NEWS FEATURE
Too much too young: self-harm in children

PROFILE
Cynthia Servis
NSPCC counsellor
Cetraben complete emollient therapy, for effective treatment of eczema and dry skin

Prescribing Information: Please refer to Summary of Product Characteristics before prescribing. Presentations: Cream – a thick white cream containing white soft paraffin 13.2% w/w and light liquid paraffin 10.5% w/w. Bath additive – Clear liquid containing light liquid paraffin 82.8% w/w. 

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

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

Contra-indications: Hypersensitivity to any of the ingredients.

Special Warnings and Precautions: Care should be taken if allergy to any of the ingredients is suspected. Care should also be exercised when entering or leaving the bath. Avoid contact with the eyes.

Side Effects: (Refer to the SmPC for full list) very rarely, mild allergic skin reactions including rash and erythema have been observed, in which case the product should be discontinued. Marketing Authorisation Numbers: Cetraben Emollient Cream: PL 06831/0259 Cetraben Emollient Bath Additive: PL 06831/0260 Basic NHS Price: Cream – 50g pump dispenser £3.40, 150g pump dispenser £3.88, 500g pump dispenser £9.99, 1050g pump dispenser £17.62. Bath Additive – 500ml plastic bottle £5.75.

Legal Category: GSL.

Date of Preparation: July 2012.

Further Information is available from: Genus Pharmaceuticals Ltd, Park View House, 65 London Road, Newbury, Berkshire, RG14 1JN, UK. Cetraben® is a registered trademark. CET.API.V13

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.mhra.gov.uk. Adverse events should also be reported to Genus Pharmaceuticals on 01635 568400.
Community Practitioner

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Community Practitioner
The journal of the Community Practitioners’ and Health Visitors’ Association (Unite/CPHVA)

May 2013 Volume 86 Number 5 Community Practitioner | 1
Introducing... the first infant formula with friendly bacteria*

Introducing the first ever formula in the UK to contain the probiotic culture L. fermentum hereditum®, or ‘friendly bacteria’, originally isolated from breastmilk.

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*Contains L. fermentum hereditum®, originally isolated from breastmilk

Important Notice: Breastfeeding is best for babies. Breastmilk provides babies with the best source of nourishment. Infant formula milks and follow on milks are intended to be used when babies cannot be breastfed. The decision to discontinue breastfeeding may be difficult to reverse and the introduction of partial bottle feeding may reduce breastmilk supply. The financial benefits of breastfeeding should be considered before bottle feeding is initiated. Failure to follow preparation instructions carefully may be harmful to a baby’s health. Infant formula and follow on milks should be used only on the advice of a healthcare professional.
Education and learning: the new era

Most of us who are in full-time employment have come to realise the importance of education and learning in our lives. You probably still remember the days when you learned through the use of a blackboard and chalk; however, over the last century there have been great advances in education – and the way that we learn has undergone many changes. The advent of technology has made learning more varied and interesting.

Education has become fundamental to all of those in work. We need to keep up-to-date with our work, environment and our relationships with others. The use of email is now a part of our everyday communications. Some of us feel lost without our smartphones or iPads. Distance learning can help to enhance the flexibility of education, making use of time efficiently and effectively without needing to attend a class or meet your tutor in person.

‘Lifelong learning’ and ‘continuing education’ are terms that, broadly, refer to adult learning, which has become a buzzword in our everyday working lives and careers. We can never separate ourselves from learning new things, even as we get older.

Access to a personal computer has become the norm, even for those who have never been near a typewriter, let alone something as modern as a portable laptop. Libraries all over the world allow free access to these modern phenomena that have become part of the furniture in every home.

For those who are still in work, let us appreciate and be grateful for the advances in technology that make learning more varied and help to add spice to our sometimes mundane lives.

At some point, most of us will complete training courses to update our knowledge and skills, either for the post we hold currently or if we want a change of career. If we do not make use of such training our livelihoods may be at risk. This is all the more reason for us to embrace education and learning as the bread and butter of our lives in these modern, hectic times.

Here at Unite/CPHVA, we are extending this lifeline for you to grasp educational opportunities you can use to enrich your working lives and future career. For more information about training and education opportunities visit the website: www.unitetheunion.org/growing-our-union/lifelonglearning
The Health Secretary has ruled out regulation of healthcare assistants, claiming it would only serve as a ‘box-ticking bureaucratic exercise’.

Tuesday 26 March 2013 saw the government publish its initial response to the findings of the second Francis Inquiry into 1,200 ‘unnecessary’ deaths at Mid Staffordshire NHS Foundation Trust.

In a bid to inject a ‘culture of compassion’ back into the NHS, nurses will now be expected to spend a year carrying out basic care duties as a healthcare support worker before they would be eligible to receive NHS funding for full nurse training.

Jeremy Hunt said the new structure will allow ‘the right people to become nurses’ and weed out those who ‘aren’t prepared to roll their sleeves up to do frontline work’.

He rejected the idea that the move will diminish the professionalism of nursing.

While Hunt confirmed the creation of a code of conduct and minimum training standards for healthcare assistants, he ruled out full statutory regulation of the workers.

‘We wanted to follow the spirit of Francis and offer assurance to the public that the healthcare assistant looking after them has had proper training’, he said.

‘The reason we have not chosen to implement full-blown statutory regulation of healthcare assistants is because we were concerned that creating a database of up to one million healthcare assistants could end up being a bureaucratic quagmire, which inevitably because of its size ends up being about ticking boxes rather than making sure people are qualified to do the job.’

This is despite a survey by the British Journal of Healthcare Assistants finding an overwhelming 93% of healthcare assistants back compulsory regulation of the profession – with two-thirds of those polled willing to pay for the pleasure.

Hunt’s response to Francis has been criticised by Unite, which claims he has ignored the ‘thrust’ of the report and offered ‘no evidence’ to show how putting nurses-in-training into healthcare assistant posts will change the culture of the NHS.

Unite Head of Health, Rachael Maskell, said: ‘Hunt’s continual failure to understand how the NHS works and the drivers needed to change the culture of the NHS is reflected in his announcement.

‘He has presented no evidence as to how putting nurses-in-training – just one profession in the NHS – into the healthcare assistant role will change the culture in the NHS. Healthcare assistants need to be recognised as a profession in their own right and regulated accordingly.

‘There are issues of training, supervision and resources that need to be addressed if student nurses are going to spend more time on the frontline.

‘He has also ignored the central thrust of the Francis report to enable patients and staff to whistleblow, without repercussions, and to guarantee that their concerns will be investigated and appropriate change enforced.’

Unite has called for all NHS institutions to have an independent ‘patient safety officer’, so staff and patients can raise concerns without reprisal, and the creation of a national intelligence unit to co-ordinate information about problematic trusts.

Hunt said the current regulatory ‘complexity – one of the most damning areas of the report – will be solved through OFSTED-style ratings of hospitals and care homes and the appointment of a Chief Inspector of Hospitals, a post that is also going to be replicated in social care.

‘The appointment of a Chief Inspector of Primary Care is still something that is being explored’.

He confirmed providers will have a duty of candour to patients but stopped short of widening the measure to all NHS staff, warning of the possibility of ‘unintended consequences’ such as the establishment of a ‘culture of fear’.

Hunt said the government will wait until Professor Don Berwick, former advisor to American President Barack Obama, finishes his work on the overhaul of patient safety in the NHS, expected in the summer months of this year, before coming to a final decision on whether to link criminal sanctions to a duty of candour for all NHS employees.

The government will report back by the end of the year with a detailed response to each of Francis’ 290 recommendations.
Registration fees to remain at £100 for another year

Nursing and Midwifery Council (NMC) registration fees will remain at £100 during 2014. However, the regulator’s post 2013 budget forecasts are based on a further fee rise to £120.

Council members at the NMC meeting in March 2013 heard that a ‘slower than expected’ staff recruitment drive, operational efficiencies and lower operational costs meant the regulator can hold its registration fee stable for another year.

The rise of the NMC fee from £76 to £100 this year was based on an expected 8% annual increase in referrals. However, referral rates overall declined in 2012–13, this is not the experience of other regulators who are experiencing significant increases. The publication of the Francis report has been accompanied by the raising of concerns in a number of other NHS trusts which may translate into referrals to the NMC.

The regulator also agreed to review introducing variable fees and alternative payment mechanisms – such as payments by instalments – next year.

Nurses expected to ‘drop off’ NMC register thanks to new insurance requirement

The NMC expects up to 5% of nurses will lose their registration following the new requirement to hold their own professional indemnity insurance (PLI).

By October 2013, all UK nurses will be legally required to demonstrate they have adequate indemnity cover in order to retain their license to practise in the European Union. The change is due to an EU Directive published in March 2011.

Unite/CPHVA Professional Officer for Regulation, Jane Beach, said the directive means self-employed health visitors or school nurses will have to fund their own indemnity cover.

Mark Smith, Director of Corporate Services at the NMC, estimates between 2% and 5% of nurses will either not be able to secure or afford PLI and, therefore, will ‘drop off the register’.

Unite/CPHVA Professional Officer for Regulation, Jane Beach, says: ‘We are pleased the NMC is back on track with its overseas applications. We have worked hard with the regulator on this issue and we are happy it remains vigilant in addressing problems in this area. However, it is a worry that it is forecasting a rise in registration fees to £120 in 2015. We would hope the NMC would be able to make some efficiency savings to allow the fees to remain at £100 – or even drop, CPHVA would be strongly opposed to any planned increase and will work with the NMC to try to avoid this at all costs. Lastly, the indemnity insurance changes are proving to be a far bigger issue than anybody realised. It is important to stress the PLI insurance that Unite offers is predicated on employers having vicarious liability. However, we are hearing stories that some of the new organisations delivering contracts on behalf of the NHS are not providing this to their employees. The NHS landscape has altered from when the government first ordered the change to be implemented, and this could be a potential problem for members. You need to make sure you do not get caught out and ask your employer about vicarious liability cover as soon as you can.’ Does the change in personal indemnity insurance affect you?

Let Jane know at: jane.beach@unitetheunion.org

Overseas nursing application process restarts

The NMC has resumed processing applications for overseas registration.

The regulator announced a suspension of overseas registration on 1 February 2013 while an external review was carried out.

Dr Katerina Kolyva, the NMC’s Director of Continued Practice said the process was now ‘stabilised but not perfect’.

A new set of Standard Operating Procedures (SOPs), coupled with guidance and training to the overseas teams and clear criteria and thresholds of qualifications and training from overseas applicants hopes to provide consistency in decision-making and clarity for all parties involved.

Dr Kolyva also confirmed a more ‘fundamental review’ of overseas registration will take place ‘in due course’ where council members will be invited to discuss the possible introduction of face-to-face ID checks for overseas applicants.

‘Too early to say’ if referral rise is linked to Francis

The NMC has seen an increase in the number of referrals so far this year, but claims it is ‘too early to tell’ if it is the result of a ‘Francis effect’.

Referrals rose to 357 in February 2013, up from 352 in January 2013 and 300 in December 2012.

Chair of the regulator, Mark Addison, questioned whether the rises were linked to the publication of the second Francis report earlier in the year on the Mid Staffs scandal.

But Sarah Page, Director of Fitness to Practise at the NMC, said it was ‘too early to come to any conclusions that the rise comes down to Francis’.

Disappointingly for council members, the NMC’s caseload increased by 29 in February 2013 to a total caseload of 4,350.

It is claimed the end of 2014 will see the regulator’s caseload brought down to a ‘more manageable level’.
Scotland plans to go smoke free

Scotland has committed to becoming smoke free by 2034. The country is only the third nation in the world to set the ambitious target, meaning it hopes to have less than 5% of the population smoking in just over 20 years’ time.

The strategy supports the introduction of standardised packaging and will strengthen services to help people stop smoking.

Launching the strategy, Minister for Public Health, Michael Matheson, said: ‘Our vision of a tobacco-free generation is about reaping the health, social and economic benefits that a significant reduction in smoking would bring – it would be an achievement of which we could all be proud.’

The Scottish government will await the UK government and the other devolved administrations’ responses to the UK-wide consultation on standardised packaging before deciding on how best to introduce the measure.

Unite/CPHVA Professional Officer, Gavin Fergie, said: ‘The success of this target depends on how committed this government and, indeed, successive governments are to tackling smoking. Scotland is now involved in an evolving public health situation alongside Finland and New Zealand in going smoke free and if we could achieve this ambitious goal, it would be a major boost for public health in Scotland. I’m sure our members are committed to doing all they can to help us.’

Other key actions from the tobacco control strategy include: investing in education programmes for young people, implementing smoke-free hospital grounds by 2015, delivering a national marketing campaign on the danger of second-hand smoke and setting a target for reducing children’s exposure to passive smoking.

Revised safeguarding guidance gives ‘flexibility’ to professionals

A new national panel of independent experts will offer advice to local safeguarding children boards (LSCBs) under revised child safeguarding guidance.

Ministers say the new 97-page Working Together to Safeguard Children guidance makes it ‘explicit’ that safeguarding is the responsibility of all professionals who work with children.

Children’s Minister, Edward Timpson, said: ‘[The] guidance makes absolutely clear the core legal requirements on all organisations and individuals working with children to promote their welfare and keep them safe.’

In a bid to reduce the ‘layers of prescription’ claimed to ‘constrain professional judgment’, the government has removed the requirement to have a separate ‘initial’ and ‘core’ assessment of children in need and the related 10-working-day timescale for completion of the initial assessment.

It is hoped this will allow professionals the flexibility they need to carry out an assessment designed around individual children.

Infant mental health highlighted

Health visitors should be trained in video interaction, according to a new report by charity WAVE Trust and the Department of Education in England, Conception to Age Two – The Age of Opportunity.

The report highlights the lifelong effects of early years relationships. It also recommends mental health risk assessments should be carried out ‘as early as possible’ in expectant mothers.

In addition to the six-week health visitor assessment, a follow-up at three/four months should then take place to focus on the quality of interaction between mother and baby. A further review of parental attachment should take place when the child is one year old.

Under these measures, health visitors should be trained in video interaction guidance, where parents are shown clips of themselves interacting with their baby.

Chief Executive of the WAVE Trust, George Hosking, said the video tool would only be used to give positive feedback.

Unite/CPHVA Professional Officer, Dave Munday, said: ‘The report introduces positive ideas that need further development. Many health visitors have already extended their knowledge about the importance of relationships between parents and children and, in some areas, have begun using videos of interaction. Not only is this tool extremely useful for day-to-day work with families, it is also really powerful to use when training new staff to identify interaction cues, and in work with parents before they have their children to build up their knowledge.’
Diet survey reveals UK breastfeeding habits

Two in 10 infants under the age of 18 months have never been breastfed, a UK-wide survey shows.

In Scotland alone, this number rises to 68% of children who are never breastfed.

According to the Department of Health’s one-off Diet and Nutrition Survey of Infants and Young Children, 57% of children aged four to 18 months were not breastfed beyond three months of age. Again, this figure grows to 65% when considering Scotland alone.

More than 2,600 children took part in the DH’s survey between January and August 2011 – with 600 children taking part in the Scotland-specific diet survey, and were involved in interviews, dietary diaries, blood samples and estimates of breast milk intake, fluid intake and body composition.

Despite guidelines encouraging parents not to introduce follow-on formula and ‘goodnight’ milks to their child before they are six months of age, 32% of infants aged four to six months had been given follow-on formula.

Complementary foods were also introduced before the age of three months in 10% of children and before five months in 75% of children. For 22% of children foods were introduced at six months and 3% at seven months or more. In Scotland, baby rice was the most common first food for children (63%), followed by pureed fruit or vegetables (18%).

Unite/CPHVA Professional Officer, Gavin Fergie, said: ‘This survey highlights the realities that our members face. Ideally, there would be enough staff to work with families to ensure the best nutritional start for their children – but with demands on time this is not always possible. ‘With ever-increasing rates of diabetes and obesity, the Departments of Health across the UK need to seriously address the need for robust public health support and education.’

Welsh measles epidemic bites

The measles epidemic in Swansea shows no signs of slowing with around 15 to 20 new cases being confirmed every day.

Numbers of confirmed cases reached 620 and around 60 people have been hospitalised since the start of the outbreak as Community Practitioner went to press.

Public Health Wales warned 6,000 children in the county have still not received the MMR jab.

Confidence in the vaccine fell in the early 2000s thanks to a now-discredited MMR jab.

Dr Mary Ramsay, Head of Immunisation at Public Health England, said: ‘The only way to prevent measles outbreaks is to make sure there is good uptake of the MMR vaccine across all ages, and that when cases are reported, immediate public health action is taken to target unvaccinated individuals as soon as possible.

‘Parents of unvaccinated children, as well as older teenagers and young adults who may have missed MMR vaccination, should be advised it is never too late to get vaccinated against measles and they should make an appointment to do so as soon as possible.’

Unite/CPHVA welcomes FNP expansion in England

The Family Nurse Partnership (FNP) programme is to be extended across England, it has been confirmed.

Health Minister, Dan Poulter, said the move will allow 16,000 of the most disadvantaged new young mums receive one-to-one tailored help and support by 2015.

Research shows mothers who are supported by FNP nurses stop smoking, have high levels of breastfeeding, improved self-esteem and are more likely to return to education or employment.

Dave Munday, Unite/CPHVA Lead for Health Visiting, said: ‘We welcome the announcement. This scheme delivered by our members is shown to have a wide-ranging impact on the families they serve. Combined with the expansion of the health visiting profession, won through tireless campaigning by our members, this will have a profound effect.’

Unite/CPHVA has said it will monitor closely the impact of expansion of the programme on health visitor caseloads, and will seek assurances the move will not water down the government’s commitment to raise the number of health visitors by 4,200 by 2015. The government recently admitted the recruitment drive is currently ‘off trajectory’ by 157 places.
Specialists should have ‘guiding’ role in community care

The NHS’ urgent care system is ‘on the verge of failure’, the head of a Birmingham trust has warned.

Speaking at a King’s Fund event in London in March 2013, Mark Newbold, Chief Executive of the Heart of England NHS Foundation Trust, said the current model of care is ‘not sustainable and called for hospital specialists to have a bigger role in guiding home-based care.

Unite/CPHVA Lead Professional Officer, Obi Amadi, said: ‘We have seen hospital staff provide appropriate services in the community, so we know it can be done. However, the issue remains the same – that it is always been to better for the patient to prevent the need for hospital admission in the first place.

