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

August 2013 Volume 86 Number 8 Community Practitioner | 1
Updated guidelines for authors and contributors to Community Practitioner

Although the journal’s new look means that there have been some changes in our guidelines for authors, most of our guidance remains the same.

Articles are considered for publication on the understanding that they are not being offered to any other journal and have not been published or accepted elsewhere.

Manuscripts should be submitted with full author contact details to the editor via email: polly.moffat@tenalps.com and authors should keep a copy of the material they submit.

Presentation and house style
The following information should always be included: title of article, first name and surname of author(s), qualifications, details of position held, number of words in article.

- Where either ‘s’ or ‘z’ can be used, use ‘s’ (eg organisation)
- One to nine should be in words, 10 and over in figures
- Percent should be written as %
- Full stops should not be used to indicate abbreviations: CPHVA, eg, ie, NHS
- Some abbreviations do not need to be explained – eg CPHVA, NHS, NMC – but most should be spelled out in full when first used followed by the abbreviation in brackets (if in doubt, spell it out on its initial use)
- Capitals should not be used for role titles or professions, such as ‘health visitor’ or ‘nursing’.

Article content and length
Articles should be written with our readers in mind – health visitors, school nurses and community nursery nurses, and others working in primary care and community settings.

We welcome the inclusion of relevant figures, tables and images, though original work on paper is submitted at the owner’s risk. Electronic images should be at least 300dpi resolution and in tif, jpg or eps format.

Types of article
Professional and research
Papers should be between 2000 and 3500 words in length (including references), and are subject to double-blind peer review following submission. Papers should begin with an unstructured abstract of 150 to 200 words, and up to five key words or terms that reflect the article’s subject and focus accurately. Research articles should be arranged in the usual order of introduction, background, study aim/purpose, method including confirmation of ethical approval, results, discussion, implications and recommendations, conclusion, acknowledgments and references.

Clinical
Either 1400 or 2100 words in length, these should review clinical management, present case studies etc.

Other features
The content of first-person articles (700 words) and general features (1400 words) should be discussed with the editor prior to submission.

Other contributions
Letters of up to 300 words in length are always welcome, and any readers interested in writing reviews of resources should contact the editor.

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

Author of article. (2010) Name of article. Journal Volume(issue); page numbers.

Potentially competing interests
Authors of professional, research and clinical papers are asked to declare:

- Any support from any organisation for the submitted work other than a funding grant
- Any financial relationships with any organisations that might have an interest in the submitted work during the previous three years
- Any other relationships or activities that could appear to have influenced the submitted work. We are not looking to exclude authors with competing interests, but do want to improve transparency for our readers.

Editing and publication
The editor reserves the customary right to style and shorten material accepted for publication. The editor also reserves the customary right to determine priority and time of publication, though every effort is made to publish without delay. If you have any queries, please do not hesitate to contact the editor.

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A member wasteland?

When you are in the cycle of work, rest and play it is easy to become parochial, and only to see events as they unfold in your own region or country. When we read or see the UK media reporting on an item specific to where we live it often boils down to the colour of a flag being waved or the colloquialism being used rather than anything more insightful or specific. The London-based media are largely anglocentric in their reporting, covering decisions and strategies that are specifically English in their delivery and outcome. Seldom are the policies reported upon in the way they have been interpreted, formulated and packaged in Belfast, Cardiff and Edinburgh. The media analysis from these seats of government is more concerned with paramilitary activity, the depressed valleys and whether my fellow Scots will vote yes or no to independence. Under devolution the management and delivery of health care may be different, with alternative metrics, but the policy makers are largely proposing the same direction of travel with the added commonality that all of us are now suffering, that of a tightening public purse.

‘Integration and Collaboration’, ‘Transforming Your Care’ and ‘Delivering Local Healthcare’ may mean nothing to you as you read this, but to those in Scotland, Northern Ireland and Wales these policy proposals will have far-reaching consequences for our professional practice and relationships.

Community Practitioner and the Unite Professional Officers with responsibility for the devolved administrations offer coverage and opinion on what is occurring elsewhere, but at times it feels that these messages are being beamed to a member wasteland with nothing reflecting back in the form of critical analysis or positive feedback. Are members who live outside England in danger (by their comparative silence) of promoting this lack of awareness of what is going on within their country? Is there is a need for members on the ‘Celtic fringe’ to become more participatory in their journal and in their engagement with professional officers and CPHVA structures? For too long, members in these countries have been silent, reluctant to contribute to their professional debates.

Those who control the story can influence history, but perhaps it is time that CPHVA members took this to heart and participated to ensure that their particular professional voice is heard. Decisions are being made: are you happy to stay silent as politicians and others decide your professional future for you?
Unite/CPHVA members split over support for uniforms

Unite/CPHVA Facebook users are torn over whether health visitors, school nurses and community nursery nurses should wear uniforms.

Of the 761 members asked their views on uniforms for the community nurse workforce, more than 10% responded, with members split almost right down the middle.

Just over half (51%) were against the introduction of a uniform and 49% were supportive of the move.

Cathy Ullah says uniforms ‘make us identifiable as health staff’.

Leanne Loveridge agreed a uniform may be what is needed to improve the public’s knowledge of the role health visitors do.

However, Caroline Moore said it would be ‘sad’ if health visitors feel that they need to wear a uniform to earn a client’s respect.

Indeed, Paula J Price believes uniforms can ‘sometimes create barriers’.

And Karina Meidlinger Dyer said: ‘No thanks, I want the relationship I develop with my families to gain me respect, not a uniform, which can easily create a barrier to partnership working. If people don’t know what we do, then it’s our fault for not communicating effectively.’

‘It does appear that organisations have decided to make these changes without any consultation with families/service users and this undermines the legitimate concerns of some of our members who feel this may have a negative effect,’ he said.

And it seems organisations all over the country are seriously contemplating the move.

Unite Regional Officer, Sarah Carpenter, commented that employers in the south east are ‘talking’ about bringing in a uniform for all staff despite health visitors and community nursery nurses in the area being of the view that relationships between them and families would be made ‘more difficult’ if uniforms were to be introduced.

She said she will be looking to survey member opinion in the south east region on the issue.

Munday also said Unite/CPHVA is in talks with Netmums to carry out a survey with parents to gather their thoughts on uniforms.

‘Any area considering these sorts of moves should investigate whether it would have any adverse effect on health visitor, school nurse or community nursery nurse relationships with the family,’ he said.

Unite slams school’s ‘lame excuse’ over refusal to serve school dinner

Unite has said a news report that a child was refused a school meal on the grounds his parents owed £1.75 ‘beggers belief’.

Hayes Primary School pupil 11-year-old Jacob was said to be in tears after being refused the meal as the pre-paid system showed his family had not paid in enough money.

Jacob’s father, Gary Lynn, accused the school in Paignton of physical and emotional neglect. ‘When he was expecting to get served he was told he wouldn’t be allowed a meal and burst into tears,’ he said.

‘He went to sit down and one of the mealtime assistants brought over an apple because she felt sorry for him. I was completely outraged. I hadn’t had any teacher come to tell me there was an issue. I found it horrific.’

In an internal response, seen by the BBC, Sean Hindle, Business Manager at the academy-status school, said: ‘The kitchen was abiding by school rules.

‘They normally phone parents to let them know that their account doesn’t have any money, and that their child won’t get a lunch that day unless the account is credited.’

