Under pressure: support for CPTs

An alternative vision for the NHS

Child health workforce competence framework

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COMMUNITY PRACTITIONER

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Wales now points the way forward

The World Health Organization estimates that nearly two-thirds of premature deaths and one-third of the total disease burden in adults are associated with conditions or behaviours that began in youth – tobacco use, harmful alcohol use, lack of physical activity, unprotected sex, poor nutrition leading to obesity, mental health problems and exposure to violence and accidents.

School nurses have a mix of skills covering all aspects of public health and health promotion, safeguarding, and supporting children and young people with medical, special and complex needs. It is obviously crucial that they are employed in sufficient numbers so that young people have full access to them.

The Welsh Assembly Government is to be congratulated on its achievement to secure a named school staff nurse for nearly every secondary school in Wales. At the start of this parliament, there was no clear school nurse pathway and inconsistency in training and employment. A great deal of organisation was needed to encourage nurses into specialist community public health nurse education, and we understand this is an on-going process so that eventually all lead school nurses will be qualified.

Wales is on target to offer an equitable public health service to all school-aged children throughout the year. This rejuvenated service will also hopefully encourage more men into the profession.

Westminster sadly lags far behind Wales. For all of England’s 3300 secondary schools, nearly 17 000 primary schools, almost 1000 special schools and 452 pupil referral units, there are fewer than 1500 school nurses. It is therefore quite shocking to hear that some trusts are proposing to retrain school nurses as health visitors in order to ‘fudge’ the numbers needed to achieve the government’s expectation of 4200 extra health visitors in post. ‘Robbing Peter to pay Paul’ is no solution to the long-term issues of public health in children and young people, and must be resisted.
Early implementer sites: support to meet potential

Unite/CPHVA has welcomed the launch of 20 health visiting early implementer sites (EISs), which will lead the way in implementing the new health visiting vision.

Unite/CPHVA lead professional officer Obi Amadi stated: ‘The introduction of EISs is a positive way forward in helping to achieve the 4200 health visitor target. However, we appreciate that not all of these sites are at the same level – some appear to be itching at the starting blocks and others will have to work much harder to deliver the vision by March 2012.’

Unite/CPHVA National Professional Committee chair Alison Higley commented: ‘We trust that the selection of some sites – despite that some are not at an as advanced stage as others in delivering the new health visiting vision – has been made to boost support and to add value to sites that we believe are in need of extra support. We watch with interest and optimism at how these EISs move forward.’

Bespoke support packages

The 20 EISs – two from each strategic health authority (SHA) region – have been chosen by SHAs because they are believed to be in a position where they are able to deliver the four levels of the new vision – ‘community’, ‘universal’, ‘universal plus’ and ‘universal partnership plus’ – by 31 March 2012.

In an interview with the journal at the launch of the EISs in London last month, the two named nurses leading the 20 sites spoke about their work in devising bespoke packages of support. Sally Batley, the head of the health visiting implementation network, said: ‘Some of these sites are further down the road to delivering the vision than others, and so the bespoke support packages that we will put in place will depend on what each site needs.’

Sharing learning

Referring to the EISs that are in a more advanced position to delivering the vision, Sally Batley added: ‘It’s about them sharing their learning with other EISs and to encourage the early implementers to learn from each other.’

Co-head Sally Brown reinforced: ‘We are there to be the “glue” in getting the sites to work together and to share ideas seamlessly, so that sites are not working in isolation.’

The two EIS leads appeared optimistic that all early implementers would be in a position to deliver all four levels of health visiting. Sally Brown stated: ‘The confidence comes from the SHAs, which know their individual sites very well and which have nominated them because they felt that they would be able to deliver the vision by 2012.’

A Department of Health (DH) spokesperson confirmed that EIS support packages would include access to:

- Support from the DH development team
- NHS Institute work.

The two leads were due to meet with all of the EISs on 5 May to further discuss delivery plans.

Measuring potential

SHAs were expected to identify early implementer sites based on DH criteria including:

- To have delivery plans in place for the full implementation of the new health visiting service, with clear milestones for delivery, by March 2012
- To either have in place or have commissioning arrangements for the Healthy Child and Family Nurse Partnership programmes, and provisions that meet the new health visitor vision
- Good local safeguarding arrangements
- Evidence of plans to develop and strengthen partnership working across general practice, Sure Start children’s centres, other early years services and social care
- A local system in or set to be in place to collect families’ views
- Confirmation from commissioners that they have sufficient capacity and capability to move toward the new service
- Assurances from SHAs that the chosen EISs have the ability to deliver the new health visitor service by March 2012.

England deputy chief nursing officer Viv Bennett commented that the criteria were not about already having health visitor numbers, but having the potential to deliver the new vision.

Minister meets local health visitors

A visit by public health minister Anne Milton’s to Outer North East London Community Services (Waltham Forest) was well received by local health visitors, though concerns remain over local service delivery, a Unite local accredited representative (LAR) has reported.

Unite/CPHVA president Lord Victor Adebowale and lead professional officer Obi Amadi accompanied the minister, and LAR Norma Dudley stated: ‘We raised concerns over cuts to services, high workloads and an overall reduction in qualified health visitors. The minister appeared to have understood our concerns and the visit has really helped to boost morale. We would like to thank Anne Milton and Lord Victor Adebowale for visiting our trust.’

She added: ‘We understand that England deputy chief nursing officer Viv Bennett is due to follow up on the minister’s visit and we hope to confirm a future date.’

Unite/CPHVA professional officer Dave Munday commented: ‘We are pleased that the minister has visited the trust and has heard first hand what the reality is for some health visitors. NHS trusts continue to cut back on services at the same time the government is insisting that investment must be made. We hope that the minister will not only use this visit to support our members in Waltham Forest, but also all those across England in similar circumstances.’

The minister made the visit following a promise made to one of the trust’s health visitor and Unite LAR Elaine Baptiste at the Unite/CPHVA 2010 annual professional conference.

Dave paid credit to the work of Norma and Elaine, who were ‘desperately standing up for families’. Waltham Forest has previously been indented by Unite as a ‘crisis area’, suffering from severe staff shortages. Despite the visit, worries still exist. Norma stated: ‘The way forward is unclear because we are still concerned about the local financial constraints and whether our commissioners understand the qualitative nature of the health visitor role and the importance of a universal health visitor service.’

The introduction of EISs is a positive way forward in helping to achieve the 4200 health visitor target’

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Health Bill delay due to successful campaigns

The government’s delay in pushing forward the Health and Social Care Bill to allow for a two-month consultation ‘listening exercise’ with NHS staff is the result of successful campaigning, Unite has stated.

However, it stressed that although there is a delay, it is not confident that the ‘listening exercise’ will be genuine. Unite assistant general secretary Jennie Bremner stated: ‘This is a result of the success and the pressure brought by campaigns such as Unite 4 Our NHS and the Trades Union Congress March for the Alternative. The March was unbelievably successful, with over 400 000 people saying that we are unhappy. Now the government has called for a “listening exercise” – this is just a token gesture and a PR exercise, and I am not confident that anything will change.’

Jennie was commenting following press reports of a leaked memo by NHS chief executive David Nicholson, claiming that elements of the Bill, such as establishing GP consortia, transferring all NHS trusts to foundation trusts and abolishing primary care trusts, cannot be changed.

The reports came amid calls from the House of Commons Health Committee for ‘NHS commissioning authorities’ instead of GP consortia, and for other healthcare workers including public health and social care professionals to be involved within these authorities.

While Unite/CPHVA professional officer Gavin Fergie stated that ‘it is more than just medical practitioners who deliver and manage services and therefore everyone who is involved in public health should be actively encouraged’, he also stressed: ‘We have no confidence in this government and this proposal could well be a smokescreen.’

Unite continues to campaign against the Bill and held a briefing on the same day the 2011 Budget was announced. Jennie stated: ‘We had over 41 MPs attend and even though the Budget announcement was a key day, MPs were interested in hearing about what we had to say about the Bill. There is a lot more opposition, more than the coalition government realise.’

Jennie added: ‘We hope that there will be organised protests specifically for the NHS. But in the meantime members can help our campaign by writing to their MPs.’

The union collected 13 000 signatures on its letter to the Health Bill Committee, which highlighted the negative impact of the Bill. It identified aspects of the Bill that it said must be amended, including competition legalisation to ensure that competition is measured on quality and not price, and protection of NHS staff terms and conditions.

For more on the Bill, please see pages 14 to 15.
More marches if government does not listen

There could be more organised marches in protest of job and service cuts, Unite has stated following the Trades Union Congress March for the Alternative on 26 March.

Unite assistant general secretary Jennie Bremner stated: ‘The title of the march says it all, “March for the Alternative” – there is an alternative to simply making real slash-and-burn cuts, and I envisage there to be more marches until the government gets the message that we are a country that will not put up with it.’

She added: ‘Morale on the day was exceptionally high. There were 400 000 people from all over the country demonstrating their strength of feeling over the government’s draconian measures.’

More and more people are worried about losing their jobs and restricted access to NHS services because of widespread cuts, Unite has stated following findings from a poll that it commissioned.

The poll, conducted and analysed by Mass1, highlighted five key areas that the 143 000 respondents had worries about:

- Money, with many reporting a real struggle to make ends meet
- Job cuts
- Council service cuts
- NHS cuts affecting access to services
- Cuts to teaching staff.

Voluntary early intervention services are hardest hit by cuts according to a survey by Children England, which represents voluntary children and young people’s services. Of 72 member organisations surveyed, 71% said they would experience cuts to their income for 2011 to 2012.

Unite/CPHV A has commended the progress of the Welsh Assembly Government (WAG) to meet its one school nurse per secondary school commitment, and is encouraging it to keep up efforts to raise the number of specialist community public health nurse (SCPHN) qualified school nurses.

Unite/CPHV A professional officer Ros Godson stated: ‘The WAG has done well in such a short period of time to increase school nurse numbers and to put this promise into action. We acknowledge the work it has done by redesigning the school nurse curriculum and job descriptions so that the service is equitable across the country. This work needs to continue in order to raise the number of full-time SCPHN-qualified school nurses to improve access to the service by young people.’

Preliminary figures provided by a WAG spokesperson indicate that the government was not far off meeting its pledge by the end of April 2011. However, it was unable to provide any indication as to how many of its school nurses were SCPHN-qualified. The spokesperson stated: ‘We are currently undertaking a data collection exercise, and hope to have more details in mid-May.’

According to the WAG there are 223 secondary schools in Wales, and figures indicated a total of 226 school nurses (see Box 1).

Unite/CPHVA school nurse strategy

Unite/CPHVA is calling on school nurses and other staff who work with school-aged children to get involved in the development of its school nursing strategy.

Unite/CPHVA professional officer Ros Godson stated: ‘We are preparing a strategy to raise the profile of school nursing across the UK, taking into account the recent policy changes in the four countries. We are encouraging any nurses working with school-aged children to get involved with this agenda.’

The strategy aims to:

- Improve career pathways, both toward and after qualifying
- Set school nursing within the wider public health context
- Emphasise to commissioners and managers that school nurses are the only qualified health professionals who work across health and education.

Those who want to get involved should contact Ros on email: rosalind.godson@unitetheunion.org

Welsh school nurse efforts to continue

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Box 1. School nurse numbers in Wales

<table>
<thead>
<tr>
<th>Type of Nurse</th>
<th>Number</th>
</tr>
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<tbody>
<tr>
<td>Full-time year-round</td>
<td>43</td>
</tr>
<tr>
<td>Full-time term-time only</td>
<td>22</td>
</tr>
<tr>
<td>Part-time year-round</td>
<td>71</td>
</tr>
<tr>
<td>Part-time term-time only</td>
<td>58</td>
</tr>
</tbody>
</table>

The above figures do not include staff from one health board, which has 28 schools and employs 32 school nurses. Information on these nurses’ work patterns is not yet available.

The spokesperson added: ‘While some of the school nurses may be part-time, each secondary school will still have access to a member of the school nursing team full-time.’

Despite progress, Unite/CPHVA School Nurse Forum member Teleri Roberts, who works in Wales, raised concerns over whether there will be enough money to sustain the new school nurse service, and added: ‘Introducing skill mix to the teams as a means of saving money has the potential to dilute public health provision unless a comprehensive community profile is undertaken.’
Reforms create unclear path for HIV education

Unite/CPHVA has raised concerns over a lack of clarity about how public health promotion and education on HIV will be effectively managed in the future due to NHS reforms, following statistics indicating that there has been a rise in diagnoses.

Referring also to guidance published by the National Institute for Health and Clinical Excellence (NICE) recommending HIV tests to be offered in high prevalence areas, Unite/CPHVA professional officer Dave Munday stated: ’While offering tests in high prevalence areas is a good move in early identification, public health education and prevention is vital to keeping rates down.’

However, he added: ’With reforms to the NHS, it is unclear how public health promotion around HIV and other sexually transmitted diseases will be effectively managed in the future. Primary care trusts and strategic health authorities, which would have had the ability to monitor and ensure that appropriate and local public health education provisions are put in place, will be abolished.’

Latest figures from the Health Protection Agency (HPA) suggest that the number infected with HIV in the UK has almost doubled in 10 years – over 1950 diagnosed in 2001 and 3780 in 2010.

The HPA stated that if the 3780 HIV cases had been prevented in 2010, over £32million would have been saved annually.

The guidance from NICE recommends that GPs should offer HIV tests to everyone living in areas where more than two in 1000 people are diagnosed with HIV. The guidance also sets out a strategy to increase the uptake of HIV testing among black African communities in England.
Young people’s cancer rates: education needed

Improved and continued health education throughout childhood and adolescence on skin cancer prevention is the best way to tackle an increase in the disease, Unite/CPHV A has stated.

Unite/CPHV A professional officer Ros Godson was commenting following statistics by charity Cancer Research UK, which indicated that rates of malignant melanoma among 15- to 34-year-olds across the UK have tripled since the late 1970s.

Referring also to a change to the Sunbeds (Regulation) Act 2010, which will see businesses permitting the use of sunbeds among under-18s to be fined up to £20 000, Ros stated: ‘Although under-18s are now banned from using sunbeds in commercial premises, it will be several years before the benefits are shown. Meanwhile, all young people already exposed to the sun’s radiation and who regularly use sun beds will continue to be at risk. The only real solution is to get serious about a protracted education campaign, started during childhood, to persuade everyone in the medium- or high-risk groups to use high-factor sunscreen and to stay out of the midday sun. School nurses and practice nurses are best placed to lead such campaigns.’