Draft NI abortion guidelines revealed

Northern Ireland’s Health Minister has published long-awaited draft guidance on abortion law in the country.

Terminations of pregnancies are only granted in cases where the mother’s life or mental wellbeing is considered to be at risk.

Edwin Poots’ 30-page document The limited circumstances for lawful termination in Northern Ireland proposes that two doctors rather than one should make an assessment over whether an abortion should be carried out and describes the lawfulness of advocating terminations outside NI as a ‘grey area’.

It also includes a recommendation that consultant psychiatrists should be involved when a mental health assessment is required and covers an allowance for conscientious objection, accountability and data collecting.

Consultation on the draft guidelines is expected to close in July 2013.

Public sector workers offered 1% pay rise

The 1% rise in public sector worker pay is ‘woefully inadequate’, Unite has said.


During his 2013 Budget speech, Chancellor George Osborne also announced the 1% pay increase cap will be extended to 2015–16.

Employers Dean Royles remains ‘perplexed’ as to why the independent pay review bodies recommended any increase in pay at all and maintains the rise will harm patient care and put jobs at risk.
Bio-Oil® is a skincare oil that helps improve the appearance of scars, stretch marks and uneven skin tone. It contains natural oils, vitamins and the breakthrough ingredient PurCellin Oil™. For comprehensive product information and results of clinical trials, please visit www.bio-oilprofessional.co.uk. Bio-Oil is the No.1 selling scar and stretch mark product in 11 countries. £8.95 (60ml).

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Save our NHS: join the campaign

The NHS will celebrate its 65th birthday on 5 July 2013 and Unite is preparing several events to coincide with this milestone. However, with the current government pushing its pro-privatisation agenda, the fight to make sure it reaches 70 has never been so urgent.

We love our NHS. David Cameron doesn’t. He’s broken every one of his promises to the NHS. Billions have been wasted on the biggest ever reorganisation in its history – hospitals are closing, rationing is rife and £20 billion of our health pounds are now lining the pockets of private sector giants, including Virgin Care and Serco. Unite is backing the fight to stop the break up and sell off of our greatest national treasure.

MP email action
Email your MP today to ask them to sign the newly tabled special form Early Day Motion (1188), which calls for the s75 regulations to be annulled once and for all. Visit the Unite website (www.unitetheunion.com) and fill in the online form. Simply enter your postcode to get started. Don’t forget to enter your name, email and home address so that your MP knows you are a constituent.

Remember to tell your MP that Jeremy Hunt’s rewrite of the section 75 regulations do not go far enough to stop the privatisation of our NHS. Ask that these regulations, which continue to dramatically extend competition, are debated, voted and ultimately defeated. Sign EDM 1188. Don’t forget to add your MP’s name at the top, your address and signature. If you’ve already written to your MP about the regulations, please remember to mention their response in your email if relevant.

Cuts to the NHS are now accelerating and we are calling on all members to get involved in local campaigns to #saveourNHS.

Campaign event
18 May 2013
A London-wide demonstration will take place at 12 noon at Jubilee Gardens, Waterloo.

CPHVA Education and Development Trust: call for trustees

The Trust was established in 1997 following a bequest by Dr Ian McQueen. We currently have four members and need to recruit a further four trustees.

We have two meetings a year – one held in London in the Spring and an Autumn teleconference. Trustees also attend our AGM at the annual professional conference. If you are interested in furthering the professional development of community practitioners through the aims of the Trust; why not join us as a trustee? Applicants will be able to demonstrate:

- An understanding of the role of community nursing and the public health contribution
- Understanding of the role and responsibilities of a trustee of a registered charity
- Experience of committee work
- Excellent communication and interpersonal skills
- Impartiality, fairness and the ability to respect confidences
- The ability to bring additional experience to the committee.

Trustees will consider the applications of candidates and make a recommendation for appointment to the AGM in October. The successful applicants will be included in meetings and discussions prior to the October AGM. A brief professional history and supportive narrative should be emailed to the Trust’s Hon Secretary, Judy Conn, at: judymconn@btinternet.com

If you would like more information, please feel free to email Judy or the Trust’s Chair, John White: john@j-white.com

Back the Unite political fund ballot

On 1 May 2013 Unite members across the country will have received a ballot paper about the Unite Political Fund. Unite is calling on all members to vote ‘yes’ to retain the fund – that’s ‘yes’ to retain a political voice for Britain’s biggest union. Without a political fund we cannot do any political campaigning to stand up for Unite CPHVA members.

Union campaigns succeeded in introducing the NHS, health and safety legislation, the minimum wage, employment tribunals, redundancy payments and much more. That’s why Unite is calling on all members to vote ‘yes’ in the ballot.

The 1984 Trade Union Act requires unions to ballot their membership every 10 years to continue with the political or campaigning fund. Without a ‘yes’ vote Unite would be barred from spending any money at all on any national campaigning activity that criticises the government of the day.

The ‘yes’ vote matters
Contemplate the next general election. A rampant Conservative party proposes privatisation of the NHS, banning strikes in all public services, ends collective bargaining and wants to outlaw equality legislation including maternity rights. Unite would have to speak out against all these attacks, but that is only possible with a political fund. A ‘yes’ vote to a political fund is a vote for a voice – back the political fund and vote ‘yes’. Help back the Unite campaign.

What you can do…
Make sure your colleagues know about the ballot, are eligible to vote, and urge them to vote ‘yes’. Why not organise a briefing session for your workplace or union branch?

- Put the dates in your diary – the ballot runs from 1–22 May 2013
- Download the activists guide to the Unite political fund ballot
- Vote ‘yes’ as soon as your ballot paper arrives.
There are times when only an independent, assessor-blinded, randomised controlled trial will do.

We know how much you value clinical evidence to support the advice you give. Especially when it’s a matter of safety and tolerability. That’s why we believe you’ll be interested to hear about the largest ever clinical trials of newborn skin cleansing methods. This independent research, led by midwives, with a total of over 500 mothers and their newborn babies, has now been peer-reviewed and published and the results are clear: JOHNSON’S® Baby Extra Sensitive Wipes and Top-To-Toe® Bath are both as safe to use as water alone – right from day one. It’s great news for parental choice, because there are mothers who like the convenience of baby wipes and others who prefer water and cotton wool, just as some mothers prefer to use a bath product and others would rather not. Now you’ve got the evidence to reassure her she’s making a safe choice for her baby’s skin, whichever method she chooses. She’ll be glad you told her.

See the evidence at www.johnsonsbaby.co.uk/professional

References:
If you have completed secondary school in the UK and are ambitious but from a poor background, how do you improve your lot in life? Generally, through further education and training. However, if you are living in the developing world, where access to further education and training is restricted to those who can afford it, what do you do?

The UK-based organisation, Do Good Charity, sponsors people in Sierra Leone and Malawi in Africa while they train as nurses. They are ordinary but ambitious women and men without the means to get on the first rung of the career ladder to even begin to realise their dreams. They want to achieve, to better themselves, contribute towards health care and support their relatives’ educational, health and other needs.

Our sponsorship programme in Sierra Leone aims to support people who take themselves seriously and who have gone through the national application process that allows them to enter nursing school to train as State Enrolled Community Health Nurses (SECHN) if they can afford the school training fees and associated costs. They train at the St John of God Nursing College in Mabessenah-Lunsar associated with the St John of God Hospital.

The three-year course covers a broad range of subjects, including holistic nursing care, health education, midwifery, community health care, public health and social care. When qualified, they are expected to work in urban hospitals and rural clinics, provide obstetric care, manage communicable disease programmes and help reduce the morbidity and mortality rates of vulnerable people such as women and children, and people with HIV.

In Malawi, the nurses supported by the charity are already qualified, but want to have a career in mental health so need a BSc in psychiatric nursing. Mental ill health is poorly understood and carries a social stigma, so patients are often ostracised, living in poverty and in dire need. Individual, family and community education is as important an area of the nurses’ work as treatment is. We offer them a two-year training course at the College of Health Sciences, Mzuzu.

Some lucky nurse graduates in Malawi continue to be paid a small wage by the government while they study, but many need full sponsorship as well as funds for accommodation and food and to meet family responsibilities.

As a community practitioner you’ll have successfully trod the road so many men and women in Africa would like to take. Your support in helping them realise their ambition to become nurses or to further their training is vital. Regular donations of anything from £8–£80 per month could make a huge difference to their lives and their futures, to the people who depend on them and ultimately their population health.

We’ve sponsored 42 nurses in Sierra Leone to date and 30 are currently looking for sponsorship.

In Malawi:

- £2,620 will pay for a two-year BSc in mental health psychiatric nursing course
- £655 will pay for a semester
- £1,760 will pay for board and lodgings for the two years.
- £1,000 enables a student nurse to train for three years and includes accommodation and support costs
- £205 will pay for a student’s first year tuition fees
- £77 will cover their basic accommodation costs annually.

Contributions towards the cost of textbooks, computers and materials like exercise books, watches, scissors, calculators and drug dosages booklets are also welcome.

Applications are being considered now for next year’s intake in Malawi – 25 enrolled this year. For more information visit: http://sponsorship.dogoodcharity.co.uk/
First-time parents and safety of infants

Unintentional falls and poisonings are major causes of death and disability among infants. Although guidelines are available to prevent these injuries, safety behaviours are not performed by parents, causing unnecessary risks. Little is known about safety behaviours of first-time parents and whether they behave according to these guidelines. A total of 1,439 parents visiting a preventive youth healthcare centre in the Netherlands were invited to complete a questionnaire with regard to the prevention of falls and poisonings. Parents were categorised into first-time parents and non-first-time parents. The results showed first-time parents are not well prepared for the safety of their infant. The parents’ safety behaviours were influenced by different variables; for example, age of the infant, crawling of the infant, mother’s educational level, mother’s ethnicity, self-efficacy and vulnerability.


Delivery of smoking cessation interventions to primary care patients

This study aimed to quantify the extent to which smokers with indicators of poor mental health receive smoking cessation support in primary care consultations compared to those without. Approximately half of smokers with indicators of poor mental health receive advice to quit during primary care consultations in the UK and one in 10 receive a cessation medication. Interventions are lower per consultation for smokers with mental health indicators compared with smokers without mental health indicators.

Addiction 2013 Mar 27; doi: 10.1111/add.12163

Children under one with very low birth weight

This study aimed to identify the characteristics of health care in infants with very low birth weight during the first year of life and the factors associated with this care. Considering families with lower socioeconomic status, women with a higher number of children, and women who did not breastfeed were factors associated with poor health care of children born with very low birth weight, the authors recommend these variables should be included in measures of public health planning.


Letter: The consequences of whistleblowing

‘On completion of the Specialist Community Public Health Nurse course I was elated to have survived the year. As a newly qualified health visitor I was excited and extremely enthusiastic to begin work with the community and help children and families.

However, after a few weeks had passed, I came across issues of unsafe practice involving a colleague and shared these concerns with another colleague in the team. It seemed the ‘issues’ I had raised were common knowledge; yet other team members had chosen to keep this contained within the team. I began feeling very alone, believing very strongly that these issues of unsafe practice could consequently cause the death of a child. Talking to colleagues within the team I found these issues dated back years. Management had periodically investigated but no action had been taken. As the issues continued I arranged to discuss them with a senior manager. I had to remind myself that I was now a leader and that I had to make a stand for the families we work with.

I had built up evidence and provided this to senior management. Again, I felt very alone and unsupported. Initially, his reaction was positive; after all, I had evidence to support my claims. However, I was informed that the evidence was not enough. I advised management that further evidence could be accessed via the trust computer system. His reaction became very negative and he then informed me that he was unfamiliar with the system so was unable to access it. My concerns were for families continuously failed by our trust. Children’s lives were potentially being placed at significant risk, yet my concerns were not taken seriously. This practice remains ongoing.

The effects of this experience have been significant for me. Colleagues have never come forward to support me and, I believe, have allowed unsafe practice to continue. I am unsure how long I can continue in this profession as my face no longer ‘fits’ because I tried to do the right thing for the children and families of our community.

The Francis Report, published following the Mid Staffordshire scandal, states: ‘What the NHS needs is a fundamental change in culture. One that puts patients, not numbers at the heart for every staff member, whether they are frontline, clinicians or managers, commissioners or regulators.’

Must we continue to have innocent deaths and inquiries before people listen?’

Name and address withheld

New resources

New guide to formula milk advertising for UK health professionals

A new document from UNICEF, A guide for health workers to working within the International Code of Marketing of Breastmilk Substitutes, sets out the ways in which formula manufacturers may seek to influence health professionals or trusted organisations to endorse their product. By recognising how these techniques can undermine breastfeeding and increase formula sales it will be possible for health professionals to make decisions that are in the best interests of mothers and babies. To obtain a copy of the new guide visit: www.unicef.org.uk/babyfriendly/formulamarketing

FSID becomes the Lullaby Trust

The Foundation for the Study of Infant Deaths (FSID) has decided to change its name to help better reflect the support it offers to bereaved parents and parents with young babies. The charity is celebrating 25 years of its health-visitor led support service, Care of Next Infant (CONI) programme, run in partnership with the NHS. The service is a targeted intervention supporting parents before and after the birth of a subsequent baby. It is available in 86% of England and Wales and is backed-up by CONI Plus. CONI families are some of the most disadvantaged in the country and the programme is highly valued by those enrolled. For more information about CONI’s anniversary and free training opportunities in your area please visit: www.thelullabytrust.org.uk
School Nurse 121 Campaign

Rosalind Godson
Professional Officer, Unite/CPHVA
rosalind.godson@unitetheunion.org

All school nurses in England are now being commissioned by the local authority. You may well not have noticed any changes yet – but changes there will be. For a start, the perennial question raised by the children’s services director in your area will be, ‘What exactly do school nurses do that other agencies can’t?’

See and be seen
It is a constant surprise to me that, despite emails, websites, journals and other written publications, the method of communication that seems to work best among health and social care professionals is face to face. Now is the perfect time to get yourself seen and heard as a school nurse.

Action
Invite the children’s services director and the director of public health to a showcase of school nurse work in your area so that you can help them answer their questions.

Before you do this you must find out what is it that matters to your local authority. There will be local public health priorities, such as increasing immunisations, reducing under-age smoking, or reversing the trend of childhood obesity. Consequently, your showcase will need to put an emphasis on this.

Most local authorities are engaged in the Troubled Families Programme, which is a (English) government-led initiative to target the 120,000 most vulnerable families where adults aren’t in work and children may be missing school. This is a ‘Payment by Results’ scheme to:
- Get children back into school
- Reduce youth crime and antisocial behaviour
- Put adults on a path back to work
- Reduce the high costs these families place on the public sector each year.

Multi-agency working
Number four of the Department of Health (DH) health visiting and school nursing pathways shows the rationale for interventions and explains how school nurses can carry out effective multi-agency working.

Action
You will need to bring this to the attention of local authority troubled family co-ordinators so that they know where school and public health nurses fit in and, above all, how they can contact you. See: http://vivbennett.dh.gov.uk/public-health/

Local issues
The updated and reduced Working Together document on safeguarding has been published by the Department for Education and the DH in England. The professional guidance has been removed – so the CPHVA school nursing organising professional committee (OPC) will publish this information separately for our members. Meanwhile, there is information on how school nurses can work effectively – see number five of the health visiting and school nursing pathways at the following website: http://vivbennett.dh.gov.uk/public-health/
SCHOOL NURSE CAMPAIGN

Action
If there have been any recent serious case reviews in your area, school nurses should ensure they have taken on board any local issues in order to impress their new colleagues and promote better practice.

Immunisation programme
From next year all four countries in the UK will offer immunisation with Fluenz (inhaled) to 2–16 year olds. Younger children will attend the GP surgery but it is more effective for older children to receive this at school or nursery. Local authorities in England will have the public health responsibility to deliver this programme.

Action
There will be some pilot schemes happening this September to work out feasibility issues, so if your local authority is involved with these make sure there is school nurse attendance at all planning meetings; you must be seen to be vital to proceedings.

‘Every contact counts’
The government’s public health nurse for England declared recently that every nurse has a responsibility to make every contact count for health and wellbeing, providing support, information and education.

Action
This is another thing to bring to the attention of commissioners and local authorities; anyone can carry out tasks, but the school nurse is the only health professional to have a background understanding of the education system, combined with an in-depth public health knowledge and the skills to work with young people. The Welsh government has recently appointed a public health nurse; does she know all about school nursing or would you be willing to do a presentation?

There are various definitions of public health and, as all countries move their health and social care agencies into alignment we will need to remind ourselves to see the whole picture. For example, changes in the benefits system will be wreaking havoc on the public health of some families, where choices need to be made between heating and food or nappies and utility bills. As nurses we cannot ignore the effects of poverty and must follow the Nursing and Midwifery Council (NMC) Code of Conduct, Performance and Ethics, which states:

- Make the care of people your first concern, treating them as individuals and respecting their dignity
- You must support people in caring for themselves to improve and maintain their health
- You must act as an advocate for those in your care, helping them to access relevant health and social care, information and support.

Advocating for children and young people whose health is at risk owing to benefits cuts or service reorganisation is within the remit and duty of a school nurse. It’s not easy, but if you are involved with the CPHVA and well supported by Unite colleagues, it is possible.

For more information or to advertise in Community Practitioner’s recruitment section, call our advertising team on 020 7878 2319

Alternatively email: claire.barber@tenalps.com

TENALPS MEDIA
Too much, too young

More young people than ever are turning to self-harm to cope with the increasing pressures of teenage life. Louise Naughton investigates the triggers, patterns and effects of this dangerous and disturbing behaviour.

Louise Naughton
Assistant Editor

Emily* is 13 years old. To the outside world she looks and acts like a normal teenager, but inside she hides a dark secret. Every day, at every minute, during every second, she is self-harming. Deliberately wearing shoes several sizes too small, every step Emily takes is excruciating and agonising. The simple act of walking is a constant reminder of her self-loathing and acts as a punishment for – in her words – being a rubbish human being.

Sadly, Emily is not alone. Behind family problems, abuse and bullying, self-harm is now the fourth most common problem facing young people. Recent research released by ChildLine found more children and young people than ever are self-harming, and sufferers are getting younger year on year. Latest figures show the charity has seen an increase in counselling sessions relating to self-harm of 68% in the past two years alone to 16,284 – around 45 sessions a day. What’s more, the issue is now among the top five concerns for 13 year olds for the first time ever. Just two years ago, self-harm made its first appearance in the top five concerns among 15 year olds.