Unite/CPHVA Professional Officer, Ros Godson, said: ‘The news report from Devon about a child being refused a school meal because his parents had not pre-paid for it makes perfect sense in a world where schools are seen as businesses and children as customers. However, most right thinking people believe that schools should be places where children are cared for and nurtured, and staff are “in loco parentis”. What parent would refuse their child a lunchtime meal?

‘The lame response from the school governors that “the staff were only following procedure” beggers belief!

‘Under this government’s policies, where every school is a stand-alone commercial business opportunity, it seems that money talks; and in this case it said “no”.”
NMC grant fears as concerns grow over missing government targets

The Nursing and Midwifery Council (NMC) is in danger of breaching the conditions of the government’s £20m grant as it continues to fall far short of its targets.

Currently, only 50% of fitness to practise (FtP) cases progress through to the hearing stage within six months of a referral from the investigating committee – way off the target of 90%.

The NMC must meet the 90% target by December 2014 if it is to meet the conditions of the government’s much-needed grant.

NMC Chief Executive, Jackie Smith, said missing the target ‘doesn’t bear thinking about’ and conceded it is the ‘biggest risk’ to the organisation.

‘We have to meet that target and we need to have assurance we will get there,’ she said. Chair of NMC Council, Mark Addison, said it was clear everybody was ‘uncomfortable’ on the issue and said it was a ‘big concern’.

Answering the concern from council members over the failure to meet the target, Sarah Page, Director of FtP, insisted the target is ‘realistic’ and said she is ‘confident’ the work that is being done will mean the regulator will achieve the target by 2013/14, Page claimed other regulators are ‘limited’ by what they can close at the screening stage and aims to ‘change this’ in the September 2013 council meeting.

‘Currently, the screening team cannot close any case that could amount to impairment,’ she said.

‘We need to review where we set the bar on what we [the NMC] want to deal with as a regulator and what can be dealt with elsewhere.’

While the NMC forecasts screening teams will close around 35% of cases in 2013/14, Page claimed other regulators close around 70% at the same point.

If the NMC was to bring its screening closure rate more in line with other regulators, it could stand to make savings of between £5 million and £7 million.

‘We shouldn’t close cases to save money but as things stand we are not using our resources effectively to protect the public,’ she said.

Referrals on the rise

The NMC has seen a ‘small’ increase in the number of nursing complaints from the public and employers following the Francis report.

Referrals have risen to 418 in May – up from 354 in March 2013.

Sarah Page, Director of FtP, confirmed there had been a ‘spike’ in the number of referrals being received by the regulator but said she is ‘unsure’ over whether it is a trend that will continue.

Council member Louise Scull said the rise in referrals was a ‘real red flag’.

‘Over the past 18 months since I have been involved with the NMC, I am concerned the caseload has not come down,’ she said.

Scull also voiced concerns that the rise in referrals could get ‘stuck’ and lead to another historic case flow.

NMC to review FtP thresholds

Nursing and Midwifery Council (NMC) screening teams may be awarded more powers to close FtP cases earlier as council members are set to review its activity thresholds.

Sarah Page, Director of FtP, said teams are ‘limited’ by what they can close at the screening stage and aims to ‘change this’ in the September 2013 council meeting.

‘Currently, the screening team cannot close any case that could amount to impairment,’ she said.

‘We need to review where we set the bar on what we [the NMC] want to deal with as a regulator and what can be dealt with elsewhere.’

Jackie Smith, has accepted a permanent position as the Nursing and Midwifery Council’s Chief Executive and Registrar.

Smith was appointed to a one year fixed term in the position in October 2012, having acted in the role since January 2012.

Unite/CHPVA Professional Officer, Ros Godson, said: ‘It is difficult to turn an organisation around, but we hope to see progress soon. It is a good idea to have a robust triage type of system, so that only those cases where the nurse might be a risk to the public go forward to a full hearing. It will be interesting to see whether the slight increase in referrals is a blip because of increased press coverage, or a sustained trend, which might indicate a deeper problem.’
Breastfeeding increases upward social mobility

Breastfeeding boosts a child’s chances of climbing the social ladder, a study suggests. Children born in 1958 and 1970 who had been breastfed were found to be ‘consistently more likely’ to have climbed the social ladder than those who had not been breastfed.

Researchers suggest the combination of physical contact and the ‘most appropriate’ nutrients required for growth and brain development plays a part in the better neurocognitive and adult outcomes of breastfed infants.

The social class of almost 17,500 breastfed and non-breastfed children born in 1958 and more than 16,500 children born in 1970 – based on the social class of their father when they were 10 or 11 – were pitted against their social class as adults, measured when they were 33 or 34.

Social class was categorised on a four-point scale ranging from unskilled/semi-skilled manual to professional/managerial.

The study, published in the Archives of Disease in Childhood found ‘significantly fewer’ children were breastfed in 1970 than in 1958 (68% compared to 36% respectively) and those born in 1970 were ‘more likely’ to be more upwardly mobile overall.

However, the ‘breastfeeding effect’ for both groups were the same, increasing the odds of upwards mobility by 24% and reduced the odds of downward mobility by around 20%.

Unite/CPHVA Professional Officer, Dave Munday, said: ‘This study gives some further positive statistics on the benefits of breastfeeding. We know our members make a huge impact in this area and we’re pleased that they now have even more evidence to back this up in their practice. Nationally, we’re involved in further initiatives including Best Beginnings work to introduce smartphone apps, which CEO Alison Baum presented at the recent parenting and family support SIG conference.’

Child obesity levels in Wales outstrip England

One in three five year olds in Wales are overweight, figures from Public Health Wales show.

One in eight (12.5%) of children in the country are classed as obese. The prevalence of overweight and obese children in Wales stands at 28% – higher than England, where 23% of children are overweight or obese.

The Welsh region of Merthyr Tydfil had the highest number of overweight children at 34% followed by Rhondda Cynon Taf (32%) and lowest in Monmouthshire (22%).

Dr Ciárán Humphreys, Consultant in Public Health for Public Health Wales, said: ‘This is the first time we have had a clear picture of how children in Wales are growing and although the headline figures are worrying, this is something that can be reversed.

‘We must have a response from all sectors in society including health, education and local communities themselves to ensure our children are able to adopt healthy lifestyles.’

Findings have been drawn from the Child Measurement Programme, which has collected information on the height and weight of 29,400 reception-age children in Wales during the 2011/12 academic year.

Dr Ruth Hussey, Chief Medical Officer for Wales, said: ‘We have made some steps forward in Wales, such as the Flying Start early years programme, Change4Life campaign and the Welsh Network of Healthy School Schemes, which has now extended to pre-school settings; as well as working at the UK level on issues such as front-of-pack food labelling. The Welsh government is committed to support healthy growth and reduce obesity through a range of actions, particularly on the root causes such as poverty.’

Unite/CPHVA says: ‘Childhood obesity is a problem throughout the world and needs sustained public health measures to reverse the trend. The World Health Organization has recently published a critical look at the marketing of foods high in fat, salt and sugar to children, and this is one of the areas which must be brought under control if we are to succeed.’ The report can be downloaded at: www.euro.who.int/en/what-we-publish/abstracts/marketing-of-foods-high-in-fat,-salt-and-sugar-to-children-update-20122013

Government recruitment drive sees 1,000 more health visitors

There are more than 1,000 more health visitors employed in the health service than there were in 2010, a Department of Health (DH) progress report on England’s Health Visitor Implementation Plan has revealed.

