Hearts and minds
An approach to becoming ‘Baby Friendly’

Improving outcomes
The impact of tongue tie

Infant feeding
Celebrating breastfeeding past, present and future
Cetraben® Emollient Cream and Cetraben® Emollient Bath Additive
White Soft Paraffin, Light Liquid Paraffin Prescribing Information

Please refer to Summary of Product Characteristics before prescribing.

Presentations: Cream – a thick white cream containing white soft paraffin 13.4% w/w and light liquid paraffin 10.5% w/w. Bath additive – Clear liquid containing light liquid paraffin 82.8% w/w.

Indications: Symptomatic relief of red, inflamed, damaged, dry or chapped skin, especially when associated with endogenous or exogenous eczema.

Dosage: Cream – apply to dry skin areas as required and rub in. Bath additive – Adults: Add one or two capfuls; Children: add half/one capful to a warm water bath or apply with a wet sponge to wet skin before showering.

Contra-indications: Hypersensitivity to any of the ingredients.

Special Warnings and Precautions: Care should be taken if allergy to any of the ingredients is suspected. Care should also be exercised when entering or leaving the bath. Avoid contact with the eyes. Side Effects: (Refer to the SmPC for full list) Very rarely, mild allergic skin reactions including rash and erythema have been observed, in which case the product should be discontinued. Marketing Authorisation Numbers: Cetraben Emollient Cream: PL 06831/0259 Cetraben Emollient Bath Additive: PL 06831/0260

Side Effects: vary rarely, mild allergic skin reactions including rash and erythema have been observed, in which case the product should be discontinued.

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The Future of Public Health Nursing
Best Practice in Home, School and Community

Wednesday 7th - Thursday 8th November 2012, Brighton Centre, Kings Road, Brighton

Keynote speakers:

**Len McCluskey**  
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Unite the Union

**Jackie Smith**  
Acting Chief Executive and Registrar,  
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**Professor Viv Bennett**  
Department of Health’s Director of Nursing and the  
Government’s Principal Advisor on Public Health Nursing

**Dame Elizabeth Fradd**  
Chair, Health Visitors’ Taskforce; Independent Health  
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Nursing in the community faces challenges across the UK: the importance of a good start for the infant in the family; the implementation of the Health Visitors’ Plan in England; the shift of public health finance to local government; the growth of the extended school day and the shift to academies; the transfer of community nursing services to Foundation Trusts, Community Trusts and Social Enterprises.

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Breastfeeding past and present: a time for celebration and reflection

UNICEF’s 20th World Breastfeeding Week, taking place in August 2012, has as its theme ‘Celebrating the present, understanding the past and planning for the future’. Twenty years ago the World Alliance for Breastfeeding Action (WABA) launched the first World Breastfeeding Week with the theme ‘Baby Friendly Hospital Initiative’ and much has happened since then.

This was followed in 2002 with the WHO and UNICEF jointly developing the ‘Global Strategy for Infant and Young Children Feeding’, recognising the need to protect, promote and support exclusive breastfeeding for six months and continued breastfeeding for two years or more, with appropriate complimentary feeding from six months.

We have another celebration of breastfeeding, with events taking place around the country during National Breastfeeding Awareness Week, running from 24–30 June.

Globally today, 32% of the world’s children are exclusively breastfed for six months, but the figure in the UK is only 10%. The reasons for this are complex, ranging from cultural practices and lack of confidence in women’s bodies, to the power of the multinational advertising of formula milks.

Immigrant mothers in the UK have told me that they have exclusively breastfed previous children in their countries of origin, but report that here they do not have enough milk. So what messages are women and their families receiving when they move here? Is formula feeding regarded as a sign of wealth or upward mobility? Or are advertisements on television and the pervasiveness of bottles in the media and the public space influencing our attitudes?

We need to celebrate our achievements in the UK with over 80% of women now initiating breastfeeding, compared with 65% 20 years ago. Health visitors are leaders in child public health and the challenge to us all now is to support women, and give them the confidence to continue to breastfeed exclusively for six months. This will result in significant improvements in child public health and a reduction in hospital admissions.

Alison Spiro
Specialist Health Visitor
Ealing Hospital Trust,
Harrow Community Services
The Nursing and Midwifery Council (NMC) has announced controversial proposals to increase its registration fees by 58% from next year. The plans come after a difficult time for the regulator, during which it has come under intense scrutiny over criticism of its performance and cost-effectiveness.

CPHVA responded to the move, announced on 17 May, by stating a 58% fee increase would be ‘another tax’ on hard-pressed and dedicated community nurses already hit by a two-year pay freeze, a steep increase in pension contributions and the prospect of regional pay.

Unite/CPHVA Lead Professional Officer, Obi Amadi, said: ‘Our members are horrified by this proposed 58% rise from £76 to £120 a year – a fee they must pay if they wish to practise their profession. ‘Our members resent having to pick up the bill for the failings of the NMC, which have been highlighted by two independent reviews saying how dysfunctional the organisation is. The NMC has cut back on services. It has shelved work on the third part of the register and restricted the ability of NMC registrants to raise concerns about practice issues. This is daylight robbery from a body that urgently needs to put its own house in order before dipping into the purses of nurses for outrageous fee increases.

‘The proposed fee rise is out for consultation and we hope that strong representation from stakeholder organisations will cause the NMC to have a serious rethink on this.’

Professor Judith Ellis MBE, Interim Chair of the NMC, said: ‘While the final level of the fee will be determined by the outcome of the consultation, I must warn registrants that an annual fee in the order of £120 is the level that is needed to protect the public and to ensure the integrity and the reputation of the professional register’. CPHVA have been inundated by calls and emails from concerned members over the potential increase, and are, therefore, calling on the tens of thousands of Unite NMC registrants to voice their opposition to this proposal by sharing their reasons for opposition, by email, to: healthsector@unitetheunion.org

UNICEF UK Baby Friendly Initiative call for feedback

UNICEF UK Baby Friendly Initiative Director, Sue Ashmore, has issued a call for feedback on the standards for Baby Friendly accreditation. UNICEF is inviting comment from health professionals as part of its consultation on the standards, which ends on 29 June.

Sue says: ‘Many people will already be aware of the work that the Baby Friendly Initiative has been doing over the last 18 years in the UK. However, due to significant changes within public services and the wealth of new evidence relating to what makes a difference for mothers and babies in terms of practical and emotional support, we realised the time had come to review the original standards.

‘We have listened to the hundreds of facilities implementing the current Baby Friendly standards to update them so that they continue to support public services in delivering the best possible care for mothers and babies, and their families, in the UK. And when a baby is not breastfed nurturing this bond is even more important.

‘The mother–baby relationship, which is at the heart of the new standards, lays the foundation for all future relationships, and supporting it will help build long-term health and wellbeing. The standards recognise that breastfeeding supports this bond and makes a vital difference to health.

‘We now need to know whether or not we have got it right. These new Baby Friendly Initiative standards should help UK public services promote the importance of breastfeeding and support for mother–baby and family relationships.

‘If you are a health worker who cares for mothers and babies, an infant feeding lead, or a voluntary worker/peer supporter, we would love to hear from you. Read the standards and then go to: www.unicef.org.uk/babyfriendlysurvey and fill in the survey.’
Fair and Square: loss of free school meals ‘will stop parents working’

According to a report from the Children’s Society, the Universal Credit system that is to be introduced in October 2013 to merge low-income benefits means that 350,000 children will lose their free school meals.

The Fair and Square report states that reforms to welfare entitlement mean that the government will stop paying for certain benefits including free meals if a household earns over £7,500.

Elaine Hindal, Director of the Children’s Society ‘Campaign for Childhood’, said: ‘If the government introduces a free school meals earnings threshold into the Universal Credit, then as many as 120,000 families could end up in the perverse situation where they are better off taking a pay cut, or working fewer hours. This could mean 350,000 children suffering as a result.’

Currently, around 700,000 children in poverty in England are not entitled to receive free school meals, even though they are from low-income, working families.

CPHA Professional Officer, Ros Godson, said: ‘School nurses are very concerned that those children who lose their entitlement to free school meals will not be able to afford school lunches and will have to bring food from home. However, as more families become poorer owing to (English) government policies, these children may have to eat poorer-quality food.’

A spokesperson for the Children’s Society said: ‘As well as providing vital financial support for low-income families, free meals also have important health and educational benefits for the children who receive them.

‘Evidence shows that eating a healthy school meal improves children’s concentration during afternoon lessons and can have a positive impact on classroom behaviour. Nutritious school meals can also help children to develop healthy eating habits and have the potential to reduce health inequalities.’

The Children’s Society is recommending that the government promotes work incentives for parents by extending free meal entitlements to all school-aged children and families who receive universal credit. By extending eligibility they estimate that an extra 1.3 million children in England would receive free school meals.

Children’s minister, Sarah Teather, commented: ‘We remain totally committed to continuing to provide free school meals to children from the poorest families. We are reforming welfare to get more people into jobs, as that is the surest way of cutting poverty. The reforms mean we will have to think hard about the best way to decide who is eligible for free school meals so they continue to be targeted at those who need them the most. No plans have yet been set and we will be consulting later this year about the best way forward.’

The charity is also recommending that, to reduce the stigma attached to children receiving school meals, all schools should introduce a cashless distribution system. It also wants the government to continue to look at ways in which it can improve the quality and nutritional value of free school meals.

New proposals for regulation of health professionals

As part of its investigation into the regulation of health and social care professionals, the Law Commission has recommended scrapping all nine single health professional statutes and creating a single UK law to cover all healthcare professionals.

On Thursday 3 May the Commission made the next leg of its consultation journey to the Unite building in London, where representatives from health professions gathered to hear the latest developments.

The consultation, supported by the Department of Health in England and each of the devolved administrations in Scotland, Northern Ireland and Wales, represents a long-overdue review of the laws relating to the regulation of healthcare professionals.

Unite/CPHA Lead Professional Officer, Obi Amadi, welcomed everyone to the event, stating: ‘This is something we feel is really important and has potentially far-reaching consequences.’

Tim Spencer-Lane and Justin Leslie, representing the Law Commission and leading the consultation, attended to present the findings so far and encouraged everyone present to get in touch if they had anything further to say: ‘Consultations are very important to the Law Commission and we are very interested in your views.’

The reform proposals have been met with tentative approval from some corners. It has been said that the nine statutes covering the governance of separate healthcare professions can often confuse by crossing over each other and are arguably full of inconsistencies. Consequently, combining all of these into one comprehensive law might well prove to be a good thing. However, implementing a viable alternative will be a long and complex process. Several potential problems have been raised, such as ensuring the accountability and security of the registrants – will this mean an enhanced role for the Council for Healthcare Regulatory Excellence (CHRE)?

If so, the CHRE will have to expand dramatically to cope with the volume of registrants – but how will this be paid for?

Unite/CPHA Professional Officer, Dave Munday, says: ‘It seems disturbing that this is happening before publication of the Francis report [the findings of the Mid-Staffs inquiry]. There appears to be a perfect storm developing at a time when our members are really having to fight for services.’

CPHA was also represented at a presentation in Belfast on 3 May, ensuring that the Northern Irish contribution and opinions were aired and shared.

The three-month consultation period reached its end on 31 May and the final report will be published in early 2014.
**NEWS IN BRIEF**

**English pilot study to expand newborn screening**

A Department of Health pilot study in England will double the number of genetic conditions newborn babies are screened for by adding five rare disorders to the current disease tests.

The scheme, which will take place in Sheffield, Leeds, Manchester, Birmingham and London, will lead to 430,000 newborns a year getting tested for five further rare, debilitating diseases: maple syrup urine disease, homocystinuria, glutaric acidemia type 1, isovaleric acidemia and long chain fatty acidemia, all of which affect approximately one in every 100,000 births, or about seven babies per year.

**Funding announced for autism in Wales**

Gwenda Thomas, Deputy Minister for Children and Social Services in Wales, has announced a funding package of £2m for 2012–13 to support children and adults with Autistic Spectrum Disorders (ASD) across Wales. The funding is designed to support existing projects and includes £880,000 to maintain local ASD leads and action plans in each of the 22 local authority areas. The Deputy Minister also confirmed the extension of the Wales ASD Employment Ambassador’s contract for a further 12 months, until March 2013.

‘Personal, fair and diverse NHS’ campaign launched

NHS Employers are working with the Equality and Diversity Council (EDC) to encourage NHS staff to become ‘champions’ for a ‘personal, fair and diverse NHS’. The aim is to create a network of champions who are committed to taking action, however small, to create a personal, fair and diverse NHS. The campaign hopes to bring renewed energy and focus to building and sustaining a diverse and inclusive healthcare service. For more information about becoming a ‘champion’ visit: www.nhsemployers.org/EmploymentPolicyAndPractice/EqualityAndDiversity/CreatingPFDNHS/Pages/Signup.aspx

**New regulations permit nurses and pharmacists to prescribe controlled drugs**

Changes to the Misuse of Drugs Regulations will finally allow qualified nurses, midwives and pharmacists to prescribe controlled drugs to patients.

Nurses, pharmacists and midwives with the right experience and who have completed additional post-registration training, will be permitted to prescribe Schedule 2, 3, 4 and 5 controlled drugs, which include morphine, diamorphine (heroin) and prescription-strength co-codamol.

Up to 20,000 nurses and midwives and 1,500 pharmacists who qualify as ‘independent prescribers’ will be allowed to prescribe controlled substances. They will also be allowed to mix a controlled drug with another medicine for intravenous use, which will be most valuable in A&E pain relief and palliative care settings. Under Patient Group Directions, they will be able to supply or administer morphine and diamorphine for urgent treatment of very ill or critically injured patients.

Dame Christine Beasley said: ‘These changes will help deliver faster and more effective care, making it easier for patients to obtain the medicines they need without compromising safety. ‘Enabling appropriately qualified nurses and pharmacists to prescribe and mix those controlled drugs they are competent to use completes the changes made over recent years to ensure we make the best use of these highly trained professionals’ skills, for the benefit of patients’.

**Rickets death: research needed**

Mrs Justice Theis, the judge presiding over the case of a baby who died from severe rickets has called for more research into the impact of vitamin D deficiency aged under six months. Parents Rohan Wray and Chana Al-Alas, who were accused of abusing their four-month-old son Jayden, have called for an enquiry into the two hospitals that cared for him, but failed to diagnose rickets, which caused his bones to soften and his skull to fracture on 2009, leading to his death.

The couple from North London maintain that had the diagnosis of rickets been successfully identified by either Great Ormond Street Hospital or University College Hospitals, Jayden would have survived. Wray and Al-Alas were acquitted of abuse at the Old Bailey when Mrs Justice Theis instructed the jury that the congenital rickets was the most likely cause of death, after around 60 experts and witnesses were unable to agree on why Jayden’s brain damage occurred. A University College Hospital spokesperson said: ‘We regret that we were unable to reverse his deteriorating condition, despite our intensive efforts in the short time he stayed with us.’

Criminal charges against Jayden’s parents were dropped as witnesses could not agree causes that led up to the infant’s death. However, civil action was brought by Islington local authority. A Crown Prosecution Service spokesperson said: ‘In bringing this prosecution we considered all of the evidence in details and out policy on non-accidental head injuries. We were satisfied that there was a realistic prospect of conviction.’

CPHVA Professional Officer, Ros Godson, commented: ‘All health visitors and Family Nurse Partnership nurses must ensure that they are able to recognise the symptoms of rickets and refer appropriately’.

**NEWS ROUND-UP**
Integrated adult health and social care consultation in Scotland

The Scottish government is asking for views on plans for patients to receive more treatment closer to home as part of a consultation on the integration of health and social care, launched on 8 May.

There are now around 10,600 nurses working in communities across Scotland – 2,500 more than in 2006.

The integrated approach aims to cut unnecessary hospital admissions, reduce the number of people being delayed in hospital longer than they should, and to meet the target of a four-week maximum wait for discharge to be achieved by April 2013, and a two-week maximum delay by April 2015.

Integrated care has already been implemented in some areas across Scotland. NHS Highland and Highland Council are working together to deliver health and social care, with members of staff transferring from the NHS to the council and vice versa. Perth and Kinross Council and NHS Tayside have formed a partnership to work with local people to look at how health and social care services should be run.

Scottish Health Secretary, Nicola Sturgeon, said of the plans: ‘We know that in Scotland more people are living for longer, and this brings challenges in terms of the way we plan for, organise and deliver our health and social care services, particularly for people in their later years.

‘That is why we are looking at developing a more integrated system, and through closer working between local authorities and health boards, we expect to see improvements in the quality of care our patients and service users receive.

‘By allowing people to be treated closer to home, and adopting a more community-based approach, this will help us to improve health and social care, consistently, for older people in all parts of the country’.