Too much, too soon, too fast

Suzie Hayman, national agony aunt and Trustee of the charity Family Lives; which runs Bullying UK, is not surprised by the news. Blaming the rise in ‘sexualised bullying’ born out of more ‘explicit and nastier’ online pornography, which is more accessible to young boys than ever before, she says young girls are faced with more expectations and demands on their behaviour than they can cope with.

Child psychologist of almost 20 years, Kerry Daynes, attributes the increase in reports of self-harm to the fact that children are growing up and experiencing ‘too much, too soon and too fast’. ‘Self-harm is a clear sign of immense psychological and emotional distress, and that a person cannot cope,’ she says.

‘We are treating our children as adults and exposing them to adult images, and adult technology, much too soon. Parents must take a more policing role to nurture and protect childhood.’

The growing number of family breakdowns is also taking its toll. Over the last 40 years UK family life has changed considerably and, with the Office for National Statistics (ONS, 2011) expecting 42% of all marriages to end
in divorce, Hayman says parents embroiled in arguments are guilty of ‘taking their eye off the ball’ when it comes to acknowledging their children’s suffering.

‘Many parents believe they are hiding the pain of a family breakdown from their children or are simply just too consumed by their own miserable situation to notice when their kids are struggling to cope,’ she says. ‘We don’t handle the impact of family instability on children very well.’

Rachel Welch, Director of the charity Selfharm.co.uk, questions whether the increase in the numbers of children self-harming is actually a reflection of a technological and societal shift. She warns we must not forget that, thanks to increased access to the internet and mobile phones, making the call to ChildLine is easier than it has ever been. ‘When I was young we had one telephone in the hallway at home and it was impossible to have a private conversation,’ she says. ‘Young people can ask for help in lots of ways that were not thought possible years ago.’

Greater awareness of self-harm and a shift in societal thinking has also meant those young people displaying self-harming actions who, traditionally, would have been labelled as ‘difficult’ or ‘badly behaved’ are now more likely to recognise the behaviour in themselves and receive recognition from others as having more complex problems.

‘I personally think we are seeing an increase in the number of young people self-harming, but I don’t think the increase is as huge as the ChildLine figures are suggesting,’ says Welch. ‘We are recognising self-harm better now – but that doesn’t necessarily mean more children are doing it.’

While greater access to information has, no doubt, benefited hundreds of children and young people seeking help for self-harming behaviour, agony aunt Hayman says educational websites and sources of online information can actually be the culprit for starting a young person on the road to self-harm in the first place.

‘If you are an unhappy child or adolescent, perhaps needing some way of expressing that misery and unhappiness, and you find your way onto a website explaining self-harm, it is something you might try,’ she says. And it is not just self-harm-advocating websites that can have this effect.

ChildLine counsellor, Patricia Stephens, says she often wonders whether the prominence given to self-harm on ChildLine’s own website could plant the seed for the behaviour in the first place. ‘It’s a “Catch 22” situation of the worst kind,’ she says.

**Self-harm triggers**

It is estimated around one in 12 young people in the UK have self-harmed at some point in their lives (Mental Health Foundation, 2006); but why do they do it? Many self-harm to punish themselves; some use physical pain as a distracting mechanism from intense emotional pain; and others find they can release bad feelings through hurting themselves. There are many reasons why children and young people resort to such measures to feel this way.

Self-harm could follow a significant trauma, such as a bereavement or an episode of abuse, or can be the product of ‘copycat’ learned behaviour from older siblings or peers. It can also be a by-product of the intense stress and pressures that come with exams and constant testing at school. Others don’t even know themselves why they self-harm.

Charity Director Welch – who herself self-harmed for 10 years – says: ‘The way all the hormones and emotions manifest in adolescence make some young people feel as though they don’t have any control over their lives; and for some inexplicable reason self-harm just feels like a good way to deal with all of these emotions and regain control.’

**Accepting responsibility**

Bullying is a major trigger for self-harm. Research from King’s College in London suggests children bullied during their early years are up to three times more likely to self-harm than their classmates when they reach adolescence (Fisher et al, 2012).

Bullying UK patron Hayman says she is ‘slightly despairing’ over the lack of progress being made by schools in stamping out bullying culture. This change in ‘whole-school’ culture has to start with a recognition from head teachers that bullying exists in their institutions – something they are often very reluctant to admit. Hayman claims schools cannot quash bullying without this culture change and without the whole school on board. All members of staff have to understand why people become bullies and why people become victims of bullying, and then be fully committed to stop the behaviour. Merely dealing with one incident at a time will not bring about the necessary ‘seismic’ change.

For Hayman, this feels a long way off as she claims the majority of schools in the UK are failing to prioritise the emotional needs of their pupils. ‘I am ever hopeful there will come a time when schools will finally step up and take responsibility for the bullying that happens within their walls; but it does seem we are stuck,’ she says with an exasperated sigh.

‘We are in the year 2013 and bullying should not be something that is allowed to happen; but each time I receive a letter from a child being bullied, I am reminded that it very much is.’

Self-harm can also be an indicator of the state of a young person’s mental health. While self-harm does not necessarily mean a young person is mentally ill, the behaviour can be the symptom of an unmet mental health need, such as depression or a personality disorder.
Psychologist Daynes says it is ‘very difficult’ to distinguish between those who self-harm because of deep psychological difficulties, and those for whom the coping mechanism will be a passing phase. Research cited by the Mental Health Foundation in their report, The Truth Hurts, found that, while young people usually start to self-harm as the result of a complex combination of experiences rather than one single event, sufferers repeatedly mention mental health problems, such as hopelessness and depression (Mental Health Foundation, 2006).

Another survey questioning around 8,000 young children found self-harm occurred in 28% of those with an emotional disorder, 2% with a conduct disorder and 8% with a hyperkinetic disorder (Green et al., 2005). Despite this, Child and Adolescent Psychiatrist, Gillian Rose, says the number of people self-harming as a result of a mental illness ‘would be far lower’ than those who do so as a consequence of ‘copycat’ behaviour.

‘Doing more harm than good’
ChildLine counsellor Stephens says, too often, professionals try to stop a young person self-harming before establishing and treating the cause of the behaviour. ‘It can take forever to find out why a child is self-harming after they have disclosed the information to you,’ she says. ‘Often, they might not know the reasons themselves or can take a long time skirting around the issues they face.

‘Professionals often want the best result – which is the young person to stop harming themselves – but what they don’t realise is they might not be ready. Then, if the child returns to cutting, or whatever means they use to self-harm, they can be left totally devastated and ashamed that they have let themselves and others down. Professionals must understand it is a long process.’

Daynes believes that parents or professionals who discover self-harm and try to get rid of everything a person could potentially use to hurt themselves, may be doing more harm than good.

‘If you try to remove what is a child’s only way of coping, without giving them some alternatives and other more adaptive ways of coping, then you are actually taking something away from them that is quite important and leaving them in a worse state.’

Selfharm.co.uk’s Welch continues to be frustrated by society’s reluctance to move away from its traditional view of self-harm. Statistics suggest four times as many girls self-harm as boys (up to age 16; the figure then reduces to twice as many between the ages of 18 and 19) (Social Care Institute for Excellence, 2005). However, according to Welch, shortfalls in the way self-harm is measured may mean the gap between the genders is, in fact, a lot smaller.

‘A lot of boys are likely to engage in self-harming behaviours, including punching walls and putting fists through windows, that are not always classified as ‘self-harm’; says Welch.

‘Often, such boys are labelled as violent or as having some kind of anger management issue.’

Welch feels this labelling arises from a ‘false view’ of self-harm. ‘You mention self-harm to a lot of people and their assumption is automatically an angst-ridden teenage girl of around 14 years old who takes a razor blade to her wrist or arms, and is someone who is very screwed up and probably wants to kill herself. It is such a dangerous misconception and couldn’t be further from the truth.

‘If you are a 15-year-old boy struggling with self-harm and you have got the whole world around you telling you it is a girl’s problem, it is going to make it difficult for you to admit you need help, which inevitably skews the figures and widens the gender gap.’

If we take the statistics at face value, psychologist Daynes says there is a ‘kernel of truth’ in the self-harm stereotype described by Welch as she claims girls are ‘more likely’ to turn their emotional stress inwards and engage in more ‘secretive and intense’ self-harming behaviour, while boys will turn their emotional turmoil outwards through aggressive actions, which usually gets people’s attention.

Dangerous misconceptions
Self-harmers do not always turn to the stereotypical behaviour of ‘cutting’ as a way of expressing or coping with their emotions. Other more unusual methods of self-harm can be just as dangerous and do not mean the young person is any less distressed than those who turn to razor blades.

Young people can be very imaginative in their quest to find solace in self-harm. Scratching the back of their arm with a compass in a maths lesson; biting nails until they bleed; hair pulling; discreet pinches around the upper and inner arms; burning skin; bruising by banging arms and legs against corners of doorframes and wardrobes; and bleach drinking are just a few of the ways in which young people can self-harm. ChildLine’s Stephens says such methods can be the ‘most worrying’ as they are often chosen by the more secretive self-harmers.

Rachel Welch warns against assessing someone’s mental distress by the level of his or her self-harm. ‘You will get some people who can cut themselves down to an artery; and then you will find others who barely make a
from this view. Young people have most definitely ‘moved on’ professionals who work with children and this traditional perception of self-harm, that, while wider society may be ‘stuck’ in time and resources are always going to be against them’, she says.

Of all the schools Welch has visited not one has a bespoke self-harm policy in place – something she hopes to change. ‘We want to challenge schools to think differently about self-harm so that when a school nurse is faced with the issue there is a very clear flowchart to guide them in managing the situation.’

In the meantime, school nurses are urged to network as widely as possible to find out how other schools deal with self-harm from their peers.

**Busting myths**

Despite this alleged shift in thinking, research published in 2012 by children’s mental health and wellbeing charity, YoungMinds, showed that, while self-harm was the number one issue young people and adults – including GPs and teachers – were most concerned about and wanted the most information on (above drug use, gangs, alcohol and bullying), it was the ‘least comfortable’ issue for both parties to talk about.

‘Worryingly, half of GPs said they ‘didn’t understand’ young people who self-harmed, nor their motivation for the behaviour. Two in three teachers surveyed said they ‘didn’t know what to say’ to students who self-harmed and a third of parents said they wouldn’t seek professional help if their child was self-harming. It is little wonder, then, that three in four young people said they didn’t know where to turn for help.

Media and Public Affairs Officer at YoungMinds, Chris Leaman, hopes the ‘myth-busting’ campaign launched by the charity, in collaboration with ChildLine, YouthNet and Selfharm.co.uk in March 2013, which aims to educate people that self-harm is neither attention-seeking nor a fashion fad, will get more people talking about the behaviour.

‘A lot of the stigma that comes with self-harm is rooted in a lack of understanding,’ he says. ‘It is a type of behaviour that a lot of people struggle to comprehend and they, therefore, choose to live in ignorance. The more we talk about it, the faster we can create an environment where young people can feel comfortable asking for help.’

**Feeling powerless**

Sometimes, however, this ignorance among health professionals is not born out of a conscious choice to turn the other cheek but through a lack of resources and support. Welch says Selfharm.co.uk receives numerous frustrated emails from school nurses desperate for information, who often feel powerless to manage a self-harming episode. They know only too well that patching up someone who has cut themselves with a compass in class is not the end of the story. ‘I really feel for school nurses as they don’t get the support they need from their schools to tackle the issue, yet are expected to deal with self-harm when confronted by it.’ Time and resources are always going to be against them’, she says.

Of all the schools Welch has visited not one has a bespoke self-harm policy in place – something she hopes to change. ‘We want to challenge schools to think differently about self-harm so that when a school nurse is faced with the issue there is a very clear flowchart to guide them in managing the situation.’

In the meantime, school nurses are urged to network as widely as possible to find out how other schools deal with self-harm from their peers.

**Battling the stigma**

Yet, a lack of resources cannot be wholly blamed for the low level of understanding of the behaviour among some professionals. Stigma certainly plays its part and the idea that self-harm is merely ‘attention-seeking’ gets agoony aunt Hayman particularly fired up.

‘That phrase makes me want to grit my teeth and scream, ‘If somebody is seeking attention, usually it is because they need attention!’’, she says. ‘Kids do not self-harm for the fun of it – they do it because they are in need, unhappy or traumatised.’

What’s more, psychologist Kerry Daynes, who works with adult self-harmers, says the stigma doesn’t end when the sufferer leaves adolescence behind. ‘Adult self-harmers who present at A&E are often treated quite dismissively and roughly because it is seen as attention-seeking behaviour. ‘I have heard horrendous stories from clients who have needed a couple of stitches for a cut and were told that if they were going to cut again to “do it properly next time or don’t bother coming back.” I have heard numerous cases of people being treated in complete silence with little or no effort being made to build a rapport.’ Thankfully, she says, this is something that is changing in the NHS.

Certainly, Patricia Stephens says she has yet to come across a caller who has been turned away or treated dismissively by health professionals. ‘Generally speaking, when children look for help and support, they can get it’. Hayman believes the real stigma with self-harm lies with parents.

‘The idea of childhood depression is one that is relatively new’ , she says. ‘There are more likely to say they have a “problem child”. It is seen as an awful thing if a parent has to say, “Maybe I need help and support for the way I am behaving and the relationship I have with my child”— that is where the real stigma is. If help for parents was much more normalised and easier to access, family relationships would improve dramatically.’

**Public health concern**

Rachel Welch believes the stigma associated with self-harm comes from an inability to capture the long-term effects of the behaviour. ‘We know that falling pregnant in the teenage years can prevent young people from accessing higher education and make them more likely to become dependent on social welfare. You can’t do the same with self-harm and for that reason, sufferers are just seen as a nuisance.’

However, while she believes the majority of young people grow out of self-harm, and emerge relatively unscathed, some will find more socially acceptable forms, such as smoking, drug abuse or binge drinking to replace their cutting behaviour as they continue into adulthood, making it a very real public health issue.

‘It is very difficult to assess how many young people will go on to become adult self-harmers, as the statistics for adults are even more vague than they are for children’, she says. ‘For the long-term effects of self-harm in adolescence to become clearer society needs to become better at reading the motivation behind the more socially acceptable ways of self-harm.’

As the prevalence of self-harm among children and young people shows no signs of slowing, health professionals and wider society need to better prioritise the emotional needs of children and quickly. To remain ignorant in this dangerous and complex issue is to fail in our duty to protect the generations to come.

**References**


Coping with cuts

More than three decades after qualifying as a health visitor, Cynthia Servis retired from the profession and joined the NSPCC. She speaks to Louise Naughton about battling against rising caseloads and her work as a helpline counsellor dealing with child protection issues.

Louise Naughton  
Assistant Editor

Why did you decide to be a nurse?  
When I was younger I had great ambitions to be an artist; nursing didn’t even enter my mind until I was around 21 years old. I resisted expectations to go to university like other family members and siblings had done as soon as they left school and, instead, got a job as a lab technician in the pathology department at University College London Hospitals. I worked there for three years but I wasn’t very suited to the role as I was very shy at the time.

I also worked with a consultant radiologist, which was quite boring and isolating, and as a clerical officer at the Greater London Council. I grew tired of the endless paperwork and that’s when nursing called. There was no real trigger or reason that led to me becoming a nurse – all I can say is it just felt right.

What drew you to health visiting?  
I decided I wanted to be a health visitor – again, I am not sure why! It may have come from tagging along with my sister when she received a visit from her health visitor for her newborn baby. It was the first time I had seen the community side of nursing and a combined role of social and medical work. I did my nurse training at Westminster Hospital and my health visitor training at North London Polytechnic in Highbury. I enjoyed being a health visitor, particularly because it was in an environment that was very free in managing your own caseload and planning your days.

What were the most challenging aspects of being a health visitor?  
Managing your caseload was a very challenging area and was an issue that got worse the longer I stayed in the job. Plus, the cuts didn’t help. About eight or nine years ago there was a drive to cut almost half the health visiting workforce in Waltham Forest. Unite/CPHVA reps Norma Dudley and Elaine Baptiste were absolutely brilliant in fighting our corner. We thought we...
had managed to stop it, but they failed to replace staff when they left. The number of health visitors there now is minimal compared to what it was. You just can’t do health visiting as it should be done on those numbers. Health visitors in the borough are spreading themselves so thinly that they simply cannot help everyone as much as they would like.

They have been trained to give holistic care and that’s what they want to do and will do, regardless of the workload they have. Health visitors come across all sorts that they have to deal with. You cannot ignore a new mother who is depressed, upset or anxious – you have to offer help and support even if you haven’t scheduled time. Those people making the decisions think you can walk into a family’s life and then walk out, but you know you’re accountable if something goes wrong.

Have you ever been attacked or abused by clients?
Yes I did and it was very frightening. At times when making home visits you didn’t know what you were walking into. On one occasion, I was visiting a mother who had a personality disorder with a child on the child protection register. I mentioned that I was going to call the social worker to try to get her some help, and that I would come back the next day. I did as I said and the next day she started screaming and shouting at me, inches away from my face. I remember backing out of the door and going to sit in the car, before bursting into tears. Thankfully, I had a great team who were very supportive and that helped me immensely.

Do you think health visiting is recognised sufficiently within the NHS?
I think a lot of people working in the NHS and the wider public don’t actually know what health visitors do. Since I have worked at the NSPCC and talked to others here – some of whom are social workers and trained counsellors – that view has only been strengthened.

Why did you leave health visiting?
I retired from health visiting three years ago, when I was 61. The pressures of the job became too much and I didn’t feel particularly supported by my managers towards the end of my career. I didn’t want to quit working completely, and I wanted something else to keep my brain ticking over. That is when I stumbled upon the job advert for NSPCC counsellors.

How does your background in health visiting help you in your role as an NSPCC counsellor?
It can be difficult when working on the phone as you are blind to body language and only hear one side of the story when assessing the situation. But my time as a health visitor has helped me. As well as carrying out home visits, I would encourage families to call me if they had any problems – this was a good way of being accessible to clients and saving time. It gave me the skills I needed to talk to people on the phone and so it seemed like a natural move.

Do many health professionals call the NSPCC for advice or support?
While I have had a few teachers call the helpline raising child protection issues, I don’t hear from many health visitors or school nurses. Perhaps this is because they are not aware that the NSPCC is there for them to talk through any issues they may have.

