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Making a difference

As we prepare to welcome newly qualified health visitors into practice, I thought I would share a few additional thoughts with you that Sarah Creer’s excellent reflection on her first year in practice (pages 38-39) triggered. My suggestions for surviving and enjoying practice are from my own experience as a health visitor. Top of the list is to maintain a sense of humour, as laughter in the office is important to keep everyone sane.

Second, is to give yourself a pat on the back every day for surviving it – never underestimate the impact of what you do and the emotional toll it can take on you. Look after yourself and nurture yourself and your colleagues.

Care, compassion and empathy are some of the most important qualities in health visiting. The ability to work alongside and in partnership with families and colleagues is fundamental in all you do. You will meet challenging families (and colleagues). A psychologist told me that those we find the most difficult are the ones we need to work hardest at to understand and connect with.

Sebastian Kramer, a psychiatrist speaking at a past CPHV A conference, told us that you cannot work with, or help, families you don’t like. You may have to work hard to find things you like about a person and equally they may have to do the same to find things they like about you! Clients are very good at spotting if you are genuine or not and you can’t fake authenticity. You have to be very persistent with some families to gain access and engage them so that you can build a trusting therapeutic relationship. Keep going back and knocking on that door – it is worth the effort. The families I remember the most and have found the most rewarding are those who have been the most resistant and challenging.

I have loved health visiting and still care deeply and passionately about it. It is rewarding, frustrating, stressful and hard work – but ultimately deeply satisfying, as you know it makes a difference to children and families. This is the most important aspect for me and keeps me in the profession. I have very much enjoyed health visiting – I really hope you do too...

Maggie Fisher
Health Visitor Forum Chair
Aged between three and six years:
- Parents not playing with their child
- Parent offering less praise to child and general lack of communication

Signs to look out for in the child’s interactions when aged under-18 months include:
- Unnaturally passive or quiet child
- Does not suffer from anxiety when separated from parent

In children aged between one and three years:
- Child’s passive behaviour may turn into aggressive or hostile behaviour when interacting with others or trying to compete tasks
- Child will not solicit help from parent as they perceive their parent as unavailable to meet their needs

The resource was produced as part of the NSPCC’s CORE-INFO series, in conjunction with Cardiff University’s Child Protection Systematic Review group, who have been researching into features of emotional neglect and abuse in children from birth to six years old. Dr Sabine Maguire, of Cardiff University, said: ‘The review showed there are clearly observable emotional, behavioural and developmental features in pre-school children who have been emotionally neglected or emotionally abused. Early recognition of these features potentially enables the cycle of emotional neglect or emotional abuse to be broken, thus preventing longer term consequences, which may include increasing aggression, poor social skills and language delay.’ Dr Gardner added: ‘By bringing together the learning from a wide range of research in an accessible way, the new CORE-INFO resource will be very valuable in helping practitioners identify these children and seek specialised assessment where necessary.’

To download the leaflet for free, or to receive printed copies, please visit: www.nspcc.org.uk/core-info

New DH guidance released for practice teachers

New guidance specifically targeted to those working in health visiting in the areas of commissioning, practice teachers, service leads, line managers and newly qualified health visitors has been unveiled by the Department of Health. A Health Visiting Career aims to promote understanding of the profession and the current circumstances, whilst identifying areas of good practice, and suggesting ways that these can be shared and enhanced.

You can access the report here: http://www.dh.gov.uk/prod_consm_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_134574.pdf
Fast food giant in talks with school to provide concession

A school is considering opening a counter selling Subway sandwiches – whose slogan is ‘Eat Fresh’ – at their sixth form college.

Parrs Wood High School in Didsbury, Greater Manchester, could be the first school in England to house a branded fast food counter on site. This issue is particularly pertinent, as Education Secretary Michael Gove has recently ordered an enquiry into the quality of school meals.

Parrs Wood Headteacher, Andy Shakos, contacted the US food giant after he became aware that students were visiting the nearby store during their lunch hour.

He said: ‘The meeting was to investigate whether our own on-site healthy meals provision could be enhanced by incorporating some of Subway’s healthy options.’

Unite/CPHVA’s Ros Godson said: ‘We do not understand why any school would consider accepting fast food concessions onto the premises, when surely parents want their growing adolescents to be offered healthy wholesome food with far less salt, saturated fat and hidden sugar than that which is currently offered at fast food outlets. There is specific government advice on school food standards and the school nurse should be involved with the staff team to ensure that school policies reflect this, so that young people are supported in school to resist marketing of unhealthy products and are empowered to make healthy choices for themselves.’

Subway has previously been criticised for the high levels of salt found in their sandwiches. In 2008, results showed that a six-inch meatball sandwich contained the amount of salt equivalent to nearly 12 packets of crisps. The chain has since cut down on their salt levels and joined the government’s Public Health Responsibility Deal.

Speaking last year, Health Secretary Andrew Lansley said: ‘One in six meals are now eaten outside the home and for those meals we often have no idea how many calories we are eating. That’s why it’s great to see that Subway have signed up to this commitment as part of the Responsibility Deal, which will help customers know the calories in their favourite foods and think about the choices they're making.’

Ros said: ‘It can’t be difficult for the average school canteen to supply sandwiches and rolls made with nourishing bread and filled with a variety of delicious fillings to suit the nutritional needs and tastes of young people, but if that is a problem for this school, then they should surely be in discussion with local bakers.’

Free milk for nursery children consultation

A consultation will take place into the future delivery of free milk for nursery children.

Public health minister Anne Milton has announced that there will be a consultation into the most cost-effective way of securing the future of free milk to all children.

Milton said: ‘Milk has many benefits to children’s health and it is important for their development – we are committed to provide free milk for all under-fives.’

Figures show that currently the government are paying around twice the amount on a pint of milk than the average consumer does – 92p compared to 45p.

However analysis shows that, by modernising the scheme, up to £30million could be saved each year.

The free milk scheme, which has been running since the 1940s, gives childcare providers a full reimbursement of the cost of milk. Currently, all children under five in day care for more than two hours a day are eligible for one-third of a pint of milk each.

Milton said: ‘The current scheme has not changed operationally since it began and costs have ballooned. In four years costs have jumped from £27million in 2007 to a staggering £53million in 2011.

The consultation, called Next Steps for Nursery Milk, will explore a cap in the price that childcare providers can claim for milk; issuing an e-voucher, which providers can use to pay for milk; and the possibility of introducing a contract with an external provider to directly support and deliver milk to all childcare providers.’

Milton commented: ‘Everyone is encouraged to take part in this consultation and share their views on the proposed changes.’

Shadow Public Health Minister Diane Abbott said: ‘Trying to cut the cost of this scheme may end up snatching milk away from the country’s children, disproportionately affecting the poorest.’

For more information or to take part in the consultation please contact: nurserymilk@dh.gsi.gov.uk or visit: http://consultations.dh.gov.uk/nurserymilk/nextsteps
NEWS ROUND-UP

Scottish schools lead on PE classes

According to the latest Scottish government health survey, 84% of primary schools are now providing a minimum of two hours of PE per week to all pupils, compared to the 3% that were recorded in the previous Healthy Living survey of 2004-5.

Secondary schools have also raised their PE provision rates for pupils, providing 92% of pupils with two hours of PE each week, compared to 46% in 2004-5.

Scottish Sports Minister Shona Robinson said: ‘We want to increase opportunities for children to get involved in sport and physical activity, which in turn improves health, educational achievement and life chances,’ she added: ‘We are committed to ensuring the provision of at least two hours per week of PE in primary schools and at least two periods of PE in secondary schools for pupils in S1 to S4 by 2014. While we still have some way to go these statistics demonstrate good progress.’

The Scottish government is investing £6million over the next two years in conjunction with sportscotland and Education Scotland.

Chief Executive of sportscotland, Stewart Harris, commented: ‘Today’s figures are encouraging and show that significant progress is being made on meeting PE targets in Scotland’s schools.’

Dr Bill Maxwell, Chief Executive of Education Scotland, said: ‘Education Scotland continue to monitor that two hours of PE is undertaken by pupils and young people in primary and secondary schools through inspection. In addition, we’re working closely with sportscotland and Scottish government on the initiative to support this commitment.’

CPHVA President is named a Non-Executive Director of the NHS Commissioning Board

President of the CPHVA, Lord Victor Adebowale, has been named as a one of the four new Non-Executive Directors of the NHS Commissioning Board.

Lord Adebowale, who is currently Chief Executive of Turning Point and a cross-bench peer, will be joined by Dame Moira Gibb, Naguib Kheraj and Margaret Casely-Hayford.

Andrew Lansley said: ‘I am delighted to announce these new appointments to the NHS Commissioning Board. All of them have a track record of success and will bring a diverse range of skills and experience to the Board. Their expertise will benefit the NHS and help ensure that patients get the high quality care that they deserve.’

The role of the NHS Commissioning Board will be to make all of the preparations needed to ensure that the Board is fully operational when it comes into force in April 2013.

The Board will aim to ensure a full and comprehensive service across the country and to promote the NHS Constitution and champion the interests of patients.

Professor Malcolm Grant, Chair of the NHS Commissioning Board said: ‘These are appointments of the highest quality, and they bring to the NHS a wealth of experience and expertise from a wide range of backgrounds. I am pleased that we now have a full group of non-executive directors, with complementary strengths and skills, to work alongside the executive team led by Sir David Nicholson.’

The appointments will commence this summer and will last until 2014 for Adebowale and Gibb and 2016 for Kheraj and Casely-Hayford.
According to the annual Health Protection Agency (HPA) influenza report, the 2011-12 flu season is the lowest ever recorded with only 30 cases per 100,000 compared to the 2010–11 season, which saw 130 cases per 100,000.

The HPA’s Head of Influenza Surveillance, Dr Richard Peabody, said: ‘This year’s low and late flu season comes straight after one of the most intense flu seasons we’ve seen in recent years.’

The figures were based on GP consultation rates for flu-like illnesses in England and Wales, which is one of several systems used by the HPA to measure flu rates.

However, despite the low rates of flu recorded, the number of respiratory infections caused by flu was higher than the previous year and was localised predominantly in elderly care home settings.

This is despite the fact that 74% of people aged 65 and over received the flu jab – up marginally from the previous year, where 73% were vaccinated. Of those in the over-65 age group deemed clinically ‘at-risk’ there was a slight increase in vaccinations from 50% to 52%.

Dr Peabody said: ‘We remain concerned that just over half of those under 65 who were eligible for vaccination last winter took up the offer of the jab.’

He also stressed the importance of healthcare workers receiving their jab, stating: ‘Healthcare professionals have an important role to play in encouraging those at risk to take up the offer of vaccination, as well as setting a good example by taking up the offer of vaccination themselves.’

According to a study carried out by Leeds Metropolitan University, 2,000 11-year-old girls’ waist measurements exceeded 31.5 inch (80 cm) the measurement at which women have an increased risk of developing type 2 diabetes.

A study has shown that the established system of using Body Mass Index (BMI) measurements to judge a child’s obesity may be outdated and would be more useful when used in conjunction with a three-part system that uses BMI, waist measurement and waist-to-height ratio.

In addition to this, the study found that 2,000 11-year-old girls’ waist measurements exceeded the 31.5 inch (80 cm) the measurement at which women have an increased risk of developing type 2 diabetes.

The Leeds-based study published in the journal Obesity also found that 429 (6%) of boys and 992 (15%) of girls would have been classed as overweight or obese, who would not have been identified using the BMI-only measurement system.

The senior lecturer leading the study, Claire Griffiths, said: ‘The data could have serious implications for public health, suggesting that there is a need to understand the relationship between BMI and waist circumference, with growth and health risk.’

The study measured nearly 15,000 school children over a three-year period.
Early years staff should be qualified to a minimum of Level 3

Hot on the heels of her final report into education and childcare qualifications, Foundations for Quality, Professor Cathy Nutbrown has said that all workers in an early years setting should be qualified to a minimum of Level 3.

She said: ‘Our present qualifications system does not always equip practitioners with the knowledge and experience necessary for them to offer children high quality care and education, and to support professional development throughout their careers.’

She is aiming for the changes to be universal by 2022. In order to reach this goal, she is recommending that as of September 2013, 30% of staff should have reached this level, rising to 70% by September 2015.

Professor Nutbrown spoke out stating that a Level 2 qualifications was ‘not sufficient to equip a practitioner for work in the early years.’ She has also said that Level 3 qualifications need to be made more robust, with a focus on SEN and disability, diversity, and a focus on the birth to seven age range.

Although these measures will be a start, Nutbrown is hoping that in order to raise the status and reputation of the Early Years sector, an early years specialist route to qualified teacher status to bring the practice more in line with teaching should be established, which, if accepted by the government would render the need for a licence to practice defunct.

She said: ‘There is an urgency and though some improvements will not be immediate, others of my recommendations can, and should, happen quickly. Longer term commitment will be needed to arrest a decline in the standards of qualifications and enhance their quality for the future. However, there cannot be a compromise on quality and we must be unrelenting in our insistence on improving experiences for all babies and young children.’

Wales organ donation Bill is published

A draft of the Human transplantation (Wales) Bill, which if successful could see Welsh organ donations rates increase by a quarter if successful, has been launched by Health Minister Lesley Griffiths.

The system, which could be operational by 2015, will give people the option to either formally opt in to the organ donor scheme or to opt out of being a donor, by placing their name on a register. The current situation whereby only people who have died in hospital, even if a registered donor, are considered eligible as donors, will remain.

Advocates of the system claim that the money saved by using donor organs in only one transplant will be enough to implement all of the changes required to introduce the soft opt-out system.

In 2010-11 there were 228 potential donors in Wales, only 67 of who had previously agreed to leave organs. Griffiths said:

‘We are seeing a change in the law to increase the number of organ and tissue donors and to save lives. Wales has seen a 49% increase in the donation rates since 2008, which is a huge achievement to be proud of. I believe the time has come to introduce a change in the law together with an extensive communication and education programme encouraging people to make a decision and to ensure their families know their wishes.’

Chair of the Welsh Organ Donation and Transplantation Committee, Dr George Findlay agreed, stating:

‘It is a terrible time to talk to families. It helps if you know what a patient’s wishes are, but was keen to stress that no action would be taken if against the wishes of the deceased’s family: ’As a doctor, we are not going to do anything against family wishes.’
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Kate Clarkson, a Unite representative and Health Visitor for County Durham and Darlington NHS Foundation Trust tells CP why she became an altruistic kidney donor

In November 2010 I was invited to take part in a service of thanksgiving for people involved in transplantation, and it was the most moving event I have ever attended. It prompted me to put myself forward for the altruistic kidney donation programme.

Having a spare kidney and knowing that there are thousands of people with kidney failure whose lives could be transformed or saved by receiving a donation made my decision easier.

‘Non-directed altruistic kidney donation’ started in 2007-08 and it became possible after the enactment of the Human Tissue Act 2004. The donor gives a kidney to someone they have never met, whose identity is not known to them. I contacted my nearest transplant centre and was invited in to meet one of their transplant co-ordinators, who talked me through the process and checked I still wanted to proceed. I was given the opportunity to change my mind at every stage and there was absolutely no pressure to carry on. After 12 months of investigations to ensure I was healthy, including assessments by a renal physician, a renal surgeon and a psychiatrist, a final interview with an independent assessor representing the Human Tissue Authority took place. I was soon recommended as a suitable candidate.

As I had recently moved into a new role at work it helped that my new employers were completely supportive. Soon afterwards a match was found and the operation was scheduled. However, things didn’t go according to plan. On the Friday before it was due to take place I received a phone call to say the recipient was unwell and the surgery was to be cancelled. However, another recipient was identified and a new date scheduled for a week later. The operation went ahead successfully and I was home four days later, feeling fine but tired.

I would like to pay a huge tribute to Mr Rix, the surgeon who took such good care of me, and to Kim Russell, the transplant co-ordinator at the Freeman Hospital in Newcastle who did everything she could to make sure I was fully informed and had everything I needed. I would also like to thank a health visitor colleague and good friend, Marion Dinneen, who travelled up from Manchester to look after me when I was discharged.

By taking part in the donation I have saved the NHS a great deal of money, too. It costs £290,000 to keep someone on dialysis for 10 years. I feel that not enough people know this is an option, and that we need to spread the word. I am now completely back to normal and my life hasn’t changed at all. The recipient is, I am told, doing really well – and I have absolutely no regrets.

