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May 2012 Volume 85 Number 5 Community Practitioner 1
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Register for free news, updates and access to infant feeding resources.
As you spend your lives bridging the gaps in our society to ensure the next generation have health equality, the government is driving a divide in every segment of society. The passing of the Health and Social Care Act has now created the most segregated health system for 64 years across England. The most deprived areas will have the least resources per capita and therefore access to services will be further challenged.

At the same time we are seeing mass cuts and the biggest attack on NHS staff pay and conditions for a generation. Ministers, with their gold-plated pensions, are making NHS workers take a cut to their average pension of less than £4,000 a year. At the same time, NHS staff will pay more for their pension and work longer in physically, mentally and emotionally challenging environments. Ministers have simply made this ruling from their desks.

In parallel, we are seeing an ideological attack on pay, against the backdrop of a 11.6% real terms pay cut to date. Regional or local pay will drive down pay in less affluent areas, and will create a north-south divide. But perhaps a greater divide will be the NHS Employers agenda to introduce a performance-related pay system. This will result in colleagues doing the same job but being paid differently – totally demoralising for staff who all exceed their performance, but won’t all be recognised. Employers are looking to cut other terms and conditions too.

Those at the top of the NHS and government are wielding disproportionate power over the rest. This is nothing new. However, when staff organise, stand together and resist changes to services and their own terms and conditions, they can take their power back and build a fairer system.
Chair of the NMC steps down as ‘the time is right’ – yet another blow to the regulator

- CHRE interim report is published – NMC pledges to go ‘back to basics’, but warns fees increases likely
- All future publications from the body to be electronic
- Focus will be on ‘core regulatory activities’
- All change: answering questions of a professional nature is no longer a ‘core function’

Chair of the NMC, Professor Tony Hazell, who extended his term of office by 12 months in December, has made the shock decision to resign.

He said: ‘The past few months have been extremely challenging but I am confident that the organisation is now going in the right direction and will continue to do so under the excellent leadership of Acting Chief Executive Jackie Smith.

NMC council members have nominated Professor Judith Ellis MBE, a current registrant member of the council, to the position of deputy chair. Ellis is executive dean for Health and Social Care at London Southbank University and was a former director of nursing at Great Ormond Street Hospital.

Hazell’s resignation follows that of former Chief Executive Dickon Weir-Hughes in January and also of Roger Thompson, the NMC’s director of standards and registration. In addition, the NMC is currently undergoing a CHRE strategic review.

One of Professor Ellis’ first moves as interim chair has been to advise nursing directors to carefully consider all circumstances before referring registrants to the NMC’s fitness to practise (FtP) process. Currently, 40% of FtP referrals are found to have no case to answer.

The backlog of FtP cases – an increase of 52% referred over the last two years – has caused the regulator to overspend by £8.9million. At the most recent NMC council meeting, the council agreed upon the corporate plan for the coming year, against the backdrop of the CHRE strategic review. The council made it clear that the primary focus must be on core regulatory activities, in particular, concentrating on the FtP backlog.

In view of this review, certain existing development projects will not go ahead, including the development of additional materials to support the use of the code in leadership and military setting; a review of the record-keeping guidance; and the review of the specialist community public health nursing and specialist practice qualifications.

Another area due to change is that of the role of the NMC as an advisory body. Having previously run a professional advice service, the council has now decided that answering questions of a professional nature is no longer a core regulatory function, and the service will be withdrawn over the coming weeks. Instead, the council believes that these enquiries would be best answered by unions, professional bodies or at a local level by nursing and midwifery managers.

In addition, the NMC will be changing the way that it communicates with its members by completely phasing out the printing of paper copies of standards, guidance and supporting information, and solely focusing on online communication.

An NMC statement said: ‘All the changes being introduced are designed to ensure the NMC’s focus is wholly on public protection. It is clear that the NMC will be a very different organisation going forward, committing us to effective regulation and putting the needs of patients, not professionals, first.’

This news came at a time when the CHRE published its interim report on their strategic review of the NMC.

In light of the report Jackie Smith has pledged to go ‘back to basics’ in a bid to tackle the backlog of 4000 FtP cases. In addition, the NMC has warned that this means that fees for registrants are likely to rise.

Smith said: ‘The report reflects the fact that the NMC had lost its way and perhaps focused on non-core priorities. The NMC has a problem; that problem is fitness to practise and until we sort it out we should not be focusing on activity that deflects us from that functions … we need to get back to basics’.

The report recommends that the NMC’s 14-member council be reduced in size, that the body considers splitting the role of chief executive and registrar into two separate positions, and that the posts of chair and chief executive be filled ‘swiftly’. Smith added: ‘Fitness to practise requires a significant amount of money. We are reviewing our resources practically on a daily basis and will be taking a financial strategy to our council in June … the strategy will have to look at fees’.

The CHRE’s interim report is critical of relationships between the NMC’s chief executive and his team who are criticised for not being ‘sufficiently transparent and accountable’.

Unite/CPHVA Professional Officer Dave Munday said: ‘We have a continuing dialogue with the NMC. A team from the CPHVA met with the NMC in March and specifically raised concerns that in the current climate nurses and midwives need their regulator to be as robust as possible. We are concerned that the CHRE review will result in the NMC reducing services to registrants which will put the public at risk.’

Among other failings the report says: ‘At the heart of the NMC’s inability to succeed lies confusion over its regulatory purpose, lack of clear, consistent strategic direction, unbalanced working relationships and inadequate business systems’.

CHRE Chief Executive, Harry Cayton, said there was ‘no reason’ why the posts of chief executive and registrar should not be held by a nurse or midwife, adding: ‘Professionally led regulation has been dying for some time. I’m certainly not suggesting that there shouldn’t be 50% of the council from the nursing profession.’

Prof Judith Ellis MBE, has stepped in to replace Prof Tony Hazell, who has resigned

NEWS ROUND-UP

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New government advertising campaign shows the ‘hidden dangers’ of second-hand smoke

Most gases in second-hand smoke are invisible and odourless, putting children at increased risk of lung disease, meningitis and cot death. Each year in the UK second-hand smoking leads to over 300,000 GP visits among children and 9,500 hospital visits, costing the NHS more than £23.6 million.

A new advertising campaign shows a baby surrounded by cigarette smoke as her mother smokes by the kitchen door, while another shows a child in the backseat of a car inhaling the smoke from his father’s cigarette as he smokes and drives.

As part of the campaign, a survey of 1,000 children aged eight to 13 whose parents smoke was carried out, which found 98% wanted their parents to quit smoking entirely; 82% wished their parents would not smoke in front of them in the home, and 78% did not want smoking in the car. Cigarette smoke made 41% feel ill and 42% cough.

Health Secretary, Andrew Lansley, said: ‘This campaign will raise awareness of this danger and encourage people to take action to protect others from second-hand smoke.’

The Royal College of Paediatrics and Child Health want smoking in cars with children present to be made illegal.

Doctors in Scotland support a similar ban there, and the Welsh government last year said it would consider legislation if attitudes did not change.

Professor Dame Sally Davies, England’s Chief Medical Officer, said: ‘Smoking damages our lungs, causes cancers and is now the biggest risk for cot death. Parents who smoke need to think about the effect it has on their family.

‘Giving up smoking or making sure you have a completely smoke-free home and car is the only way to protect your family.’

Meanwhile, new legislation has come into effect banning tobacco displays in shops and supermarkets in England. It is hoped that covering tobacco displays will lead to fewer children taking up smoking, as statistics show that more than 300,000 children aged under 16 try smoking every year.

Jo Butcher of the National Children’s Bureau said: ‘Children and young people tell us that outside influences make it even more difficult for them to choose healthier lifestyles’.

Health Minister Anne Milton said: ‘We cannot ignore the fact that young people are recruited into smoking by colourful, eye-catching cigarette displays.

Banning displays of cigarettes and tobacco will help young people resist the pressure to start smoking and help the thousands of adults in England who are currently trying to quit.’

Pregnancies in Wales in under-18s is at lowest since 1992

The teen pregnancy rate in girls under the age of 18 in Wales is now at its lowest point for 18 years, according to statistics revealed by the Welsh government.

The figures were announced in the wake of evidence released from the Office of National Statistics last month, which showed that teen pregnancies in England and Wales were at their lowest since 1969. However, the statistics also show that there has been a slight increase in the number of pregnancies in girls aged under 16 in Wales, rising from 7.3 per 1,000 in 2009 to 7.8 in 2010. Helen Rogers, Director of the Royal College of Midwives Wales, commented: ‘Wales had one of the highest rates in Europe at one point so we are going in the right direction.’

The statistics also show that 45% of conceptions for under-18s were terminated, compared to terminations for all ages, which was 20%. Rogers said: ‘While I’m not saying there’s a direct correlation between the pregnancy and abortion figures, I am worried that abortions may be being used as a form of contraception’.

The statistics show that overall in Wales there were 40.1 pregnancies per 1,000 in girls aged under 18 in 2009. This figure reduced to 37.7 per 1,000 in 2010. Ros Godson, Unite/CPHVA Professional Officer, said: ‘Now that Wales has committed to having a school nurse for every secondary school, we will look forward to continuing public health improvements in the country.’

A Welsh government spokesperson said: ‘While we expect these figures to fluctuate slightly year on year, it does appear as though the overall trend in teenage pregnancy in Wales is downwards. The overall decrease reflects our integrated approach in Wales outlines in the Sexual Health and Wellbeing Action Plan 2010 to 2015.

There significant differences across areas of Wales, with some communities seeing a significant success and some staying almost static. Merthyr Tydfil, for example, saw a staggering reduction from 99.8 to 44.5.'
As the Health Bill gains royal assent and becomes law, opposition groups have warned that this is ‘not the end of the story, but simply the beginning’.

As Parliament reopened after Easter recess, ministers began to finalise the finer details of the Bill.

During its tumultuous 25-day passage, the ‘deeply flawed’ piece of legislation received a staggering 375 amendments and was only passed in the House of Commons by a margin of 82 votes.

Primary care trusts and strategic health authorities are due to be scrapped in April 2013 when clinical commissioning groups (CCGs) will become statutory organisations.

Dr Clare Gerada, Chair of the Royal College of GPs, said: ‘Though I am disappointed as I have worked hard to mitigate the problems, we have to move on and work with the government on the secondary legislation and implementation. We have to analyse the Bill now. We want to be there to help implement what I suspect is a very complicated and conflicting Bill.’

The new act will devolve 60% of the NHS’s £100billion budget to GP-led committees, which will replace the current primary care trusts.

On the same day, an early draft of the risk registers for the Bill, dated 28 September 2010, leaked to health writer Roy Lilley and was published in the Guardian.

The current risk register has not been released, despite a ruling from the Information Commissioner in response to Labour’s freedom of information request, making the draft the only public version.

The draft identified 43 areas of potential risk, rating each on a scale of one (rare/low impact) to five (almost certain/very high impact). Some of the concerns with higher ratings included poorer preparation and response to health emergencies, greater costs incurred by GP-led consortiums making more use of the private sector and a loss of financial control.

Other concerns dealt with unfavourable media coverage, which could negatively affect public perception of the document, and the risk of industrial action by workers angered by the reforms.

Although parts of the Bill underwent major change after the original publication of this document, not everyone believes the risks have been addressed.

Mr Lilley told the BBC: ‘Ninety per cent of the risks that were identified in this September document have manifested or are manifesting now.’

Labour used the document in their condemnation of the bill, with shadow Social Care Minister, Liz Kendall, calling it a ‘damning indictment’ of the Bill. Shadow Health Secretary, Andy Burnham, said:

‘Now we know why David Cameron refused to publish the risk register before the bill was through parliament – it’s because civil servants were telling him his reorganisation was likely to cause major damage to the NHS’.

A Department of Health spokesperson said: ‘We do not comment on leaks. We have always been open about risk and have published all relevant information in the Impact Assessments alongside the Bill.

‘As the latest performance figures show we are dealing with those risks, performance is improving and we are on course to make the efficiency savings that the NHS needs to safeguard it for the future.’

CQC ‘fails to perform effectively’

The Rt Hon Margaret Hodge MP, Chair of the Committee of Public Accounts, has described the Care Quality Commission (CQC) as being unable to cope with the challenges ahead. She said: ‘The CQC plays an absolutely vital role in protecting people from poor quality or unsafe care, but it has failed to perform that role effectively. It has clearly been struggling for some time and the Department of Health, which is ultimately responsible, has not had a grip on what the Commission has been doing.

We are far from convinced that the CQC is up to the major challenge of registering and assessing 10,000 GP practices this year. Registration will now be decided on the basis of information from GPs themselves and there is a risk that the CQC will simply become a postbox. Unless the assessment of GP practices is meaningful and robust the Commission cannot be sure that basic standards of quality and safety are being met’.

Hodge was speaking as the Committee published its 78th Report of this Session which, on the basis of evidence from the Care Quality Commission (the CQC) and the Department of Health (DH) examined the Commission’s operations to regulate the health and adult social care sectors. The Commission is the independent regulator of health and adult social care in England. It was formed in 2009 from the merger of three previous regulators. It currently regulates over 21,000 care providers against 16 essential standards of quality and safety.

The Report stated: ‘The Commission plays an absolutely vital role in providing assurance to the public, both by ensuring appropriate quality standards and by deterring poor quality and unsafe care. The Commission takes action where it finds standards are not being met. To date, however, it has failed to fulfil this role effectively. The Commission has more responsibilities but less money than its predecessors. Despite this, it has consistently failed to spend its budget because of delays in filling staff vacancies. It is overseen by the DH, which underestimated the scale of the task it had set in requiring the Commission to merge three bodies at the same time as taking on an expanded role.’
Big companies join Responsibility Deal ‘calorie reduction pledge’ to combat obesity

Coca-Cola, Subway and Tesco have all signed the government scheme, which was developed by the Department of Health.

England currently has one of Europe’s highest obesity rates, with over 60% of adults and one-third of 10 and 11 year olds overweight or obese. High calorie consumption is a large part of the problem.

Health Secretary, Andrew Lansley, said more than three-quarters of the retail market has joined the plan, including Marks and Spencer, Sainsbury’s, Waitrose, Kraft, Mars, Nestle, PepsiCo, Premier Foods and Unilever.

One idea is to put re-sealable packaging on chocolate bars. Other plans include a 250-calorie cap on chocolate bars and a 30% reduction in some Coca-Cola soft drinks by 2014. Supermarket Asda will develop a new low-calorie brand.

Lansley said: ‘We all have a role to play – from individuals to public, private and non-governmental organisations – if we are going to cut five billion calories from our national diet.

‘This pledge is just the start of what must be a bigger, broader commitment from the food industry. But it is a great step in the right direction and will help millions of us eat and drink fewer calories.’

But Labour criticised the scheme, favouring better food labelling and protecting children from adverts for junk food as starting points.

Noted absences from the list include McDonald’s, KFC and Burger King.

Scottish children miss out on health visiting checks

A joint study carried out by researchers at NHS Scotland and the University of Edinburgh has shown that less than 80% of children from deprived areas were likely to be seen by a health visitor, compared to 93% in more affluent areas.

The study looked at a take-up of child health reviews among 80,000 children born between 1998-99 and 2007-08. The research was designed to analyse whether the shift from universal to targeted health visiting services has improved access to health visiting for families from deprived areas.

Dr Rachael Wood, a consultant in public health medicine at NHS Scotland, who led the research, said: ‘With this move away from universal checks and to a targeted service, one would have hoped to see an uptake among families in deprived areas. When we spoke to health visitors we found that they are offering these reviews but for whatever reason parents are missing appointments or choosing not to attend.’

The study also found that only 78% of children were seen by health visitors for the checks that take place between 39 and 42 months.

Unite/CPHVA Professional Officer, Gavin Fergie, commented: ‘The research highlights a concern that CPHVA and its members have expressed that targeting practitioners and resources does not always deliver the required results. We would encourage the Scottish government to reflect on their figures and why there is a discrepancy.’
Dementia research funding will double to £66million by 2015

A t the time, Andrew Lansley announced the launch of the first nationwide NHS screening programme to identify dementia patients earlier. Under the plans, dementia checks will become routine when any person aged over 75 enters the hospital and screening will become part of the NHS health check programme for people aged 40 to 74.

Nutbrown report published

A review into the qualifications of community nursery nurses and childminding staff in England has shown that there are concerns over literacy and numeracy levels among workers. The report, led by Professor Cathy Nutbrown and commissioned by the Department of Education, explains that, currently, nursery workers are not expected to have a minimum level of competency in English and maths.

Professor Nutbrown said: ‘Getting qualifications right will help to ensure that women and men enter the profession with the skills and experiences they need to do the best work with children and their families. Well-taught courses and learning routes, which lead to reliable qualifications, can help early-years practitioners to improve their skills knowledge and personal qualities, constantly developing their roles.’

Ros Godson, Unite/CPHVA Professional Officer, said: ‘Our Community Nursery Nurse Forum has long been aware of the fact that many early years courses are not fit for purpose. We published a document last year, Determinants of a good community nursery nurse, which was written to help managers work out what various qualifications equate to, and therefore what further training this particular applicant would need.’

Chief Executive of the charity 4Children, Anne Longfield, said: ‘Clearly there are some areas that show up some real gaps in some areas that need urgently addressing, one of those being about entry-level qualifications.

‘The suggestion of introducing a licence to work in early years is brave and forward thinking and we fully support this.

‘The care and education of our children is of utmost importance and it seems only right that we provide children and their parents with the kind of assurance of quality that we have come to expect as a norm in other professions and positions of trust.’