How many calls do you take during an average shift?
If it’s quiet you could get two or three referrals; but other times you could get up to nine or 10 in an eight-hour shift. If it’s particularly quiet I would be expected to answer emails and texts, and go through the completed anonymous online questionnaires. The calls are meant to be limited to 17 minutes in length and that can be quite difficult, especially if you receive a call from someone who is anxious and requires you to be particularly encouraging and reassuring.

Why do callers become anxious? How do you calm them down?
Many people phone in kidding themselves there is no problem and that they just need advice. When you say it could be a very real child protection issue they can get very distressed. It does take a lot for someone to phone us in the first place, and when you talk it through with them the anxiety usually stems from concern over the fallout of the disclosure if it is a family member or friend concerned. It panics them when they think about social services or the police getting involved as they hear so many horror stories – and what if they are wrong?

You have to try to get them to think about all the other children who could be put at risk if nothing is done. Management do recognise these calls take longer than the average – you can’t squeeze that conversation into 17 minutes.

Do you receive many malicious calls?
Sadly, we do get a few malicious calls that, generally, are made by repeat offenders. Some have mental health problems but they may also be disgruntled fathers calling after a family feud, or just people making mischief. Recent statistics showed only 1% of referrals made by NSPCC counsellors were from malicious calls, but we always err on the side of caution.

Hundreds of Jimmy Savile’s victims called the helpline following the ITV exposé last year. What was it like listening to their stories first hand?
Some of the calls we took regarding Savile were very difficult to listen to, and at the height of the scandal it was very intense. We have a rule that there should be no calls waiting, but at one point after the scandal hit there were 26 calls outstanding. It was extremely busy and we were receiving one call after another. My colleagues received calls from people who had never talked about the abuse to anyone before and, as you can imagine, these conversations could be very lengthy and distressing at times.

All we could really do was refer callers to their GP or the National Association for People Abused in Childhood for counselling. It was important callers got time to speak and that someone was there to listen, so we often ended up talking through the abuse with them and reassuring them that it was not their fault and that it is never too late to get help. What worried my colleagues and I was whether they did go on to get the help they needed.

Do you find it difficult to switch off after your shifts?
It is easier to switch off for me personally because you don’t see the person you are talking to face-to-face. Although you are very much involved with the call and cancel out everything else around you, you don’t have to follow any referrals up. It is not the same as health visitors working with families face-to-face because they are responsible for the whole care journey.
Improving smoking cessation data collection via a health visitor community of practice

Introduction
Health visitors, like all NHS practitioners, collect considerable amounts of data about the people to whom they deliver services. They also work within an environment that seeks to promote evidence-based practice. We report a project that sought to bring these two aspects of professional life together. How can routinely collected data contribute to research and hence to evidence-based practice? and how can research findings be made more accessible for health visitors in their everyday work?

The spur to this project was Cooksey’s Review of Health Research (Cooksey, 2006), which identified gaps in the translation of evidence into practice. The first gap was the identification of new and effective interventions, and the second was the process of implementing these interventions in everyday clinical practice. Bridging the first gap has been generally interpreted as the responsibility of the research community. But if we emphasise ‘effective’ rather than ‘new’, then the insights of practitioners about what does and does not work in the specific circumstances they encounter is crucial.

The second gap, how to disseminate knowledge about new interventions and accelerate their translation into routine clinical practice (Balas and Boren, 2000; Lean et al., 2008), requires new ways of thinking by both researchers and practitioners.

Facilitating new ways of thinking and interdisciplinary working has been the focus of the Collaborations for Leadership in Applied Health Research and Care (CLAHRCs), a major National Institute of Health Research (NIHR) funding initiative. CLAHRCs were established to enhance knowledge transfer between academic researchers and clinicians via large-scale collaborations between universities and NHS organisations. Their remit was to conduct high-quality applied health research, implement research findings into clinical practice and increase the capacity of NHS organisations to engage with and apply research (Kisol et al., 2011).

Background
Nine CLAHRCs were set up in 2008, each receiving up to £10 million over five years from the NIHR with additional matched funding from participating NHS organisations. CLAHRCs were designed around an assumption that putting clinicians and academics together would effect a change in each group. The expectation was that academic researchers would re-orientate their focus towards applied research, while clinicians would help generate research ideas, collaborate in the research and change practice to reflect findings. One of the new CLAHRCs involved NHS trusts and universities in Leeds, York and Bradford, and had a number of themes, including one on Child and Maternal Health. Activities in this theme were focused on Bradford, a city in the north of England, and it is these we report.

The approach to enhancing collaboration between academics and clinicians was to be pursued via a community of practice (CoP). CoPs are groups of individuals who share a concern, a set of problems or passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis (Wenger et al., 2002: 4). They have been used in the business world as an alternative to formal, top-down education and training programmes. A systematic review (Li et al., 2009) underlined how Wenger’s initial formulation regarding what constituted a CoP has been adapted, with variable success, to healthcare settings, usually in the guise of collaborative learning networks but also via clinical placements and healthcare collaboratives (Bate and Robert, 2002; McCannon and Perla, 2009).

The aim of this project was to use a bottom-up, peer-led approach to improve data quality on a single topic in Bradford; here, data collected on smoking cessation. In doing so the project aimed to demonstrate how this approach could also introduce research evidence into clinical practice and facilitate the dissemination of this through collaboration between academics and clinicians via the CoP.
### Study aim

With CLAHRCs providing the organisational context and funding for this study and with the collaboration of local NHS trusts, the project we report aimed to engage health visitors in investigating the ways in which data routinely collected in the course of their work are captured, stored, transferred, analysed and then used to inform clinical practice. Specialist input summarising the state of research knowledge was made available to the clinical staff involved. This enabled them to critically assess the appropriateness of routine data and make recommendations for improvement. This report focuses on the outcome of investigations into the collection and use of data on maternal smoking behaviour.

### Method

Wenger’s (1998) initial formulation of CoPs saw them as bottom-up, organic entities that developed naturally from people concerned with the same issues. He later proposed that CoPs can be actively guided and nurtured (Wenger, 1998). Consistent with this, and with the support of senior managers in the local primary care trust (PCT), health visitors from across the district who expressed enthusiasm to explore how information could be used in more helpful ways were recruited to constitute a CoP. Initially, only HV clinical leads were recruited to the CoP, but over the course of the project it became apparent that having HVs from services across the district was not sufficiently representative of what was happening in practice. Further recruitment was undertaken and additional participants from across all grades of HV staff, both experienced and newly qualified, and also representatives from the HV managers, joined the CoP.

Regular meetings, with protected time, allowed the CoP to discuss the patterns of their work and the information they collected and used in their everyday practice. A CLAHRC research fellow based at the University of York, one of the collaborating academic institutions, provided support as a knowledge manager for access to, and rapid reviews of, the latest research on smoking in pregnancy and the postpartum period. Characteristically, the research fellow would respond to requests from the CoP members by providing reports summarising academic knowledge on topics about which they needed more information.

The CoP also had access to an analyst based in the PCT, who made local sources of maternal and child health data available to them and who carried out analyses as required on data specific to their topics of interest. The activities of the CoP were facilitated by a programme manager funded by CLAHRC.

To establish a robust understanding of which data were relevant to maternal smoking behaviour, where these data were generated and how and by whom the data were transferred, stored and used, the CoP adopted a conventional process mapping approach (NHS Institute for Innovation and Improvement, 2008). A process map is a visual representation of a patient/ client journey that allows the procedures and administrative processes involved to be recorded. The map shows how things are and what happens in practice, rather than what should happen. This enables problems and areas for improvement to be identified.

Mapping sought to capture the patient’s/ client’s perspective rather than that of the clinician. This enabled the CoP to identify the sequence of steps required to provide clinical care for a mother from first contact through to discharge from the care of the health visiting service.

At each contact point the CoP recorded information about what data were recorded and by whom, how the data were recorded, whether on paper or electronically, how the data were recorded, and by whom, how the data were recorded, and by whom, how the data were recorded. This allowed the CoP to build up

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### Box 1. Examples of issues identified

<table>
<thead>
<tr>
<th>Data capture</th>
<th>Information not possible to identify the smoker where this is someone other than the mother from data collected via the Personal Child Health Records (PCHR) which asks, ‘Smoker in the household? Y/N’</th>
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<tbody>
<tr>
<td></td>
<td>Lack of space precludes recording whether a child is exposed to environmental tobacco smoke in the PCHR, or recording actions recommended by HVs to address this</td>
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<tr>
<td></td>
<td>Documentation and sharing of information on maternal and household smoking status is inhibited by the lack of an appropriate place to record the information</td>
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<tr>
<th>Data transfer</th>
<th>Information transferred between midwives and health visitors varies in quality and content across the district and does not always include information on smoking status, interventions or referrals to Stop Smoking Services (SSS)</th>
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<tbody>
<tr>
<td></td>
<td>Methods for referrals to SSS vary across the district</td>
</tr>
<tr>
<td></td>
<td>Data collected via the Child Health Information Service (CHIS) cannot be linked to data collected via GP surgeries for analytical or clinical purposes</td>
</tr>
<tr>
<td></td>
<td>No established process exists for sharing information on smoking status, interventions or referrals between the services involved in caring for the mother and infant, eg midwives, health visitors, children’s centres, GPs, SSS, etc</td>
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<tr>
<th>Data quality</th>
<th>Information on smoking not recorded by all HVs at every contact with mothers</th>
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<tbody>
<tr>
<td></td>
<td>Information on smoking not captured consistently at every visit by all clinicians in contact with the mother, eg immunisation visits, postnatal checks, etc</td>
</tr>
<tr>
<td></td>
<td>Data, eg birth records, incomplete in PCHR</td>
</tr>
<tr>
<td></td>
<td>Inaccuracies in client data compiled by SSS</td>
</tr>
<tr>
<td></td>
<td>Data missing from electronic records compiled by the CHIS</td>
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<tr>
<th>Using data for evaluation</th>
<th>No feedback to the referring clinician on the outcome of referrals to the SSS</th>
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<tr>
<td></td>
<td>Analyses of the data collected by HVs are not consistently returned to clinicians and may not be in a format appropriate for use in informing clinical practice</td>
</tr>
<tr>
<td></td>
<td>HV activities to target smoking cessation cannot be quantified, therefore it is not possible to determine whether brief interventions delivered by HVs, or referrals to SSS by HVs, result in reduced smoking rates</td>
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<tr>
<th>Procedures and structures</th>
<th>There is no universally accepted definition for a ‘brief intervention’ to support smoking cessation in use across the HV service, leading to wide variations in practice</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Not all HVs have completed training to deliver smoking cessation advice</td>
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a comprehensive picture of data collection and flow throughout the mother’s journey. By networking with colleagues from other services who were also involved with these mothers they were able to assess the range, quality and functionality of the data recording systems in use, the methods employed for transferring and storing data for subsequent analysis, how these data were analysed and used, and what feedback was returned to practitioners.

The mapping exercise generated a large volume of information captured manually on paper by the CoP. Analysis of this presented significant challenges because of its complex and repetitious nature. Inspection of the collated information revealed that although novel issues were encountered at some individual data collection points, in many cases the same problems with data processes were replicated at multiple points along the patient/client journey. The CoP prepared a series of recommendations designed to address the problems identified.

It should be noted that, although this study was focused on data quality, a number of clinical issues were identified by the CoP. This allowed recommendations for improvements to be made, not only to data processes but also to clinical practice.

Results

Examples of the issues uncovered by the process mapping exercise are shown in Box 1. Having highlighted the issues, the CoP considered their underlying causes and compiled a series of recommendations, suggesting what could be done differently and what changes could be expected as a result. Their recommendations were informed by local data and research evidence provided by the CLAHRC research fellow. Where the causes of the issues identified lay outside the immediate remit of the health visiting service, collaboration with colleagues across the services involved with the collection, recording, transfer, storage and analysis of the data was sought so that a negotiated solution could be proposed.

Examples of the changes in practice recommended by the CoP are shown in Box 2. These ranged from simple changes to the daily working practices of HVs, which were easily implemented within HV teams through dissemination via the CoP, to major inter-service changes that would require collaboration and cooperation to implement together with, in some cases, a need for specific funding. An example of the latter was a recommendation to link data that are currently held on separate systems to

<table>
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<tr>
<th>Box 2. Recommended changes in practice</th>
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<tr>
<td><strong>Simple changes to daily working practices</strong></td>
</tr>
<tr>
<td>• Ensure that all staff:</td>
</tr>
<tr>
<td>- Complete all handwritten data entries legibly</td>
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<tr>
<td>- Attach the correct identity labels to personal child health record (PCHR) forms and, if not available, complete by hand</td>
</tr>
<tr>
<td>- Send second carbon copy of the PCHR form to the Child Health Information Service (CHIS) instead of the third copy currently sent because this is more legible</td>
</tr>
<tr>
<td>- Record data on maternal and household smoking at all contacts</td>
</tr>
<tr>
<td>- Are aware of, and use, the universally agreed definition for a ‘brief intervention’ for smoking cessation when delivering and recording interventions</td>
</tr>
<tr>
<td>- Complete training to deliver smoking cessation advice</td>
</tr>
<tr>
<td>• Disseminate information to staff about:</td>
</tr>
<tr>
<td>- What happens to information sent to the CHIS and what it is used for</td>
</tr>
<tr>
<td>- Why completing the PCHR, and doing so accurately, is important</td>
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<tr>
<th><strong>Enhance collaboration</strong></th>
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<tr>
<td>• With SSS colleagues:</td>
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<tr>
<td>- Develop a system for referrals to the SSS to be used by all HVs across the district</td>
</tr>
<tr>
<td>- Establish a process for feedback on the outcome of referrals to SSS to be returned to referring HVs in order to facilitate follow up and HV support for smoking cessation</td>
</tr>
<tr>
<td>• With the CHIS:</td>
</tr>
<tr>
<td>- Arrange timely return of non-identifiable, illegible or incomplete PCHR forms to the submitting HV team</td>
</tr>
<tr>
<td>- Ensure timely correction and return of amended PCHR forms to the CHIS</td>
</tr>
<tr>
<td>• With analysts:</td>
</tr>
<tr>
<td>- Establish an appropriate format and method for the return of analyses of routinely collected data to clinicians so that these can be used to inform clinical practice</td>
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<table>
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<tr>
<th><strong>Procedure and practice changes (in collaboration with senior managers)</strong></th>
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<tr>
<td>• Amend the PCHR in order to:</td>
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<tr>
<td>- Enable HVs to record information on the identity of smokers in the household where this is someone other than the mother</td>
</tr>
<tr>
<td>- Allow exposure of the child to environmental tobacco smoke to be recorded, together with actions recommended by the HV to address this</td>
</tr>
<tr>
<td>- Allow recording of HV activities to target smoking cessation so that the outcome of brief interventions delivered by HVs, and referrals to the SSS by HVs, can be analysed to determine whether these result in reduced smoking rates (this will require changes to electronic data storage by the CHIS)</td>
</tr>
<tr>
<td>- Negotiate the antenatal distribution of PCHR forms so that information sharing between midwives and HVs is improved and specifically includes information on smoking status, interventions and referrals to the SSS</td>
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<tr>
<th><strong>Data capture:</strong></th>
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<tr>
<td>• Identify the contacts at which it is essential to collect information on smoking and cease collection where the data are not subsequently used to inform clinical practice or for statutory monitoring purposes, eg immunisation contacts</td>
</tr>
<tr>
<td>• Negotiate changes to data recording methods in order to improve the accuracy of data reported by the SSS</td>
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<tr>
<th><strong>Data sharing:</strong></th>
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<tr>
<td>• Seek the establishment of effective processes for the sharing of information and data on smoking behaviours, interventions delivered and referrals made between the services involved in caring for mothers, eg midwives, health visitors, children’s centres, GPs, SSS, etc.</td>
</tr>
<tr>
<td>• Recommend that ways of linking data collected by different services on different systems be designed to facilitate better analysis and use of the extensive data collected</td>
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<tr>
<th><strong>Evaluation:</strong></th>
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<tr>
<td>• Monitor impact of the changes implemented on data quality and service targets</td>
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</table>
Discussion

Improving health care requires good quality data so that decision making is supported by sound evidence about the current situation and about the effects of any intervention (Heinig, 2010). Given that at each patient/client contact data is recorded for clinical purposes and for statutory and local monitoring, it is important to know that these data are relevant, accurate, transferred appropriately and used to inform future actions.

The process mapping approach employed by the CoP proved to be an effective tool to trace data collection points along the patient/client journey, to rigorously examine data collection, recording, storage and transfer methods, and to identify the issues impacting on data quality and unearth their underlying causes. This approach also revealed that in many cases, the issues uncovered about data on smoking were also relevant for other data recorded at these time points.

Achieving change, especially in the current shifting organisational environment of the NHS, is challenging. The insularity of services can make it difficult to gain the co-operation of colleagues where this is needed to access data and to examine the processes in use. Many of the informal communication networks that existed in the NHS have fragmented. Throughout the course of this project this was particularly noticeable in links between midwives, health visitors and GPs. Through the activities of the CoP many of these links have been re-established and it remains to be seen whether they survive into the future. It is hoped that resources will become available to monitor and evaluate these changes.

Implications and recommendations

With good data we can define the processes and people involved in the patients'/clients' journey, identify problem steps, prioritise opportunities for improvement and identify barriers and enablers to change. Good-quality data increases the likelihood that the correct cause of a problem is identified and tackled, and that the correct solution is implemented.

Changes implemented as a result of the CoPs' work will be monitored over time to ensure that the desired effects have been achieved. Evaluation of the CoPs' work will enable the methodology to be replicated and further tested and refined by the CoP themselves, as they move on to examine other routinely collected data on topics with a high priority for tackling health inequalities.

Conclusions

The work of this CoP to improve data quality on a single topic in Bradford has demonstrated that this bottom-up, peer-led approach can identify the need for significant changes across many areas of clinical practice. A focus on improving routine practice needs to be maintained and not sidelined when new initiatives to enhance care are introduced. The CoP has shown that it can act as a vehicle through which research evidence can be effectively disseminated via the networking activities of the group, suggesting that systematically closing Cooksey's (2006) second gap in translation topic by topic through clinicians working in partnership with academics and analysts is possible.