For more information about altruistic kidney donation contact:
Human Tissue Authority, Finlaison House, 15–17 Furnival Street, London EC4A 1AB.
Tel: 020 7211 3400.
Email: enquiries@hta.gov.uk
Website: www.hta.gov.uk

In 2012, health visitors celebrate 150 years of the profession since the first health visitors (or sanitary inspectors as they were known in 1862) first started work in Salford, Greater Manchester. Throughout 2012, Unite/CPHVA will be celebrating this anniversary and we’ll be updating the website with activities, information and available promotional material.

Health visiting timeline
Unite/CPHVA have put together a timeline outlining the history of the profession, including key events that have taken place over the years involving health visiting and public health. The timeline can be accessed at: http://unitetheunion.org/pdf/150%20yr%20timeline%2025.4.12.pdf
We’ll be updating this document as we do more research. If you have any comments or want to add a moment in time, get in touch at: dave.munday@unitetheunion.org

Don’t forget to have a look at the CPHVA Facebook page (www.facebook.com/CPHVA), which has some images from the last 150 years, or email the editor with your own stories and memories at: polly.moffat@tenalps.com

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A new report, In the eye of the storm: Britain’s forgotten children and families, highlights the need to protect children from the impact of austerity measures and start a national debate on the needs of children.

The research was conducted by Landman Economics, on behalf of three organisations: Action for Children, the Children’s Society and the National Society for the Prevention of Cruelty to Children (NSPCC).

**Key findings of the report**

The research shows that the most vulnerable families and their children are being most heavily affected by changes to the tax and benefits system, as well as being hit by spending cuts affecting public services. The main findings from the research are as follows:

- Families with four or more vulnerabilities are set to lose around 8% of their net income from the tax and benefit changes, compared to less than 5% for families with no vulnerabilities.
- Combining the changes to the tax and benefits system with spending cuts to public services shows that families with five or more vulnerabilities lose approximately £3,000 per year.
- Between 2008 and 2015 it is estimated that the number of families with five or more vulnerabilities will increase from 130,000 to 190,000 – an increase of just over 14%. The number of children living in families with five or more vulnerabilities is set to rise by 54,000 to 365,000, an increase of around 17%.
- The number of children living in families with four or more vulnerabilities is set to rise from 885,000 in 2008 to just over one million by 2015, also an increase of 17%.
- Particularly worrying is the projected increase in the number of children living in extremely vulnerable families – families with six or seven different risk factors. Although currently fewer than 50,000, the number of children living in extremely vulnerable families is set to double by 2015 to 96,000.

**Recommendations to government**

The charities are using these findings to make the following recommendations to government:

- Re-think how to better protect children from the impact of the recession and the resulting austerity measures. A strategic approach should not start and end with a single unit or government department, but instead join up policies between health, education, social care, tax and benefits, employment and housing to ensure that the most vulnerable children are better protected. It should also address the full range of vulnerabilities that children and families face, rather than be limited to certain types of disadvantage.
- Assess the impact on vulnerable children and families of any further changes to public spending, including any reforms to the tax and benefits system, in order to prevent unintended consequences.
- Commit to monitoring changes to the number of vulnerable children and families in Britain, and report on the impact of public policy decisions on them.

To download the report visit: www.actionforchildren.org.uk/media/4012135/in_the_eye_of_the_storm.pdf

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**Book review: Helping children reach their potential**

*The Genius of Natural Childhood: Secrets of Thriving Children*  
Sally Goddard Blythe  
Hawthorn Press (2011)  
£14.99  
ISBN: 9781907359040

For a new generation of parents this book aims to highlight why free movement, music, dancing, stories, and rhyme are such an intrinsic part of children developing to their full potential. The term ‘natural childhood’ is a reference to this process starting pre-birth and working through the early years. Acknowledgement is made that in a technological, risk-averse age many parents are not aware of the importance of this process.

The book provides practical support, photos and musical examples to enable confidence in providing opportunities from birth onwards. However, the author goes further, discussing convincing arguments from research about why these areas are so important. Links are made between music and language, the use of poetry and fairy stories in teaching moral messages, and movement in achieving sensory integration.

The author also examines other countries’ approaches to supporting the early developmental stages. There is a focus on Finland, where less emphasis is given on more formal types of education in children under six years but, in complete partnership with parents, children are able to develop through playing, movement, exploration and self-expression. A causal link is made between immature physical skills and low achievement in children under six.

Each section of the book ends with a summary of the benefits to the child. This book is easy to read, both as a whole or in short chapters, as the need arises. I thought this was an excellent book and I would thoroughly recommend it for parents and professionals.

Barbara Evans  
Community Nursery Nurse, Hinckley and Bosworth Community Hospital, Leicester
Impact of birth complications on breastfeeding duration
This study aimed to explore reasons why underlying cessation of breastfeeding in mothers with uncomplicated vaginal deliveries and those experiencing complications during childbirth. Interventions during labour and childbirth can have a negative impact on breastfeeding. Mothers who experienced birth complications breastfed for a significantly shorter duration than those who did not. Specifically, caesarean deliveries, foetal distress, failure to progress, and postpartum haemorrhage were each associated with a shorter breastfeeding duration. Maternity health professionals should be alert to this possibility to offer enhanced attention and care to overcome these issues and prolong breastfeeding duration. J Adv Nurs 2012 doi: 10.1111/j.1365-2648.2012.06067.x

Changes in adolescent mental health and use of alcohol and tobacco
This Finnish study examined the 10-year time-trend changes of adolescent psychiatric symptoms, smoking and alcohol use. Representative population-based samples with same methods at two time-points, same age range and with 10-year period between the time points were gathered in Finland to investigate secular changes in adolescents’ emotional and behavioural problems. Seventh and ninth grade students filled in the Strengths and Difficulties Questionnaire (SDQ) and questions regarding alcohol use and smoking anonymously during a school lesson in 1998 (n=1458) and 2008 (n=1569). The self-reports of SDQ showed substantial stability in emotional and behavioral problems from 1998 to 2008. The self-reported alcohol use, drunkenness and cigarette smoking decreased within the 10-year time period. Of alcohol use, the number of non-users increased from 44 to 63% between the years 1998 and 2008. Similarly, the proportion of non-smokers increased from 56 to 68 %. Although rates of substance use declined within the 10-year study period, drunkenness-oriented alcohol use and regular smoking are still prevalent among Finnish adolescents. Eur Child Adolesc Psychiatry 2012

Preparing leaders for safeguarding children
The purpose of child safeguarding is to identify children at risk of abuse or neglect and to reduce this risk. NHS trusts are required to have named and designated safeguarding children clinicians, who need strong leadership skills. This article presents the design and implementation of a leadership training programme developed for these professionals, and an evaluative research study of the programmeperiod. Nurs Times 2012; 108(21):20–2.

Use of folic acid supplements and risk of cleft lip prevention
Oral clefts occur when the lips or the roof of the mouth do not fuse properly during the early weeks of pregnancy. There is strong evidence that periconceptional use of folic acid can prevent neural tube defects but its effect on oral clefts has generated debate. This study aimed to identify factors associated with suboptimal periconceptional use of folic acid and its potential effect on oral clefts. The population-based infant cohort of the national Growing Up in Ireland study, which consists of 11 134 nine-month-old infants. The findings support the hypothesis that taking folic acid may partially prevent cleft lip and palate. Br J Gen Pract 2012; 62(600): 466–72.

New resources
Free iPhone app to help parents choose the right childcare
The Pre-School Learning Alliance has launched a free iPhone app to help parents choose the right childcare. The app is available to download free from the Apple App Store. Visit: www.apple.com/uk/iphone/from-the-app-store, search for ‘childcare’ and look for the Alliance purple icon.

Autism: recognition, referral, diagnosis and management of adults on the autism spectrum
This clinical guideline offers evidence-based advice on the diagnosis and management of autism in adults: http://guidance.nice.org.uk/CG142

Valuing Maternity campaign
A new campaign, called Valuing Maternity, is being led by Maternity Action and is calling for job security for pregnant women and new mothers, maternity and parental leave that promotes equality and services to support a safe and healthy pregnancy. Visit: http://valuingmaternity.org/

Common medicines dictionary approved
The Information Standards Board for Health and Social Care in England has approved a new NHS dictionary of medicines and devices (dm+d) as a fundamental standard which must be used by all staff. It is hoped this will help reduce the number of medical errors made, by ensuring all staff who work in the NHS and health care use the same common language when referring to medicines.
The long-awaited CHRE review into the performance of the NMC has shown that the nursing regulator has let registrants down ‘at every level’, yet plans for a doubling of fees are still on the table

Chloe Harries
Assistant Editor

At the start of 2012, the Council for Healthcare Regulatory Excellence (CHRE) was commissioned by Public Health Minister Anne Milton to perform a strategic review of the Nursing and Midwifery Council (NMC), the regulatory body that oversees health visitors and midwives, a few days into the start of this year.

The results of the interim review were released in April, a damning prelude to the final report, which has just been released and has made for very uncomfortable reading.

The NMC holds the largest register of any UK regulator, with over 670,000 nurses, health visitors and midwives in their system and generates an annual income in excess of £52 million. One of the main duties of the NMC is to investigate fitness to practise (FtP) cases, and if necessary to remove registrants that have been found to be in breach of regulations from the register, either permanently or temporarily. The issue of FtP has been one of the core focuses of the report. As well as reviewing council papers, minutes, management accounts, business plans and performance reports, the CHRE also interviewed council members, directors and assistant directors and held nearly 20 separate focus groups with staff at all every level of the organisation.

Dysfunctional

The final review, which was published in July, highlights major failures across the board and sets out 14 key recommendations covering leadership, strategy, decision-making, finance and culture. The report has found long-standing problems at ‘every level’, including confusion about its regulatory purpose, weak governance, poor planning, unreliable IT systems and poor management.

Laying out the background to the review, Harry Cayton, Chief Executive of the CHRE, said that the NMC have been in difficulty for a ‘significant number of years’, following the previous review by the CHRE in 2008 into FtP and governance, which concluded with the resignation of the then Chair, Vice Chair and Chief Executive. Cayton commented that even after the 2008 report it had become ‘evident that the NMC was still struggling’ and needed a ‘more far-reaching and forward-looking review’.

Acknowledging the report, Acting Chief Executive of the NMC, Jackie Smith, said: ‘We recognise the failings that the CHRE have set out in the report, and we are sorry.’

She stated: ‘The strategic review report and annual performance report together make difficult reading for the NMC. They highlight substantial failings in the delivery of our regulatory functions and in the management of our organisation. It is clear that the NMC has not delivered effective and efficient regulation, and we are committed to putting that right. We will use the reports as a catalyst for change at every level. I would like to add my personal thanks to all those who have responded so positively to the strategic review. We would like to thank the CHRE for the acknowledgment of the progress we have made so far.’

The CHRE has also said that the new Chair and Chief Executive, which are currently being recruited and expected to be in place by the end of this summer, will need to ‘lead by example’ to rebuild confidence and help the troubled regulator to become an efficient body. Cayton stated: ‘The NMC is fulfilling its statutory functions but not the standards that nurses, midwives and the public should expect. We would not go as far as to say that the NMC are dysfunctional – it is functional, but it doesn’t function very well.’

He was also keen to add that the interim Chief Executive and Chair had gone far to reverse the fortunes of the regulator: ‘The report states that leadership, in particular the appointments of the new Chair and Chief Executive are ‘crucial to both public protection and public confidence in the NMC.’

The report states: ‘Despite their actions, no one should be complacent about the difficulties ahead for the NMC nor the challenge facing the new Chair and Chief Executive.’

Unite Lead Professional Officer, Obi Amadi, disagreed about the functionality of the regulator: ‘The CHRC report is a searing indictment that highlights a dysfunctional organisation, which appears not to be fit for purpose in regulating the nursing professions and ensuring that the public has confidence in the regulatory framework.’
Low morale
As outlined in the interim report the main areas of weakness were governance and leadership, but Cayton said, during the review in some areas they discovered that their concerns had become ‘greater rather than less.’

Despite finding evidence that many of those who work for the body are enthusiastic and have a ‘strong passion’ for public protection, they are also part of a hierarchical culture of ‘resigned resilience’, borne out of ‘years of criticism and frustration,’ said Cayton.

The report explained: ‘By ‘resigned resilience’ we have described a temperament we have found in longstanding members of staff; ‘resilience’ because they have endured years of criticism and frustration and yet keep going; ‘resigned’ because they have … to accept and tolerate poor standards and believe that nothing can change and that they cannot influence improvement.’

This would account for the staff turnover rates – 34% of staff, out of a total of 400 employed, left in the last year alone. But there is a core of loyal staff remaining, but feel that they have no voice and little influence. The report advises the NMC: ‘To succeed, it will need to shift its culture from resigned resilience to an open culture, which engages and empowers staff to perform their best.’

Cayton said: ‘Staff need greater decision making at every level in the organisation and real leadership that they haven’t had in the longer-term past.’

Money matters
According to the report, the NMC has shown a ‘lack of competence’ towards financial matters. After inheriting a poor financial position from the previous incarnation of the regulator the UKCC, the NMC decided to follow the Charity Commission’s guidelines and build up six-months of reserves to spend on operating procedure. The reserve levels were achieved in March 2010. However, the Commission’s guidelines are intended for use by charities or similar bodies with unreliable and fluctuating income levels, not for statutory bodies with a guaranteed income, such as the NMC. By limiting their expenditure through excessive saving to build up reserves, the NMC underinvested in its FtP system, which has led to the current backlog now being experienced.

Cayton said that the regulator had ‘to some extent acted as though it was unsure about its income’, he continued: ‘It decided not to spend its money usefully and if it had invested in FtP we would not be in this situation now.’

Since 2011, the NMC has been aware of the need to gain additional investment in FtP, especially in light of the rising number of cases. This led to the budget being increased by £6million, which was redirected from other areas. These calculations were included in the calculations for the original 2012-2013 budget, on the understanding that there would be no further increases in referral rates, or that increases would be created through efficiency savings. Now it has become apparent that further funds must be found. The NMC states that the only way to do this is by increasing registrants’ fees.

However, professional bodies, nursing groups and registrants have spoken out against this, questioning why registrants should have to foot the bill for the regulator’s failings. As of March this year, the budgeted expenditure approved by the council was £56million. FtP cases alone are estimated to cost £43million for this year. Revisions to the NMC’s budget have since forecast that expenditure is likely to be around £73million for this year.

When questions as to whether any other source had been approached, discussed or even considered, to fill the deficit, Smith stated: ‘We’ve spent the last few months saying “what is it going to cost to deliver public protection?” we have had the courage and responsibility to say “this is how much this is going to cost”, adding: “There is no alternative, I’m afraid.”

Cayton said: ‘We’ve seen the figures, and the figures are pretty grim.’

Amadi said that in light of the CHRE’s findings, the NMC needs to find alternative funding sources: ‘The fact that the NMC is proposing a 58% hike in fees that registrants have to pay if they wish to continue to work in the health service should be withdrawn in the light of this report. Asking nurses and health visitors to pay more, when they are subject to a two-year pay freeze, sends out entirely the wrong message when the level of standards and quality of service provided by the NMC is so inadequate.’

The chances of the DH coming to the aid of registrants in terms of support with fee rises is highly unlikely, although the DH has made it clear that a fee rise should be a last report.
A DH spokesperson said: ‘We have publicly made it clear to all the health regulators that we would not expect to see rises in registration fees unless an increase is essential to fulfil their statutory duties. We expect the NMC to explore all possible options to avoid a fee increase. The NMC needs to justify any increase in fees to us and their registrants.’

Recommendation 11 of the CHRE report states that the NMC must ‘establish a stronger link between its activity levels and the impact of those activities and costs’ and provide ‘much greater clarity.’ But many are arguing that this is too little, too late.

Another key area that will potentially cost tens of millions of pounds is the NMC’s Information, Communications and Technology (ICT) system, described by Mr Cayton as ‘at the best, creaky.’