The consultation will run from 8 May until 31 July and can be viewed at: www.scotland.gov.uk/Publications/2012/05/6469

Depressed dads use ‘negative language’

A small study carried out by Oxford University has found that new fathers suffering from depression speak more negatively when talking to their child than fathers without depression.

The research, published in *Psychological Medicine*, asked 38 fathers, half of whom had depression, to play face-to-face with their three-month-old children for three minutes, which was filmed.

The fathers with depression spoke more negatively about themselves and focused more on themselves and their experiences than on the infant. Some phrases that were used included: ‘I’m not able to make you smile’ and ‘Daddy’s not as good as Mummy’.

To compare, fathers without depression had an average proportion of 11% of negative comments vs 19% of fathers with depression. Comments that were focused on the baby dropped from 72% to 60% and those focused on the dads themselves rose from 14% to 24%.

Dr Vaheshta Sethna, author of the study at Oxford University’s Department of Psychiatry, said: ‘We found there were differences in the way depressed dads talked to their babies compared to fathers without depression.

‘It is possible that babies will pick up on this negativity, that they will pick up on these cues even early in life. For example, the baby may have to respond differently to get attention.’

Around 5% of fathers are believed to suffer from depression in the postnatal period, half the rate of mothers.

Lead researcher, Dr Paul Ramchandani, said: ‘We want to try to work out the processes that lead to poorer outcomes in the children so we can work out where the parents can be helped out.

‘More research has been done with mums with postnatal depression and there are a range of early interventions to help them in the way they talk and play with their babies. Depression in fathers is less well recognised and fewer fathers tend to come forward to help.’

However, he also noted that there has not been enough research to prove whether or not the negative speech patterns have an effect on emotional development and later behavioural problems in children.

He said: ‘That’s the next step. It’s important to remember that depression among parents doesn’t mean that the children are going to have problems. Most do not’.

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A call to conference

The theme for this year’s Unite/CPHVA Annual Professional Conference is ‘The Future of Public Health Nursing: Best Practice in Home, School and Community’. The event will be held at the picturesque seafront setting of the Brighton Centre on 7 and 8 November 2012. The two-day conference and exhibition is the largest gathering of health visitors, school nurses, community nursery nurses and associated colleagues in the UK.

Unite/CPHVA Professional Officer, Gavin Fergie, encouraged members to attend in order to share and explore imaginative responses to the challenges presented during such an important time of change.

He said, ‘When your grandchildren ask “Were you at CPHVA conference during the 150 years of public health nursing celebrations?” will you be able to say you were involved? This is a unique opportunity to join with colleagues to celebrate this historical milestone and tell your public health nursing story.’

With the abolition of primary care trusts, the introduction of Modernising the Community Workforce in Scotland and changing roles in schools, plus the shift of public health work to local authorities, community nurses are going through a period of intense change in their work and employment, and there has never been a more important time to come to conference.

As well as keeping you abreast of the latest developments in public health, attending the conference will bring you up to date with the policy development that will affect practice in the coming year, including:

- GP-led commissioning
- The Implementation Plan for Health Visiting and the Development Plan for School Nurses
- Safeguarding children and the rules and practices needed
- The impact of information technology on the work of nurses across the community
- Perspectives from Scotland, Wales, Northern Ireland and internationally.

The conference will also contribute to your continuing professional development (CPD) requirement.

A number of high-profile speakers have confirmed their attendance at the conference, including:

- Professor Viv Bennett, Department of Health’s Director of Nursing and the government’s Principal Advisor on Public Health Nursing
- Dame Elizabeth Fradd, Chair of the Health Visitors’ Taskforce
- Jackie Smith, Acting Chief Executive and Registrar at the Nursing and Midwifery Council
- Ros Moore, Chief Nursing Officer for Scotland
- Angela McLernon, Acting Chief Nursing Officer for Northern Ireland
- Professor Jean White, Chief Nursing Officer for Wales.

For updates on the conference and further information, please visit the CPHVA website at: www.unitetheunion.org/cphva

Implementation Plan workshops come to a close

With the last of the CPHVA/Department of Health (DH) workshops now over, Chloe Harries attended the penultimate event at Unite’s Diskus Centre in London.

The joint CPHVA/DH roadshows have been travelling the country since February, looking at the Health Visitor Implementation Plan (HVIP) a year on, to see what has been achieved and how much of an understanding health visitors have at grass-roots level.

The workshops provided an excellent opportunity for members to feedback their concerns to CPHVA and to ask representatives from the English Department of Health questions about the initiative.

Delegates were welcomed by Chair, Sandra Humphrey, to the comfortable surroundings of the Diskus Centre. Dave Munday, Unite/CPHVA Professional Officer, got things under way, setting the scene for the day and thanking delegates for coming, especially in light of their heavy caseloads. Dave explained that the purpose of the roadshows was to ‘help people leave with more knowledge than they came with’.

In a straw poll of the room the majority of people raised their hands when asked if they had a basic level of understanding of the HVIP. More than half the room admitted to a ‘moderate level’ of understanding and none possessed a ‘very good understanding’ – a common trend seen at the workshops throughout the country.

Pauline Watts, Professional Officer for Health Visiting at the DH spoke next, leading a session entitled ‘A Call to Action – One Year On and What’s Next?’ She said: ‘I’m pleased to say that the commitment that started strong has not wavered at all.’

Speaking of the progress to date she said; ‘I feel like doing a victory dance!’

A total of 20 early implementer sites were launched in March 2011, with another six added in August 2011. The Building Community Capacity programme is now at the stage of national roll-out. Pauline said, ‘Expect to see gradual growth and we’re monitoring the numbers’. In addition, education frameworks have...
been published and research projects commissioned.

Pauline reminded attendees that, at a national level, there will be many more newly qualified health visitors. She said: ‘In September we should be able to feel the difference. It will feel like, we hope, you can see the difference on the ground’.

She ended with an anecdote about her young granddaughter, who was learning to swim, and in believing she could, was able to swim a width for the first time. ‘She had passion, belief and courage, and with that passion, determination and expectation, we can move forward as well. In a small period of time we can do so much’.

Maggie Rogers, NHS London Senior Strategic Advisor for Health Visiting, the Family Nurse Partnership (FNP) and Children’s Services spoke next, discussing the early implementer sites and the method of managing health visiting and the FNP together as one programme. She also discussed the Webex presentation about commissioning for clusters, declaring: ‘Every health visitor who wanted a job in London got one’.

At the end of her presentation Maggie urged the audience of professionals to remember that ‘this is all about children and families and preventing children from going down the wrong path’.

There was an extended question-and-answer session as the lively audience had many issues that they wanted to discuss and questions to put to the panel. Other issues that came up throughout the day related to RiO and other technology systems and information sharing for the future.

An issue that repeatedly arose throughout the workshops was continuing concerns over practice teacher ratios. There were audible gasps from the audience when CPHVA Professional Officer, Dave Munday, brought up the example of a ratio of 1:7 at a trust in the south-west of England.

Dave and Obi Amadi, CPHVA Lead Professional Officer, fielded questions from the audience and urged members to raise concerns with their employers, their union and their reps. Dave reiterated that CPHVA would fight for them, but that they had to hear about it. He ended with a message that by 2015 ‘every HV will have to fight passionately to maintain numbers’.

Ann commenced her training in Portsmouth in 1970 and worked in various healthcare settings combining the demands of nursing and caring for her young family. The family moved to Northumberlant and Ann worked for a number of years within the industry sector as an occupational health nurse.

She completed her health visiting training in Plymouth in 1989 and worked in Cornwall and South Devon.

In 1998 Ann decided to broaden her horizons and embrace a new challenge when she began working for SSAFA Forces Help, providing health visiting to British Forces families overseas. She has worked in Gibraltar and Germany.

Ann was instrumental in setting up the Health Visitor Forum in Germany and only retired as Chair in March. At the CPHVA conference 2011, along with a colleague, she delivered a workshop entitled ‘Story Book Soldiers’, identifying an innovative approach to enhancing the mental health of parents who are deployed on active duty and their children.

Colleagues from the British Forces Germany Health Service had mixed emotions as they wished her farewell; sad to see a good friend and colleague leave after 13 years, but wishing her a well-earned, happy retirement, enabling her to take up new challenges and spend time with her family – especially her grandchildren and great grandchildren.
10 May protest strikes: a call to arms

Around 400,000 public sector workers joined together to defend their pensions across the country on Tuesday 10 May

NHS workers took strike action on 10 May to demonstrate against the government’s plans for pensions changes, including extending the retirement age to 68.

In a recent ballot of Unite members, 94% voted against the pensions proposals. Staff cuts as part of efficiency savings and a possible move to performance-related pay have led to anger and frustration for many members and health professionals working throughout the UK.

The message of the protest was that this is just the beginning of strike action to try to prevent large-scale damage to the NHS and further demoralisation of those who work hard to provide a high-quality service for patients in cash-strapped times.

The march in London began at St Thomas’ Hospital and snaked across Westminster Bridge, with placards and banners making clear to the watching media and public that NHS professionals will not tolerate attacks on their pensions and working conditions by a government that wants to be seen to be making a difference in the midst of economic austerity.

The march ended at Methodist Central Hall, Westminster, where a rally took place, with speakers including Len McCluskey, General Secretary of Unite and Mark Serwotka, General Secretary of the Public and Commercial Services (PCS) civil servants’ union. In his speech, Len revealed that his mother had passed away two days previously, after receiving ‘fabulous’ nursing care, both at home and in a nursing home funded by the state. This had made it clear to him, he continued, why the country should fight to keep the health service intact and free from cuts.

He also made reference to the coalition’s ‘posh boys’ who, he said, should not be allowed to dismantle the welfare state.

He rallied the listening crowds with a rousing speech that didn’t fail to increase emotion and support for the cause. ‘If the government thought their fight was over’, he said, ‘they’d best think again. There will be more strike action in June and on into winter, spring and on and on.’

These scenes were echoed across the country with protests taking place in Wales, Scotland and Northern Ireland.

Rachael Maskell, Unite Head of Health, has urged members to continue to fight the cuts. Two pensions bills are currently going through Parliament, and health professionals need to persuade local MPs to understand the pensions issues. Unite has invited MPs to spend time with NHS staff so that they can see how working longer will impact on staff and patients. MPs can also sign up to the ‘Unite NHS Pensions Pledge’. Print off the letter (at http://unite.newsweaver.co.uk/images/3341/10792/2600695/BackNHS_Letter_2.pdf) and at your next team meeting, sign and send it to your local MP.
Current agendas across the four countries of the UK are both providing opportunities and creating difficulties for our practice teachers. Unite/CPHVA is committed to supporting the valuable role that practice teachers have in educating our future practitioners and shaping the national agenda. In an attempt to understand the developments and difficulties affecting your role we would value your feedback through the completion of this survey. Please answer the questions as fully as you wish and kindly pass on to others who may not be members, as it is important to know the views of all. Please email your responses to davemunday@unitetheunion.org or complete this form (or a photocopy) and post to Practice Teacher Survey, Unite/CPHVA, 128 Theobald’s Road, London WC1X 8TN

Please use an extra sheet of paper for your responses if necessary.

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At a recent event held at the King’s Fund in London, entitled ‘Integrated care: the political challenge’, a representative from each of the three main political parties set out their personal view on the place of integrated care in the health system of the future. Sarah Wollaston, Conservative MP, Andrew George, Liberal Democrat MP and Lord Norman Warner, Labour Peer, each gave a 10-minute presentation on the challenge of mainstreaming system and clinical integration for the future.

There was surprising consistency of views across many areas. All agreed that integration of health and social care is good for patients, and is being driven largely by demographic changes, especially the increase in people living with long-term conditions. All agreed that significant challenges and problems need to be tackled to make integration happen, with positive impact on patients’ experiences.

Clinical excellence

There was a strong focus on patient and public engagement as key to successful integration and an acknowledgement that public understanding of complex issues around service delivery needs to be facilitated. Clinical excellence for all is not about having a brain surgeon in every hospital, but about good patient outcomes.

The annual Joint Services Needs Assessment (JSNA) is an empowering document for patients, the public and professionals alike, and forms a basis for service planning. Greater understanding of these issues can help smooth the process of reductions in hospital beds – which is always unpopular but is only to be expected when more care is rightly delivered in community settings.

Health and social care integration is easier where local authority (LA) and NHS areas are the same, such as Torbay in Cornwall. The process of successful integration in Torbay was greatly facilitated by care co-ordinators. In contrast, integration will be much harder in larger areas where several LAs are served by NHS providers. Lord Warner acknowledged the lost opportunity by the previous government to push forward the integration process when money was plentiful. He pointed out that the NHS struggles to integrate primary health care with hospital care, let alone with social care. On the positive side, less top-down strategy frees up clinical commissioning groups (CCGs) to drive integration forward.

Financial arrangements

An open panel question-and-answer session followed the presentations, with the dominant topic the need to change financial arrangements. Incentives for hospitals to treat more patients were not appropriate for an integrated service, especially for long-term conditions such as diabetes for which costs across the whole care pathway should be funded.

An expert from Canada had overseen the process of moving services out of hospitals and into the community. This experience, which meant closure of around half of hospital beds was unpopular with professionals and the public, but was an essential part of successfully transferring services into the community settings.

The nurse’s role

In conclusion, what role is there for the nursing profession in integration? It is clear that successful integration will only happen with the full participation and support of nurses at all levels. This is especially so at CCG level where nurses are key to articulating to decision-makers the complexity of patient needs across the whole care pathway. Senior nurses must be involved in planning and overseeing delivery of safe transfer of services from hospital to community for those patients who don’t really need hospital care. This is what most patients would prefer – to be cared for closer to home.
I am writing to let you know why so many mothers struggle to feed their babies on their own breast milk. When a mother has low milk supply one of the first questions asked by a breastfeeding counsellor is whether the baby is having long uninterrupted periods of sleep. The reason for this is that when there are lengthy periods of sleep without feeding, the baby isn’t giving the mother enough stimulation by frequency of feeding to make a full milk supply. This cannot be compensated for by feeding more in the daytime as the breast will be painfully engorged by morning, making it hard for the baby to latch which results in the nipple being damaged and very painful, and the feed slow and frustrating. The engorgement quickly leads to blocked ducts and mastitis.

The pain from poor attachment also happens when the baby is being timed as to when he feeds, resulting in him being too hungry to be able to attach well; again, damaging the nipple and making feeding slow and painful. This often results in cracking, which is an ideal site for infection to enter the body. Having to wait until a set time to feed also results in leaking, as the baby indicates the need for a feed by rooting or crying, which brings the mother’s milk down. The wet cloth of the bra results in chafing of the nipple skin and it is no coincidence that the same over-the-counter product, lanolin, used to treat this is sold to athletes who wish to protect their skin from sweaty, damp clothing. The leaked milk is an ideal place for thrush to thrive as the milk in the bra will no longer be live and able to fight the thrush as it does in the body.

Unfortunately, the encouragement of mothers to refuse night-time feeds continues and, as a result, breastfeeding has to be replaced by artificial feeding to the detriment of the health of mothers and babies. It is important to understand the damage that refusal of night time feeds does to breastfeeding and to start the mother with good sleep habits early on by good antenatal education. The need to sleep when the baby sleeps and accept offers of help from friends and family to look after the mother and her other children are an essential part of getting breastfeeding off to a good start and ensuring that it continues for as long as nature intends.

Artificial baby milk has been successfully marketed in this country and continues to be by promoting the refusal of night feeds, variously referred to as ‘sleep training’, ‘crying it out’, ‘self-soothing’ and ‘baby whispering’, etc. Essentially, you should be suspicious of anything that will be used to distract a baby from breastfeeding as and when necessary, and should warn mothers to be on their guard too, to ensure that breastfeeding is the best time in a mother and baby’s life.

Susan Stockwell
BSc Sci(Hons)
Volunteer Breastfeeding Counsellor

Whilst being an advocate of breastfeeding and keen to encourage and support it, I am also mindful of the sensitivity required when discussing feeding. When I spoke on Radio Berkshire last year about this I also spoke about the support that mums who bottle-feed require and how it is possible to bottle-feed with love. This sparked quite a debate as it seems I struck a chord with many mums who shared how marginalised, and discriminated against they felt by some health professionals. I was shocked by the outpouring of stories on this. One mum related how a midwife refused to speak to her as she was not breastfeeding. Other mums described how guilty they were made to feel by some health professionals. This debate continued on the Netmums website and I was struck by how little support bottle-feeding mothers get and how excluded, anxious and worried they feel.