Key points

- Allowing health visitors the time and space to investigate data collection processes and data usage around an area of special interest can generate rich information about service delivery from which to plan improvements
- A Community of Practice (CoP), using a bottom-up, peer-led approach, can become a focus for improving clinical practice. It can effectively overcome barriers such as insufficient time, inadequate resources and a culture unsupportive of change, and it can lead the implementation of evidence-based practice
- A CoP can bring clinicians and managers together across services, to implement service improvements based on evidence from research and examples of best practice. This can change people, practice and procedures in innovative ways
- CoPs can form naturally around areas of common interest. Their formation can also be facilitated and their attention directed towards topics of special interest. They can identify areas where improvement is needed and embed evidence-based improvements

Acknowledgements

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References


A service evaluation of the Solihull Approach training and practice

**Introduction**

The Solihull Approach (SA) model considers the development of children’s emotional wellbeing within their family relationships (Douglas, 2010), drawing on ideas from psychoanalytic, early brain development and behavioural theories (Douglas, 2010). The SA is composed of three core concepts. They are:

- Containment – the process where one holds and understands the other’s emotional content without feeling overwhelmed, and effectively conveys this (Bion, 1959)
- Reciprocity – an attuned and appropriate form of interaction (Brazelton et al, 1974)
- Behavioural management (Skinner, 1938) – which the SA describes as consistent response techniques that foster safety and encourage self-control (Douglas, 2010).

The SA can be seen as an applied, psychologically-informed, relational approach for community practitioners that fits with current service pathways, eg, the Healthy Child Programme (DH, 2009) and which is consistent with current policies highlighting the need for early intervention (Allen, 2011).

This approach came into being through the joint working of psychotherapists and health visitors (HVs). Given the increasing needs of HVs to refine their clinical practice, a small team of HVs and psychotherapists co-operated to develop the SA theoretical concepts into a practical framework in 1999. This led to a two-day training programme and a resource pack for professionals working with families with children with difficulties (Douglas, 1999).

Training in the SA was initially offered to HVs to guide them in supporting child–parent relationships. Gradually, the training expanded to various practitioners in health, social care, education and voluntary sectors across the UK (Douglas and Rheeston, 2009; Solihull NHS Care Trust, 2006). As the training extended to include different professional groups, its application stretched beyond parent–child interactions alone to consider practitioners’ interactions with families and interactions within teams (Solihull NHS Care Trust, 2006).

The effectiveness of the SA training has been empirically investigated and supported, Douglas and Ginty (2001) found training increased HVs’ confidence and knowledge concerning children’s problems; enhanced the consistency of their practice; and promoted more holistic assessments. Whitehead and Douglas’ (2005) qualitative study of four HVs found the SA training was associated with participants’ improved views concerning their work and partnerships with other professionals. In a study that compared interventions made by HVs with and without SA training, Milford et al (2006) found better outcomes for the trained group at the end of the intervention and at three months follow-up. However, the majority of the SA assessment studies were undertaken by internal evaluators (ie, staff members, rather than external, non-staff members) and used small samples of HVs only, which limit their findings.

In the first, and currently only, study to investigate SA training in a range of health disciplines, Ottmann (unpublished manuscript, 2010) employed qualitative methodology to evaluate five professionals of a multidisciplinary team, using individual 30-minute interviews and member checking of the initial analysis. Four themes were identified:

1. Changes (to Training) – concerned the need for additional training and help with the SA terminology. It also suggested removing the behaviour management component from the training.
2. Team Ethos – the shared SA framework increased the coherence of the approach among team members and brought them closer together.
3. Positive Experience – the SA ‘made sense’ on the whole and increased team members’ confidence.
4. Enhanced Practice – the SA training provided professionals with a framework and language, and a better understanding of parent-child interactions.

Ottmann’s findings were, in part, similar to previous results regarding the effects of the training among HVs (for instance, the relevance of training to their work, need for additional training and supervision) and, in part, unique (particularly on the managers’ crucial role in incorporating the training into practice). Yet, as with its predecessors, Ottmann’s small sample is a limitation on the generalisability of findings.
Aims of the present study
This study aimed to understand the effects of SA training among different health professionals (not only HVs). Building on Ottmann’s findings, its objectives were to assess whether the SA training:

- Requires adaptation to meet the needs of different professions
- Enhances professionals’ perception of their clinical practice
- Affects the team ethos
- Allows for the three core concepts (containment, reciprocity, behavioural management) to suit the work of different professional groups.

Method
A quantitative methodology was used. Data were collected retrospectively with participants who already had the SA training, in one specific time point.

Measures
An 18-item, self-administered questionnaire was developed by the authors for this study. The questionnaire encompassed four thematic concepts. Three themes: Enhanced Practice; Changes to Training; and Team Ethos, were drawn from Ottmann’s work. A fourth theme, Utility of the Three Concepts in Practice, was informed by practitioners’ preference of the containment and reciprocity principles, described in Douglas and Ginty’s (2001) and Whitehead and Douglas’ (2005) studies.

The questionnaire items asked for respondents’ opinions about the SA training; for example, ‘The training has helped me focus more on relationships than on individuals and their problems.’ Items were rated on a five-point Likert scale (strongly agree to strongly disagree). Seven of the 18 items were reverse-phrased; for example, ‘The training had not given me a useful theory to guide my work.’ The questionnaire was piloted with three different professionals who completed the SA training over two years ago and wording adjustments had been made according to their feedback.

Demographic information was also collected: title of profession (open response); and length of time since completing the SA training (choice of less than two years, two to four years and over five years).

Participants
Participants were early years professionals working in Norfolk with families with young children, who had received the two-day SA foundation training. The study aimed to include as many professionals from as many professional groups as possible. Participants were recruited in one of two ways:

- With the aid of SA trainers who conduct the training in Norfolk. The study researcher provided the trainers with ‘service evaluation packs’ (questionnaire, stamped return envelope and information sheet) in line with the numbers of trained professionals in their records. The trainers addressed the packs to managers of SA-trained teams, together with a short explanatory letter regarding the service evaluation and to professionals who received the training independently of a team. This recruitment process ensured the confidentiality of professionals who received the SA training.
- Norfolk locality managers were contacted and the service evaluation was, consequently, introduced in an area team meeting in which ‘service evaluation packs’ were available for managers to take and distribute among SA-trained team members.

Ethical approval was obtained from the Chair of the Faculty of Medicine and Health Sciences Research Ethics Committee at the University of East Anglia. By returning their completed questionnaires by post, professionals were giving their consent to participate.

Data analysis
Data were analysed using SPSS version 17.0 (SPSS, Chicago). Reversed questionnaire items were reverse-scored.

Results
In total, based on the SA trainers’ and locality managers’ count, 275 study packs were handed to professionals. Of those, 99 completed the study questionnaires (a return rate of 36%). All participants who had returned their completed questionnaires were included in the study. The sample was composed of participants representing 32 different professional titles who had their SA training from less than a year to more than five years.

Participants’ professions were combined to form six professional categories, based on participants’ current roles and the training and qualifications associated with these. They were:

- Family support workers (n=50)
- HVs/nurses (n=26)
- Therapists (n=7)
- Managers (n=6)
- Teachers (n=6)
- Social workers (n=4).

The average time since SA training was two to four years in the HVs/nurses group and less than two years in the remaining five groups. To review the internal reliability of the constructs, Cronbach’s alpha (Cronbach, 1951) was calculated with the entire sample data. The Enhanced Practice theme (concerned with whether the SA training provided professionals with a framework and language, and a better understanding of parent-child interactions) had high reliability: Cronbach’s alpha=.74. The Utility of the Three Concepts in Practice theme (about the usefulness of the three SA principles: containment, reciprocity and behavioural management) had high reliability when item number eight was omitted: Cronbach’s alpha=.74 (or .52 if not omitted). The Changes to Training and Team Ethos themes had low reliabilities: Cronbach’s alpha=.11 and .15, respectively. Subsequent analyses, therefore, regarded only the two former themes as they had high reliabilities (with the omission of item number eight, provided below).

Items from the two low-reliability themes were examined independently. Given group sizes, only family support workers and HVs/nurses were compared.

The Kolmogorov-Smirnov test showed the data from the two themes were non-normally distributed in the two large professional groups. The Enhanced Practice theme was significantly non-normal in family support workers: D(349)=0.29, p<.001 and in HVs/nurses: D(181)=0.26, p<.001. The Utility of the Three Concepts in Practice theme was also significantly non-normal in family support workers: D(149)=0.27, p<.001 and in HVs/nurses: D(78)=0.32, p<.001.

Our findings showed the results from family support workers and HVs/nurses were not significantly different from one another. On the Utility of the Three Concepts in Practice Theme, family support workers (mdn=2) and HVs/nurses (mdn=2) scored: U=5244, z=1.36, ns, r=0.09. For the Enhanced Practice Theme, family support workers (mdn=2) and HVs/nurses (mdn=2) scored: U=39980.5, z=2.46, ns, r=0.02. This was also demonstrated in the remaining seven items that formed the Changes to Training and Team Ethos themes, as well as item number eight (see Table 1).

Discussion
This study sets out to evaluate the effects of the SA training in different health professionals who work with families with young children. It specifically aimed to assess whether the SA training requires adaptation depending upon profession; whether it enhances professionals’ perception of their clinical practice; whether it

PROFESSIONAL AND RESEARCH: PEER REVIEWED
Both groups agreed the SA training improved ‘open response’ and behavioural management) whereas this questionnaire highlighted all three concepts proved useful. Additionally, the wording within the eight independent questionnaire items contexts of the SA are easy to grasp
Item 2: I have felt the need for additional SA training since the initial two-day one
Item 3: It is essential to have regular SA supervision/consultation
Item 4: It is essential to have a manager who supports the SA in order to incorporate the training in my practice
Item 5: Team members who have done the training gained a shared language and understanding
Item 6: Untrained team members are as involved as trained members
Item 7: The training helped me to understand relationships within my team/organisation
Item 8: The SA principles are appropriate for my practice.

<table>
<thead>
<tr>
<th>Questionnaire item (reversed-items are marked in blue and had been rephrased in the affirmative for ease of reading herein)</th>
<th>Family support workers*</th>
<th>HVs/nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 1: The language and concepts of the SA are easy to grasp</td>
<td>2</td>
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<tr>
<td>Item 2: I have felt the need for additional SA training since the initial two-day one</td>
<td>3</td>
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<td>Item 3: It is essential to have regular SA supervision/consultation</td>
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<td>Item 8: The SA principles are appropriate for my practice.</td>
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*1 corresponds with strongly agree, 2 with agree and 3 with neither agree nor disagree

impacts team ethos; and whether the three core concepts (containment, reciprocity, behavioural management) are appropriate to the work of different professionals. Overall, the study found no significant differences between family support workers and HVs/nurses relating to the perceived efficacy of the SA. These are discussed below.

Utility of the Three Concepts in Practice

HV's/nurses and family support workers reported the three SA concepts of containment, reciprocity and behavioural management as useful in their clinical work. The usefulness of the behaviour management concept in this study is unlike previous research in which HV's highlighted the importance of the first two concepts only (Douglas and Ginty, 2001; Whitehead and Douglas, 2005). This may reflect the more diverse category, which includes nurses as well as HV's, for whom behavioural management has proved useful. Additionally, the wording within the first two concepts only (Douglas and Ginty, 2001; Whitehead and Douglas, 2005). Of particular importance appears to be the relational focus of the approach, as it links it to the value of attachment theory and the notion that meaningful changes tend to occur in the context of strengthening relationships on all levels (Douglas, 2007).

Non-themed items

HV's/nurses and family support workers were not significantly different concerning the remaining items. These depict the crucial role of managerial support in incorporating the training principles in practice and the need for supervision or consultation. Further SA training was not seen as necessary; a dissimilar finding in comparison with HV's requesting to extend the two-day training in Whitehead and Douglas's study (2005). This difference possibly relates to the availability of supervision and or consultation as recently suggested elsewhere (Stefanopoulou et al, 2011). Such sources of support may have reduced the need for further formal training for the current participants. The idea that managerial support, supervision and consultation can provide emotional containment for professionals resonates with Douglas and Ginty's (2001) findings about the need to provide containment for HV's in their challenging work, for instance, by offering regular telephone consultation slots.

The remaining items concern the effect of the SA training in multidisciplinary teams. HV's/nurses and family support workers described the utility of the training in considering relationships within their team or organisation. Ottmann's participants, likewise, described how team members used SA ideas within their team interactions, promoting closer relationships among team members. Such a positive impact on relationships within teams alludes to the wider service influence of the training, to relationships between team members from different professional backgrounds.

Our findings suggest the language and concepts of the SA are easy to grasp and provide a shared understanding – a sort of collectiveness which Ottmann's participants referred to as the 'team ethos.' This is likely to benefit a multidisciplinary team where members come from different professional backgrounds and training.

Interestingly, the results across the two professional groups were similar, despite differences in professional practice and in the length of time since SA training. On average, the family support workers group were trained in the SA less than two years, compared with two to four years in the HV's/nurses group. These findings suggest the benefits of this relatively short training are evident immediately after training and last for (at least) several years.

Overall, although the SA training was originally developed for the needs of HV's, the present findings provide evidence for its suitability in other professional groups. The effects of the SA training also seem to extend from professionals' work with clients to team/organisational interactions.

Methodological considerations

The larger-scale nature of this study enabled greater generalisability of findings but compromised participants' role specificity. The collapsing of 32 distinct professions into six professional categories meant that four groups were too small for statistical comparison; although, descriptively, their results appear similar to the two larger ones.

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Key points

- The two-day Solihull Approach (SA) training was found to be equally beneficial to the work of family support workers and HVs/nurses in enhancing their practice and confidence.
- All three SA principles of containment, reciprocity and behavioural management are relevant to family support workers’ and HVs/nurses’ roles.
- Managerial support, as well as supervision and consultation, were seen as crucial in maintaining family support workers’ and HVs/nurses’ use of the SA approach, its principles and ethos.
- The SA training enhances team work by providing a shared conceptual understanding and encouraging attention to professional relationships within peer groups.
- The results from the present questionnaire, which was developed for this study, highlight the need for further developmental work on measurement issues in evaluating the SA training, both conceptually and empirically.

At the same time, the four were too professionally dissimilar to be combined to a larger category and, consequently, the analyses relied on data from the two larger groups.

A further limitation concerns the variety of specific roles within the family support workers group, which may have produced within-group differences in participants’ roles, responsibilities and competencies. This is an organisational as well as a research issue as the term ‘family support worker’ can imply a range of roles and is carried out by individuals with differing levels of training.

The questionnaire items were based on themes drawn from the testimonies of five professionals, and it had not been validated before its use in this study. On reflection, the ‘Changes to Training’ items were quite diverse and, therefore, perhaps did not reflect a single construct. With regard to ‘Team Ethos’, it may have been that participants’ training varied according to whether they were trained as individuals or teams.

Clinical and research implications

Research into the effects of the SA training has been limited with respect to scope and professional variety. As the training has been provided to a variety of professions it is crucial for additional research to evaluate its impact in different professional practices. With further development and validation, the two themes that emerged in this study and the non-themed items may form the basis of a training evaluation tool, to generate a database of participants’ views of training. This may be of particular benefit in assessing the longer-term effects of the training.

Future studies are needed to examine whether the present results in family support workers and HVs/nurses will be replicated in larger samples of additional professional groups. Gathering more comprehensive information about professionals’ training, skills and experience could uncover whether any of these factors are associated with the acceptability and utility of the SA training in practice.

Clinically, the present findings suggest the benefits of the training possibly extend beyond professional–client relationships, enriching working relationships within organisations and teams. Although the results indicated team members’ involvement did not depend on whether they were SA trained, the emphasis on managerial support and supervision imply the importance of managers ‘buying in’ to the SA. Ensuring managers’ participation in the training and offering guidelines on how to implement its principles may support managers in offering SA inspired support within their organisations and teams. This fits the ‘Russian dolls’ analogy that is sometimes used in relation to the concept of containment; the baby’s anxiety is more likely to be contained if the parents’ anxieties are contained by the practitioner who, in turn, is more likely to have the capacity to contain if she is appropriately supported herself.

Additional research could also clarify whether the processes of supervision, consultation and managerial support, truly substitute for professionals’ need for additional SA training, and help plan how to best support professionals following their SA training.

Conclusion

It may be that the ‘deceptively simple’ (Douglas, 2007: 122) basis of the SA gives it an application across professional and family divides, and enables a more shared understanding of issues that arise. Our findings on the SA training in different health professionals suggest family support workers were not significantly different to HVs in perceiving the training as useful for their practice and within their teams. Therefore, this work provides initial support for the current expansion of the SA training to different professional groups. This support is especially relevant as the SA framework resonates with national health initiatives (eg, the Healthy Child Programme) and given its delivery through children’s centres where family support workers are typically employed.

A preliminary questionnaire for evaluating the SA has been introduced, with initial support for the reliability of two of its themes. This measure could be further developed to enhance the evaluation and modification of both the SA training and post-training support.

References


IMPORTANT NOTICE: Breastfeeding is best for babies. Breast milk provides babies with the best source of nutrients. Infant formula milk is not a suitable replacement for breast milk.

First Infant Milk

New SMA

Other First Infant Milks

Drop for drop, no other formula comes close.
My Time, My Space (an arts-based group for women with postnatal depression): a project report

**Background**

There is a growing body of research into the short- and long-term implications of postnatal depression for mothers and their children. It is recognised that 10%–15% of women develop postnatal depression (Department of Health (DH), 2010). However, some studies have shown that recognition of postnatal depression is much lower than this and that many women receive no treatment at all (4Children, 2011).

The Healthy Child Programme (DH, 2009) recommends women diagnosed with postnatal depression receive up to eight ‘listening visits’ from the health visiting team; however, there are wide variations in the treatment women diagnosed with postnatal depression receive across the UK, with few areas achieving this standard (4Children, 2011).

Postnatal depression has a negative impact on a woman’s self-esteem, affecting their confidence and increasing social isolation (Royal College of Psychiatrists, 2010). Women with postnatal depression often experience a stigma around diagnosis and may withdraw from social activities, thereby increasing their sense of isolation. In general, the evidence suggests a lack of social support increases the risk of illness and mood disorders when compared with individuals with good support (Kendall-Tackett, 2007). Conversely, good levels of social support have been shown to contribute to a remission in depressive symptoms (Hoffbrand et al, 2001).