Jubilee Bank Holiday

NHS Northern Ireland has determined that the Jubilee Bank Holiday will be treated as a full public holiday with staff who are required to work receiving enhanced rates of pay and a day off in lieu. In Scotland and Wales staff required to work will only receive normal rates of pay and a day off in lieu. This decision is being challenged by the NHS unions through the relevant negotiating structures. In England the local trust will determine the Bank Holiday arrangements, which could include the Bank Holiday being a normal working day with no enhancement or day off in lieu.

London hospital trusts could slash nursing budgets by 50% to save money

According to documents leaked by NHS London’s strategic health authority, the breakdown of 18 non-foundation trusts and how each could cut spending could ‘align staffing levels with clinical need’, reducing agency spending.

Savings range from £7million at North Middlesex University Hospital Trust to £54million at Imperial College Healthcare Trust, both less than a third of the current nursing budget. But other hospitals could make a 50% reduction in cuts, more than £200million each, including Newham University Hospital Trust and the Whittington Trust.

A report summarising the analyses said: ‘Other factors, such as ways of working, may be more important than resourcing levels ... efficiency improvements will enable others to deliver improved quality with fewer staff.’

New chief nursing officer

Jane Cummings, the current Chief Nurse at the NHS North of England strategic health authority cluster, is to become England’s next chief nursing officer (CNO), replacing Dame Christine Beasley.

Cummings commented: ‘I feel very privileged to have the job. I realise there are challenges ahead and look forward to working with nurses and midwives across the country to move things forward’.

Cummings trained at Bristol’s Southmeads Hospital, specialising in emergency care before moving into management. She joined the DH in 2002 and was a previous Director of Nursing at NHS North West. She added: ‘One of the challenges will be how I can communicate with the hundreds of thousands of nurses who are driving improvements in patient safety and experience. I want to be able to demonstrate the value that nursing and midwifery brings to the vast majority of patients’.

NEWS IN BRIEF
Treating fevers in babies and young children

Fever can be distressing for babies and children and cause anxiety for parents. Parents understandably want to relieve their child’s discomfort as quickly as possible. Medicines are not always necessary, but when they are, parents need to know which medicine they can use and which medicine is likely to work. So what advice can you, the community practitioner give?

The National Institute for Health and Clinical Excellence (NICE) provides evidence-based home-care advice. The first step is to keep the child cool and hydrated. NICE recommends that you advise parents to dress the child appropriately for their surroundings and keep the child’s room at a comfortable temperature. To avoid dehydration, you should also advise parents to offer regular fluids. Naturally, for a breastfed child the most appropriate fluid is breast milk. You should also advise parents to:

- check their child regularly, including during the night
- look for signs of dehydration
- encourage their child to drink more fluids and seek further advice if they detect signs of dehydration
- how to look for and identify a non-blanching rash
- keep their child away from school/nursery while they have a fever and inform school/nursery staff.

Is an antipyretic medicine necessary?

Antipyretics can reduce a fever and help a child feel more comfortable. However, some parents are overly concerned with the need to maintain a child’s normal temperature and consequently administer antipyretics unnecessarily. If a child has a raised temperature but is otherwise well, an antipyretic is not needed. But for a feverish child who seems distressed or unwell, an antipyretic can really help.

Which antipyretic?

Both paracetamol and ibuprofen are effective for the treatment of fever in children and have a good safety profile. However, since trials have demonstrated that ibuprofen has a longer duration of action, the use of ibuprofen to manage children’s fevers has increased. Using ibuprofen has many benefits – the key one being that it reduces a fever more effectively than paracetamol from 4 hours post-dose. Ibuprofen starts to relieve a fever in just 15 minutes (with a 10 mg/kg dose) and fever relief is clinically proven to last longer than paracetamol. This longer duration of action can help provide all-night fever relief. So when a fever causes discomfort or distress, provided there are no contraindications, you may recommend that parents try giving a paediatric paracetamol or an ibuprofen suspension, such as Nurofen for Children. Paediatric ibuprofen suspensions (100 mg/5 ml) are available for children who are at least 3 months of age and weigh over 5 kg.

Nurofen for Children

- For fast and effective reduction of fever – including post-immunisation pyrexia
- Starts to reduce a fever in just 15 minutes
- Sugar and colour free
- Easy-dosing device for accurate, mess-free dosing
- Also available in convenient sachets

After 24 hours use3 doses. Do not take if you have (or have had two or more episodes of) a stomach ulcer, perforation or bleeding; are allergic to ibuprofen or any other ingredient of the product; aspirin or other related painkillers; are taking other NSAID painkillers or aspirin with a daily dose above 75 mg. Consult your doctor before use if you are pregnant, a smoker, have or have had asthma, diabetes, high cholesterol, high blood pressure, a stroke, heart, liver, kidney or bowel problems. Side Effects: Hypersensitivity reactions including (a) non-specific allergic reaction and anaphylaxis, (b) respiratory tract reactivity comprising of asthma, aggravated asthma, bronchospasm or dyspnoea, and (c) various skin reactions, including pruritus, urticaria, purpura, angioedema and, more rarely, bullous dermatoses (including epidermal necrolysis and erythema multiforme). Side effects may include abdominal pain, nausea, dyspepsia, gastrointestinal bleeding and peptic ulceration. Also, very rarely thrombocytopenia. Product Licence Holder: Reckitt Benckiser Healthcare (UK) Ltd, SL 1-4 AQ, Product Licence Number: PL 00063/0667, PL 00063/0668. Legal Category: GSL. MRRP: £3.99 (100 ml). Date of preparation: September 2011.

ESSENTIAL INFORMATION: Nurofen for Children 3 months to 9 years orange / Nurofen for Children orange baby; Nurofen for Children 3 months to 9 years strawberry / Nurofen for children strawberry baby: BuPROPnen 100 mg/5 ml (equivalent to 2 % w/w).

Indications: Prescription and OTC for the fast and effective reduction of fever including post-immunisation pyrexia and the fast and effective relief of the symptoms of colds and influenza and mild to moderate pain, such as sore throat, arthritic, aches and sprains. Dosage: For pain and fever: 20-30 mg/kg bodyweight 6 x 1/2 divided doses (see pack for details). For post-immunisation pyrexia: One 2.5 ml dose followed by one further 2.5 ml dose 6 hours later, if necessary. No more than two 5 ml doses in 24 hours. If the fever is not reduced, consult a doctor. Not suitable for children under 1 month of age unless advised by the doctor for oral administration and short-term use only. Contra indications: Hypersensitivity to constituents in the product; History of, or existing, septic ulceration. History of asthma, rhinitis, urticaria, gastrointestinal bleeding or perforation associated with aspirin or other NSAIDs. Severe hepatic failure, renal failure or heart failure. Last trimester of pregnancy. Precautions and Warnings: Do not exceed stated dose. A doctor should be consulted if symptoms persist for more than 3 days (for a child aged over 6 months); for children under 6 months, seek medical advice if symptoms persist after 24 hours use (3 doses). Do not take if you have (or have had two or more episodes of) a stomach ulcer, perforation or bleeding; are allergic to ibuprofen or any other ingredient of the product; aspirin or other related painkillers; are taking other NSAID painkillers or aspirin with a daily dose above 75 mg. Consult your doctor before use if you are pregnant, a smoker, have or have had asthma, diabetes, high cholesterol, high blood pressure, a stroke, heart, liver, kidney or bowel problems. Side Effects: Hypersensitivity reactions including (a) non-specific allergic reaction and anaphylaxis, (b) respiratory tract reactivity comprising of asthma, aggravated asthma, bronchospasm or dyspnoea, and (c) various skin reactions, including pruritus, urticaria, purpura, angioedema and, more rarely, bullous dermatoses (including epidermal necrolysis and erythema multiforme). Side effects may include abdominal pain, nausea, dyspepsia, gastrointestinal bleeding and peptic ulceration. Also, very rarely thrombocytopenia. Product Licence Holder: Reckitt Benckiser Healthcare (UK) Ltd, SL 1-4 AQ, Product Licence Number: PL 00063/0667, PL 00063/0668. Legal Category: GSL. MRRP: £3.99 (100 ml). Date of preparation: September 2011.

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/downloads/adverse. Adverse events should also be reported to Reckitt Benckiser Healthcare (UK) Ltd on: 0800 653 456.

REFERENCES:

gentle, effective relief you can trust.
Health pensions campaign: join us on 10 May!

The focus of the Unite health service pensions campaign is 10 May when Unite members in the NHS will be taking industrial action. Why?

Our members need to put pressure on the government to get back round the negotiating table on the big pension issues after 94% voted against the government’s pension proposals in our ballot. Unite members are being asked to pay more for a NHS pension scheme that brings in £2 billion more to the Treasury than it pays in pensions each year.

The April net pay for all staff at the top of band 5 and above was reduced because their pension contributions increased by 1.5 to 2.4%. This took place when staff are already experiencing cuts and sacrifices under this government.

The two-year pay freeze has been a real terms pay cut and the 1% cap on pay for the future will dramatically erode the value of pay for staff in the NHS. In addition this government is committed to regional pay, which will mean a further years of pay freeze for most of our members depending on where they live and work. Postcode pay is around the corner.

We also have staff cuts as part of the government’s £20 billion NHS ‘efficiency’ savings in England alongside proposed cuts to terms and conditions including sickness entitlements, and a move from an incremental based pay system to performance-related pay.

The current government NHS pension proposals mean you will be paying more, working longer and receiving less pension. This will result in people working in physically, mentally and emotionally demanding jobs into their 70s. This will not be possible, so they will be forced into early retirement getting even less for their pension.

It is vital that we send a clear message to government on 10 May. By taking action on that day Unite members will be saying they do not accept the significant sacrifices and losses the government is imposing on them. Members can find out more about the action on 10 May at the Unite website (www.unitetheunion.org/health) and from their Unite regional officer.

Together we can win this – join the action on 10 May!

Rachael Maskell
Fiona Farmer
Barrie Brown
National Officers, Unite Health Sector
Free to participate online learning event for Unite/CPHVA members

Following our highly successful regional health visitor road shows, we’re running some online training sessions which are free to access by our members. We are currently planning to carry out three sessions, with a view to running more.

Maximising the contribution of the school nursing team: A reflection on the Department of Health guidance

Wednesday 2 May 12:30 (approx. 1h30)

This session will be delivered by Rosalind Godson (Unite Health Sector Professional Officer). If you take part in this session, you’ll hear about the guidance issued by the DH in March, CPHVA’s activity on school nursing and you’ll have the chance to ask questions of Ros. This training is aimed at members who work in England, but members are welcome to join in from across the UK if they want to find out what’s going on in England.

The Health Visitor Implementation Plan: An update

Thursday 3 May 12:30 (approx. 1h30)

This session will be delivered jointly by Dave Munday (Unite Health Sector Professional Officer) and Pauline Watts (Department of Health Professional Lead for Health Visiting). If you take part in this session, you’ll hear about the background to the current situation regarding practice teachers, mentors and long arm arrangements and some of the thinking behind what the DH is doing to support on this issue. You’ll again have the opportunity to ask any questions.

I want to take part – what do I need to do?

You need to register a place on the training session that you want to take part in. You can do this from our website: www.unitetheunion.org/CPHVA.

How much will it cost to take part?

Members of Unite/CPHVA can take part in the session free of charge. However, you’ll need to phone in using your landline or mobile and this cost will not be covered. The phone number won’t be a premium rate number!

What will happen once I’ve registered?

- Once you have registered, you will be provided with the information you need to join the conference, including dial-in numbers and passcodes. Be sure to save this information to your calendar or print this information.
- On the day of the training, when you call you’ll be given a seven-digit access code. This will enable you to join in watching the presentation at join.me (but more about that in the next section).
- You will then listen and watch the presentation where ever you want to be and hopefully you’ll get lots of information!

So I’ll hear the presentation on the phone line. But how will I get to see it?

As well as using a teleconference line, we’ll also be live streaming the presentation to you. To be able to see the presentation ‘live’ you’ll need to access a website (http://join.me). Before the event we’d suggest that you familiarise yourself with join.me first by visiting their website and clicking on the ‘More’ tab and then clicking on “What is it?’ You can do this whenever you want.

Sounds complicated!

We hope that with a bit of planning you’ll find it reasonably easy to get the full benefit of the training. We’re going to do a couple of practice sessions where you can check join.me works for you. This will iron out any problems with local IT issues (for example, you need to have flash installed on your computer’ which most computers have as standard already!). We’ll let you know in advance when these tests will happen.

I really don’t want to do the join.me bit

As well as live streaming the presentation, we’ll also email the slides out to people just before the event so if you really don’t want to do the join.me bit or if something goes wrong on the day you can still be involved.

If that’s true, why are you bothering with join.me?

Apart from it being a good opportunity to test the software for future events where seeing the presentation will be vital, you can also write questions using a screen on join.me that the presenters can see. It then means they can answer them!

But can’t I just ask my question over the telephone?

We’re hoping to get over 50 people involved in each event (and could go up to 250) so I’m sure you’ll agree we’ll need to mute the call so the only person you can hear are the presenters.

Well if it’s free to me I might as well just book on and if I can’t be there on the day it’s not costing anyone?

We’ll be using a professional conference calling service as that’s the only way we can include so many people. Each individual line we book will have a cost attached to it so it will be really important that we book the right number of lines.

If people do book on, it’ll be really important that if they then can’t join in, they let us know!
Although many people think of tuberculosis (TB) as a problem of the past, levels of disease are increasing in London and other major cities and the disease remains a serious public health issue.

According to the Health Protection Agency (HPA), there were 9,042 reported cases of TB in the UK in 2011, a 5% increase from 2010. Almost 75% of these cases were among people born outside the UK and most were reported in London.

In March 2012 the National Institute for Health and Clinical Excellence (NICE) published new public health guidance with the aim of improving the way TB is identified and managed among groups of people who are hard to reach through traditional health care services. The new guidance sets out how commissioners and providers of TB services and other statutory and voluntary organisations that work with hard-to-reach groups can achieve better outcomes through targeted action to find patients early, and by providing intensive clinical and social support to help them complete TB treatment.

Traditional hospital and primary care services are not always the best way of reaching and treating some groups of people, and services can be hard to access for some vulnerable people. People who are hardest to reach include those with drug or alcohol addiction, vulnerable migrants, homeless people, and prisoners – they can all find it difficult to recognise TB symptoms and access diagnostic and treatment services.

They may also have problems in self-administering treatment, and attending regular appointments for clinical follow-up. This can lead to incomplete treatment with serious consequences: patients who do not complete treatment are not only at risk of a relapse, they may also develop a drug-resistant form of the disease which is more difficult and slower to treat – and which can also be transmitted to other people.

The burden of TB falls disproportionately on the most vulnerable groups in our society and the factors that make these groups vulnerable are also those that make them not only harder to reach through traditional TB services, but also less likely to adhere to treatment. This guidance therefore advocates a more proactive approach through, for example, active case-finding, which involves seeking evidence of infection or disease among people who might not otherwise present for care in a timely manner. It recommends finding active TB among homeless groups by using mobile X-ray teams in places where they congregate, such as homeless day centres, rolling shelters, hostels and temporary shelters.

The guidance also recommends that all hard-to-reach TB patients should receive community based clinical and social support co-ordinated by a TB case worker. Support should include directly observing every dose of treatment and providing practical help with housing, addiction and other unmet health and social care problems.

TB is curable, so it’s important that people at risk of TB from hard-to-reach groups are able to access services tailored to their needs that allow timely diagnosis and effective treatment.

The NICE guidance and implementation tools are available from: http://guidance.nice.org.uk/PH37

Microscopic image of Mycobacterium tuberculosis

You can now find Community Practitioner on Twitter: @CommPrac and on Facebook: www.facebook.com/CommPrac

Join in and join the discussion ...
Applications are invited from individual nurses, midwives and health visitors in England to participate in the prestigious Mary Seacole Awards programme for 2012/13.

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:

- The **Mary Seacole Leadership Awards** are up to £12,500 each and provide the opportunity to enhance effective leadership and communication skills.
- The **Mary Seacole Development Awards** are up to £6,250 each and provide the opportunity to develop leadership skills.

Applications for these awards will close on 1 May 2012. Interviews for all awards will take place on the following dates: 26 June, 4 and 5 July, 17 July and candidates, if shortlisted, will be required to attend. Application forms with further details can be obtained by email from bukola.samuel@dh.gsi.gov.uk or downloaded from the following website: www.dh.gov.uk/en/Aboutus/Chiefprofessionalofficers/Chiefnursingofficer under ‘Latest news’

-Unsure about applying? Come to a workshop! Check out the website for details of workshops for potential applicants taking place on 21 March in London and 22 March in Birmingham.

Mary Seacole Statue Appeal
Visit www.maryseacoleappeal.org.uk to find out more about the fundraising campaign to build a statue to honour Mary Seacole’s work.

You do not have to be a member of any of the participating organisations to apply, to access the website information or attend a workshop.

“The Mary Seacole Leadership Award provided a real launchpad to my work on addressing health inequalities and life chances of BME populations. I met people I had admired during my nursing career. I experienced pride, wonderment and occasionally fear, and embraced all opportunities. I would not be where I am today without this.” Laura Serrat-Green, Mary Seacole Leadership Award winner

“The Mary Seacole Development Award helped me grow as a nurse and pushed me to learn more, making a difference to my patients as I tailored care to suit their needs. I would highly recommend this to anyone.”