WISER, the application used to deal with registration, is considered ‘high-risk’ and has resulted in at least two serious errors. The first concerned an inadequate script change to the registration status of a small number of registrants; the second concerned identifying discrepancies in the outcome of a case hearing as recorded in the case management system and the reported status of a registrant on WISER. However, ICT is not considered a priority area, with the report advising that other areas such as the appointments of leadership positions and clearing the FtP backlog coming first. No financial audit of the NMC has been undertaken.

Fit to practise?

Since 2009, the number of FtP cases has risen by nearly 50% to over 4,000 cases. The CHRE believes this is in part due to a greater public awareness, in light of nursing scandals such as Winterbourne View and Mid Staffordshire NHS Foundation Trust. Cayton said: ‘Every regulator is seeing an increase in referrals, we don’t know the reason, but it might be better public awareness in light of the Francis Report and Winterbourne view.’

Currently there are 15 FtP hearings every day and it has recently been announced that this will rise to 18 hearings per day as of September this year.

Over all, the NMC are dealing with a staggering 4,426 FtP cases, 1,000 of which are waiting to be heard. This amounts to only 0.6% of nursing staff, which seems negligible, but in real terms is still a large number of people, as nursing is a very large profession.

However the level of FtP cases brought against nurses is still fewer than charges brought against either doctors and dentists. Approximately one-third of NMC cases are carried forward to the next year, with some cases taking up to five years to close.

The report found that the NMC had underinvested compared to other health professional regulators, details of which are available in the CHRE’s forthcoming report, Cost effectiveness and efficiency review of the health professional regulators, which provides a comparative analysis of the regulators’ expenditure on their functions.

The NMC’s FtP problems stem from a comparative analysis of the regulators’ expenditure on their functions. The CHRE have now been clear about the expected referral rate and reasons for increases. The report stated: ‘Improving fitness to practise is a key priority for the NMC but it does not have an easily digestible narrative plan’ adding: ‘We were struck by the lack of time dedicated for staff to think strategically and to plan.’

A common issue arising among stakeholders feedback was the notion of modernising FtP, for example, dispensing with outdated practices such as the oral readings of witness statements. But these are all ideas that are unlikely to be implemented soon, certainly not before hearings increase in September.

Where next?

According to the report, the NMC has managed to carry out its public protection duties, albeit in a flawed manner. However, when it comes to upholding the public confidence in the professions that they oversee, such as nurses, midwives and health visitors, the regulator has clearly failed. This has been attributed in no small part to the fragmented and confused leadership of the Chair and Chief Executive in the past.

Cayton said: ‘The NMC has had a troubled history. It is responsible for protecting the public and upholding public confidence. Stakeholders make clear to us that there is continuing support for the NMC,’ he added: ‘Nobody was telling us that they wanted to see the demise of the NMC.’

The CHRE have now been clear about the bottom line, however, stating: ‘No regulator can be permitted to consistently underperform as the NMC has done. Staff, registrants, and the public must get the leadership and practical action they need and deserve,’ but, he stressed: ‘The public have been let down. It doesn’t mean nursing is unsafe – but the public, nurses and midwives ought to feel confident in the regulator. They haven’t been able to.

‘The regulator must finally leave its troubled past behind. Now leaders must be appointed who are competent, credible and capable of addressing its very serious organisational problems.’
The overarching health visiting structure changed again with the passage of the 1979 Nurses, Midwives and Health Visitors Act. This was the realisation of the 1972 Briggs Report recommendations in legislation as it sought to bring together these nursing practices under one general body, rather than the multiple governing bodies that currently administered them. While the legislation was passed, the Act did not officially launch until 1983, when the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and the four National Boards for England, Scotland, Wales and Northern Ireland were created, leading to the end of the CETHV.

The UKCC maintained the register and dealt with misconduct claims, while the National Boards supervised educational curriculum and the actions of the students taking the courses.

In terms of education, in 1994, health visiting courses shifted from a 51-week programme to a minimum 32-week one as it merges with a post-registration nursing framework for Specialist Community Health Care Nursing.

Then in 1986, the Cumberlege Report came out with the recommendation that qualified health visitors, nurses and midwives be allowed to prescribe medicines for patients. This suggestion was seconded by a 1989 report from the Department of Health, which seconds the suggestion, this acts as the first step towards giving nurses and health visitors more autonomy when treating patients.

The Nurses, Midwives and Health Visitors Act officially launches, creating the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and the four National Boards to co-ordinate training, examinations and registrations of members of the professions. This leads to the demise of the CETHV, the previous regulatory body.

The Health Visitors’ Association (HVA), which now has around 16,000 members, merges with the Manufacturing, Science and Finance union.

Medicinal Products: Prescription by Nurses etc Act 1992, inspired by the Cumberlege Report, passes, allowing district nurses and qualified midwives and health visitors to prescribe from the limited list, published in the Nurse Prescriber’s Formulary, which included medicines like laxatives and mild analgesics. However, this did not actually come into effect until 1994, when the Medicinal Products: Prescription by Nurses etc Act 1992 (Commencement No 1) Order launches.
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The health visitor’s role in the identification of domestic abuse

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Abstract
Internationally, domestic abuse is a significant public health issue in terms of imposing physical and psychological distress upon victims, having a detrimental impact upon parenting and causing psychological problems for victim’s children. Figures identify that one in four UK women experience domestic abuse. However, it is acknowledged that reported rates are gross underestimates of true figures and that multiple barriers exist that inhibit domestic abuse identification. This paper reviews the literature to explore these barriers and ascertain evidence-based strategies that will help practitioners to identify domestic abuse more effectively. Particular attention is paid to domestic abuse screening tools, as research suggests their use increases disclosure rates.

The paper concludes that routine and recurrent enquiry using a screening tool, information giving to all women, knowledgeable staff and supportive environments, are all potential facilitators to identification.

Keywords
Health visitor, domestic violence, domestic abuse, screening tool

Introduction
Although many definitions exist, the World Health Organization (WHO) (2010) definition of domestic abuse portrays the entire spectrum of abuse, by describing it as physical attacks, sexual coercion and psychological control within an intimate relationship. Research indicates that domestic abuse causes:

- Poor physical, sexual and psychological health for victims
- Compromised parenting
- Physical injuries to the victims’ children, as well as behavioural, educational and psychological problems
- A total cost to the UK economy of £23 billion per annum, broken down into healthcare costs, police resources, court fees and time lost at work (Department of Health (DH), 2010).

Nationally, there are over one million reported female victims, amounting to one in four women (HM Government, 2010). Disclosure of abuse is recognised as being a significant step in breaking isolation and providing access to further support (Feder et al, 2009; Spangaro et al, 2010). Health visitors are known to play a lead role; as a statutory obligation they are required to prevent and identify domestic abuse (Nursing and Midwifery Council (NMC), 2004). Additionally, as over one-third of cases begin during pregnancy and then escalate postnatally (DH, 2010), health visitors are ideally placed to identify those women experiencing abuse, as their role commences during the antenatal period and they offer universal support to all postnatal women. The aim of this paper is to review the evidence and determine strategies that will more effectively identify abuse, ultimately aiming to reduce maternal and child morbidity when implemented within practice.

Limitations
It is acknowledged that men can be victims of domestic abuse as well as women, and that abuse occurs within same-sex relationships (Hester et al, 2007). However, as the incidence of domestic abuse occurs disproportionately against females by males (DH, 2005), this paper will centre upon abuse against women by men. Furthermore, while support for domestic abuse victims is paramount, this is not the focal point of the paper.

Method
This paper takes the form of a library-based literature review conducted during August 2011. The methodology recommended by Burns and Grove (2001) was used.

Initially, a brief search was conducted using the online database CINAHL. This enabled understanding of the basic concepts and theories. From here, a more extensive search of online databases occurred, focusing upon keywords and synonyms of the paper’s title. So that literature could be thoroughly analysed, searches were limited to full-text articles.

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Furthermore, the search was limited to articles published in the previous ten years. Table 1 shows the findings.

Online searches and hand searches of professional journals were carried out. The search concluded when recurring patterns, authors and articles emerged. The search strategy located 58 potential papers in total. Each paper’s abstract and summary was read to determine its relevance. From here, more comprehensive reading occurred with articles eliminated if deemed irrelevant. Although preference was given to UK studies, due to only nine papers retrieved from this origin, papers were also included from the ‘developed world’ (particularly the USA, Canada and Australia). Although inclusion of studies from outside the UK may impede transferability, the author will comment, where appropriate, upon a study’s sampling methods to determine whether findings are applicable to the UK.

The final volume of papers for review was 18. Each paper was critically appraised to gain a balanced, objective view. This involved carefully assessing the strengths and weaknesses of the study design, methodology and findings to determine its overall credibility (Burns and Grove, 2001). During this process, a ‘summary and concept map’ (Burns and Grove, 2001) was produced to reveal similarities and inconsistencies in findings across different papers. This process also enabled similar concepts or guiding themes to emerge. Below follows a critical analysis of the literature in relation to these themes. However, the themes should not be considered in isolation since each is intrinsically linked to, and impacts upon, other themes.

**Literature review**

### Routine vs selective enquiry

Domestic abuse spans all socio-economic, ethnic, religious and age populations, and no particular group is considered more vulnerable (WHO, 2010). Organisations have attempted to categorise abuse indicators (including unexplained injuries, frequent A&E attendances, anxiety) but there is now recognition that abuse is often concealed by victims, or is not immediately apparent – particularly non-physical forms (Roswell, 2003; DH, 2005). Consequently, the DH (2005) recommends ‘routine enquiry’, which, compared to ‘selective enquiry’, involves asking all women about domestic abuse, regardless of indicators. This is pertinent to health visitors as this is a proactive approach, in line with the principles of public health that frame practice. Routine enquiry also encourages non-discriminatory practice by not defining particular social groups as more ‘vulnerable’ (DH, 2005).

Literature overwhelmingly indicates that routine enquiry results in higher incidences of abuse disclosure (Janssen et al, 2002; Bacchus et al, 2003; Spangaro et al, 2010), highlighting that, unless asked, the majority of women do not disclose abuse voluntarily. Significantly, each of these studies originates from a different country (UK, USA and Canada), with the non-UK studies being large-scale and multi-setting in nature. Although every study is setting and time-specific, these factors increase the transferability of the findings to UK practice (Burns and Grove, 2001).

### Better outcomes for women and children

Routine enquiry has been found to increase disclosure rates, but debate is lacking in the literature regarding any long-term benefits. Richardson et al (2002) report a deficit of such evidence. However, a large-scale randomised, controlled trial (RCT) has found that routine enquiry followed by disclosure and access to further information and support, was associated with significantly fewer threats and acts of abuse two years later, with subsequent improvements in maternal and child emotional and physical wellbeing (McFarlane et al, 2006). These findings are significant as this is a methodologically robust RCT – generally regarded as the most reliable form of empirical evidence (Burns and Grove, 2001). This adds weight to the value of routine enquiry in terms of improving health outcomes for women and children.

Price et al (2007) recognise that the key factor leading to improved outcomes following routine enquiry and abuse disclosure, is having clear referral pathways for support including voluntary agencies, MARAC conferences and local Independent Domestic Abuse Advisors (IDVAs). This indicates that it is not enough to simply ask about domestic abuse but, instead, that a number of agencies at various levels are required to enable women to feel supported, safe and make informed choices, and ultimately improve outcomes. This poses a dilemma, as access to local voluntary services for abuse victims is variable across the country (HM Government, 2010) and it is questionable whether it is ethical to routinely enquire about domestic abuse if support services are not easily accessible. However, it could be argued that support from national organisations such as Refuge and Women’s Aid are available to all, and that by not routinely asking regarding domestic abuse, the true need for local support agencies will never be recognised and will remain insufficient.

### Women’s preferences

Generally, research indicates that women find routine enquiry acceptable (Janssen et al, 2002; Chen et al, 2007). Bateman and Whitehead (2004) found that within a health visiting setting, women were ‘grateful’ to be asked about abuse. Conversely, Richardson et al (2002) report that 20% of their study participants objected to abuse enquiry. However, critical analysis of this paper may reveal implicit values. The way in which statistics are presented can impact upon how they are interpreted by readers; the researchers focus on the minority group rather than the 80% who found enquiry acceptable, perhaps indicating the researcher’s underlying beliefs. Nevertheless, the study provides interesting debate. In light of the majority of evidence reviewed, routine enquiry appears in alignment with women’s expressed needs. For health visitors who are concerned with identifying and satisfying the population’s health needs, this is significant.

### Screening tools

Domestic abuse screening tools take the enquiry process one step further. Screening tools standardise the enquiry approach (Feder et al, 2009) and it is this that sets ‘screening’ apart from ‘enquiry’. Feder et al (2009) state domestic abuse ‘screening’ does not meet the UK National Screening Committee’s criterion since domestic abuse is not a ‘disease’ requiring detection only in the early stages. However, Price et al (2007) remind us of our professional accountability to ensure families’ welfare, and point out that whatever terminology is used, evidence indicates that women want to be asked about abuse and this cannot be ignored.

Furthermore, Bateman and Whitehead (2004) note the importance of professionals using a screening tool because, without a consistent approach, enquiry can be vague and generate uncertainty for women. Conversely, screening tools ‘normalise’ the process and result in higher incidences of disclosure (Hamberger and Phelan, 2006; O’Reilly et al, 2010).

The literature search identified a variety of domestic abuse screening tools, for example Webster et al (see Box 1). A significant strength of some screening tools is the presence of an opening statement that provides justification for screening in terms of prevalence and health impact of abuse. This demonstrates that the organisation undertaking screening takes the
issue seriously (Hester et al, 2007). A further strength is those tools that encapsulate the entire spectrum of abuse. This is an important feature to accurately detect abuse and to enhance awareness amongst women of the various behaviours constituting abuse (Roswell, 2003). Undoubtedly, screening tools for domestic abuse need to be non-judgemental and sensitive to the needs of women, and effective in identifying the various forms of abuse.

**Barriers to identification**

Inadequate practitioner knowledge is a recognised barrier to domestic abuse identification (Rose et al, 2011). A number of studies indicate a ‘medical model’ of care adopted by some professionals. Rhodes et al (2007) found that A&E staff treated only women’s physical injuries, paying minimal regard to domestic abuse, even when suspected. Bateman and Whitehead (2004) found similar behaviours among UK GPs. This suggests perceptions that domestic abuse, as a social issue, is outside the medical domain (Rose et al, 2011). This model does little to support women’s needs or aid abuse identification (Hamberger and Phelan, 2006). This is significant for health visitors who work collaboratively, particularly with GPs.

Peckover (2003a) found that two-thirds of health visitors in her study viewed domestic abuse solely within physical realms. This has practice implications in terms of minimising the extent of abuse (Peckover, 2003a). However, the study consisted of a small sample from the same trust. It is unlikely, therefore, that this narrow sample is representative of the national health visiting profession. This limits transferability of findings to other settings, but does indicate the need for local trusts to audit staff knowledge and implement training in response, and consider that the presence of a domestic abuse screening tool within client records, as part of a clinical pathway, would promote more effective abuse identification (DH, 2005).

Time pressures and workloads are documented barriers to identification (Hamberger and Phelan, 2006). Chen et al (2007) dispute this, arguing that enquiry and screening takes only a few minutes. However, most health visitors would assert that it is not asking the question that takes time, but dealing with disclosures. With reductions in health visitor numbers, this issue is undoubtedly pertinent. Health visitors may already feel overwhelmed, without the addition of another ‘task’.

Rhodes et al (2007), in a qualitative analysis within an Emergency Department, found that the presence of a third-party member posed a barrier to women’s disclosure of abuse. However, this study’s ethics are seriously questionable as there is a general consensus that enquiry must occur privately, as a matter of safety for the client and practitioner (Bateman and Whitehead, 2004; DH, 2005). However, the very nature of the abusive partner may make it difficult to see women alone (DH, 2005). Bacchus et al’s (2003) UK-based qualitative study also indicates that lack of privacy presents a barrier for women disclosing abuse, particularly within busy clinics. Applied to health visiting, this is a likely barrier particularly within ‘Well Baby Clinics’. To counter this, literature advocates the use of appropriate posters or leaflets within clinical areas (eg, waiting rooms, bathrooms) (Bacchus et al, 2003; Hamberger and Phelan, 2006) that enable women to self-refer.