Postnatal depression has also been shown to have a negative effect on women’s relationships with their partners, other family members and the new baby (Hoffbrand et al, 2001). This is particularly significant when viewed in the context of the growing body of evidence that suggests spousal support is linked with fewer depressive symptoms and less stress, and these benefits are most significant when the baby is recognised as ‘temperamentally difficult’ (Thorp et al, 2004). Depressed mothers are less sensitively attuned to their infants, less affirming and more negative in describing their infant. These disturbances in mother–infant interaction were predictive of reduced infant cognitive outcomes at 18 months and seven years of age (Swain, 2011). Research also suggests the consequences of having a mother suffering with long-term depression can be serious for infants’ emotional development and social behaviour, which have also been shown to be adversely affected (Field, 2010; Belsky and De Haan, 2011; Hoffbrand et al, 2001). More recent evidence has highlighted that postnatal depression can lead to later problems for the child, including increased depression among children of depressed mothers in adolescence (Murray, 2011).

My Time My Space is an innovative approach to the treatment of postnatal depression, using creativity in a group setting. Post-course evaluations have shown positive outcomes with a reduction in postnatal depression and reduced social isolation.

**Study aim**

The aim of My Time My Space is to reduce postnatal depression by providing a supportive, relaxed and creative environment for women experiencing postnatal depression/anxiety.

**Method**

My Time My Space is delivered as a weekly group session for up to 10 women identified by their health visitor, GP or family support worker. The sessions normally run for about 10 weeks and are co-facilitated by a socially engaged artist, children’s centre family support worker and health visitor. Each discipline contributes skills from their individual area of expertise, which complement each other. Each session is two hours long and a sponsored crèche is available to allow women to focus on themselves and
provide a break from childcare. During the session the artist leads a creative activity and the health visitor and family support worker take part in the experience ‘alongside’ the participants. The health visitor is available throughout the session to offer guidance and support on parenting, motherhood and any other issues that may arise. The session is designed to be informal with a conversational style, which enables women to contribute as much as they feel able. A professionally-run créche is provided, which is sensitive to the needs of mother and infant. Parents value this as it facilitates their attendance and is vital to offering the time and space to allow growth and develop confidence by and in both parties.

The artist works alongside the mothers using an expanded repertoire of artistic methods and materials, including paint, fabrics, collage, jewellery, silk painting and sculpting materials. The aim is to support the mothers to engage in the artistic activity and to allow them time and space for personal and social reflection, development and progression. The artist’s role is to introduce artistic techniques, to teach new skills and to build confidence.

The emphasis is on the process rather than prescribed end products, where the women can feel proud of what they have created and the skills they have learnt and developed. Once the course is running, many participants choose to create items for their baby. A good artist facilitator is crucial to the success of the project.

The health visitor is available throughout the session to offer guidance and support on parenting, motherhood and any other issues that may arise. This is mainly provided within the group but may also include some one-to-one discussions if needed. The session is designed to be informal with a conversational style, which enables women to contribute as much as they feel able. The group is not intended to offer counselling or psychological therapy, but rather to offer a ‘safe space’ where women can be supported by other women in a non-judgmental way.

The groups are run in a relaxed and fun atmosphere. There is lots of laughter and the fact that the health visitor takes part alongside the participants is important. During the activity the artist, health visitor and family support worker will endeavour to ensure all mothers feel included in the session and the conversation invariably explores social issues, creative learning processes and artistic production.

The most economically sustainable way to deliver My Time My Space is through collaboration between the children’s centre, health visiting service and charitable sponsorship to cover the cost of the venue, créche, artist and materials. Since the project’s inception it has been funded by numerous successful applications to charities, ranging from the Arts Council to smaller-scale donations from organisations like the Lions Club and local churches. These demonstrate the ‘Building Community Capacity’ element of My Time My Space. This collaborative financing model makes it a cost-effective response for health visiting teams as only two health visiting hours are required each week to support up to 10 mothers with postnatal depression. This is a reduction on the hours required for a ‘listening visit’, which typically requires one health visiting hour per week for each mother.

The results have been collected from participants’ views expressed in post-course evaluation forms with open questions to generate qualitative data over the past two years and a more focused pilot study of eight women, which also included pre- and post-group Edinburgh Postnatal Depression Scale scores (EPDS).

Results
The results of the post-course evaluation forms indicate that My Time My Space is viewed positively by women and postnatal depression is reduced. The pilot study results found a reduction in EPDS scores; the mean pre-group EPDS score was 17.3 and the post-group score was 11.1, which was a mean reduction of 6.2 (n=8). Although these numbers are small, the qualitative results collated since 2004 suggest women felt that attending My Time My Space reduced their depression. This is also evidenced by the attendance figures each week, which have consistently been better than anticipated for this hard-to-reach group. In the pilot study seven out of eight participants attended five or more sessions out of six offered.

Interestingly, one of the participant’s EPDS scores increased from a pre-group score of 8 to a post group score of 14. However, the discussion within the group with this mother revealed how she had initially found it too difficult to accept a diagnosis of postnatal depression. She felt a pressure to be a ‘perfect mother’ and would become quite upset if healthcare professionals suggested she might be depressed. Her health visitor used her professional judgement to refer her to My Time My Space as she was becoming increasingly anxious, low in mood and socially isolated. During the sessions this mother expressed how she enjoyed the opportunity to ‘be real’ that the group provided. Her post-group score reflects a more accurate assessment of her mood, which she reported had improved during her attendance at My Time My Space.

The qualitative findings from the post-course evaluation forms from this pilot project, as well as other projects run in the south-west area of England can be grouped into emerging themes.

When asked ‘What part of My Time My Space did you find most helpful?’

Social support
Many participants described how postnatal depression had made social integration difficult and they valued the opportunity to get out of the house and meet people. They described how they had made new friends and this had a positive effect on their mood.

‘I wouldn’t have gone to any other groups. I’ve made new friends.’

‘Making me motivated to come out of the house and meet people.’

Within this theme some participants also described an additional dimension of social support that came from being with other women who had postnatal depression and were experiencing similar issues:

‘There are people who are similar to you to listen, to express, I feel more relaxed, secure and supported.’

‘What I like about the group is that we are all here for similar reasons so I feel I am not going to be judged. I can relate and chat to people, it’s more relaxed.’

Participants’ perception of improved mental wellbeing
Participants described how they felt their mental wellbeing had improved as a result of attending My Time My Space. This is best illustrated in the following quotes:

‘I go to psychotherapy and I don’t say a word, but in nine weeks of My Time My Space...’
I’ve said more than in 18 months of psychotherapy:  
‘I was having panic attacks and I wouldn’t leave the house. I have enjoyed it so much each time. All these people have come to be friends. It’s helped me to understand how I feel.’  
‘I self-harm a lot and haven’t for a long time. I just pick up a pen and book now.’  
‘My husband said it helped me come out of myself and build me up.’

‘Having (HV) and (family support worker) around helped me keep perspective.’

Participants described how they felt more confident in their abilities to parent their children. This confidence was derived from time away from their child to reflect on their issues, a more realistic perception of ‘good enough’ parenting and an opportunity to focus on their own needs.

‘Everybody in our family benefits from My Time My Space. From it the boys are happier because when they were younger I was sad. Now my confidence is pretty sky high and I am a much stronger person.’

‘I’ll enjoy my time with my child now rather than worrying all the time if I’m a good enough mum.’

‘Spending a bit of time away from my baby, albeit a short time, makes me a better mum.’

The benefits of creativity

Participants described how they enjoyed the opportunity to spend time engaging in the arts-based activity and being creative, which resulted in pleasing end products:

‘The art work was great, I haven’t been creative since school, so I really enjoyed being able to create some cool stuff for the kids.’

‘Being able to use my hands again, there’s just no time to be creative with a baby.’

‘I was worried I had to be arty, but it wasn’t like that at all, I found I could just be myself.’

‘For me it has been an inspiration, a journey of re-discovery.’ The group was led at a pace that was great for everyone. Everything was quite free and easy so that I never felt rushed or stressed and yet well organised so that I was never bored or confused.’

Their success at art within the group inspired some women to reengage in the workplace:

‘I would definitely recommend this group to anyone and I know that everyone whom I attended with would say the same thing. Now that the group is finished I feel much happier, contended and confident. As a direct result of the group I managed to even secure a job in design and I feel so much more relaxed and at ease.’

When asked ‘How could My Time My Space be improved?’ most participants left this blank or wrote something like ‘It’s great the way it is’. Some participants asked if the group could be longer than 10 weeks and this is being addressed in some areas by providing a follow-on group called ‘Out of the Blue’. In other areas the participants are encouraged to collectively join an existing children’s centre mother and baby group, and the transition appears to be easier when supported by the other participants.

Limitations

The findings reported in this paper are a collation of post-group evaluation forms and a small pilot study using pre- and post-Edinburgh Postnatal Depression Scores, in addition to the qualitative evaluation forms. The findings suggest My Time My Space has a positive effect on women’s mood and perceived social support. More rigorous research based on quantitative and qualitative scientific enquiry is needed to substantiate these initial findings. As health visiting research is beginning to focus more on evidence-based outcomes of intervention, it would also be useful to explore the effects of My Time My Space on mother–infant attachment, parenting capacity and the long-term benefits of My Time My Space using a longitudinal method.

Discussion/conclusion

The collated results from post-course evaluations suggest My Time My Space is an effective alternative or additional method of treatment for postnatal depression. This is probably most clearly evidenced using a short case study of a recent participant (Mother A) at My Time My Space.

Case study

Mother A arrived at the first session and had a panic attack. Her EPDS score was 27, which suggests she had severe postnatal depression. Everything inside her was telling her to get out and go home. The health visitor allowed Mother A time and space to talk about how she felt and encouraged her by saying that she was really encouraged by the fact that she had got in her car and driven down to the centre, which must have taken a lot of courage. She suggested although there was a large part of her that wanted to leave, it was her feeling there was a small part of her that really wanted to stay. She suggested that she just sit on the sofa and have a coffee with no pressure to participate (the sessions were generally well nourished with homemade cakes, pots of tea and cafetieres of fresh coffee). Gradually, other participants came over and started to chat in a non-judgemental way and Mother A started to relax and stay for the duration of the first session. The health visitor liaised with Mother A’s GP who was happy for her to continue attending the group. Mother A attended the group every week and never missed a session, and on her evaluation she wrote how helpful she had found it:

‘I have made friends and it has helped me through some of my darkest moments. I will miss it’ [she drew a sad face].

This provides a poignant illustration of the effects of postnatal depression for this mother. Her EPDS score had dropped from 27 to 19, but her comments told us so much more about the benefits of My Time My Space. A health visitor described My Time My Space as ‘truly transformative. This is a multi-faceted approach that meets the needs of women socially, creatively and psychologically’.

This multi-faceted approach is echoed by a mother who wrote:

‘There is a supportive artist who inspires you, there’s a health visitor to support you and there are people who are similar to you to listen, to express. And there’s time. But all of it added up together becomes more than that. A lot more than that.’
The findings are based on an approach that has been piloted and developed since 2004 as a highly successful model of collaborative working between Creativity Works – a creative community development charity, health visiting and children’s centres in the south west of England. The team are continually reflecting on their model of provision and are also in the embryonic stage of developing an ‘Our Time Our Space’ group for women and babies using creativity to improve maternal attachment and early communication.

Sharing expertise
If you are interested in developing a My Time My Space group in your area please contact Creativity Works, which specialises in supporting the delivery of creative projects within communities. As a charitable organisation, it can provide resources, training events and is happy to chat to you by phone. It can help train an artist you may already have in mind or recruit the right artist. Contact: www.creativityworksforeveryone.co.uk Tel: 01761 458852.

Acknowledgements
The authors would like to thank all the women who have participated in My Time My Space since 2004. We would also like to thank all the artists, children’s centre teams and health visitors who have developed this approach. In particular, we would like to acknowledge Janet Weeks, Health Visitor (retired) who was the originator of the My Time My Space model with Creativity Works and Heidi Limbert, Children’s Centre Manager B&NES and Health Visitor, who has helped to develop the model with Creativity Works since 2004.

References

Key points
- Postnatal depression affects 10%–15% of women having a baby; however, many receive no treatment
- My Time My Space is an arts-based group for women with postnatal depression that aims to improve mood by reducing social isolation and using creativity to improve self-esteem
- The qualitative findings suggest My Time My Space has a positive effect on women’s feelings of mental wellbeing, perceived social support and perceived parenting capacity. Participants also described benefits of creativity
- The findings from a small quantitative pilot study within this paper are limited by the sample size; however, they suggest My Time My Space contributed to a reduction in depression using the Edinburgh Postnatal Depression Scale

Read the article in full and answer the multiple choice questions at the end. Once you are happy with your answers, you have the option to print out your certificate as proof that you have read and reflected on the article.

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Can infant formula innovation help digestion in formula fed infants?

The first few months of an infant’s life can be a stressful time for their bodies as they adapt to digesting a range of nutrients and they will often experience mild gastrointestinal (GI) disturbances.1

In fact, 55% of babies will suffer with symptoms such as mild constipation, colic, and wind in the first 6 months of life.1

New parents need support from healthcare professionals (HCPs) and those using formula to feed their infants may be seeking alternative infant formula solutions.

Modifying standard infant formula to help digestion

Adaptations can be made to standard first infant formula to respond to these challenges in a variety of ways.

**Partially hydrolysed whey protein**

Breast milk provides a very fast gastric emptying time that reduces the risk of digestive disturbances. A similar pattern can be obtained using formula containing partially hydrolysed whey proteins.2

If whey protein is partially hydrolysed it will form smaller peptides.

These smaller protein peptides are more manageable than larger protein molecules for a baby’s immature GI system, making the formula easier to digest.2

**Reduced lactose**

In the immediate weeks after birth a young baby’s body is often unable to efficiently digest lactose, and this can cause discomfort due to wind.1 The symptoms of colic - fractious behaviour, crying and wind - can be difficult for baby and their parents.

Reducing the levels of lactose is one potential strategy to help reduce the amount of wind babies produce. For some colicky babies, decreasing the concentration of lactose in formula has been found to result in a reduction in crying and wind.2

**SN-2 enriched fat blend**

An SN-2 enriched fat blend structurally resembles that found in breast milk and is well absorbed by infants.4

As the fats are more easily absorbed, formula using an SN-2 enriched fat blend is proven to reduce soap formation in stools and help make stools softer.5

A recent study has also found that infants fed formula with an SN-2 enriched fat blend spent significantly less time crying than babies whose formula did not contain the same fat blend.6

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

ZCO1335/10/12

Eating a rainbow – improving liking and intake of vegetables from weaning

Beckie Lang PhD on behalf of the VIVA organising committee

The importance of vegetables in the diet
Vegetables are the most varied of the food groups, important providers of antioxidant and anti-inflammatory phytochemicals, vitamins and minerals. High vegetable intakes are associated with lower cancer, stroke and cardiovascular disease risk, lower Body Mass Indices and the potential to prevent neurodegenerative disease. They form a key component to healthy eating and help to lower the energy density of the diet. Yet national survey data highlight low intakes in UK children and school-based interventions to increase fruit and vegetable intakes produce modest effects, increasing consumption by only a quarter of a portion per day. It would seem, therefore, that infancy may be an important time for an early introduction to vegetables with the dramatic transition to the family diet providing an important window of opportunity to establish good habits that can last a lifetime.

The discovery of a palate
Flavour exposure begins in the womb, with maternal diet influencing the taste of amniotic fluid consumed by the foetus, and this flavour transmission continues if the mother breast feeds. Infants are predisposed to like sweet tastes in preparation for their initial milk diet, while bitter, sour flavours are initially rejected. This poses a challenge for the introduction of many vegetables which tend to be bitter e.g. cruciferous vegetables, which is confounded by the natural neophobic tendencies which peak at age two years.

Improving liking and acceptance of vegetables
A study by Sullivan and Birch demonstrated that repeatedly giving the same vegetable over ten occasions increased liking in infants. Liking was further heightened in those infants that had been breast fed and the authors concluded that this was as a result of exposure initially through mother’s milk. Indeed, this was confirmed by Mennella et al in their experiments looking at carrot liking and acceptance in infants following the introduction of carrot juice during pregnancy and lactation compared with infants receiving no exposure during this time. A dose response effect

was found with intakes higher in those exposed from pregnancy. However, repeated exposure can increase acceptance regardless of whether the infant is breast or formula fed, suggesting that the initial benefit of flavour introduction through breast milk may be matched by experience even in formula fed infants (see Hausner). Very recent work by Hetherington et al has also explored the introduction of new flavours to infants via milk within the weaning period. Intervention infants were exposed to twelve daily exposures of four vegetables (one per day) via puree added to their usual milk, followed by twelve daily exposures to the puree added to cereal. The control groups received their usual milk and cereal. Both groups then received eleven daily exposures of vegetable puree followed by the introduction of a novel vegetable puree on day twelve. Intake and liking of vegetables was higher in the intervention group. The authors concluded that introduction to vegetables in a gradual step-by-step approach may be helpful in increasing liking and acceptance of vegetables, particularly those with bitter flavours. Repeated exposure facilitates familiarity with a food and variety is valuable in enhancing acceptance of a new food or vegetable. Mennella et al have determined that variety between and within meals can increase liking for new flavours following an eight day exposure experiment. The impact of providing vegetable puree as a single

flavour or as part of varied vegetable flavourings both within and between days was explored. Variety increased liking for new test vegetables at the end of the exposure period and demonstrated that the infants were able to distinguish and recognise flavours used within the experiment. A prospective study of French children (Lange et al Submitted) revealed that the acceptance of new foods, especially new vegetables and fruits, is positively predicted by the variety of foods provided during the first two months of weaning. Importantly, French children tested for their response to food variety between the ages of 2–3 years and again at aged 22 years demonstrated that the more varied their choices at a young age predicted how varied their choices were in adulthood, suggesting that early introductions can influence later choices. These findings suggest that a combination of variety and repetition should be recommended at the start of complementary feeding. This is further supported by Barens et al who studied starting complementary feeding with vegetables versus fruit, with both groups receiving variety and repetition. Starting complementary feeding with a variety and repetition of vegetables resulted in higher vegetable intake than the group that started with fruit, immediately after the intervention and at the age of 12 months. Other studies have also shown increased intake of vegetables after starting complementary feeding with a variety and repetition of vegetables. The early weaning period therefore looks to be an important window of opportunity to increase liking and acceptance. Attempts to increase liking of vegetables later on, e.g. the pre-school age seem much more difficult.