A Lakshman et al (2009) systematic review of over 13,000 mothers found many felt guilty for bottle-feeding and neglected by the health services. The researchers found a lack of information and support for bottle-feeding mothers who did not feel empowered to make decisions. This was contributing to bottle-feeding errors, such as over-concentration of feeds, changing formula and the timing of feeds. These errors can have serious health consequences and contribute to obesity and malnutrition. At Netmums we have many posts from mums on both breast and bottle-feeding issues and the bewildering choice of different formula milks available. Unsurprisingly, parents are often overwhelmed by this and the bombardment of information they get from baby milk companies on why their formula is better than a competitor’s. They often ask midwives and health visitors for advice who cannot recommend any particular formula or encourage bottle-feeding at the expense of breastfeeding. Parents tell us a failure they feel when they do not breastfeed and how they are made to feel like social outcasts excluded from breastfeeding support groups. In some areas feeding support groups welcome both breast and formula-feeding mums and their babies.

My plea to practitioners during National Breastfeeding Awareness Week is to please spare a thought for bottle-feeding mums who can’t, or won’t, breastfeed and treat them with care and compassion.

Maggie Fisher
RGN NDN RHV BA(Hons) Ed PGD
Chair, CPHYA Health Visitor Forum; Online Support Health Visitor, Netmums

Reference
Research Advisory Group news 2011–12

Pauline Pearson
Professor of Nursing,
Northumbria University
Unite/CPHVA Research Advisory Group Member

As we welcome a rapidly increasing workforce over the next few years we need to ensure that we are gathering high-quality evidence to show that health visitors have an impact. At a time when academic institutions are reducing in size and some key academics (Professor Sarah Cowley for one) are retiring, we at the CPHVA need to drive forward the research agenda with some urgency. During the past year, the Research Advisory Group has held five meetings. We have continued to take forward research on health visiting practice to make use of the national perspective the group can offer and the potential of CPHVA as an organisational partner. Last year, a National Institute for Health Research (NIHR) programme development grant had been applied for to look at the health visiting contribution to universal prevention and early intervention services that led to desirable outcomes for children at one year.

The proposed research was felt not to be appropriate for the Grants for Applied Research programme. However, it was suggested that we might wish to consider applying to another funder. After some discussion, we have split the work into various packages and are pursuing further bids.

A second key concern has been to support health visitors in practice who want to dip their toes into research and early career researchers; for example, master’s and doctoral students. We have worked to have greater input into the CPHVA conference, in programme development and content, and this year will be running a masterclass. In March 2013 we will be running an early researchers meeting alongside the International Collaboration for Community Health Nursing Research conference taking place in Edinburgh. We are also continuing to offer support for people seeking to get work published.

Other ongoing work has included refreshing membership of the group — there are still some gaps. We have also provided input into the Academy of Nursing Midwifery and Health Visiting Research, the appointment of a new Chair and the development of mentoring work. We also continue to contribute to assessing the CPHVA Trust Awards.

Research evidence

Smoking cessation therapy during pregnancy
Given the adverse effects of antenatal smoking on mother and foetus, pharmacotherapy for smoking cessation should be considered. Available medications include nicotine replacement therapy, sustained-release bupropion, and varenicline. Nicotine replacement therapy and bupropion do not appear to increase the risk of major malformations; however, there is currently limited evidence on the use of varenicline during pregnancy. These agents are only marginally successful in smoking cessation, so their use should always be accompanied by behavioural counselling and education to maximise quit rates. Can Fam Physician 2012 58(5): 525–7.

Maternal vitamin D status
There are increasing reports of rickets and vitamin D deficiency worldwide. In view of the drive to promote and increase the rate of exclusive breastfeeding, the relationship between maternal vitamin D status, vitamin D concentration of human milk, and vitamin D status of breastfeeding infants deserves reassessment. This review provides current information on the interrelationship between maternal vitamin D status and the vitamin D status of the breastfeeding infant. Adv Nutr 2012 1;3(3): 353–61.

Experiences of mothers with mental illness
This study explores the experiences of being a mother with mental illness. The mothers’ experiences were understood in terms of struggling to become good enough mothers and being present in the caring relationship with their child. Addressing the existential needs of motherhood is important for their improvement and recovery, as well as for promoting their children’s mental health and wellbeing. Int J Ment Health Nurs 2012 doi: 10.1111/j.1447-0349.2012.00813.x.

Resources

Digital service launched for new parents
The new NHS Information Service for Parents will give new parents information and advice covering a wide range of issues related to staying healthy in pregnancy, preparing for birth and looking after their baby. By signing up to the service, parents-to-be and new parents will receive regular emails and text messages containing advice as their pregnancy develops and as their child grows. Links to videos of midwives demonstrating practical advice and parents discussing issues that affected them will also be sent. Visit: www.nhs.uk/informationserviceforparents

Small Wonders DVD
The Small Wonders DVD is produced by Best Beginnings and aims to support parents of premature and sick babies to play a pivotal role in their babies’ care. The DVD consists of 12 short films that follow 16 families on their journey from birth, through their first contact with their babies, to their child’s first birthday. Visit: www.bestbeginnings.org.uk

The Association of Breastfeeding Mothers contributed content to the breastfeeding supplement provided with the last issue of Community Practitioner. They would like it to be known that they did so unaware of the fact this supplement was associated with an advertising sponsor. The ABM is fully committed to supporting the WHO code on the marketing of breast milk substitutes. You can read more about the importance of the code here: http://www.babymilkaction.org/regs/theodec.html

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Helping homeless children achieve their potential

The QK House project aims to give sixth formers without accommodation a safe place to stay in order that they can continue with their studies – and many are thriving as a result

Chloe Harries
Assistant Editor

Quintin Kynaston School is a specialist technology community academy based in north-west London. Awarded a rating of ‘outstanding’ in 2008 by Ofsted, the school has just been awarded that title again. The centre has over 1,400 students aged 11 to 19, of whom 400 are currently sixth formers.

Although founded in 1886, the school is innovative and forward thinking in its approach – constantly adopting the ‘QK’ ethos of a family-like atmosphere to strive for the best. The QK House project is just one example, and is the first of its kind.

‘The idea for the project was dreamed up during an innovative three-year pilot manned by Jessica Streeter, a Band 7 Specialist School Nurse Practitioner, which put a full-time school nurse in an area of high need. The pilot is a collaboration between the Central London Community Healthcare NHS Trust (CLCH) and head teacher Jo Shuter, who felt strongly that the presence of a full-time school nurse would be incredibly beneficial to the wellbeing of students.

Jessica’s role in the QK House project has been very much a supporting one: ‘Like everyone else, I have been supporting them and the school and supporting affected students. Homelessness affects children at every level of their development; socially and emotionally, no space, no place to work, grow or play. As frontline public health members it is highly relevant.’

Irene Forster, deputy head teacher, explains what the QK House project is and why they are focusing on improving public health outcomes for students: ‘We came up with the idea first when myself and the head teacher, Jo, were driving to a school basketball match. We were talking about some of our sixth formers who were struggling and we thought wouldn’t it be great if they had somewhere to live? Then we thought: “Right – we’re going to do this.”’

That was in 2010. Since then they have worked tirelessly to get the project up and running. QK House gained charitable status last April; the plan is to buy a large house close to the school and to turn it into a temporary home for homeless or vulnerably housed students who are trying to continue their education. One of the most important distinctions that Irene is keen to make is that QK House will not be a hostel: ‘It is a family home,’ she said.

The ideal model for the project would include live-in ‘house parents’ who would ensure that the students are well looked after and aid the intended family feel of the house. Irene has had much experience of seeing pupils aged 16 and above struggle with homelessness issues. At this age, it is very difficult to find foster places and hostels sometimes seem worse for some than living on the streets: ‘In a hostel you’re left to fend for yourself’.

Fundraising

In the last year, through donations and fundraisers, including a concert at Cadogan Hall in central London, QK House has raised around £50,000. The next step is to buy the property. Irene explains: ‘We have been in negotiation with potential benefactors and looked at a few properties. We are almost at the point of signing on the dotted line and we have got a property that we are interested in.’

But nothing is secured yet. Purchasing a property is the long-term aim, and finding someone who would be prepared to buy on behalf of the charity is the preferred model. The key thing, says Irene, is to get a property close to the school.
'What we’re trying to do is support the local authority. It’s for our students; it would be a place where they can continue on in full-time education. We’re not talking about a boarding school. We would then support them into higher education and help them to get support for when they come back home during the holidays.'

The school has also been in discussions with a London university about using their halls of residence as accommodation during the holidays.

Support
At QK there is a strong network of mentoring and tutor support that is tangible even from talking to just a few of the students.

One of the sixth formers is Nafia Kaplan*, an articulate, bright and friendly girl with enquiring eyes and a soft voice. She has applied to the prestigious King’s College London to study politics and economics in September. She has also experienced homelessness. Throughout most of her young life, Nafia has been the sole carer for her two younger brothers, but has managed to excel academically and fulfil her ambitions. She is adamant that her success and survival have been down to the support she has received from her school.

Christopher Thompson slept rough in Hyde Park on and off for around four months after his mother threw him out of the house when he was only 17. He was studying full time and would come to school every day in the same clothes, tired and hungry. He is now at QK finishing his A-levels, and life is very much a different picture.

He explains what happened before he told a teacher what he was going on: 'The Southwark housing unit refused to help. It was a difficult time. But the ball never got rolling until I told someone here.'

Christopher is now reunited with his father in Reading and commutes in each day to school. QK pays for his travel and expenses so he can stay on until he has completed his studies. An interesting and bright young man, he is modest about his achievements in the face of such a trying time. He is about to take A-levels in physics, maths and sports science and has applied to several universities, including Queen Mary and Hull, to study astrophysics. His dream, he says, is to become an astronaut.

QK employs two homeless students as part-time youth advisers and a third as an evening receptionist. Of course, the school cannot give jobs to all students but, for a few, it has given them the money that they need, as Nafia says, to ‘put food on the table’.

Stigma
How does the stigma of homelessness affect a child who might want to approach an adult for help but is afraid? Christopher says pragmatically: ‘I had bigger worries – I needed a roof over my head and food in my stomach. There seems to be an entirely different teacher–student culture at QK compared to other schools. ‘It’s definitely got the family feeling going on’ says Christopher. ‘At other schools it’s only about your performance but here they’re concerned about how you’re doing as a person. They do care.’

Christopher recalls when a teacher first realised that something was wrong. He had been set homework that involved accessing the internet. Sleeping rough, he obviously had no access to a computer and had to tell his teacher that he couldn’t do the homework. Surprised, the teacher asked why he had no internet – and the rest is history.

Christopher said: ‘It snapped me awake. I know that if I want something I need to get it myself. The school took me under their wing as an adopted son.’

Nafia’s story was different. Unlike Christopher, who came home to find his possessions in bags on the street, Nafia lived a daily battle with her mother’s mental health issues and her dad’s neglect.

‘My mum is schizophrenic and my dad is a gambling addict; as the oldest I have had to look after my two younger brothers. The situation was getting worse and worse and she tried to set fire to the house and tried to stab us. Dad gambled to the point where he couldn’t pay for anything, no household bills and no food. It got to the point where I was hospitalised – I couldn’t deal with it.’

QK now employs her part time as an evening receptionist. She adds: ‘I can’t rely on social workers, they put hope in us and then they never come back.’ For Nafia, ‘the school is my main source of help. I am actually going to miss this school’. Of Irene and Jo she says simply: ‘I love them.’

The future
So far, the school nurse pilot has been a great success, says Jessica: ‘We try to adhere to the BYC (British Youth Council) advice in their 2011 guidance Our School Nurse: to be visible, accessible and confidential.

The pilot finishes in July of this year, and by then QK House might have taken its next step. Jessica will stay on in the full-time role for now. She says: ‘The best thing about being a school nurse is knowing that you really can make a difference to people’s lives. Seeing children who were struggling and then seeing that you have done something to benefit them is an incredible feeling.

She adds that she does not see the Health Visitor Implementation Plan as a threat, but instead as an opportunity: ‘It wasn’t long ago that health visitors were taking a back seat too. Now we have the chance to say “Health visitors and school nurses are working together!”’

So, as the school nurse who has piloted this very successful scheme in a school that has innovated to put the troubles of the often-neglected 16–19 age group first, what does Jessica want for the future?

Well, for a start, more school nurses: ‘There aren’t enough of us nationally. Once you put a qualified school nurse in every school full time, you will see the results. Having set out a strong school nursing vision, we need to increase the number of high-quality, fully trained school nurses, and to highlight the examples of all of the good practice that is going on across the country. Ultimately, we want children to succeed and to be healthy and happy.’

For more information on the QK House project please contact: 020 7722 8141, or visit: www.qkschool.org.uk/qkhouse

For more information about school nursing through Central London Community Healthcare NHS Trust please contact: ask.us@clch.nhs.uk or Jessica.streeting@clch.nhs.uk

*All students’ names have been changed

NEWS FEATURE
The role of health visitors continued to expand and gain legitimacy as the birth of the NHS neared. On 1 April 1928, the Ministry of Health released a circular stating that, to be hired as a full-time health visitor by a local government, the visitor must have a Royal Sanitary Institute certificate. Although the exams had been established in 1908, the certificate was not a mandatory requirement for employment until this point.

In 1929, the Women Sanitary Inspectors’ and Health Visitors’ Association (WSIHVA) changed its name for the second time, becoming the Women Public Health Officers’ Association (WPHOA) as a sign of expanding membership and inclusion of others working in public health field. In the same year, a visit from German public health workers to London inspired the WPHOA to begin its own series of international trips. Some of the places members visited included Germany (1930), the US and Canada (1939) and Sweden (1949). Two years later, a series of annual conferences began, covering a range of topics including, in the first year, a paper by M Wilson on ‘The position of women public health officers who are required to undertake duties which are contrary to their convictions eg, to assist at Birth Control Clinics’.

Then came the National Health Service. Conceived in 1946, the NHS launched on 5 July 1948. At this time it had a tripartite system, with health visitors coming under the community services umbrella. Local authorities, as before, remained responsible for employment. However, the basic role of health visitors expanded from an emphasis on the health of mothers and babies to cover preventive health of the whole family. They also began working with other groups, such as patients needing care after hospital stays, patients with long-term illnesses and families with social problems.

As of 1 April, the Ministry of Health makes it a compulsory requirement for full-time health visitors to possess the Royal Sanitary Institute certificate. At this time, if a health visitor did not have this certificate, the local government could not employ him or her.

The WPHOA begins holding an annual series of conferences from this year forward.

The Education Act of 1944 expanded on earlier education acts, putting more emphasis on giving students of all ages medical inspections. As the act also increased the school-leaving age, this expanded the role of school nurses and other medical professionals employed by the school and ensured better health in more young people.

As of 5 July, the National Health Service Act launches, revolutionising health care in the UK. The role of health visitors expanded to preventive health for the whole family rather than a specific focus on mothers and babies, as well as care for other groups, including the elderly.
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 medicines 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 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

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: Ibuprofen 100 mg/5 ml (equivalent to 2 1/2 mg/ml).

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, arthralgia, aches and spasms. Dosage: For pain and fever 20-30 mg/kg bodyweight/day in 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 2.5 ml doses in 24 hours. If the fever is not reduced, consult a doctor. Not suitable for children under 3 months of age unless advised by the doctor for oral administration and short-term use only. Contraindications: Hypersensitivity to constituents in the product. History of, or existing, peptic 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 the stated dose. A doctor should be consulted if symptoms persist for more than 3 days (for a child aged over 6 months) or children under 6 months, seek medical advice if symptoms persist after 24 hours use of three 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, SL1 1AQ. Product Licence Number: PL 00063/0667/PL 00063/0668. Legal Category: GSL. MRHP: £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/mdrcard. Adverse events should also be reported to Reckitt Benckiser Healthcare (UK) Ltd on 01306 653 456.

REFERENCES:
Establishing an antenatal group for families with a diagnosis of cleft lip

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Abstract
UK cleft teams offer antenatal packages of care, which seek to be research based and respond locally to national standards of care set by the UK cleft nurse’s special interest group (SIG). In April 2010 the 18-to-20-week National Health Service (NHS) Foetal Anomaly Ultrasound Scan Programme (FASP) standards and guidance for England were changed to include routine screening of the face to improve national pick up rates for cleft lip, which should increase referrals to cleft teams. This article aims to discuss the development of a specialist cleft antenatal group, established as a collaborative project between clinical nurse specialists (CNS) and clinical psychologists in the North-west England, Isle of Man and North Wales (NWWN) Cleft Network. Two pilot groups ran in 2008. Families referred to the team in the antenatal period were invited to attend a ‘one-off’ group before their child’s birth. The group aim was to facilitate parental adjustment to cleft diagnosis in the antenatal period. Regular groups were then established in both network surgical hubs (Alder Hey and Royal Manchester Children’s Hospitals (AHCH and RMCH)) every three or four months as part of the routine package of care provided by the team. Attendance at these groups ranged from 30–50% of those invited between 2008 to 2011. Feedback forms from attendees have informed the evolution of the group. The groups facilitate peer support at an important adjustment time for families.