Unite/CPHV A School Nurse Forum member Kathy O’Connell reinforced that early health education is needed: ‘More and more young people are using sun beds and believe that they have to be tanned to look good. Recently, there seems to be an increase in boys using sun beds too. I have found in discussions that I have had with young people that they think it is only older people who are at risk of skin cancer – and this is worrying.’

According to Cancer Research UK, there were on average 290 cases of melanoma among 15- to 34-year-olds between 1977 and 1979 compared with 900 in 2006 to 2008.

The change to the Sunbeds (Regulation) Act 2010 will also prevent under-18s from being offered the use of sunbeds, or being allowed in areas that are reserved for sunbed users. Local authorities will be responsible for enforcing the Act by inspecting businesses.

News in brief

Wales pharmacists can provide free EHC

The decision to make emergency hormonal contraception (EHC) available free from pharmacists in Wales came into effect in April, and community pharmacists can give EHC to under-16s if clinically appropriate.

Community Pharmacy Wales chair Ian Cowan stated: ‘The fact that access to this service will now be free of charge and provided anonymously in a discrete, confidential but convenient environment and under the guidance of a clinically qualified healthcare professional, is reassuring to the women who need it.’

The Royal Pharmaceutical Society noted that only around half of pharmacies in Wales are currently funded to provide the service.

Budget 2011 hinders child poverty efforts

The announcement of the 2011 Budget along with the government’s austerity measures will hinder efforts to tackle child poverty, Unite/CPHV A has stated following the Department for Education’s publication of its child poverty strategy.

Unite/CPHV A professional officer Dave Munday stated: ‘The government is simply telling people what they want to hear, but in its actions it is doing the complete opposite. The Budget has been described by the government as a “budget for growth”, but there are clear figures that indicate that the economy is shrinking. This is the same for child poverty. We have promising outlined in the new child poverty strategy – to invest in the early years – and yet some of the government’s actions, such as reducing welfare support and cutting key services, will not help in reducing child poverty.’

The charity Family Action reinforced that changes to tax rates and benefits that were implemented last month will mean that babies from disadvantaged families will be ‘born broke’. Its chief executive Helen Dent stated: ‘The government is shooting down its social mobility and child poverty strategy before it’s even got off the ground. While we welcome the emphasis on early years as a step toward addressing social mobility and child poverty, Sure Start cuts and welfare and tax changes will put huge strain on disadvantaged families, particularly those with babies and young children.’

The 2011 Budget makes pledges including to increase the personal allowance for under-65s in April 2012 and to reduce the rate of inheritance tax in 2012, however there are concerns that not enough is focused on helping families already living in poverty. A spokesperson for Action for Children stated: ‘While some of the announcements in the Budget will help families, we are particularly concerned for those who are at breaking point. The government must invest in support for families in need at the earliest possible stage.’

The government’s child poverty strategy focuses on improving life chances, proposing measures to improve under-five health services and combating worklessness and educational failure.

Record rise in complaints to the NMC

The NMC has reported a record year-on-year increase in complaints received about nurses and midwives in the first two months of 2011.

The regulator stated that improvements in complaints handling may partly explain the rise, but chief executive Dickon Weir-Hughes added: ‘The fact that other healthcare regulators have also experienced similar dramatic increases in the volume of their complaints is a serious cause for concern and indicates the need for more detailed research into the underlying reasons for these trends.’

In January and February, the NMC received 833 new referrals, up 57% on the 530 received in the same two months of 2010.

Change4Life ‘5-a-day’ national roll out

The Department of Health scheme to help people in deprived areas to eat five fruit and vegetables a day has been rolled out nationally, following successful pilots.

Shops involved with the scheme will promote the ‘5-a-day’ message and prominently display fruit and vegetables on the shop floor.

Public health minister Anne Milton stated: ‘Stores involved in the pilot have seen on average an increase of 40% in sales of fresh fruit and vegetables.’

In brief

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Health visiting workshops

Free workshops planned to help health visitors in England make the most of the health visitor implementation plan

Danny Ratnaike
Editor

Unite/CPHVA is encouraging health visitors and team leaders to attend free workshops on the health visitor implementation plan. Lead professional officer Obi Amadi stated: ‘We now have the “when” and “what”, but now is the time to understand the “how”. For this ambitious change to succeed, we need practitioners to change some of what they do.’

She added: ‘These events will consider the different issues and how best to address various elements that are relevant to you. We all need to understand the incentives and levers that we can use.’

The events, supported by the Department of Health, aim to help members to fully understand and make use of the document Health visitor implementation plan 2011-15: a call to action in improving services for children, families and communities.

For workshop dates and venues see Free workshops across England, right.

ASSOCIATION

REMINDER: Guidelines for band-7 health visitor re-banding

In reviewing the current band-6 profile, Unite’s Nursing Occupational Advisory Committee (NOAC) has identified an increase in points for at least five factors that would provide an outcome of 476 points, placing the job in band 7.

The health visitor national job profiles can be accessed from the NHS Employers website (www.nhsemployers.org), where the third edition of the job evaluation handbook can also be found.

Areas that the NOAC recommends taking into consideration include:

- Communication and relationship skills: would remain at 5(a)
- KTE – the change in role since 2004 should influence this factor and the critical issue the ‘master equivalent’ – look at postgraduate qualifications with significant years of experience
- Analytical and judgemental skills would remain at 4
- Planning and organisational skills could provide a 3 and an increase of 12 points – on-going planning, early support for children’s plans, and child protection multi-agency professional lead
- Physical skills would remain at 2, but listening skills are critical
- Responsibility for patient/client care could be placed at level 5(c) and give an additional nine points – use of interpreters, public health information and advice provision to families and specific groups such as asylum-seekers
- Responsibility for policy/service development should be 2
- Responsibility for financial and physical resources: this should be at 1-2(c) and include stock taking, stock ordering and relate to nurse prescribing role
- Responsibility for HR should be at 3 and provide an additional nine points – student nurse training and annual mentorship, on-going responsibilities for students and skill mix developments
- Responsibility for information resources should be at 2 and give an extra five points – move from paper records to electronic and writing reports for other professional agencies and court reports
- Responsibility for R&D would remain at 1-2(a) (b), but there is the effect of increased amounts of audit
- Freedom to act would remain at 4
- Physical effort should be at 2(d), moderate, to reflect equipment, 6kg to 20kg, carried, distances involved and lifts not working
- Mental effort should be at 3 to reflect concentration required for listening skills
- Emotional effort should be at 3(c) and provide an additional seven points
- Working conditions should be 3(b) – very poor home environments.

If members and local reps would like to organise meetings to consider opportunities to implement this guidance, Unite Health Sector lead for nursing Barrie Brown will be available to attend, email: barrie.brown@unitetheunion.org

Free workshops across England

- Leeds – Quarry House, 6 June
- Derby – The Riverside Centre, 7 June
- Birmingham – Conference Aston, 8 June
- Torquay – Riviera International Conference Centre, 13 June
- Sunderland – venue to be confirmed, 22 June
- East Malling – The Conference Centre, 23 June
- Liverpool – Jurys Inn Hotel, 28 June
- London – details to be confirmed.

Places are limited, so register interest now by email: jeremy.sullivan@tenalps.com or Tel: 020 7878 2487.

For the plan, see: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124202
Joint conference: AOHNE, NFSHE and UKSC

This very interesting public health conference was held at the low-key Friends’ Meeting House in London and attended by members from all over the UK. It was organised by the Association of Occupational Health Nurse Educators (AOHNE), National Forum of School Health Educators (NFSHE) and UK Standing Conference on Health Visitor Education (UKSC).

The keynote address was from George Hosking, who is the founder, CEO and research co-ordinator of the Wave Trust (www.wavetrust.org). After spending a considerable amount of his working life in the world of corporate affairs, and later retraining as a clinical criminologist, he now uses his business acumen to concentrate on bringing knowledge about the causes of child cruelty into policy and practice. He gave a motivating presentation outlining the statistics, research and effective cost efficient strategies which would reduce the problem. He particularly commended the Family Nurse Partnership and the Roots of Empathy (www.rootsofempathy.org) programmes, and stressed that the latest findings are that pre-natal depression can be as much of an indicator of later concerns as post natal depression. Wave Trust has a ’70/30’ strategy – a UK goal of 70% reduction in child abuse, neglect and witnessing domestic violence by 2030.

We had an interesting presentation about public health working with sex workers, which found that the women identified themselves as women and mothers, and appreciated all advice and support.

Professor Woody Caan, from Anglia Ruskin University, explained the new English mental health strategy No health without mental health, which takes a ‘lifespan’ approach. There is economic data to show that some of the most cost effective approaches occur in primary schools, so school nurses should be involved in delivering aspects of social and emotional wellbeing programmes. He highlighted UNICEF report card 9 (www.unicef.org.uk/Latest/Publications/The-children-left-behind-Innocenti-Report-Card-9), which points up inequalities in childhood.

There were presentations about online learning, describing the processes, pitfalls and outcomes. Apparently examinations are not too difficult to administer, but the pass rates can be disappointing. Other presentations covered a method for exposing pre-registration nurses to public health nursing, a report on young people’s perceptions of school health services, and interprofessional learning.

All in all a satisfying day – lots of networking opportunities, and I look forward to next year’s conference.

Ros Godson
Professional officer for school health and public health

CNN survey update

Unite/CPHVA’s Community Nursery Nurse (CNN) Forum thanks all of those who completed and returned the CNN Registration Questionnaire that was included in February’s journal. We plan to report fully on the findings in a later issue, but the initial results indicate overall support for the forum to look further into regulation, in line with feedback from CNNs at last year’s annual professional conference.

We also want to thank those who offered to support working toward regulation in various ways, including by helping to establish a regulation committee, and we are still keen to hear from others who may be interested in getting involved. To do this, please contact Ros Godson on email: rosalind.godson@unitetheunion.org or Tel: 07764 655762.

The CNN Forum will be discussing this further at its next meeting at the end of May, so do watch this space for more information.

Barbara Evans, CNN Forum chair

Award deadlines

Mary Seacole Leadership and Development Awards
Deadline for applications is 12 May – see page 23 for further details and how to apply.

MacQueen Award for Excellence in Practice
Deadline for applications is 3pm on 5 August – see page 34 for further information.

Unite/CPHVA website
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Being involved in professional forums and networking is a useful activity for practitioners. Network forums allow like-minded people to engage in open discussion and build relationships. They offer opportunities to meet new people to share and exchange ideas and different ways of working. Such groups also provide a means to support and guide practitioners, particularly those working in isolated roles, and help to enhance professional development. Forums are often face to face, but we increasingly communicate electronically.

**Professional forums:** sharing information and mutual support

**Hazel Hawkins-Dady**  
School nurse manager, Wolverhampton Primary Care Trust

**Sarah Sherwin**  
Senior lecturer/course leader for school nursing SCPHN, University of Wolverhampton

Being involved in professional forums and networking is a useful activity for practitioners. Network forums allow like-minded people to engage in open discussion and build relationships. They offer opportunities to meet new people to share and exchange ideas and different ways of working. Such groups also provide a means to support and guide practitioners, particularly those working in isolated roles, and help to enhance professional development. Forums are often face to face, but we increasingly communicate electronically.

**SHINE**  
The Midlands School Health Innovation Network Exchange (SHINE) was set up 10 years ago for specialist practitioners in school nursing, and meets bimonthly in various locations around the Midlands.

The aim is to provide a networking forum to proactively discuss, develop and take forward key issues in relation to school nursing practice. The group also provides support for specialist practitioners and clinical leads to be able to continually shape services for school-aged children and young people through the sharing of innovation, best practice, resources and ideas.

SHINE endeavours to act as a lobbying group to inform and make representation to commissioners, professional bodies, decision makers, public health departments and educational providers at a local, regional and national level about the health needs of school-age children and young people. This also helps to raise the profile of school nursing in general.

**Overcoming challenges**

One of the main aims of the group is for members to share ideas, experiences and suggest ways of how to overcome challenges in relation to the implementation of national and regional policies such as the Healthy Child programme. Another function is to improve practice. One example of the group’s current work is exploring how best to support and develop training for band-5 staff nurses within school health teams in the region.

**Wider audiences**

The forum also allows professionals and practitioners with key responsibilities for children and young people’s health to meet with and disseminate information to a wide school nurse audience from across the Midlands. Group members then feed back information to school nursing colleagues within their own organisations.

**Get in touch**

We would like to hear from any similar regional groups to share ideas and experiences, and also from any other school nurse specialist practitioners in the Midlands. To get in touch, please email: hazel.hawkinsdady@wolvespct.nhs.uk

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**Letter: Teething and the use of systemic analgesia**

The drug company sponsoring last month’s ‘learning module’ on teething must no doubt be delighted with its anticipated increased sales figures. However, an unwell baby, who is in such pain that they require regular analgesia, is in need of medical assessment. Furthermore, there is absolutely no research evidence (as conceded in the ‘learning module’) to support the use of systemic analgesia to treat the subtle physiological symptoms associated with uncomplicated tooth eruption, and indiscriminate drug use may lead to risks of toxicity and mistaken dosage.

Surely community practitioners should be educating parents about the normality of infant behaviours such as drooling, mouthing and clinging, rather than advocating potentially harmful pharmaceutical non-solutions.

Frankie Campbell, health visitor

**Unite/CPHVA response:**

The main purpose of the Unite/CPHVA supported educational supplements is to encourage and inform practitioner reflection and debate. My own personal reflection does not arrive at the same conclusion on this supplement as yours. The reflection box on page 8, it seems to me, is quite clear regarding medical intervention – including the primacy of non-pharmaceutical interventions (rubbing gums and giving a cool object to bite). Alongside expected professional standards, readers’ own experience and expertise will impact on their practice, client interaction and understanding. These educational supplements should contribute to this.

Gavin Fergie, Unite/CPHVA professional officer
Book review: a useful balance

How to detect developmental delay and what to do next by Mary Mountstephen
ISBN: 9781849050227

This book is aimed at parents, carers and teachers of primary aged children. The author, who is a teacher and specialist in educational and neuro-developmental delay, provides guidance in identifying and dealing with problems associated with child development in a logical and straightforward manner.

An initial overview of early child development and factors that affect it includes genetic, in utero, environmental and experiential childhood features.

Expected developmental milestones are outlined in intervals from birth to 12 years. The author points out that these are for information and guidance rather than for diagnosis, and that they need to be considered in context with the individual child.