Around 2,500 more health visitors are also in training for the role.

Viv Bennett, Director of Public Health England and the DH, said she was ‘delighted’ by the numbers but warned the extra health visitors must signal change.

‘To get the numbers and not make a difference is a terrible waste of public money,’ she said.

While welcoming the new 1,021 full-time equivalent increase in the health visiting workforce, Unite/CPHVA remains concerned over the quality of training for the new recruits.

Unite’s Lead Professional officer, Obi Amadi, who sits on the Health Visitor Implementation Taskforce, acknowledged the ‘good progress’ that has been made in implementing the plan, which Unite/CPHVA has stridently campaigned for, in reversing the long-term decline of the health visiting profession.

Yet, she said she does have ‘continuing concerns’ about whether the new students will all have the same quality training across the board.

‘There is also the issue whether there will be enough senior colleagues to meet the supervision needs for the new recruits when they come into post, as they are often thrust straight into dealing with some very challenging situations with clients,’ she said.

‘More generally, the constant state of organisational upheaval in the health service, with the private sector bidding for lucrative contracts and public health now falling under local government, creates a climate of great uncertainty.’
Scottish health visiting workforce campaign launches

A campaign for ‘tougher’ legislation to establish Scotland’s commitment to health visiting in law has been launched by CPHVA and partner organisations.

CPHVA, together with the Royal College of Nursing Scotland, Children in Scotland, the Royal College of GPs, the Queen’s Nursing Institute Scotland and others have joined forces to safeguard Scotland’s health visiting service.

Unite/CPHVA has urged the Scottish government to boost the number of health visitors by 20%.

It is claimed the Children and Young People (Scotland) Bill, which was recently proposed by the Scottish government, ‘does not go far enough’ to address concerns around the sustainability of the health visiting workforce.

People are being asked to sign a petition to the Minister for Children and Young People, and the parliamentary committee with responsibility for the Bill, asking them to strengthen the legislation.

Unite Professional Officer for Scotland, Gavin Fergie said: ‘Unite fully supports this initiative to increase the legislative support for health visitors in Scotland.

‘Unite calls on the Scottish government to place health visiting at the centre of its universal health provision for children and families – legislating for this would be a progressive step forward.

‘While the government’s support and financing of the Family Nurse Partnership (FNP), which specialises in helping young mothers, are welcome ministers must realise the majority population needs their health needs met too.

‘FNP is placing a strain on the universal health visiting service and its practitioners. Action must be taken now if the government’s aim to make “Scotland the best country in the world to grow up in” is to be fully realised.’

Scotland’s Commissioner for Children and Young People, Tam Baille, said: ‘Health visiting is a vital service in the early years, and the Children and Young People (Scotland) Bill is an opportunity to underline Scotland’s commitment to that service. Health visitors are absolutely central to the delivery of the ambitions of the legislation.

‘We need to invest now in improved health visiting services to ensure that children born today get the services they have a right to expect and we have a responsibility to deliver.’

In a poll of Scottish parents carried out for Parenting across Scotland, nine out of 10 parents said that they found the health visitor’s advice ‘reassuring’ and 76% agreed they would have missed the help provided by the health visitor if they had not had it.

NSPCC identifies ‘worrying’ gaps in mental health services for new mothers

‘Major’ gaps in access to mental health services for pregnant women and new mums damage the wellbeing of one in 10 newborn babies.

A report Prevention in Mind. All Babies Count: Spotlight on Perinatal Mental Health by children’s charity the NSPCC describes how a lack of focus on a mother’s mental health has led to a ‘postcode lottery’ for families with more than four in ten new mothers reporting neither their health visitor nor midwife had ever asked them about depression.

Unite/CPHVA Professional Officer, Dave Munday, described the findings as ‘sad’. It also highlights evidence showing less than half of mental health trusts have specialist mental health services for expectant and new mums.

Mental health problems, including depression, anxiety, post-traumatic stress disorder and schizophrenia can begin or escalate when a woman is pregnant or in her child’s first year.

The charity is campaigning for health ministers to lead a drive to address major gaps in access to support for preventable and treatable mental health issues for pregnant and new mums.

Peter Wanless, CEO of the NSPCC, said: ‘[The] report clearly shows that with the right services, it is possible to prevent the harm caused by maternal mental illness. But opportunities to help many more families are being missed.

‘We have to start treating the mental health of mums and babies with the same importance as their physical health.

‘Pregnancy and the first months of a child’s life are critical for their future wellbeing and parents naturally play a vital role. If the government is serious about giving every child the best start in life it must take action to fill the gaps in services.’

Research by the NSPCC has shown more than 120,000 infants under one are living with a parent who has a mental health problem.

‘This NSPCC report is a must read for our members and also should be pushed under the noses of managers and commissioners,’ said Munday.

‘The charity repeats many of the issues that CPHVA have campaigned on as part of the health visitor implementation plan and we’ll continue to push this as the plan is implemented.’

Wales measles outbreak over

Swansea’s measles outbreak has been declared over eight months after it began.

Public Health Wales has announced there have been no confirmed measles cases linked to the outbreak area since 22 May.

The outbreak began in November 2012 and resulted in 1,219 notifications of measles cases in the Abertawe Bro Morgannwg, Hywel Dda and Powys health board areas.

A total of 88 people visited a hospital due to measles during the outbreak.

Dr Marion Lyons, Director of Health Protection for Public Health Wales, said: ‘With no confirmed measles cases in the outbreak area since the end of May, we are able to say that the outbreak is over. This is in no small part due to the unprecedented efforts to give tens of thousands of catch-up vaccinations to those who had missed out at an earlier stage and we are grateful to all of those health professionals who worked so hard.

‘Without so many vaccinations being given, we know that the outbreak could have continued for many more months.

‘The only reason this outbreak could happen was because not enough young people were fully vaccinated and there is absolutely no guarantee this could not happen again.’

‘There are still around 30,000 unvaccinated children in the 10 to 18 age group across Wales, Public Health Wales claims.

Unite/CPHVA Professional Officer, Ros Godson, said: ‘Well done to all those school and community nurses who have worked their socks off to immunise the children and young people against this serious disease. Immunising those who come forward is relatively straightforward, but we need to put a great deal more resource into immunising hard-to-reach children.’
Scottish schools miss PE targets

There has been a drop in the number of secondary schools in Scotland meeting physical education (PE) targets, figures show.

The latest Statistical Bulletin shows there are now 1% fewer secondary schools in the country providing at least 100 minutes of PE a week. Furthermore, 12% of Scottish primary schools are not providing two hours of PE a week and the number of primary schools meeting the government’s target of PE provision has moved up just 4% in the past year.

Unite/CPhva Professional Officer, Gavin Fergie, said: ‘The Scottish government continues to lag behind in the competition to improve the opportunity for school students to be active and involved in physical education.

‘The Commonwealth Games may be coming to Glasgow in 2014 but it can’t all be about the big event; Scotland has documented health problems directly attributed to physical inactivity.

‘The Scottish government’s PE report card would say, “Shows willing but needs more application if they are to meet their goals”.

Alison Johnstone, Green MSP for Lothian and education spokesperson for the Scottish Greens, said: ‘The Scottish government needs to invest in proper facilities, proper coaching and ensure exercise is fundamental part of our education system rather than an optional extra.’