Key words
Antenatal group, cleft lip and or palate, adjustment, peer support


No potential competing interests declared

Introduction
Cleft lip and palate is a common condition that occurs between six and 13 weeks of pregnancy due to a failure of fusion of the facial tissues. A recent UK national audit reported the incidence of clefting as one in 670 live births 2005–2009 (Blair and Nurses4cleft SIG, 2011). Half of these will involve a cleft lip and or palate. For the nine regional cleft networks that are commissioned to provide care for the cleft population in the UK, prompt referral from scanning units provides an opportunity to optimise health outcomes for families (Davalbhakra and Hall, 2000).

Research is limited, but studies looking at the impact of discovering a cleft in pregnancy, report that although stressful, it is generally better to know before delivery, as it gives time to prepare and adjust to the diagnosis (Hendrick, 2005; Nusbaum et al, 2008). Cleft teams seek to offer families support in line with what research suggests helps. Specialist cleft nurses have agreed national standards relating to the minimum level of care families should receive (Box 1).

Box 1. National standards for the antenatal diagnosis of a facial cleft (SIG, 2011)

The minimum standards of care that should be offered to families following an antenatal diagnosis of a facial cleft are as follows:

Standard 1
Parents are to be referred by relevant professionals to the cleft team on the day of initial diagnosis

Standard 2
Parents are to be given written details of the cleft team, on the day of initial diagnosis

Standard 3
Parents are to be contacted by the clinical nurse specialist within 24 hours of receiving a referral

Standard 4
Parents are to be offered a visit at an appropriate and negotiated time and place

Standard 5
The clinical nurse specialist shall make contact with the primary healthcare team during the antenatal period

Standard 6
All parents are to be offered these services in the antenatal period:
- Counselling and support
- Appropriate feeding preparation and plan for immediate postnatal period
- Verbal and written information regarding cleft treatment and management
- Opportunity to meet other families
- Opportunity to meet the cleft team
- Written information about Cleft Lip & Palate Association (CLAPA)

Standard 7
The prenatal diagnosis of classification of lip and alveolar clefting should correspond with the diagnosis at birth

In April 2010 the 18-to-20-week NHS Foetal Anomaly Ultrasound Scan Programme (FASP, 2010) standards and guidance for England changed to include routine screening of the face. Before this, examination for facial clefting was optional and detection rates varied across the UK. For a child, the cleft diagnosis heralds long-term health implications. A cleft lip diagnosis can affect parent and child emotional wellbeing. If the palate is also involved, speech, hearing and feeding issues may occur. The standard set by FASP of 75% of facial clefts detected pre-birth should substantially improve antenatal referrals of facial clefts (Klein et al reported detection rates of only 30% in 2006).

Parents often see the 20-week anomaly scan as an opportunity to see a healthy baby. Being informed their ‘ideal baby’ will
The findings from a patient satisfaction audit, et al (1995) found parents valued and they wanted more opportunities to meet with other parents.

Bannister et al (2008), in presenting findings from a patient satisfaction audit, identified how parents may have very different emotional reactions to the cleft and differing needs. They identified a need to normalise feelings and concerns, and work from a strength-based approach to try to instil hope and optimism for the future and decrease worry. An antenatal group with skilled facilitators appeared to be a safe environment where parents could be encouraged to share their experiences and fears with each other and offer support to each other.

Discussions between the nursing and psychology teams led to plans to develop an antenatal group to help facilitate these unmet needs. This group being set up and developed by the team could be seen as an example of applying the principles of health visiting in a specialist nursing field (Cowley and Frost, 2006). It was envisioned as acting as a preventive and health-focused method of facilitating parental adjustment to their child’s diagnosis of cleft lip and/or palate.

Two pilot groups were run in early 2008 with the following objectives:

- To orientate parents to the cleft department
- To introduce parents to members of the cleft team who may be involved in the care of their baby
- To address concerns or questions that parents had about their child’s cleft management
- To normalise parental experiences of adjusting to their baby’s cleft in the social context of a group
- To facilitate the parent/child bond
- To provide social/informal support from other parents in a safe, supportive environment
- To invest in parents’ views and model a working environment where parents communicated openly with professionals.

The groups were held mid-to-late morning and lasted about two hours. They were facilitated by CNSs and a clinical psychologist. Other cleft team members were introduced briefly at the start of the session. Parents were invited with the option of bringing a friend or family member if their partners were unavailable. General inclusion and exclusion criteria were agreed but these were flexible so the nurse responsible for care could invite outside those criteria if appropriate. An example was that a basic command of spoken English was needed as interpreters for the project were not initially funded or easily accessed. If someone was available to assist with language then families could participate and would be welcome. Extra consideration was also given to the appropriateness of the invitation if it was known antenatal scans had indicated the baby had additional serious health concerns.

Method

Fourteen expectant parents attended the two pilot groups, mostly as couples (half of those invited by post). Some went to considerable effort to attend, travelling up to two hours to participate. The format of the group included a brief tour of the cleft unit on arrival followed by introductions and agreement of ground rules including establishing that discussions would be confidential.
A talk from a CNS about feeding a baby with a cleft was followed by staff guiding parents to consider open-ended questions the team felt would facilitate discussion about parental feelings including:

- What excites you and what worries you about the arrival of your new baby? (Parents may want to talk about how they may feel when they meet their baby with others who can identify with the mixed emotions of this. They may also want to share enjoying being pregnant and spend time focusing away from the medical/cleft-related issues)
- How do you feel about the way your baby might look?
- Do you have other questions?

‘Pamper packs’ (containing small gifts for parent and child) were given to all participants. Refreshments were available and attempts to make the environment comfortable and welcoming were made. The staff tried to ensure all parents had an opportunity to speak if they wanted to and staff were available to input cleft specialist information as needed. Feedback questionnaires identified participants valued meeting team members in addition to their allocated nurse and familiarising themselves with the department and gaining information about cleft care. It was explained that when they delivered their baby a 24-hour response requirement meant it may be the CNS on call who visited initially, rather than their own nurse, so meeting more of the team was seen as helpful.

Parents liked hearing about others’ experiences, meeting each other and sharing together. Some expressed feeling less isolated in their situation (Box 3). A feedback form was completed by all who attended. The feedback was unanimous in saying the group should continue in the future.

**Professional outcome of pilot**

The nursing staff believed it was beneficial to have met mothers from other nurses’ caseloads who they may meet in the future while covering for colleagues. This was an unexpected benefit for the team. They felt the group offered families the chance to share feelings and realise that others have similar fears and worries. They perceived the group as a positive health promotion opportunity and felt it a good forum to introduce families to the wider team and cleft service.

**Recommendations**

Taking note of the written feedback, a team decision was made to continue the groups in Alder Hey and Royal Manchester Children’s Hospitals. A CNS was identified to facilitate the practicalities of this at each centre. A telephone call to families a week or so before the group was held was found to increase uptake. A local parent representative from CLAPA and a family with a baby from a previous antenatal group with an unrepaired cleft were invited to attend. This was popular and was valued on feedback forms. An opportunity to share 4D and 3D images was made and feedback confirmed findings of Cadogen et al (2009) that attending for such a scan in the antenatal period decreases worry, helps parents visualise the cleft and adjust to it. Parents reported excitement at seeing their baby move and kick and felt it focused attention on the whole baby rather than the cleft.

Feedback forms completed at both groups have been valuable and have informed a change in emphasis of current groups, with a move away from information giving by the professional team. Families have a lot of input as users of the service on a one to one basis about all aspects of cleft care from their cleft specialist nurse. It has become evident that the thing they most value is to share feelings and experiences with each other and meet a baby with a cleft, as evidenced by Smith et

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**Box 3. Comments on feedback sheets from pilot groups**

**What was gained?**
- ‘Helps to know you’re not the only one going through it’
- ‘Confirmed that we won’t be left to sort out feeding on our own’
- ‘More information’
- ‘Peace of mind with resolving uncertainties, and the knowledge that we are not on our own’
- ‘You can put your own position into perspective’
- ‘I was more comfortable’
- ‘More information about cleft lip and palate’
- ‘A chance to meet other expecting parents with cleft babies. Also to get an insight on what happens and where to go for audiology and the dentist’
- ‘Meeting the team and a tour of the department’
- ‘Other people’s experiences really help’
- ‘It was good to share experiences with other parents’

**Good things?**
- ‘Information’
- ‘Gives information to pregnant women who are having a baby with cleft lip/palate or both’
- ‘The friendly stuff, who are very assuring in questions we asked. Also other parents who come sharing their experience’
- ‘Meeting others’
- ‘Good idea to meet all the team and get used to the surroundings’
- ‘You meet people who are going through the same thing and you feel like you are not alone’
- ‘Nice to make the connection with other people’
- ‘Finding out that other people’s apprehensions are same as ours is useful’
- ‘Seeing other scans was interesting’
- ‘Meeting more of the team’
- ‘Gives information and you meet different people with baby with cleft lip’
- ‘The way you feel you can ask anything freely in a welcoming environment’
- ‘Sharing experiences you have with others and being able to see other people’s perspectives’
- ‘It’s an uncertain time so making the effort to meet and talk is worthwhile. Thanks’
- ‘Thanks, great team’

**Improvements**
- ‘No (improvements). I think the group was calm and relaxing with lots of advice at hand’
- ‘Perhaps further groups could involve new parents to share recent experiences’
- ‘It’s perfect’
- ‘It could appear to some intimidating having so many different professionals in one room’
Regional cleft networks offer antenatal support to parents who are found to be expecting a child with a facial cleft at their 20-week anomaly scan.

The news of a cleft diagnosis comes as a shock to parents who need time and support to adjust and reorganise their constructs about parenthood.

In 2007 the NWNW Cleft team nurses reviewed antenatal services. Peer support was reported valuable in cleft research literature, yet it appeared few families served by the network benefited from this.

A cleft specific antenatal group was developed and regular feedback from clients has informed its evolution.

The antenatal group for families expecting a child with a facial cleft at their 20-week anomaly scan.

Families are motivated to travel the long distances to meet each other. Once provides. Families are motivated to travel the routine care the NWNW Cleft Network a child with a facial cleft has become part of.

The antenatal group for families expecting their baby.

As the discussion opened up it also allowed other parents to share how they were coping. People felt less isolated as a result and various issues became easier topics to discuss in the group format. The couple attending with their baby were able to contribute from other units interested in learning from our experiences.

References
Students’ experiences of a placement with health visitors during their adult nurse training

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Abstract
This qualitative study explored the experiences of adult nursing students from one university who had undertaken a clinical placement with health visitors. A convenience sample of 10 students were recruited to the study and semi-structured interviews used to gather data. Interviews were digitally recorded, transcribed verbatim and subject to thematic analysis. Three global themes emerged: the learning experience; mentors and mentorship; and the nursing and health visiting relationship.

Key words
Health visiting; nurse education; placement experience


No potential competing interests declared

Introduction
Government reform (Department of Health [DH], 2009) has guided a shift of patient care into home and primary care settings with 80% of patients’ healthcare journeys now beginning and ending in the community (Arnott, 2010). The ‘heart of public health’ lies within communities (DH, 2010: 1) and successful delivery of the public health agenda relies on an appropriately skilled, educated and motivated workforce. The government’s pledge to increase appropriately skilled, educated and motivated communities (DH, 2010: 1) and successful programmes of study to meet the demands of these changes. There is a perception that nurses are not best prepared for a primary care career (Ali et al, 2011) and recommendations for closer working between nurse educators and practice colleagues to better understand the demands of practice have been made (Ali et al, 2011). There is little research that explores the experiences of those students who have worked with health visitors and the impact of those experiences on their perception of health visiting practice. This study sought to add to the knowledge base and begin to address that gap through exploring the individual experiences of students studying at one Higher Education Institute (HEI).

Aim
To explore the experiences of adult nursing students who have undertaken a placement with health visitors.

Ethical approval
Ethical approval was granted by the HEI’s ethical committee. Pseudonyms protected participants’ confidentiality and anonymity. Digitally recorded data were stored securely and computer-based data were password protected.

Method
A qualitative approach was adopted. Not all adult students are offered a placement with health visitors but those who did were invited to take part. A convenience sample of eight female and two male volunteers were recruited. Consent included permission to digitally record the interviews and use quotations in any subsequent report of the findings. Semi-structured interviews were used to gather data and interview schedules made available to participants in advance. Questions related to students’ perceptions and understanding of the role of health visitors; their thoughts about links between health visiting and adult nurse training and their considerations of health visiting as a future career choice.

Data analysis
Interviews were transcribed verbatim and subject to thematic analysis using a thematic network approach (Attride-Stirling, 2001). Thematic networks aim to provide a systematic means of analysing textual data (Attride-Stirling, 2001). Nineteen basic themes were based on commonalities, individual experiences, and recurring ideas and feelings linked to the study aim and objectives. Detailed analysis enabled the interpretation of eight organising themes. Three global themes unifying the organising themes summarise the thematic network (see Table 1).

Findings
The learning experience
Placement duration averaged five weeks but there were notable differences in the depth and breadth of acquired learning associated with a number of factors, including expectations of and preparation for placement.

‘The university could have made me more aware of what I’d be doing … I found it a shock.’ (P. 9)

Participants were universally unsure of the extent of the health visiting role. Post-placement, participants’ understanding of the role remained largely limited to responsibility for children under three, but included public health interventions, including domestic abuse and safeguarding.

The physical environment was not always conducive to optimum learning. Feelings of isolation and loneliness were expressed.

‘We stood or sat in the corner or in the canteen and they would come and find us. I didn’t feel involved at all when we weren’t sat in there.’ (P.8)

Participants who were better accommodated reported positive experiences and felt more engaged in the placement experience.

‘There was a chair for me ... one of very few placements where I felt part of a team.’ (P.2)

Restricted access to busy mentors reduced opportunities to participate in some activities and limited time for reflection on progress.
was described: ‘Being sent home was an everyday occurrence.’ (P.8)

Male participants felt their gender was an issue of concern to mentors and expressed feelings of inadequacy and prejudice. They felt health visitors sometimes assumed clients would prefer them not to visit because of their gender and were told their gender may threaten the wellbeing of female clients. Male participants would have valued explanations for health visitors’ refusal to involve them in visits they considered valuable learning opportunities, such as teenage parents and women who had endured miscarriage.

‘Health visitors made a deal about the “male thing” and wouldn’t take me anywhere where they viewed I might be a threat to women.’ (P.8)

‘I felt awful. I thought do I look intimidating? It made me question whether a community nurse role for a male is really appropriate because of the way they were.’ (P.6)

Exposure to a variety of health visiting practice varied considerably. There was universal exposure to well baby clinics, developmental assessments and Sure Start centre initiatives, including smoking cessation, although predominantly through observation. Participants felt they could have been more involved under supervision in record keeping, initiating conversations, offering health promotion advice, charting measurements and handling babies and children.

‘I was very restricted to what I could do ... never responsible for anything.’ (P.3)

Few participants were able to engage with home visits where sensitive issues, such as domestic abuse and safeguarding, were concerns, while others were engaged with all aspects of their mentor’s work.

‘I was told student nurses aren’t allowed to get involved because of confidentiality.’ (P.2)

‘I got the chance to see all the cases where there’s been abuse or violence.’ (P.4)

Missed opportunities for developing a better understanding of safeguarding practice were voiced and participants considered health visitors might have done more to explain their work when access to families was denied: ‘I want them to tell me what they would do.’ (P.5)

Participants all reported development of communication skills. There was an acknowledgement of a better understanding of the wider determinants of health, maintaining dignity and confidentiality, making judgements and working in partnership.

‘The skills of health promotion practice and how to adapt your health promotion to different people at different levels of need.’ (P.5)

The emotional impact of a placement with health visitors was tangible in all participants’ interviews. A range of emotions were expressed including excitement, surprise, shock, sadness, powerlessness, nervousness, guilt and frustration. Positive emotions related to discovering the health visiting role and the career opportunities this might bring. Negative emotions related to experiences of safeguarding.

Participants were often unprepared for what they would see and hear: ‘I used to go home and cry ... emotionally draining.’ (P.1)

‘I felt nervous ... almost overwhelming.’ (P.2)

Participants described feeling more confident and less judgemental post placement. They reported having matured and felt better able to consider the complex influences on people’s lives.

‘I matured as a nurse. I learnt everyone is different ... health visiting helped me to do that.’ (P.4)

**Mentors and mentorship**

There was universal praise for the positive impact of a welcoming team.

“They involved me all the time ... I felt like I had gone there to work and they were training me up.” (P.2)

Participants expressed admiration for the skills and knowledge of health visitors working in challenging environments: ‘Really capable and knowledgeable.’ (P.1)

They observed health visitors’ excellent communication skills and noticed how they adapted advice, listened actively, organised their workload and attended to safety issues: ‘The health visitor had really good judgement and I trusted her.’ (P.9)

Participants noticed when mentors seemed uncertain about how far students could be involved in the delivery of care.