Opal Greyson, Mary Seacole Development Award winner
As it marks 150 years as a profession in 2012, health visiting is modernising to meet the needs of today's families. Health visitor recruitment is currently ongoing across England. The government aims to have 4,200 more health visitors in the workforce by 2015. A health visitor is a registered nurse or midwife who has undertaken further training.

Through their wider public health role, health visitors aim to improve the health of families and children in the first few years of life. Pauline Watts, Professional Officer for the Health Visitor Programme, comments:

"Working with all families providing a universal service, as well as supporting families with specific problems, such as a sleepless baby or a mother experiencing post-natal depression, health visitors develop strong relationships to support the needs of families. Health visiting is a diverse, satisfying and challenging role that suits those with an interest in health promotion, public health and working in the community."

Independent evidence underlines the importance of the role of health visitors:

"We have found overwhelming evidence that children’s life chances are most heavily predicated on their development in the first five years of life. It is family background, parental education, good parenting and the opportunities for learning and development in those crucial years that together matter more to children than money, in determining whether their potential is realised in adult life."

Frank Field, Independent Report on Poverty and Life Chances (December 2010)

Visit NHS Careers to read about training and development opportunities in health visiting
www.nhscareers.nhs.uk

Flexible and part-time working options for health visitors: Q&A

For health visitors who want to work flexibly, or part-time, options are available, whether or not you have started to collect an NHS Pension.

From 1 April 2008, there are two sections of the NHS Pension Scheme – the 1995 section for members who joined the Scheme before 1 April 2008 (including members with special class status) and the 2008 section for new joiners from 1 April 2008. There are no special class members in the 2008 section.

Q. Who can be a special class member?

A. Special class status applies to members of the 1995 Section who work as a nurse, physiotherapist, midwife or health visitor. To qualify you must have been awarded special class status on or before 6 March 1995 and at no time since have had a break in pensionable employment of five years or more. You must also hold special class status when you retire and have had this status for the five years leading up to retirement.

Special class members of the 1995 section may be able to retire from age 55 onwards. A fact sheet about special classes is available here: www.nhsbsa.nhs.uk/Pensions.aspx

Q. If I retire at 55, can I come back and work as a Health Visitor?

A. If you have retired and would like to return to work in the NHS, flexible options are available.

Although many pensioners will be unable to rejoin the NHS Pension Scheme after retirement, this does not mean that you cannot work again in the NHS. You do need to consider the effects of NHS re-employment on your pension, for example:

• if you return to NHS employment working more than 16 hours per week within one month of taking your pension it may be suspended until you cease work or reduce your hours
• your pension may be abated (reduced), until age 60, depending how much you earn in your reemployment.

Q. Having retired from working, if I return to work part-time is my pension affected?

A. Yes. Your pension may be suspended depending on how soon you return to NHS employment after retirement and may be abated (reduced) depending on how many hours you work in your new job. If you are thinking of returning to work in the NHS after retirement, speak to your employer, who may be able to help you avoid any suspension or reduction of pension.

Health visitors will offer a universal service to families, with targeted and tailored support for those who need it.

Health visiting: celebrating 150 years of the profession 1862-2012

Visit www.dh.gov.uk/healthvisitors or www.unitetheunion.org/cphva to find out more
UK Standing Conference on Specialist Community Public Health Nurse Education: ‘Positive Outcomes in Adversity’

The keynote speaker at this excellent one-day conference in London was Camila Batmanghelidjh, the founder of Kids Company, who is always worth listening to. She described how she has studied child psychotherapy and decided to set up a drop-in service as a place of safety for vulnerable young people in London several years ago. Ms Batmanghelidjh encompasses child and adolescent mental health as a crusade, and explained the neuro-physiological damage many children sustain owing to their adverse circumstances. She explained that the ‘system’ thinks that behind every child there is a ‘competent carer’ whereas, in fact, many children and young people suffer from ‘motherlessness’.

The model required is a combination of psycho/medico/social interventions. She asked whether budget holders are making ethical decisions when designing services for young people, and called for a Royal Commission to thoroughly examine the issue. For those who are not familiar with her work, visit: www.youtube.com/watch?v=mrk2wKN40j4

Catherine Kelsey, a Queen’s Nurse, described her research project, ‘a model of excellence for practice teachers’, and asked who is benchmarking practice-based evidence. She also gave a plug for the Queen’s Nurse award and asked those present to publicise it.

There was a presentation by Dr Jane March-McDonald on cultural notions of resilience, risk and protection, where she described Somali women’s approach to ‘strength’ as homemaker, but not outside the home. She thought that health professionals need to understand the role religion plays in society and be cautious about making assumptions about how individuals and communities respond culturally to adversity and life in exile.

Karen Downer, a school nurse, reported on a health-related absence project, which was set up to reduce sickness absence from school. The outcomes were positive, but would need resourcing. Parents were very keen on the pocket guide to illnesses they could fix to the fridge, and liked to be able to contact the school nurse each morning.

After an excellent buffet lunch, we continued with Wendy Wigley who explored ‘What influence might practice experiences have on pre-registration nursing students’ awareness and understanding of their own spirituality?’

This was followed by Lynn Sayer and Val Thrutle’s audit on SCPHN course data.

Group discussion centred on the pressures caused by the increase in health visitor students. Issues raised were cultural approaches to learning and the variable expectations and standards of students, leading to time-consuming monitoring and higher than desirable attrition rates. Some practice teachers do not realise that dyslexic students can get support from HR departments, in the form of computers and dictaphones.

There were plenty of networking opportunities, and delegates left with a renewed sense of camaraderie.

Rosalind Godson
Professional Officer
Unite Health Sector

Nurse First Programme

My name is Ruth Oshikanlu. I am a nurse, midwife and health visitor working in Tower Hamlets. I am also a member of the CPHVA. I have recently been selected for the first ever Nurse First Programme provided in partnership by the Queen’s Nursing Institute, Buckinghamshire University, the Shaftesbury Partnership and Johnson and Johnson. It is a 12-month programme designed to provide skills and knowledge to practitioners with the aim of creating new innovations in health care for the benefit of the community. As part of the programme, I have to take a project from idea to implementation within 10 months. (For further information please see www.nursefirst.org.uk).

Why I need your help ...

Over the last five years I have worked part-time in several primary care trusts with many health visitors. I have observed that morale is at an all-time low due to all the changes imposed on them. I am passionate about our profession and the great work we do with children and families. Often, the good work we as health visitors do is ignored, especially in this climate of cuts. I believe that a failure to invest in health visitors is a false economy. By improving the morale of HVs, this will increase their retention and help retain HVs and recruit people with the right mindset to the profession. Therefore, as part of the Nurse First Programme, I want to do some work on HV retention rates and motivation in HVs, particularly in London where morale is so low.

Calling all practising health visitors

If you are a practising health visitor, I would appreciate your help in finding out what the biggest challenge or problem you are facing as a HV is, and how you think this can be solved, by completing the online survey.

What will happen to the results?

All results will be anonymised. You will be sent the findings of the survey. They will also be published in a future issue of Community Practitioner. Finally, I will also use the findings from this survey to create innovative solutions with other health visitors. If you would like to take part in a focus group please send me your contact details.

If you require further information, please contact me by email: ruth.oshikanlu@bartsandthelondon.nhs.uk or on: 075577 49419.

I look forward to reading your responses.

Regards,
Ruth Oshikanlu

Visit the survey here: www.surveymonkey.com/s/V6G9GKF
Chernobyl Children

Twenty-six years after the Chernobyl nuclear disaster, the health of the children of the region continues to be seriously affected. Babies are now being born with cancer or leukaemia or with genetic disorders. For children constantly living in a contaminated environment, a four-week holiday abroad can provide a major boost to their damaged immune systems. Many of the Belarusian children invited to Britain by Chernobyl Children’s Project (UK) are in remission from cancer, and a ‘clean air’ holiday is particularly important for them, especially teenagers who get a great psychological boost from the experience.

The charity:
- Delivers much needed humanitarian aid to orphanages, schools and family associations
- Provides holidays in Belarus for children with disabilities from orphanages
- Has set up two small homes to give children and young people with disabilities a chance of family life
- Runs a Home Hospice Programme in Gomel
- Has set up the first overnight respite care centre in the country
- Provides training programmes which have been an important part of the process of moving children from institutional care into families.

The children whose lives have been blighted by this disaster will need our support for many years to come.

Chernobyl Children’s Project (UK) Registered Charity No: 1059832
11–13 Chapel Street, Glossop, SK13 8AT
Tel: 01457 852621/863534
Email: ccprojectuk@gmail.com
Web: www.chernobyl-children.org.uk

Book review: breaking the glass ceiling

No More Casualties: breaking the glass ceiling in the care profession
By Shirley Baah Mensah
ISBN: 9781780350158
Upfront Publishing
(2011)
£7.99

This book deals with the difficult topic of inequality in career progression for black and minority ethnic (BME) practitioners in the NHS, and unpicks the workings of health and social care from the perspective of ‘career casualties’. The author uses a narrative approach, threading the story of two nurses: Sarah James, a West Indian nurse, repeatedly passed over for promotion, and new West African staff nurse Adenike Oladejide. The issues are explained using the discourse between these two women. I liked the clarity of the policy reflection on recent and ongoing policy change. I found the liberal use of metaphorical language unhelpful at times: for example, a third party explanation of the NHS management structure was likened to Guinness, ‘black at the bottom white at the top’.

It is well documented that BME staff are worse off than white colleagues in respect of advancement in the NHS. The author is more powerful in her work when she steers clear of anecdotal and emotional language, and offers the reader the factual detail which I found to be more interesting. Using data the author asserts the over-representation of BME staff in disciplinary proceedings, bullying and other grievance procedures. Alongside this there is clarity in the discussion of under-representation of BME employees in the management structure.

I found all of the issues raised in this book interesting and thought-provoking. The story-telling narrative style was a little irritating for example the introduction of what the protagonists had to eat on a regular basis distracted somewhat from the importance and depth of the issues presented. However, I can appreciate that for some readers this style might be very welcome.

At the end of the book I wondered if the illusory guide ‘Judith’ was indeed the lightly disguised author showing the way forward. In these times of change no one could fault the information offered regarding the need to be outcome driven, to maintain and develop skills and to regard problems as opportunities. These wise words are useful for all nurses and particularly BME colleagues working in the changing NHS.

Anna Houston, Health Visitor
Fathers’ experiences following a complicated birth

The aim of this study was to describe fathers’ experiences of being on a postnatal ward and during the first days at home following a complicated birth. Fifteen fathers were interviewed, and content analysis was used for the analysis. The theme illustrated that fathers were a resource for both mother and child through practical and emotional engagement. The categories describe how the father empowers the mother and illustrates adapting to new family roles. Following complicated birth, fathers should be invited to stay around-the-clock on postnatal wards because it gives them the opportunity to place their resources at the disposal of mother and child. In antenatal courses, fathers should be prepared for their empowering role after a complicated birth. J Perinat Educ 20(2): 91–9

Injury in preschool children

Injuries in childhood are largely preventable yet an estimated 2,400 children die every day because of injury and violence. Despite this, the factors that contribute to injury occurrence have not been quantified at the population scale using primary care data. We used The Health Improvement Network (THIN) database to identify risk factors for thermal injury, fractures and poisoning in pre-school children in order to inform the optimal delivery of preventative strategies. Maternal depression, hazardous/harmful adult alcohol consumption and socio-economic deprivation represent important modifiable risk factors for thermal injury and poisoning but not fractures in preschool children. Since these risk factors can be ascertained from routine primary care records, pre-school children’s frequent visits to primary care present an opportunity to reduce injury risk by implementing effective preventative interventions from existing national guidelines. PLoS One 7(4): e35193

Young men and sexual health

Sexually transmitted infection testing rates among young men remain low, and their disengagement from sexual health services has been linked to enactments of masculinity that prohibit or truncate discussions of sexual health. This study explores the discourses that facilitate or shut down sexual health communication with peers and sex partners and explores how men’s conversations about sexual health are constituted by masculine hierarchies (such as the ways in which masculinities influence men’s ability to construct or challenge and contest dominant discourses about sexual health). Men’s conversations about sexual health focused primarily around their sexual encounters, something frequently referred to as ‘guy talk’. Also described were situations where participants employed a discourse of ‘manning up’ to exert power over others with disregard for potential repercussions and deploy power to affirm and reify their own hyper-masculine identities. By better understanding how masculine discourses are employed by men, their sexual health needs can be advanced. SocioHealth Illn doi: 10.1111/j.2047-9566.2012.01471

Ethnicity and childhood obesity in England

Some studies suggest that British Afro-Caribbean girls and Pakistani girls have higher levels of obesity than girls in the general population of England. However, the interplay between child obesity, ethnicity, mother’s socio-economic status and other parental characteristics is unclear and requires exploration. This study examines the relationship between child ethnicity and child obesity after controlling for a wide range of mothers’ socioeconomic characteristics and parental weight/obesity. Health Survey for England data (1999 and 2004) are used to examine 7047 children aged two to 15 years. Body mass index (BMI) for children is classified using the International Obesity Task Force age-specific BMI thresholds for obesity and overweight. Having overweight or obese parents is a stronger predictor of childhood obesity than ethnic origin of the child. Interventions aimed at reducing childhood obesity should focus on parental characteristics rather than the ethnicity of the child, but they also need to be sensitive to gender and ethnic differences. Pediatr Obes doi: 10.1111/j.2047-6310.2012.00051

Sickle cell and thalassaemia Working Group

A Working Group has recently been set up to develop core competences in genetics for sickle cell and thalassaemia counselling. The SCRT Screening Programme is trying to eliminate some of the gaps in training requirements for healthcare professionals who deliver antenatal and newborn screening for sickle cell and thalassaemia. The project will assist the development of Core Competences in genetics for sickle cell and thalassaemia counsellors. These new competencies will focus on counselling/advice, including counselling of ‘at-risk couples’ in pregnancy and advising families/carers of newborns who have a significant sickle cell or thalassaemia condition. This latter role may frequently be undertaken by health visitors. We very much hope to build on work which has already been done by the National Genetics Education & Development Centre (NGE&DC) so we hope this project can be undertaken fairly quickly and efficiently. The project Working Group will be chaired by Heather Skilton (Professor of Health Genetics, School of Nursing & Midwifery, University of Plymouth). The draft competencies will soon be out for consultation. If any members with a specific interest would like to be involved please email Irene Fynch: Irene.fynch@unitetheunion.org

Research evidence
Rickets revival – a return to Victorian health standards?

In February of this year, all four of the UK’s Chief Medical Officers decided to issue a follow-up to their warnings of 2011, after a resurgence of childhood rickets was recorded and fears of a return to Victorian-era illnesses is anticipated.

Chloe Harries
Assistant Editor

Dame Sally Davies, Dr Tony Jewell, Dr Michael McBride, and Sir Harry Burns (England, Wales, Northern Ireland and Scotland’s CMOs) wrote a letter to GPs, health visitors and community nurses to encourage better awareness of vitamin D guidelines and recommendations due to an alarming rise in illnesses linked to vitamin D deficiency.

The letter stated: ‘The National Diet and Nutrition Survey demonstrates that up to a quarter of people in the UK have low levels of vitamin D in their blood, which means they are at risk of the clinical consequences of vitamin D deficiency. It is important for public health that low levels of vitamin D are avoided. As health professionals, you can make a significant difference to people’s health by making those at risk aware of how important it is to make sure they get enough vitamin D, and how they can get access to these important daily supplements. We, the Chief Medical Officers, thank you for your continued help and support with raising awareness of this issue, which in turn should raise the levels of vitamin D in those at risk, and vulnerable groups.’

The dangers of deficiency

Vitamin D deficiency impairs the absorption of dietary calcium and phosphorus leading to bone problems such as rickets in children and osteomalacia in adults.

The at-risk groups identified include pregnant and breastfeeding women; children aged under five; people aged over 65; and dark-skinned people who have little exposure to the sun. The letter urges people to be aware of the ways in which they can access vitamin D naturally, recommended guideline daily amounts of vitamins, and of the different schemes that provide supplements to eligible individuals.

Dame Davies said: ‘A significant proportion of people in the UK probably have inadequate levels of vitamin D in their blood. People at risk of vitamin D deficiency, including pregnant women and children under five, are already advised to take daily supplements. Our experts are clear – low levels of vitamin D can increase the risk of poor bone health, including rickets in young children.’

Travelling back in time?

In the Victorian era rickets was a common ailment, but it was largely eradicated in the 1940s in the UK due to added fortifications of the vitamin to products like margarine and cereal. The most common cause of rickets is a lack of vitamin D and calcium.

In rare cases children can be born with a genetic form of rickets. It causes the bones to become painful, soft, and weak, leading to deformities of the skeleton, such as bowed legs, curvature of the spine and a thickening of the ankles, wrists and knees.

In older children, symptoms can include waddling when walking, bent bones, muscle weakness and pain. Rickets can be prevented by eating a diet that includes vitamin D and calcium and by spending some time in the sunlight. The disease can be successfully treated in most children by ensuring that they eat foods that contain calcium and vitamin D or by taking supplements. A child may need a higher dose or a yearly vitamin D injection if they have trouble absorbing vitamins.

Sir Harry Burns, Scotland’s Chief Medical Officer, said: ‘Health professionals can make a significant difference to people’s health by making those at risk aware of how important it is to make sure they get enough vitamin D and calcium and by spending some time in the sunlight. The disease can be successfully treated in most children by ensuring that they eat foods that contain calcium and vitamin D.’