NI public health cash injection

Public health research into children’s health and mental wellbeing in Northern Ireland is set to receive a cash boost.

The £9m funding has been awarded to the UKCRC Centre of Excellence for Public Health Northern Ireland (CoE NI) at Queen’s University Belfast, one of the UK’s first centres of excellence for public health research.

Monies have come from the UK Clinical Research Collaboration (UKCRC), the HSC Research and Development Office, the University of Ulster, Queen’s University, and the Atlantic Philanthropies.

Re-launching the Centre of Excellence, Health Minister, Edwin Poots, said: ‘It is a testament to the quality of public health research here that the Centre is to receive further investment for the next five years. I congratulate all involved.

‘Going forward, the aim is to build additional strength in tackling the public health issues affecting both the young and the older population.’

The Centre was originally launched in 2008 as part of a £20m investment across the UK towards research into public health issues such as obesity and health inequalities.

Unite/CPhva says: ‘Additional finance to bolster research is always a positive move. Members will await outcomes with interest.’

Obi Amadi has been appointed as an ambassador to the Mary Seacole Memorial Statue Appeal. Unite’s Lead Professional Officer will assist with fundraising events to help the appeal reach its target £300,000 needed for to erect a statue of Jamaican/Scottish nurse Mary Seacole in the grounds of London’s St Thomas Hospital.
Drop for drop, no other formula comes close

Breast milk

New SMA First Infant Milk

Other first infant milks

References:

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

Jane Beach
Professional Officer, Unite Health Sector

The Greece Solidarity Campaign (GSC) in the UK was established after a delegation visit to Athens in February 2012. It exists to build support for those people in Greece who are opposing austerity. During the first visit the delegation, which included representatives from Unite, the Fire Brigades Union (FBU), Communication Workers Union (CWU), the National Pensioners Convention and the Coalition of Resistance and the People’s Charter, saw the impact of austerity on the Greek people and learnt about the work to build a movement for an alternative.

The GSC has worked to raise awareness in the UK about the causes of the economic crisis in Greece, the impact of the austerity policies, demolish the myths that that the crisis is a Greek problem or caused by the Greek people and to build solidarity links between the Greek people and organisations in the UK and Greece. The scale of the humanitarian crisis now unfolding means that the campaign is increasingly focussed on raising support for community projects providing food and medical assistance and building support for the Medical Aid for Greece appeal.

Unite sent two delegates on the second visit to Athens from 21–23 April: Pilgrim Tucker, Regional Coordinator for Communities and Jane Beach, Professional Officer in the Health Sector. The aim of the second delegation, which was set up jointly by GSC and the FBU, was to meet with the anti-austerity movement in order to continue to build links and ascertain what further help may be required.

The trip was a packed programme, including visits to a number of solidarity initiatives such as:
- ‘Without Middlemen’, a food distribution centre in a deprived suburb of Athens
- Social health clinics in central Athens and a deprived suburb
- The Network of Unemployed and Precarious Workers

The group for women’s right to reproductive and sexual health
Food Co-op of Sesoula and Children’s Nursery Coop of Chalandi.

The delegates also visited a local public hospital and met with the members of ADEDY, the federation of public health unions, including health leaders, the local committee of Solidarity For All, health unions in the public hospital and SYRIZA MPs. In addition, we took part in an anti-fascist demonstration to mark the anniversary of the beginning of the military junta of 1967.

The similarity to what is currently happening within the UK NHS is alarming. The same policies that have led to the poor state of services in Greece are being actioned here; increased privatisation, fragmentation, hospital mergers and closures, attacks on pay, terms and conditions and reductions in staff. Look out for more about Jane’s trip to Greece in a forthcoming issue of Community Practitioner.

Working Longer Review: call for evidence

The new pension arrangements, which were implemented on 1 April 2012 despite their rejection by Unite and other unions, included provisions for a review of working longer in the NHS. The review group was established in September 2012 and Unite is a member of the group.

Following research work undertaken by Bath university for the review, it is apparent that there is little evidence for working longer in the health service. As a response to this, there is now a call for evidence and letter of invitation and cover sheet for responses. These can be downloaded from the NHS Employers website at: www.nhsemployers.org/wlr

Unite believes that staff in the NHS will not be able to sustain their working in later life due to the requirements of their jobs and the demands of providing high-quality services. Working until the age of 68 will not be an option for most staff in the NHS.

The call for evidence invites unions and employers to respond individually or jointly. It is vital that Unite members respond to this at all levels to ensure that the concerns and issues for our membership are fully aired.

The deadline for responses is 5 September 2013 – please ensure that you, your colleagues and local staff sides submit a response to this and provide a clear message for the review.

LAR of The Year Award

Is one of your colleagues an exceptional Local Accredited Representative (LAR)?
We are looking for nominations for outstanding work undertaken on behalf of Unite, CPHVA and members.

Visit the Unite website to nominate colleagues for Unite CPHVA LAR of The Year 2013: www.unitetheunion.org/CPHVA
Q. I've seen differing detail for the CPHVA Professional Conference 2013. Can you clarify please?
A. The Unite/CPHV A Annual Professional Conference 2013, 'Public Health Nursing: The Foundation of the Future', will be held at York Racecourse on Tuesday 22 and Wednesday 23 October 2013.

Q. What's in the CPHVA Professional Conference 2013 programme?
A. You will find a conference brochure as an insert within this issue of Community Practitioner. Many hours have been spent by your fellow members on the programme planning committee to ensure the content reflects the challenges faced and goals being met by CPHVA members today.

Q. Is there a website for the CPHVA Professional Conference?
A. All current information can be found at the Unite/CPHV A website pages on the website (www.unitetheunion.org/CPHV A/events/).

Q. Is there an Annual Professional Forum this year?
A. Yes. This year, the name has changed to the Professional Officer Report will be presented to the meeting, with an opportunity for questions to the Professional Officers. This will be presented in a 'Question Time' panel format – all Professional Officers will outline their work over the last year and questions will be open to the Professional Officers to respond. The debate part of the Annual Meeting will take place after this.

Q. Isn't that a lot in three hours?
A. Yes. This will be held on Monday 21 October in the afternoon, after the Annual Meeting, at York Racecourse. Please refer to the CPHVA website for more information (www.unitetheunion.org/CPHV A).

Q. Will there be a Local Accredited Representative training session again this year?
A. Yes, as a result of the dinner being well received last year there will be a similar event in York on the evening of Tuesday 22 October. Details are being finalised but please keep visiting the Unite CPHVA website for more information (www.unitetheunion.org/CPHV A/events) to keep up to date.

Q. Will there be a conference dinner again this year?
A. Yes, the CPHVA Annual Meeting delegates will need to have prepared and rehearsed their arguments, and be able to stick to their allocated time, and this will be strictly applied by the chair of each session. The Professional Team will be issued with official CPHVA watches to remind them to be pithy and timely in their responses.

Q. Will there be financial support to attend the CPHVA Professional Conference?
A. The CPHVA Professional Conference is competitively priced when compared to similar events in size and reach. The 2013 conference ticket price is the lowest it has been for several years. Book now as delegate places are filling fast. Keep reading Community Practitioner and visit the Unite CPHVA website and conference pages for updated information.