Parental strategies at weaning
In addition to starting complementary feeding with variety and repetition of vegetables, the approach of mothers presenting a new flavour may also be important. If mothers do not like the food being offered, this dislike may be demonstrated in her style of feeding. Indeed, role modelling of parents to promote vegetable consumption and healthy eating generally has been recommended as a method to ensure ongoing acceptance of healthy food habits. Interestingly, attitudes and official advice to introducing complementary foods differ across countries. French mothers approach weaning...
as a taste journey, appreciating that this period of introducing the infant to the family diet is a learning process and a critical milestone for development. Discovering tastes and gaining pleasure from food was their primary concern when interviewed. They were also conscious that later rejection of foods like vegetables is likely as children get older but were aware of strategies to try and reduce this, such as repeated exposure and combining with familiar foods. In contrast, British mothers tended to mention healthy eating and a balanced diet as important outcomes of weaning not taste development, yet variety of vegetables at this time was relatively low and introduced by stealth. This would suggest that British mothers understand the ‘what’ to try and introduce during complementary feeding, but may need some guidance on ‘how’ best to introduce vegetables for optimal intakes.

Other strategies to increase vegetable intakes

In addition to repeated exposure, variety and role modelling, other strategies used by parents to increase vegetable intakes have been tested for their efficacy. These include the introduction of a novel vegetable flavour with a flavour or food already liked by the infant (flavour-flavour learning FFL) or through its introduction as part of an energy rich combination (flavour-nutrient learning FNL). Comparisons have been made between mere exposure, FFL and FNL to determine the most effective method for increasing liking and acceptance for vegetables over a period of ten exposures. Studies across infancy and the pre-school years have shown that repeated exposure to the vegetable appears to be most effective at increasing vegetable intake compared with FFL and FNL, but pairing of a flavour with a sweet flavour or added energy does not greatly benefit intake. Increasing vegetable consumption in infancy through repeated exposure, variety and modelling are clearly methods for promotion to parents to aid increased liking and intakes of vegetables from an early age. Familiarisation of flavours throughout pregnancy and subsequent breastfeeding are valuable first tastes, but variety and repeated exposure during weaning seem more powerful and are methods that enhance an infant’s likelihood of consuming vegetables even if earlier exposure via breast milk has been limited. Parents need support in recognising that initial dislike is not predictive of refusal and that perseverance is a critical element of acceptability.

Acknowledgements

This article is based on outputs from the international congress VIVA (http://www.vivacongress2013.co.uk), for which national and international experts in the field of infant feeding convened in St Andrews in March 2013 to discuss the collective evidence on not only what to feed from early childhood, but how to feed infants to provide the optimum environment for healthy eating habits into childhood and beyond. The congress was part of project VIVA, a collaboration between the Universities of St Andrews, Leeds and Aberdeen and Danone Baby Nutrition, which aims to promote and increase the intake and acceptance of vegetables in children. Project VIVA is part of a large EU funded research programme which supports the inter-disciplinary collaborations of academia and industry. Participants of the congress shared scientific evidence and discussed practical strategies for supporting parents in the promotion of vegetables as part of a varied and healthy diet. This work was funded by an EU FP7 MarieCurie Mobility Programme Industry-Academia Partnerships Pathways (IAPP 230637; RON0786).

References

The role of the Unite Health Sector Representative

You have been asked if you want to become a Unite ‘rep’, but you don’t really know much about it. Well, this is where you start...

With all the change happening across the health arena it’s important that Unite Health Sector members get involved and actively support each other. Having a union representative or ‘rep’ for your group is the best way of improving conditions at work for members – and ultimately patient care.

Unite organises health sector members in their region according to:
- Who they work for (employing organisation)
- Where they work (site, department, clinic or team)
- The job role they do (staff occupational and professional group).

Reps are the first port of call if members have individual or collective issues at work. It makes sense to have a rep for each team or department, clinic or staff group – someone who really understands what you face. Where there is no rep it’s vital to identify one or find someone who is willing to act as a contact.

Unite is proud of its active health sector reps who are well respected by staff and management. With training and experience reps can develop excellent interpersonal skills and become real leaders at work.

Why does your team need a rep?
You and your colleagues should be involved in change rather than letting it happen to you – and a group working together is much stronger than individuals. Do you have any colleagues who aren’t members of a union? If so, ask them to join – it’s easier when everyone is involved.

A well organised workplace has a good structure with trained reps, active members, officer support and beneficial working relationships (at work and in the community). As a result members feel they have a voice.

Reps are ideally placed to understand things that affect their workplace or team and the roles they carry out. Unite calls these ‘industrial’ and ‘professional’ issues, which sometimes overlap because members are affected by changes where they work and because of what they do.

An individual rep’s role depends on the ‘culture’ of their workplace – where it is, (urban or rural, the workforce or the local community), relationships between managers and staff, and the types of job that people do, as well as what is happening nationally or locally to their services.

As a health sector rep you may be responsible solely for your own team or for your whole department. This depends on where you work, the number of members and whether there are any other reps. More experienced reps may cover different parts of their organisation and help tackle major issues that affect all staff. Reps or contacts should feel comfortable about how much they take on.

A rep’s team working together across the organisation means that union work is shared, so each person has less to do, which might please their manager!

Unite regional and professional officers and local admin teams are there to support reps. You’ll also have opportunities to get involved in regional or national networks of Unite reps to share information, learn from each other and tackle issues affecting you and the health service.

What will I have to do?
Active reps don’t only represent members, they also get involved in organising and campaigning around health issues, promoting Unite and encouraging non-members to join (recruitment). Many members tell us that they joined Unite because of our credible, well trained reps and the support they give.

Unite trains reps according to their talents and preferences. Becoming a rep doesn’t mean being all things to all members, nor is it doing things for people – you’ll help and support members to do things together or for themselves.

Reps can be known as locally accredited reps (LARs) or stewards and, occasionally, convenors or seconded reps depending on what they do and where they work.
Types of rep

- **Workplace reps** are trained to look after day-to-day situations at work, such as staff and management issues and relationships, grievances or other policy-related matters. They communicate effectively with members, managers, other Unite reps, reps from other health trade unions and with contacts at their Unite regional office.

- **Health and safety reps** ensure the workplace is safe and secure for staff, patients and the public. They often sit on their organisation’s health and safety committee. The training is quite technical and, with experience, reps can develop their leadership, negotiation and communication skills.

- **Learning reps** (union learning reps or ULRs) support members with lifelong learning at different levels: continuing personal and professional development (CPD) or language, literacy and numeracy (key or functional skills). They are trained to signpost members towards personal learning opportunities and work with the organisation to promote vocational and professional training and education. Each staff group has different requirements for practice so learning reps can provide valuable support to their colleagues.

All rep roles have statutory time off and facilities to carry out union duties and training.

Other ways to support members

Although the following examples are not formally recognised in statute, some employers, Unite and the TUC (Trades Union Congress) encourage union members to get involved in a wider range of activity at work.

- **Professional reps/advocates** support the role-related interests of members, focusing on professional development and advancing clinical practice. Unite’s health sector team includes experienced professional officers who help reps deal with professional and regulatory body issues.

- **Equality reps** ensure fairness and dignity for colleagues at work and may sit on their organisation’s equality committee. Some specialise in women’s rights, gay, lesbian and transgender, disability, age, black, Asian and ethnic minority issues. Unite has a dedicated Equalities team to support these reps.

- **Green reps**’ passions lie in global issues, such as the environment, or individual and corporate social responsibility.

Where will I find the time?

In the NHS Unite reps are given statutory (by law) paid time off and facilities to carry out their duties on behalf of the members they represent, as well as time for their own training. Wise employers welcome the contribution trained reps can make to their organisation. If you can give your manager enough notice, together you can plan and adjust work around your union duties, meetings, and training. Health service managers should try to ‘backfill’ a rep’s time spent on union work or adjust their caseload. Don’t forget, it’s the employer’s responsibility to manage people and the service.

**Could it affect my career prospects?**

It may well enhance them! Unite reps are sometimes promoted because of their knowledge, involvement, professionalism and credibility within their organisation. Whatever role you prefer, eventually you could support members and work with colleagues at all levels of the organisation. Remember, it is unlawful for employers to discriminate against trade union representatives.

**How do I get started?**

Talk to your regional officer or another Unite rep (see Further information). Your colleagues who are Unite members will need to elect you (agree to you becoming their representative) and you’ll receive an ‘official’ card from Unite identifying you as one of our reps.

We’ll write and tell your employer that you’ve become a Unite rep and ask them to give you paid time off to attend your first-stage training course. You can choose training that suits you and your work or family commitments. We also offer specific training for health sector reps. Unite will pay for your travel and out-of-pocket expenses.

Later on you may want to take more advanced courses; for example, employment law, equalities, IT, health sector campaigning, pensions or negotiating skills. Unite also runs weekend schools on a variety of subjects and interests.

**Regional reps’ health training days ensure you’ll keep up-to-date on issues and you’ll have the chance to network with other reps.**

We’d be delighted to welcome you on board as a health sector rep or contact – so what’s stopping you?

**Further information**

For a list of Unite regions and contact details in your area please visit: www.unitetheunion.org/regions

Reps’ education programmes can be found at: www.unitetheunion.org/education

For further information about becoming a rep, including a detailed handbook, see: www.unitetheunion.org/health

For more information on time off and facilities for trade union duties and activities, see the ACAS Code of Practice and guides at: www.acas.org.uk/index.aspx?articleid=2391
Identifying victims of human trafficking

Human trafficking has a huge impact on the health of victims, but what are the referral and support mechanisms in place for practitioners? Dawn Eccleston looks at the signs of trafficking and the consequences for victims.

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In March 2007 the UK government signed the Council of Europe Convention on Action Against Trafficking, declaring itself committed to providing minimum standards for the protection of victims. The UK ratified the Convention on 17 December 2008 and it came into force on 1 April 2009. Despite this, many of those working within the ‘caring professions’ are still ignorant about the signs and the consequences of the trade in human beings.

Currently, it is estimated between 27 and 29 million people are being trafficked from 127 countries to 137 countries. In 2008, the International Labour Organisation (ILO, 2008) estimated the international trade in human beings generated US$32 billion. In the UK, there is little recognition of the scale of the problem and research is difficult to carry out due to the sensitivity of the issues involved. The UK Human Trafficking Centre (UKHTC) is at the forefront of research in Britain and, in 2009, it identified 527 cases of potential victims of trafficking. These were victims that had been referred to the National Referral Mechanism (NRM) part of the Serious Organised Crime Agency. By the beginning of 2010 this number had risen to 557, but this number is thought to be the tip of the iceberg.

What is human trafficking?
The accepted definition of human trafficking is provided by the United Nations (UN):

‘The recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs.’ (UN, 2000)

Types of trafficking
People may be trafficked between areas within a country, or between countries. There are many types of exploitation, as defined in the UN Palermo Protocol (2000), with victims often being subject to multiple types of abuse. In the UK, the most common reasons for trafficking are sexual exploitation, forced labour, domestic servitude and, increasingly, criminal activity (Hope for Justice, 2012). According to some estimates, approximately 80% of trafficking involves sexual exploitation and 19% involves labour exploitation (Do Something, 2013).

Sexual exploitation may involve ‘grooming’, as in the recent cases in Rochdale (Rochdale Safeguarding Board, 2012), and involvement in pornography, ritual abuse and prostitution. Children as young as three are reported to be trafficked into the UK for the purposes of sexual exploitation (ECPAT UK, 2007). During 2003, there were an estimated 4,000 victims of trafficking for prostitution in the UK at any given time (House of Commons, 2006).

Forced labour includes ‘debt bondage’, where a person is forced to work to pay off a debt or loan. Loans are never paid off due to ‘extra’ charges and extremely low pay. Forced labour often occurs in the hospitality industry, agriculture, food packaging and construction (Hope for Justice, 2011). It is often difficult to detect. However, the ILO (2004) has produced specific guidance on what constitutes forced labour. Victims are often subject to threat or actual physical harm, restriction of movement or actual confinement, removal of passports and identity documents by the traffickers and threat of exposure to the authorities as an illegal immigrant.

Domestic servitude differs from forced labour in that a victim will be confined in a person’s home with no space of their own and often with no bed. Many victims are expected to work most hours of the day without pay (Hope for Justice, 2011). Physical force may not be used but there may be psychological coercion to exert control. Victims may be deprived of essential needs and be subject to humiliation, insults and threatening behaviour.

In forced labour and domestic servitude, victims may be forced to pay high rents for accommodation. Accommodation may have been promised along with employment so victims may be frightened if they lose their employment they will also lose their accommodation.

Criminal activity includes cannabis cultivation, benefit fraud and forced begging. Reports show ‘high numbers of children, largely from South East Asia, are trafficked into the UK to work in cannabis farms’ (ECPAT UK, 2012). They are kept confined and subjected to violence, physical and emotional abuse and hazardous working conditions, such as dangerous fumes and constant heat and light. Figures from the
that practitioners can look out for. Victims will differ but there are some common indicators. What should they do about it? Each situation is different, and practitioner should be aware of the signs and know what sorts of questions to ask.

Signs and symptoms of trafficking

Dozens of children identified as going missing from local authority care between March 2009 and February 2010 and, of these, 67% were Vietnamese. A number were discovered they may not be seen as victims of trafficking. They are often arrested and charged with drug and/or immigration offences. ECPAT UK report children who have been discovered in cannabis factories ‘are going missing from local authority care while, for example, they are waiting to be age assessed, or when they have been released on bail or from a custodial sentence’ (ECPAT UK, 2012).

In 2010, the Child Exploitation and Online Protection Centre (CEOP) found Vietnamese children comprise the largest number of children going missing from local authority care. Forty-two children were identified as going missing between March 2009 and February 2010 and, of these, 67% were Vietnamese. A number were rediscovered in cannabis factories (CEOP, 2011).

Victims of sex trafficking may experience pelvic pain, STIs and gastrointestinal or dermatological problems. They may undergo unhealthy weight loss and experience extreme fatigue. ‘Juju’ witchcraft is also used by traffickers. In ‘juju’, rituals are used to coerce victims into believing they have a debt of bondage to the trafficker and a demi-god. They are then forced to pay off the debt through working as prostitutes. Police found that at least 28 victims were smuggled in and out of Britain as prostitutes. Police found that at least 28 victims were smuggled in and out of Britain as prostitutes. The traffickers took the adult women to one clinic for STD and HIV services and took the underage girls to a different place. These Latin American traffickers evaded detection of crimes of forced child prostitution and sexual abuse, while managing to repeatedly get their victims tested and treated for STIs.

One sex trafficking survivor, in describing who accompanied her to the clinic, reported the traffickers took the adult women to one clinic for STD and HIV services and took the underage girls to a different place. These Latin American traffickers evaded detection of crimes of forced child prostitution and sexual abuse, while managing to repeatedly get their victims tested and treated for STIs.

Dental problems and have extreme dental decay (Hope For Justice, 2013).

Child victims of sex trafficking may suddenly start going missing or truanting. They may become secretive and have unexplained money and presents. They may start experimenting with drugs and alcohol, and associating with older men. They may start self-harming and have low self-esteem and/or eating disorders (Blackburn with Darwen Children’s Services, 2013).

A report by Baldwin et al (2013) found survivors of sex trafficking in the US had undergone brutal experiences: ‘Sex trafficking survivors reported visiting traditional healers, known as curanderas. One participant said, “They used to take us to people who used to… do cleansing, like witches, like curanderas. They used to take us maybe twice a week, or sometimes daily, when they said that we were not getting enough clients”’.

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Dr Hermione Harris, an anthropologist and African ‘juju’ ritual expert at the London University School of Oriental and African Studies, says the influence of such longstanding traditions is powerful and inspires a great deal of fear.
The traffickers want to have some of the young women’s blood as it contains the essence of the spirit; if you have the blood it means you have control. This goes deep into their consciousness, especially if accompanied by a ritual where the priest is dressed in a terrifying way for dramatic effect. The women are so frightened by this. They think if they speak about it something dreadful will happen to them. (VOR, 2013)

This poses great challenges for health professionals. Victims are hidden and terrified. They suffer terrible physical and psychological abuse.

As well as health issues surrounding sex trafficking, there are also issues when people are victims of other forms of trafficking, such as forced labour, domestic servitude and criminal activity. Victims often work long hours in dangerous conditions, where there is no ‘health and safety’. They may be lifting very heavy weights and be subject to beatings and other physical abuse. This can result in headaches, broken bones, extreme fatigue, dizziness and other physical problems.

Victims may be forced to spend long hours begging in cold, wet conditions, under constant threat of physical abuse and injury. These conditions often result in infections, particularly chest infections. There may be unusual noises from a property, windows particularly chest infections. There may be constant threat of physical abuse and injury. This can result in headaches, broken bones, extreme fatigue, dizziness and other physical problems.

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When and how to refer

The National Referral Mechanism (NRM) uses the concept of ‘competent authorities’ (Anti-Trafficking Monitoring Group (ATMG), 2010). These authorities have the power to aid people who are presumed to have been trafficked. Currently, the UK Border Agency (UKBA) (soon to be replaced by a new organisation as the government announced in March) and the UK Human Trafficking Centre (UKHTC) make the decisions as to whether a person has actually been trafficked and whether to give that person a ‘reflection’ period of up to 45 days. This reflection period gives victims a chance to think about whether they will co-operate with a police investigation and to start to recover from their ordeal. These agencies are not specialised support services, they just decide on whether the person has been trafficked.

The NRM has various groups called ‘first responders.’ These consist of frontline agencies and statutory bodies that come into direct contact with people who may have been trafficked. These groups can refer to the NRM. They include police, local authorities, Crown Prosecution Service, the NHS and designated non-government organisations, such as the NSPCC, Barnardo’s and the Salvation Army, which holds the UK contract for after care of victims and is a key source of information and it produces a useful resource pack.

Generally, first responders refer to the UKHTC who, then, refer to the NRM if an individual’s immigration status is questionable (ATMG, 2010).

An excellent tool for identification of victims is the London Safeguarding Trafficked Children Toolkit (London Safeguarding Children Board, 2011). This toolkit is supplementary guidance to Working Together to Safeguard Children (DH, 2013) and is aimed at child trafficking, although it can be adapted to explore issues of adult trafficking. It includes an extremely useful matrix to aid practitioners in the identification of trafficking.