Psychological and sociological perspectives may also aid understanding of why some women conceal abuse. Roswell (2003) describes the ‘mystery of the perfect family’, which can act as an oppressive force to disclosing abuse. Additionally, Wallace (2007) describes a psychological phenomenon known as ‘Stockholm Syndrome’ whereby women create strong emotional bonds with their abusers. Superficially, it may appear that women are minimising abuse, even colluding with their abuser (Hester et al, 2007). Deeper analysis, however, reveals a strategy for survival in terms of appeasing abusive partners and ultimately reducing abusive episodes (Wallace, 2007). This offers an interesting perspective for why women do not disclose abuse. It is important therefore for professionals to acknowledge the complex nature of abusive relationships and the strategies that women adopt to stay safe (Roswell, 2003).

**Importance of ‘trust’ and information-giving**

Analysis of the literature reveals that ‘trust’ is a key feature influencing disclosure. Literature identifies that women are frightened that disclosure may cause abuse escalation or result in children being removed (Rose et al, 2011). However, research reveals that women...
who trust their practitioners disclose abuse, regardless of fears (Bateman and Whitehead, 2004; Hamberger and Phelan, 2006). Bateman and Whitehead (2004) reveal that trust is associated with open communication, ‘feeling heard’, maintaining confidentiality (within professional limits) and having a caring disposition. They found that, generally, health visitors adopted this approach with women feeling that this profession were less judgemental and more in tune with their needs. Thus, disclosure came more readily. However, for professionals such as health visitors, who have statutory obligations within the safeguarding arena, some women may be cautious to disclose abuse. Indeed, Peckover (2003b) found that women perceived health visitors as ‘policing the family’; ultimately resulting in women’s concealment of abuse. It is unclear why two studies of similar methodological design, both undertaken within Northern England, revealed such varied perspectives. Nevertheless, it is important that health visitors have awareness of the public’s perspective and the subsequent impact upon disclosure.

Hester et al (2007) identify that trust is a concept that materialises over time. This supports literature indicating that recurrent enquiry/screening is necessary before disclosure occurs (Hamberger and Phelan, 2006; O’Reilly et al, 2010). Importantly, for several studies, routine screening occurred simultaneously with giving easily concealed, wallet-sized information cards to all women – regardless of whether they disclosed abuse – that provided key information on domestic abuse support services (Janssen et al, 2002; Spangaro et al, 2010). The DH (2005) recognises this as good practice. Moreover, this practice acknowledges those women who fail to disclose abuse – known as ‘false negatives’. Significantly, Spangaro et al (2010) report that 81% of all study participants read or used the information card in some way, either for themselves or for a friend/family member. This indicates the value of information-giving to women.

Conclusion

The literature review highlighted that domestic abuse spans all sections of society, is largely hidden and not readily disclosed. Consequently, the majority of literature advocates routine enquiry for domestic abuse. Literature identifies that women favour this approach and that it has long-term benefits in terms of reducing threats and acts of abuse. The use of screening tools was also found to result in even higher disclosure rates. However, it was found that some women may continue to conceal abuse as part of their coping strategy. The literature review therefore advocated multiple assessments, information giving to all women following enquiry/screening, a caring disposition from practitioners, and clinical environments that promote self-referral. Health visitors are recognised as being ideally placed to routinely enquire about domestic abuse due to their universal contact with women during the antenatal and postnatal period – a time when abuse is most likely to begin or escalate. While some research indicates the health visitor’s holistic, non-judgemental approach facilitates disclosure of abuse, their statutory obligations within the child protection arena is a likely barrier and health visitors need to be aware of this.

References


Parental experiences of cleft lip and palate services

Introduction
A cleft of the lip and or palate is the most frequent birth defect, the incidence quoted as 1 in 700 live births (Cleft Lip and Palate Association (CLAPA), 2009). In Northern Ireland from 1981 to 2000 the incidence was 1.47 per 100 live births (Gregg et al, 2008). Cleft means 'split' or 'separation'. During early pregnancy separate areas of the face develop individually and then join together. If some parts do not join properly the result is a cleft, the type and severity of which can vary. A cleft lip is a condition that creates an opening in the upper lip between the mouth and nose. A cleft palate occurs when the roof of the mouth has not joined completely and can range from just an opening at the back of the soft palate to a nearly complete separation of the roof of the mouth (Watson, 2001).

The cause of the failure of the face to fuse, resulting in a cleft of the lip and or palate, is not known. It may occur as 'uniquely' within a family or it may be the result of a number of genetic and environmental factors that occur together in a way that could not have been predicted, or prevented in advance (CLAPA, 2009). A cleft lip and, on occasions a cleft palate, may be visualised antenatally by ultrasound scan and if identified early allows an opportunity to inform parents prior to birth. However a facial cleft may also remain undiagnosed until birth, when the full extent of the anomaly becomes apparent at delivery (Beaumont, 2006). New birth examination following delivery, by the neonatal doctor would include this check as part of the new birth examination. If not picked up, late diagnosed palate babies may present as failing to thrive or be slow feeders and may have been unable to breast feed (Jones, 2009).

A cleft lip and palate can affect a child’s ability to feed, chew, breathe and hear and can cause disturbances to dental facial, speech and language development (Clinical Standards Advisory Group, 1998). In the United Kingdom (UK) to address the functional and appearance related consequences of having a cleft, a long term programme of surgery, orthodontic treatment and speech therapy is offered by multidisciplinary teams of specialist clinicians (Nelson et al, 2011).

Most parents experience feelings of guilt, anxiety, fear, and sadness as reactions to having a baby with a cleft lip and or palate (Rey-Bellet & Hohlfield, 2004). Parents appear to go through similar reactions and emotions whether they found out about their child’s cleft antenatally or at the time of the delivery (Nusbaum et al, 2008). A small number of in depth qualitative studies have also highlighted parents’ feelings of anxiety about surgery and their perceived need for emotional support through treatment (Nelson et al 2011).

UK cleft services
Across the UK many regions already have a cleft lip and palate clinical nurse specialist. This speciality service was not widely available in Northern Ireland. However, since 1995 a cleft liaison team was developed in one locality in the province comprising health visitors and midwives from an acute hospital and community. The cleft liaison team also includes a consultant orthodontist.

Two midwives and two health visitors who had a particular interest, skills and experience in the care of children born with a cleft, nominated themselves to develop the specialist service. Further professional development was completed at that time and updates continue regularly to maintain and develop their knowledge and skills. This cleft work is done in addition to their existing roles and caseloads.

A member of this team provides information and counselling in the early stages following diagnosis of cleft whether antenatally or post delivery. The team help establish the feeding of these babies and help the parents and extended family involved in care to develop the special skills and techniques required. The aim of the service is to allow mother and baby to stay together, facilitate earlier discharge post partum and reduce the requirement for readmission of the baby due to dehydration or failure to thrive. Before the introduction of the service cleft babies were frequently readmitted
with conditions that could have been prevented such as failure to gain weight resulting in a need to introduce enteral feeding. Minor surgery was often compromised by infections such as oral thrush. The fact the there have been no readmissions of these cleft babies to hospital since the introduction of this service, suggests that the consistent, accurate information and support provided by the service is having a positive effect. While anecdotal evidence had indicated that the service was of great help to parents it had never been formally evaluated. It was not known whether the service was effective and efficient, and also from the families’ perspective, what support was provided and needed.

Study aim
The aim of this service evaluation was to clarify the information and support most valued by parents in receipt of care from the cleft liaison nurse service and to identify areas where the service could be improved.

Methods
Prior to the study starting, permission to proceed with this service evaluation was given by the relevant Research Governance committee to ensure compliance with local policy and NHS guidance (HQIP, 2011).

Design
The service evaluation was designed to explore the needs and views of parents who have a baby or child with a cleft of the lip and or palate, within the service locality. A qualitative approach was adopted, using semi-structured interviews, as it was thought that this method would illuminate the health and social care issues that are important to parents themselves, rather than focusing professionally-led interventions and outcome measures from a professional perspective.

Data collection
Letters were sent out to 35 families, who have had a child diagnosed with cleft lip/palate from 2000 to 2008, by a member of the cleft liaison team explaining the study and inviting them to participate. The invitation explained that the study was taking place to investigate how well the current service was working by listening to their views, attitudes and feelings, of learning to cope with a baby/child with a cleft lip and palate, and the impact that the liaison team had on helping them. Previously unmet needs were also sought. The participants were assured that any information provided would be completely confidential and the data anonymised. For those who self selected to participate, a date and time suitable to the participant was then arranged. The interviews were conducted on an individual basis, in participants’ homes or at the clinic by an impartial researchers, using an interview schedule (Box 1) designed by a steering committee (comprising key stake holders eg, a consultant orthodontist, speech and language therapist, and parent representation). The interviews were recorded with the participant’s permission and lasted no longer than an hour. The recording ensured that the whole interview was captured and provided complete data for analysis. Following transcription of the interviews verbatim, a thematic analysis was conducted by the same researcher who had carried out the interviews (Braun & Clarke, 2006). Twenty interviews were carried out with 16 mothers, one father, and one grandmother, who were the main carer for the child. The ages of the children at the time of interview ranged from 12 months to eight years of age. Only two of the interviewees had been given a diagnosis of cleft in the antenatal period.

Findings and discussion
The following themes were identified: Emotional experiences of having a child with a cleft; the information needs of parents; service related experiences of parents with a child with a cleft.

Box 1- Interview Schedule
1. Was the Cleft diagnosed during your pregnancy? If yes:
   ● At what stage of your pregnancy was the cleft diagnosed?
   ● What were your thoughts at this time?
   ● Who did you discuss these thoughts with?
2. Do you recall meeting a member of the Cleft Team?
   If yes:
   ● How soon after the cleft was diagnosed did you speak to someone from the Cleft Team?
   ● If you can remember can you tell me about the information received?
   ● Was the information useful?
   ● In what way?
3. While in hospital do you remember how many visits from the specialised cleft nurse/consultant did you receive?
   ● Was the information received informative?
   ● Was the nurse/consultant supportive?
   ● In what way?
4. What type of Cleft did your baby have?
   ● Was the practical advice sufficient re feeding system selected?
   ● On leaving hospital would you say you were confident in feeding your baby?
5. On leaving hospital:
   (a) Were you aware of support services and where to get support?
   (b) Were you given a follow up appointment for the consultant orthodontist?
   (c) Did you meet a member of the Community Cleft Team?
6. When was your first visit at home by a member of the Cleft Team?
7. In what ways did the Community Cleft Nurse provide support and information?
8. Was advice given re support group? (Cleft Lip and Palate Association (CLAPA))
9. What advice did you get from your surgeon in Belfast, in preparation for surgery?
10. What practical advice prior to surgery did you receive and from whom?
11. Did you think the Cleft Nurse was important in helping you deal with your baby’s cleft lip or palate?
12. What kind of support did you appreciate most/least?
13. Were there other ways you could have been supported by the Cleft Team?
14. Did you source information from anywhere else? Was it useful?
Emotional experiences of having a child with a cleft

Shock
The birth of an infant with a facial cleft can be an emotionally traumatic time initiating feelings and reactions in the parents in response to the facial appearance (Beaumont, 2006). Regardless of the timing of the diagnosis, parents mostly used ‘shock’ as a response to describe their initial reaction to news of the cleft: ‘I was in just complete shock’ (Interview 6, diagnosed at 23 weeks antenatally); ‘Complete and utter shock. I found it very hard to take in and very hard to cope with’ (Interview 10, diagnosed at birth).

Causal attribution
On initial diagnosis, some looked for a cause for their child’s cleft:
‘Yeah, well my first thought was that I had done something wrong maybe during the pregnancy. Why did she have this because it’s not in either family at all anywhere?’ (Interview 2, diagnosed at birth).

‘I was almost resentful that I would eat healthy and I don’t smoke and I don’t drink and why was this happening to me?’ (Interview 6, diagnosed at 23 weeks antenatally).

This is echoed by Nusbaum et al (2008) who highlighted that participants searched for possible explanations as to the cause of the cleft and often ended up blaming themselves. Rey–Bell and Honfeld (2004) evaluated the specialised counselling received by parents after the prenatal diagnosis of an oral facial cleft and documented common parental reactions at the time of diagnosis included guilt, anxiety, fear and sadness.

Need for reassurance
Participants reported a need for psychological support and reassurance.
‘They just reassured you, they made you feel that although he had a need at the time, he was still normal and everything was still healthy and that it was just a short term problem’ (Interview 5, diagnosed at birth). ‘I remember at the time that I had my son you think ‘I’m the only one that has a child like this’. They were reassuring. Very reassuring’ (Interview 18, diagnosed at 24 weeks antenatal).

In the absence of a psychologist, the cleft liaison team role has a strong counselling element, since parents go through an adjustment process following diagnosis not unlike that of bereavement for the loss of an anticipated ‘perfect child’ (Martin & Bannister, 2004). The findings indicate that the cleft service provided, in and out of hospital, comfort and support helps alleviate fears.

Parents’ information needs
The cleft liaison team assist in the transition between hospital and home by visiting the postnatal ward prior to discharge, continuing the important requirement of consistent and accurate information, to reduce parental anxiety as much as possible. With time, parents’ initial feelings usually become less acute, as the parents become accustomed to the diagnosis and begin caring for their child (Beaumont, 2006). The results of this study are consistent with those reported by Maris (2000) suggesting that despite initial negative reactions parents are able to reorganise their thoughts and feelings and develop acceptance of their infant with a facial cleft, because of the support provided by the Cleft Service. ‘Went through everything in such detail that I felt so comforted by it. I know then that it wasn’t something so major or whatever’ (Interview 6, diagnosed at 23 weeks antenatal).

Written information
The team provide leaflets and paper information:
‘That picture booklet of other people that had cleft babies, what they looked like, just even after the operation, looking at their wee arms in splints - after that, nothing was a shock to me. It was absolutely brilliant. I was so prepared for what was ahead of me’ (Interview 6, diagnosed at 23 weeks antenatal).

It could be argued that the written material acts as an aide memoir. However, it appears from the study results that practical, hands-on advice, is more useful than the written information.

Feeding
Cleft babies are slow to feed, and can be very ‘colicky’. The team gave the parents support with feeding and winding techniques, and assist with the management of Haberman feeders which are specially designed for babies with impaired sucking. ‘I think I was scared in case I would have choked her, you know. But they had told me “no you won’t choke her.” They told me about the slow, medium... different types of flow. It was very good’ (Interview 8, diagnosed at 23 weeks antenatal).

‘They would have went through with me how to hold the teat and how to clean it out and you know the fact that sometimes you might get a choking, the baby might choke and what to do and you know, just all of that was great’ (Interview 5, diagnosed at birth). The results of this study are similar to an investigation by Young (2001) that examined what information parents feel they need and desire when being informed after delivery that their newborn has a cleft. The results showed that parents wanted information about feeding methods and home management. This is reiterated in another study that concluded one of the major issues for parents seemed to be problems with feeding (Johansson & Ringsberg, 2004).

Practical advice regarding surgery
Surgery usually starts with lip repair at three months. Allowing three months before the first surgery gives the mother time to recover after childbirth, get to know her baby and adjust to the appearance of the cleft (Coy et al, 2002). The surgery takes place at the regional centre, which is located about 75 miles from the locality of this study. Whilst the surgeon explains what the surgery will entail, what he was going to do, how long it will take and that it may be necessary to have more than one operation, the practical advice given by the team pertaining to living away from home, in the hospital was also reported as very valuable support.

‘And she was able to tell me what was going to be there and that there was microwaves there, that there was a kitchen that you could use, shower room and things like that, that I would never even have known. So I was so prepared on even what to take with me because when you’re so far away from home’ (Interview 6, diagnosed at 23 weeks antenatal).

‘What to take with me for him like button down things so as you’re not pulling (the clothes) over his head. She said look they may put splints on his arms to stop him rubbing his face. She went through everything’ (Interview 4, diagnosed at birth).

‘The findings of Johansson & Ringsburg (2004) indicated that parents expressed anxiety about the anaesthetic, the risk of infections and the expectations of the surgery. As the regional tertiary centre is over 75 miles away and at times, not easily accessible to parents, these topics have also been addressed by the local support that the cleft liaison team provide pre and post surgery.