If you have any queries about conference 2013 please email Unite Professional Officer, Gavin Fergie, at: gavin.fergie@unitetheunion.org
Research evidence

Sudden infant death syndrome: cry characteristics

The aim of this study was to acoustically evaluate the cries of sudden infant death syndrome (SIDS) infants and compare these to a group of healthy term (HT) infants, as well as previously published results for SIDS infants. The SIDS infants were found to produce cries with longer duration compared to HT infants. The cries of SIDS infants also differed from HT infants in regard to the absolute difference in F2-F1 frequency. The acoustic features considered support the contention that the cries of SIDS infants are reflective of atypical respiratory–laryngeal control. Although research of this nature is rare, there is evidence to suggest an acoustic profile of crying that is specific to SIDS.


Poor sleep quality and its relationship with body mass index among teenagers

The link between sleep quality and weight status among teenagers has gained more attention in the recent literature and health policy but no consensus has been reached. Considering all three types of poor sleep quality, 20.9% of teenagers in Taiwan experienced some form of sleep problems. After adjusting for the other variables, two factors independently and statistically predicted sleep problems: current smoking and working night shifts by the head of the household. Teens experiencing difficulty in initiating sleep had higher BMIs ranging from 0.86 to 1.41 units. Efforts to address childhood obesity need to take into consideration sleep problems that are highly prevalent among teenagers.


The association of contraceptive methods and depression

This study aimed to compare depression between contraceptive methods associated with low-dose estrogen (LD) combined pills, condom and intrauterine devices (IUD). In a cross-sectional study, 216 women were selected through systematic random sampling from 10 health care centres in Iran in 2011. Depression was observed in 47.8% of participants; however, there was no difference between the mean score of depression in the users of three contraceptive methods. The findings of this study showed that depression is not correlated with family planning type and fear of depression should not be an obstacle to choose between these methods. Depression is a multifactor issue. This study showed that type of family planning method in itself cannot be the cause of depression and family planners and consultants should consider this.


Domestic violence from the male perspective

This article explores violent behaviour within a relationship from the male abuser’s perspective. A systemic approach was used, combining qualitative and quantitative information in two parallel studies. The first (Study one) is a descriptive analysis of a group of men (n=220) who participated in a programme to address violence within the couple. In the second (Study two), a subgroup of 8 participants was interviewed in-depth for describing and analysing their perceptions of violence. The data analysis suggest that relationship violence (a) begins in the early stages of the relationship, (b) is long-term, (c) rarely includes serious physical aggression, (d) is dominated by a growing hostility and isolation, (e) is characterised by a lack of awareness and responsibility for the violent behavior, and (f) includes intentional and strategic use of violent behaviour.


New resources

NICE standards for postnatal care

The NICE quality standard on postnatal care is designed to improve the care and support every woman, their baby, and if appropriate, their partner and family, receive during the postnatal period. For most women, babies and their families, this time is uncomplicated, but for some who have developed complications, care during this period must be tailored to meet their specific needs. Visit: http://guidance.nice.org.uk/QS37

NSPCC FGM helpline launched

The NSPCC Female Genital Mutilation Helpline was launched on 24 June 2013 as a UK-wide service. It operate 24/7 and is staffed by specially trained child protection helpline counsellors who can offer advice, information, and assistance to members of the public and to professionals. The helpline can be contacted on: 0800 028 3550 and emails sent to fgmhelp@nspcc.org.uk

Cussons Mum & Me Research Fellowship

Cussons Mum & Me, working in partnership with The Royal College of Midwives and UK charity Wellbeing of Women, has announced a new Research Fellowship where they will provide sponsorship of £60,000 to support a midwife through a PHD. The Research Fellowship began its recruitment of its midwife in July and the chosen candidate will begin their sponsored PHD study in September 2014. For details visit: www.wellbeingofwomen.org.uk
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

To get in touch with JOHNSON’S® Baby, please email us at jbhcpcontact@its.jnj.com
Your query will be dealt with by a qualified midwife who is also an expert on the JOHNSON’S® Baby range of products.

References:
Relax! I’m not going to harangue you at all this month. Just a gentle round up of what has been going on. Many of you are on holiday, reversing the trend I hear that some areas are returning to term-time only working. Whether this is a cost-cutting measure or the result of difficulty filling posts, I’m not sure. If you have an opinion, let me know.

I discussed commissioning last month, and have had feedback from the Organising Professional Committee (OPC) that some nurses are finding it difficult to understand it, so I will try to get a clear fact sheet out. Meanwhile, if you are still not sure about how the new health organisations are supposed to relate to each other, you might be interested in this from the King’s Fund: www.kingsfund.org.uk/sites/files/kf/media/structure-of-the-new-nhs-animation.pdf

I was privileged to be invited to see the posters designed by Wolverhampton Specialist Community Public Health Nurse (SCPHN) students as part of their course. The standard was very high and emphasised once again to me that school nurses who undertake the SCPHN course enter another dimension. They see everything from a public health (preventive) point of view. Topics that caught my eye included resilience-building workshops, safeguarding issues due to faith or belief, developing a mobile app and raising awareness of hate crime in young people with learning disabilities. If you are a student who has done an interesting piece of work, do consider writing it up for Community Practitioner as other public health nurses are always interested in reading about different practice.

SRE
The National Children’s Bureau sex education forum held its summer meeting, including a display of games and other materials on the topic of ‘porn versus reality’. The subject of young people’s exposure to pornography and the corrosive effect this may be having on their body image and ability to form loving relationships is something that needs more research. The children’s commissioner for England carried out a scoping exercise earlier this year and discussed this with the group. I specifically asked her, ‘What do you want school nurses to do with this information?’ She replied that awareness, listening and reporting (as a safeguarding concern) are crucial. Be wise to the risk of sexual exploitation within the school environment and especially concern yourselves with children missing from school. ‘How am I going to be everywhere at once?’ I hear you cry. It would be wonderful to have the time to get involved with sex and relationships education (SRE), but we don’t! Well yes, the service is differently organised over the country, but if you want resources you must show the need via the Joint Strategic Needs Assessment (England).

Online presence
If you can’t physically be there at your schools all the time, do you have an online presence? I visited a school in London this week where the school nurse had set up an interactive webpage on the school’s intranet. The
advantage of the intranet is that only young people and families from that school could access it. Through the site, young people can search for specific health information and see if the FAQs are useful. They can ask questions and receive answers within a day or two, and make an appointment to see the nurse. They now know who the school nurse is, and what she does; it has raised her profile no end! Student health forms, healthcare plans, health policies and immunisation consent forms are all downloadable.

Online first aid updating training for staff is also possible, and specific resources available commercially, such as YouTube and websites can be signposted. Really, every school should have one! Talking of being interactive, don’t forget to use the twitter hashtag #SNSoMe, which stands for school nurses in social media.

Setting an example
Public Health England held an inaugural conference for nurses and midwives recently, as we are the largest group who could make the greatest impact on upstream work. It was well attended and there was constant tweeting throughout. School nurses were regularly mentioned as being an important group in the system. The emphasis was around linking evidence to practice, using a ‘life course’ approach to public health, and ‘making every contact count’.

However, there was one niggling concern: are nurses and midwives themselves the greatest exponents of a healthy lifestyle? Do we walk the walk or just talk the talk? Should we improve our own public health first before expecting others to change their lifestyle? One interesting fact: all NHS England staff are being allowed five paid days a year to do voluntary or charity work. Most nurses present thought that they already ‘volunteered’ five days extra a year in overtime hours to the NHS!