The chapters on attention, balance and co-ordination (‘ABC’) and visual and auditory development refer to evidence from other specialists. The relation of ABC to dyslexia, dyspraxia, attention deficit hyperactivity disorder and other autistic spectrum disorders is informative and easy to relate to, and the effect of visual and auditory problems on learning in childhood is very enlightening.

There are tips and strategies for parents and teachers to help children both at home and in the classroom. These are presented in a form that could be used to provide handouts.

The book provides a useful balance of theory and practical guidance to understand and help children with developmental delay. As well as parents and teachers, it would also be very helpful for other professionals, particularly those working in the school health team.

Judith Moore
Health Visitor Forum member

Research evidence

Breakfast and blood lead levels
Analysis of Chinese child cohort data suggests association between eating a regular breakfast and lower blood lead levels. Liu et al Environmental Health 10: 28

Trends in life expectancy
Analysis of changes in European life expectancy over the last 40 years, with improvement overall despite obesity epidemic. Leon Int J Epidemiol 40(2): 271-7

Over-35s and contraception
US qualitative study of women aged over 35 and their perceptions and use of contraception. Godfrey et al BMC Women's Health 11:5

New playgrounds and child activity

Roots of health inequalities
Dutch birth cohort data analysed to investigate the development of socio-economic health differences to age eight. Ruijsbroek et al BMC Public Health 11: 225

Alcohol and cancers
Analysis of prospective cohort data to find cancers attributable to alcohol consumption in eight European countries. Schütze et al BMJ 342: d1584

Primary care symptom iceberg
Postal questionnaire researching the use of self-care or primary care professionals other than GPs in the UK. Elliott et al BMC Fam Pract 12: 16

New resources

Pregnancy and complex social factors
National Institute for Health and Clinical Excellence guidance, with link to new complications of pregnancy online learning tool: www.nice.org.uk/CG110

Major changes to child maintenance
Greater encouragement for parents to make their own arrangements, with charges for statutory services: www.dwp.gov.uk/docs/strengthening-families.pdf

Resources for child protection in Scotland
New and growing resources page on the Multi-Agency Resource Service website: www.mars.stir.ac.uk/resources

OCD at School: new information website
Obsessive-compulsive disorder (OCD) resource for young people and parents: http://school.ocdaction.org.uk

Children experiencing domestic violence
New research review report from Research in Practice, available for £10: www.rip.org.uk/publications/research-reviews

Antenatal and newborn screening e-learning
Free online resource from the UK National Screening Committee, with assessment and certificate of completion: http://cpd.screening.nhs.uk/learncare

Bump to Baby parents’ search engine
New tool from NHS Local for expectant and new parents that searches carefully selected partners and trusted websites: www.bumptobaby.info
An alternative vision

Unite has been highlighting its alternative vision for the NHS to the proposals in the Health and Social Care Bill, drawing on examples from Scotland, Wales and Northern Ireland in the run up to devolved and local elections on 5 May

Ahead of elections in Scotland, Northern Ireland (NI) and Wales on 5 May, Unite has set out its ‘ideal’ health manifesto, emphasising that all three countries should avoid following England’s ‘damaging’ NHS reforms.

Not in England’s footsteps
The delay in passing the Health and Social Care Bill through Westminster – to allow for a two-month ‘listening exercise’ in which parliament has invited the views of NHS staff following growing opposition – provides evidence of how little support there is for the reforms, Unite states.

Fiona Farmer, Unite national officer for health in Scotland, NI and Wales, says: ‘The admin costs of England’s health bill will be a further drain on public funding, and funding under the bill will favour certain services to the detriment of others.’

Unite/CPHVA professional officer Gavin Fergie states: ‘There is a difference between “any willing provider” and any suitable provider, and in England Unite has come out against proposals to allow “any willing providers” of health services.’

The Scottish Conservative Party manifesto proposes giving NHS boards in Scotland the freedom to be able to commission services from private or voluntary sectors (see Box 1), but Gavin warns that this may imply an unwelcome move toward the English model. Speaking after the manifesto was published, he stated: ‘There is absolutely no reason for members in any of the devolved countries to support a manifesto that may not explicitly support a health market, but that hints at increasing competition.’

Outlining an alternative
As details of the listening exercise in England were being confirmed, Unite highlighted positive aspects of NHS provision in Scotland, NI and Wales that it says the English government should consider.

The union also stressed that the devolved administrations should not introduce policies that would remove the NHS from public hands.

Not for profit
Commenting in the run-up to the devolved elections, Fiona stated: ‘In Scotland, NI and Wales, pre-election manifesto commitments on health care are predominantly based on outcomes and not profit. It is important that the NHS in these countries does not follow England’s damaging health market.’

Free of competition and internal markets
England is the only country that operates with an internal market, and Fiona stresses that the other three countries are at an

Box 1. The NHS across the UK and key health pledges from major political parties

England Health Bill
The Health and Social Care Bill is being debated at Westminster, with a delay to allow further consultation with NHS staff. Key reforms include:
- Abolishing all primary care trusts and strategic health authorities and transferring commissioning responsibilities to GP consortia, which will commission the majority of primary health services
- ‘Any willing provider’ would allow commissioners to buy services from all providers, including from NHS, private and voluntary sectors, and increase competition
- Replacing all NHS trusts with foundation trusts, and removing the cap on the private income that they can earn

Northern Ireland Assembly election
Democratic Unionist Party
- To shift the 25% to 30% of care that is currently carried out in hospitals into the community
- Reconfigure commissioning so that budgets are held locally, and decisions on non-regional services made locally
- Increase spending on health promotion and prevention, including early years services and programmes in schools to tackle teenage pregnancy

Sinn Féin
- Provide a universal public health service that is free for everyone at the point of delivery and on the basis of need alone across the whole of Ireland
- Restore health services that have already been cut and ensure no others are cut
- Adopt a central focus on prevention, health promotion and primary care, including mental health care, providing full health screening to everyone

Ulster Unionist Party (UUP)
The UUP was due to launch its pre-election manifesto at the time of going to press, and was unable to detail NHS pledges prior to its publication.

Social Democratic and Labour Party
- Increase the public health budget to 4% of the overall health budget by 2015, with a view to a further increase by 2020
- More focus on primary prevention, including:
  - Involving local sports clubs, leisure centres, local councils, schools and families in promoting a two-hour weekly allocation for physical education
  - Banning smoking in cars carrying children

Alliance Party
At the time of writing, the Alliance Party had launched its election campaign, but the manifesto was still due. Alliance leader David Ford promised: ‘We will launch our most comprehensive policy manifesto ever.’

NHS: reforms and pledges
Some of the parties were yet to publish their pre-election manifestos at the time of writing, but key pledges relating to health were ascertained from them wherever possible
advantage because they are free of competition: ‘There is no evidence that the internal market delivers better care, in fact the opposite is true – health care in Scotland, NI and Wales have not been compromised by keeping the NHS public and we must ensure that this does not change.’

No conflict of choice
Gavin adds: ‘As it stands, the devolved countries do not have the same conflict of choice in terms of the provider of health services as England – the NHS is provider of primary and acute care services and this is how it should be in England.’

There is no evidence that the internal market delivers better care

‘Good partnership is key to bringing about change and Fiona stresses that this is what is needed to bring about improvements to the NHS. She stresses: ‘In Scotland, NI and Wales change is managed through partnership working, and these countries have demonstrated that this works – the Employee Directors in Scotland is a good example of this.’

Presenting a manifesto for change
Unite has identified key aspects that it says should be included in any post-election plan.

Protected terms and conditions
Gavin stresses that NHS terms and conditions must be protected, as quality could fall with cuts to this area: ‘Money is going to be tight but the more governments take from the worker delivering the service, the more they will detract from service quality.’

He adds: ‘There is no use referring to “frontline services”, because as part of the health service family, we have auxiliary staff, scientists and therapists, for instance. These professionals are all Unite members and all provide that service, and without them the service will stop. We have to try and encourage governments to stop thinking only about doctors and nurses, and make them realise that the health service worker is part of a wider health service family.’

Further investment in early intervention
There is mounting evidence that investing in early intervention and other early years health services will improve health outcomes in adulthood and bring about huge financial savings in the future.

Gavin stresses that governments need to provide the financial investment to act on this: ‘The political rhetoric for many years has been for a greater emphasis to primary care with a shift from the acute sector. However, the finances to support this ideal has been slow in following the dream and politicians would do well to make this happen.’

Protected budgets
Gavin says that promises to protect and ring-fence budgets are admirable and a good way forward to ensure services are well-resourced, but stressed that ring-fencing should not be to the detriment of other services and their workers.

No compulsory redundancies
Gavin adds that the Scottish Government has implemented a no compulsory redundancy policy across the NHS, and that this is a measure that needs to be implemented across the UK.

‘There is an alternative’
Unite stresses that there is an alternative to the NHS reforms proposed within the Health and Social Care Bill in England, and in the lead up to elections on 5 May it is urging devolved governments to keep the NHS public and free of competition.
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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 baby’s health. Infant formula and follow up milks should be used only on the advice of a healthcare professional.
A fever (when body temperature rises to 38°C or more) is common in babies and young children. It is usually due to a self-limiting viral infection such as a cold, but is sometimes due to a more serious bacterial infection, such as meningitis. A mild fever after an immunisation is sometimes due to a more serious bacterial infection, but is due to a self-limiting viral infection such as a cold, but

How should a feverish child be assessed?
The National Institute for Health and Clinical Excellence (NICE) describes a ‘traffic light’ system for assessing children with fever, which is available at www.nice.org.uk. Following this system ensures that children receive prompt and appropriate management.

If a child has life-threatening signs, emergency medical care (usually by 999 ambulance) is necessary. Prompt assessment by a paediatrician is also required for any child:
- under 3 months with a temperature ≥ 38°C
- under 6 months with a temperature ≥ 39°C
- with worrying symptoms that may indicate serious health problems such as dehydration, meningitis, septicaemia, urinary tract infection or pneumonia.

In other cases, if a child has a fever but seems otherwise well (with all the green, but none of the red or amber alert features described by NICE), you can reassure the parent that they can look after their child at home. Most children recover quickly from a fever without any problems, but you should explain how to keep the child cool and hydrated, and when to seek further advice. Your Community Practitioner Educational Supplement on fever gives lots of information to help you.

When should parents use an antipyretic?
NICE recommends that parents consider using an antipyretic if their child has a fever (due to infection or immunisation) and seems distressed or unwell.

Which antipyretic should parents give?
Ibuprofen and paracetamol are both effective antipyretics. However, ibuprofen is a non-steroidal anti-inflammatory drug which reduces a fever (over 39.2°C) more effectively than paracetamol. It starts to work in just 15 minutes to relieve fever and lasts for up to 8 hours – which is up to 2 hours longer than paracetamol.

A trial published in the British Medical Journal, comparing ibuprofen plus paracetamol with ibuprofen or paracetamol alone, led the authors to conclude that, parents wanting to use medicines to treat young, unwell children with fever should be advised to use ibuprofen first. So, if a child seems uncomfortable with a fever, provided there are no contraindications, you can advise the parent to use a paediatric ibuprofen suspension, such as Nurofen for Children, to alleviate their child’s symptoms.
CPTs’ perceptions of their role satisfaction and levels of professional burnout

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Introduction
Making a difference and Placements in focus (DH, 1999, 2001) emphasised the importance of practice-based education for students. Implementation of their recommendations is dependent upon adequate numbers of appropriately qualified community practice teachers (CPTs) (Hudson and Forrester, 2001). However, it is suggested some trusts and universities have failed to train and support educators adequately in primary care (Henderson et al, 2006), potentially making practice teaching a negative experience.

The paper concludes with recommendations to support learning and assessment in practice, but this document fails to acknowledge fully the complex duality of the CPT role as teacher and caseload manager. The draft document stated that CPTs should spend 40% of their time with students and have a reduced clinical caseload (Thurtle, 2006). The recommendation in the final document was for one hour reflective practice per week, though Newland (2008) states learning in practice is improved when students reflect daily. Studies on mentorship within nursing have consistently highlighted difficulties relating to role conflict and lack of time to optimise teaching opportunities (Moseley and Davies, 2008), with additional academic requirements increasing role dissatisfaction and professional burnout (Reni et al, 2005).

Literature review
Role satisfaction is pertinent to the NHS because of its much purported relationship with staff turnover (Larabee et al, 2003). Hegney et al (2006) cite reasons for nurses leaving, compounding pressures on those remaining. However according to Kovner et al (2006), high workloads do not necessarily lead to dissatisfaction but inequality in distribution of workload does. Best and Thurston (2006) state that autonomy, recognition and good communication with supervisors and peers improve job satisfaction. According to Espeland (2006), conflict between an individual’s expectations and reality characterises professional burnout, with change, work instability, job content, poor resources and managerial support cited as factors associated with stress (Edwards et al, 2001).

Burnout is strongly related to job satisfaction (Arikan et al, 2007). According to Happell et al (2003), ‘burnout’ was originally used to describe emotional exhaustion of public sector workers, leading to decreased productivity and negative emotions, and is of growing concern for the nursing profession. Maslach (1982) divides burnout into three components – emotional exhaustion, depersonalisation and personal accomplishment. The Maslach Burnout Inventory (MBI) (Maslach, 1996) measures the frequency of each component and has been used extensively in the field of satisfaction and burnout research (Sarmiento et al, 2004). Sarmiento et al (2004) found higher empowerment associated with lower burnout and greater work satisfaction, and job satisfaction decreased as burnout increased, with workload having the greatest impact on stress levels.

Happell et al (2003) compared forensic and mainstream psychiatric nurses, finding lower burnout and higher job satisfaction in the forensic nurse sample despite the dangerous and unpredictable nature of their role. This was attributed to better organisational support. Spears et al (2004) found association between work stress and heavy workload, rapid change, inadequate leadership and resources in elderly mental health services. Team work, social support and role clarity were found to have a positive association with job satisfaction and a negative association with burnout and stress. Despite limited sample size, findings were consistent with previous research (Thomsen et al, 1998) showing a negative association between job dissatisfaction and burnout. Similarly, Arikan et al’s (2007) descriptive cross-sectional study of 180 intensive care unit and dialysis nurses in Turkey found decreased stress and burnout in the dialysis group, citing access to education, good professional interactions and decreased intention to leave.