It is thought that spending on vitamin D supplement prescribing, which has tripled from £28m in 2004 to £76m in 2011, will continue to accelerate and will hit £100m this year.
Healthy Start
A programme that offers access to supplements is the Healthy Start scheme. Pregnant women, or families with a child under four who are on certain benefits qualify, as do all women under 18, whether or not they are claiming benefits.

The vouchers can be spent on milk, fresh or frozen fruit and vegetables, and infant formula milk. Pregnant women get one voucher per week (£3.10); babies under two get two vouchers (£6.20); and children aged one to four get one voucher. Every eight weeks beneficiaries also receive green vitamin coupons with their vouchers, which they can swap for Healthy Start vitamins in their local area. The coupons are for the Healthy Start women’s tablets or Healthy Start children’s drops. It is the responsibility of the primary care and health trusts and health boards to make both of these products available locally to beneficiaries – and they may also sell them on to members of the general public if they wish to.

Dr Nick Harvey, spokesman for Arthritis Research UK and Senior Lecturer at the MRC Lifecourse Epidemiology Unit at the University of Southampton, said: ‘We believe that more research is needed to understand the role vitamin D supplements play in optimising bone strength and what the correct level of supplementation is.’

One case in particular highlighted the crucial need for vitamin D in pregnant women. In a recent Old Bailey trial, a judge instructed a jury to find a couple not guilty of shaking their four-month-old baby to death, as a post-mortem had clearly shown that the baby was suffering from a severe case of rickets. The rickets had caused the bones and skull to weaken and fracture very easily, mimicking the effects of deliberate shaking. The baby’s mother had been found to have so little vitamin D in her body when pregnant that the baby had not received the vitamin either in the womb or through breastfeeding. Although this is an extreme example, it is a fact that a lack of vitamin D can be fatal in some circumstances.

The ‘sunshine vitamin’
One factor affecting people’s intake of vitamin D is likely to be covering up from the sun for fear of the health risks of being exposed to too much ultraviolet sunshine (UVB). Although the risks of melanoma should not be ignored or taken lightly, small bursts are advised, as exposure to sunlight is the most effective way to absorb vitamin D.

British Dietetic Association spokesperson Laura Watson explains: ‘“Vitamin D” is an umbrella term used to describe the many forms of a fat-soluble steroid. Sometimes called the “sunshine vitamin” most of our intake occurs as a result of the interaction between our skin and exposure to direct UVB sunlight. Our diet can also contribute, although to a lesser extent. We require vitamin D to help to maintain plasma calcium concentrations within the normal range.’

Regular, short periods of UVB exposure without sunscreen during the summer months are enough for most people; however, thanks to the unpredictability of the climate, air pollution, latitude, more time spent inside and the increased use of sunscreen when we do have sunny days, there is growing evidence of sub-optimum levels. Around 90% of our vitamin D is made in the skin with the help of sunlight, which converts the cholesterol found in every cell to the vitamin. Ideally, vitamin D levels should be around 75 nanomoles per litre of plasma (nmol/L) or more. Fewer than 25 nmol/L is considered deficient.

Arthritis Research UK Medical Director, Alan Silman, explains: ‘Vitamin D is essential for strong, healthy bones. Our advice to people is to step outside, as this is the best way to get vitamin D. When the days are sunny, go out for a few minutes and expose your face and arms to the sunshine. Don’t allow your skin to go red, and take care not to burn, particularly in strong sunshine and if you have fair or sensitive skin. From June to August just 15 minutes is generally enough time.’

Nick Harvey agrees: ‘Young women and mothers can top up their vitamin D levels by getting enough sunshine on their skin – enjoying the sun safely, while taking care not to burn. The time needed to make sufficient vitamin D varies according to a number of environmental, physical and personal factors but it is typically short and less than the amount of time needed for skin to redden and burn. Eating a healthy balanced diet, including more oily fish and foods fortified with vitamin D, such as breakfast cereals and some margarines can help. There is significant research to suggest that bone strength starts at birth or even in the womb. Arthritis Research UK is currently funding research at Southampton University to prove that giving vitamin D supplements to pregnant women who are deficient in the vitamin can increase the bone density of their babies at birth and reduce the risk of their babies developing osteoporosis in later life.’

In a recent study, Caucasian British people were given a simulated dose of a summer exposure to sunlight, while dressed in casual summer clothes that revealed a third of their skin. These controlled conditions (the equivalent of 13 minutes of midday exposure to the summer sun given three times a week for six weeks during winter) raised 25(OH)D levels to greater than 50 nmol/L in 90% of people and greater than 70 nmol/L in 26% of people. The true amount of time may be greater and will vary depending on other factors including posture, time of day, outdoor activities, and the presence of shade.

The way forward
In Wales plans are already under way to improve the rate of vitamin D consumption. A government health spokesman said: ‘The uptake of Healthy Start vitamins is lower than we would like in Wales, as in the rest of the UK. To address this, the Welsh government has been running a pilot in Cardiff to explore different approaches to the distribution of vitamins in order to maximise uptake. Results of the pilot so far have demonstrated a significant improvement. It has another six months to run, but following the evaluation of this work, the lessons learnt will be applied across Wales to improve awareness and distribution, and we hope will lead to a substantial increase in the uptake of Healthy Start vitamins, and hence the vitamin D status of some of those most at risk.’

However, a Scottish government spokesperson said: ‘Given that research and surveillance data point towards inadequate awareness and intake within at-risk groups, our primary focus at present must be on encouraging compliance with current guidelines. We have no plans at this time to change the recommended levels of supplement.’
Join more than 500 public health professionals as we celebrate the 150th anniversary of public health nursing practice at this year’s Unite/CPHVA Annual Professional Conference and Exhibition and:

• Get up to date with policy development that will affect practice in the coming year, including the new GP led commissioning
• Discover the best innovations and working practices from around the UK
• Receive an update on the Implementation Plan for Health Visiting and the Development Plan for School Nurses
• Review the new employment destinations of nurses after the closure of PCTs
• Discuss the safeguarding of children and the rules and practices needed
• Understand the impact of information technology on the work of nurses across the community
• Look at the issue of social networking in promoting health, but also creating risk for children and professionals
• Learn from different experiences in Scotland, Wales, Northern Ireland and internationally
• Examine the evolving regulations and standards environment, and their implications for health visitors and community nurses
• Discuss whether public health nursing is going back to its local government and community roots

Who should attend
Health visitors, school nurses, community nursery nurses and associated colleagues throughout the UK

Event Highlights
Community Nursery Nurses’ Symposium
Research and best practice seminars
Masterclasses
Educational poster display
The Nick Robins’ Memorial Lecture
More than 50 exhibitors
150th anniversary party
Drinks reception
Fringe meetings
Free exhibition visitor workshops
Professional visits

Confirmed Exhibitors
✓ Unite/CPHVA
✓ Aptamil
✓ Pfizer Nutrition (SMA)
✓ The London Orthotic Consultancy Ltd
✓ Johnson’s Baby
✓ Solihull Approach
✓ Journal of Family Healthcare
✓ Genus Pharmaceuticals
✓ Nursing and Midwifery Council
✓ Lansinoh
✓ Cow & Gate
✓ Sudocrem - Forest Tosara Ltd

Register at www.neilstewartassociates.com/cphva
From 1908 to 1927, the role of health visitor began to receive more recognition, both in the community and legally. In London, the London County Council (General Powers) Act of 1908 gave qualified health visitors legal status, allowing local authorities to employ and pay them as health visitors, rather than calling them sanitary inspectors. The Act, which took effect in 1909, listed a number of different methods of qualification for the role, including receiving a certificate from the Royal Sanitary Institute (RSI), which began setting examinations in 1908. In 1918, the Maternity and Child Welfare Act launched, effective nationalising what had been done with the 1908 London Act, as it gave local authorities the power to employ health visitors. In 1925, the Ministry of Health, established in 1919, took over the training of health visitors and appointed the RSI as the sole central examining body.

The Women Sanitary Inspectors’ Association (WSIA) also evolved during this time. It held its first conference in 1910, although this did not become an annual event until 1931. It changed its name in 1915, becoming the Women Sanitary Inspectors’ and Health Visitors’ Association (WSIHVA), reflecting the growing status of health visiting as a separate entity. In 1918, it registered as a trade union, joining the Women’s Trade Union League, then in 1924 affiliating with the Trades Union Congress, becoming the first health service to do so. Finally, in 1927, the WSIHVA released its first journal, *The Woman Health Officer*.

By Julia Miller

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The Royal Sanitary Institute sets the first health visiting examinations, issuing a certificate of completion to those who pass. It remains the examining body until 1965.

At the same time, the London County Council (General Powers) Act of 1908 allowed the local government to hire qualified health visitors as such, rather than hiring them under the umbrella of ‘sanitary inspector’. The practice officially began in 1909.

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The WSIHVA registers as a trade union. Also, the Maternity and Child Welfare Act gives local authorities the ability to fund services like health visitors and day nurseries. This is similar to the 1908 act in London, but instead nationalises the practice of providing health visitors to families.

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The WSIHVA publishes its first journal under the title, *The Woman Health Officer*.

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The WSIHVA undergoes its first name change, officially becoming the Women Sanitary Inspectors’ and Health Visitors’ Association (WSIHVA), reflecting the growing awareness and legitimacy of the profession of health visitor. The two remain in similar realms, but begin to split into two distinct professions.

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The Ministry of Health becomes responsible for the training of health visitors from the Board of Education. It declares the RSI as the sole central examining entity for health visitors.
Breastmilk

Aptamil

Cow & Gate

HiPP

SMA

LCPs*  Nucleotides  Galacto-oligosaccharides (GOS)  Fructo-oligosaccharides (FOS)  Antibodies  Other

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The financial benefits of breast feeding should be considered before bottle feeding is initiated. Failure to follow preparation instructions carefully may be harmful to a babies health. Infant formula and follow up milks should be used only on the advice of a healthcare professional.
Leading in practice: a case study of how health visitors share and develop good practice

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Abstract
The aim of this study was to find out more about health visitors’ current situated practice in the context of national policy drivers outlining a new lead role for them in delivering co-ordinated and integrated services for children and families, tailored to local needs. The study focused on health visitors within a recently merged primary care trust and a qualitative approach was adopted with use of focus groups to generate data. The transcripts were subsequently analysed for key themes and dimensions. These related to how health visitors define their own role and the skills with which they carried it out, the development of their expertise, role tensions and factors affecting leadership development. By drawing together the grounded experience of health visitors, policy drivers and theoretical interpretations a rich picture of existing practices was established, with recommendations made to promote distributed leadership and change.

Key words
Situated practice, policy drivers, integrated services, role tensions, distributed leadership, relational agency


No potential competing interests declared

Introduction and background
The particular expertise of health visitors in supporting children and young families was recognised in a government report outlining the future of health visiting, Facing the Future (Department of Health (DH), 2007) and they were seen as central in delivering the Child Health Promotion Programme (DH, 2008), now called the Healthy Child Programme (HCP) (DH, 2009a). In it there is ‘an agreed and defined lead role for the health visitor … to ensure that the various practitioners contributing to the [HCP] communicate with one another and provide a holistic, co-ordinated service tailored to local needs’ (DH, 2007: 67).

Pilot schemes have been put in place to test the role and explore the training and support needs of health visitors to lead the HCP. Subsequently, a report was published on the first phase of Action on Health Visiting Programme called Getting it right for children and families (DH, 2009). This defined five key areas of work for health visitors covering both leadership of multi-skilled teams to deliver the universal HCP and targeted support for vulnerable families.

The importance of health visiting in government policy has been further reinforced and a momentum developed by a recent commitment in the 2010 spending review to invest in 4,200 new health visitor positions by 2015. The Health Visitor Implementation Plan 2011–15 (DH, 2011) outlines the key role health visitors will play in providing support to children and families. The approach is progressive, ranging from signposting to community services and ‘universal’ delivery of the HCP, to ‘universal plus’ for more acute needs through to ‘universal partnership plus’ for complex and ongoing needs requiring multi-agency input. The role of health visitors, in conjunction with other professional groups, in relation to safeguarding and child protection is flagged and, in addition, there is greater emphasis placed on building community capacity and taking on community leadership roles.

Purpose and aims of the study
The study was carried out in partnership with a primary health community trust and supported with a Higher Education Funding Council in England grant allocated to the Open University Centre for Excellence in Teaching and Learning. The broad aim was to generate qualitative data related to the situated practice of health visitors and interpret this with reference to policy drivers and conceptual frameworks in order to provide insights to underpin recommendations to the trust. The data generated by the focus group interviews were interpreted through frameworks related to a ‘communities of practice’ approach (Wenger, 1998; Wenger et al, 2002) and by drawing on other relevant literature related to workplace learning (Eraut 2007 and Gherardi, 2006), inter-professional collaboration (Edwards et al, 2009) and leadership (Chreim et al, 2010; Harris and Spillane, 2008). The study aimed to explore the following areas:

• Participant perceptions of their role and skills with a particular emphasis on leadership dimensions and the extent of their influence
• How participants coped with new challenges, difficulties or problems
• How they shared expertise (to benefit from or act as a resource for others)
• How they worked with other agencies on shared agendas.

Method and data collection
Approval for the study was granted by the internal Research and Development Team via Learning and Development and Clinical Effectiveness committees. It was established through a local Research Ethics Committee that the study did not need to go through formal ethics review.

Four focus groups were organised (total sample=32) with health visitors drawn from two primary health community trusts (two focus groups per trust). There were challenges in getting this level of engagement due to workload pressure issues and the sample was self-selected rather than purposive. This provided limitations in terms of representativeness and generalisability and the study provided a snapshot in time rather than being longitudinal. However, it is recognised...
that the purpose of focus groups is varied (Barbour, 2010) and in this instance the aim was aligned to action research. It was hoped that by engaging health visitors in a process of discussion and reflection that this would in itself contribute to changes in perspectives and practice. Health visitors were reassured about confidentiality and agreed to verbatim quotes being used anonymously in the report to the trust and in any subsequent published work. A broad framework of questions was used for the first focus group based on the defined areas outlined in the previous section and the discussion was recorded, transcribed and analysed through categorisation of key themes. As data were restricted to transcripts from four focus groups this categorisation was done manually rather than through a software package. Authors undertook the task independently and discussed and refined categories until consensus was reached. The key themes were used to shape the framework of questions for subsequent focus groups and a similar process undertaken to identify dimensions of the themes, with ongoing dialogue between the three authors to challenge and refine these emergent dimensions and cross-check the validity of the initial categorisation. The authors met at intervals as a research steering group to interrogate the data as described and also to make iterative links to theory. Two of the authors were involved in moderating the focus groups and were able to add additional insights into group dynamics, mood of the group and non-verbal behaviour.

Results and discussion
The main themes emerging from the data and their dimensions are found in Table 1.

### Theme 1: Role, knowledge and skills
The data reflected a focus on early intervention and health promotion in relation to children from 0 to 4 years old and their families. Participants acknowledged the value of initial training in preparation for the role, but stressed the importance of gaining experience while having an effective management structure:

*Although university gave me the paper qualification it didn’t necessarily give me what I needed to actually be a ground-based worker.* (Focus group 2)

They emphasised the contextual nature of their ‘insider knowledge’ comprised of useful information about family networks in a particular community:

*‘When you drive a taxi in London you have to learn what’s called The Knowledge to know where the streets are, so I call it the Health Visitors’ Knowledge ... you are aware of what issues might be impacting, so you can direct your questioning ... to be more focused.’* (Focus group 2)

This reflects Eraut’s observations that professional knowledge and understanding is often tacit and takes the form of shared meanings and understandings which have not been codified (Eraut 2007) and are actively created rather than acquired from established sources (Gherardi 2006). Participants did make reference to codified knowledge such as research-based evidence but less frequently, with no applied examples and keeping up to date with government policies and directives and current practice debates was generally seen as an individual responsibility. The distinction between codified and non-codified knowledge is similar to the distinction made by Appleton and Cowley (2008) between propositional and non-propositional types of knowledge. In their study of health visitors’ assessment of family health needs they undertook a detailed categorisation of different types of knowledge utilised and were able to identify more frequent applied examples of propositional knowledge, possibly because they were involved in direct observation of practice (Appleton and Cowley 2008). The need to know ‘who’s who and what’s what’ (focus group 2) highlighted the local nature of knowledge and the skills of health visitors in establishing relationships with different groups to access their knowledge and expertise. This type of ‘know who’ is discussed in Edwards et al 2009 as an important, but not sufficient, skills component important in the development of relational agency. This is a ‘capacity for working with others to strengthen purposeful responses to complex problems’ (Edwards et al, 2009: 133) and is particularly relevant to inter-professional work where challenging issues can be examined from a range of different perspectives to give enhanced insights and stimulate new forms of action. Health visitors were able to give some specific instances of inter-professional dialogue that had developed their understanding and...
practice and stressed that being challenged by colleagues and challenging them are important learning opportunities. Participants valued their universal, proactive and preventative role and the privileged non-stigmatising access they had to families. They identified communication skills as essential in undertaking an holistic assessment of family needs and the critical importance of relationship building in being able to work effectively with families, ‘when you know you’ve developed that relationship that’s huge … you think I’ve actually got there, I’ve cracked it’ (focus group 3). Participants also gave examples of signposting, referral and co-ordination skills entailed in forming effective formal and informal networks and partnerships with colleagues and a range of agencies. Their role in referral and co-ordination is also flagged in the DH (2011) document, but this falls short of collaborative work and what Edwards refers to as the building of common knowledge, that is a key factor in the development of relational agency across boundaries of practice (Edwards, 2005; 2011).