WHO food campaign
The World Health Organisation (Europe) has released an update on the marketing of foods high in fat, salt and sugar to children (www.euro.who.int/en/what-we-publish/abstracts/marketing-of-foods-high-in-fat,-salt-and-sugar-to-children-update-20122013). I hardly need to tell you in which direction it is going. Do keep your eyes open for inappropriate marketing and sponsorship at schools, youth clubs, summer play schemes and other places where children and young people congregate. If you can take photos please let us have them and tell us about the promotion. Have a happy and relaxing holiday.

Molluscum Contagiosum

- New MolluDab (5% potassium hydroxide)
- Clinically proven, effective treatment* for molluscum contagiosum that means parents don’t have to just watch and wait for this highly contagious virus to spontaneously resolve
- Results in 1-5 weeks*
- Easy dab on applicator
- You can now advise parents that MolluDab is available on prescription

For more advice and guidance to share with parents on treating molluscum contagiosum, visit www.MolluDab.co.uk.

Further information is available from:
Alliance Pharmaceuticals Ltd, Bath Road, Chippenham, SN15 2BB.
www.alliancepharma.co.uk

AL/1493/05-130.001 *Data on file Date of preparation: May 2013

MolluDab is a medical device and may be prescribed under part IX of the drug tariff. Medical Device safety and performance events should be reported to Pharmacovigilance at Alliance Pharmaceuticals (tel: 01249 466 966, email: pharmacovigilance@alliancepharma.co.uk). Adverse reactions can also be reported to the MHRA.
No smoke without fire?

Electronic cigarettes have exploded onto the UK market, with hundreds of thousands of people making the switch from tobacco last year. However, quality concerns and fears over the long-term effects of ‘vaping’ mean that regulation is now on the cards. Louise Naughton investigates

Louise Naughton
Assistant Editor

Would you allow your client to use an e-cigarette around a baby or small child? It is a question a lot of health professionals are struggling to answer since the product exploded onto the market five years ago. On the face of it, the question seems an easy one to answer. After all, you would presumably have no problem with a parent wearing a nicotine patch, chewing gum or ‘smoking’ an inhaler. So what is it about the look-a-like product that has caught regulators all over the world ‘on the hop’ and left smoking cessation experts scratching their heads in confusion?

It is often said there is no smoke without fire; and while they have no use for a lighter or matches e-cigarettes have undoubtedly set the world alight, with millions choosing to make the switch to ‘vaping’. But what are these curious devices? Are they really ‘just’ another smoking cessation tool and the long-awaited long-term answer to the tobacco industry’s seemingly unbreakable grip on billions of smokers? Or are they something more sinister?

A Chinese invention, the e-cigarette was launched in 2004, allowing users to suck on battery-powered devices that have the look and feel of tobacco cigarettes, cigars and pipes to get their ‘hit’ of nicotine, without all the toxins and cancer-inducing carcinogens of tobacco products. Now, a rumoured 1.5 million Brits are self-confirmed ‘vapers’, with 700,000 believed to have made the switch last year. Owner of e-cigarette manufacturer Safercigs, Darren Burns, predicts the number could rise to two million at the end of the year and five million by 2016 – the year the Medicines and Healthcare Regulatory Agency (MHRA) hopes to introduce medical regulation of the devices. With the momentum around the e-cigarette market showing no indication of slowing and signs all pointing to the possibility that the technology may outstrip tobacco sales, the MHRA has decided now is a good time to step in and investigate the long-term effects of the products – something that is yet to be done despite their growing popularity. Action on Smoking and Health (ASH) research notes use of e-cigarettes has grown from 3% of smokers to 11% in 2013 with 34% confirming they had ‘tried’ the product compared to 9% in 2010.

No guarantees

The National Institute for Health and Care Excellence (NICE) claims the use of nicotine replacement therapy (NRT) products, such as gum and patches, are safe when used continuously for a period of up to five years and are proven to help smokers cut down before kicking the habit completely. However, the same cannot be said for
e-cigarettes, with the body recommending against healthcare professionals offering the products to smokers wanting to quit.

‘There are no guarantees at present of the safety, efficacy or quality of e-cigarettes. We don’t know what else is in them,’ says Professor Mike Kelly, Director of Public Health at NICE.

Jeremy Mean, Group Manager of Vigilance and Risk Management of Medicines at the MHRA, is clear about one thing – smoking tobacco is the most harmful thing a person can do to their health, and when pitted against the killer products, e-cigarettes are inevitably the better – and safer – bet.

However, research commissioned by the agency found that levels of nicotine in the devices were ‘inconsistent’, and that the presence of contaminants highlighted a possible breach of standards during the manufacturing process.

‘Smoking is very dangerous and kills around half of its users every year in the UK,’ Mean says.

‘What we want to avoid is replacing it with a product that still has safety concerns we are not clear about. Our findings lead us to believe the products are unlikely to be as effective as they should be in helping to reduce the harms of smoking.

‘Both us and the public simply do not have the reassurance over their safety.’

‘Healthier alternative’

Angered by the MHRA’s claims over the lack of research, Safercigs’ Burns says there is ‘conclusive proof’ that e-cigarettes are the ‘healthier alternative’ to smoking and describes any questions over the quality of the products as a ‘complete fabrication’.

‘Nobody has ever come forward and said e-cigarettes are 100% safe because there hasn’t been enough time to conclusively prove that – but what has been proven by experts all over the world is that e-cigarettes are less harmful than tobacco,’ he says.

‘Contained in the vapour we exhale is trace elements of nicotine, but given that a lit tobacco cigarette contains thousands of toxins, I know what side of the fence I want to be on.’

‘Tobacco cigarettes kill more than 50,000 people a year in the UK, possibly more. In the five years e-cigarettes have been around how many deaths have been reported as a result of the products? Absolutely none.’

Monitoring e-cigarettes

The level of contaminants and concerns over nicotine levels are ‘far less’ in e-cigarettes than they would be in tobacco cigarettes, admits Lynne Dawkins, Senior Lecturer in Psychology at the University of East London. She claims a ‘handful’ of studies have proven that while e-cigarettes do release toxins, they do so at a level that is up to 400 times lower than those carcinogens released by tobacco cigarettes. Mean insists the new regulatory framework will enable the MHRA to monitor the long-term safety of e-cigarettes and whether they are effective in helping people to quit or not.

Dr Andrew Furber, Director of Public Health for Wakefield District in West Yorkshire, doubts e-cigarettes are a ‘completely harmless’ alternative and has heard anecdotal reports of ‘vapers’ contracting pneumonia after inhaling solvents in poorly made devices. Welcoming the MHRA’s announcement on the regulation of e-cigarettes, he hopes it will pick up on such adverse events, allowing the body to decipher whether they are indeed a ‘one-off’ or indicative of a symptomatic problem with the products.

Access route to smoking

Going further, the British Medical Association’s Director of Professional Activities, Dr Vivienne Nathanson, says she wouldn’t be surprised if research shows e-cigarettes are a ‘much less successful’ tool to quit smoking than the products already licensed. It is the only form of nicotine replacement that acts as an ‘access route’ to smoking thanks to the ‘reinforcement’ of the habitual hand-to-mouth smoking behaviour that the e-cigarette so artfully mimics.

Dr Nathanson says the devices may also lure ex-smokers back to their old ways.

‘Let’s say you were a heavy smoker and gave up successfully, and you were sitting with friends in a public place where a number of them were ‘vaping’. Can you be sure that you are not inhaling any nicotine from the vapour your friends are breathing out? It is very important for us to know this sort of information because it could be just enough for a fresh quitter to start having nicotine cravings again.’