Abstract
This paper reports on a multi-method research project that explored perceived role satisfaction and professional burnout among community practice teachers (CPTs) while facilitating post-registration education and caseload management. A bespoke Satisfaction Questionnaire and the Maslach Burnout Inventory (Educators) were completed by 23 participants to elicit quantitative and qualitative data. Findings are presented in relation to three themes – aspects of the CPT role leading to satisfaction, aspects leading to dissatisfaction or burnout, and ways to enhance satisfaction and reduce burnout.

The majority of CPTs were satisfied with their current role. A number of factors were elicited that affected participants’ perceived satisfaction. Respondents scored low levels of burnout overall, with high levels of personal accomplishment and low levels of depersonalisation. The relationship between participants’ satisfaction and their levels of burnout was not found to be statistically significant. However, mean scores on the emotional exhaustion subscale indicate moderate levels of emotional exhaustion.

The paper concludes with recommendations to improve the support provided by employers and partner universities for CPTs.

Key words
Burnout, practice teacher, role satisfaction


Declared potential competing interests: The lead author was a CPT for one of the trusts included in this research and her employing trust part-funded her dissertation module fees.

May 2011 Volume 84 Number 5 Community Practitioner 19
Government reforms have affected clinical and educational practice (Gillespie and McFetridge, 2006), challenging credibility of nurse teachers with a clinical role. Inadequate resources, constant change and workload pressures are also highlighted in the research (Hutchings et al, 2005). However, intrinsic rewards from student contact and autonomy rank high on satisfaction scales for nurse educators (Usher et al, 1999). Satisfaction levels for CPTs may be affected by the type of education in which they are engaged. One-to-one teaching of specialist students is an intensive educational process concerned with development of cognitive skills relevant to graduate and postgraduate study (Canham and Bennett, 2002). Within a limited time frame, CPTs engage in a process of education concerned with development of essential specialist competencies and self-awareness. This type of learning is congruent with adult learning theory (Knowles, 1990) and post-technocratic education (Schon, 1987), which encourages the relationship between practice and theory. The CPT creates conceptual meaning through tailor-made education, relying on positive student-teacher relationships. This individual teaching has the potential to transform as opposed to transmit knowledge, bridging the theory-practice divide (Girot, 2000). However, this intensive relationship relies heavily on the individual skills of the CPT and may prove difficult for the CPT to sustain without risking professional burnout. Finally, it is the CPT who acts as gate-keeper to the NMC register, which can be a rewarding experience or a heavy responsibility, possibly increasing the risk of burnout and dissatisfaction.

The literature depicts practice education as problematic for students, teachers and health service providers. Onerous workloads, lack of time, limited human or financial resources, lack of support or acknowledgement, difficulties associated with balancing dual roles and the importance of recognition, autonomy and empowerment are all emergent themes in the literature. A paucity of research regarding community practice teaching was identified.

### Research aim and questions

This research explores links between role satisfaction and burnout in the CPTs dual role of clinician and teacher. The research questions were:
- Are CPTs satisfied with their current role?
- What contributes to role satisfaction?
- Is there a relationship between CPTs’ role satisfaction and professional burnout?

### Methods

Qualitative and quantitative research methods were used as recommended for exploratory research questions (Robson, 2005). The total population sample consisted of 23 CPTs employed by five primary care trusts (PCTs). All were either currently teaching or had previously taught a specialist practice public health nurse or a specialist practice qualification student. They were approached at a university CPT update.

A Satisfaction Questionnaire was developed following the literature review, incorporating open and closed questions (see Box 1). This was piloted with a group of CPTs from one PCT to ensure face validity, and was modified prior to use with the main sample. Analysis of the satisfaction survey included quantitative analysis of data, which was tabulated for prevalence, frequency and distribution. Qualitative data generated from the open-ended questions were examined for any emergent themes and coded to aid retrieval and organisation of the data (Miles and Huberman, 1984). All participant comments were analysed, including outliers, to ensure that the full picture was presented.

The MBI (Educators) (MBIE) (Maslach, 1996) was used to identify the CPTs perceived levels of burnout and is a reliable, standardised and validated instrument based on extensive research (Pierce and Malloy, 1989). The respondents independently completed the questionnaire, which includes three measures of professional burnout:
- Emotional exhaustion (EE, eight items) – severe tiredness as emotions are depleted
- Depersonalisation (DP, five items) – a consequence of EE as the person finds themselves becoming indifferent to their work

### Figure 1. Range of issues identified by participants

![Figure 1. Range of issues identified by participants](image-url)
Personal accomplishment (PA, eight items) – as the person feels detached and that they are no longer making a difference to their work, they experience a lack of personal accomplishment and satisfaction. These are rated according to frequency, with high scores on the EE and DP scales and low scores on the PA scale representing burnout. Scores were categorised into low, average and high burnout according to available normative data for post-secondary educators (Maslach et al, 1996).

The four principles of ethical research – beneficence, non-maleficence, respect for autonomy and justice, and fairness in the distribution of benefits and risks – were applied (WMA, 2004). The university and local NHS research ethics committees granted approval and participation in the research was voluntary.

Findings
Respondents (n=23) comprised CPTs for health visiting (n=11), district nursing (n=7), community mental health nursing (n=3) and school nursing (n=2). Community mental health nurses were included as the local trusts also commission a practice teacher to support these students (NMC, 2008). Respondents ranged in specialist practice experience from 18 months to 30 years, and in practice teaching experience from six months to 21 years. Analysis of the data elicited the following three broad themes:

- Aspects of the practice teacher role leading to satisfaction
- Aspects of the practice teacher role leading to dissatisfaction or burnout
- Ways to enhance satisfaction and to reduce burnout.

Aspects leading to satisfaction
Data from the Satisfaction Questionnaire provided evidence that the majority of participants were satisfied with their role (n=16, ‘agree’ or ‘strongly agree’) and with the support they received from their employers (n=15, ‘agree’ or ‘strongly agree’). Aspects of satisfaction included use of skills (n=18), access to funding for training (n=17), study leave (n=16), clinical supervision (n=14), teaching supervision (n=9) and reduced caseload (n=1).

The majority of respondents were also satisfied with the support received from the higher education institution (HEI), which included access to CPT study days (n=22), placement visits by lecturer (n=19), good links with HEI staff (n=16) and access to academic modules (n=16).

In addition to the quantitative data, open response questions were included to enable participants to comment freely on issues affecting their role satisfaction (see Figure 1). Factors that positively influenced satisfaction included support for the CPT role; opportunities to develop practice and student relationships.

‘The recognition I receive from my line manager or organisation that the learning environment is important is a source of satisfaction’ (school nurse).

‘The support received and the opportunity to feed back to the practice education facilitator contributes to my satisfaction’ (health visitor).

‘Good links with the HEI are a source of satisfaction’ (mental health nurse).

The opportunity to influence professional development was a source of satisfaction identified by all professional groups. This was in relation to both practice development and the development of students:

‘Opportunity to advance practice and to share knowledge’ (district nurse).

‘Students blossom as they develop’ (health visitor).

Satisfaction was also derived from the relationships which practice teachers had with their students:

‘The student relationship makes me more motivated’ (health visitor).

‘Structured quality time with the student makes me satisfied’ (district nurse).

Aspects leading to dissatisfaction/burnout
Analysis of the MBIE identified mean scores for participants in relation to its three measures of professional burnout, and these were classified as low, moderate or high (see Table 1).

In order to undertake statistical analysis of the relationship between variables, the data were entered onto the Statistical Package for Social Sciences (Bryman and Cramer, 2005). Data suggested participants demonstrated moderate levels of emotional exhaustion (17.86), low levels of depersonalisation (2.39) and high levels of personal accomplishment (29.69). This indicated that participants were experiencing a low degree of burnout.

Bivariate analysis of the data from the satisfaction survey and burnout inventory was undertaken to identify relationships between variables. Scatter diagrams demonstrated weak positive relationships between participants’ satisfaction with trust support and with their current roles. They also identified weak positive relationships between the length of time qualified (both as a specialist practitioner and as a CPT) with personal accomplishment, and between the length of time qualified as a practice teacher and emotional exhaustion. However, further analysis using the Pearson chi-square non-parametric test identified that none of these relationships were statistically significant. Pearson chi-square was selected as it is used to measure significance in sample sizes of 20 or more cases. The chi-square test entails a comparison of actual frequencies with those that would be expected to occur on the basis of chance alone.

Data from the Satisfaction Questionnaire provided evidence that participants were least satisfied with workload pressures and

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lack of appreciation, and expressed their dissatisfaction with organisational changes:'Juggling of student, safeguarding, NNEB supervision and newly qualified staff supervision, I may opt out of being a practice teacher' (health visitor).

In contrast to those participants who answered that they were satisfied with the support they received from their employers, one participant reported that they were unhappy and three ambivalent:'Trust rush teaching, they don’t listen to concerns in clinical practice' (health visitor).

Some participants highlighted their dissatisfaction with changes to the length of the specialist practice public health course:'I’m concerned re the 52-week course as there will be even less time to catch up with caseload and own development' (health visitor).

**Ways to enhance satisfaction**

The main suggestions to enhance satisfaction were protected time, reduced caseload and increased supervision and support. In response to the question asking what factors would further enhance satisfaction, several respondents (n=21) wrote:'Increasing staffing levels to allow more time to be spent with students' (district nurse).

'Protected time for reflection and portfolio preparation would enhance satisfaction' (district nurse).

'Protected time out of caseload to spend with students to look at their learning needs would enhance my satisfaction' (health visitor).

**Discussion**

The majority of participants were satisfied with their roles identifying effective relationships with students and facilitating their learning and development as major sources of satisfaction. Participants reported recognition of their skills and support from employers improved their role satisfaction. This is important within the context of the range of responsibilities undertaken by CPTs (Newland, 2008) including the development of cognitive and clinical ability. The majority of participants were satisfied with support provided by employers and the HEI. This is not consistent with the literature, which suggests that HEIs have failed to provide adequate training and support for educators in primary care (Henderson et al, 2006). It also reinforces the importance of developing effective support mechanisms for CPTs, both within their employing organisations and with partner HEIs.

Participant’s highlighted dissatisfaction with their trust’s lack of support for their dual role. According to Renzi et al (2005), the main factors influencing role satisfaction are perceptions of being well managed. Fostering of relationships and recognition of practitioners accomplishments is therefore key to enhancing role satisfaction and protecting employees from stress and burnout (Espeland, 2006). As previous studies have demonstrated, access to support is strongly associated with job satisfaction (Sarmiento et al, 2004), and this lack of supervisory support could have implications for the CPTs satisfaction levels and subsequently their effectiveness as educators. Participants cited a more supportive framework as important to decrease stress, as all trusts in the study had practice education facilitators and link lecturers, these would seem well placed to identify suitable supervisory systems and enhance the satisfaction levels of CPTs.

Emotional exhaustion is a clear signal of distress in emotionally demanding work (Maslach et al, 1996). Arguably, CPTs are at increased risk of distress due to their emotionally demanding work with both clients/patients and students. This lack of control over the teaching environment can contribute to stress and is linked to increased levels of professional burnout, whereas an empowering work environment is associated with lower burnout levels (Espeland, 2006). The implication is that CPTs should be offered both clinical supervision and supervision for their teaching role. This would enhance satisfaction by alleviating stress and offset CPT’s dual role demands, thereby reducing the risk of emotional exhaustion.

Participants identified managers failing to support the CPT by not authorising a reduced clinical caseload, directly affecting teaching time and role satisfaction. Such a reduction in clinical activity was highlighted as necessary to release the CPT in order to plan, supervise and assess student practice in accordance with NMC guidelines (NMC, 2008). Essentially a reduced caseload was seen as management recognition of the time and skills needed to undertake the dual role. According to Lu et al (2007), organisational commitment has the strongest impact on job satisfaction. This is confirmed in this study.

**Recommendations from this study**

- Placement providers need to introduce supervision specific to practice teaching. Group supervision in particular facilitates experiential learning and reflection
- Employers should authorise reduced CPT caseloads and protected time for planning, supervising and assessing student practice in line with NMC guidelines (NMC, 2008)
- Employers and practice education facilitators should familiarise themselves with the causes and signs of burnout to prevent burnout phenomena.

**Conclusion and recommendations**

Satisfaction Questionnaire data analysis demonstrated that the majority of CPTs were satisfied with their role and the support they received from their employing trust and HEI. Factors identified that positively affected CPT role satisfaction were student-teacher relationships, the time and opportunity to develop students and clinical practice, and the support received from colleagues, employers and the HEI. The vast majority of the CPTs identified that heavy clinical caseloads and a lack of protected teaching time were the factors causing most dissatisfaction, along with working over contracted hours to ensure all duties were fulfilled. The findings from the MBI demonstrate that respondents scored low levels of burnout overall, with high levels for personal accomplishment and low levels of depersonalisation. The relationship between participants’ satisfaction and their levels of burnout was not found to be statistically significant. However, the mean scores on the emotional exhaustion subscale indicate moderate levels of emotional exhaustion.

Increasing demands on community nursing and relentless government reforms make the dual clinical and educational role increasingly more complex, causing challenges to facilitation and assessment of students in practice (Gillespie and McFetridge, 2006). This study has highlighted the relationship between role satisfaction, organisational support and professional burnout. The inverse relationship between job satisfaction and burnout means it is in the interests of employers to keep CPTs supported and satisfied in their role. CPTs are at risk of emotional exhaustion due to their dual teaching and clinical role, both of which require high levels of emotional input. It is therefore essential that employers provide a culture of support and communication to help protect CPTs from professional burnout and ensure that practice placements remain of the highest quality.

Although this is a small-scale study, the rich data obtained will be used to develop strategies locally, to improve support for CPTs in their dual roles as teachers and caseload managers. It is hoped this improves role satisfaction and reduces burnout potential.

**Recommendations for future research**

- Wider research on CPTs satisfaction with HEI support is conducted.
Future research is conducted on CPTs from the differing professional groups.

Acknowledgments
The author thanks Alex Haydock for his invaluable help with editing.

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invaluable help with editing.
The author thanks Alex Haydock for his
Acknowledgments
Future research is conducted on CPTs

Mary Seacole Awards 2011/12
for health visitors, nurses and midwives in England

Funded by the Department of Health and NHS Employers, awarded in association with the RCM, RCN, UNISON and Unite/CPHVA

Applications are invited from nurses, midwives and health visitors in England to participate in the prestigious Mary Seacole Awards programme for 2011/12.

These awards provide the opportunity to undertake a specific health care project, or other educational/development activity, that benefits and improves the health outcomes of people from black and minority ethnic communities.