The unpredictability of practice was highlighted and this required skills in time management and complex decision making around priorities: ‘You’ll get a phone call and that’s it ... you know they [planned visits] have to go by the wayside and you could have a domestic violence case where you’re there for a few hours, and it’s juggling.’ (Focus group 2)

Making decisions and professional judgements were flagged in relation to child protection issues in particular, and this was a recurrent area of concern for health visitors. Judgements were often couched in terms of knowing when to refer and supporting families at risk was identified as the main focus of their role.

**Theme 2: The development of expertise**

Participants identified various factors they saw as helping them to undertake their work effectively and develop expertise against other negative factors that mitigated against this (see Table 2). Participants in all four focus groups stressed the importance of informal peer support and guidance and valued opportunities for shared learning. They also said that supervision had a key role in their development and identified a range of functions of supervision including maintaining and demonstrating accountability, facilitating professional learning and development and providing personal support. There was a view that the potential richness and supportive dimension of supervision is compromised if it is reduced to ‘ticking boxes’ and there were negative comments about what participants saw as a ‘managerial structure’ of clinical supervision which over-stretched the supervisors in terms of the number of people they had to supervise and excluded practitioners employed at Band 6 level. In any change process, capacity for effective supervision that encourages reflection on an ongoing dynamic situation is essential and there are risks in adopting an approach that ‘may discourage learning, reflection and knowledge sharing – for instance by putting value exclusively on individual tasks and performance’ (Wenger, 2002: 156).

Peer relationships between health visitors, relationships between health visitors and supervisors and between health visitors and other colleagues within their immediate domain eg, community nursery nurses might be said to constitute their ‘community of practice’ (Wenger, 1998). However, an exclusive focus on their community of practice as the site for knowledge sharing, learning and development would minimize the importance of learning across professional boundaries (Akkerman and Bakker, 2011). This is of particular relevance to health visitors as they are positioned at the boundaries between nursing, public health and high input safeguarding, between general practice and children’s centres and between the NHS, Local Authorities and the voluntary sector.

**Theme 3: Role tensions**

The main tensions identified from the data have been categorised along four dimensions related to: autonomy and integration; universality and targeting; flexibility and standardisation and quantity and quality. In the transcribed data it could be seen that these tensions were played out against an organisational, regulatory and policy context and were potentially influenced by the extent to which health visitors were located within their own community of practice or engaged in multi-professional and inter-agency practices (see Figure 1).

Participants valued their standing as ‘autonomous practitioners’ and there was some evidence that any change brought with it fear of losing that autonomy and professional identity: ‘It’s almost they are afraid to let go of that model and then if they did come into the bigger team and share more … oh dear, what may happen … I think there is a lot of that.’ (Focus group 1)

This relates to the work of Edwards et al (2009) where findings from their study highlighted practitioner concerns about loss or dilution of their professional identity and losing their specialist and core expertise in more integrated ways of working: ‘The negotiation of changing identities is perhaps particularly challenging for practitioners who are relatively low status and who work in systems of high accountability’ (Edwards et al, 2009: 26).

This can become a barrier to change with practitioners holding on to established ways of working that maintain existing identities. Participants spoke of ‘excellent relationships’ with other healthcare professionals and social workers and ‘good links’ with Sure Start. Some participants found it helpful, particularly in terms of professional support and networking,

### Table 2. Factors participants saw as helping them to undertake their work effectively

<table>
<thead>
<tr>
<th>Supporting development of expertise and effective practice</th>
<th>Increasing vulnerability and mitigating against effective practice</th>
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<td>Sense of achievement and enjoyment</td>
<td>Heavy workload</td>
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<td>Positive feedback from clients</td>
<td>Feelings of guilt/blame culture</td>
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<td>Management support to encourage innovation, flexibility and working through challenges</td>
<td>Working in the dark, having to ask permission</td>
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<td>Support from peers and other colleagues</td>
<td>Isolation and feeling overwhelmed</td>
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<td>Opportunities for shared learning</td>
<td>Being out of control</td>
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to be attached to a GP practice. Problems in having a truly integrated workforce were identified, such as the bureaucracy related to shared decision-making:

‘You share those concerns early on and unfortunately they wait till there’s a crisis mode before they actually say there is a need.’ (Focus group 1)

There were criticisms of some of the tools of integrated working such as the Common Assessment Framework. Selbie (2009) also found that health visitors in her study were not convinced that the tools they had at their disposal supported them in their role of management of risk to children.

The increased focus on targeted child safeguarding, in the context of national pilots of the Nurse-Family Partnership Programme (DH, 2009c), has impacted on the amount of time spent on universal ‘public health’ and there was some unease about this.

There were concerns about being ‘too much of a generalist’ and indications that individuals rose to the challenge of child protection – ‘I just think I get a buzz from it’ – and could, therefore, play a significant role in more intensive work with vulnerable families.

However, there was also a view that over-specialisation in child protection could lead to ‘burn out’ and being ‘de-skilled’ in certain areas (focus group 2). An associated dilemma was that targeting services can bring with it stigmatisation and act against building trust and relationships; a highly valued aspect of the health visitor role.

There was much debate in all the focus groups about whether the effectiveness of health visitor practice could be measured accurately and concerns about whether quantitative evidence really reflected the nature and the quality of the work undertaken:

‘A eureka moment for a family that’s been very difficult to engage is when they pick up the phone and ask you something – that is a massive shift for that family. A commissioner wouldn’t be interested – I cannot see them being interested in that ... because it’s of no consequence, it doesn’t bring any money in.’ (Focus group 3)

There was a firm view that the recording and standardising of the number of visits alone in response to regulation did not reflect the quality of the work or the flexibility and autonomy required to be an effective practitioner.

**Theme 4: factors affecting leadership development**

Leadership is a key dimension of the health visitor role, identified in policy documents and outlined in the NHS Leadership Framework; but this was the area that participants found most difficult to articulate directly. The dimensions identified that impacted on leadership development included role clarity, combining hands-on delivery of services with a leadership role, professional barriers to effective partnership work and organisational culture.

In terms of influence, health visitors talked about their influence on children and families (although they acknowledged this was difficult to quantify) but there were more limited examples of influencing other professional groups: ‘GPs very much ask our opinion, and will use us as a resource’ (Focus group 4). Although some shared activities and positive relationships with colleagues from other professions were highlighted: ‘We have got a good relationship with the social services, they do address our concerns and they think very highly of us ...’, these appeared to be mainly in the form of information giving or sharing and referral rather than more in depth collaborative work that would give more opportunities for influence and leadership.

The data reflected the view that their practice role lacked boundaries: ‘Health visiting is so poorly defined in terms of the job description it’s like if you’ve got a job and nobody else fits into the category give it to the health visitor’ (Focus group 3) and this is potentially exacerbated by new policy drivers to take on enhanced community leadership and capacity building roles (DH, 2011). Participants emphasised the amount of stress created by depth collaborative work that would give more opportunities for influence and leadership.

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**Figure 1. Health visitor professional and practice based analysis tool**
influencing and shaping them; and that they are generally in the dark about the direction of change and feel powerless and disengaged from decision making processes. There are tensions around paying lip service to the notion of distributed leadership without creating the organisational conditions in which health visitors are able to draw upon and develop their skills in building relationships of trust and influence to drive forward change.

The logical corollary of more distributed leadership is a flatter, less hierarchical structure with more opportunities for engagement and participation of key groups to influence and effect innovation and change.

**Recommendations**

Areas for consideration to initiate change in the direction of policy drivers are based on the perspectives of health visitors and aligned to the perspective of distributed leadership and change and Edwards’ framework for inter-professional working discussed previously:

- Clear vision articulated and communicated within and across all organisations responsible for universal/targeted service provision for children and families
- Consultation and specification of new role(s) within this broader vision. Clarification over combination of leadership role and universal delivery of services plus more intensive targeted input to vulnerable families
- Increased organisational capacity for delivering supportive and developmental reflective supervision (to cover both generic and child protection practices)
- Specific areas for multi-professional work and service improvement identified to enable health visitors to take on distributed leadership roles
- Training needs analysis with a focus on leadership development needs
- Time frame that enables systemic learning – ie, interaction between practitioners learning about new ways of working and shaping of broader strategies.

**Conclusion**

The study has highlighted a number of challenges in the current health visitor role including workload pressures, role overload and lack of inter-professional influence. There was some evidence of disaffection and negativity within the focus groups but also a wealth of evidence related to skills and expertise in networking, co-ordination, use of

**Key points**

- Health visitors draw heavily on local contextualised knowledge in their day-to-day practice rather than codified, research-based knowledge
- Valued ways of working with clients, peers, managers and other professionals are based on building relationships of trust
- Role tensions within the health visitor role need to be understood and accounted for in plans for change
- Recommendations for change are based on actions to clarify vision and roles and promote collaboration, distributed leadership and influence

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Parents’ evaluation of ‘Understanding Your Child’s Behaviour’, a parenting group based on the Solihull Approach

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Abstract
Understanding Your Child’s Behaviour (UYCB) is a 10-week parenting programme based on the Solihull Approach model, which has previously been shown to reduce problematic behaviour in children. This study examined the views of 236 parents of all literacy levels who attended 37 UYCB programmes provided by the Solihull Borough’s children’s workforce between 2005 and 2010. Simple weekly evaluation forms were used to gather both quantitative and qualitative data. Ninety-five per cent of parents reported that they found the group relaxing, 89% found it very effective at helping them make changes to their parenting and 88% found it very helpful for understanding their children. Qualitative themes demonstrate that the group enables parents to implement the three cornerstones theories of the Solihull Approach: containment; reciprocity and (sensitive) behaviour management in their parenting. The study also supports the National Institute for Health and Clinical Excellence (NICE) guidelines that parenting programmes should be eight to 10 session long.

Key words
Solihull Approach; Understanding Your Child’s Behaviour; parenting group; parental satisfaction; parent–child relationship.

Introduction
The Solihull Approach Parenting Group, ‘Understanding Your Child’s Behaviour’ (UYCB), aims to help parents with universal to complex issues concerning children aged 0 to 18 years by enhancing the parent-child relationship and promoting a reflective style of parenting. The Solihull Approach (Douglas, 2012) has used the psychotherapeutic concept of containment (Bion, 1959), combined with the child neurodevelopment concept of reciprocity (Brazelton, 1974), and learning theory’s behaviour management as the basis for developing a relationship model that focuses on providing a containing experience for parents so that they are able to be calm, process emotions and retain the capacity to think.

This, in turn, enables parents to be more in tune with their child’s feelings and developmental needs so that, where necessary, they can use individualised, sensitive and appropriate behaviour management strategies with their children. Douglas (2010) argues that combining these theories contributes to positive emotional and mental wellbeing in both the parent and child.

Systematic reviews have consistently shown that parenting programmes are effective in improving behaviour problems in young children (Barlow, 1999; Barlow et al, 2010; Barlow and Stewart-Brown, 2000; Gibbs et al, 2003), children with conduct disorder (Dretzke et al, 2009) and teenage children (Barlow et al, 2011). Bateson et al (2008) demonstrated that attendance at a UYCB group results in a decrease in problematic behaviour in children (as measured by the Strengths and Difficulties Questionnaire, and the Child Behaviour Checklist) and can significantly decrease the anxiety of parents (as measured by the Becks Anxiety Inventory).

Parental satisfaction with group-based interventions tends to be high, with parents citing the support they receive from other parents, including a mirroring of problems as beneficial (Barlow and Stewart-Brown, 2001).

In a review of a range of parenting programmes 97% of parents indicated that they had enjoyed the programme they attended and 83% reported that it had been successful in improving their child’s behaviour at home (Hallam et al, 2004), although the sample size was small in this review (n=73 parents attending up to 30 different programmes). The purpose of this study was to measure parents’ views about the UYCB programme.

Method
UYCB is a parenting programme that takes place two hours a week, for 10 weeks, and which forms the basis of the universal level parenting support strategy in Solihull to parents and carers of children aged between birth and 18 years. Up to 15 programmes ran each term from September 2005 to July 2010, grouped into parents of children aged 0 to 4, 0 to 11 and 10 to 18 years, during the day and evening in children’s centres, schools, community buildings, church centres and health clinics across the borough. Parents self-referred but were required to commit to

Table 1. Programme sessions

<table>
<thead>
<tr>
<th>Session</th>
<th>Title</th>
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<tbody>
<tr>
<td>1</td>
<td>Introduction</td>
</tr>
<tr>
<td>2</td>
<td>How are you and your child feeling?</td>
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<tr>
<td>3</td>
<td>Tuning into your child’s development</td>
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<tr>
<td>4</td>
<td>Responding to your child’s feelings</td>
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<tr>
<td>5</td>
<td>Different styles of parenting</td>
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<tr>
<td>6</td>
<td>Parenting child partnership – having fun together</td>
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<tr>
<td>7</td>
<td>The rhythm of interaction and sleep</td>
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<tr>
<td>8</td>
<td>Self-regulation and anger</td>
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<tr>
<td>9</td>
<td>Communication and attunement – how to recover when things go wrong</td>
</tr>
<tr>
<td>10</td>
<td>Celebration</td>
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</table>
analysed using Content Analysis, a qualitative methodology that involves identifying coherent and important themes, patterns and examples in the data (Patton, 1987). The percentages of responses for each of the three points on the visual Likert scale, at each session, are shown below (Figure 1). Of note is that the ‘poor’ response is consistently low (0 to 2%) across all three questions, indicating that at least 98% of responses were neutral or positive at all data points across the 10 sessions.

From the very first session the vast majority (82%) of parents reported finding the group relaxing and felt it was a place they could share experiences. Figure 2 shows that the number of parents reporting ‘great’ in response to this question steadily increased across the 10 sessions and that by the end of the group this reached an impressive 95%.

The extent to which the programme helped parents to understand their child is shown in Figure 2. Only 52% scored this as ‘great’ in session one but this increases session by session reaching a consistently high level (81 to 82%) in the latter half of the group (sessions six to nine) finishing at 88% by the last session. Of note is a ‘dip’ at session 5 which is rated ‘great’ at helping parents to understand their child by fewer parents (62%) than previous sessions (76% at session four). The content of session five focuses on parenting styles and intergenerational patterns of parenting, and thereby purposefully shifts the focus away from the child. It is considered by facilitators to be a powerful session, usually involving a great deal of self-reflection, and is often the first time parents share emotionally vulnerable content with other parents at all 10 weeks; they were not permitted to join after session 2 and if two consecutive sessions were missed they could not continue with the programme. Detailed demographic data were not collected. Parents known to have complex issues were redirected to other services, such as Mellow Parenting, Child and Adolescent Mental Health Services (CAMHS) or children’s services. Programmes were free to attend, including free crèche where necessary.

Two professionals from a range of agencies (health visitors, school nurses, education welfare officers, family support workers, extended schools child and family support workers, psychologists, education workers, learning mentors), who had attended a two-day Solihull Approach Foundation training, plus a one-day UYCB facilitation training, facilitated one or more of the 37 groups. A manual set out the content and methods (presentation, group discussion, role play, video, homework setting) for delivering the programme, and mentoring was provided by the local CAMHS service (see Table 1 for session content).

Data were collected via simple, weekly evaluation forms designed specifically for UYCB and piloted with 72 participants (Bateson, 2008) (see Table 2).

The use of a simple visual Likert scale enabled parents of all literary levels to respond. In the final session open questions were added to those in Table 2. These were:

- What do you feel has changed as a result of you being in this group?
- What do you feel you have learned in this group?
- Any other comments?

Parents were familiarised with the form by facilitators and each parent was asked to complete it anonymously every week before they left the group.

Ethical approval was not required as the study is classed as a service evaluation (National Research Ethics Service, 2009).

Results

There were 37 groups during the data collection period, with a total of 345 attendees. Attendees are defined as parents/carers who joined the programme by session 2 and missed no more than two consecutive sessions. There was an average response rate of 58% (n=200), with a maximum of 236 respondents in session 2, and a minimum of 137 in session 9. See Figure 1 for response rates. A total of 199 parents responded to the open questions in session 10, giving 404 comments.

The Likert scales were converted into numerical scores. These data were then subjected to descriptive statistical analysis, enabling comparison between individual sessions, as well as an evaluation of parents’ overall satisfaction with the group. Open questions were

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Table 2. Weekly evaluation form

<table>
<thead>
<tr>
<th>How was the session today?</th>
<th>Great</th>
<th>OK</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>To help you relax and share experiences?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To help you understand your child better?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To help you identify any changes you want to make?</td>
<td></td>
<td></td>
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group members. Interestingly there is no such reduction in the percentage of parents reporting session five as ‘great’ at helping them make changes (see Figure 3), suggesting that a focus on parents themselves, rather than their children’s feelings and behaviour, does not diminish the likelihood of change occurring.

The percentage of parents who gave the highest rating in response to the third question, about the group helping them to make changes, rises only slightly between session one and three, when it might be assumed that something is being established, such as group dynamics or an understanding of the principles behind the Solihull Approach model. However, this leaps from 61% in session three to 77% at session 4. The content of this session builds on the previous topics, which are all aimed at helping parents to see things from the child’s perspective, but begins to focus on how parents can respond to this increased awareness. Figure 3 clearly shows that from the fourth session onwards parents increasingly report that the group helps them make changes, with 89% of parents scoring this as ‘great’ by session 10.

