workers experiencing a real-term pay cut from 2005 until the end of 2008. The upward underlying trend in public sector pay over the past decade was necessary to close the gap between public and private sector incomes. Modernisation and improvements in public sector pay structures meant public sector pay rose faster than private sector pay between 2002 and 2004. This levelled out in 2005, and private sector earning growth was larger than in the public sector from 2006 to 2008 (TUC, 2007).

A public sector pay freeze is a pay cut in real terms. The rate of inflation is projected to be consistently above 0% (see Table 1) – the amount that the government wishes most NHS workers to receive (IDS, 2010a). It should be emphasised that this uplift is separate to staff receiving incremental points, as discussed and reaffirmed in previous years’ NHS PRB reports. All NHS staff, regardless of pay grade or point, continue to be entitled to incremental point increases under Agenda for Change.

Staff workload

As highlighted in previous years’ evidence, the experience of NHS staff is of consistently high workload volumes. In this year’s Incomes Data Services (IDS) survey, 51.4% said their individual workload had increased a lot compared to the same time last year, with 83.5% reporting an increase in individual workloads (IDS, 2007). A similar percentage previously reported increased individual workloads (IDS, 2007). This was also the story told by Unite members, highlighted in our submission last year (Unite, 2009).

Workloads that are consistently too high are detrimental to staff morale, motivation and health, and this has a negative, knock-on consequence for service quality. The IDS surveys (2007, 2010b) suggest that workloads are not only too high, but too high and growing, and this is supported by comments and incidents reported by Unite members.

Through the regular working of uncontracted, unpaid extra hours over a number of years, staff have been subsidising the NHS. Yet rather than this being recognised, they are being given a pay cut in real terms and face being further run into the ground.

The recent IDS survey (2010b) found NHS vacancy freezes to already be affecting workloads – 33.9% reported that they were a cause of increased workload, and redundancies were reported as a cause by some.

The number of vacancy freezes and redundancies are likely to increase in the coming years, yet there will be increased demand for health services as poverty deepens, combined with a growing and ageing population. This is a toxic combination, and Unite is greatly concerned about dramatically increasing workloads causing stress, with a detrimental impact on staff health and services.

The IDS survey (2010b) highlights that staff experience an increase in workload when reorganisations take place. In England, staff are about to be hit by the implications of the NHS White Paper (Department of Health, 2010), and this is reflected in the IDS survey – NHS staff are fearful of the future, with concerns over pensions, privatisation, pay and job security (IDS, 2010b).

The joint staff-side and Unite evidence in recent years have pointed toward the increasing fragility of NHS staff morale and motivation, while 55% to 60% of staff have reported worsening morale (IDS, 2007, 2010b). Not only are staff left struggling with growing workloads and below-inflation pay, but also with fears over future job security.

Recruitment and retention

The early 1990s saw recruitment and retention difficulties as public sector pay fell behind private sector pay. The combined prospect of much higher university tuition fees and falling wages in comparison to the private sector will create recruitment and retention difficulties.
Although vacancies currently appear to be low, there have long been concerns about the accuracy of data on NHS vacancies.

A wealth of experienced staff may be lost through redundancy and early retirement – for example, through ill health.

Training
Unite has previously highlighted cases of staff being asked to shoulder the financial burden of training, even when training is mandatory to maintain professional registration. These costs can run to hundreds of pounds, and Unite is concerned that the percentage of staff paying for their own training will grow over the coming years.

Cutting back on staff training has a negative impact on staff morale and confidence, and harms service quality. The culture change needed in the NHS to bring about on-going staff development has not yet been achieved, and Unite fears that this is an area of spending that will be vulnerable over the coming years.

Conclusion
NHS staff are committed and hardworking, regularly putting in extra unpaid hours. This effectively subsidises the running of the NHS. But their commitment and dedication is being taken advantage of – they have received below-inflation increases for years that have reduced their standard of living.

The NHS PRB should use the leeway it has to send a clear signal that enough is enough. The government’s pay policy is unfair and unjust and this should be acknowledged. Unite believes that all of those working in the NHS should receive a fair uplift in their pay, recognising the commitment and dedication shown by staff to delivering services, and should not experience a pay cut in real terms.

References


IDS. (2010b) NHS staff survey: a research report for the joint NHS trade unions. London: IDS.


‘The government’s pay policy is unfair and unjust and this should be acknowledged’

On-call guidance: paving the way for local agreements

The original Agenda for Change (AfC) on-call arrangements were tested in early implementer sites in 2003, and it was apparent that these would create a number of problems when AfC was rolled out nationally. It was decided to retain pre-AfC on-call agreements while the NHS Staff Council conducted a review to establish a new single national agreement.

That review commenced in September 2008 with a deadline for a new national agreement to be applied from 1 April 2011. The first 15 months of the review focused on creating a data collection methodology to provide extensive information on the range of on-call agreements across the NHS and support the review to develop a new harmonised single agreement.

However, technical and other difficulties were encountered and in early 2010 it was concluded that it would not be possible to gather the data as planned. The Staff Council agreed that the review would establish a framework of principles and guidance to provide the basis for locally negotiated on-call agreements. The review group reported to the Staff Council in July and there was a consultation on the on-call principles. Unite undertook a ballot of members with a recommendation not to accept the principles without amending two of them. Members rejected the principles and Unite successfully sought changes that led to revised principles and supporting guidance.