There are two award programmes:

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● The Mary Seacole Development Awards are up to £6250 each and provide the opportunity to develop leadership skills, see: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124909.doc

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Interviews will take place on either 26 or 27 July, or on 2 or 3 August. Application forms with further details can be obtained by email from buko-la.samuel@dh.gsi.gov.uk or downloaded from the following website: www.dh.gov.uk/en/Aboutus/Chiefprofessionalofficers/Chiefnursingofficer/index.htm under ‘Latest news’


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Development and validation of a child health workforce competence framework

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Abstract
Providing high quality, effective services is fundamental to the delivery of key health outcomes for children and young people. This requires a competent workforce. This paper reports on the development of a validated competence framework tool for the children and young people’s health workforce. The framework brings together the policy, strategic agendas and existing workforce competences.

The framework will contribute to the improvement of children’s physical and mental wellbeing by identifying competences required to provide proactive services that respond to children and young people with acute, continuing and complex needs. It details five core competences for the workforce, the functions that underpin them and levels of competence required to deliver a particular service. The framework will be of value to commissioners to inform contracting, to providers to ensure services are delivered by a workforce with relevant competences to meet identified needs, and to the workforce to assess existing capabilities and identify gaps in competence.

Keywords
Workforce competence, validated tool, children’s health workforce, health outcomes

No potential competing interests declared.

Introduction
The provision of high quality care for children, young people and those involved in their care requires a competent workforce equipped with the knowledge and skills to deliver services commissioned to meet the needs of both individuals and local populations. As services evolve to reflect changing healthcare need, the workforce has to be prepared for this changing context of healthcare delivery in order to achieve the identified outcomes aimed at promoting, protecting and improving the health of the population and reducing health inequalities.

Current health policy and strategy continue to stress the need for health improvement and ill health prevention (DH, 2010). The particular emphasis for the health workforce in primary and community care has been on prevention, early intervention and enabling children, young people and their families to make healthy choices. However, there is an increasing shift of health care from secondary to community and primary care. This will require further development at strategic, operational and individual levels. Children with complex disabilities, life-limiting conditions and chronic disease also need to be supported in terms of their overall health in order to fulfil their potential. It is essential therefore that those in the business of delivering health and wellbeing, health care and health services are able to articulate the skills and competence required in their workforce.

This paper details the development of a competence framework for the children’s health workforce located primarily in community and primary care settings and is aimed at all health workers or practitioners, working in these settings.

The framework
The framework is the result of a year-long project commissioned by Yorkshire and the Humber NHS and supports the need for a children’s health workforce that has the necessary core competences to meet the health and wellbeing needs of parents, children and young people.

The main purpose of the project was to develop a user-friendly framework that brings together children and young people’s policies, strategic agenda and current competencies such as Skills for Health (Skills for Health, 2009), NHS Knowledge and Skills Framework (DH, 2004) and GP training standards (Royal College of General Practitioners, 2007). The project consisted of a series of phases involving a range of data collection methods to develop and validate the competence framework. The core competences needed by the workforce emerge from and are informed by contemporary policy documents and consultation with users, carers and frontline practitioners.

The development of the framework should therefore support the effective use of the workforce supporting the development of a pluralist market of providers by:

- Identifying the competences that can be used by commissioners to identify the characteristics of the workforce they need to deliver best outcomes for children and young people
- Assisting new organisations in the NHS such as community foundation trusts and social enterprises, as well as the independent and voluntary sector, to identify the workforce need to deliver children’s community services.
- Supporting joint working and commissioning between primary care trusts (PCTs) and local authorities to deliver better outcomes for children, young people and their families.

Phase 1: Scoping exercise
The scoping exercise built on earlier work by Yorkshire and the Humber NHS that had identified five themes – safeguarding and health protection, health and wellbeing, vulnerability and inequalities, working with partners and partner organisations, and engagement and knowledge management. Using these themes as the basis of a more in-depth scoping exercise, a much larger number of documents were analysed. The content of each document was reviewed and
Creating the framework

Once the structure of the framework had been agreed with the project team and steering group, the detailed content that was collated in Phase 1 for each of the five core competence themes could be arranged. Each core competence comprises a series of functions. These are detailed at the four levels of performance and describe the knowledge and skills required to fulfil each function (see Figure 1). The performance levels and core competences work in conjunction with one another. Each function of a core competence can be performed at Levels 1, 2, 3 or 4. The levels assume successive progression of knowledge and skill (eg Level 2 competence descriptors are in addition to those at Level 1). Members of the children’s health workforce will contribute to the delivery of a function at differing levels according to their role within an organisation. The framework performance levels provide a sense of what is expected from a member of the workforce operating at each level (see Box 3).

Phase 3: Validation of the framework

A number of approaches were taken to validate the content of the framework.
involving the project steering group, key stakeholders – commissioners of services, education commissioners, providers and practitioners, and children, young people and parents. Draft versions of the framework structure and competences were extensively circulated for comment and consensus among the steering group and project team.

**Delphi survey of key stakeholders**

Consensus agreement on the content of the framework was achieved with key stakeholders using Delphi methodology (Slocum, 2003). This is a systematic interactive method used for obtaining consensus from a panel of independent experts. A modified E delphi survey was circulated and cascaded via existing groups and networks throughout the region to achieve agreement as widely as possible. Those who responded were asked a series of questions about the functions that comprised each core competence. They were asked to rate the relevance of these functions, with a score of one being low and five being high. Relevance was defined as indicating clearly the specific knowledge and skill areas necessary to meet the needs of the core competence, that it was comprehensive (contained all the elements needed to fulfil the core functions) and that it was core in so far as the knowledge and skills are essential to everyone working with children, young people and those involved in their care.

At the end of the first round of consultation, the data collected were synthesised and the feedback incorporated into a second final round. Participants were asked to revise their previous answers in light of the replies of other group members to reach a consensus. Agreement was said to have been reached when more than 75% of respondents rated the relevance of the functions to be four or five. Where 75% or less of respondents rated the function to be one to three, these would be considered by the steering group for amendment or removal.

The response rate to round one was disappointing, with nine completions despite extensive circulation and reminders. The data collected showed all functions were rated with a relevance score of four or five, the majority being rated five. Where additional comments were made, these were considered by the steering group and the project team and following discussion minor amendments made to the framework. A number of contributions were received in the form of comments rather than completion of the survey. These were also considered for their potential to inform the framework’s development. The second round resulted in only one completed survey and rated the relevance of the functions either four or five. The framework was shared at other forums where key stakeholders were present and their views sought on the framework structure and content, and this also contributed to the refinement of the framework.

**Children, young people and parents**

Six focus groups were held in different parts of the region to ensure that children, young people and parents had an opportunity to influence the development of the framework. Two focus groups took place with year groups 5 and 6 (n=20) and two with year groups 9 and 10 (n=16), all in different schools across the region. Focus groups with parents (n=11) were held in two different geographically located children’s centres with diverse social and cultural makeup. As a service evaluation, this aspect of the project did not need to be approved by a research ethics committee. School head teachers and children’s centre managers were approached in the first instance for permission to conduct a focus group. Project team members have connections with a number of schools and children’s centres by virtue of the work they do. Informed consent to participate in the focus group was obtained from parents and assent from the children who participated. Information leaflets were developed for each group of participants. For the parents, these were distributed through children’s centre staff as part of the recruitment process. For the children and young people, the content of the leaflet was fully explained and discussed prior to commencement of the focus group as part of the consent process.

The attributes that emerged (see Box 2) are listed in the framework where competence is defined, and are therefore integral to the behavioural component. The attributes are also explicit in the competence descriptors.

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**Box 2. Attributes of service providers: views of focus group members**

**Views of children and young people**

- Role models for health
- Knowledgeable and qualified
- Provide personalised care and service
- Supportive, kind, positive, encouraging, motivating
- Provide age-appropriate care, information and decision-making
- Explanations (`telling you what’s wrong in a kind way, answering questions’)  
- Listening skills and believing you (`not being told it doesn’t hurt when it does’)
- Gentle, friendly, approachable, calm (`if they shout it scares you and you think it’s proper serious’)
- Treating the child or young person as an individual – feeling they are interested in you

**Views of parents**

- Knowing them and taking an interest in them as an individual
- Adopting a proactive approach (providing assistance before problems get out of hand)
- Accessible and responsive
- Knowledgeable and experienced – able to offer appropriate information and advice
- Friendly and approachable
- Willing to listen
- Being concerned for the welfare of the child
- Helpful
- Holistic family support
- Serving as gateway to other services
- Able to provide early intervention
are detailed within the full framework document

Achieving consistency of use and application.

essential everyone uses the one framework to

ed that in order to maximise the benefit it is

would also support new ways of working and

skill mix in light of competences needed

consistent approach were identified as

Enabling redistribution of resources,

have the potential to support delivery of

refinement of the framework into its final

implications, cost benefits (real or potential),

Class Commissioning competency, especially

prevention, productivity) challenges, World

inequalities, QUIPP (quality, innovation,

their usability and impact in terms of health

institutions, PCT-based commissioners,

three service providers, two higher education

approach was used to gather information

assess its validity, acceptability and usability

The framework was piloted and tested to

Piloting and testing with stakeholders

The framework was also piloted with practi-
tioners – registered and non-registered – from

two PCTs, using an online survey to map their

level of practice against it. A total of 43

questionnaires were completed, identifying the

to which they had the knowledge and skills to perform the functions of each

competence at the different levels. They also

identified the level of practice to which they

considered themselves to be working, and the

results were consistent with their different

expected levels of practice.

Conclusion

The framework has the potential to support

development of a competent, flexible

registered and non-registered workforce that

is able to provide a high quality, effective

patient and family journey through the

services they engage with. The way forward is

not only to take the opportunities presented by

having this framework, but also develop its

capability for use within secondary care to

provide a consistent approach across

children's health services. The framework

will be of value to a range of children's service

stakeholders:

● For commissioners, it will inform the

contracting of services by providing clarity

on core functions that underpin workforce

competence, and the level of competence

required to deliver a particular service

● The tool will inform commissioners of

education and training and development

about the commissioning process, in terms of the quality and outcomes

expected from education programmes delivered at any level

● Service providers and prospective

providers can use the framework to ensure the

service is delivered by a workforce that

has the relevant competences to meet the

individual and community needs. The tool

will indicate the knowledge and skills

needed by the workforce at the different

levels of practice and inform on-going

education and training development

needs. It can then provide a profile of the

workforce skill mix that is available or

needed to fulfil the commissions

● The tool will enable individuals to assess their existing capabilities in relation to their

work role and identify gaps in competence. This could inform their organisations staff
development review processes and determine their education and training needs

● For the wider workforce, the tool will be able to inform on-going work relating to the

wider children’s workforce pertaining to the personalisation and enablement

agenda, by identifying competences that can be used by workers in care settings

related to health services, such as carers employed by individual budget funding.

As integration of children’s services continues, the framework has clear potential to

move beyond health care to involve other agencies delivering services to children and

young people. It has the potential to be instrumental in shaping and supporting the

development of the future children’s workforce and to promote the continuing development of

community practitioners at a time when new models of training and professional
development are under discussion.

Further information

For the full report and interactive competence framework tool Competence in teams
caring for children, please see: www.yorksandhumber.nhs.uk and select ‘Tools and publications’.

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Box 3. Example function statement and competence descriptors

Function statement for core competence – health and wellbeing: support for parenting and family environment

● Work effectively with mothers and fathers to develop self-efficacy and support change

● Promote strong parent-child attachment and positive parenting

Performance Level 1 competence descriptors

● Knowledge of the impact of parenting capacity, family and environment on the health and wellbeing of children and young people (adapted from SFH-CS2-K30,31)

● Know about the contribution of fathers to child development and wellbeing (a)

● Help parents interact with their children in positive ways (adapted from NOS WWP)

● Provide information and signpost to supportive resources (a)

Performance Level 4 competence descriptors

● Knowledge of commissioning frameworks for children’s services (a)

● Knowledge of the needs of the local population (a)

● Collaborate with different groups and stakeholders to plan for the needs of the local population (a)

● Contribute to on-going design of evidence-based programmes to meet children’s needs (a)
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The complexities of children missing from education: a local project to address the health needs of school-aged children

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Abstract
The issue of children missing from education has been of concern both nationally and locally for many years. Following a local audit of health visitor and school nurse caseloads, the existence of unallocated child records or children who could not be found came to light. These records were held and managed by the local child health department. Children who did not attend school were not offered a school nursing service, and were monitored solely by the educational welfare service.

This paper reports on a project to identify and investigate the whereabouts of these children and to allocate the remaining records to school nursing teams. This would ensure that all children in the local area were visible and that any unmet health needs were assessed and addressed. The project was led by the safeguarding children team and involved forging and developing cross-agency links. The involvement of the school health department, team managers and school nursing teams was integral to its success. The school nursing service was reconfigured taking into account identified need for an inclusive service to all local children.

Key words
Children missing education, school nurse, educational welfare service, safeguarding children


No potential competing interests declared.

Introduction
Laming (2003) estimated that there were around 10,000 children of school age across the UK who were not attending for education, and hence were potentially ‘invisible’ to services. Those children who do not attend school are, due to service provision limitations, largely invisible to health services. They are therefore potentially at risk of harm and more likely to have unmet health needs.

For the purposes of this project, children missing from education referred to children of a compulsory school age who were not on a school roll (those registered as attending that school as a pupil) – apart from those being educated otherwise, such as children being home educated or receiving an ‘alternative learning package’ outside standard school provision. It also included children who have moved with no forwarding school or home address. Children missing from education are categorised as ‘children in need’ or ‘children in special circumstances’ due to their less visible nature (DH and DfES, 2004).

This paper reports on a local project to identify children missing from education in one primary care trust (PCT) area in order to ensure that their health and education needs were being met and to address risks of harm.

Background
Development of policy and guidance
Following on from the death of Victoria Climbié in 2000 and the subsequent report by Lord Laming (2003), there has been increased attention to the risk and possibility of ‘child in need’ or ‘child at risk’ status, as referred to in sections 17 and 47 of the Children Act (1989) (HM Government, 1989).

The Every Child Matters agenda (HM Government, 2004a) emphasised five outcomes, with the general emphasis being upon all children being enabled to reach their full potential. Every Child Matters stated that every local authority should have systems in place for the identification and tracking of children missing, or at risk of missing education by December 2005.