Psychology Lecturer, Dawkins, says e-cigarette users are, in the main, white, middle class, male and have a mean age of 43 years old. ASH research shows e-cigarette use is most common among smokers and those who have kicked the habit. Encouragingly, just 1% of 1,680 never-smokers surveyed by the charity said they had experimented with the devices and almost one in four had ‘never heard of them’.
However, despite the fact it is illegal to sell e-cigarettes to under 18s, one in ten 16–18 year olds reported they had flirted with the products, with this experimentation rarer among younger teenagers.

**E-cigarette use in children**

Martin Dockrell, Director of Research and Policy at ASH, predicts e-cigarette use among children has ‘got to increase’.

‘I think the users of e-cigarettes are entitled to know they are safe and effective and the rest of the population also has a right to know that these products will not be sold to children and not marketed towards them,’ he says. That is where MHRA regulation comes in.’

The MHRA is well aware of the ‘theoretical risk’ of e-cigarettes becoming a ‘gateway’ into smoking tobacco products for children, ex-smokers and never-smokers. Aggressive marketing campaigns by e-cigarette manufacturers transport our homes and communities back to the 1950s by showing glamorous men and women puffing away on the devices. E-Lites became the first e-cigarette company earlier this year to run a TV ad ‘related to smoking’ since 1965, featuring Waterloo Road actor Mark Benton playing a father who missed his child’s first steps because he had to go outside for a cigarette. The advert tells smokers ‘You don’t know what you’re missing’, inferring that smokers can ‘vape’ within the comfort of their own homes instead.

‘De-normalising’ smoking

Celebrity endorsements of the products have also not gone unnoticed, with pop singers, presenters and reality stars being pictured with e-cigarettes in hand. Hollywood royalty actress Katherine Heigel even ‘vaped’ her way through a TV interview with David Letterman in the US, professing her love for the devices. Such promotion of smoking behaviours is causing unease among public health experts.

‘From a public health point of view this is a major concern because a big part of the strategy for reducing tobacco harm is de-normalising it,’ says Dr Furber.

‘E-cigarettes look so much like tobacco cigarettes that it might reverse all the gains that have been made in this area.’

Such promotion may have led to anecdotal reports of a ‘flourishing’ e-cigarette market in the UK’s secondary schools with the BMA even receiving reports of children buying them from their peers at school.

‘The worry is of course, is that once children are nicotine addicted they will go elsewhere for their “hit”,’ says Dr Nathanson.

‘The MHRA’s Mean stresses that the planned regulation of e-cigarettes as medicines will curb all irresponsible marketing endeavors by manufacturers. Grouped in the same bracket as other nicotine replacement therapy (NRT) such as patches and gum, e-cigarette suppliers will only be able to market their product as a smoking cessation tool in helping people cut down or quit smoking – quite a change from the advertisements being beamed across the media today.

**Regulation ‘not a done deal’**

But what if consumers do not want to use e-cigarettes as a means to quit smoking, but as a long-term ‘healthier’ alternative to tobacco cigarettes? Safercigs’ Burns says he ‘has never and will never’ advertise the products as a route to stopping smoking.

‘Smoking cessation products are for people who want to give up smoking, but a lot of my customers don’t want to give up smoking – they enjoy it,’ he says.

‘The goal of e-cigarettes shouldn’t be to get smokers off the drug – it should be to give them a better alternative.’

And for those who think the MHRA’s plan to regulate e-cigarettes as medicines is a done deal, think again, as Burns plans to take the fight to the courts – and what’s more, he
'We have medical experts on hand to fight our corner and we are going to make ground on this,' he says.

'We will conclusively prove [e-cigarettes] are the safer alternative [to smoking] and have made the MHRA look like fools, which inevitably is what will happen, we will then sue them for damage to business. This is our livelihood.'

Death sentence for millions
Burns has an even more chilling message for the MHRA and public health experts, claiming regulation will give millions of people a ‘death sentence’ by forcing them back onto tobacco cigarettes. While the Mean insists the planned regulation will be ‘proportionate’, Burns says in order to comply with the regulation he will have to fork out millions for market authorisation – money this small business just doesn’t have.

‘There are only two companies that can afford this kind of money, and one of them is owned by British American Tobacco,’ he says.

‘I know this company is planning on producing an old style e-cigarette from five years ago that is not sustainable and not viable – a 10-a-day smoker will suck through the battery in an hour. It is doomed to failure as it will force millions back on tobacco – something this company will be happy about. ‘If medical regulation is enforced, everything we know about e-cigarettes will cease to exist.’

Health improvements
Burns can himself testify for the improvements he has seen in his health since switching to ‘vaping’ more than two years ago after smoking 40 a day for 17 years.

‘Near where I used to live when I was a smoker there was a big hill, and walking up and down it left me sweating and grossly out of breath,’ he says.

‘I can now walk up and down the hill with ease and my fitness has improved greatly since switching to e-cigarettes. The way I look at it, the devices give me all the pleasure of smoking without the death.’

Resisting tobacco industry input
Smoking cessation experts attending the UK National Smoking Cessation Conference in London voted to support the development of e-cigarettes but were almost unanimous in their resistance to tobacco companies muscling in on the act.

There seems to be a universal acceptance that e-cigarettes are the healthier alternative to smoking and if the technology has indeed contributed to the 250 billion fewer tobacco cigarettes smoked across Europe last year, then they should be applauded.

However, health professionals are rightfully uneasy when it comes to advocating the use of the devices as an ‘alternative’ rather than as a quitting tool and question whether they should be complicit in keeping smokers hooked on the nicotine drug without knowing the effects of life-long use. The MHRA’s announcement is only the beginning of the story for e-cigarettes and there are many questions left to answer from both sides.
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.

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hipp4hcps.co.uk
I am given instructions to meet Dr Ranj Singh at a café beyond the furthest rocket lift at the end of the playground. Stay with me, it is not some fantastical universe but the Evelina Children's Hospital, part of Guys and St Thomas’ in Westminster, London.

He is surprisingly upbeat for our interview considering he has just clocked off from a 13-hour night shift at the hospital. When I ask him what his secret is he shyly laughs and says it’s all down to the magic of coffee.

Dr Ranj is instantly likeable. It is often said that TV stars have that that added something, the so-called X-Factor, which makes them stand out on the small screen. But while some disappoint in person, this TV doctor has charisma in bucketloads.

The paediatrician is best known for creating and fronting the whimsical CBeebies series Get Well Soon. Aimed at preschool children, it centres on a child’s experience of being sick and visiting a doctor. Five puppets with very different personalities take it in turns to visit the all singing Dr Ranj: shy Deep, inquisitive Riz; confident Kiwa; boisterous Jobi; and sweet Petal; for help with common childhood complaints such as head injuries, broken arms, chicken pox, coughs, colds and constipation.

The show’s theme tune ‘Be happy, be healthy, and get well soon’ tells kids ‘the doctor and nurse will know what to do, they’ll always take good care of you’. In Dr Ranj’s surgery, children find out that visiting a doctor doesn’t need to be scary and can actually be a fun experience.

In one episode, Dr Ranj tells a constipated Deep: ‘Taking a poo is like your body telling you to take the rubbish out’ and then bursts into a humorous song to explain his toilet troubles further.