Cleft Service related experiences
The cleft liaison service was able to provide information to the parents about future care and treatment. The parents of babies with cleft lip and or palate must cope with many problems and health related issues and they are in need of specialist professional support. ‘Visits are, not rushed unlike hospital appointments – time to listen and chat over a cup of tea’ (Interview 7, diagnosed at birth).
at birth). 'Great support; one to one - invaluable' (Interview 18, diagnosed at 24 weeks antenatal).

As oral clefts are immediately apparent at birth Byrnes et al (2003) suggest that access to professionals who are trained to provide parents with difficult information about their children’s health as well as professionals with expertise in management of clefts should be immediately available. The standard endorsed by the Clinical Standards Audit Group (1999) also recommends that a member of the cleft team should visit all parents with a baby born with a facial cleft within 12 hours of birth. The service provided in this locality is flexible, and not just on a Monday to Friday basis. The team build a strong supportive relationship and provide a continuity of care. 'Building self-esteem as well as seeing the baby' (Interview 14, diagnosed at birth).

This finding is in contrast to the Byrnes et al (2003) study which found parents of children with a cleft diagnosis are dissatisfied with aspects of cleft care and want informed health professionals to show increased caring and confidence. The cleft service evaluation demonstrates that communication of realistic, relevant and appropriate information to parents is possible and is a basic but fundamental requirement in an often traumatic and emotional period. The quality of the service and the dedication of the staff were most eloquently described by a mother diagnosed in the antenatal period. 'The cleft team that I got to know have my appreciation for life, without them I would have been lost, I feel lucky to have had so much support, everyone was fantastic and still is’ (Interview 6, diagnosed at 23 weeks antenatal).

**Implications for practice**

The use of patient interviews has provided insight into individual parents’ experiences that numbers from quantitative data alone could not have produced. It is important to evaluate services, to provide evidence to justify their existence, identify priorities for service development and learn about the patient/client experience. This study demonstrates what the service users need to know, when they need to know it and how that information is best conveyed. The support given by the liaison service, to the parents and babies has been valued by the users. This work is carried out in addition to the teams’ usual responsibilities. Recognition of the time spent over and above the normal duties of the cleft team has been recognised by service managers, especially if the midwife or health visitor is working beyond contracted hours. Release from busy wards and community settings to carry out other specialist duties will always be difficult, but has been facilitated as far as possible with the support of colleagues. The study provides additional supportive evidence for a business case that there needs to be provision to sustain and maintain the service on a more permanent basis. The possibility of having the role incorporated into job plans could be a solution, not only for the sustainability of the service, but also in the future commissioning of services. Other acute care nurses, midwives and community clinical colleagues need to be kept updated and abreast of changes, to allow for times when members of the team are not available. Delayed parental contact at what is often a critical and traumatic time for distressed parents is unacceptable within the clinical governance framework. Professionals with expertise in management of clefts need to be immediately available to speak to parents and carers at this time. Continuing professional development, to keep the team up to date with latest advances and knowledge in the care of cleft lip and palate, will ensure that the team continue to provide accurate and up to date information.

**Conclusion**

Many parents felt they could not have coped with their child with a cleft without the benefit of this specialist service. This study provides the evidence to support the need for securing recurring funding and expanding this to other areas. In addition colleagues with a more general role need updating in this aspect of care.

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**Key points**

- A cleft lip and palate can affect a child’s facial appearance as well as the ability to feed, chew, breathe and hear and can cause disturbances to dental facial, speech and language development.
- Most parents experience feelings of guilt, anxiety, fear, and sadness as reactions to having a baby with a cleft lip and palate.
- This study was designed to explore the needs and views of parents who have a baby or child with a cleft of the lip and or palate.
- The parents of babies with cleft lip and or palate must cope with many problems and health related issues and they are in need of specialist professional support.
The role of Specialist Community Public Health Nurses: students’ perceptions

Introduction
This article will give an overview of an informal exploration of the initial perceptions of student specialist community public health nurses (SCPHN) of qualified public health nurses. The article will discuss the role perceptions of specialist community public health nursing (SCPHN) students, the focus for discussion includes the context, teaching methods utilised to identify student’s perceptions, resulting key themes identified from the teaching activity and a possible rationale for these key themes. Consideration will be given on how these perceptions can be used to support focused educational programmes to develop future competencies in line with the new vision for health visiting (DH 2012).

This paper was written as a result of classroom-based teaching activity by two senior lecturers responsible for teaching SCPHN students on the SCPHN programme, it was sparked by interest and is not intended to be a research paper, merely a thought provoking insight into the feelings and perceptions of SCPHN students with regard to their future roles be it health visiting, school nursing or sexual health advising.

With 150 years of health visiting (DH 2012) SCPHNs are at the forefront of delivering a well established public health service. Equally, school nurses and sexual health advisers are key to individual, community and family, positive public health outcomes. Delivery of robust educational programmes to equip future Specialist Community Public Health Nurses (SCPHN) to meet Nursing and Midwifery Council (NMC) Standards for practice is essential with detail outlined in the standards for SCPHN, developed following extensive consultation and approved by the NMC in June 2004. Equally important is the need to elicit the perceptions of SCPHN students to determine their views on public health and how they perceive public health practitioners, namely the role of SCPHN (health visitors, school nurses and sexual health advisers).

As educationalists teaching SCPHN students within Higher Education we were keen to explore the perceptions of a group of new students within the first week of commencing the programme. This took place in a class-based public health session using the medium of art as represented by drawings. It aimed to support our understanding of their future public health roles and provide an opportunity for debate and discussion. The group comprised of 44 SCPHN students who were recruited from a range of professional nursing backgrounds and were undertaking the BSc (hons)/Post Graduate Diploma Specialist Community Public Health Nursing programme. As a result of the drive for increasing health visiting numbers (DH 2011a) and reenergising the workforce (DH 2011a, page 23) we had a larger than normal number of health visiting students within the group. For all students involved, their future public health role would follow an intense training period with a 50:50 balance of clinical practice and academic theory as outlined by the NMC (2004). It is noteworthy that the programme team had recently been commended (2011) by the NMC for their delivery of the SCPHN programme and partnership working with the organisations involved.

Rationale
The rationale to explore student perceptions was incorporated into the session objectives and determined by the need to gain a baseline understanding of the students’ perceptions of their future roles as SCPHNS. Thus to support a greater understanding of the students’ learning needs in relation to achieving the NMC Standards for Public Health Practice (NMC 2004). It is acknowledged that students bring with them prior knowledge that is gathered through exposure to their experiences of health care combined with personal events and resulting personal schemas (Smith 2003) we...
wanted to access that knowledge to gain an understanding of the perceptions, values and beliefs of the students. How did they view the generic role of qualified specialist community public health nurses (health visitors, school nurses and sexual health advisers) in this early stage of their studentship? Through accessing this information we hoped to be able to identify gaps in knowledge and any potential misperceptions. This is in line with educational theory which emphasises the need to know your student in order to shape the education to meet their specific needs (Gibbs and Habeshaw 1996).

As educationalists we employed ‘active learning strategies’ defined by Bonwell and Eison (1991:1) as ‘instructional activities involving students in doing things and thinking about what they are doing’ in order to encourage participation from the students in the learning process. Utilising drawings as a means of collecting information from the students was thought to be of benefit as it was a universal activity and a quick and efficient way of eliciting information (MacPhail and Kinchin 2007). Additionally, the students were allowed to have free choice as to the content of the drawings without prompting (MacPhail and Kinchin 2007). A possible weakness of this approach is the limitation of the skill of the artist, in this case, the students. The content of the drawings could only reflect subject matter that could be visually represented (MacPhail and Kinchin 2007) and this approach may not have captured the desirable information we sought such as the students’ values and beliefs. This is acknowledged as a limitation of this process. Should we have the luxury of revisiting students’ perceptions at a later stage in the programme we will elicit how these initial perceptions may have changed as a result of the students’ learning journey as they progressed through the SCPHN programme and as a result of experiencing and exposure to a combination of theory and practice.

Process – Gathering and interpreting students’ perceptions

As part of their first taught session of the public health module the students were asked to go into small groups and depict using drawings their perception of the generic role of the qualified SPHCN (health visitor, school nurse and sexual health adviser). We explained the rationale for this being to gain a baseline understanding of their future role and to stimulate discussion. They were then asked to share these images with the larger group, exploring their drawings to generate discussion around their ideas, thoughts, feelings, values and beliefs of what their future role may hold. As we gathered the drawings we generated notes from the student discussions which were explored and used to identify any key emerging themes. These themes were then grouped into three distinct areas: personal attributes, practical tools and role activities, this took place during the session. (Table 1). Following the session a mapping exercise was undertaken where themes were then mapped against the NMC (2004) SCPHN proficiencies. We were able to identify how these themes related to the SCPHN role at this initial stage of SCPHN studentship by focusing on the content and the language used. In doing so, both drawings and discursive material identified the students’ early perceptions of the SCPHN role. This activity was subjective on our part as at this point we had excluded the students altogether relying on our own interpretation of the materials we were presented with and the resulting themes we explored. This is acknowledged as a further limitation of the process.

Discussion

The themes easily identified were those that the students related to the practical elements associated with the role, namely, the ‘tools of the trade’. These included amongst others; scales, vaccinations and IT skills. These were depicted as of equal importance in the drawings to the other themes and held prominent positions in the way they were expressed. In terms of the role activities, students demonstrated a good understanding of groups and individuals they would be working with and appeared to understand the broad remit of their role. In fact, we were able to identify 21 separate role activities from the SCPHN student drawings and resulting discussion. We were reassured

| Table 1. Key themes identified from student drawings during the teaching session. |
|-----------------------------------|-------------------------------|-------------------------------|
| **Personal attributes** | **Practical Tools** | **Role Activities** |
| Observant | Transport/mobile | Health promotion |
| Good listener | Bag of tools | Smoking |
| Good communicator in all ways | Boots/shovel | Adviser on weight management /diet |
| Approachable | A to Z | Mental health |
| Big heart/caring | Scales | Negotiation |
| Able to balance/juggler | Measuring kit | Record keeping |
| Able to compartmentalise | Vaccinations | Immunisation |
| Broad shoulders | IT | Breast feeding |
| Studious | | Dental health |
| Teacher | Telephone | Surveillance |
| Clever/knowledgeable | | Audit and data collection |
| Up to date on policy | | Inequality |
| Team worker | | Partnership |
| Role model | | Housing |
| Negotiator | | Access issues |
| Progressive | | Children and families |
| Leader | | Older people |
| Able to work in partnership | | Empowerment |
| Open | | Evidence based practice |
| Prescriber | | Sign poster |
| Organised | | Global/national/local communities/families |
| Good time keeper | | |
that although many of the SCPHN students were novices with regard to working in the community and a public health context, they appeared to have a broad perspective upon which to build upon in relation to their role as a student and as a qualified health visitor, school nurse or sexual health advisor. Students emphasised Breastfeeding, Immunisation, Evidence Based Practice, Leadership, Children and Families, Mental Health and Partnership which would be part of their role activities. It was noted that SCPHN students were not specific, preferring to identify broad areas of practice rather than give specific examples of the type of work involved in any great depth. This is in keeping with the notion of novice status although they did emphasise areas identified within the recent Department of Health plans for Health Visiting (DH 2011a).

What came through particularly strongly were the personal qualities, attributes and skills that the students identified as necessary for their future role. Through our analysis and subsequent theme identification we outlined 22 personal attributes, again these were subjective to our analysis of the themes however they were particular in emphasising the emotional and psychological nature of the SCPHN students’ future public health roles. They demonstrated some of the key elements believed to be required to be successful such as ‘caring, listening, open and a good communicator in all ways’ alongside the ‘ability to balance and juggle’ the role.

What was also prominent was the need to have a ‘big heart, broad shoulders and be approachable’. Personal attributes such as these were depicted in the drawings very clearly as large cars and central hearts. Drawings established the need for speed in order to move between client groups swiftly and manage client crisis efficiently using knowledge, teaching, negotiation and partnership working skills. This fosters a notion of romanticism with regard to the ideal way in which the SCPHN students view their future public health role and an ethos emphasising the need for a humanistic approach to relationships with clients.

It led us to consider what draws individuals towards a public health nursing career in the first instance, and if we carried out a similar exercise with service users would the same themes have emerged, or would public perceptions differ? This article does not profess to debate these particular issues and only includes their mention as a side thought, perhaps one that we as authors could explore at a later date.

SCPHN students did not appear to include or consider risk assessment, planning and strategic working as part of their future public health role. It could of course be argued that these elements were difficult to depict using drawings, however they were also absent from the discussion that took place with the students around the drawings. Expectations are that as the programme progresses these would be seen as a crucial element of the role. They also omitted themes such as Safeguarding, Child Protection and Building Community Capacity (BCC) the latter relates to that outlined in the recent Health Visitor Implementation Plan (DH 2011a). We acknowledge that BCC has only recently re-emerged and appears to have been a neglected part of the public health role due to staff shortages and recruitment and retention difficulties, particularly in relation to health visiting (DH 2011a). This has prevented public health activities that could build community capacity being realised (DH 2011a). Furthermore, in relation to school nursing increased safeguarding and child protection responsibilities and hefty pupil to school nurse ratios have prevented public health activities from taking place as part of the daily role of the school nurse (Coates 2011).

We are unclear as to why SCPHN students did not highlight role activities around the above particularly safeguarding or child protection. This could be due a number of variables including past experiences, their views of public health and that they may consider that safeguarding and child protection may not be viewed as public health activities in the same way as health promotion (advising on weight management or smoking). This is linked to our earlier comments and the notion of a novice status undoubtedly one that would be more clearly defined as the SCPHN students progressed.

With regard to safeguarding/child protection this is already a strong component of the programme and reflects NMC SCPHN proficiencies. In relation to BCC this has been highlighted as a gap in the SCPHN workforce and as educationalists we have been carrying out a mapping exercise against the Service Vision for Health Visiting in England (DH 2010) and Educating Health Visitors for a Transformed Service (DH 2011b) to identify where in the SCPHN programme we can strengthen these core competencies in building and using community capacity to improve health outcomes. This has led to a stronger emphasis on BCC across the programme including capitalising on opportunities within practice for the students to link with projects specifically working within the BCC model.

Conclusion
The use of art to support students in considering their future role has proved an enjoyable classroom experience and an effective tool to use within the delivery of the SCPHN programme. As educationalists it has enabled us to gather key themes mapped against the SCPHN proficiencies generated from the SCPHN students’ drawings and subsequent discussion and add to the variety of active teaching and learning strategies to support SCPHN learning. It was interesting that at the start their SCPHN programme the students focused on the practical elements of their future role including tools of the trade alongside personal qualities of the practitioner, a clear gap remained with some of the broader aspects of the role including safeguarding and community capacity building. This led us to consider how to place a greater emphasis on these elements within the current curricula with the aim of developing deeper understanding and knowledge of these areas of practice, this in line with the government policy to support the education of future SCPHNS.

Although it is acknowledged that this activity had its limitations in the way that themes were generated, it outlines that these
SCPHN students had a specific knowledge base upon which to build their future public health roles and scope to develop their initial ideas on the role they were about to undertake. Emphasis was on the nature of the personal attributes and skills of the public health nurse, health visitor, school nurse or sexual health adviser with both romantic and humanistic elements identified.

Should the opportunity arise to revisit this as the students move towards the end of the SCPHN programme we can consider these initial findings against those of more experienced SCPHN students. This will enable us to identify how they have developed in relation to the SCPHN proficiencies and subsequent perceptions, values and beliefs of their future public health role.

**Acknowledgements**
With our thanks to the Specialist Community Public Health Nursing Students cohort September 2011.

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Optimising nutritional intake to promote growth and development in children

Introduction
It is important to encourage children to consume a wide range of foods to optimise their nutritional status, which, in turn, promotes good health (Edmondson, 2011). Harris (2010) asserts that a child’s nutritional status has been shown to have a significant impact on health, both in the present and as the child progresses to adulthood.

A recent report from the Scientific Advisory Committee on Nutrition (SACN) (2011) suggested that, while children’s diets in the UK have improved over the last 15 years, there are still certain nutritional areas that are significantly lacking. These include children who have:
- Significantly low intakes of iron and vitamins A and D
- High intakes of foods high in saturated fats and sugars.