The Children Act (2004) underpinned the requirement that it is the duty of all agencies to safeguard children and co-operate with investigations with regard to children in need and children at risk (HM Government, 2004b). Guidance from Working together to safeguard children (DCSF, 2010) further emphasised the importance of information-sharing and working together to prevent, or identify early risk factors with regards to safeguarding children. There was a particular focus on key areas of risk that have special relevance to health, and the potential for unmet needs.

Service requirements
The National Service Framework (NSF) relating to children, young people and maternity services (DH and DfES, 2004) asserts that all young people should have access to age-appropriate services, which are responsible for their specific needs as they grow into adulthood. It also indicates that health promotion should be targeted to needs, and that young people are actively involved in planning and implementing initiatives and services.

The services provided should be supportive to young people, enabling them to achieve their full potential (HM Government, 2004a). By providing targeted support, it is not possible to fulfil this where children are not seen by universal health services. The social and emotional needs of young people should be addressed, and this includes their existing education and career development by providing improved access to services that are designed with young people in mind, as addressed within the Healthy lives, brighter futures strategy document (DH, 2009b). These children are often marginalised within their communities, and are not able to maintain social links with peers.
Invisibility and risk

Work undertaken by Lancaster University (Broadhurst et al, 2005) found that children who were categorised as missing were symptomatic of a wider picture of issues associated with children in need.

Children who are missing from education are ‘invisible’ to many universal and mainstream services, are often unregistered with GPs and they tend to access services on a reactive or emergency basis with their existence becoming apparent through attendance at accident and emergency (A&E) or following a child protection referral. This is particularly apparent when families move around frequently, rather than those families who are permanent residents of an area.

The progress report by Laming (2009) identified the need for vigilance by A&E staff with regard to, for example validation of address, GP details, contact details and any other welfare or safeguarding children concern, and called for them to act accordingly where they had concerns. Families move frequently for many reasons, and multiple moves and address changes are viewed as risk factors for child protection (DCSF, 2007).

Other known risk factors include trafficking, forced marriage and children seeking asylum. These are children who may be marginalised within their communities, not accessing mainstream services, and who may be known or unknown to the local health economy or education department.

Information-sharing

The Laming Inquiry (2003) recognised that during the 10 months Victoria lived in London, her great aunt Theresa had contacted several schools for information and prospectuses, but Victoria remained unregistered with any school at the time of her death. There was no checking mechanism in place locally to ensure that all children eligible for education were registered and monitored. The system was reliant upon children being registered with a school and then attending. Those who were never registered fell into a ‘void’, and were not open to the caseloads of either school nurses or educational welfare officers.

It remains the responsibility of the individual school to inform the local education authority of changes to admissions and changes within the school register. This is monitored on a statutory level by the children missing from education lead for the local authority. Hughes and Owen (2009) suggest that information-sharing between and across agencies is of particular value and importance at times of transition (school entry and moving to secondary school).

Trafficking

The trafficking of children into and out of the UK has become an issue of growing numbers and understanding with regard to associated risk factors. Children may be separated from their parents and disappear from public view, as in the case of Victoria Climbié, who entered the UK as an immigrant under the care of her great aunt (Laming, 2003). The issues of trafficking have been highlighted in national guidance (DCSF, 2007), as has the value of inter-agency working to prevent and detect these children (DCSF, 2010). Hughes and Owen (2009) indicate that children can be trafficked within the UK, and these can be children of foreign or British nationality.

Home education

In her response to the revised guidance on identifying children not in suitable education (DCSF, 2009), Baroness Morgan suggested that in some extreme cases home education may be a cover for abuse (Paton, 2009), and that we should assure ourselves that the right systems are in place to ensure the welfare and safety of all school-aged children.

Project context

The identification of children missing from education was a defined project that was undertaken following concern about the potential for both unidentified needs and possible risks associated with children who are in effect ‘invisible’ to service providers.

Provision of health services to school-aged children was determined solely by the school they attended, hence if they were not ‘on roll’ at any local school the child would receive a limited school nurse service. The NSF (DH and DfES, 2004) states that all children should have access to services that are supportive and co-ordinated to enable their social and emotional needs to be addressed.

Project aim and objectives

The aim of this project was to cross-reference the information held by partner organisations in order to enable the PCT to develop a list of children who were unallocated to school nurses and missing from education. The ultimate goal was to allocate health notes for these children to enable assessment of health needs and development of plans of care, to ensure that all children within the geographically defined area received an inclusive health service.

The objectives of the project were to identify the numbers of children and young people who were ‘invisible’ within their community and not accessing universal service provision, including immunisations and the Healthy Child programme (DH, 2009a). We also needed to understand why and how this was happening in order to enable us to make recommendations for action and the improvement of service to children and young people, and to affect service delivery.

The project

The records of children missing from education had historically been referred to as being in the ‘lost box’. There was an implication that these records were few in number and that all methods to suitably place them had been unsuccessful.

Initially work was undertaken with the school health department, which ran reports from its database to identify those children who were either educated at home or who did not have an allocated school. This brought forward in excess of 350 children’s names out of a local child population of over 62,000. As such it was not in itself a large proportion, but with regard to potential safeguarding risk it was the individual risk that provided the driving force for the project.

Cross-referencing: health and education

The educational welfare officer with responsibility for children missing education agreed to meet to compare information, and the databases were cross-referenced. There were around 100 children who had changed school, moved area or moved abroad. The names of children who were officially home educated were confirmed. These children already received an annual contact from the educational welfare service in line with Every Child Matters guidance (HM Government, 2004a), and an annual review is offered by the school nursing service.

The information gained from this exercise was processed by the school health department and an updated list was prepared. From this point, administration workers within our team checked the updated list against the NHS Spine (a national database including all children residing in England), the databases of GPs and with Care First (the system used by social care). This was a labour-intensive and time-consuming exercise due to the absence of a single database within children’s services. All GP surgeries were then contacted to confirm that these children were on their practice list, and if so when they were last seen. This gave some indication of the location and address of the child in this area. The difficulties
Cross-referencing: housing, benefits, policy and immigration

Links into the local housing offices were made via the main housing offices, and they were able to cross-reference the addresses of all children either living in local government housing or in private properties that the local authority had bought. The Department for Education and Skills (2006) identified benefits and immigration services as being the two ‘worst offenders’ in respect of information-sharing. Subsequent links were enhanced with the local police public protection unit (PPU), which can access information held by the Borders Agency, and we have been offered assistance by school nursing teams with children who remain ‘missing’ following exhaustive enquiries.

Children known to be from asylum-seeking families and those detained in migration centres are known to be at risk, and as such the homeless health team were able to confirm the existence of any families known to them. Within the PCT, we have a dedicated homeless team that co-ordinates health records for these families and children, and which assesses and provides a ‘needs-led’ service for them.

Partnership working

Partnership working is deemed to be required within a safeguarding arena (DCSF, 2010), and as such links were developed with partner agencies to ascertain the potential whereabouts of the children who we had identified. The DCSF (2010) guidance clearly states the importance of partner working with regard to the whereabouts of missing children, and suggests that the police and social care should be informed following concerns. These concerns may arise following on from a series of missed appointments, which may indicate that the child has moved or gone abroad.

The main aim of cross-referencing this was to leave a definitive number of children who we could then confirm were living in this area and not accessing health services and education. Those children remaining on the list were allocated on a geographical basis to the school nursing teams for them to access and assess health needs, and link into the appropriate agencies – for example to education welfare for those confirmed as being educated at home or in need of allocation onto a school roll.

Implementing local recommendations

To enable the outcomes for children to be realised into a service delivery model, the recommendations from this report were included in the school nursing review, and included a protocol and flow chart for new working practices. These are beginning to become embedded in practice and to become a mainstream service to this vulnerable group of children.

Children who are not within the education service are not ‘visible’, and hence should be seen as potentially at greater risk, and they are now to be afforded intervention to address this. Children who are home educated or missing from education are now afforded a level of service that is commensurate with their potential risk status. As such, they are seen annually at the very least following the offer of a health needs assessment. The protocol, standard letter and request for information from schools was devised in conjunction with the professional leading the local school nursing review, and in conjunction with the flow chart will enable a clearly defined service to be offered to these children.

Future plans

This was a defined project and has now been completed and implemented into changes in service delivery through the development of protocols within the local safeguarding children overarching policy (CHCP, 2010). Local information-sharing protocols are in place and partnership working is vastly improved. Secure cross-agency electronic networks have been established and, although there have been some minor problems, new working practices are becoming embedded.

Conclusion

It became apparent during the course of this project that one of the largest contributors to the issues associated with children missing education were deficiencies in the accuracy of information held on databases that occurred as a result of poor information-sharing between agencies, in particular education and health. This was also apparent within the wider health family, in particular...
between the child health department, school nurses and general practices. The gaps in service delivery were closed to enable a seamless transition between the health visitor and school nursing service. This issue had existed for many years, some children having had no contact from health following the transfer of records to school health, and many of these children are now teenagers. This project has enabled us to formally address the issue and now any new ‘missing’ records will be dealt with promptly following guidance from associated new protocols and procedures within the trust. It can be said we now have a sound base to work from, and all identified school-aged children will be offered a comprehensive needs-led service.

Recommendations

The problem associated with children missing education is not an isolated local issue, and needs to be addressed in all areas:

- There is value in national tracking systems and we believe that there is a need for this to be relaunched to add significant value to the safeguarding of vulnerable children living in England.
- Good working practices with regard to information-sharing protocols, regular meetings and active and sustained interest is required to ensure that the needs of this vulnerable group of children are met.

Acknowledgments

The author was awarded the MacQueen Award for Excellence in Leadership 2010 for the project reported on in this paper. The success of this project has been due to the dedication and professionalism of the school nursing teams, the support and leadership of clinical team managers, the child health department, and all of the author’s valued colleagues within the safeguarding children team.

The multi-agency response of partner agencies has shown a true dedication to safeguarding children locally.

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Preparing for parenthood: 
the role of antenatal education

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Abstract
The transition to parenthood is a time of great change for mothers and fathers, and also lays the foundation for the long-term health and wellbeing of the child. This emphasises the importance of preparation for parenthood.

A Department of Health-commissioned review found provision and uptake of antenatal education to be variable, and so brought a group of experts together to consider Preparation for Pregnancy, Birth and Beyond. This paper provides an overview of the learning from the expert group's work, offering a new framework that professionals may use to plan effective local programmes and services.

Key words
Preparation for pregnancy, birth and beyond, parentcraft, antenatal education.

Introduction
The transition to parenthood is one of life's most significant events and having a baby is a time of great change. As well as being important for mothers and fathers, it is also a key time for a child, as their experience in the womb and in early life will lay the foundation for their future health and wellbeing.

Growing knowledge in the field of neuroscience emphasises the importance of early infant experience and its impact on later physical, social, emotional and cognitive outcomes. This serves to emphasise the importance of preparation for parenthood, be it in the form of antenatal education, parentcraft classes or antenatal groups.

A recent review commissioned by the Department of Health (DH) and carried out by the University of Warwick (Schrader McMillan et al, 2009) found antenatal education provision to be variable and patchy, with low uptake by the most disadvantaged and excluded families and health professionals feeling ill prepared and unsupported in this work.

Given the evidence, the financial challenges and the changing role for public services, it made sense to review the purpose of antenatal education and look at different ways to support expectant and new parents in their journey to parenthood. To this end, the DH brought together a group of experts to consider what needs to be in place to prepare today's mothers- and fathers-to-be for pregnancy, birth and beyond. The work of the expert group was informed by the above review of the evidence, surveys of expectant and new mothers and fathers, visits to existing programmes and a review of digital materials.

This paper summarises the learning from this work and offers a new framework to help professionals to plan effective local programmes and services.

The evidence
The systematic review (Schrader McMillan et al, 2009) looked at the effectiveness of antenatal education, the cost benefits and the views of parents and professionals (Barlow et al, 2009). They found that, while evidence on what works in antenatal education is rather limited and unclear, there is some evidence that:

- It has a role in improving knowledge and preparation for parenthood
- It can increase a mother's satisfaction with the birth and birth experience
- Good quality, focused antenatal education can help manage and reduce maternal anxiety and depression during pregnancy and early childhood, leading to improved coping, more partner support and better birth experience
- Group-based provision has been associated with lower rates of pre-term and low birthweight delivery, higher incidence of breastfeeding initiation, higher levels of knowledge and better support from partners.

However, this is an under-researched area and the evidence is limited.

No potential competing interests declared.
Where learning is tailored to meet fathers’ needs, research shows that they engage well, with benefits to themselves and their partners. Fathers seem to respond well when they can discuss their hopes and concerns with other experienced fathers, and when programmes explore how having a baby can change their relationship.

Poverty and disadvantage, especially where this is enduring, can significantly affect children’s life chances and the fulfilment of their potential. Many of the factors associated with inequalities are present in pregnancy and infancy, so tailored and targeted parenting programmes can contribute to reducing inequalities. For example, factors that are more strongly linked to poor outcomes include being a teenager (at first birth), having no or low qualifications, mothers experiencing poor general health or emotional difficulty, and living in poverty (Kiernan and Mensah, 2009).

The literature review found that although many needs and experiences are common to all parents-to-be, particular groups have specific preferences and needs to be taken into account. For example, adolescent parents engage best in interactive antenatal education designed for teenagers and offered to young parents with a similar social background. Different ethnic groups also have different preferences, and in general want to explore information in relation to their own cultural beliefs and norms.

What parents told us
A wide cross-section of parents (mothers and fathers) from different ethnic groups, ages, socio-economic statuses and stages of pregnancy gave us their views on their experience of becoming a parent and what they wanted to learn about, when and how. Some key points to emerge were:

- Having a first baby was quite a different experience, marked by feelings of excitement, anxiety and change
- This is a time when mothers and fathers are highly receptive to making changes that can benefit their baby
- Mothers say how profound the changes are for them, in every part of their life – a ‘psychological journey’ as much as a biological one
- Parents want information and support matched in a timely way to the milestones of the developing baby
- The age of the mother makes a difference to the way she perceives pregnancy and parenthood, but feeling in control, confident and able to exercise choice is important at any age

Family and friends are key sources of support and information for all parents, and communities are important to give a sense of belonging ‘with people like me’, especially for young parents in disadvantaged areas.

Expectant fathers have different and specific needs, and being seen as a provider remains an important role.