‘My mentor could get more anxious than me ... was a little unsure about knowing what I could and couldn’t do.’ (P.10)

When mentors strived to ensure participants were always working and learning this was described as valuable. Structured timetabling of work, thoughtful placement with other team members and regular reflection on progress were all conducive to learning.

‘My mentor was excellent ... really interested in my learning ... asking me questions ... trying to get me to think.’ (P.10)

Participants recognised mentors could not be with them all of the time but expressed concern about the amount of time they were left without direction. Some were regularly invited to arrive late and leave early.

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### Table 1. Basic to global themes organisation

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**Mentors and mentorship**

There was universal praise for the positive impact of a welcoming team.

“They involved me all the time ... I felt like I had gone there to work and they were training me up.” (P.2)

Participants expressed admiration for the skills and knowledge of health visitors working in challenging environments: ‘Really capable and knowledgeable.’ (P.1)

They observed health visitors’ excellent communication skills and noticed how they adapted advice, listened actively, organised their workload and attended to safety issues: ‘The health visitor had really good judgement and I trusted her.’ (P.9)

Participants noticed when mentors seemed uncertain about how far students could be involved in the delivery of care.

‘My mentor could get more anxious than me ... was a little unsure about knowing what I could and couldn’t do.’ (P.10)

When mentors strived to ensure participants were always working and learning this was described as valuable. Structured timetabling of work, thoughtful placement with other team members and regular reflection on progress were all conducive to learning.

‘My mentor was excellent ... really interested in my learning ... asking me questions ... trying to get me to think.’ (P.10)

Participants recognised mentors could not be with them all of the time but expressed concern about the amount of time they were left without direction. Some were regularly invited to arrive late and leave early.
"They didn’t give me anything to do. They were on the phone a lot but I didn’t know what about or what was going on.’ (P.3)

The nursing and health visiting relationship
The community rather than acute setting was described by participants as better able to facilitate high-quality health care: ‘It feels more like nursing as I perceived it was going to be ... get to know your patients more.’ (P.7)

All participants affirmed the relevance of a placement with health visitors as part of their training. Health visiting as a potential career appealed to a majority of participants. Autonomy, supportive teams and time to spend with people in their care were appealing. Not all felt they would be ready to enter the profession upon qualifying as a nurse. Anxieties centred on perceived loss of clinical skills and a lack of confidence.

‘It seemed like one of those jobs where if you took your eye off things it could all go horribly wrong ... you have so much responsibility, I want a few more years of being comfortable being a nurse before I’d think about that.’ (P.9)

Discussion
The call for increased ‘home nursing’ placements for students has been made (NMC, 2010), yet placements with health visitors are currently too few to meet the demand (Drennan et al, 2004). Bender et al (2009) highlighted the need for nurses to contextualise practice within different settings to manage unpredictable situations, work flexibly and improve care. In this study all participants valued their health visiting placement making reference to a range of learning opportunities. The government is committed to increasing health visiting numbers (DH, 2011) and high-quality placements are a recognised way of highlighting this career pathway to a new generation of nurses (Drennan et al, 2004).

The community as a setting for healthcare delivery appealed to many participants in this study who valued the opportunity to explore an area of practice with which they were previously unfamiliar. A less hierarchical structure, time to care, excellent teamwork and professional autonomy were considered appealing. Many participants remained uncertain about entering health visiting immediately after qualifying, citing a lack of confidence and loss of nursing skills as contributing factors. This finding accords with the work of Ali et al (2011) who emphasised how both nurses themselves and NHS managers considered novice nurses to be unprepared for a primary care-based career. So how can educators respond?

Mentors have a vital role to play in ‘promoting’ their profession to students and literature supports this study’s finding that mentors with a positive attitude, approachable and friendly manner and an understanding of individual students’ learning objectives facilitate optimum progress (Wilkes, 2006).

While the precise nature of the placement experience varied between participants, in common with Betony’s (2012) survey of community placements, participants in this study reported their experiences to be predominantly observational. With supportive mentorship and guided learning the value of observational activity is acknowledged, yet literature suggests placements that encourage direct patient care and enable students to experience the ‘reality’ of the community nurse’s role better meet their learning needs (Baglin and Rugg, 2010).

When mentors adapt and ‘juggle’ their work to balance the competing needs of clients and students (Kenyon and Peckover, 2008) or fail to expose students to all aspects of their day-to-day practice, the realities of health visiting may remain a mystery. As more nurses are recruited directly into community nursing roles at the point of registration, consideration of how best to prepare them to meet the challenges of primary care nursing remains a priority for nurse educators and mentors. Inadequately prepared nurses may compromise patient care through unconscious ‘acts of omission’. Strategies for education in practice, including a team approach to mentorship, may prove useful as well as a clear understanding by mentors of the strengths, developmental needs and anxieties of individual learners.

Health visiting offers unique learning opportunities, particularly for increasing students’ awareness of safeguarding, yet the impact of restricted access to families where safeguarding issues were paramount seemed to limit participants’ knowledge and understanding of this aspect of nursing practice. The NMC (2010) has called for safeguarding awareness to be more explicit within nurse training. While participants were better able after undertaking their placement to recognise the role of the health visitor in safeguarding situations they remained uncertain of the responsibilities and practical steps other adult nurses might take in such situations.

If direct access to safeguarding experience through home visiting is not feasible then consideration of how best to educate students in this regard remains important. Better preparation within universities may offer one solution but working with and learning from health visitors seems a way of valuing their expertise and forging direct links to the practice environment where the complexities of people’s lives are brought to life. Case-based discussion with students in practice may be useful and support from management to release health visitors to support the planning, delivery and evaluation of the curriculum would be valuable.

Despite acknowledging the use of and development of communication skills during their health visiting placement many participants expressed concern about not using and losing other practical skills. Baglin and Rugg (2010) suggest the acquisition of practical skills competence is linked to confidence and may help to explain this study’s findings. Sayers’ (2011) study highlighted how even experienced nurses moving into a community-based career felt de-skilled in their journey from ‘nurse’ to ‘community nurse’; yet, as more novice nurses begin their careers in community settings (NHS Employers, 2009) the profession must address this anxiety and consider how best to prepare students for working in a range of environments where different skills sets are used.

Flexibility and creativity in the way essential skills clusters (NMC, 2010) can be incorporated into undergraduate training programmes provides a valuable means of demonstrating the value and use of a broader range of nursing skills to students.

A paucity of current research limits knowledge and understanding of both the needs of male nurses seeking a community-based career and of clients’ attitudes towards men in the community professions, but male nurses within health visiting ‘may play a particularly valuable role’ in preventive health work (Williams, 1996: 398).

Male participants in this study were left frustrated by their experiences. Mirroring findings elsewhere (Stott, 2007), they felt excluded from core aspects of health visiting work and personally rejected. The needs of male students might be given specific consideration within health visiting teams and this study highlighted a felt need for students to spend time talking to male colleagues working in the community. While the welfare of families must remain paramount, avoiding assumptions about clients’ willingness or otherwise to engage with students might be considered and
adopting a team approach to mentorship may prove useful (Mallick and Hunt, 2007). This study highlighted the emotional impact of a health visiting placement and a need for those involved in nurse education to be more attentive to addressing students’ needs in this regard. Positive emotions including hope, excitement and fulfilment were voiced, but negative emotions including feelings of sadness, anxiety, shock and an overwhelming sense of responsibility were keenly expressed.

Despite the impact such emotional engagement had on participants there were limited opportunities for many to explore and reflect upon these feelings with mentors. Nursing inevitably triggers emotional engagement and a nurse’s ability to manage his or her own emotions is essential to providing quality care (Evans and Allen, 2002). Anxiety can affect students’ levels of confidence, yet supportive mentorship can facilitate a secure atmosphere where exploration of thoughts and feelings can provide some containment of anxiety (Holmes, 2005).

Conclusion

This study was undertaken in one HEI in the UK and the findings are therefore limited in their generalisability. However, the opinions of students in this study support the value of a placement with health visitors as part of an adult nursing programme and should be used to encourage placement providers to maintain and expand where possible their network of health visiting placements for adult nursing students. The expressed enthusiasm and interest by students in this study considering health visiting as a potential career option is encouraging at a time when government investment in the profession has been made.

The emotional impact on students of a placement with health visitors should not be underestimated by nurse educators. While a wealth of literature has highlighted the value of proficient mentorship, the opinions of students within this study offer new insights into the supportive role mentors in health visiting play when encouraging students to focus on some of the more challenging public health concerns in a community setting.

Ensuring students are prepared in advance for the nature of health visiting practice and offered a meaningful placement experience with support and encouragement to learn is crucial if a future generation of nurses are to take over the reins and continue to meet the challenging public health agenda.

Key points

- The community as a setting for health care appeals to a new generation of nurses. Time to care, team working and autonomous practice were appealing
- Valuable learning opportunities afforded by health visitors include safeguarding, public health awareness, health promotion, family-centred care and community engagement
- Awareness of individual students’ learning needs will optimise skills development, confidence and progress
- Mentors have a pivotal role to play in promoting the profession to a new generation of nurses

Recommendations

- A placement with health visitors was valued. There is continued need for increasing the capacity and capability of HV placements for adult nursing students
- Mentors are reminded of their value in the teaching and learning process and encouraged to maximise the depth and breadth of students’ experiences in order to better prepare a new generation of nurses for a career in primary care
- This study highlighted the emotional impact of a HV placement, supporting a need for better preparation for practice within university and more opportunity for reflection of with mentors
- The particular needs of male students working with health visitors warrants attention. Planning for placement and a team approach to mentoring might be considered.

Acknowledgements

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References

Nursing and Midwifery Council (NMC). (2010) Standards for Pre-Registration Nursing Education. London: NMC.
Befriending breastfeeding: a home-based antenatal pilot for South Asian families

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Abstract
In the last decade recognition of the impact of social inequalities on health has resulted in a refocus of the public health agenda, with health visitors having a pivotal role. While this involvement is in the form of family-centred public health, it is also intended to involve work with the wider community and primarily focuses on beginning to address the injustice of inequality before a child is born, acknowledging that early intervention is key to breaking the cycle of deprivation. Such inequalities disproportionately affect those from black and minority ethnic (BME) groups who are more likely to report long-term ill health than their white counterparts. Access to healthcare services is restricted not only by family choices but also by difficulties of location and language. Numerous initiatives to address these issues have been implemented in the last 10 years, from Sure Start centres to maternity service reform, but the level of engagement from women from BME groups is not equal to their counterparts. In one locality in Oxford there is a high concentration of families from Pakistan and Bangladesh who, despite concerted efforts, have remained hard to reach. This project attempted to redesign the current antenatal breastfeeding information service, and aimed to produce evidence to guide practice to better connect with this group. The review considers evidence provided by the literature base due to inconsistent results are correlated and compared, and recommendations for the future are presented.

Key words
South Asian, breastfeeding, home visiting, service redesign, antenatal information


No potential competing interests declared

Introduction
In the last decade recognition of the impact of social inequalities on health has resulted in a refocus of the public health agenda, with health visitors having a pivotal role (Smith, 2004). Following the 2010 election the government strengthened this emphasis, underlining a commitment to the redevelopment of the health visitor workforce and reinforcing the health visitor position (DH, 2011). While this involvement is in the form of family-centred public health, it is also intended to involve work with the wider community (DH, 2010a), and primarily focuses on beginning to address the injustice of inequality before a child is born, acknowledging that early intervention is key to breaking the cycle of deprivation (DH, 2010a).

The Marmot Review (2010b) clearly acknowledged that inequalities across all areas of life – particularly in employment, education and skills – impact on life choices and long-term health outcomes. Such inequalities disproportionately affect those from BME groups who are more likely to report long-term ill health than their white counterparts. The last 10 years have seen numerous initiatives address this, from Sure Start centres to reforms within maternity services, but the level of engagement from women from BME groups is not equal to that of their counterparts.

One locality in Oxford contains a high concentration of Pakistani and Bangladeshi families who have remained hard to reach. This has been evidenced in the very poor uptake of antenatal breastfeeding information services offered routinely to all families. Anecdotal local reports demonstrate that breastfeeding support and information is only partially supported by the literature base due to inconsistent collection of ethnicity data in primary care from which to assess access to services. However, a 2004 NHS review reported that women from minority ethnic groups used antenatal services less intensively than their white counterparts (Aspinall and Jacobson, 2004). These results are repeated in a survey published in 2010 indicating little change in behaviour among this group (Raleigh et al, 2010). Aspinall et al’s report (2004) highlights the use of bilingual workers as one means of addressing such difficulties of access. Despite these enduring imbalances there is a paucity of studies which attempt to redesign health care to more culturally appropriate standards. The exceptions are two studies

Literature
There is little literature to address the breastfeeding support mechanisms specifically used by South Asian women. Swanson and Power’s (2005) assertion that support from within the family or the woman’s close network is crucial for successful breastfeeding is supported by the results of a study by Twamley et al (2010), which identified family pressure to give formula, and the context of life in extended family households, as strong influences in infant feeding decisions for South Asian women. Twamley’s findings concur with a Birmingham-based study of South Asian women’s experience of breastfeeding in England, which suggests that cultural beliefs and practices heavily influence feeding decisions (Choudhry and Wallace, 2010). Griffiths et al (2007) noted in their study of differing feeding practices of ethnic groups that factors associated with increased breastfeeding duration among white women, such as professional status and education, had the opposite effect among non-white women. The study does not suggest a rationale for this difference but consideration of the extended family networks and shared responsibilities and pressures as suggested above indicate that increased education impacts on a woman’s time at home with a baby, which then impacts on breastfeeding.

Anecdotal information surrounding access and information is only partially supported by the literature base due to inconsistent collection of ethnicity data in primary care from which to assess access to services. However, a 2004 NHS review reported that women from minority ethnic groups used antenatal services less intensively than their white counterparts (Aspinall and Jacobson, 2004). These results are repeated in a survey published in 2010 indicating little change in behaviour among this group (Raleigh et al, 2010). Aspinall et al’s report (2004) highlights the use of bilingual workers as one means of addressing such difficulties of access. Despite these enduring imbalances there is a paucity of studies which attempt to redesign health care to more culturally appropriate standards. The exceptions are two studies

No potential competing interests declared
The project also aimed to produce evidence to increase breastfeeding rates at six weeks. This project attempted to redesign current antenatal pilot for South Asian families to consider the potential of a home-based service to redress inequity of access, and to guide practice to better connect with this group.

**Aim of the project**
This project attempted to redesign current service to redress inequity of access, and consider the potential of a home-based antenatal pilot for South Asian families to increase breastfeeding rates at six weeks. The project also aimed to produce evidence to guide practice to better connect with this group.

**Method**
A small, self-selecting sample participated in this pilot. All pregnant women of South Asian origin within a catchment area of three children’s centres, in areas of high ethnicity, were invited to be part of the study. The women were identified via local midwives and health visitor antenatal lists. Each family received a letter in English, Bengal or Urdu explaining the project, how they had been identified and informing them they would receive a telephone call from a children’s centre (CC) worker to discuss it further. At this visit all families were offered the ante- and postnatal schedules of care (see Boxes 1 and 2).

Visits were delivered by either a CC worker or a health visitor, who had completed UNICEF breastfeeding management training and who was assigned to the family for the duration of the project. Some CC workers were of South Asian origin themselves and spoke the relevant languages. One CC worker and the health visitor were accompanied on visits by trained volunteers to help with the language barrier.

Pre-pilot questionnaires, delivered by the assigned worker at the introductory visit, were used to assess both initial breastfeeding and post-pilot knowledge at six weeks. Topics assessed included knowledge of the benefits of breastfeeding, positioning and attachment, and where to get support. Aggregate scores were given and the data compared. Routine breastfeeding data were gathered at birth, the primary birth visit at day 10–14, and six weeks. Qualitative data were generated via an end-of-pilot evaluation for both participants and staff.

Ethical approval was sought from the local Research Ethics Committee, and the Chair indicated that as it was a service redesign initiative ethical review was not required. For the same reasons participants in the pilot were not required to sign a consent form. All families were informed on their first visit that they could leave the project at any time, without it affecting their routine care.

**Results**

**Sample**
Four families identified from the initial health visitor antenatal lists were not contacted. Two of these due to incorrect contact details, one moved out of the area, and one referral was not followed up by CC staff due to resourcing issues. Most families who declined felt they did not need the service as they would get support from within the family, and they had older children. Some families did not decline, but blocked contact with the mother or were evasive and did not keep appointments. One of the workers on the project explained that culturally to decline might appear impolite, whereas not keeping appointments was acceptable and should be taken as a sign the family did not wish to participate.

Results pertaining to breastfeeding practice were disappointing as the majority of women continued to mix feed. The primary reasons given were family pressures, the baby slept...
better and perceptions of not making enough milk. However analysis of pre- and post-test questionnaires indicated that all participants had increased their knowledge and understanding of breastfeeding.