Poor-quality diets can increase the risk of obesity, which is already a growing health issue in young children (Harris, 2010) and can predispose an individual to a greater risk of developing coronary heart disease (Gidding et al, 2005) and type 2 diabetes in later life (Copeland et al, 2005).

Iron deficiency is said to be one of the most common nutrient deficiencies in the UK (Hignett, 2011) and children whose diets are lacking in iron are at risk of developing poor cognitive and physical performance in adulthood (Pasricha, 2011). Box 1 gives some practical guidelines as to how iron levels can be enhanced in childhood.

Current best practice suggests that mothers should be encouraged to breastfeed infants where possible (Jennings et al, 2011), as this and other modifiable dietary factors, including weaning and feeding style, all contribute to the development of food preference (Shim et al, 2011). Early exposure to different flavours – bitter, sweet salt and sour – through breast milk and weaning can also help to determine food preferences and affect long-term health (Beauchamp and Mennella, 2011).

Weaning
The National Institute for Health and Clinical Excellence (NICE) (2008) defines weaning as: ‘The transition from an exclusively milk diet to a diet based on solid foods’. Current government guidelines state that a healthy infant born at full term requires no other forms of nutrition than breast or formula milk for the first six months (Shaw and McCrann, 2007).

A recent study by Shim et al (2011) proposed that introducing solid foods to children before six months may mean they are far more likely to develop food neophobia and to consume a limited variety of foods compared to children who were exclusively breastfed for six months. Food neophobia is defined as ‘the rejection of novel or unknown foods’ (Scaglioni et al, 2011). Both neophobia and fussy eating (the rejection of a wider range of foods including novel ones) are well known barriers to healthy eating in childhood (Van der Horst, 2012). However, Harris (2010) argues that in most children these are normal behaviour patterns that will gradually resolve as the child gets older.

However, every child is an individual and some babies may be showing physical signs that they can be weaned safely from four months (Shaw and McCrann, 2007). Table 1 identifies the types of behaviour associated with readiness to wean a child.

Box 1. Enhancing a child’s iron status (adapted from Shepherd, 2008a and Edmondson, 2011)

- Encourage a good intake of green, leafy vegetables
- Serve orange juice, which is high in vitamin C, with meals
- Avoid tea and coffee after meals as the tannin decreases absorption
- Encourage red meat consumption at least twice a week
- If a child does not consume meat encourage vegetarian sources of iron
- Give foods fortified with iron, such as breakfast cereals
- Monitor intake of cow’s milk as this is low in iron and too much can inhibit absorption
PRACTICE: PEER REVIEWED

Wright et al (2004) propose that larger infants and male children may need weaning earlier to promote healthy growth and nutritional status. There is no evidence to suggest that weaning at four months confers any significant harm to the child (More et al, 2011).

As an infant’s mouth is very highly sensitive (Harris, 2010), Webster-Gandy et al (2005) propose that solid foods should be introduced at six months without delay, as this will desensitise the mouth and help to reduce the gagging and retching that is often seen when infants are offered lumpy foods.

Avoidance of lumpy foods can lead to problems with food acceptance later on during childhood (Cordain et al, 2005). Harris (2010) suggests that it is best practice for parents to introduce foods with different textures and tastes at the appropriate times. Infants are born with a natural innate preference for sweet foods (Pepino and Menella, 2005) and foods with a fatty texture (Mattes, 2009). Other tastes, such as bitter and salt, will develop as they become older. Salt should not be added to infant foods as this can cause bowel disease may show stunted growth (Goulet, 2010); for early identification of children with growth faltering or excessive weight gain (Waddell, 2011). Some infants have a high risk of developing a food allergy because their parents or siblings are atopic (More et al, 2011).

Common food allergies seen in early childhood include:
- Cow’s milk protein
- Hen’s egg
- Soy
- Peanuts
- Tree nuts
- Fish
- Shellfish
- Celery
- Mustard wheat
- Kiwi fruit
- Sesame seeds (Meyer, 2008).

Symptoms of food allergy can range from anaphylaxis – which is life threatening if not treated immediately with epinephrine (epipen or adrenaline) (Cianferoni and Muraro, 2012) – to generalised symptoms that are slower in onset and may present as eczema, wheeze, mood changes, failure to thrive, gastro-oesophageal reflux, diarrhoea and vomiting (Geissler and Powers, 2009).

Grimshaw (2009) proposes that such infants should be exclusively breastfed where possible and high-allergen foods should be introduced one at a time, so that any potential reaction can be attributed to a specific food. There is no clear evidence to suggest that delaying foods that are considered to be high allergens after six months of age will reduce the risk of allergy (Venter, 2009).

It is really important that food allergy is not confused with food intolerance, which Carney (2009) defines as ‘an adverse food-induced reaction that does not involve the immune system, and does not produce life-threatening symptoms’. The symptoms of food intolerance tend to manifest themselves in a slower manner and include abdominal pain, nausea, vomiting and diarrhoea.

It is important to be aware that the range of symptoms in food allergy and intolerance is diverse, making diagnosis difficult (Fox et al, 2011). If parents think their child is reacting to any specific food or foods, it is best practice to

<table>
<thead>
<tr>
<th>Signs of readiness</th>
<th>Stage 1 4 – 6 months</th>
<th>Stage 2 7 – 9 months</th>
<th>Stage 3 9 – 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demanding more feeds</td>
<td>Picking up objects between thumb and forefinger</td>
<td>Drinking from a cup unsupervised</td>
<td></td>
</tr>
<tr>
<td>Not lasting more than 3-4 hours between feeds</td>
<td>Showing interest in what the family are eating</td>
<td>Ability to place items in a container and remove them again</td>
<td></td>
</tr>
<tr>
<td>Waking in the night when previously they have slept through</td>
<td>Showing signs of beginning to chew objects</td>
<td>Ability to hold their objects between thumb and forefinger</td>
<td></td>
</tr>
<tr>
<td>The ability to hold their head up straight without support</td>
<td>Attempting to feed themselves</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Hignett (Edmondson, 2011) argues that most children who show faltering growth are more likely to have issues with their food intake.
Social eating behaviour
According to Shaw and Lawson (2008) a five-year-old child has the ability to modify his or her eating behaviours in accordance with ‘social rules’; for example, eating when others are eating, even when they are not hungry, or learning to ‘clean their plate’. Harris (2010) warns that such behaviour should be discouraged as this may lead to comfort eating and obesity. Observational studies have found that children’s intake at meal times, particularly young toddlers, will vary considerably; for example, a child will eat well one day and a great deal less the next (Shaw and Lawson, 2008). This situation often causes parental anxiety, but research has suggested that young children have the ability to adjust their food intake across successive meals, which compensates for higher or lower intakes at a given meal, making their total daily intake fairly consistent (Hanley and Hutcheon, 2010). Family mealtimes are a social activity that, in some families appears to be waning. A recent study (Hammons and Fiese, 2011) found that in families who eat five or more meals together during the week, children are 25% less likely to encounter nutritional health issues than those in families who eat less than one meal together per week. It has been suggested that having one parent present during an evening meal is more likely to encourage children to increase consumption of fruit, vegetables and dairy foods and not to skip breakfast (Scaglioni et al, 2011). Keeping mealtimes free of arguments may also encourage children to eat more of the food they are given (Burnier et al, 2011).

How much food do children need?
As a child progresses from the toddler years, Hignett (Edmondson, 2011) proposes that it is best practice to offer ‘little and often’. Three small meals and two snacks per day should provide the right level of energy intake for an individual child.

The Food Standards Agency (FSA, 2007) proposes that children aged five years and older will require a wider variety of foods from the five food groups for healthy growth and development. Care should be taken to ensure that portion sizes are appropriate for the child’s age and body size, limiting fast foods and avoiding oversized portions (ESPGHAN et al, 2011).

Achieving a healthy balance
To optimise growth, development and to maintain a healthy weight there needs to be an effective balance between food intake and exercise.

Physical activity is defined as ‘any bodily movement produced by skeletal muscles that results in energy expenditure beyond that of resting expenditure’ (Thompson et al, 2003). There is a growing body of evidence to suggest that physical activity plays an important part in the prevention of becoming overweight and obese in childhood and adolescence, and reduces the risk of obesity in adulthood (Hills et al, 2011).

It is important for parents to encourage regular exercise, which according to the Department of Health (2004) should incorporate 60 minutes of moderate-intensity exercise each day. This can be broken down into four 15-minute periods; three 20-minute periods or two 30-minute periods of exercise per day, depending on family circumstances (Shepherd, 2008b). Activities can include:

- Walking to and from school
- PE lessons at school
- Active play at break times and out of school
- Skipping, jumping, swimming, cycling, skating, dancing and family games/activities.

Conclusions
One in three children is overweight by the age of nine in the UK, and this number has increased by 40% in the last few years. If this continues nearly half of the children in the UK will be overweight or obese by 2020 (Academy of Medical Royal Colleges, 2012). It is vital for parents to promote good eating habits from an early age, and it

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### Table 2. Weaning to promote optimal nutrition in infants (adapted from Shepherd, 2008; 2012)

<table>
<thead>
<tr>
<th>Time</th>
<th>Stage 1 4 – 7 months</th>
<th>Stage 2 7 – 9 months</th>
<th>Stage 3 9 – 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early morning</td>
<td>Breast milk formula feed total of 500-600 ml through the day</td>
<td>Offer 500-600 ml breast milk or formula milk through the day</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Breakfast</td>
<td>Infant cereal fruit/ vegetable puree</td>
<td>Infant cereal</td>
<td>Infant cereal</td>
</tr>
<tr>
<td>Mid-morning</td>
<td>Milk feed</td>
<td>Milk feed</td>
<td>Boiled water or diluted fruit juice</td>
</tr>
<tr>
<td>Lunch</td>
<td>Milk feed</td>
<td>Pureed vegetables including carrot, potatoes, pumpkins or pureed apples</td>
<td>Milk feed</td>
</tr>
<tr>
<td>Mid-afternoon</td>
<td>Milk feed</td>
<td>Cooled boiled water or dilute fruit juice</td>
<td>Chopped banana, apple or pear or baby rusk/breadsticks</td>
</tr>
<tr>
<td>Dinner</td>
<td>Milk feed</td>
<td>Pureed vegetables including butternut squash, potato or sweet potato or pureed fruit including; apricots, bananas</td>
<td>Milk feed</td>
</tr>
<tr>
<td>Bedtime</td>
<td>Milk feed</td>
<td>Milk feed</td>
<td>Milk feed or follow-on milk</td>
</tr>
</tbody>
</table>

Refer them to their GP for investigations with a qualified allergy specialist, rather than start an elimination diet, which could have serious nutritional consequences (Shepherd, 2012).
is best practice, where possible, to exclusively breastfeed infants for the first six months, and
wean them according to their individual needs using a wide range of foods textures and tastes.
Parents should aim to promote regular, enjoyable family mealtimes and encourage their children to
participate in regular exercise if they are to grow into happy, healthy adults.

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Breastfeeding is best

Drop for drop, no other formula comes close1-9

Breast milk
New SMA First Infant Milk
Other first infant milks

References:

IMPORTANT NOTICE: Breastfeeding is best for babies. Breast milk provides babies with the best source of nourishment. Infant formula milk and follow on milks are intended to be used when babies cannot be breastfed. The decision to discontinue breastfeeding may be difficult to reverse and the introduction of partial bottle feeding may reduce breast milk supply. The financial benefits of breastfeeding should be considered before bottle feeding is initiated. Failure to follow preparation instructions carefully may be harmful to a baby's health. Infant formula and follow up milks should be used only on the advice of a healthcare professional.

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Newly qualified SCPHN? Tips for your first year in practice

Sarah Creer graduated with honours in Specialist Community Public Health Nursing (SCPHN) in September 2011. Here she provides some advice for newly qualified health visitors contending with their introduction into the profession

I have found the first year in practice as a health visitor in south-west England very rewarding but challenging – and at times the learning curve has seemed almost vertical! My previous community practice teacher (CPT) asked me to discuss with her current students how to prepare for their first year in SCPHN practice and what follows is the advice I felt was most useful. This information is by no means exhaustive and is based upon self-care suggestions rather than practice techniques.

Identify a professional support network
My trust arranged a preceptorship group for newly qualified SCPHNs. We met monthly and were facilitated by an experienced health visitor. The group aimed to provide a supportive, confidential environment for each SCPHN to discuss with our peers issues that were concerning us, relating to professional practice or relationships. Lots of coffee, cake and tissues were always provided! In addition, we were encouraged to identify a mentor from our discipline and arrange to meet with them, again to provide support for practice-related concerns. I found the support from both these areas invaluable.

Arrange supervision
All those involved with protecting children from harm should have access to advice and support in the form of regular supervision (Department of Health (DH), 2010) and I found this indispensable for support and advice. Your supervisor may be able to review your child protection reports if you request this, and accompany you to child protection meetings if you feel it is required. I requested support during a distressing child protection case and found my supervisor’s presence very encouraging. Clinical supervision may be provided to you within a mentorship aspect, as discussed above.

Learn how to say no – tactfully
When I reflect back on my first few months in practice I can see I was taking on too much and trying to solve everyone’s problems. My mentor summed this up nicely by suggesting I was ‘health visiting for England’! Don’t take on too much work. Meet regularly with your team and share the workload; use your skill mix team if you have these resources available. Be confident in asserting yourself and the boundaries of your role, albeit tactfully. This has been a gradual learning process for my newly qualified peers and I, but of great use when working with other agencies such as children’s services. Assertiveness may benefit you and others. Clark (2003) believes by becoming more empowered and assertive you can show clients how to become more empowered and confident to meet their own health needs.

Organise your work
The ability to organise your time, which you learned during the SCPHN course, will be great preparation. Identify your priorities (for example, child protection, school drop-in/well baby clinic, primary birth visits) and...
arrange everything else around those. Having your diary planned can be reassuring and also help you to identify if you can take on extra work.

**Set realistic goals**
Robotham (2005) has stated that, traditionally, home health visiting intervention was professionally led. However, this approach has now changed and SCPHN work should be (mostly) client led. I discovered through my limited experience that, when working with some clients, it is helpful to consider a structured approach. I have applied Egan’s (1986) three-stage counselling model (problem clarification, goal setting and action) to give structure to my work with clients when at risk of losing focus of the SCPHN’s involvement.

The SMART (specific, measurable, achievable, realistic and time-bound) framework could be useful informally, but be careful not to apply your own goals to the intervention or to give enough consideration to the client’s needs. Training in brief, solution-focused therapy may also assist your practice and allow you to remain client focused.

**Don’t accept unacceptable behaviour from clients, colleagues or other professionals**
If you experience unacceptable behaviour from a colleague you should find that your trust has an acceptable behaviour policy, with advisors available to discuss and resolve the issue. In relation to child protection, a ‘resolving professional differences’ policy should also be available to you for concerns related to professional decisions. During separate child protection meetings I experienced verbal aggression from a parent. I was able to consult with our local security management specialist who supported me and took appropriate action.

**Don’t be afraid to admit you may not have all the answers**
I was probably most concerned about this before I took on my caseload. ‘What will I say to parents who ask me questions to which I don’t know the answer?’ Remember, no one can know everything. I have found that, when asked about something I’m not sure of, parents appreciate it when you admit it.

I normally say something along the lines of, ‘That’s a good question; I’m not sure on that one ... I’ll find out for you and let you know’. Make sure you do follow it up in a timely manner, and that the advice you give is current and evidence-based (Nursing and Midwifery Council (NMC), 2008).

**Take time out to reflect, read and revise**
This would also help with the above point. I found it helpful to make a little list of topics I wanted to revise and identify time to do so. I also made a resource folder of local information and other relevant material I could keep to hand in the office. Reading Community Practitioner is a valuable learning activity and will provide you with evidence-based health promotion information. If you record your reading and reflection within your portfolio it could contribute towards your prep and continuing professional development (CPD) requirements (NMC, 2011).

**Learn how to switch off**
Health visiting and school nursing can be very emotive and it is in our nature as nurses to care about the families we work with. However, if you are dreaming about your clients at night, more effort is required not to take your work home with you; I learned the hard way! I think ‘blocking out’ the day’s events after you’ve left work is a skill you learn, and on occasion I have found it tricky. I was discussing this with an experienced colleague who said to me: ‘As soon as I get in the car to go home, I switch off’. I asked her how she achieved this and she couldn’t remember! Job stress can lead to burnout and loss of empowerment (Clark, 2003), so it’s important to have time to yourself to disconnect every day, even if it’s only listening to music on the way home. I found that increasing the exercise I was doing was a great stress reliever.