Framework: preparation for parenthood
The expert group developed a Preparation for Pregnancy, Birth and Beyond (PPBB) framework (see Figure 1) for planning local provision. The starting point for this is the recognition that most learning and reflection takes places through family and friends, people finding out for themselves, by observing others and using the multiple media sources of information and opportunities that are now available to parents. It is all too easy to think that preparation for parenthood is solely dependent on midwives and health visitors. While they are important to families, much learning goes on elsewhere.

The four levels of the framework reflect how parents-to-be want to receive information and support from different sources and at different times.

Starting with ‘family and friends’ means thinking beyond health professionals and services, and drawing on the wealth of experience and knowledge in local communities and families that mothers- and fathers-to-be naturally turn to when they find out they are expecting a baby. These networks can offer a rich and valuable source of support.

We all learn best when seeking out knowledge for ourselves. Expectant parents are intrinsically motivated to want to protect and do the best for their child, and are keen to learn how to do this and to find out what is happening to the baby. Self-directed learning through magazines, books and TV have always been important, but freely available digital information and online virtual communities have become a major source for helping expectant parents to prepare. This is transforming how people learn and, with professionals guiding them, parents can reflect on their learning and make sense of the information in the context of their particular life and circumstances. Health visitors can improve knowledge and understanding of babies and parenting through their role in communities (real and virtual), helping to build a ‘big society for mothers, fathers, families and babies’ by developing well informed and supportive families, friends and communities.

What should preparation cover?
Drawing on the research, the expert group developed a list of six themes (see Figure 2) for the content of any preparation for parenthood or antenatal education programme, be it one-to-one contacts, groups, self-directed learning or one-off events. Each theme has a menu of topics for mothers and fathers to choose from, including those traditionally underplayed in groups and classes, ie the psycho-social aspects of early childhood and parenthood and understanding babies. The content is interconnected and designed to assist parents and professionals to tailor programmes to suit different groups (and individuals) rather than be a standard prescription. The skill of the practitioner is in understanding the needs of the group and each individual within it, respecting and drawing out what parents know already and providing the opportunity for them to reflect on what this means for them and their lives.

Figure 1. The PPBB framework

- Start with family, friends and communities using social networks for learning and support
- Offer opportunities to learn and build social support through community-based groups
- Making learning and preparation part of routine care (maternity and Healthy Child programme)
- Enhanced evidence-based services and support for the most needy individuals
Supporting professionals in this work

Parents value health professionals as a trusted source of advice and information. While others have an important part to play, health visitors and midwives will always have a leading role. However, Schrader McMillan et al. (2009) found that many health professionals feel unable or ill equipped to undertake groups, with antenatal education being seen as having low value. This is an issue that needs to be addressed by the professions and services. To help, the expert group is developing a guide for professionals and parenting practitioners to help them to run local groups tailored to their community. Using the themes and menus above, the pack will offer useful resources and reflective exercises to assist practitioners with planning a programme, and developing skills and confidence in facilitating groups.

Summary

The physiology of pregnancy and childbirth may change little over the years, but the social and technical context is changing and we have to place a greater emphasis on pregnancy and early infancy. Antenatal education is therefore in need of development to make sure that it better reflects what mothers, fathers and families want and our deeper understanding of early childhood development and the importance of family life. There are many examples of people running groups and sharing information in new ways, especially in Sure Start children’s centres and those run by non-state providers such as the NCT.

Health visitors and public services in general are facing multiple demands and limited resources. We need to find different ways of supporting parents as they make the journey to parenthood. This work suggests that there are many assets available in a community such as family and friends, other parents who want to share their learning and multiple sources of information, as well as children’s centres and new providers. Health professionals can multiply their impact by mobilising these resources and working with others. The framework described here is a first step in rethinking the purpose and content of ‘antenatal education’ and how we can work together to guide mothers and fathers as they make what is probably the most important transition of their lives.

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References


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Adjusting to motherhood

One mother’s experiences underline the need for care, sensitivity and time to support what may be a difficult transition to motherhood

Laura Hill
Clinical psychologist and mother, Peak District

In childbirth itself, there have been many changes since my mother gave birth to me. The information available, the shift away from medicalisation, recognition of the role of partners and the importance of environment in the whole process have all signalled progress. The ‘active birth’ movement, once pioneering and opposed to the hijacking of a natural process by the medical, now seems to have become mainstream in much medical care itself.

Antenatal-postnatal disparity
I gave birth in a hospital, and yet I had a pool, a wonderful, soothing room with dim lighting and fish on the curtains (I spent hours staring at those fish!), non-intrusive, respectful and positive staff, and my partner with me throughout. I could not fault my care, and ultimately I was very grateful that when I needed medical help, it was available.

However, once my son was born, there seemed to be a huge and growing disparity between my actual experiences and the portrayal – in all those booklets – of how I supposedly should be feeling. It has led me to feel that the progressive changes in the experience of childbirth have not been mirrored in the postnatal period regarding social perceptions of early motherhood. To me, these perceptions are still rooted in a medicalised, outdated and categorical view of the world in which any acknowledgment of negative feelings or recognition of struggle is quick to be labelled a ‘disorder’ or an illness.

Confusion, doubt and loss
In our society, the image of new fathers, sitting in hollow-eyed shock, bemoaning over a beer the day they ever had the thought of being a dad, may be likely to induce reactions such as understanding and wry smiles, even sympathy. It has felt to me that women, on the other hand, are still expected to react very differently, wrapped in an insulating bubble of hormones, fusion and love, oblivious to all else, including the need to sleep.

Maybe some people truly are insulated in a blissful state in the first few weeks, but I was not, and having spoken to many people since I know I am not alone. I was not depressed, psychotic or even inexplicably, hormonally, tearful. I was just very, very tired, very frightened and overwhelmed with the responsibility. Couple that with the uncertainty – no, make that utter cluelessness – of how to manage this new little miniature human, having spent almost no time with newborns before he arrived in the world, and it does not seem surprising that I felt lost. Living the reality, day after day and night after sleepless night, I also became uncertain of whether it had, despite being a much wanted and planned for pregnancy, been the right decision after all (and terrified of the implications of even thinking this). My partner and I voiced this together one evening, our words muted for fear (and how utterly encompassing that fear was, as if our lives depended upon it) of waking him. Maybe for fear too of what we were admitting – we’ve made a mistake, we’ve ruined our lives, and there is no going back.

Voicing it both helped and did not help. It made the feeling real, inescapable, but it also helped me to feel more sane. It occurred to me that it was perhaps the only decision I could not change that I had ever made. You can leave jobs, relationships, homes, but you cannot walk out on your newborn child. No one can tell you what it is really like. The only way to find that out is to do it, and by then it is too late. During those early, sleep-deprived weeks, I felt taken over by this person that could not even respond to me could not do anything, who was so tiny, so helpless and yet had assumed such monstrous proportions in the colonisation of our lives – overnight.

I had expected to feel many things after the birth, but bereaved of my former self and life was not one of them. It ambushed me from behind. Maybe if I had felt prepared to deal with it, if I had expected it, I would have not felt so panicked. I would have also known that it would, like everything, change. My process of falling in love with my son was just that – a process. It took time.
One year on

Now, one year on, I can say genuinely that I am delighted we have our son, and looking back I can see that this year has held some of the happiest, as well as some of the worst, moments. This does not mean there are not still days when I miss my old life, or when it feels hard and unrewarding. But surely a range of feelings about such a huge change is, and should be, normal. Why are we still so shy to openly discuss the less than glowing side of those early months without feeling guilty that we are somehow not grateful we have healthy babies, are not good mothers or are not nurturing?

I feel lucky, I have a supportive partner, understanding and honest friends, a very helpful and wise health visitor, and enough conversations with enough people to start questioning some of these social assumptions. Were it not for these, I may have started to unravel in the face of the contrast between how I actually felt and how it seemed society expected me to feel.

Expectations and categorisation

In pregnancy, I recall being inundated by well-meaning magazines referring to the special time ahead through a blissful haze of blue and pink. Smiling mothers, make-up intact, beamed out from the cover page clutching cute (and never crying) babies. When the reality may feel so different, it is easy to lose trust in one’s own perceptions. This in itself may be enough to make one conclude that there must be something wrong, in turn destabilising mental health.

If people fear that they will be categorised, labelled as mothers who are not coping, failing to bond, mothers who are depressed, they will understandably not be likely to openly express their struggles. Yet psychiatric diagnoses, based on the medical concept that mental health problems are predominantly diseases residing inside individuals due to chemical abnormalities in the brain, while having usefulness, can also serve to take diseases residing inside individuals due to genes, can trigger us to feel distressed and unable to cope. So, I think a focus on the joys of becoming a parent should not obviate the need to consider just how stressful such a transition can be, and that finding it stressful can be a normal and totally understandable response for many people (see Box 1). Perhaps some more open talk about the whole spectrum of reactions to having a new baby, not just the fluffy stuff, may help some people feel more sante, rather than a focus on the arbitrary division between those who are ‘well’ and enjoying every minute, and those who are in the grip of a ‘disorder’ and not doing so.

Importantly, this focus may also allow people to speak more openly about how they are feeling, rather than possibly fearing that they will be deemed mad or incapable of parenting. Open discussions can allow everyone, professionals and friends and families, to help. If people fear the response they will close down, and try to hide their true struggles, with the potential result that their experiences will escalate and the chance for helping early will pass by.

Spectrum of reactions

By all counts it seems to me, a new baby – however much loved and wanted – is a stressful life event, and stress and sleep deprivation, not only hormones or lousy genes, can trigger us to feel distressed and unable to cope. So, I think a focus on the joys of becoming a parent should not obviate the need to consider just how stressful such a transition can be, and that finding it stressful can be a normal and totally understandable response for many people (see Box 1). Perhaps some more open talk about the whole spectrum of reactions to having a new baby, not just the fluffy stuff, may help some people feel more sante, rather than a focus on the arbitrary division between those who are ‘well’ and enjoying every minute, and those who are in the grip of a ‘disorder’ and not doing so.

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Box 1. One mother’s perspective: considerations for practice

- Develop a supportive, open relationship by taking time to listen and empathise without prior assumptions about how people should be feeling – it is a very individual process
- I found home visits much more conducive to discussing my true feelings and concerns than visits to the clinic, which were time pressured and stressful. Home visits can also give a context to distress or problems
- Help people feel empowered through noticing and encouraging the positive, however small or seemingly obvious. I found much reassurance was needed in the early weeks and this helped immensely. Coming from a professional, this carried more weight than from friends or family
- Normalise struggles by giving permission for a range of feelings to be expressed. Mention that it can be a stressful and exhausting period and that it is natural to find such a big adjustment hard at times. People may not feel they can voice this unless it is raised as an understandable reaction to the transition to parenthood
- Avoid over-reliance on checklists, especially at the initial meetings. They can be useful tools but can also get in the way (if applied insensitively or to the exclusion of more informal discussions) of forming a trusting human relationship. Screening measures can also lead to the assumption that if people feel a certain way they will simply say so if asked. People may not – unless they feel safe and supported
- While recognition of postnatal mental health problems is important, pathologising too early could be detrimental, leading to further feelings of vulnerability and undermining confidence. Unless risk issues are identified, increasing supportive contact – visits or phone calls – and thinking (with the wider family if appropriate) about other sources of support and ways to get more sleep may be a most helpful first step. Can the father, a close friend or family member do more at night?
- There is a reason why sleep deprivation is used as a form of torture as it can utterly undermine our resources, both mentally and physically. It is taken for granted that new parents (especially mothers) will be very tired, but before other sources of low mood are explored or suggested, sleep should be assessed and its role in contributing to low mood made clear to people

I ‘felt as if I was on a rehabilitation programme’
Steering through change

A personal perspective on the many changes in community practice and the lessons from having been there

Jacqueline Mountford-Green
Retired health visitor and school nurse

With over a year of retirement from health and education under my belt, and listening to another government discussing changes to practice, I have been reflecting on how policy changes informed and influenced my practice.

This article aims to show that throughout change, if we have good management, support within our team and are willing to learn from our experiences, then we can continue to develop and provide best practice.

Best able for change

After entering nurse training with 10 years’ experience as a mother, first aid volunteer, teacher and a successful business in selling, I was surprised to find that the training of all medical staff was centred around a model of patch or manage, especially as hospital admissions were a known disruption to people’s lives, and a drain on the economy. I also learned that the profession best able to change this, was health visiting.

Consolidating my nurse training on a professorial unit taught me how team discussion of embryonic ideas could provide revolutionary thinking that could then be debated nationally, through unions and associations, and contribute to best practice. Politically, this was post-Salmon – all staff rotated onto nights maintaining a continuity of care, and volunteers supported staff through making beds and befriending patients.

Importance of support

Health visitor training required the completion of a 12-week obstetric course, where I was joined by other staff nurses, specialist nurses, sisters, midwives and nurse teachers, who provided dynamic discussions and innovative project presentations.

The health visitor course was the toughest I ever encountered and demanded continual self-analysis – 52 weeks long with no holidays was a trial on any relationship and our group experienced enough stress to last a lifetime. However, we also learned the importance of peer support and I was grateful for the calm presence of my clinical practice teacher.

Sharing and training

Over the next three years, I experienced high standards of professionalism and life events that would ground me for many years. These were the days of large health centres shared by GPs, midwives, school nurses, district nurses, dieticians, physiotherapists, speech therapists, community psychiatric nurses and dentists.

Colleagues who job-shared overlapped at ‘baby clinics’ that our community paediatrician attended to discuss best practice. I believe he was one of the first to perform peripatetic immunisations to the travelling community. Health visitors had backgrounds in special care baby units, registered sick children’s nursing, midwifery, family planning and management, and all took on an area of special responsibility.

It was a time of change in politics, immigration and employment, but we had a strong HVA (the predecessor of Unite/CPHVA) section and I was lucky to rub shoulders with some of the greatest thinkers of our time.

Management advised all newly qualified health visitors to complete the first-line management course, and encouraged individual development through City and Guilds 7307.

Community psychiatric nurse support, practice discussion groups and three-month exchanges for city and rural health visitors encouraged an environment of respect, reflection and responsibility, where
we found funding to produce teacher-practitioner posts and research-led practice.

Management arranged training days with guest speakers and encouraged attendance of the HVA conference, and we all gratefully accepted the resources supplied by infant formula and food companies.

**Changing workloads**

My next post sat in the context of the Community Care Act. Practice nurses were medicalising many of the roles of the health visitor, leaving child protection as a disproportionate amount of our workload. We looked at different opportunities for health promotion, attending market stalls and established groups.