Content analysis of the open questions revealed five broad themes which have been labelled as follows: ‘Making Changes’, ‘Feelings’, ‘Improved Interactions’, ‘Improved Knowledge (of Strategies, Solutions and Child Development)’; and ‘Improved Understanding’. These are presented in Table 3, which includes a description of each theme, a selection of illustrative quotes and the distribution of themes.

The most frequently occurring theme was ‘Making Changes’, which accounted for almost 30% of comments. The second most frequently occurring theme was ‘Improved Knowledge (of Strategies, Solutions and Child Development)’, which accounted for 25% of the comments. This finding suggests that parents feel satisfied with the strategies and parenting skills they feel they gain as a result of this programme, despite the fact that behaviour management is not an explicit focus of UYCB.

Discussion

The results show that parents found UYCB highly satisfactory as measured by a simple, non-literacy-based evaluation form. By the last session all three measures were scored neutrally to positively by 100% of respondents, with 95% rating the group as ‘great’ at helping them feel relaxed and safe at session 10; 88% describing it as ‘great’ at having helped them understand their child, and 89% ‘great’ at helping them make changes.

The number of parents rating the programme ‘great’ at helping them make changes increases significantly after session 4 and subsequently increase as the sessions progress, suggesting that it takes four to six sessions for parents to understand the issues and report making changes, with sessions 7 to 10 allowing for consolidation and further development of these gains. This supports the recommendation that parenting programmes should be eight to 12 sessions long (National Institute for Health and Clinical Excellence (NICE), 2006).

The most frequent comments made by parents were in the categories of ‘Making Changes’ and ‘Increased Knowledge (of Strategies, Solutions and Child Development)’. The theme ‘Improved Interactions’ fits with the concept of ‘Reciprocity’ (which focuses on attunement to children and enhancing parent–child interactions). The ‘Feelings’ and ‘Improved Understanding’ themes demonstrate an appreciation of ‘Containment’ and parents’ improved ability to connect behaviour with the child’s perspective and feelings, as a result of the group. These data show that parents comment positively on the three cornerstone theories of the Solihull Approach model, which indicates consistency in the delivery of the programme across a range of facilitators from a range of agencies.
### Table 3. Description of themes

<table>
<thead>
<tr>
<th>Theme name</th>
<th>Description</th>
<th>Examples</th>
<th>Percentage of all comments (n=)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Making Changes</strong></td>
<td>References to changes of attitude, behaviour or routine. Indications of more time given to children, references to becoming more confident</td>
<td>'My outlook and attitude towards parenting have changed. My understanding of my daughter and the way I deal with situations. I have re-evaluated everything and made changes for the better' 'I feel I have changed the way I manage my life and my child's life' 'I personally am a lot calmer' 'I have more empathy for my child' 'Lots of things have changed like my son’s sleep routine and the way I ask the children to do something' 'I’m a better me'</td>
<td>29.5% (119)</td>
</tr>
<tr>
<td><strong>Increased Knowledge (of Strategies, Solutions, and Children’s Development)</strong></td>
<td>Accounts of parents learning new strategies for managing behaviour or solutions when their children show challenging or emotive behaviour. References to learning about children's developmental stages, and learning parts of the Solihull Approach</td>
<td>'It’s made me step back and look at the situation and relate it to the child’s age' 'It has made me step back and look at how I am sometimes, ie, occupied with something else and not noticing the frustration building up in the child' 'I try to deal with problems in a different way' 'I’ve been able to look at different ways to approach things and look at ways how others feel'</td>
<td>25% (101)</td>
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<tr>
<td><strong>Feelings</strong></td>
<td>References to the feelings of either the child or parent. References to parents’ experience in the group of not feeling alone as a parent and to their support network</td>
<td>'I can link into my child’s emotions and vocalise them' 'I feel I have learnt a great deal about understanding feelings, my own as well as my child’s’ ‘I have learned to listen to my child and respect their feelings’ ‘I have learned that anger is OK and that you can repair situations rather than leaving’</td>
<td>16.8% (68)</td>
</tr>
<tr>
<td><strong>Improved Understanding</strong></td>
<td>Indications that the parent thought to see things from a child’s perspective, understand the behaviour, and can think how to help their child in particular</td>
<td>'I feel I have learned more about understanding a child and looking at everything from a child’s perspective’ ‘I feel I can listen and understand them better’ ‘My behaviour towards [child] has started to change as a result of understanding more about why she is behaving in a certain way’ ‘My understanding of my child’s behaviour is better. My child’s tantrums are shorter and less often’</td>
<td>15.3% (62)</td>
</tr>
<tr>
<td><strong>Improved Interactions</strong></td>
<td>Interactions between parents and children, references to relationships at home, including partners, or interactions with other mothers and the group</td>
<td>‘I have learned how to communicate with my child effectively. I’m more relaxed playing with the kids and I feel calmer and more organised’ ‘Taking a step back and thinking first about what and how to say to a child’ ‘I definitely listen to my child more and spend more time with them in terms of playing and “quality time”’ ‘Playtime with the children has changed. If I want to do something I play with them first’</td>
<td>13.4% (54)</td>
</tr>
<tr>
<td><strong>Total comments</strong></td>
<td></td>
<td></td>
<td>100% (404)</td>
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Limitations of the study are that the three-item evaluation form does not provide objective evidence of actual changes occurring as a result of attendance at UYCB and, therefore, of the programme’s effectiveness. However, it does show that parents like and value the UYCB programme. One major limitation of the study is that demographic data are not available, which means it is not possible to demonstrate for which parents the programme is more helpful; nor to rule out the possibility of a response bias on weeks with a low response rate. Also, comparisons cannot be made between individual participants’ responses in subsequent sessions, nor between the 37 groups.

Recommendations

The implications for practice of this study are that more parents are ready to change their parenting after four to six weeks of a parenting programme, with improvements continuing over the remaining sessions of a 10-week programme. Therefore, it is important to continue to offer parents the full programme rather than reducing the number of sessions; for example to six weeks.

Further research is required to measure the effectiveness of the group against longitudinal child outcomes; compare the effectiveness of the group with a control group; and to investigate its effectiveness with specific groups of parents, such as fathers, teenage parents and parents with learning disabilities.

Conclusion

This evaluation demonstrates that UYCB is very well regarded by parents. The vast majority of participants (95%) found the UYCB parenting group highly satisfactory, as defined by how relaxed they felt in the group. By the end of the group 88% of parents reported that it had been very helpful at helping them understand their children and 89% said it was highly effective at helping them make changes to their parenting.

In addition, 100% of the remaining parents rated the group neutrally, with no parents rating it poorly on any of the evaluation questions by the end of the group.

Themes emerging from parents’ comments demonstrate that parents leave the group having made changes; increased their knowledge of strategies and solutions for responding to behaviour and of what to expect at different ages and stages of childhood; improved their understanding of their children’s behaviour; improved their interactions with children and others, and enhanced their ability to recognize and respond to feelings in themselves and in their children.

The length of UYCB is compliant with NICE guidelines that effective parenting programmes should be eight to 12 sessions long (NICE, 2006) and this study supports the view that parents need time to understand the issues before they change, plus time to consolidate change.

Acknowledgments

The authors wish to thank all the parents who took part in the study, as well as the group facilitators, who made the evaluation possible. Thanks to Lisa Baker, Parenting Administrator, and Jill Delaney, Parenting Coordinator during the data collection period. Finally, thanks to Hazel Douglas for support and encouragement.

References


Working together to keep children safe and well when parents have learning difficulties

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Abstract
A serious case review, where parental learning difficulties were a factor in the serious injury of a child, prompted review and strengthening of the collaborative work between universal children's services and specialist adult learning disability services. Focus groups enabled wider knowledge of the factors that were barriers to good partnership work, and those factors that required strengthening. Consideration of research findings and literature review has informed the development of a local protocol that focuses on the safety and wellbeing of children.

Key words
Parental learning difficulties, safeguarding children


No potential competing interests declared

Introduction
This paper outlines multi-agency work that took place following a serious case review to strengthen collaborative safeguarding children work between children's services and specialist adult learning disability services. It outlines the literature review and the group work that informed the development of a local protocol, which was endorsed by the Safeguarding Children Board.

Review of government policy since the Every Child Matters green paper in 2003 shows a developing narrative that recognises the importance of early recognition of vulnerability for children, and understanding that parental attributes and capacity are important influences on children's vulnerability. Early collaborative work with parents is increasingly acknowledged as having a positive influence on children's safety and wellbeing (Department of Health (DH), 2008; Allen, 2011). Similarly, review of child protection practice reinforces the importance of a collaborative and integrated approach to improving children's circumstances and safety (Munro, 2011).

Parental learning problems are one of many parental attributes that can cause vulnerability and increased risk for children. Clarity about what is meant by the term 'learning disability' is fundamental to understanding the complexities health professionals must consider when working with families where a parental 'learning problem' is felt likely to be a barrier to effective joint working.

The terms 'learning disability' and 'learning difficulty' are often interchanged. Learning disability is defined (DH, 2001: 14) as: 'A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence); with a reduced ability to cope independently (impaired social functioning); which started before adulthood, with a lasting effect on development'.

Learning difficulties are defined as 'difficulties in acquiring knowledge and skills to the normal level expected of those of the same age, especially because of mental disability or cognitive disorder' (Oxford Dictionary online).

The use of the correct terminology becomes important when accessing specialist services. Local community learning disability teams offer services to individuals who fulfil eligibility criteria of an IQ of less than 70. Health visitors or school nurses meeting a family for the first time are unlikely to have knowledge of a parent's IQ. Assessment may well suggest to the health practitioner that some degree of parental learning problem is a barrier to effective work. The health practitioner will need to consider how their perceived barrier to effective joint work with families can be acknowledged, understood and overcome. Individuals with learning difficulties also may have a preference for the use of a particular term.

Non-statutory guidance (DH, 2007) discusses this issue and suggests that, for some individuals, the term 'learning disability' can be seen as pejorative, so the terms 'learning difficulty' or 'learning problem' may be preferred. Non-statutory guidance (DH, 2007) suggests that, from a parenting perspective, it is more helpful to 'identify needs associated with impairment and the disabling barriers of unequal access' rather than to regard the issue as related to 'impairment and personal limitations'. Understanding these issues is essential if the health practitioner is to initiate a meaningful dialogue with parents and ensure that services are offered in an accessible and appropriate manner. For the purpose of this paper the term 'learning difficulty' will be used, as the diagnosis of learning disability, as defined, is unlikely to have been made, but learning difficulties are perceived as a barrier to collaborative and effective work by health professionals.

Statutory requirements place a 'safeguarding' responsibility on professionals under section 11 of the 2004 Act (Children Act, 2004) to ensure that 'their functions are discharged with regard to the need to safeguard and promote the welfare of children'. Correct identification of safeguarding vulnerability must happen, if this responsibility is to be addressed.

While parental learning difficulty does not correlate with child abuse (DH, 2010), there are established links between children suffering neglect, and inadequate parental support, in the context of parental learning difficulty (Department of Children, Schools and Families, 2009). Prevention and empowerment are promoted by the legislative framework, which requires health practitioners to ensure that assessments, and interventions are provided equitably and do not discriminate on grounds of disability. Statutory provision further requires the promotion of independence and empowerment when health and social care is provided (Social Care Institute for Excellence (SCIE), 2005).

The planned review prompted consideration of established academic knowledge regarding the most effective ways of working with parents with learning difficulties. A briefing paper (SCIE, 2005) provided a resume of the key issues
influential in helping parents with learning disabilities in their role as parents, informed by a literature review of research papers, and policy.

Factors that were found to be unhelpful for families were the ‘tendency to pass responsibility between adult and children’s services’ and the ‘lack of skills amongst professionals’. The importance of information about services in accessible formats for families was acknowledged. Most effective interventions were those tailored to the specific ability of parents and those provided in the families own home, and developed in conjunction with parents, promoting self-help and maintaining families’ control.

Partnership with parents, and training for professionals and generic service providers, were key learning points expressed in a further review of research studies (McGaw, 2000). McGaw emphasised the importance of careful holistic assessment work, which acknowledged both parental strengths and needs. The review of the current provision needed to establish to what degree these elements of good practice were part of local service delivery to parents with learning difficulties and how new processes could be put in place to ensure their inclusion.

Estimates of the numbers of adults with learning disabilities who are parents vary from 23 000 to 250 000 (DH, 2007). Qualitative research in Merseyside (Barkby et al, 2009) sought to review the numbers of parents with learning difficulties accessing health visitor services; the health visitors’ perceived needs of these parents and the needs of health visiting services to support the families.

This research, which gathered data from three focus groups, found that perceptions of prevalence of parents with learning difficulties varied from between 0.8% to 14.7% of caseloads. While the research is small scale, and is based on qualitative judgements of learning difficulties experienced by parents, it does suggest that there is a significant prevalence of parents who are likely to have needs associated with learning problems.

These findings have wider implications for many health teams, suggesting a significant prevalence of parents with learning difficulties. The research found that there were common themes emerging from the focus groups relating to the importance of effective co-operation and communication between health visitors and families, and between health visitors and specialist services. The health visitors identified that they needed greater resources, and more information and training, but they understood the ‘significant challenges’ faced by parents with learning difficulties and acted as advocates on their behalf. It was important to ensure that these elements of work were established in new working relationships between universal children’s services and specialist learning disability services.

Research undertaken by the Nora Fry Centre provides insight into the perspective of parents with learning difficulties. Marriott and Tarleton (2008) reviewed the prevalence and quality of materials aimed at people with learning difficulties available to support them in their parenting role, and that of safeguarding their own and other children. The research reviewed resources that had been sourced by a variety of methodologies. Parents with learning difficulties were integral to the review of the quality of resources, together with representatives from the NSPCC and other key organisations.

A systematic review of the resources enabled them to be critically analysed from a user perspective. The researchers identified a paucity of resources specifically identified for parents with learning difficulties and, therefore, included in the research, resources intended for support of parents with wider literacy needs. The research identified that while there are many resources suitable for parents with learning difficulties, specific resources on topics such as bullying, stranger danger, gaining independence were still needed.

The authors identified that resources needed to be produced in response to a demonstrated need and should be accurate, and developed in consultation with people with learning difficulty.

Review of collaborative work between specialist learning disability teams and universal children’s services

Locally, direct access to the specialist learning disability service is restricted to those individuals with an IQ of less than 70, or to those individuals who have attended ‘special schools’ and have a diagnosis of learning disability. Referral routes into the service are via telephone and written referral through one Service Information point. To strengthen work between the community learning disability service and universal children’s services it was necessary to seek the views of practitioners working in both specialist community learning disability teams and in universal children’s services. We needed to establish those elements of collaborative work between the teams that were established and working well, and the specific elements of collaborative work that needed to be strengthened.

It was important to establish the views of as many professionals as possible to be sure that the strengths and weaknesses of the current system had been correctly identified. It was also essential to capture the views of as many professionals as possible, to inform planned improvements. It was hoped that greater professional understanding between the adults and children’s services would be

<table>
<thead>
<tr>
<th>Table 1. Themes from focus groups</th>
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<tr>
<td><strong>Factors which are barriers to good collaborative working</strong></td>
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<tr>
<td>- Lack of understanding that the community learning disability team is an adult-focused service, which does not provide ‘parenting assessments’</td>
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<td>- Individuals need to satisfy IQ eligibility criteria to qualify for direct access to learning disability services</td>
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<td>- Frustration by both adult and children’s services that advice is often requested at a late stage, when child protection concerns are becoming urgent for families</td>
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<td>- Frustration by both teams that early intervention work does not take place</td>
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<td>- Lack of understanding of the skills within the community learning disability team (CLDT)</td>
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<tr>
<td><strong>Factors which would strengthen collaborative working</strong></td>
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<tr>
<td>- Consultation with the CLDT at an early stage, to inform the assessment work of colleagues working in children’s services</td>
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<tr>
<td>- Provision of advice and support to colleagues in children’s services without the need for direct referral into the community learning disability service</td>
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<tr>
<td>- Commitment to discussion and collaboration about a family’s needs, without the need for direct referral</td>
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<tr>
<td>- Agreement about record keeping to support the process</td>
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<tr>
<td>- A process for working together that is endorsed by the safeguarding children board</td>
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fostered, and would promote better future collaborative working. For these reasons focus groups were the review method chosen (Morse and Field, 1996; Denscombe, 2007). Further, it was hoped that practitioners involved in the focus groups would have ownership of any new process agreed. A series of four focus groups were held. The focus group format enabled the views of a large number of participants to be sought, and facilitated professional challenge in a supportive and constructive environment.

Focus group work
Four focus groups were held, at which there was representation from the community learning disability team, and practitioners from different children’s services teams. The purpose of the groups was:
- To widen joint understanding of current working practices
- To widen understanding of professional roles and responsibilities
- To share ideas as to how services could improve collaborative working to ensure children were safe.

The focus groups used a semi-structured format, which was replicated at each group. Non-statutory guidance (DH, 2007) was used as a starting point for discussions. The facilitator of each focus group used a flip chart to record, and confirm with the group, the discussion points that arose in each focus group. Common themes emerged, from review of the records made in each focus group (see Table 1).

A working party of nominated representatives from the universal children’s services and the community learning disability team were brought together by the Safeguarding Children Board to consider the themes that had arisen from the focus groups. The working party comprised representatives from children’s social care safeguarding provision, primary health, specialist adult learning disability services and legal services. The working party formalised agreements and suggestions made in the focus groups into a locally agreed protocol that was placed on the Safeguarding Children Boards website, after formal ratification by individual agencies (see Figure 1).