The majority of women also indicated that they would not have received this information other than through the project. Towards the end, the service received requests from women who had heard of the project by word of mouth.

**Discussion**

Language or literacy barriers and a lack of cultural competence are frequently cited as the largest causes of inequality of access to services for clients from black and minority ethnic backgrounds (Latiif, 2010). Yet our pilot indicates that other factors, less easy to define, also impact on client engagement. The difficulties expressed by staff in keeping appointments indicates a mismatch of values and expectations of the service. Furthermore, clients are expected to keep appointments in ‘office hours’, which may not meet the needs of the family. One of the CC workers offered to hold a group in her home in the evening as a way of engaging the grandmothers. This would be acceptable within the community, and would also be considered ‘neutral’ to families who may have contentious relationships. Due to professional boundaries and insurance issues, this option could not be pursued. The service in its current form did not have great success in engaging other family members.

Participants were enthusiastic about the project and appreciated receiving information in a variety of formats in their home environment. The ability to communicate in their own language and ask questions were highlighted as important, as were the staff themselves. Cultural traditions and roles continue to strongly influence behaviours. New information must be provided in line with this and requires confidence and respect for the information provider by the family. The intensity of contacts enabled CCs, via the workers, to attain an ‘acceptable’ status with the families and as a result of the home visits, some mothers have begun to attend the centres. Such intensive contact was, however, very difficult for staff to integrate with regular work, which reduces the likelihood of effective engagement. Ultimately, due to personnel constraints, the service was deemed to be unsustainable by the health visitor leading the project.

Enabling informed choice through the provision of appropriate information is fundamental to health promotion and a key facet of client empowerment (Scriven and Orme, 2001). Raw results from pre- and post-test questionnaires and evaluations demonstrate increases in knowledge for almost all areas, yet very few women exclusively breastfed to six weeks. The implication is thus that increased knowledge is not sufficient to bring about behaviour change. Or indeed that it may result in an informed choice, which may not be that desired by professionals. Certainly, the decision-making process for infant feeding is complex and many women indicated that balancing the work of feeding a baby with their other responsibilities was difficult. Additionally, within the extended family hierachy, women of childbearing age were not in a position to autonomously determine their child’s feeding method. Nevertheless, all acknowledged the ideal of exclusive breastfeeding and were prepared to recommend it to others. The potential for a ‘ripple effect’ to be seen among other women who did not participate, or indeed in their daughters, should not be overlooked when considering the value of projects such as this.

A positive effect of the pilot was that more women used the support available. CC workers completed home visits in the postnatal period to support with positioning and attachment, loaned breast pumps and liaised with community midwifery staff to ensure women had the support they wanted. All participants were confident about where they could obtain breastfeeding support if they wished, and particularly cited CCs as venues for this. Interestingly, women still considered their GP as an option for support with breastfeeding difficulties, despite never receiving this information from the CC workers.

**Implications**

Results of this project indicate significant areas for research. The gatekeepers to women are the elders (Becher and Husain, 2003), particularly the grandmothers. Projects that address behaviour will always be limited in their success if they cease to work within this construct. Therefore, a primary area for further research must be around how and where to engage the senior women in communities. Questions that examine why families and communities remain reticent also need investigating. Despite addressing language and cultural understanding by using South Asian workers, this project continued to experience difficulties engaging with families, suggesting there are other unidentified factors which contribute to health access inequalities, continued research in this area is required.

All the women involved with the project were aware that breastfeeding was good for their baby, but found it difficult to juggle with other household responsibilities. This was particularly evident in multi-generational households. Questions thus arising from this project are how does breastfeeding fit into cultural roles and expectations of women? And where should information be targeted?

Despite demonstrating an increase in their knowledge and understanding of breastfeeding, there was still an underlying lack of confidence in the idea that breast milk is sufficient. This question needs further exploration to determine how health promotion should communicate messages about breast milk to families.

As recommended in the literature base, bilingual staff are essential to providing an equitable service to families (Aspinall and Jacobson, 2004). However, breastfeeding is a complex issue, which has many cultural influences. To address these effectively the breastfeeding support workforce needs to reflect the multicultural population we serve locally. Such staff need to be sufficient in number, and have enough available time to acquire the confidence and trust of communities, before they will be able to achieve long-term behaviour change in their clients. Equally, programmes require a realistic timeframe to have an impact. The longevity of a project or programme of this nature will effect how well information becomes embedded in a community.

Results of the questionnaire showed high regard for health visitors and GPs as medical professionals, and highlights the need for more training in the area of breastfeeding so consistent messages can be relayed to families. It is important to engage GPs in such training programmes as they do not traditionally receive in-depth breastfeeding education, but are identified by clients as resources for support. The care of families should be conducted under models of transcultural medicine or nursing, incorporating cultural understanding and context into care. It would be an advantage for professional staff in areas of high ethnicity to be equipped with some skills in the majority languages of the area, and professionals from BME backgrounds should be actively recruited to reflect the diversity of the population.
Recommendations
On completion of this project the following recommendations were made as part of the project report to the Mary Seacole steering group:
- Health and social care services should actively recruit and train more South-Asian women to specific breastfeeding support posts, and as part of the strategy to increase the health visitor workforce the Department of Health should specifically target nurses of South-Asian origin to become health visitors
- To achieve breastfeeding behaviour change Public Health England should implement long-term initiatives not subject to review at each end of financial year
- Appropriate breastfeeding training should be included in training of GPs
- Community and health services should consider alternative locations and timings, acceptable to target communities, for information sessions
- Organisations, such as children’s centres, responsible for the promotion and training of breastfeeding should recruit breastfeeding peer supporters and peer champions from local BME communities
- Targeted packages of breastfeeding education within ‘Universal Plus’ and ‘Universal Partnership Plus’ should be explored within the new service model for health visiting
- Further research is needed to understand how to best meet the needs of South-Asian communities in Britain.

Limitations
This project had a number of limitations. The duration was very short and results are difficult to achieve in a short time span. The results do not necessarily indicate that the approach is ineffective, but any repeat of the project should be for a longer period. However, the small sample size and lack of control group does limit the external validity of the study.
Various difficulties throughout the duration of the project required the proposed schedule of care to be altered. Initial discussions with midwifery colleagues proposed that midwives would introduce the project to families and refer on an opt-out basis. Due to staffing difficulties and time pressure during consultations this did not happen. Client details were, therefore, obtained from health visitor antenatal lists. The impact this had on recruitment to the project is unclear but it is possible that the less personalised method subsequently adopted, via letter, may have reduced participation, and thus project sample.
Shortfalls in staffing were also experienced by CC colleagues, who were including project work as part of their routine outreach services. Reductions in staff numbers, and requirements to support other services during the project resulted in some participants not receiving the proposed schedule of care at the allotted times. This may have impacted on the feeding choices families made as evidence currently suggests that beyond 34 weeks of pregnancy women are less receptive to information about feeding as they are focused on the birth (DH, 2010b).

The lack of standardisation of awareness and knowledge regarding data collection among CC workers resulted in late acquisition and compilation of all questionnaires and evaluation forms. As a result, data were subjected to hand coding and rudimentary comparison of mean aggregate scores rather than sophisticated statistical analysis by a computer programme which limits reliability of the findings.

Conclusion
The introduction of a small service redesign pilot has demonstrated an ability to increase knowledge and understanding about breastfeeding among South Asian women, but this did not in itself result in behaviour change manifest by increased rates of exclusive breastfeeding at six weeks. Provision of a home-based visiting service did increase the numbers of women from this community accessing antenatal breastfeeding information; however, the project was not successful in engaging with family members and less than 50% approached accepted the service. The results of this project highlight further areas of research regarding engagement with this community and reinforce the need for long-term public health issues to be addressed by long duration public health initiatives.

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References
Breastfeeding in Brighton and Hove: a success story

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Breastfeeding in Brighton and Hove is in the enviable position of having good breastfeeding rates. For the last quarter with national comparators (Q3 2011/2012), Brighton and Hove were second for actual numbers of babies receiving breast milk at six to eight weeks and top for drop-off rates between birth and six to eight weeks.

This article explains the current work of the Brighton and Hove Children and Families Services (BHCFS) Breastfeeding Team and looks at some of the reasons why breastfeeding in Brighton seems to be working so well. Current best practice guidance shows there is no one answer and, as we will see, Brighton follows this multifaceted approach (Department of Health (DH), 2009a; National Institute for Health and Clinical Excellence (NICE), 2008).

Brighton has a reputation as a relatively affluent city whose inhabitants enjoy a liberal, alternative lifestyle. Caroline Lucas, the first Green Party MP, was elected in 2010, with the first Green Party ‘controlled’ council. However, there is another side to Brighton. The unitary authority of Brighton and Hove ranks as the 79th most deprived authority (out of 354) in the Index of Multiple Deprivation (IMD) 2007, and 69th in the Income Deprivation Affecting Children Index (ADACI) most deprived out of 354 (NHS Brighton and Hove, 2011). It is generally true that the most deprived parts of the city correspond with areas where breastfeeding rates are lower. For instance, in our Q3 2011/12 data, the variance in breastfeeding rates at six to eight weeks was from 67.7% in a poorer area to more than 85% in a more affluent area.

Of course, this is no surprise. Evidence shows that breastfeeding is lower among women with low incomes, those on benefits, those with low educational achievement and living in disadvantaged areas (DH, 2009). This is also why breastfeeding remains a public health priority; it is one of the effective ways to reduce our growing health inequalities (DH, 2010).

Breastfeeding work in the community

One of the current focuses of the community breastfeeding team (see Box 1) is on increasing breastfeeding rates in these deprived areas of the city. One advantage that we do have is that our data coverage is good but, crucially, is broken right down to children’s centre area. This gives us a map of breastfeeding across the city so we not only know where to make interventions, but we can also measure our outcomes in these areas.

From 2008/9 the team has had Choosing Health money from the PCT with the express purpose of reducing breastfeeding inequalities in the city. This relatively small, yearly, additional finance enables us to fund our breastfeeding peer support volunteer programme and one breastfeeding support worker.

Breastfeeding peer support volunteer programme

This is an in-house programme, devised, taught and supervised by the two peer

Box 1. Community Breastfeeding Team Structure

2x Breastfeeding Coordinators (IFTE)  
2x Breastfeeding Peer Support Coordinators (IFTE)  
2x Breastfeeding Support Workers (IFTE)  
Admin support, 6 hours a week  
Breastfeeding Peer Support Volunteers
support coordinators. The first pilot training was in 2008 and they are currently teaching two courses a year, with approximately 10 women graduating from each course. There are about 40 active volunteers at the moment, with the programme having a drop out rate of about 42%. This is very good for retention of volunteers with many acknowledging 50% as good for volunteer programmes (Regional Public Health Group for London, 2012).

The programme has been most successful on the postnatal ward of the local hospital. There is an almost daily coverage of four hours volunteer time. While this service is universal, it offers additional support to those women who might stop breastfeeding at the first ‘crisis’ and it normalises breastfeeding for everyone. There are also several volunteers in community/children’s centre groups across the city – either breastfeeding drop-ins or other baby groups. In this community work we plan for a more targeted approach and aim to place volunteers in areas with lower breastfeeding rates. The whole programme is well evaluated by the volunteers themselves and qualitative feedback from mothers on the postnatal ward is also very good.

Breastfeeding support worker
A part-time breastfeeding support worker has been in post since October 2010. The role is currently operating in the two areas of the city with the lowest breastfeeding rates at six to eight weeks. She has been able to implement a programme of antenatal contact and early postnatal support, as well as helping to run a breastfeeding drop-in in each area. The postnatal support can be from as early as three days, and can be in the home, on the telephone or at the children’s centre. This service also takes referrals from midwives and health visitors.

This work has been very successful. In one area, North Portslade, we have seen an increase in breastfeeding rates at six to eight weeks of 6.4% (the four quarters to Q3 2011/12 compared to the preceding four quarters). The whole city rates increased by 4.45% over the same time, so we have been able to demonstrate a reduction in breastfeeding inequalities.

We have also been able to undertake some qualitative evaluation of the postnatal support part of this role. This has been very positive, perhaps as expected, but comments such as: ‘With first child, mixed feeding. Breastfeeding didn’t last long, this time 13 weeks still exclusively breastfeeding!’ are very gratifying.

The other breastfeeding support worker is part of the children’s centre team establishment for east Brighton, the part of the city with the most deprived areas. This worker has been in post for some time but has been within the breastfeeding team structure since 2010. This has enabled her to be even more focused on areas of particular need, but also to work in a proactive way. This support is essential as we know that women from this demographic are the least likely to seek support (NICE, 2008). Her work plan includes: antenatal contact, early postnatal support, referrals and breastfeeding drop-ins.

If this is the more targeted end of breastfeeding support, we are also able to offer a comprehensive universal service comprising not just the breastfeeding team but the whole children’s centre team workforce. We have a network of six breastfeeding drop-ins across the city, and several more baby groups that offer dedicated, health professional or peer support with breastfeeding.

Breastfeeding ‘champions’
Within our children’s centre teams, we also have a system of breastfeeding champions. These are health visitors, community staff nurses, community nursery nurses and early years visitors who have additional breastfeeding training. They act as a resource for their team and often facilitate the breastfeeding drop-ins. To underpin this work, we have a bimonthly, city wide, multi-agency operational group, the Brighton Breastfeeding Initiative. Lastly, but by no means least, there is the fantastic breastfeeding support work that is done day in and day out by the health visitors and other members of the children’s centre team.

Partnership working
Many of you will be thinking that there is nothing unusual in the work that we are doing in Brighton, and of course that is right. However, we do have other factors in our favour. Historically, we have had a supportive and forward thinking management. A breastfeeding coordinator has been in post for some time, and succession planning has been thought about. We have mentioned partnership working in the operational group, but we also have a multi-agency strategic partnership, which has published a breastfeeding strategy for the city (NHS Brighton and Hove, 2009). Partnership working with our hospital trust is good, and they are going for Baby Friendly Initiative status which helps in lots of ways, not least by keeping initiation rates high. We also work well with voluntary sector colleagues, most notably the NCT in Brighton and Hove.

Where next?
Our main aim is to continue with the fantastic work that is happening across the city, with a focus on reducing breastfeeding inequalities. As a team, and a whole children’s service, we are very aware of the political and financial challenges we are facing. We are working to maintain our funding and keep the importance of breastfeeding as a public health priority high.

Acknowledgements
Heartfelt thanks to the rest of the breastfeeding team, Lynda Watson, Dawn Kielty, Zoe Faulkner, Sheila Smith and Donna Cronin.

References

DH. (2009a) Commissioning local breastfeeding support services. London: DH.


A ‘Hearts and Minds’ approach to becoming ‘Baby Friendly’

Since November 2007, Wirral Community Trust and Wirral Primary Care Trust have been working towards the UNICEF Baby Friendly Initiative. The area has embraced UNICEF’s challenging mantra that ‘Baby Friendly is the minimum standard’, using a community-wide strategy to improve breastfeeding rates.

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The Wirral, a peninsula in north-west England between Liverpool and North Wales, is home to more than 330,000 people. It is predominantly white British (96% of the population) and has areas of both extreme affluence and poverty. There are significant variations within health and lifestyle choices and family history traditions. Most residents are native to Merseyside and often those who venture away for higher educational and/or work opportunities find themselves returning to raise their families.

This variety is reflected in a diverse range of breastfeeding attitudes. Wirral is among the 10 lowest rated community trusts (CT) in the UK for breastfeeding at six to eight weeks, but there is wide local variation with some areas above the national average of 47% at six to eight weeks (Department of Health, 2011).

Increasing breastfeeding figures and accessing all areas of our local communities needed to be a team effort, so we developed a birth-to-older age Breastfeeding Action Plan. The Plan is being implemented with multidisciplinary services within the health services locally, including health visitors, midwives, paediatric dietitians, GPs and community health workers. We have also developed key service delivery channels with Home Start breastfeeding peer support, children’s centres, local church groups, voluntary organisations and a commissioned midwifery service, ‘One to One’.

Developing the Breastfeeding Action Plan has enabled us to continue implementing the Seven Point Plan while creatively looking at ways of engaging people in different settings. Strategies we have designed and implemented to date are outlined below.

Breast Start app
The Infant Feeding Team identified an opportunity in the high-tech world of smart phones around effective infant feeding resources. The Breast Start app is aimed specifically at the hard-to-reach population of younger mothers who may prefer to access an online app for help rather than calling their health visitor or GP, or attend a baby clinic or breastfeeding group. This innovative element of the Action Plan offers modern mothers a 24-hour private resource for breastfeeding help and advice, and will be particularly useful for those without access to the internet or those hesitant to talk on the telephone for fear of having their issue documented.