Departments of health and social care divided, and as managers tried to find a working definition of health care, health visitors saw the reality as the lack of money to support social workers further increased our workloads. Voluntary groups took on more and more skilled work and skill mix, together with regular collection of statistics and the ability to use a computer, became a financial necessity. These influences meant that practitioners had to contribute to their own training, managers were encouraged to accept free or cheap work environments for their staff, mileage allowances fell further behind petrol prices and registration costs continued to rise.

Diverse health information confused individuals and health visitors stopped giving out samples at a time when unemployment and prescription costs rose. I took on the role of health and safety representative and found the MSF (the union that the HVA merged with in 1990) to be an excellent source of support.

And smokers were seen as victims of their own ignorance, or choice. I no longer felt comfortable in my role, and so I returned to teaching.

**School nursing**

After 10 wonderful years of working as a freelance trainer and assessor in child health and social care settings as well as in a Category C prison, I accepted the opportunity to work as a school nurse. The remit was based on the government document *Looking for a school nurse* and followed pertinent recommendations that bought practice up to date. I felt the years in teaching had provided me with very relevant skills and understanding, not only of the teacher’s role, but also that of the support workers and parent of the older child.

Once again, I was surrounded with dynamic practitioners in education, social services and health. Primary children, ripe and eager for information, were willing to take health messages home, and parents demonstrated a desire to get their school on the Healthy Schools agenda.

**Busy, busy, busy**

However, instead of the multi-skilled teams that we had dreamed of in the 1990s, many localities had placed the health visitor as manager of band 5s and 4s who were doing much of the routine work. Health visitor time was spent increasingly on staff appraisals and reviews, and an increasing number of strategic, children in care reviews, and case conferences on families they hardly knew. Records and meetings became essential in order to keep hold of the picture, which fuelled the discontent of band 4s who saw health visitors doing less and ‘less work’. The growth in community groups and sharing information seemed to compound this and health visitors found their capacity continually reducing. Resources now seemed so scattered that practitioners were using increasing time collecting them and often used their own holidays for personally financed training.

Some primary care trusts (PCTs) combined the teams, further reducing the number of band 6s while giving health visitors responsibility for children in primary schools. Although this enabled school nurses to focus on the increasing health issues in secondary schools, many health visitors did not feel they had the knowledge or skills to work in schools.

Teachers also appeared to be in resource poverty and desperate for our personal, health, citizenship and social education input, but there were fewer staff with school health and education diplomas available for the primary children. Families moving across PCTs were confused by the different services that community health teams provided, and community practitioners were continuing to struggle to maintain the role that they knew worked. Staff meetings became a platform for information giving and target setting, training opportunities decreased, conference costs rose, the letters page disappeared from the journal, and colleagues found fewer opportunities to share. It began to feel like innovative practitioners were a dying breed.

A culture of ‘I work harder than you’ developed and everyone was ‘busy’. Public holidays, marriages, births and departing colleagues passed without celebration. We discovered a colleague had been in hospital and didn’t even manage to send a card. Christmas parties disappeared as December and January became the time to take holidays that had been impossible to take earlier.

**Back to sharing**

With two years left to retirement I decided to go back into freelance, and found a community health team who worked a corporate caseload providing health promotion. Weekly case discussion provided time to share best practice and identify resource requirements, which their manager prioritised. They all attended a monthly clinic, held over a whole day, and arranged a shared lunchtime where they caught up on each other’s lives. This enabled the team to grow in a supportive environment.

**The right questions**

Over the years I have been invited into many homes, schools and work environments working with many different families and professionals, learning how life events are affected by various cultures and rituals, and how cultures and rituals influence the development and implementation of policies and practice.

Through these families I have experienced joy and success, sorrow and tragedy and been able to facilitate the creation and interpretation of policies.

Health visiting and school nursing taught me to ask the right questions, that you can’t judge a book by its cover and neither book nor religion will tell how a person will live, learn or develop because each person develops through their interpretation of their experiences, making each family unique. That is why it’s been a privilege.

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**References**

EMPLOYMENT

Not a pretty picture

The most recent NHS Staff Survey once again paints a picture of an under-resourced workforce delivering a good service despite conflicting demands on their time

Siân Errington
Unite research officer

And so to the eighth annual NHS Staff Survey. The NHS Staff Survey remains, despite some criticisms, a mine of information – particularly when it is used in conjunction with other sources of information, such as the staff survey conducted by Incomes Data Services (IDS) on behalf of the trade unions (which had 33,770 responses) and information produced by the Chartered Institute of Personnel and Development. The results also produce an annual antidote to the narrative of under-worked, overpaid public sector workers.

Timing and size

The survey was conducted during October and December last year. This means that it was being carried out while many trusts were in the process of working out how to implement the £20 billion ‘efficiency savings’, but had yet to fully decide upon a plan. In its analysis of the survey results, the CQC has structured its findings around the four pledges to staff in the NHS Constitution (see Box 1). While this article is not structured in the same way as the CQC’s briefing, it is worth flagging these pledges up, since it may be useful for readers to structure their response to the survey results in their own trust by addressing each pledge in turn.

NHS Constitution pledges

In its analysis of the survey results, the CQC has structured its findings around the four pledges to staff in the NHS Constitution (see Box 1). While this article is not structured in the same way as the CQC’s briefing, it is worth flagging these pledges up, since it may be useful for readers to structure their response to the survey results in their own trust by addressing each pledge in turn.

Familiar story

The NHS Staff Survey results contain the familiar story of a workforce who feel strongly about the contribution they make towards the health, care and wellbeing of patients and users but feel under pressure, unappreciated, disenfranchised and disempowered and are carrying a heavy workload.

Satisfaction with care provided

In the positive column, 90% of staff feel that their role ‘ultimately made a difference to patients and users but feel under pressure, unappreciated, disenfranchised and disempowered and are carrying a heavy workload.

Under-resourced

A total of 58% of staff said they had suffered from attendant upheavals and threats for the NHS were much lower than they are now. Readers should be aware that they can download a ‘briefing note’ produced by the Care Quality Commission (CQC) on the national headline survey results as well as the results for their individual trust. Almost 310,000 NHS staff were surveyed, with a response rate of 54% (n=164,916).

Working over contracted hours

However, in delivering this level of service the CQC briefing notes that ‘nearly two-thirds of staff (65%) across the NHS reported working more than their contract-ed hours’. In the IDS survey last summer, staff were asked how many extra hours they regularly worked each week in total (which they are not asked in the NHS Staff Survey) – 39.5% weekly work over four hours extra (including 11.7% working more than eight extra hours a week).

Further to this, the CQC briefing notes: ‘A lower proportion of all staff (29%) were paid for these extra hours compared with 31% in 2009... 53% of staff regularly worked extra unpaid hours (compared with 51% in 2009).’

Working while unwell

Two-thirds of staff reported that they had gone to work in the previous three months even though they had felt unwell. Of these staff, 91% said they had put themselves under pressure to attend work, 30% felt under pressure from their manager to attend work and 21% felt under pressure from other colleagues. Just under one-third (29%) of NHS staff said they had suffered from work-related stress.

Box 1. NHS Constitution: pledges to staff

- Pledge 1 – to provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers, and to communities
- Pledge 2 – to provide all staff with personal development plans, access to appropriate training for their jobs and the support of line management to succeed
- Pledge 3 – to provide support and opportunities for staff to maintain their health, wellbeing and safety
- Pledge 4 – to engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working
Recognition and feeling valued
These different indicators knit together to form a picture of a workforce ‘going the extra mile’ to deliver health services and is in stark contrast to how work in the NHS, and the wider public sector, is usually portrayed in the media at large.

At the same time that respondents were reporting high levels of extra hours, often unpaid, and pressure to attend work when unwell, less than half (45%) are satisfied with the recognition they receive and only one-third (33%) with the extent to which they feel their trust values their work. Only 52% indicated that they look forward to going to work and 67% were enthusiastic about their jobs. This leaves a very sizable minority who do not look forward to work and are not enthusiastic.

Appraisals and development
There has been a good increase in the number of staff having appraisals (77% compared to 69% in 2009), and 94% have taken part in at least one form of employer supported training, learning or development in the last 12 months.

This is important, since staff have consistently reported that they feel training is beneficial to their ability to do their job and to keep up to date with professional requirements, and it is an agenda Unite strongly supports. However, a note of caution must be sounded – the phrase ‘taking part in at least one’ can hide a multitude of sins. In the IDS survey, 32.4% of respondents reported that they had not had any training other than mandatory training over the past year. Just under one-third (30.3%) received between one and two ‘days’ training and 23.2% had had between three and six days.

Further, when it came to bearing the cost of training, 23% of respondents had to pay for all or part of their training. Comments received included the following from a Band 6 nurse: ‘There’s only essential training and you have to wear your uniform for mandatory training in case you get called on to the ward – which often happens.’

Pause for thought
The NHS Staff Survey results – only a snippet of which have been touched on here – should give employers and the government pause for thought as they try to implement the massive upheavals and privatisations threatened by the Health and Social Care Bill and the NHS budget faces cuts in real terms over the coming years.

These results show that staff are delivering a good service despite the conflicting demands on their time and the access they have to current resources, but there will be a breaking point in how long this can continue. Staff cannot work many more unpaid extra hours to cover demands.

Pay freeze for NHS staff earning above £21 000
The NHS Pay Review Body (PRB) has published recommendations for NHS pay from April 2011 to 2012 in its 25th report, saying that there should be:
- An uplift of £250 to Agenda for Change spine points 1-15 from April 2011
- Increments applied to all grades.
In line with Treasury guidance, all NHS employees will be subject to a pay freeze, except for those who earn less than £21 000, who will receive an increase in their annual salary of £250.

In its response, the PRB reports: ‘We acknowledge that the imposition of a limit of £21 000 and the decision to seek or (in the case of Scotland and Northern Ireland) to commit to an increase of £250 were matters of judgement for the UK Government and devolved administrations rather than being specifically linked to economic or labour market circumstances.’

It adds: ‘We also note that the chief secretary to the Treasury’s remit letter of July 2010 said that the UK Government would seek an increase of at least £250 per year and the health departments, in their November 2010 evidence, did not consider any additional uplift to be justified or affordable.’

Inflation is currently higher, with the Consumer Price Index at 4.4% and Retail Price Index at 5.5%. This means that our members will be receiving real-term pay cuts. Unite and the other health unions have responded by expressing our concern that the PRB is not reflecting the real pressures on pay that NHS staff are experiencing and the high rises in the cost of living. As a union, we will need to assess how we respond to this.

Increments are to be applied to all staff, and were beyond the remit of the PRB as it is a separate element of Agenda for Change. The Budget confirmed the £250 and NHS PRB conclusions in full.

We are also very dissapointed about the lack of progress made on the recruitment and retention premium for pharmacists and maintenance craft workers and technicians working in the NHS.

The PRB only makes recommendations, and here is the health secretary Andrew Lansley’s response: ‘We welcome the NHS PRB’s 25th report and accept its conclusions in full. We will take forward the suggested actions, which will help us to continue to improve our support for the NHS PRB’s important work.’

The full PRB report is available on the Unite health sector website along with the evidence submitted to the PRB by the union, see: www.unitetheunion.org/sectors/health_sectors/agenda_for_change_and_prb/pay_review_body.aspx

Rachael Maskell, Unite national officer health
Coventry and Warwickshire NHS Partnership Trust

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Baby Yoga

On-going, across UK
Two-day workshop for qualified baby massage teachers to enhance teaching skills. Supports bonding, attachment, parenting skills, physical development, relaxation. Tel: 01889 566222 email: yoga@touchlearn.co.uk www.touchlearn.co.uk

Baby Massage Courses for Health Professionals and Family Centre Workers

Train to become a certified infant massage instructor with the International Association of Infant Massage (IAIM). By far the largest and the only worldwide organisation with over 30 years of teaching experience now in more than 40 countries. For further details of our training throughout the UK, visit www.iaim.org.uk.
Our four-day highly acclaimed, comprehensive course has been endorsed as the highest quality for parent education, comprising:
- Theory and latest research
- Supervised practical teaching
- Extra curriculum activities including reading, further practical teaching and a take-home written assessment.
All of our students will feel confident in empowering parents to give nurturing touch and communication so that children are loved, valued and respected throughout the community. On-going support is always available from our trainers.
We also have many specialist instructors working in diverse areas from special needs to music, who can offer support and post-certification workshops.
We value our members – membership of the IAIM(UK) chapter is given to all students and facilitates:
- Support and networking at local, national and international level
- Continued professional development – regular educational conferences with expert speakers and trainer-led stroke reviews
- Marketing advice for your class set-up and a triannual informative newsletter.
IAIM Ltd
Tel: 0208 989 9597 email: info@iaim.org.uk www.iaim.org.uk

Touch-Learn International Infant Massage Teacher Training Programme

Venues across UK, plus in-house
An accredited five-day comprehensive infant massage programme for health and parenting practitioners, provided by Touch-Learn, the exemplary international training provider. This dynamic course includes simple massage techniques coupled with in-depth knowledge to practice safely and professionally, so practitioners feel confident to teach parents in a variety of settings. Also included:
- Research-based evidence
- Anatomy and physiology
- Free biannual newsletters
- Tutorial and on-going support
- Free membership to the Guild of Infant and Child Massage
- Quality and up-to-date supporting material.
Touch-Learn International Ltd Tel: 01889 566222 email: mail@touchlearn.co.uk www.touchlearn.co.uk

Nought-to-19 skill-mix teams

We are interested in developing skill-mix teams to deliver nought-to-19 health care across health visiting and school nursing services.
I wonder if anyone who has experience of this could email me their views, both positive and negative, and perhaps share any models they found useful?
Pat Carr
email: p.carr@nhs.net

Audiology screening: targeted or universal

Currently, a colleague and I are undertaking the specialist community public health degree (school nursing) and want to develop a local best practice guideline for audiology screening. We have been informed that there are varying practices in Greater Manchester between how audiology screening is undertaken, for example universal screening or targeted screening.
To gain an insight into the differences of how this service is offered nationally I would be grateful to hear from school nurses in relation to what their organisation offers.
Anthony Ogden
email: anthony.ogden@nhs.net or helen.flinn@nhs.net

Diary listings
These are paid for, please
Tel: 020 7657 1804 or email: james.priest@tenalps.com

Noticeboard listings
These are free, email: danny.ratnaike@tenalps.com
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5pm Friday, 27 May 2011
Submit your paper online at the conference website.

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