A brief case history is presented to illustrate the benefits to an individual family, and the learning made by a health visitor, which have resulted from using the protocol. Family names and details have been changed to protect the identity of individuals. The case history is presented using a reflective structure (Kolb, 1984).

**Case history**

**The experience**
I have been working with Stacey since the last trimester of her pregnancy. Stacey has learning difficulties and lives with her parents. Stacey needs the help and support of her family to ensure that she is safe and well. Her baby Evie is now nine months old. Stacey is a loving mother and is caring for her baby safely. I have used the 'Protocol to Safeguard Children' to facilitate collaborative work with the community learning disability team, and ensure that my work with Stacey is accessible and appropriate for her.

**Reflective observation**
I felt very worried and anxious about Stacey’s capacity to care for her baby when I first met her. Stacey hardly spoke to me, and let her mother do the talking. Stacey’s presentation suggested to me that she found it difficult to address aspects of her own personal care. I was aware that I did not know Stacey’s strengths, or what she might need from my service to ensure that her baby was safe and well. I felt that it was likely that Stacey’s baby would not be safe, and that she would not be able to parent her baby successfully. By using the protocol, I feel more secure in understanding Stacey’s abilities, and

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**Figure 1. Protocol for integrated working to safeguard children when parental learning difficulties are a factor**

- Identification by universal service that a parental learning problem is a barrier to effective work with families, likely to lead to safeguarding vulnerability for a child
- Discussion with the family, to advise them that the advice of specialist team is to be sought to ensure that work is offered to them in an accessible format
- The practitioner completes and sends ‘consultation request’ form outlining the nature of support and advice that is needed from community learning disability team. A copy is retained in the child’s health record
- The consultation request is considered at weekly allocations meeting in Community Learning Disability Team (CLDT). Telephone consultation between learning disability specialist and universal children’s service practitioner provides initial support and advice. Agreement is made about how the effectiveness of support is to be evaluated, and reviewed. A record is made by both parties of the discussion that takes place
- Practitioner uses advice provided by CLDT to ensure assessment and interventions offered are accessible to family
- Further assessment confirms that child is safe and well
- Practitioner uses the advice provided by CLDT to ensure that assessment and interventions offered are accessible to family
- Further assessment shows that concerns persist for safety/wellbeing of child
- Child protection procedures must be followed
- Further consultation takes place with CLDT. Consideration of joint assessment work is made
more confident working with her to address her needs, and more confident that her baby is safe.

**Conceptualisation**

By working with the family with the help of the Community Learning Disability Team (CLDT) I have gained a greater understanding of Stacey’s learning difficulties, and how I need to modify my approach to her, so that I have better understanding of her needs. The protocol has made me think constructively about my concerns, and be honest with the family. By asking for the support of the CLDT, the family know that I am committed to working them, and finding a way to ensure that Evie’s best interests are served. The protocol has improved my knowledge of learning difficulties, and my understanding of the contribution I can make to addressing ‘needs relating to learning disability’ (DH, 2007).

The calibre of my assessment work has improved (SCIE, 2005). I have learnt that I am able to undertake ‘parenting assessments’ when parents have learning difficulties, informed by discussions with colleagues in specialist teams, and that I will have a better understanding of possible risks to children. ‘Cooperation and communication’ between myself and the family, and with specialist adult services has been facilitated (Barkby et al, 2009). I have learnt the strategies that best address her learning needs (Marriott and Tarleton, 2008) and Stacey has been provided with the information she needs to ensure her baby is safe.

**Experimentation**

I plan to make sure that work with the family continues to be informed by consultation with colleagues in the CLDT, as Evie develops and her needs become more complex. By this approach I hope that I will contribute to an ongoing assessment of the family’s needs, and that ‘long-term commitment’ (DH, 2007) to Evie’s safety and wellbeing will be demonstrated.

**Discussion**

The case history illustrates how the local protocol has prompted good collaborative work, between specialist CLDT services, universal children’s services, and the family. Many benefits for the family are identified by the health visitor, that are outlined as beneficial and best practice in non-statutory guidance (DH, 2007) and literature reviews (SCIE, 2005; Marriott and Tarleton, 2008). It is likely that the health visitor has gained skills and expertise that will be used to benefit other families on her caseload. These skills and knowledge provide the health visitor with professional resources that are identified as important in research (Barkby et al, 2009; SCIE, 2005); to address the significant challenges which parents with learning difficulties face. The acquisition of these skills is likely to make a contribution to targeted, early intervention work, which is advocated in current policy (Allen, 2011; DH, 2008).

The health visitor attributes the benefits outlined in the case history to the greater collaborative work with specialist adult learning disability services that the local protocol has facilitated. Consideration of specific case histories, such as the one provided, reinforce the likely benefits to families from locally agreed protocols, advocated in non-statutory guidance (DH, 2007). Formal review of this local protocol, that captures the views of families about the benefits they have received and the improvements to children’s safety, in addition to professional evaluation, would provide more rigorous understanding of its effectiveness.

**Conclusion**

Multi-agency focus group work, informed by literature review, widened understanding about the factors that both promote and act as a barrier to collaborative work between specialist community learning disability services and children’s services, and enabled the development of a local protocol, which has been endorsed by the local safeguarding children board. The protocol acknowledges that all services are equal stakeholders, and share responsibility for improved collaboration, focused on improving the safety and welfare of children who live in the context of parental learning difficulty.

Focus group work contributed to the development of a process that was acceptable to all services, and which promoted professional standards in line with statutory and non-statutory guidance (DH, 2007; DH, 2010). Consideration of a case history illustrates advantages to children and professionals, when the protocol is used.

**Key points**

- Focus group work widened understanding of roles and responsibilities in universal children’s services, and specialist adult learning disability services
- Focus group work identified key factors which were influential on good collaborative working
- A working party led by the safeguarding children board used themes from the focus groups to develop a locally agreed protocol
- Case history review illustrates how the protocol has influenced collaborative work that focuses on the welfare of the child

**References**

Drop for drop, no other formula

Breast milk

New SMA
First Infant Milk

References:
5. Yao M et al Poster presented at 3rd Annual Meeting of ESPGHAN, Istanbul, Turkey, June 9-12, 2010

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When did you first qualify as a nurse? I qualified in 1969, although I started as a cadet nurse at the age of 16 in 1964. In those days, of course, girls left school when they were 15 without much hope of a career. Choices were limited and girls usually became a nurse, a teacher or a secretary. From the ages of 16 to 18 I worked in the Western Ophthalmic Hospital in London, which was linked to St Mary’s Hospital and that’s where I went to do my nurse training.

I qualified as a health visitor (HV) in 1981 but prior to that my nursing career had been within education so I moved into clinical teaching, which was, in a way, what brought me into health visiting. Once I had started, I never once thought it was the wrong decision or wanted to leave health visiting. I worked as a HV, I got my degree and became a field work teacher, then achieved my doctorate in 1991. There were all sorts of reasons why I went on to do my doctorate and I went straight from practice as opposed to the usual route, which is going into an educational post and getting support there. Throughout my career I’ve been very privileged and had lots of positive experiences. Being chair of the CPHVA was a highlight – it was very hard work but it was a real privilege and I was one of the last chairs to be elected by the whole membership. It was also one of the most difficult times, because it was in the period leading up to closure of the dedicated health visiting register, which meant there was enormous debate and conflict in the organisation.

I’ve had the opportunity to do lots of travelling in the last few years because of my research. I am a visiting professor at the University of Sao Paulo in Brazil, and adjunct professor at the University of Technology in Sydney, Australia. I have travelled to exotic places and I’ve engaged with people all over the world who are all absolutely fascinated by health visiting in the UK, and want to learn from it.

Have your experiences abroad changed your perspective on health visiting in the UK? My experiences travelling have made it clear to me that we haven’t got it right at the moment in the UK in terms of numbers and all sorts of bad things that have happened in health visiting over the last 10 or 15 years, but it is also clear that we have got a lot of things right. I get cross when people in this country say that health visiting is ‘just nursing’. Some countries, such as Brazil, don’t have a separate qualification for any specialist nursing post, such as health visiting, and they’re fascinated by this idea of a different way of doing things and of organising services.

In Japan they have a separate public health nursing licence but because it got absorbed into the general nurse training they became concerned about standards of qualification. I think they’ve managed to pull back from that now but, again, they were looking to health visiting as they felt that integrating the public health nurse qualification within general nursing training was harming standards of practice and harming the population they served. The Japanese looked to publications from the UK health visiting world to support their argument.

Also, I think we can learn a lot from the Australians as they have had similar experiences to us in the UK. They call health visitors ‘child and family health nurses’ and the numbers have gone down and down, but they were ahead of us in research and saying we’ve got to do something about increasing and improving practice.

New Zealand’s health visitors are called ‘Plunket nurses’ – which doesn’t make any sense to anyone outside the country, but...
every New Zealander knows what that is and changing the title would result in uproar. The idea in this country that you should change the title ‘health visitor’ to ‘public health nurse’ is unnecessary and very unhelpful. I think in the UK the term HV is very well regarded and very well established, and I get angry when people want to use the term ‘public health nurse’ as an umbrella term to include HVs and others.

Do you think that the profession has changed since you came into health visiting in 1980?

Undoubtedly, the world has changed a lot and the health service has changed a lot. One of the interesting differences between then and now is that, in the 1970s, health visiting was particularly strong, partly because of the Council for the Education and Training of HVs (CETHV). HVs moved from local authorities to the health service in 1974, so the CETHV did a lot of work to establish the principles of health visiting, but it (CETHV) was dissolved just after I qualified. We had a very strong sense at that time of health visiting as a profession. We felt we were a moral source for good and we had a very strong professional ethic.

What happened shortly after I qualified was the beginning of managerialism within the health service. HVs were a bit of a target because they were clearly described as autonomous professionals and as practitioners operating within their own right. Essentially, you were given a caseload and told to manage it. In training we had a lot of education and practice around managing a caseload but there weren’t the guidelines and requirements that there are today, so there was some really creative and excellent practice. Of course, there may also have been awful practice but there may also have been awful practice but there were some really creative and excellent practice. Of course, there may also have been awful practice but there may also have been awful practice but there were some really creative and excellent practice. Of course, there may also have been awful practice but there were some really creative and excellent practice. Of course, there may also have been awful practice but there were some really creative and excellent practice.

What part has the CPHVA played in your career?

When I was a student my practice teacher took me to a Health Visitors’ Association meeting, and at that time they were much bigger events than they are now. All the HVs in the area would come together for a two-hour meeting. I became a local officer, which brings with it a lot of work, but it was a great opportunity to find out what was happening in the local area and what the local issues were.

I got involved at a national level when it was still the HVA and I attended executive meetings, then I was appointed to the finance and general purposes committee, which was the committee for introducing people to national work for the union then. From there I moved to the professional committee. At the time local officials were elected and the national officers were elected but the committees were appointed to meet a range of needs for the organisation.

What are the greatest challenges facing health visitors today?

The first challenge is surviving the next few years until we can get new troops on the ground. The reputation of health visiting has suffered dreadfully among the people who really matter: the service users. It’s not the fault of any one individual, but HVs have been asked to do the impossible task of coping with huge caseloads, and I think that’s the biggest challenge.

The second is to maintain educational standards when we’re trying to recruit all these new people. We haven’t got the infrastructure to match the numbers of students and I don’t know how we’re going to recruit the numbers of students we need. We did well in the current academic year and we’re about to go into the next, during which I hope we manage to recruit again.

The third challenge will be driving up the standards and bridging the gap between what we need for practice and the managerial and financial requirements. We’re in a much better position in terms of evidence than we were when I came into health visiting. In the past, people believed in the job and there wasn’t much evidence to show whether it mattered that children got a good start in life but we have that evidence base now. It’s a big challenge and there are still commissioners and managers who feel they want to somehow reduce the spend on health visiting or see it as a profession that shouldn’t have so much money spent on it and that needs changing.

What do you think about the Health Visitor Implementation Plan?

I feel it’s the most incredible opportunity and a good, clear vision for health visiting. The amount of activity going on, driven by the Department of Health to support it, is unprecedented. Usually policies are written and the government says ‘This is what we expect you to do’ and then moves on. But this plan has a large infrastructure, with roadshows and documents that explain for everyone, including GPs, local government members or local trusts, what it is that’s expected.

The vision itself is positive for HVs and if we can make it work it will be really positive for children and families. It’s not just a vision for the profession but for how the profession can improve health for children and families, and their wellbeing in the future. It’s an opportunity that if we let slip we will never have again, so it’s important everyone gets on board.

How important is the HV role today?

The way those first lady sanitary inspectors in Salford 150 years ago envisioned their work was very soundly based but we now have evidence to back up our practice. We know about the importance of pregnancy and the early years and that this is the best time to really set someone up for life. We know from evidence such as the Marmot report that health inequalities are established within those...
early months and years of life, and that they are reversible. Just because someone is born into a poor family, it's not inevitable they will have a shorter life or a poorer education.

Do you feel that child protection has improved in recent years?
Child protection is one of the most fundamental things that HVs are engaged with and it's also one of the biggest distractions. Nothing can be more important than identifying and rescuing a child who would otherwise be harmed for life. However, if we concentrate on that sharp end, and I worry tremendously about the suggestion that this is where skills are needed and everything else can be delegated to a junior person, it's a distraction from the main business of reaching every child in the community and every child that needs and deserves help.

If we see every child as the future for this country and the need to keep the next generation healthy and strong, it's clear it has to be every child and not just those in imminent danger. We also need to remember disability as there's been a huge increase in the numbers of children with different disabilities.

What do you think about the new DH school nursing initiative?
I'm really pleased that a government that came in only talking about HVs has been persuaded that they need to talk about the school-age population as well. I was always against the idea that you stop training HVs for all ages, as when I trained I worked with all age groups and we worked in schools, with the under-5s and also with the elderly. I think we need to recognise the importance of school health as much as preschool health and the fact that they're not aiming to push the numbers with this initiative is a disappointment. But the fact that civil servants and professional bodies have managed to push school nursing to the fore, when it wasn't on the table to begin with, should be seen as a success, and we need to keep on pushing.

What advice would you give any readers who feel disillusioned?
I think we need to somehow convince HVs that the cavalry is coming over the hill – and that's a role for the managers and commissioners. It's difficult for those managers who, five years ago were congratulated for introducing a dilute skill mix or a regimented way of working, and were coping with a reduced budget. We're now asking those same people to introduce a very different sort of change, and to expand not just their workforce with more money and more people but to allow HVs more autonomy.

The Implementation Plan talks about restoring professional autonomy and decision making which has gone out the window often because managers want to protect HVs from over work. I think we may need to spend more time working with managers to help them with the change they're experiencing and to get to that point when the first tranche of newly qualified HVs appear in September. There will be a lot more new HVs and they need to be encouraged to believe in the vision that's going to get us there.

Do you think health visiting has a bright future?
I do believe that yes. I think the Implementation Plan has given us an opportunity we need to grab, and if we don't do that we deserve to fail – and it will be children and families who lose out.
Midwife and health visitor: precarious, problematic ... but possible?

In December 2007 the Nursing and Midwifery Council (NMC) announced that specialist community public health nurses could no longer appear solely on the third part of the register. One health visitor explains how this has altered her working life and aspirations for the future

Stephanie Stevens
Health Visitor and Midwife

Although this had little effect on the majority of health visitors, for those of us who had previously been direct entry midwives it was devastating news. It is now almost five years since this change occurred, but it has strongly impacted on the health visiting careers of direct entry midwives (DEMs). Is it now deterring midwives from becoming health visitors?

Although the NMC council voted in 2005 to allow SCPHNs to appear solely on the third part of the register, the Department of Health in England advised them that they did not have the jurisdiction to make this decision, they were only allowed to regulate nurses and midwives and, therefore, in 2007 the NMC reversed its decision and advised all SCPHNs that they must also appear on either the first or second part of the register for them to be covered. For nurses who were SCPHNs their registration on part 1 was automatically renewed. For those who were direct entry midwives and had only previously been on part 2 of the register it was far more difficult. To work as a health visitor we now also required a supervisor of midwives (SoM) to sign our Notice of Intention to Practice (NoP) annually saying we had maintained our midwifery registration and were fit to practice as midwives. In addition, we had to show 450 hours of health visiting practice (as did nurses) and an additional 450 hours midwifery practice. Confusion ensued on how this was going to happen and we found ourselves in a very precarious position.

These 450 hours of midwifery equate to approximately one month full-time working per year. As a full-time health visitor I realised this would be difficult but I took on a midwifery bank post working night shifts and weekends, to make sure I had the hours to keep my registration up to date and, in the hope that this would be quickly sorted out. Those of us affected by this began contacting the NMC, writing letters in professional journals and asking unions and professional bodies for help and support. The NMC responded by producing a set of guidelines (NMC, 2007), which outlined how midwifery registration could be maintained while working as a health visitor. However, these were vague and were not supported by the Royal College of Midwives who commented, ‘Although there may be some shared knowledge, HV practice is not midwifery and therefore this practice does not count toward maintenance of midwifery registration’ (RCM, 2010).

After a few months it became apparent to me that I would not be able to continue to work as both a health visitor and a midwife. Trying to juggle both roles was physically exhausting. The bank shifts were not always available when I was able to do them. Even when I did have shifts I became concerned that my midwifery knowledge and skills were diminishing due to my sporadic working pattern.