Final Staff Council documents were published in November, paving the way for staff sides at local level to negotiate new harmonised on-call agreements with management. In the three devolved administrations there will be countrywide agreements, but in England each employing organisation will establish its own. All of the Staff Council documents are available on the Unite health sector website, see: www.unitetheunion.org/health

Barrie Brown, Unite Health Sector lead for nursing

Have you added yourself to the Unite 4 Our NHS map yet? See: www.unitetheunion.org/unite4ournhs to sign up
Guidelines for authors

Updated guidelines for authors and contributors to Community Practitioner

Although the journal’s new look means that there have been some changes in our guidelines for authors, most of our guidance remains the same.

Articles are considered for publication on the understanding that they are not being offered to any other journal and have not been published or accepted elsewhere.

All manuscripts should be submitted, with full author contact details, directly to the editor Danny Ratnaike, by email to danny.ratnaike@tenalps.com and authors should keep a copy of the material they submit.

Presentation and house style

The following information should always be included: title of article, first name and surname of author(s), qualifications, details of position held, number of words in article.

- Where either ‘s’ or ‘z’ can be used, use ‘s’ (eg organisation)
- One to nine should be in words, 10 and over in figures
- Percent should be written as %
- Full stops should not be used to indicate abbreviations: CPHVA, eg, ie, NHS
- Some abbreviations do not need to be explained – eg CPHVA, NHS, NMC – but most should be spelled out in full when first used followed by the abbreviation in brackets (if in doubt, spell it out on its initial use)
- Capitals should not be used for role titles or professions, such as ‘health visitor’ or ‘nursing’.

Article content and length

Articles should be written with our readers in mind – health visitors, school nurses and community nursery nurses, and others working in primary care and community settings.

We welcome the inclusion of relevant figures, tables and images, though original work on paper is submitted at the owner’s risk. Electronic images should be at least 300dpi resolution and in tif, jpg or eps format.

Types of article

Professional and research

Papers should be between 2000 and 3500 words in length (including references), and are subject to double-blind peer review following submission.

Papers should begin with an unstructured abstract of 150 to 200 words, and up to five key words or terms that reflect the article’s subject and focus accurately.

Research articles should be arranged in the usual order of introduction, study aim/purpose, method including ethical approval, results, discussion, implications and recommendations, conclusion, acknowledgments and references.

Clinical

Either 1400 or 2100 words in length, these should review clinical management, present case studies etc.

Other features

The content of first-person articles (700 words) and general features (1400 words) should be discussed with the editor prior to submission.

Other contributions

Letters of up to 300 words in length are always welcome, and any readers interested in writing reviews of resources should contact the editor.

Referencing

Please check that references are complete and accurate. References should be set out in the Harvard style – author and year of publication referred to within the text, and listed alphabetically at the end. Examples include:


Normally, references should not exceed 25 in number, and should usually be far fewer.

Potential competing interests

Authors of professional, research and clinical papers are asked to declare:

- Any support from any organisation for the submitted work other than a funding grant
- Any financial relationships with any organisations that might have an interest in the submitted work during the previous three years
- Any other relationships or activities that could appear to have influenced the submitted work.

We are not looking to exclude authors with competing interests, but do want to improve transparency for our readers.

Editing and publication

The editor reserves the customary right to style and shorten material accepted for publication.

The editor also reserves the customary right to determine priority and time of publication, though every effort is made to publish as soon as possible.

If you have any further queries, please do not hesitate to contact us – we look forward to discussing your ideas.

- Danny Ratnaike, editor
  Tel: 020 7878 2404 or email: danny.ratnaike@tenalps.com
- Jane Appleton, professional editor
  Tel: 01865 482606 or email: jvappleton@brookes.ac.uk
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Closing Date for Applications: 17th December 2010

Unite/CPHVA website

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See: www.unitetheunion.org/cphva
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Tel: 024 7652 2035 or email: H.J.Cann@warwick.ac.uk

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Noticeboard

Homeless specialist or liaison roles

I am interested in making contact with any health visitors who are working in a liaison or specialist health visitor role with homeless families or those in short-term temporary accommodation. I would appreciate the opportunity to discuss the role and how it is working in differing areas of the country.
Louise Stewart-Roberts email: louise.stewartroberts@southdowns.nhs.uk

Information for a review of skill mix

We are reviewing our skill mix in health visiting, having introduced several community nursery nurses into the service five years ago. I would be very grateful if anyone who has any information on skill mix in their service, particularly at Band 4, could contact me.
Ceinwen Frost email: ceinwen.frost@wales.nhs.uk

Access the online journal archive

All Unite/CPHVA members should be able to access the online journal archive:
- Select 'Journal archive' at www.commprac.com and log in using your Unite membership number
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- For the table of contents of a particular issue, select the issue from the list. From each table of contents, you can select a specific article and download a pdf of it
- If you’d like to search for articles on particular subjects or by specific authors, then select 'Advanced search' (toward the top of the page, on the right-hand side of the main search box) – remember to type 'Community Practitioner' in the publication box.
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Information about adverse event reporting can be found at www.yellowcard.gov.uk. Adverse events should also be reported to Forest Laboratories UK Ltd. Tel: +44 (0) 1322 421800.

References:
3. BP Value and Volume Sales 52 w/e 10 July 2010.
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