Aimed at providing a ‘two clicks’ solution to any problem, the information has been specifically designed for an app. The ‘gooey front end’ (a term with which we are now familiar, meaning page design!) has been carefully developed to link into the social marketing campaign and to be appealing and useable, even at 2 am. More importantly, the app is free to the user and available as an iPhone and Android version. According to our research into other breastfeeding apps on the market, most focus on timing of feeds (both breastfeeding and bottle), whereas ours is a comprehensive and referenced-based information source.

The unique format, compared to other apps, has been factored into a long-term plan by the NHS for further expansion, and the design will offer both local and national information sections, available for other health organisations to add their own data. This will...
ensure that people can use it wherever they travel in the world. The Breast Start app was aimed at supporting breastfeeding mothers at the point in the ‘cycle of change’ when they are contemplating stopping breastfeeding (Prochaska and DiClemente, 1982).

**Breastfeeding incentive scheme**

This scheme was not only designed to encourage sponsorship from local businesses but also to reward breastfeeding mothers. It has been developed significantly over the past year and now includes over 30 local and national businesses offering unique rewards (gift vouchers) to breastfeeding mothers. Women receive the incentive after they finish breastfeeding through our partner services (midwifery and Home Start breastfeeding peer support). There is a choice of vouchers available for every week up to eight weeks post-natal. We have received no funding to develop this scheme and it has been exceptionally well received by the local mothers. One testimonial says, ‘It was lovely to realise that other people care and that I can get something for me.’

‘Breast Milk – It’s Amazing!’

As part of a regional social marketing campaign, Wirral CT has sponsored a number of promotional information posters on the back of local buses. The ‘bus back’ campaign will run for a year (and included another 60 exterior and interior bus side panels sponsored during the month of March 2012). The campaign was further supported with information in the local papers; a Facebook link to encourage people to look out for the buses; diary covers for all staff working with families and a website (www.amazingbreastmilk.nhs.uk). The main purpose of this particular campaign was to target the pre-contemplative phase of decision-making, i.e., those women who are yet to decide how to feed their babies (Prochaska and DiClemente, 1982).

**Market stall**

Birkenhead, the largest town on the Wirral holds an indoor market where the PCT has rented a stall for the promotion of health initiatives. The Infant Feeding Team, Home Start peer support, children’s centres and health visitors all staff the stall on the first Tuesday of the month and work together to promote breastfeeding. The market largely attracts older adults and people local to the area. The stall has proved to be a fabulous venue for debriefing older women about their own breastfeeding experiences. It has given us the opportunity to discuss changes in information, dispel any myths and give our *Breastfeeding on Wirral* information leaflet to share with their families, as well as any other

![Image](image_url)
relevant signposting. We have also kept a diary of some of the older women’s experiences that have been shared with us at the stall.

‘Get Wirral Breastfeeding’
Our Facebook page has current information about local breastfeeding activities as well as supporting users who visit the page. The space is monitored voluntarily by a trained Home Start peer supporter.

Accessing schools
Part of the Breastfeeding Action Plan was to try to reach more children and young people. Our Infant Feeding Team has taken part in local activities in schools including ‘Options Days’, which looked at job roles that involve supporting breastfeeding, contributing to childcare and PHSE (Personal, Social and Health Education) lessons and a poster board display (entitled ‘Normal and Natural Infant Feeding’) at the local training venue for all teachers on the Wirral.

Breastfeeding In Wirral leaflet
This leaflet incorporates all the local information for a family wanting to breastfeed, such as groups, health services, contact numbers and websites. It also has a list of local cafes and restaurants that are members of our Breastfeeding Friendly Scheme. All of the businesses have been personally approached and agreed to participate, and have a sticker and certificate to display in their premises. The leaflet not only supports families, but also engages local business people, which helps to raise the profile of breastfeeding locally and promote cultural change.

National Breastfeeding Week 2012
To celebrate breastfeeding this year we are hosting a series of local events, themed around our Breastfeeding Action Plan. The Plan is aimed at engaging a wide range of the population, featuring local ‘teams’; for example, Wallasey Royal Marines Association (see picture below), Wirral Gymnastics Club and Managers at Wirral CT on posters, highlighting the concept that mums and babies don’t exist in isolation.

All of the events for National Breastfeeding Week are highlighting a ‘Team Effort’ theme and will co-ordinate with the social marketing campaign. Planned events include:
• A ‘Big Feed’ at a local children’s centre
• Stalls at the market, hospital and local shops with interactive displays and activities
• A ‘Milk Trail’ competition providing a series of clues to lead participants between two breastfeeding venues in a town in one of the most deprived areas on the Wirral
• Colouring and ‘Donate a Doll’ competitions
• A roadshow event on Saturday 30 June involving an exciting list of events including a flash mob (www.youtube.com/watch?v=AM3a_RBEzR0), majorettes, rugby display, suckling animals, stalls, breastfeeding toddler and competitions.

Last year’s ‘flash mob’ event has had over 1,100 hits on the YouTube page so we know the word is spreading and it has cost us nothing! We are hoping that this year it will be even more successful, so if you would like to join us we would love to see you.

So what is next? We are currently reorganising all our Breastfeeding Support Groups around the exciting new format and content, so hopefully that will provide us with some data that we can share. As well as many other ideas, we are also keen to develop a local art event … so the rest of 2012 will be really busy. Thank goodness that breastfeeding really is a ‘team effort’ as the Infant Feeding Team certainly could not do it alone!

References
Mary Seacole Award:
Improving the health and wellbeing of the Nepalese community in Hampshire

Sarah Amani
Team Manager, NE Hants and Surrey Heath Early Intervention in Psychosis Team, Aldershot Centre for Health (ACFH) Youth Mental Health Network Lead, NHS South of England (East)

In October 2011, Sarah Amani and five other health workers were honoured with the Mary Seacole Award. Each year, these awards are given out to six nurses, midwives or health visitors to undertake projects to improve health equality for black and minority ethnic (BME) communities.

The awards ceremony took place at a time of uncertainty for public services, with an unprecedented set of changes being driven to improve the UK NHS and save £20 billion by 2015. Despite, and in some ways because of these changes, the awardees sensed an element of urgency to progress their projects, requiring no less than a firm determination and commitment to successful and timely completion.

Mary Seacole projects are varied and range from targeting mental health and hepatitis C to dementia care and diabetes. The ‘Reach Out’ project was established in Rushmoor, Hampshire, and aims to improve the mental health of the local Nepalese community.

The project was inspired by the fact that one in four people in the UK will experience a mental illness in their lifetime. Furthermore, mental illness is currently the leading cause of disability in the world (World Health Organization (WHO), 2007). In the UK, suicide is the leading cause of death for young males under the age 35. Having worked as a mental health nurse for the past eight years, Sarah had seen first hand the devastation and tragedy that can result if mental health problems are not addressed and treated proactively. The project was also motivated by a recent Social Care Institute of Excellence (SCIE) report, *Think child, think parent, think family: a guide to parental mental health and child welfare*, which concluded that:

- Parents with mental health problems and their children need services that are effective and accessible for the family
- Getting it right for families is hard given workloads and organisational barriers, but can help tackle problems now and across generations
- Implementation sites in England and Northern Ireland have developed promising ways to ‘think family’ and improve services as a result
- By raising awareness, developing strategic goals, training staff and tackling stigma, sites have created the conditions for think family working to flourish
- By thinking family throughout the care pathway, individual staff can make small but effective changes for parents and children
- Further work in this area could produce further improvements.

The reasons for undertaking this project were rooted in her wish to be part of a movement that is determined to reduce stigma and promote good mental health.

The Reach Out project was carried out in Rushmoor, located in north-east Hampshire about 30 miles south east of London. The two main towns, Aldershot and Farnborough, both have historical significance with Aldershot cited as the home of the British Army and...
Farnborough as the birthplace of British aviation.

Assisted by the campaigning of Joanna Lumley, the residency rights of former Gurkhas changed in 2008, leading to an influx of people from Nepal to this area, including the military town of Aldershot. Latest Office for National Statistics (ONS) figures show the population of Rushmoor to be 91,000 residents and approximately 15,000 people to be of Nepalese origin. The paucity of local data on the Nepalese community and their needs is a major stumbling block for any researcher or policy maker in this area (Casey, 2010). Rushmoor has an estimated 10,000–15,000 people of Nepalese origin and this is likely to increase over time. However, research on UK Nepali populations and their health needs have had to resort to estimates as the Census and data-gathering tools omit ‘Nepalese’ as a choice when asking for ethnic background, leaving those from Nepal to choose the ‘Asian Other’ option.

The Reach Out project was a result of an observation that, although the local mental health services had made positive strides towards engaging the local community, they rarely saw those from the Nepalese communities unless it was in a mental health crisis and often in an acute mental health setting. The team had noted this pattern and was concerned, particularly as research has shown that people who access mental health services later on in their illness tend to access them in the community (particularly as a significant proportion may have recently arrived in the UK and are yet to adjust to the health system which is very different to the Nepalese health system).

The stigma that is generally and inherently associated with mental illness may prevent those needing support from admitting to having a problem and seeking help. This may very well be due to fear of being ostracised from the Nepalese and wider community. The services offered by local mental health services may be less accessible and acceptable due to lack of cultural competency and lack of understanding between the cultures.

The Reach Out project began with a listening event, which attracted 450 local residents who shared anecdotes that were organised into themes. A consensus on the themes was reached and the project set as follows:

• Improve the Nepalese communities’ equal access to mental health care and reduce health inequality
• Strengthen the relationship between local statutory and non-statutory mental health services
• Enhance the cultural competency of mental health staff, thus improving the myriad of interventions offered by local services.

The agreement was to achieve the above by:

• Developing a mental health mobile app for the local youth who voted this to be their preferred mode of communicating the basics of positive mental health and wellbeing. The Reach Out project made a point of meeting those affected, ie, the Nepalese community, on their own ‘turf’. This was a simple but necessary effort and show of respect. Of similar importance was the need for consistency; so the project team met with the key stakeholders every two months to ensure that the project did not lose direction and continued to strive for what is important to the local people.

Reach Out owes a significant part of its progress to support from senior leaders across several organisations like Surrey and Borders Partnership NHS Foundation Trust (SABPFT), Rushmoor Borough Council, Insight Service User Forum, Rushmoor Healthy Living, TalkPlus, Naya Yuva and the local pathfinder Care Commissioning Group (CCG) in NE Hampshire – to name but a few.

The Mary Seacole Award steering group and mentors have given exemplary guidance and support to enable the project to progress. As the project nears its end, the wishes and hopes of those who have been involved is that people facing mental health difficulties feel less fearful and less confused about when, where and how to seek help.

The author would like to thank the Nepalese communities in Rushmoor who have trusted the team enough to help them and from whom they have learned so much.

References

SCIE. (2012) Think child, think parent, think family: a guide to parental mental health and child welfare. London: SCIE.

Recognising psoriasis in children

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Abstract
Psoriasis is a chronic skin condition, which can affect children and young people at any age. This article will provide a basic overview of the condition and describe those types common to children. Treatments and general nursing management will be discussed.

Key words: Psoriasis, children, emollient, skin, dermatology


No competing interests declared

Introduction
Psoriasis is a chronic, non-infectious inflammatory skin disease, commonly characterised by flares and remissions. Psoriasis affects 2–3% of the population and 10% develop psoriasis under 10 years (Psoriasis Association, 2011). There is a genetic predisposition for it to run in families. A trigger is required for psoriasis to develop, even with a positive family history. There is no cure for this condition although there are many treatments for flares of psoriasis. Parents should be reassured it is not infectious or contagious.

The exact cause of psoriasis is not known, but the immune system is thought to be overactive, resulting in inflammation. An excessive production of cytokines affects the growth of extra blood vessels within the skin and increases the turnover of skin cells. This is seen as red, scaling and thickened areas of skin known as plaques.

The normal epidermal transit time is approximately 28 days but for reasons not fully understood, in psoriasis epidermal cell proliferation is increased to approximately four days. This results in large numbers of immature epidermal cells reaching the surface of the skin and sticking, layer on layer, to form plaques.

Children are prone to various rashes, some of which may be an early indication of developing dermatoses. Other causes such as infection or infestation or eczematous lesions should be considered. Children need to be frequently reassessed as early presentations can be unclear and it is not until a rash is more florid that a definitive diagnosis can be made (Peters and Turnbull, 2003).

It is crucial to carry out a full, systematic skin examination of the body, including hair and nails, to assess extent of skin disease. It is advisable to inform the child and family that it is necessary to compare affected skin with unaffected skin. All affected areas must be accurately and clearly documented (a body planner chart is a useful tool for this). The child/young person’s overall appearance including posture and dress can indicate any issues of poor self-esteem, anxiety or embarrassment.

As with any skin diseases, the child and family will need support, understanding and education to come to terms with a condition that has no cure. They will need realistic information on treatment options, time it will take to apply treatments and also demonstrate application of topical therapies (Van Onselen, 2001).

Potential triggers for psoriasis
There are several triggers for psoriasis, including the following.

- Infection – beta haemolytic streptococcal throat infection. Often triggers Guttate psoriasis
- Trauma – a psoriatic lesion can occur at site of trauma referred to as Koebner phenomenon. These lesions may not appear immediately
- Sunlight – sunlight is generally helpful but in 10% of patients it is a trigger factor
- Drugs – antimalarial, propranolol and other beta blockers, or oral steroids
- Stress – difficult to assess but generally recognised as trigger to flares.

There are several types of psoriasis so treatment and management is individualised depending on type. The most common forms in children and young people are outlined below.

Common forms of psoriasis
Some forms of psoriasis are extremely rare in childhood and are not covered here. These include erythrodermic psoriasis and pustular psoriasis. Psoriatic arthropathy is well recognised but uncommon in children.

Plaque psoriasis is the most common from of the disorder, and is seen in approximately 65% of cases in children. It is characterised by well demarcated red/pink plaques with dry, silvery-white scales. They vary in size of diameter from a few millimetres to centimetres (Gawkrodger, 2003). Any areas of the body will be affected but the most common areas seen are generally the elbows, knees and lower back. A differential diagnosis here could be eczema or a fungal infection. Plaques in flexural areas or skin folds are not usually scaly but have a red, shiny appearance.

Guttate psoriasis is a more common presentation in childhood and teenage years and will often be the first indication of the disease. It may be triggered by streptococcal throat infection. It is characterised by the sudden appearance of multiple red macules on the trunk and limbs. Soon after appearance they become scaly. Guttate psoriasis may clear spontaneously within several months, but there is the potential for the child to go on and develop chronic plaque psoriasis. A differential diagnosis could be acute drug eruption, Gionotti Crosti or Pityriasis rubra pilaris.

Scalp involvement is common in children. The scalp is generally dry, scaly and itchy. Touch is indicated as the severity is often masked by child’s hair. Gently feel the scalp and raised scaly lesions may be felt. In severe cases the scalp will be red with thick, scaly lesions and may have bleeding areas due to scratching. Plaques may extend to hairline and behind the ears. Differential diagnosis would include seborrhoeic dermatitis, atopic eczema or an infestation.

Napkin psoriasis: psoriasis in babies is very rare but may present as napkin psoriasis. It can present as a bright red, wet rash in the nappy area that is not scaly. The psoriatic rash is well demarcated – it ends where normal skin starts. This may indicate the
potential development of plaque psoriasis later in life. Differential diagnosis may include irritant nappy rash, candida or seborrhoeic dermatitis.

Emollient therapy
Complete emollient therapy is an integral part of psoriasis management and should consist of bath/shower oils, soap substitutes and moisturiser. They will provide a surface lipid layer on the epidermis, reducing water loss, minimising dryness and reducing scaling and pruritus. This results in the plaques being softer and allowing easier penetration of other topical treatments (British Association of Dermatologists, online). The child/parents are encouraged to moisturise the entire body regularly, applying a thin layer, as the effects are short lived. Moisturisers are applied in a downward movement in the direction of hair growth to minimise plugging of hair follicles and subsequent folliculitis. Often, emollient therapy alone is indicated in mild psoriasis. It may take many consultations for the child and family to find an emollient regimen that they like, so it is important they are able to try various emollients. It is often advisable to give several emollients to enable choice.

Coal tar treatments
Preparations containing crude coal tar have been used to treat active psoriasis for many years. The exact mechanism is unclear but they are thought to inhibit DNA synthesis. They can have an unpleasant odour and messy to apply. They do have potential to stain clothes/linen, so advise use of old clothing. As with all products used it is crucial to demonstrate correct application, in that it must be applied to the plaque only as there is potential to irritate normal skin. Such products will also make the skin more sensitive to the sun. Cleaner, more refined preparations are available, making the use of crude coal tar at home unusual, but many dermatology departments offer this as part of a day treatment service.