Conclusion

There is a general acceptance that ‘safeguarding is everyone’s business’. Trafficking is an issue which, as well as being a UK problem, spans the globe. Sillen and Beddoe point out that it is accepted that the development of counter-trafficking policy and procedures is, in the main, still in its infancy in the UK. If health workers are going to be effective in safeguarding these people, whether young or old, there is a need for recognition and action, with resulting policies and procedures. As health practitioners it is up to each individual to know how to recognise the signs and to act on them for the best possible outcomes for clients and families.

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ATMG. (2011) All Change: Preventing Trafficking in the UK. London: ATMG.


Proceduresonline.com/pdfs/BwD_Sex_Exp_Strat_ Engage.pdf


Evidence-based portion sizes for children aged 1–4 years

Judy More
Paediatric Dietitian
Infant & Toddler Forum Member

Abstract
Existing guidelines on how to feed preschool children have left parents and carers unsure about how to offer a diet that will provide their young children with adequate nutrition but prevent excess weight gain. The consequences of malnutrition, such as iron deficiency anaemia and obesity, remain prevalent in this age group and giving parents more specific guidance will help address this. The evidence-based portion sizes from the Infant & Toddler Forum for 1–4-year-old children have been calculated to meet, but not exceed, their energy requirements and provide all their nutrients, with the exception of vitamin D for which they need a daily supplement. These portion size ranges can be used as serving guides by parents, carers and staff in early years settings. Their use will both reassure parents who worry about how to offer a diet that will provide their toddlers (Bazalgette, 2012).

What are current healthy eating guidelines for toddlers based on?
A balanced diet for children in this age group must provide adequate energy and nutrients to support growth, health and development. However, accessible healthy eating guidelines for this age group have always been rather vague. Government guidance is limited to advice on how to move from the largely milk-based diet of infancy to healthy eating guidelines defined in the Eatwell Plate (Food Standards Agency, 2007) by around five years of age. In between infancy and five years of age is just defined as a transition phase and further qualified by the following recommendations:
- Toddler diets should be higher in fat and lower in fibre than healthy eating guidelines for adults and older children
- Reduced-fat milks should not be used for milk drinks before at least two years of age (Department of Health, 1994).

Food safety
Food safety advice for the under-fives has been specified by the Food Standards Agency:
- No large fish such as shark, swordfish and marlin because of the risk of high levels of mercury (NHS, 2011a)
- Limit oily fish to two servings per week for girls and four servings per week for boys to reduce the risk of high levels of pollutants that can be found in oily fish (NHS, 2011a)
- No whole nuts as they may be inhaled or cause choking (NHS, 2011b).

Salt
A guideline on salt intake for different age groups was introduced by the Scientific Advisory Committee on Nutrition (SACN) and the Food Standards Agency in 2003. The aim of low salt recommendations in young children is primarily to avoid taste preferences for only salty foods developing in children. Nutritious foods preserved with salt, such as cheese and bread, are acceptable when offered alongside a variety of low-salt foods, such as vegetables and fruit and fresh meats and fish.

Children will develop a preference for salty foods if they are only offered processed foods with a high salt content. The salt content of pre-packaged foods can be found on the label. The report advised aiming for a population average daily sodium intake in children 1–3 years of 0.8g sodium (or 2g salt) and 1.2g sodium (or 3g salt) for 4–6 year olds.

This is impossible for parents to calculate on a daily basis for an individual child and is difficult to achieve in menu planning for this age group. Furthermore, these recommendations were not evidence-based as the report states, ‘There are insufficient reliable data on long-term effects of salt on cardiovascular disease outcomes to reach clear conclusions’ (SACN, 2003: 3).

Allergy prevention
Allergy prevention advice was also issued by the Department of Health and the Committee on Toxicity in 1998 restricting the intake of peanuts before the age of three years in children at high risk of atopy (Committee on Toxicity of Chemicals in Food, 1998) but this was subsequently withdrawn in 2009.

Serving frequencies from the five food groups
The Paediatric Group of the British Dietetic Association proposes more specific advice in the 4th edition of their textbook Manual of Dietetic Practice and their consumer leaflet ‘Food for the growing years’ by specifying the number of servings of food from each of the food groups for all children from one year of age (see Table 1).
Table 1. Food groups and serving frequencies defined by the Paediatric Group of the British Dietetic Association (Thomas and Bishop, 2007)

<table>
<thead>
<tr>
<th>Food group</th>
<th>Foods included</th>
<th>Main nutrients supplied</th>
<th>Recommendations Toddlers and preschoolers 1–4 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Starchy foods: bread, rice potatoes, pasta other starchy foods</td>
<td>Bread, chapatti, breakfast cereals, rice, couscous, pasta, millet, potatoes, yam, and foods made with flour, such as pizza bases, buns, pancakes</td>
<td>Carbohydrate B vitamins Fibre Some iron, zinc and calcium</td>
<td>Serve at each meal and some snacks</td>
</tr>
<tr>
<td>2. Fruit and vegetables</td>
<td>Fresh, frozen, tinned and dried fruits and vegetables</td>
<td>Vitamin C Phytochemicals Fibre Carotenes</td>
<td>Offer at each meal and some snacks – about 5 small servings a day</td>
</tr>
<tr>
<td>3. Milk, cheese and yoghurt</td>
<td>Cow’s milk, goat’s milk, yoghurts, cheese, milk puddings, toddler milks, calcium-enriched soya milks, tofu</td>
<td>Calcium Protein Iodine Riboflavin</td>
<td>3 servings a day 1 serving is: – 120ml milk drink – 1 pot of yoghurt (120g) – A serving of cheese in a sandwich or on a pizza – A milk-based pudding – A serving of tofu</td>
</tr>
<tr>
<td>4. Meat, fish, eggs, nuts and pulses</td>
<td>Meat, fish, eggs, nuts and pulses (lentils, daal, chick peas, hummus, kidney beans and other similar starchy beans)</td>
<td>Iron Protein Zinc Magnesium B vitamins Vitamin A Omega 3 long chain fatty acids: EPA and DHA from oily fish</td>
<td>2 servings a day or 3 for vegetarians Fish should be offered twice per week and oily fish at least once per week</td>
</tr>
<tr>
<td>5. Foods high in fat and/or sugar</td>
<td>Cream, butter, margarines, cooking and salad oils, mayonnaise, chocolate, confectionery, jam, honey, syrup, crisps and other high-fat savoury snacks, biscuits, cakes, fruit juices and sweetened drinks</td>
<td>Some foods provide: – Vitamins E – Omega 3 fatty acids: alpha-linolenic acid</td>
<td>In addition to, but not instead of, the other food groups</td>
</tr>
<tr>
<td>Fluid</td>
<td>Drinks</td>
<td>Water Fluoride in areas with fluoridated tap water</td>
<td>6–8 drinks per day, each of 100–120ml More in hot weather or after extra physical activity</td>
</tr>
</tbody>
</table>

The need for recommendations on portion size

Without more accessible guidance parents and carers have been left to serve toddlers whatever food and portion sizes they have considered suitable. Morbidity directly related to poor nutrition has continued, most notably iron deficiency anaemia (Cowin et al, 2001; Thane et al, 2000), dental caries (NHS, 2007/8) and diarrhoea (Hoekstra, 1998). Overweight and obesity, once infrequently seen in this age group, have increased to a prevalence of around one in four (NHS Information Centre, 2012). Large portion sizes, particularly of energy-dense foods, may well be one of the key contributing factors to obesity in this age group. Adult portion sizes have increased in the UK (Benson, 2009) and one predictor of how much young children eat is how much is put on their plates (Birch et al, 1991; Faith et al, 2004; Galloway et al, 2006).

Evidence-based portion size ranges

To address the need for more specific advice on portion sizes to offer this age group, the Infant & Toddler Forum has supported a project developing evidence-based portion size ranges and recently launched a Factsheet displaying them entitled ‘Portion Sizes for Children 1–4 Years’. A sample of these is shown in Table 2.

Portion size ranges, rather than specific portion sizes, were developed because the quantities that toddlers eat and drink vary widely from day to day and from meal to meal. Toddlers may eat towards the upper end of the range after a busy, active day when they are particularly hungry and towards the lower end of the range when they are less hungry.

The portion size ranges do not require weighing as they are specified in standard household measures of 5ml teaspoons, 15ml tablespoons, small bowls, and millilitres and ounces for drinks. With a little practice, parents and carers will be able to estimate them by eye.

The ranges were developed using the portion sizes of food and drink consumed by the children as reported in two large UK dietary surveys: unpublished data from the Avon Longitudinal Study of Parents and Children (ALSPAC) and published data
from the National Diet and Nutrition Survey (NDNS) (Wriedan, 2008) for 1½–4½ year olds. Both were carried out in the early 1990s when obesity rates in toddlers were much lower than today. The weights of the midpoint of the ranges were taken as an average intake and a variety of foods in each food group were analysed to give an average nutrient and energy content from each of the five food groups. The number of daily servings from each food group according to that recommended by the Paediatric Group of the British Dietetic Association (Table 1) was then combined and the overall average daily energy and nutrient content, with the exception of vitamin D, was shown to meet the recommendations for this age group:

- Estimated Average Requirements (EARs) for energy which have been recalculated recently by SACN using the more accurate method of doubly labelled water (SACN, 2011)
- Reference Nutrient Intakes (RNIs) for protein, vitamins and minerals which were defined for all age groups by the COMA panel in 1991 (DH, 1991).

The RNI for vitamin D is not met but this is expected as it is not provided solely by food. The main source in the UK is sunshine on exposed skin when outside during the summer months April–September. To guarantee under-fives have enough vitamin D, it is recommended to take a daily supplement of 7.5µg is recommended for this age group (DH, 2012, National Institute for Health and Clinical Excellence (NICE), 2008; DH, 1991). Food group 5 (foods high in fat and sugar) has been subdivided into three subgroups to take into account a variable serving frequency within the food group. The first subgroup of puddings and starchy snacks contributes towards micronutrient intakes as well as small amounts of fat and sugar as foods in this subgroup are based on flour, fruit, eggs, milk and nuts eg, apple crumble, scones and teabread. The second subgroup of sauces and spreads are recommended in very small amounts but enhance meals by making them more palatable and enjoyable. The fat spreads are a good source of vitamin A. Both these subgroups are included on a daily basis.

The third subgroup of confectionery and savoury snacks only contribute energy as fat or carbohydrate having insignificant amounts of micronutrients. Under-fives have an innate preference for these low-nutrient, energy-dense, often sweet foods and tend to overeat them when they are offered. By highlighting the very small serving sizes of these foods that should only be offered occasionally – two servings or fewer per week – they will not be providing excess low nutrient energy to toddlers’ diets.

In addition to helping address the high rates of overweight and obesity in this age group, these evidence-based portion size ranges can also be used to reassure parents and carers who worry their young children aren’t eating enough.

Parents and carers will be able to offer a balanced diet using these portion sizes and then allow toddlers to eat to their appetite. When parents or carers are relaxed at mealtimes, the whole family can enjoy a happy, social occasion, rather than a battleground between a reluctant toddler and a coercing parent/carer.

References

Table 2. Small sample of portion size ranges for toddlers from the Infant & Toddler Forum Factsheet ‘Portion Sizes for Children: 1–4 Years’ (Infant & Toddler Forum, 2012)

<table>
<thead>
<tr>
<th>Food group</th>
<th>Foods</th>
<th>Range of portion sizes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Bread, rice, potatoes, pasta and other starchy foods 5 servings per day</td>
<td>Bread</td>
<td>½–1 medium slice</td>
</tr>
<tr>
<td></td>
<td>Mashed potato</td>
<td>1–4 tsp</td>
</tr>
<tr>
<td></td>
<td>Pasta (cooked)</td>
<td>2–5 tsp</td>
</tr>
<tr>
<td></td>
<td>Rice</td>
<td>2–5 tsp</td>
</tr>
<tr>
<td>2. Fruit and vegetables 5 servings per day</td>
<td>Apple</td>
<td>¼–½ medium apple</td>
</tr>
<tr>
<td></td>
<td>Broccoli/cauliflower</td>
<td>1–4 small florets or ¾–2 tbsp</td>
</tr>
<tr>
<td></td>
<td>Clementine/tangerine/ mandarin</td>
<td>¼–½ fruit</td>
</tr>
<tr>
<td></td>
<td>Sweetcorn</td>
<td>¾–2 tbsp</td>
</tr>
<tr>
<td>3. Milk, cheese and yoghurt 3 servings per day</td>
<td>Cow’s milk</td>
<td>100–120mls/3–4oz</td>
</tr>
<tr>
<td></td>
<td>Grated cheese</td>
<td>2–4 tsp</td>
</tr>
<tr>
<td></td>
<td>Yoghurt 125mls</td>
<td>1 average pot-125ml</td>
</tr>
<tr>
<td>4. Meat, fish, eggs, nuts and pulses 2 servings per day or 3 servings per day for vegetarians</td>
<td>Baked beans in tomato sauce</td>
<td>2–4 tbsp</td>
</tr>
<tr>
<td></td>
<td>Chicken drumsticks</td>
<td>¼–½ drumstick</td>
</tr>
<tr>
<td></td>
<td>Liver pâté</td>
<td>1–2 tbsp</td>
</tr>
<tr>
<td></td>
<td>Peanut butter</td>
<td>½–1 tbsp</td>
</tr>
<tr>
<td></td>
<td>Red meat</td>
<td>¼–½ slice roast meat</td>
</tr>
<tr>
<td></td>
<td>Scrambled egg</td>
<td>2–4 tbsp</td>
</tr>
<tr>
<td></td>
<td>Tinned fish</td>
<td>½–1 ½ tsp</td>
</tr>
<tr>
<td>5. Fruits high in fat and sugar Divided into 3 sub groups: – 1 servings per day of puddings and starchy snacks</td>
<td>Fruit crumble (eg, apple or rhubarb)</td>
<td>2–4 tbsp</td>
</tr>
<tr>
<td></td>
<td>Ice cream</td>
<td>2–3 heaped tbsp</td>
</tr>
<tr>
<td></td>
<td>Plain biscuits</td>
<td>1–2 biscuits</td>
</tr>
<tr>
<td></td>
<td>Honey/jam</td>
<td>1 tsp</td>
</tr>
<tr>
<td></td>
<td>Butter/margarine</td>
<td>Thinly spread or 1 tsp</td>
</tr>
<tr>
<td></td>
<td>Oil for cooking</td>
<td>1 tsp</td>
</tr>
<tr>
<td></td>
<td>Crisps</td>
<td>4–6 crisps</td>
</tr>
</tbody>
</table>
CPD questions: please visit www.communitypractitioner.com/CPD to submit your answers

| 1. Why are clear guidelines and portion size ranges important for feeding preschool children? | A. To prevent over eating and a consequent risk of obesity  
B. To reassure parents/carers that picky eaters are eating enough  
C. Both of the above |
|---|---|
| 2. How do young children get a balanced diet? | A. Eating more fruit and vegetables and less fat, sugar and salt  
B. Eating a variety of family foods  
C. Eating a combination of foods from five food groups |
| 3. To guarantee under-fives have enough vitamin D a daily supplement of what quantity is recommended for this age group? | A. 6μg  
B. 7μg  
C. 7.5μg |
| 4. Overweight and obesity, once infrequently seen in this age group, have increased to a prevalence of what? | A. One in two  
B. One in three  
C. One in four |
| 5. How much milk should preschool children be having each day? | A. ½ pint  
B. 1 pint  
C. 3 cups of 100–120ml but each of these can be substituted for a serving of cheese or yoghurt |
| 6. What is an appropriate portion size range of fruit to offer preschool children? | A. ¼–½ apple/orange or 2–4 tablespoons of cooked or tinned fruit or 3–10 berries or small grapes  
B. ½–1 apple/orange or 4–6 tablespoons of cooked or tinned fruit or 10–20 berries or small grapes  
C. 1–2 apple/orange or 5–6 tablespoons of cooked or tinned fruit or 20–30 berries or small grapes |
| 7. What is an appropriate portion size range of vegetables to offer preschool children? | A. ½–2 tablespoons cooked vegetables  
B. 2–4 tablespoons cooked vegetables  
C. 4–6 tablespoons cooked vegetables |
| 8. What is an appropriate portion size range of meat or baked beans to offer preschool children? | A. ½–1 chicken drumstick or 2–4 tablespoons baked beans  
B. ½–1 chicken drumstick or 4–6 tablespoons baked beans  
C. 1–2 chicken drumsticks or 4–6 tablespoons baked beans |
| 9. What is an appropriate portion size range of bread, pasta and potatoes for preschool children? | A. ½–1 slice bread or 1–3 tablespoons cooked pasta or ½–2 tablespoons of mashed potato  
B. ½–1 slice bread or 2–5 tablespoons cooked pasta or 1–4 tablespoons of mashed potato  
C. 1–2 slices bread or 3–6 tablespoons cooked pasta or 4–6 tablespoons of mashed potato |
| 10. What is an appropriate portion size range of crisps to offer preschool children about once a week? | A. 4–6 crisps  
B. ½ small packet  
C. 1 whole small packet |
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Noticeboard

I have been employed in a specialist post as a health visitor for teenage parents in Bristol. The post is developmental and funded for 18 months with the aim of discovering whether having a specialist HV post helps to improve outcomes for young parents and their children. We do not currently have the nurse partnership programme. I would be really grateful to learn about the experiences and models of practice from other health visitors who are working or have worked in this role with young parents.

Please contact: Rosie Dimond, Health Visitor for Teenage Parents
Tel: 07768 632 339
Email: rosie.dimond@nbt.nhs.uk

I am inviting all practice teachers, trainee practice teachers (including those in preceptorship) and qualified mentors involved in the training of SCPHN health visiting students to take part in a research study. The purpose of the study is to gain feedback from practice teachers (including those in training and preceptorship) and qualified mentors to obtain their views on the way the increase in the number of SCPHN health visiting students has been managed in practice, what models are being used, what support has been made available, advantages and disadvantages of long arm mentoring and the quality of current provision.

To participate you can either contact me (julaowen@toppenworld.com) and I will email you the participant information sheet to ensure informed consent and the link to the online survey or, alternatively, the questionnaire can be accessed directly online at: www.commart-survey.co.uk/s/julaothen2013

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