**Don’t panic and enjoy it!**
Every day, whether good, bad or inbetween, I remind myself why I wanted to join the profession and how privileged I am to be a health visitor. I had a quandary at three months in practice; I felt there was a lot of emotionally demanding work, I was ‘health visiting for England’ and I couldn’t see what ‘the point’ of health visiting was. However, after using the support that was in place for my peers and I, and discussing and reflecting on these experiences, I realised the energy I put in had achieved something and made a notable difference to numerous families. If it gets tough, don’t underestimate how valuable our work with children and their families can be.

I hope the above suggestions help and good luck! Any correspondence would be welcomed to: sarahcreer@nhs.net

**References**


Family Nurse Partnership programme in Scotland: an update

The FNP is a preventive early intervention home visiting programme for first-time teenage mothers aged 19 and under, and in Scotland it has enabled a new way of working with some of the neediest families.

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Family Nurse Partnership
National Implementation Lead (Scotland)
Children and Families Directorate,
Scottish Government and NHS Education Scotland (NES)

The Family Nurse Partnership programme (FNP) is a preventive programme for young, first-time teenage mothers aged 19 and under. It offers intensive and structured home visiting, delivered by a team of family nurses specifically trained for the role. The programme is delivered from early pregnancy until the child is two years old. FNP has three aims – to improve:
- Maternal health and pregnancy outcomes
- Child health and development
- Parents’ economic self-sufficiency.

The methods are based on theories of human ecology, self-efficacy and attachment, with much of the work focused on building strong relationships between the client and family nurse to facilitate behaviour change and tackle the emotional problems that prevent some mothers and fathers caring well for their child.

FNP is strength based and focuses on an expectant mother’s intrinsic motivation to do the best for her child. The programme consists of structured home visits using materials and activities that build self-efficacy, change health behaviour, improve care-giving and increase economic self-sufficiency.

Background
FNP is a licensed programme, developed in the USA by Professor David Olds at the University of Colorado, Denver (UCD), where it is known as the Nurse–Family Partnership (NFP). Over 30 years of rigorous research has shown significant benefits for vulnerable young families in the short, medium and long term across a wide range of outcomes, including decreased incidence of child maltreatment; improved language and academic achievement; fewer subsequent pregnancies and wider spacing between second births; and reduced criminal behaviour for both children and mothers.

FNP was first introduced into England in 2006 and is now delivered across 80 areas by 73 teams. Subsequently, it was implemented in Scotland in 2010 in NHS Lothian, City of Edinburgh Community Health Partnership. It is now part of Scottish government policy, with Nicola Sturgeon, the Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy, announcing a further expansion for FNP to reach three times as many clients as now by the end of 2013. Five NHS Board areas are licensed to test the FNP model in Scotland – NHS Lothian, NHS Fife, NHS Tayside, NHS Greater Glasgow and Clyde, and NHS Ayrshire and Arran – with more to be announced.

The licence for FNP is held between Professor Olds and the Scottish government. The cost is $3 per family and ensures that replication of the model is respectful of the findings from the randomised, controlled trials (RCTs) in the USA. Support for implementation of the programme in Scotland is given by the FNP National Unit within the Department of Health (NU). NU has offered consultancy support to the FNP National Unit in Scottish government (NU Scotland), which has been invaluable in ensuring that the learning from FNP sites in England has been embedded into the Scottish experience of implementing the programme. NU also delivers the mandatory education and training for family nurses and supervisors, as well as offering support and learning experiences for supervisors and psychologists across the UK.

Sustainability will be key to the long-term success of FNP in making a difference to the lives of many young families. We ask at the outset for NHS Boards to demonstrate their commitment to FNP sustainability by contributing to the funding of the first cohort. We also work with sites early on to ensure that the gains across all areas: education, social work, police, third sector and housing are shared across local authorities and colleagues across agencies who work with vulnerable families. NHS Lothian has worked very closely with colleagues in City of Edinburgh council to ensure there is a wide understanding of the potential that FNP can bring in areas other than health. The success of this collaborative working
is shown in the joint commitment to part fund a second cohort of FNP families in August 2012.

**Evaluation**

Following earlier evaluations of FNP implementation in England by Birkbeck University, NU has funded Cardiff University to undertake a major RCT to look at the impact of FNP in England. The first findings are due to be reported in 2013 and will be of significance to FNP development in Scotland. The Scottish Government has also commissioned an external evaluation of FNP, looking at the transferability of the model to the Scottish context. Early findings show the enrolment rate onto the programme is high (>75% of eligible clients, offered the programme enrolled), attrition rate low (<10% (in pregnancy)) and the family nurses report feeling well equipped to support vulnerable families through a robust education and training programme.

The evaluation also illuminated the challenges of learning a new programme while delivering it to this population; one particular challenge being the long working hours worked by the FNP team, particularly in the first year. This is similar to the experience of FNP delivery at the early stages in England and we anticipate a similar decrease in the working hours as confidence in programme delivery increases.

There are numerous examples of FNP clients developing self-efficacy and growing confidence in their parenting approaches. As 16 FNP clients and their families are being interviewed about their experiences throughout the duration of the programme, such examples are also being captured sequentially in the evaluation report.

**Sharing learning**

Although it is early days, there is learning worth sharing from FNP that we are feeding into the Chief Nursing Officer’s Modernising Nursing in the Community work streams. Some sites are looking at implementing the principles of FNP such as; robust supervision models; CPD; updated on-site education, such as the importance of neuroscience; and the use of motivational interviewing for colleagues working with vulnerable families.

NHS Tayside has implemented the ‘Test of Change Programme’ in response to colleagues working alongside the FNP team who are keen to adapt the principles of the supportive model that FNP brings for practitioners. NHS Education for Scotland (NES) is working with executive nurse directors to look at whether learning from the FNP approach can help service delivery for vulnerable families across all NHS Board areas.

Professor Olds advises ‘airing caution’ when sharing FNP learning and we are mindful that the credibility of FNP is underpinned by the rigorous evidence to support the approach and evidence that can also be defended. The success of programme replication is based on this evidence being so robust. We are sharing the learning incrementally with FNP colleagues in Northern Ireland and England and through the local evaluation we are looking particularly at the learning within the Scottish context.

### Self-efficacy

Being part of a UK-wide ‘FNP family’ has many advantages, not least, like young FNP parents, we are being supported to be ‘self-efficacious’ in delivering this programme. We have a lot in common with our colleagues in England and Northern Ireland in that we share a common philosophy for wanting to break the cycle of disadvantage, are supported by a government who values the importance of early input with families and we share a keenness to support FNP teams to work effectively with clients.

The Scottish Government is funding the first sites in delivering the programme, with the expectation that NHS Boards will contribute financially to costs. The Scottish government currently plans to ‘match fund’ future second cohorts in existing sites and this funding agreement will be reviewed as the roll-out continues. In time, we will need to develop local education and training development and support systems to make the programme viable, as travelling and residential training adds to the challenge of learning in Scotland.

A positive effect of FNP implementation in Scotland (similar to the experience within FNP sites in England) is that FNP testing areas have began to look at care and referral pathways for this client group generally. Awareness of the potential success of the programme for these clients has galvanised work locally, looking at what can be done to support all teenage parents and their children. This is being pioneered within NHS Lothian led by the Child Health Commissioner. Scottish government has undertaken a costing exercise to look at how, eventually, the programme could be delivered to every teenage mother across Scotland. NHS Boards need to be willing to consider this approach as part of the universal service provision to this client group. The growing evidence base regarding the impact of FNP will be crucial to Boards making informed decisions about their continued commitment to the programme.

### The future

The success and sustainability of FNP will be underpinned by strong relationships with colleagues delivering universal service support along with specialist support services. The continued support from universal services after the programme has ended will be crucial to FNP families reaching their potential as parents.

We are learning how different the approach needs to be, for example, when delivering a home visiting programme in rural areas, across several CHPs and potentially supporting hybrid models across several NHS Board areas. We are also seeing local areas review and develop their approaches for supporting teenagers and staff, both within and outwith health, by reflecting on the FNP approach.

The healthiest of families share their challenges and problem solve together when faced with adversity. The fidelity requirements of the FNP license will ensure that we work closely with NHS Boards following the evidence base for implementing the programme but our collective learning will allow us to support new sites while being respectful of the individual challenges they face.

For further information on FNP in Scotland go to [www.scotland.gov.uk/Topics/People/Young-People/Early-Years-and-Family/family-nurse-partnership](http://www.scotland.gov.uk/Topics/People/Young-People/Early-Years-and-Family/family-nurse-partnership)
Initiating public health activities in Uganda

Liz Staples, recipient of the CPHVA Education and Development Trust’s Travel Bursary in 2010, spent three weeks in Uganda in 2011, working as part of a health promotion project. She describes her experiences with the people of the Kyoga village.

My work with the Kyoga villagers came about in 2007 through a church project in conjunction with Food for the Hungry Uganda to build school facilities in Mukono, 10 miles north west of the capital, Kampala. At the time, I thought I was merely swapping my health visitor hat with a builder’s helmet because my role was to be manual – to physically dig, mix cement and build a classroom by hand. However, I visited the area for five weeks in 2009 and 2010, and during this time there were numerous occasions for me to undertake some low-level health promotion activities. These regular contacts with the community forged strong, trusting relationships, openness and a deep desire to focus on public health issues.

Child development programme

Food for the Hungry, an international non-governmental organisation, set up a child development programme in Kyoga in 2002, supporting 210 children to attain good health, education and social development. This was achieved through building close links with the local chairman, who agreed a development plan to rebuild the Kyoga primary school. Sponsorship for each of the children came from Food for the Hungry Japan; they made up about two-thirds of the school register. Selection of individual children was based on a needs assessment carried out by the Ugandan Food for the Hungry project staff as part of their child development programme, and took into account the financial position of the family and the health of the children. Interestingly, from a health visiting perspective, their child development programme was delivered through a home visiting programme that encouraged basic hygiene, nutrition and valuing children enough to educate them. This was especially true for the girls as, traditionally, they are not educated.

Japanese sponsorship will only be available for a further two years, so considerable effort is being invested in income generation projects with individual families to ensure this initiative is sustainable. Already, the proportion of sponsored children in the school has dropped to a third, as families are able and want to pay fees for their own children.

Since 2002 the school at Kyoga has developed through a multi-agency partnership of the local villagers, the government, the Church of Uganda and Food for the Hungry. Provision of free school uniforms and lunches for the poorest children has ensured that education is accessible to all the village children from four to 13 years, regardless of gender.

The food for the Hungry analysis has revealed that 90% of sponsored children are cared for by their grandmother, who may have over 10 children to look after. Grandmothers become the primary carer either because the children's parents have died due to the HIV pandemic or for economic reasons, due to the parents working away in Kampala where conditions are too dangerous for children. During the church-sponsored school building projects (2007 to 2010) many of these grandparents and parents gave their time to build classrooms and teachers’ accommodation.

As English remains the national language in Uganda, classes were offered to the parents in the afternoon. During my second visit in 2010, when my involvement with the project was solely as a labourer–builder, I found that I couldn’t ignore the health promotion opportunity these classes offered. Rose, a Ugandan retired nurse, asked if we could discuss hygiene and nutrition with the parents. That year my single resource was a book from the What to do when there is no doctor (Werner, 2007) range that a health visiting colleague, Faith Turner, had given me.

Access to health care

At the end of the 2010 project an incident occurred that reinforced for me the acute health needs of the community. One particular night, I was woken by a Ugandan Food for the Hungry worker, who was concerned about her eight-month-old daughter who had pyrexia. She had approached me because I was the only person on the team with a health background.
The Bill and Melinda Gates Foundation has
2006, the birth rate in Mukono was the
rate of 115 deaths per 1 000 live births. In
live births. This is higher than the national
rate among under-fives is 129 deaths per 1 000
deaths per 1 000 live births and the mortality
mortality in the Mukono region stands at 66
develop a health centre in Kyoga village. Infant
trigger for discussions about the need to
This medical emergency served as a primary
assessment of need

Moving soil to level the site
Following a very quick history taking,
examination and assessment of the infant, it
was determined that she needed urgent
medical attention. Fortunately, we were able
to telephone the father in Kampala who came
and took the mother and baby to the nearest
medical centre, where she was diagnosed and
treated for a chest infection and malaria.
This was a salient incident for me, as it
brought home the lack of medical facilities and
vulnerability of these villagers. It also
prompted me to question the villagers
about their access to health care in similar
situations. Initially, I was met with a stony
silence; the villagers reluctantly volunteered
that they would have no recourse but to wait
until morning and then trek to the medical
centre 7 km away, a journey in the range of
two hours. It is more likely that ‘waiting until
morning before being able to take appropriate
action’ for such a medical emergency could
have an adverse outcome for a nutritionally
compromised infant.

Assessment of need
This medical emergency served as a primary
trigger for discussions about the need to
develop a health centre in Kyoga village. Infant
mortality in the Mukono region stands at 66
deaths per 1000 live births and the mortality
rate among under-fives is 129 deaths per 1 000
live births. This is higher than the national
rate of 115 deaths per 1000 live births. In
2006, the birth rate in Mukono was the
highest in Uganda at a rate of 6.7 children per
The Bill and Melinda Gates Foundation has
discussed the correlation between good health
provision and the drop in the birth rate (www.
gatesfoundation.org). The Foundation believes
that if a family is confident it has a good
chance of raising its children to adulthood,
it will have a lower birth rate. This is exactly
how things evolved in the UK 100 years ago.
It means the family’s limited resources will be
shared among fewer children, increasing each
child’s life chances further, as there is more
money for better nutrition and education.

After local consultation, a partnership
between the government health service, the
Church of Uganda, local villagers and Food
for the Hungry, the vision for Kyoga Health
Centre was established. The synergy between
my observations of the health needs, the tacit
recognition of health promotion opportunities
and the direct request for help in the field
led to my return in 2011 to deliver a tailored
health promotion programme.

Building the centre
In the summer of 2011 a team from
Huntington Church York (HCY) returned
to help build the health centre. Thanks to
the travel bursary, I was able to be part of
this team and fulfil the vision to provide
health promotion talks in English during the
afternoons. The primary purpose of my visit
in 2011 was to deliver a specifically tailored
health promotion programme for the parents
in English in the village of Kyoga Uganda (see
Table 1).
My guiding principle during the design
phase of this programme was that it must be
fit for purpose for the environment in which
it was to be delivered. Through my previous
experience with the Kyoga community I
knew that it was essential for the planned
programme to be flexible, easily adaptable
to the time available and responsive to the
changing needs of the group. During
the design phase of the programme, I was
fortunate that a health visitor colleague
(Vivienne Lumley) with experience of working
in Uganda, recommended suitable teaching
materials (Teaching Aids at Low Cost: www.
talciuk.org). These are produced by a charity
and are specifically designed to be culturally
appropriate to third-world communities. A
team has now returned to complete the health
centre building and to fit it out.

Unlike the UK models of health centres, the
Kyoga Health Centre will need to be a ‘mini
community hospital’, incorporating inpatient
facilities and primary care. The plan is to
build two single-sex wards, an HIV clinic, a
malaria clinic and an immunisation clinic. It
will also include an emergency obstetric unit
to promote healthier and safer childbirth, which
should contribute to a reduction in infant and
maternal mortality.

The challenge will be to ensure the centre
is well staffed and run in the future. The
plan is that this will be done by Food for the
Hungry and the Church of Uganda Hospital
in Kampala who have a history of successfully
implementing a similar model in the north
of Uganda. This approach offers and ensures
sustainability and clinical governance.

Funding
Food for the Hungry is scheduled to withdraw
from Kyoga in 2013, at which point the agency
will move to another village to repeat another
cycle of community development. On its
departure, it will leave behind a chairman
and a strong community group, a local co-
operative savings/lending scheme to promote
income generation projects to ensure poorer
families can afford education, a strong, well
run and equipped school, and one of the
biggest health centres in Mukono.
It is gratifying to witness an effective
model of community development using
international sponsorship and local
partnerships; one that has achieved sustainable
improvements and has potential for
ongoing opportunities for these families for
generations to come. On a personal level, I would recommend becoming involved in undertaking public health activities abroad to anyone. There is much value in becoming involved with such a project. I believe I have grown as a person doing this, enabling me to bring new skills back to my health visiting practice in the UK.