A tar-based shampoo may be sufficient to manage dry scaly scalp. If used, massage into scalp and leave for 5–10 minutes and then wash in the normal way. If the scalp has thickened scale it will need to be descaled using a keratolytic based product (this must be used with close supervision). Depending upon severity it can be massaged into the scalp and left for up to one hour overnight. The hair should then be carefully combed to remove loose scale and the hair washed as normal with a tar-based shampoo. A topical steroid application may also be used (Penzer and Ersser 2010). This can be a lengthy process, taking several weeks to clear.

Topical steroids
Topical steroids may be helpful for localised areas only. It is imperative that their use must be properly monitored. Using appropriate strengths and amounts (Penzer and Ersser, 2010) reduces the risks of an acute rebound in psoriasis on withdrawal (Gawkrodger, 2003).

Vitamin D analogues
Some vitamin D analogues are licensed for children and provide a cosmetically acceptable and effective topical treatment for psoriasis.

Further advice
As with any skin disease there are some additional factors to consider.

• The child and family will need ongoing support and advice. It is advisable to discuss treatment plans with the child and family so as not to interfere with school and school activities
• Encourage avoidance of dark clothes to minimise the visibility of shed skin cells
• Encourage the parent to inform the child’s school – this is crucial for the prompt detection of any peer pressure
• If the child is struggling to cope with psoriasis encourage counselling to help develop coping mechanisms
• Encourage and support the child to continue to lead a normal life and not view this as a handicap
• Avoidance of stressful situations and be mindful if there is a sudden flare-up of stable disease
• Give detail of a psoriasis support group.

When to refer
Children should be referred to a dermatologist if the diagnosis is unclear or in the following situations.

• Failure to respond to basic management
• Lesions that do not respond to topical treatments or relapse rapidly as light therapy may be indicated
• Some forms, such as palmar plantar, are very difficult to manage and specialist advice should be sought
• If the family cannot cope with basic management
• If the child requires a treatment which needs to be undertaken in hospital
• If the condition is unstable for whatever reason (unresponsive to treatment or treatment failure (not treated).

Shared care
It is beneficial to the child and family if a shared care package can be developed and implemented. Working with the family will enable you to support and arrange for development of coping techniques, stress management and listening and talking to the child and/or parent (Lawton, 2003).

References

Box 1. Further reading
Psoriasis Association: www.psoriasis-association.org.uk
British Association of Dermatologists: www.bad.org.uk
British Dermatological Nursing Group: www.bdng.org.uk

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Improving breastfeeding outcomes: the impact of tongue-tie

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Abstract

A tongue-tie (ankyloglossia) is defined as a lingual frenulum that is short, tight and restricts normal tongue movement. The tongue-tied newborn baby then has a mechanical difficulty attaching to his mum’s breast and maintaining attachment to feed effectively. In the hands of skilled carers, this mechanical problem can be resolved by releasing the frenulum (frenulotomy) and the baby’s access to his/her mother’s breast milk be preserved. Published research on this subject has undergone justifiable criticism. Robust methodology was lacking in earlier studies. An overview of the course of researchers’ response to critique is discussed. The care pathway in place in mid-Norfolk for mother and baby dyads where the baby’s tongue-tie compromises efficient breastfeeding is outlined.

Key words: Tongue-tie/ankyloglossia, breastfeeding, mechanical feeding problem, positioning and attachment


No competing interests declared

Introduction

To breastfeed effectively a baby needs to be attached correctly at its mother’s breast. ‘Attachment at the breast’ is the term used for how a baby’s mouth is fixed, or appended, to the mother’s breast to feed. For a baby to be able to attach correctly there are two essential factors that must be in place. The first is that mum needs to offer up her baby to her breast in a manner such that he is physically able to suckle. Put more simply, it matters how she holds him, or positions him to feed.

The other crucial factor is that there is no physical reason, in the baby, why he cannot suckle. During normal suckling a baby needs to be able to extend his tongue to the lower lip to create an effective seal, along with his palate and buccal pads (cheeks), around mum’s breast. Abnormalities such as a cleft palate or, the relatively less well developed buccal pads of a premature baby, can also diminish the baby’s ability to create or maintain the seal.

The principles of positioning and attachment all need to be in place for efficient breastfeeding. Information on the four principles of positioning and seven principles of attachment can be accessed on the Baby Friendly website (www.unicef.org.uk/babyfriendly).

If a baby is tongue-tied, by definition, the frenulum is short, tight and restricts normal tongue movement. The manner the baby moves his tongue up and down during suckling is also altered by the tongue-tie (Geddes et al, 2008a). The suboptimal or lack of, ability to attach and the altered tongue movements are responsible for the signs and symptoms seen in differing combinations, in effected mother and baby dyads (see Table 1 below).

The term ‘mother and baby dyad’ is used advisedly. When discussing lactation/ breastfeeding, a mother and baby are seen as a dyad, or pairing. A baby that cannot feed efficiently – such as having a tethered frenulum – will adversely affect his mother’s lactation. Carers must have a working knowledge of the mechanisms at play in order to guide breastfeeding through problem situations. Where a tongue-tied baby is having difficulty breastfeeding, but mother and baby are not referred to an appropriately skilled carer, the problem can escalate to the baby being under-fed, failing to gain weight (with all associated sequelae) and great distress in the mother/parents. Ultimately, the scenario is likely to result in the baby being exclusively formula-fed, accompanied by long-felt disappointment in the mother, at feeling she failed to breastfeed her child.

Research

There has been controversy over whether a tongue tie is problematic to breastfeeding and whether release improves breastfeeding. This has been because the appearance of a tethered frenulum does not always accompany compromised function (Hazelbaker, 1993). Moreover early research on the topic lacked robust methodology. Case series demonstrated positive breastfeeding outcomes for these babies, but this research design is open to the influence of various forms of bias. A lack of standardised, objective assessment tools for defining a frenulum as a tongue-tie, further complicated the debate.

Alison Hazelbaker developed the Assessment Tool for Lingual Frenulum Function (ATLFF) in order to clarify the impact of a tethered frenulum in babies with breastfeeding problems.

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| Table 1. Signs and symptoms of poor attachment in the presence of tongue-tie (where positioning has been assessed as correct) |
|---|---|
| **In mother** | **In baby** |
| Sore/painful/cracked nipples | Repeated loss of attachment |
| Mishapen nipples upon detachment | Clicking or smacking noises with all or some suck/swallow cycles |
| Poor drainage of milk | Poor weight gain or weight loss |
| Mastitis | Frustration at loss of attachment or inability to attach |
| Poor milk supply | Marked windiness |
| Exhaustion | Frequent feeds |
| Distress as breastfeeding not as fulfilling as she had anticipated | Feeds lasting a long time (unable to take milk efficiently) |
| Or short feeds (as baby becomes progressively tired and weak) |  |
(Hazelbaker, 1993). On reliability testing, the ATLFF’s first three Function items (tongue lateralisation, elevation and extension) were found reliable but other Function items relating to sucking, were less reliable, (Amir et al, 2006). It could be argued this may have been due to inaccuracies in beliefs in the 1990s, about tongue movements during breastfeeding, that have now been revised by Donna Geddes’ research using submental ultrasound scanning during breastfeeding, (Geddes et al, 2008a; 2008b).

In the 1990s it was believed a baby’s tongue stripped the milk from its mother’s breast with peristaltic action. Geddes et al’s (2008b) research has demonstrated that this is not the case: as the tongue moves down in the mouth, negative pressure is applied to the breast, breast milk flows into the baby’s mouth, the baby then elevates its tongue, returning the pressure in the mouth to baseline level and the baby swallows. The nipple is not compressed. In tongue-tied babies one of two actions occurs: either the tip of the nipple is compressed by a humping of the tongue on elevation in the mouth, or the base of the nipple is compressed on tongue elevation, (Geddes et al, 2008a). Tongue-tie release was observed to resolve or lessen this compression. The rate of milk transfer post-release was almost doubled and the mothers’ 24-hour milk production quickly increased.

In an effort to respond to design critiques, researchers investigating breastfeeding outcomes following tongue-tie release, used the randomised, controlled trial (RCT) methodology: Hogan et al (2005) found 10.7% of babies born during their research appeared to be tongue-tied but only 44% of those experienced feeding problems. Consenting participants were randomised to either 48 hours of care from a lactation consultant (LC), or immediate release of the tongue tie. Only 1/29 in the LC group’s breastfeeding improved, but 96% (27/28) of the release group improved. After the 48 hours, all in the LC group requested the release procedure for their babies. Overall, for 95% of those that were released, feeding improved (one taking a week to improve). In the control group only 5% improved. Critique of this study focused on the lack of blinding to the intervention of the mother and breastfeeding counsellor, which may have resulted in the placebo effect artificially improving their results from frenulotomy.

Some of the above research team went on to conduct a double blinded RCT, Berry et al (2011). Participant mothers were randomised into either the release arm or non-release arm. Their babies were taken to another room for their allocated intervention. On the baby’s return, each mother was asked to breastfeed her baby immediately without looking in their baby’s mouth. Both the mother and breastfeeding counsellor were blind to the randomisation. The mother was asked if attachment and feeding were improved and to decide if the release procedure had been carried out.

The immediate results demonstrated that the majority of mothers correctly identified which arm of the study they had joined. Seventy-eight percent in the release group were correct and 47% in the non-release group were correct (p<0.02). Experienced breastfeeding mothers were more likely to be correct. Breast pain scores post-intervention (prior to randomisation being revealed) did illustrate an influence of the placebo effect.

In another RCT (Buryk et al, 2011), mother and baby dyads where the tongue-tied baby (assessed using ATLFF) had been experiencing difficulty breastfeeding, or the mother experiencing nipple pain, were randomised to either the release group or sham procedure group, following written consent. The mothers in the release group had significantly better post-intervention assessment scores of their baby’s competence at breastfeeding (p 0.029). A lesser placebo effect on breast pain post-procedure was found than in Berry et al, (2011), so that the release group’s pain scores were significantly lower than the sham group (p<0.001).

It is apparent that all those offering support to breastfeeding mothers need to be able to assess attachment and milk transfer from mother to baby. Since NICCE’s decision (NICCE, 2005; NICCE, 2006) to support the conduct, within the NHS, of the release procedure to relieve the attachment problems a tongue-tie can cause, more trusts have developed care pathways that facilitate assessment of feeding problems, diagnosis and release of problematic tongue-ties.

Care pathway in mid-Norfolk
Since 2006 a guideline for the care of tongue-tied babies experiencing feeding difficulties has been in place within the acute NHS Trust’s Maternity Services. Where a breastfeeding baby is experiencing difficulty feeding, despite good positioning by mum, the mother and baby dyad are referred to a midwife breastfeeding-key worker for assessment of breastfeeding efficacy. Having addressed any remaining sub-optimal positioning, the midwife will assess for the presence of a tongue-tie, that is, whether normal tongue movement is compromised by a tethered frenulum. Should it be identified that a tongue-tie is causing the breastfeeding difficulties; a discussion takes place with the parents encompassing their choices for dealing with the problem. Where the parents wish to proceed to the release procedure, the Key Worker will complete and send a referral to the paediatric and neonatal surgeon.

While awaiting an appointment with the surgeon, the best advice will be for the mother to stimulate her breast milk production by expressing after feeds and using the milk to supplement her breastfeeds. This extra
stimulation will go some way to compensating for the sub-optimal sucking action of the tongued-tied baby, until the release procedure allows normal tongue movement. Mum’s supply will naturally increase to meet the baby’s needs. Support appointments are advisable while awaiting the appointment with the surgeon.

Release procedure

Following the consultation between surgeon and parents and where parental consent is given, the tongue-tie is released. The baby is brought to the appointment hungry (without feeding in the previous two hours) as this ensures the baby will open his mouth. No anaesthetic is needed for the procedure on a neonate as this would add significant, unnecessary risks to the baby. The baby is laid flat on his back, wrapped in a blanket/towel so his arms do not impede the surgery. The surgeon examines the frenulum by lifting the tongue and uses sterile surgical scissors to release the tethered frenulum. There is often a small blob of blood. The mother is asked to breastfeed her baby immediately. Haemostasis is ensured before the family can leave the clinic. Parents are asked to feed back in two weeks as to whether the baby’s feeding has improved, and the appropriateness of undertaking the release procedure without anaesthetic or sedation, along with any other comments/suggestions they might wish to make regarding the referral system. All babies are followed up by midwifery staff. Where a mother and baby have had a breastfeeding problem support appointments continue until the mother is confident to be discharged. Key workers in this care pathway will follow up mothers via phone calls to monitor their progress.

Conclusion

It is clear how uncompromised tongue movement is vital to a breastfeeding baby and how valuable Geddes and her team’s research has been in understanding why tongue-ties interfere with breastfeeding. The levels of evidence now coming out of studies on tongue-tie release supporting breastfeeding have improved as researchers have responded to scientific critique of their research methodology.

More NHS trusts are putting in place care pathways to resolve this mechanical problem that can have destructive effects on breastfeeding outcomes. Consequently, more babies born with this anomaly are benefiting from their mothers’ breast milk.

Acknowledgement

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References


The NHS in England: a good place to work?

The 2011 NHS Staff Survey for England was published in March 2012. What message did it give? Not surprisingly it is a mixed one ...

By Barrie Brown
Unite National Officer for Health

The 2011 NHS Staff Survey was carried out when significant structural changes were taking place across the NHS, against the background of English NHS employers required to make £20 billion of savings and cuts over a three-year period. It is important to compare the survey outcomes with previous years. The results for 2011 were broadly similar to 2010. But …

A key question in the survey is whether staff would recommend their employer as a place to work. In 2011 51% said yes. In 2010, 53% said yes. Why has there been a decrease in the proportion of staff who would recommend working for their employer? This can be explained by some of the other outcomes from the survey:

- Thirty per cent said there are enough staff in their organisation for them to do their job properly, compared to 32% in 2010.
- Only 26% said that communication between senior managers and staff is effective.
- Just 40% of staff felt that their employer is committed to helping staff to balance their work and home life.
- Few staff indicated being satisfied with the level of freedom they have to choose their own working methods – 61% in 2011, 63% in 2010.
- Just 32% of staff were satisfied with the extent to which they felt that their trust values their work – 33% in 2010.
- Thirty-one per cent of staff said that they often feel like leaving their employing organisation.
- Almost half of staff said they felt they do not have enough time to carry out all their work (46%).

Under Agenda for Change and the Knowledge and Skills Framework, annual staff appraisal, training and personal development are critical to the opportunities for staff to progress in their careers. What does the 2011 staff survey say about these issues?

Overall, 80% of staff had an annual appraisal, which is an increase from 77% in 2010. This is good news but only a third of staff felt their review was ‘well structured’ insofar as the appraisal improved how they work, set clear objectives and made them feel their work was valued. This outcome is not such good news.

Forty three per cent of staff agreed that there had been strong support for training and 55% felt encouraged to develop their own expertise. This is similar to 2010. Alongside this there had been a substantial increase in the number of staff undertaking e-learning or online training – from 50% in 2010 to 68% in 2011.

The survey is based on the pledges in the NHS Constitution, which set out what staff should expect from their employer. Pledge 3 is maintaining health, wellbeing and safety.

Health and wellbeing

Sixty-three per cent of staff indicated that they had not experienced any difficulties in completing their daily work because of their physical health (63% in 2010).

Sixty-five per cent of staff reported that they had attended work in the previous three months, despite not feeling well enough to perform duties. Of those who had attended work while unwell, 92% stated that they had put themselves under pressure to attend; 31% (30% in 2010, and 28% in 2009) felt under pressure from their manager and 22% from other colleagues to attend.

Safety

Thirty per cent (29% in 2010) of NHS staff overall reported they had suffered from work-related stress.

Moving and handling injuries (11%) were the second most common cause of work-related injuries or illness across the NHS. Only 1% of all NHS staff reported injuries as a result of exposure to dangerous substances.

Results in primary care trusts (PCTs) from 2011 showed a decrease in most key findings compared to 2010. While these organisations are undergoing radical changes and will cease to exist in 2013, the survey results reflect the uncertainty among PCT staff and highlights the risks arising from the transition to clinical commissioning groups.

The future

It is likely that staff with the skills needed for the future may be lost to the NHS. Taken together with the continuing pay freeze, the restructuring of services in England, the impact of the NHS pensions changes and the significant threat of private sector companies taking over NHS services as a result of the Health and Social Care Act, future NHS staff surveys will provide vital findings on the future direction of the NHS in England.


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Check that references are complete, accurate and in the Harvard style – author and year of publication referred to within the text, and listed alphabetically at the end, eg:


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1 Pelen F et al. Treatment of fever: Monotherapy with ibuprofen. Ibuprofen paediatric suspension containing 100mg per 5ml, multicentre acceptability study conducted in hospital. Annales de Pédiatrie 1998; 45(10): 719-728.