In all professions there are distinct roles, cultures and boundaries. Even though these can often be blurred, particularly in health visiting, they still exist. Practice teachers recognise one of
the biggest challenges for a new student HV is coping with the overwhelming feeling of being de-skilled and disoriented when they first start. They need to nurture them out of their previous role and help them adapt to their new one. When working as both a midwife and HV I felt that I didn't have any professional identity.

Requirements
I was lucky; I had a SoM who was supportive and very experienced. This SoM also supervised midwives that worked in posts that did not involve hands-on midwifery, such as lecturing and research. We had several discussions with each other and sought advice from others, about how I could meet the NMC requirements solely in health visiting practice. As a result of this, I now provide the SoM with an annual portfolio. This includes:
- Examples of my HV practice which are mapped to the NMC competencies
- A time sheet showing HV practice which is also acceptable as midwifery hours (antenatal visits, new-birth visits, breastfeeding advice)
- Evidence of relevant study days (resuscitation, hand hygiene, child protection)
- A testimonial report from my health visitor manager.

I am required to attend mandatory midwifery updates on emergency skills. By doing all this, my SoM has signed my NoP each year and I continue to work solely as a full-time health visitor but this is time consuming and attending the mandatory training takes me away from my health visiting post putting a strain on my already overworked colleagues. I realise that I am fortunate as I work for a trust that is supportive and where there are also other qualified HVs and student HVs who were DEMs so we can provide peer support for each other.

Many other DEMs are not having the same experience. Following an article I wrote when this problem began, my SoM has contacted potential student health visitors, as well as qualified health visitors who are struggling and asking how I have managed to maintain my registration. Although I had expected the number of DEMs contacting me would diminish, they have increased. This is worrying, especially as the majority of midwives are now direct entry and in view of the current recruitment drive for health visitors.

SoMs are struggling to manage supervision of their own staff due to workload. The NMC need to ensure that there is a robust regulation process that meets both the needs of families and the professionals who work within it.

"WE NEED TO ENSURE THAT THERE IS A ROBUST REGULATION PROCESS THAT MEETS BOTH THE NEEDS OF FAMILIES AND THE PROFESSIONALS WHO WORK WITHIN IT"

Midwives’ Rules and Standards (2004) states, ‘The role of a Supervisor of Midwives is to protect the public by empowering midwives and midwifery students to practise safely and effectively (rule 11). Can it possibly be considered reasonable (or safe) for them to continue to supervise health visitors?

Discrimination
Just as worrying are the reports of discrimination when recruiting to both health visitor training and qualified posts. My first application for a health visiting post didn’t even get to the interview stage. When I asked for feedback I was told that I did not meet the essential criterion, which was to be a registered nurse. This hasn’t changed. At the time of writing, NHS Jobs have 36 trusts advertising for qualified HVs but only 17 include midwife in the essential criteria. All the rest have registered nurse only.

The Law Commission now recognises that the boundaries of healthcare professions are becoming more blurred, meaning that regulatory systems based purely on job title are increasingly difficult to manage. It has released a consultation paper looking at clarifying and modernising the regulation of health professionals. This will hopefully find an acceptable solution to this current dilemma of registration and allow all of us in this situation to continue in the job we enjoy.

I have no doubt that my midwifery career, particularly my time as a community midwife, provided me with a wealth of skills that I use alongside my health visitor training. Having health visitor teams with such a breadth of knowledge and skills is essential to provide the care and support that is required for the complex needs of families today. However, we need to ensure that there is a robust regulation process that meets both the needs of families and the professionals who work within it.

Unite/CPHVA response
Dave Munday, Unite Health Sector Professional Officer says: ‘Unite/CPHVA has been aware of our (DEM) members concerns on this matter and we have worked to support each member that has contacted the team. I hope that members remember that when the NMC announced that they would be changing the rule regarding their ability to register registrants solely on the third part that we registered grave concerns with the NMC at the time and our National Professional Committee took the very difficult decision to take a vote of no confidence in the NMC.

‘Despite this, the NMC continued with the rule change and following this we have worked with them and our members to ensure that they haven’t suffered negatively. We issued a briefing paper giving both our members and their SOM and employees information. We have also highlighted that some members have raised concerns that the changes were negatively impacting on DEM access to courses and employment. Again, we have encouraged members to give us examples so we can respond formally on each.

‘We were encouraged by the NMC when their ex-chief executive committed to addressing concerns regarding the third part of the register last year and we had raised this as an issue to be urgently improved upon. We are, of course, concerned that with the CHRE review at the NMC the third part work has been mothballed. In our meeting with the interim CEO I raised again my concerns and there was commitment given to continue the work to address our concerns and I hope to report back on this in the next few months. I have also personally met with SOMs who were resistant to signing off ITPs for a group of our members in the West Midlands, and with reasoned argument we certainly improved the situation for our members there.’

Have you had similar experiences to Stephanie Stevens? Or do you disagree? We would love to hear what you have to say on the issue, so get in touch with the editor of the journal, Polly Moffat: polly.moffat@tenalps.com

FIRST PERSON
Regional pay – unfair, unnecessary and unacceptable!

By James Lazou
Unite Researcher

As this column goes to press, the NHS Pay Review Body is receiving evidence on market-facing pay – a remit announced in George Osborne’s autumn statement last year. The government argues that this review is in response to immediate pressures to boost private sector employment and economic growth, apparently stultified by relatively ‘high pay’ in the NHS.

Unite and all the staff side unions have strongly rejected the premise of this review – national pay bargaining in the NHS bears little to no relevance to the performance of private sector employers, either local or nationally, with the exception of the privateers baying to take over running the NHS. Pay in the NHS is not higher than the private sector when the statistics are compared honestly – comparing the pay of highly skilled professions such as health visitors, perfusionists, biomedical scientists or brain surgeons with retail workers or junior bank clerks in the high街 is entirely disingenuous and does not compare like with like.

Another attack on NHS staff

In reality, this review is part of a much wider attack on NHS employment. Since the financial crisis in 2008 NHS staff have consistently suffered from real-term pay cuts due to below inflation pay rises and pay freezes. This pay cut doesn’t take into account many other reductions to overall package, such as reductions in on-call or out-of-hours payments, sickness policies and the enormous attacks on pensions.

If the government’s assertions about local labour markets were correct, then these pay cuts would have been expected to benefit those local private sector markets in recruiting staff. In reality, these reductions in pay have had no bearing on private sector employers. If anything, the private sector will have suffered due to the reduction in consumer purchasing power of staff from the largest employer in the UK.

Rather than supporting the local private sector market, local or regional pay structures are likely to lead to distortions within the health labour market itself, with wealthier areas being able to recruit staff from less wealthy areas. This would reduce career mobility and dissuade health workers from moving to lower cost areas. This has already happened between trusts that pay different on-call rates or where health visitors are on different grades in two adjacent trusts. This will lead to poorer services in deprived areas and the return to a health service post code lottery.

What is the real motivation?

The motivation for the Chancellor’s remit must be viewed in its broad context. The government has just forced through the biggest reorganisation of the English NHS in its history, despite the overwhelming opposition of health staff and professionals, and is expected to lead to large swathes of the NHS being outsourced to ‘Any Qualified Providers’ in the private sector.

At the same time, the Bill makes it obligatory for all trusts to become foundation trusts, with the flexibility both to receive unlimited numbers of private patients and set their own wage structures.

Local pay or zonal pay?

The NHS staff side unions have successfully defeated any idea of decentralising pay to local bargaining. Research commissioned by the unions clearly shows that moves to local pay determination would significantly increase transaction costs and time resources for trusts, leading to damaging outcomes for workforce planning as trusts compete for staff. The current experience of negotiating local changes to terms and conditions shows just how inefficient local HR is at this and the evidence from NHS employers shows that they have no appetite for shouldering the responsibility.

The government has now said that it is in favour of implementing zonal pay through High Cost Area supplements that would be set nationally through the Pay Review Body, as well as greater use of local Recruitment and Retention Premia. While these policies would be allowed under the Agenda for Change agreement, the government is again being disingenuous. In their own words, they announce plans to introduce ‘a framework where basic pay awards are constrained to generate headroom for greater pay differentiation through HCAS payments’.

As staff side evidence has shown, the only substantial variation in pay across regions lies between the London/South East area and the rest of the country. This reinforces the existing structure of Agenda for Change, which has offered a robust, flexible and equality proofed pay system that has served the NHS well. The flexibilities in Agenda for Change allow employers to adapt to any local market issues while preventing damaging competition for staff between trusts.

Using zonal pay as a way to enforce further unjust pay cuts on hardworking NHS staff is unfair, unnecessary and unacceptable! Unite will continue to resist it at every turn.

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**Unite/CPHVA website**

The Unite/CPHVA website provides access to the association’s many valuable online professional resources and updates.

See: [www.unitetheunion.org/cphva](http://www.unitetheunion.org/cphva)
Peter Walker International School of Developmental Baby Massage

- Two-day certificated teacher training for health professionals, children centre staff and complementary therapists with Peter Walker at VIVEKA, Queens Terrace, St Johns Wood, London NW8 6FA.

23rd and 24th June 2012

Peter Walker is the leading international trainer for Developmental Baby Massage with over 35 years of group teaching experience and working with families one to one, specialising in supporting families with children with special needs in their development. Peter’s work can be viewed on www.babymassageteachertraining.com

This two-day certificated course includes:

1) Holding Reassurance Programme empowers parents to:
   - Get more ‘in touch’ with their baby, learn different holding positions and introduce gentle stroking and stretching prior to introducing massage sequences
   - Be spontaneous and trust their instincts to develop more confidence in getting to know their baby
   - Observe, listen and respond sensitively to their baby's cues and communication including non-verbal cues.

2) Developmental Baby Massage Routine including:
   - Key principles of underpinning neuroscience, psychodynamic and child development with focus on empowering parents to develop a positive relationship with their baby; thus promoting baby's emotional development
   - Parents are first and foremost taught to respect their baby. To do massage with and not to their baby. These sessions are led by the baby
   - The correct way to massage baby
     1) Stimulate the baby’s circulation and breathing
     2) Reduce physiological flexion and the occurrence of plagiocephaly
     3) Increase flexibility and strength
     4) Relieve birth trauma and other common infant ailments
     5) Common sense anatomy and physiology relative to early infant motor and emotional development
     6) Elementary Motor Delay and correction
     7) Using the correct oils
     8) Easy to learn massage sequences with inclusion of singing, kissing, talking and playing with the baby, making it a quality and enjoyable time for both mother and child.

3) High quality resource: Peter Walker’s DVD and new book ‘Elemental Baby Massage’ hard back copy with full set of course notes for all students.
   - In-house training for this two-day course and continuous professional development workshops are available for NHS and other organisations providing care for children and families.
   - Also available ‘in-house’ teaching:
     - Two Day Soft Mother and Baby Yoga Certified teacher training. Excellent follow through for Developmental Baby Massage Teachers
     - One day in-house refresher for Developmental Baby Massage teachers
       - Certificate of Attendance given
     - One day in-house additional needs teaching Certificate of Attendance given
     - One day teaching for all other qualified baby massage instructors who wish to include ‘Developmental Baby Massage’ techniques and the rationale behind this teaching in their practice Certificate of Attendance given.
   - Comments from delegates on previous course:
     - ‘Thanks again for an inspiring two days.’
     - ‘Thank you again for the fabulous training last week.’
     - ‘Really enjoyed your baby massage training and I was very inspired by your life and your work.’
     - ‘I found the course to be really fascinating and I cannot wait to put what I have learnt into practice.’
   - For this course and ‘in-house’ course bookings email: walker@thebabieswebsite.com Accreditation & Insurance: Independent Professional Therapists International

Touch-Learn International’s Baby Massage Teacher Training Programme

Venues across UK, plus in-house option. A five-day, comprehensive baby massage course for health professionals and parenting practitioners provided by Touch-Learn International, the exemplary training company. This highly acclaimed programme is accredited by the Guild of Sensory Development (GoSD). This quality training programme includes simple massage techniques, coupled with an in-depth knowledge to practise safely, ethically and professionally, so practitioners feel confident to teach parents in a variety of settings.

Included within the course:
   - Strategies to empower parents
   - All mechanisms identified in current research to support parent-infant relationships
   - Underpinning theory based on current research
   - Practical teaching in the field
   - Relevant anatomy and physiology
   - Quality supporting materials and books
   - Summative assessment
   - Free, informative biannual newsletter
   - Tutorial and on-going support
   - Core membership of the GICM.
   - Touch-Learn International Ltd
   - Tel: 01189 566222
   - Email: info@touchlearn.co.uk
   - Website: www.touchlearn.co.uk

For further details of training in the UK please visit
   - www.touchlearn.co.uk
   - In-house training available.

Announcing the next round of Deborah Robertson’s Breastfeeding Specialist Course:

- Dates: Study days are one Monday per month, May 2012 to April 2013.
- Location: Chatham, Kent
- Cost: £80 per month, or discount for paying in full at booking.

AARC Approved: 120 hours (study days plus optional homework). CEERPs awarded. More information: www.breastfeedingspecialist.com

Contact: Deborah 01634 814275

Milpond Children’s Sleep Workshop – London, Wednesday 26th September 2012

Our popular one-day interactive workshop, designed for professionals working with families with babies through to school age.

Delegates will:
   - Explore sleep cycles/sleep needs
   - Understand sleep problems
   - Interpret sleep information
   - Summarise and questionnaires and diary
   - Plan a wide range of sleep techniques
   - Practical session

Evaluate intervention

£175, EARLYBIRD PRICE £155 for bookings received before 1st August 2012. Tel: 020 8444 0040 E: info@mil-pond.co.uk W: www.mil-pond.co.uk

The Brazelton Centre in Great Britain

Understanding newborn behaviour and supporting early parent–infant relationships. Training Course

Newborn Behavioural Observations (NBO)

24th and 25th May 2012

Royal Society of Medicine, London

For further details, please contact: Email: info@brazelton.co.uk

Tel: 01223 245791

Children with special needs

The special needs interest group will be holding a networking meeting with speaker on Friday 11 May from 10.30am to 2pm in meeting room 4, Ground Floor, Unite, 128 Theobald’s Road, London WC1X 8TN. Health visitors and school nurses with an interest in children with special needs are very welcome to attend.

Lunch is provided.

For more information please contact Helen Pickstone: helen.pickstone@nhs.net
Aquamazing difference in eczema!

AQUAMOL® is the effective new emollient that’s clinically proven to relieve the itching and dryness associated with eczema.¹

In trials, it reduced skin dryness by 34% compared to pre-treatment values.¹

Itch was reduced by 30% and steroid use reduced by 21%.¹

AQUAMOL® is easy to use, non-greasy and free from SLS, colours and fragrances. It’s a 2-in-1 emollient that can be used as an occluding moisturiser with penetration enhancers and as a beneficial soap substitute.

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Abbreviated Prescribing Information. Aquamol®

Presentation: A soft white cream. Each pack contains purified water, white soft paraffin, liquid paraffin, cetaryl alcohol, PPG-5-ceteth 20, disodium cetylphosphatidate, polysorbate 60, chloroacet, sodium chloride, citric acid monoacetate.

Indications: For the management of mild to moderate eczema, psoriasis and other dry skin conditions. Directions: Adults and children over 1 year: Apply liberally to the affected area and smooth gently into the skin following the direction of the hair growth until the cream turns from white to colourless. Use as often as required, but at least twice daily at regular intervals. Aquamol can also be used as a soap substitute. For external use only. Precautions: Hypersensitivity to any of the ingredients, or if the skin is broken, badly cracked or bleeding. Avoid contact with the eyes. If this product is absorbed by dressings or clothing, the fabric can be more easily ignited with a naked flame. Avoid fire or naked flames when using. Pack Size: 50g and 300g (Medical Device). Trade Price: 50g - £1.22, 300g - £4.40. Manufacturer: Thornton & Ross Limited, Holderness, HD7 5QH. Date of preparation: April 2011. Reference: 1. Clinical data on file at Thornton & Ross Ltd.
Uses: Diprobase Cream and Ointment are emollients, with moisturising and protective properties, indicated for follow-up treatment with topical steroids or in spacing such treatments. They may also be used as diluents for topical steroids. Diprobase products are recommended for the symptomatic relief of red, inflamed, damaged, dry or chapped skin, the protection of raw skin areas and as a pre-bathing emollient for dry/eczematous skin to alleviate drying effects.

Dosage: The cream or ointment should be thinly applied to cover the affected area completely, massaging gently and thoroughly into the skin. Frequency of application should be established by the physician. Generally, Diprobase Cream and Ointment can be used as often as required.

Contra-indications: Hypersensitivity to any of the ingredients.

Side-effects: Skin reactions including pruritus, rash, erythema, skin exfoliation, burning sensation, hypersemia, pain, dry skin and bullous dermatitis have been reported with product use.

Package Quantities: Cream: 50g tubes, 500g pump dispensers; Ointment: 50g tubes, 500g jar.

Basic NHS Costs: Cream: £1.28 (50g), £6.32 (500g); Ointment: £1.28 (50g), £5.99 (500g).

Legal Category: GSL.

Marketing Authorisation Numbers: Cream: PL 00025/0575; Ointment: PL 00025/0574.

Marketing Authorisation Holder: Merck Sharp & Dohme Limited, Hertford Road, Hoddesdon, Hertfordshire, EN11 9BU, UK.

Date of Revision: February 2012.