I would like to thank the CPHVA Education and Development Trust’s MacQueen Bursary for Public Health Activities Abroad for the bursary which met my travel costs last year. I very much appreciate and value the support from my health visiting colleagues at Holm Moor Children’s Centre, York, who kept our corporate case load running in my absences. My thanks to Dr Vina Mayor, Trustee of the CPHVA Education and Development Trust for her support in writing this article.

If you feel able to donate any resources for the project – especially those that can be carried in a suitcase – please contact me at: liz.staples@ymail.com or make a donation at Just Giving (www.justgiving.com), at the ‘Women of Action – Kyoga Team’ page. Thank you.

References

Table 1. Health promotion programme

<table>
<thead>
<tr>
<th>Session 1: Nutrition</th>
<th>Session 5: Food hygiene/fly traps</th>
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<td>Malnutrition is common in Kyoga because of the high consumption of easy to grow carbohydrates, such as cassava and sweet potato. Other nutrients, such as protein and vegetables, are more expensive or have a high crop value at market. Using the TALC Family Nutrition Guide, we discussed food group values. Through discussion of ideas in the group others were encouraged to grow more vegetables and beans for family consumption. Progress noted from the previous year included more mixed crop cultivation and one lady, Susan, had started a small business raising chickens with the support of the village savings club. Twelve adults, including two men, attended this session.</td>
<td>This session built on topics from previous classes. It looked at food hygiene and preventing transmission disease by trapping flies. This session was a joint delivery with Ben and Dom helping me. Based on a TALC idea, the whole group made fly traps out of old water bottles and then loaded with them cassava flour and water paste as a cheap local sweet substance (jam or honey being too expensive). A good discussion around food preparation and storing food was facilitated with local knowledge from older women in the group. Attendance was high with 21 adults (3 men and 18 women) present.</td>
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<th>Session 2: Hand washing</th>
<th>Session 6: Malaria</th>
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<td>Basic hygiene after using the toilet and before food consumption is difficult for children and adults due to lack of hand washing facilities. We adapted an idea from the TALC Wash Your Hands information sheet to demonstrate a practical solution for hand washing by fashioning an old food oil can (something that is easily available) into a ‘hand washing station’. Everybody present washed their hands using soap and water following the six steps recommended on the TALC Hand Hygiene Technique poster. The wash station was put into immediate use by the teachers at the school to increase hygiene for the children. Attendance was less than expected with only nine adults attending. This was due to its timing whereby some women were at home preparing food.</td>
<td>The prevention of malaria is a huge problem in the village. Treatment is available but it costs the equivalent of a week’s wage for each family member affected. Emily and Holly presented a story (from a book in the TALC range: Living Health: Buzzing Children) of a village grouping together to fill in stagnant pools where mosquitos breed. We had an open discussion of other ideas to prevent transmission (Malaria – A Handbook for Health Professionals). FHU supplied 30 malaria nets which were given out. There were 35 attendees at this session: eight men and 27 women.</td>
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<th>Session 3: Dental hygiene</th>
<th>Session 7: HIV and AIDS</th>
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<td>Dental caries is a new problem for the village as access to refined sugar in drinks and sweets is becoming more common. In villages, dental care is poor in terms of attendance to daily dental hygiene; there is no access to dentists. Many adults adopt the traditional way of cleaning their teeth by chewing on a stick. Three of the team explained the need for oral hygiene to the group, followed by a practical demonstration. Tooth brushes and toothpaste were distributed to attendees and their family members. Fifteen adults attended this session. We were pleased to note that as the weeks progressed there was an increase in the number of teachers attending from the village school.</td>
<td>Unfortunately, this session was not delivered due to a school netball match. Due to time constraints, a session could not be arranged prior to my return to the UK. The resources were given to the local FHU team for them to deliver the session.</td>
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<th>Session 4: Minor Illness</th>
<th>Evaluation</th>
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<td>The purpose of this session was to focus on recognising when your child is sick and where to get help and treatment. The topic was introduced using a book from the TALC range: Child-to-child: A Simple Cure. It was explored through a group discussion using peer support within the class. The facilities the proposed health centre will bring were discussed with much excitement. Clinical thermometers were given out with practical demonstration, a leaflet and advice on storage to ensure safe use. Sixteen adults attended this session.</td>
<td>At the end of each session the class was evaluated with the FHU staff and any school teachers present. There was good and lively participation noted throughout the sessions and a positive response was received from all those involved. Planning and implementations of sessions had to be flexible to reflect Uganda timing which is very laid back. Therefore, health promotion sessions happened at a time that fitted in with their other commitments. I was very grateful to the FHU staff for their communication with the school and the community, nevertheless, one session was cancelled at the last minute due to another priority (see Session 7). The increasing numbers of attendees as the weeks progressed is an indication that the villagers valued the sessions, were willing to engage in the health promotion activities and made time to attend.</td>
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<th>Resources</th>
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<tr>
<td>• TALC teaching tools</td>
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<tr>
<td>• Soap, brow thermometers, toothbrushes and toothpaste (donated by friends and colleagues in the UK)</td>
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<tr>
<td>• Malaria nets (donated by FHU)</td>
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M y Dad was taken to hospital recently. He was too weak to get down the stairs by himself, so I was really pleased when two healthy young women paramedics turned up. They helped him gently, but firmly, into a heavy chair and carried it down a curved staircase into the ambulance. Jokingly, but with a hint of irony, I said to them, ‘I bet you don’t want to be doing that when you’re 68!’ They knew exactly what I meant; that under the government’s plans to reform NHS pensions, there could be a real danger to patients, to paramedics and many other health workers, as the pension age is raised to 68 years, or even beyond that.

Unfortunately, instead of ‘linking’ the NHS retirement age to the state pension age (for example, state pension age minus three years), the government has decided to equalise the ages under the new scheme. Potentially, children born today could be working until they are 70, or even older.

Current NHS retirement ages are 55 for special classes (like nurses), 60 for members of the 1995 scheme, and 65 for those in the 2008 scheme. The average retirement age for NHS staff is now around 63 years.

For staff who could retire at age 60, working until the age of 68 is a double hit to their pockets – they will be working eight years longer and paying pension contributions for those eight years. By the same token, they will receive eight years’ fewer pension payments in retirement. In effect, those eight years spent working longer mean they’ll have paid twice for what they would have been able to take at age 60.

These changes don’t just affect staff financially. A report by the Office for National Statistics (ONS, 2012) indicates that, although medical advances mean that people are living longer, healthy life expectancy is increasing much more slowly. In fact, the healthy proportion of life is decreasing as average mortality rises. This is linked to poverty. A young man in the north east of England can expect a 45-year healthy working life after the age of 16, meaning he would be unfit by the age of 61. Even in affluent areas like the south east of England, men are only expected to stay healthy until the age of 67. This does not bode well for NHS staff working to age 68 or even longer, or the patients they are making clinical decisions about and treating. Proper risk assessments need to be carried out, so that what our health workers actually do can be properly understood.

THE PENSION AGE CHANGE MEANS THAT BRITONS WILL BE WORKING LONGER THAN ANYONE ELSE IN EUROPE

Unite knows that working longer has an impact on mental agility, occupational stress, the personal wellbeing of staff and their physical ability to do their job. Employers propose to use redeployment or alternative employment as solutions. This could also mean staff receive even less pension, since jobs that they are forced to do, instead of their own, may affect their pay band; consequently, the ‘Career Average Revalued Earnings’ part of the scheme will mean less pension than from the final salary scheme.

Concerns

Unite’s Head of Health, Rachael Maskell, wrote to Andrew Lansley about the concerns of our members who want a discussion about the increase in pension age as part of the imposed NHS pension scheme changes. Not only did 94% of members reject these changes for a second time, many staff are very worried. As Rachael puts it: ‘Our members have real clinical and service concerns about their patient and personal safety in working above 65 years of age.’ The Scottish government has agreed to re-open talks with health trade unions, and Unite has urged Andrew Lansley to involve ACAS (the conciliation service) to find a solution to the dispute, ahead of the Working Longer Review Group, which commenced in July. The pension age change means that Britons will be working longer than anyone else in Europe, despite belonging to the seventh richest nation in the world.

There is inconsistency across uniformed and emergency services. Our health service staff are expected to work until they are 68, but fire and police services are not, which is not fair, and dangerous for staff and patients.

I dread to imagine my sister and I having to carry Dad down the stairs because 68 or 70-year-old paramedics turned up at his house! It could happen . . .

Campaign

A campaign group, ‘68 Is Too Late’, has been formed by Unite, together with PCS (Public and Commercial Services Union) and National Union of Teachers (NUT), and is supported by 10 other trade unions, plus a growing number of union branches. Visit the website (www.68istoolate.org.uk) follow them on Twitter (@68_is_too_late) and ‘like’ them on Facebook (www.facebook.com/68IsTooLate). You can even email David Cameron to tell him that ‘68 is too late’!

For more information about working longer, paying more and getting less, check the Unite health sector web pages regularly, and subscribe to our health sector e-bulletins by allowing us to contact you by email. Make sure your own membership details are up to date on ‘MyUnite’ on the website (www.unitetheunion.org). Unite will be fully engaged in the Working Longer Review Group. We cannot let this change go through; for patients and staff 68 really is too late.

Reference

Health Visitor

Band 6

£25,528 - £34,189 pa pro rata (if part-time)
Ref: 201-12-0138

Base: Cornwall and the Isles of Scilly

We are looking for innovative and highly motivated Health Visitors to join our Integrated Children’s Service. This includes Primary Mental Health, CAMHS, Paediatrics and Speech and Language Therapy, together with close links with the Local Authority Children’s Services. We provide a range of universal and targeted services in some of the most rural and challenging areas of deprivation making this a varied and interesting place to work.

We are recognised for our innovative practice and we are one of the first of 20 Early Implementer Sites to deliver the Early Implementation Plan of the future investment in Health Visiting.

We can offer you:

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• Continuing personal and professional development
• Opportunities for future career development within a variety of specialist roles
• Additional staff benefits; including a discounted bike purchase scheme, salary sacrifice car scheme, Childcare Coordination & Childcare vouchers.
• The opportunity to work within the beautiful setting of Cornwall with some of the best areas of outstanding natural beauty in the Country.

If you would like to be part of our multi-disciplinary team contact us for further details.

Contact: Anne Hall, Senior Manager and Professional Lead for Health Visiting/School Nursing, Tel: 01872 246937 or Jan Bray, Locality Team Manager, Tel: 01209 886531.

To access the job pack and apply on-line for any job, go to www.jobs.nhs.uk and enter the appropriate reference number.

Closing date for completed applications:

Coventry and Warwickshire Partnership Trust

Health Visitor

Band 6 £21,176 - £27,625/Permanent/Bank/
Part-time/Full-time/Ref 785-112-13

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As part of our commitment to modernise the service, in keeping with the Department of Health agenda, you will be expected to work in partnership with other key agencies and lead and deliver on developments in local communities.

We are working towards a move back to individual caseloads to provide illness prevention services to the local population on a planned and opportunistic basis.

A qualified Health Visitor with evidence of professional development, you will have recent and relevant experience of interagency/multi-professional working combined with energy and enthusiasm to drive change. In return we offer excellent development opportunities.

Access to own transport and the ability to travel is essential together with a working knowledge of the current health agenda.

To discuss these opportunities informally please contact Penny James, Team Leader on 07747 790327.

This post is subject to a Criminal Records Bureau Check.

NB: In future, the post holder may be asked to work flexible hours i.e. outside the standard 8.30am - 5.00pm, weekdays.

Apply online: www.jobs.nhs.uk/in/cwpt If you have difficulties please contact the Partnership Trust Recruitment Department on 02476 536717 or email StaffingDept@covwarkpt.nhs.uk quoting ref 785-112-13.
Nottingham CityCare Partnership is a staff led, dynamic organisation commissioned to provide NHS community services. Recognised for innovation in approach, we work with the community to deliver high quality, needs led services. We provide high quality evidence-based practice and embrace research activities in order to drive innovation and contribute towards the professional evidence base.

Nottingham is an Early Intervention City which is committed to improving the health and life chances of young people and families who live here. It is a vibrant and diverse place to work. We are committed to developing excellence in Health Visiting and through our ambitious Health Visitor Implementation Plan we have several exciting opportunities. We are currently looking for exceptional individuals with vision, passion and determination to transform Health Visiting practice in Nottingham City.

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Would you like to join us as we transform Health Visiting Practice in Nottingham City?

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- **Health Visitor Practice Teachers** 37.5 hours per week, 2 years fixed term contact, Agenda for Change Band 7 £30,460 - £40,157
- **Health Visiting Team Coordinators** 22.5 – 37.5 hours per week, Permanent, Agenda for Change Band 6 £25,528 - £34,189 (pro rata)
- **Health Visitors** various hours, Permanent, Agenda for Change Band 6 £25,528 - £34,189 (pro rata)

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All posts will be advertised on NHS Jobs Website [www.jobs.nhs.uk](http://www.jobs.nhs.uk)

For more information, please contact Becky Savage on 0115 8833904 or e-mail rebecca.savage@nottinghamcitycare.nhs.uk

Nottingham CityCare Partnership CIC serves the community of the city of Nottingham. We are a staff led organisation and give those on the front line a central role in service development. More information can be found on [www.nottinghamcitycare.nhs.uk](http://www.nottinghamcitycare.nhs.uk)

For more information or to advertise in *Community Practitioner’s recruitment section*, call our advertising team:

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Alternatively email us: claire.barber@tenalps.com
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Be sure to bookmark the address in your favourites now:
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● Plan a wide range of sleep techniques
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W: www.mill-pond.co.uk

Diary

Peter Walker International School of Developmental Baby Massage

International School of Developmental Baby Massage two-day certificated teacher training for health professionals, children centre staff and complementary therapists with Peter Walker at VIVEKA Queens Terrace St John’s Wood London NW8 6EA  
20 & 21 October 2012

Key principles of underpinning neuroscience, psychodynamic and child development empowering parents to form a positive relationship with their baby and secure their baby’s development.

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This two-day certificated course includes:
1) Holding Reassurance Programme Birth to eight weeks
a) Secure Attachment  
b) Observe babies cues in communication  
c) Identify and offer techniques in remedial touch to relieve intra-uterine and birth trauma  
d) Introduce holding positions, stroking and gentle stretching prior to any massage to relieve physiological flexion and abdominal tension and develop breathing rhythm

2) Developmental Baby Massage Routine eight weeks to standing
The Correct Use of Massage:  
a) Develop circulatory and breathing rhythms  
b) Reduce the occurrence of plagiocephaly  
c) An easy introduction to ‘tummy time’  
d) Develop muscle strength and joint flexibility  
e) Relieve some common infant ailments  
f) Common sense anatomy and physiology relative to early infant motor and emotional development  
g) Elementary Motor Delay and correction  
h) Usage of the correct oils from birth  
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A quality and enjoyable time for both mother/father and child.

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Two-day Soft Mother and Baby Yoga
One-day Additional Needs
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Comments from latest course
“The most simple, loveable, nourishing weekend course experienced so far! Going back to the origin of humanity, building babies’ body’s worth to try and feel the world through a baby’s eyes is the most refreshing experience… Going back to earth and helping mums to understand and feel their little ones is such a noble aim… Peter Walker simply embodies these values.

Peter is so passionate that he is sharing throughout the course not only his experience, his anecdotes, his knowledge, but even more…there is something beyond that, something I can’t explain with words, something you need to feel, to experience to understand…

This is exactly what I feel from the bottom of my heart…

My staff and I have thoroughly enjoyed the training over the last two days. We are really eager to put it in to practice with the families we work with.

Thanks again for an inspiring two days.

Thank you again for the fabulous training last week.

Thank you for your guidance and training in developmental baby massage, I am loving it!

I found the course to be really fascinating and I cannot wait to put what I have learnt into practice”

For this course and ‘in-house’ course bookings email: walker@thebabieswebsite.com
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