‘Where does your poo come from, why does it stop? Why does it stay in your bottom and not make a plop?’ he sings.

‘Don’t squeeze or strain or do it in a rush, Soon you will be finished then you can flush.’

Entertainment and credible health promotion are difficult bedfellows and it can be hard to find a way for them to complement each other, so how does Dr Ranj manage it?

‘Communicating to children is something you get better at with experience and is something that develops over time,’ he says.

‘Very few people are born with that skill and you have to hone it as you go through your training and get more experience under your belt.

‘Your approach has to be dynamic and you have to know how to communicate information in way that lots of different people with lots of different levels of understanding can take on board.

‘There is more to it than playing games and
acting the clown. It’s a difficult thing to do.’

Unsurprisingly, when asked what the top three health concerns facing children are today, Dr Ranj ranked obesity at number one thanks to its huge impact on a child’s health and life chances.

Calling for a change in attitudes to food and diet, the presenter believes this education should start early and his CBeebies show demonstrates this thinking well with a common thread of healthy eating, exercise and general good overall wellbeing featuring in each of his ‘surgeries’. While adult attitudes are stubbornly difficult to change at times, a child’s viewpoint can be more malleable and more easily influenced – something Dr Ranj urges health professionals to take advantage of.

‘We need to start delivering these health promotion messages early to ensure they are seen not as a chore but as part of everyday life,’ he says.

**TV target**

A doctor for ten years, Dr Ranj stumbled on paediatrics quite by chance at a time when he was taking a break from the medical world after a ‘gruelling’ first year working in a hospital as a junior doctor.

He soon found the role to be a ‘natural fit’ and as his medical career progressed, so did his interest in the media, particularly as a vehicle to champion the rights of children, young people and families. Identifying a gap in the system, he observed that ‘nobody else seemed to be doing it’.

Now a seasoned broadcaster, Dr Ranj has graced the TV sofas of CBBC’s Newsround and BBC One’s The One Show among others, as well as the airwaves on Radio One’s Newsbeat dishing out health advice.

Juggling the two worlds of medicine and the bright lights of TV is a daunting task, but Dr Ranj is adamant he will not find himself in the position where he has to sacrifice one for the other.

‘As much as I love doing the media stuff and I get to do some really cool things and meet great people, I would never give up my clinical work because that is where my passion lies,’ he says.

What’s more, despite its glitzy façade, Dr Ranj insists the world of TV doctoring is not as glamorous as it sounds.

‘It’s not all hanging around with famous people doing exciting things and earning lots of money, it is actually quite the opposite of that,’ he says earnestly.

The presenter also says he battles against a perception held by the general public and his medical peers that doctors who do media work are in some way ‘not good enough’ to be ‘normal’ doctors and are often ‘targets’ for people to ‘vent’ their personal frustrations at – professionals or otherwise.

‘If you are going to say something in the media or in the public eye, you have to know what you are talking about,’ he says.

‘If you don’t, you are going to become a target and you will have to face the consequences.

While not everything in medicine is black and white, the trick is to know how to get your point across, justify it and make sure what you are saying is appropriate.’

But it is soon evident that not all members of the public are as cynical when it comes to TV doctors. A fan wanders over to our table after recognising Dr Ranj and interrupts the interview to ask for a picture. As I take the picture of the two men, it is extraordinary how at ease the doctor is in meeting his fans. He seems genuinely pleased to hear feedback about the show (‘My sister watches your show all the time’) and delights in exchanging pleasantries.

“So is this a regular occurrence I ask? He giggles as he admits it is happening more and more since his show Get Well Soon was aired.

‘It is still very nice [to be recognised] and it is nice that everyone who does recognise me is very positive and friendly about the show – I only see it as a good thing,’ he says.

‘It is lovely that people enjoy it and feel comfortable enough to come up to me and say nice things about the show – I love that. I want
people to enjoy what we do.’

Back to Dr Ranj’s top three health concerns facing children in the UK now and coming in second place is mental health – an area that has been ‘overlooked’ by the health service for some time, he argues. Despite the Office of National Statistics confirming around 10% of 5-16 year olds have a diagnosable mental health problem – three in any one classroom – the majority of these children are not able to access the help they need, and that is surprising the support is available in the first place.

‘We are seeing more and more children with depression, self-harm and eating disorders,’ he says. ‘We need to wake up and start taking them seriously.’

Engaging the public

One of the reasons Dr Ranj is so passionate about his media work is down to the opportunity it gives him to give children a voice – something he says is sorely missing and the reason why children’s health is often a second class service.

Earlier this year, the British Medical Association (BMA) published a damning report Growing up in the UK claiming the government has failed to deliver on its promise to be ‘family friendly’.

Launching the report, Professor Sir Albert Aynsley-Green, Professor Emeritus of Child Health, University College London said there is a ‘lack of political will’ to put the health and wellbeing of children at the top of the agenda.

Agreeing with the report’s sentiment wholeheartedly, Dr Ranj says children’s health has long been a second consideration of the government and traditionally hasn’t been taken seriously enough by those in power.

The only chance for change is through people spearheading the rights of children and young people, he claims.

One way of doing this is through social networking. A self confessed Twitter addict, Dr Ranj says it is a great platform to access the public’s hearts and minds and encourages health professionals to show off their personality in engaging their fellow ‘tweeps’. Like most websites of its kind, Twitter is free and largely uncensored – anyone can use it and anyone can say anything. A frightening prospect for some. However, just as doctors and nurses are required to keep up-to-date with their professional development around their medical knowledge, the same should be said for technology, says the TV doctor.

‘Technology is no longer purely within the realms of young, techno-savvy people anymore,’ he says.

‘We know it is effective in health promotion and I’m telling you it is easy to engage with these technologies. There is no excuse not to get involved.’

It is this reluctance to engage with modern media that has led to immunisation becoming Dr Ranj’s third top child health concern.

A massive heath advance, immunisation is extremely effective but shrouded in controversy. While this is undoubtedly partly down to certain individuals who have made it their mission to create such controversy – Andrew Wakefield and his now discredited link between autism and the MMR vaccine springs to mind – Dr Ranj also claims problems have been exacerbated by health professionals who have been unable to combat and allay parental fears over the safety of vaccines.

‘A lot of people who do not vaccinate their children do so because they have found information on the internet of some kind and then visit their GP with a bunch of questions they either can’t answer or don’t have the time to answer,’ he says.

‘We need to get better at communicating the importance of immunisation and combating the controversy’.

It is this love of modern and interactive technology that led Dr Ranj to team up with children’s charity Best Beginnings on the launch of its early intervention ‘apps’. Designed for expectant and new parents, the evidence-based apps provide a free 24/7 personal support service to guide parents through the transition from pregnancy to raising a newborn.

‘There are lots of parenting apps out there but none of them are as useful as the “BB apps”,’ he says.

‘I am really excited about the launch because I believe they will become the number one pregnancy parenting app used in the country and form part of standard care for families.’

The 11th UNICEF report card ranked the UK a lowly 16th among the world’s richest countries when it comes child happiness and wellbeing. Dr Ranj says the poor position reflects that we have a ‘long way to go’ in improving the care of our younger members of society. However, he argues a greater investment of time, money and resources into child-focused projects could see the UK rocket up the list.

‘There is a new set of pressures on young people – from families, school, their peers and the environment – they are bombarded with messages from the media every turn and because of that, growing up is now tougher than it ever used to be,’ says the TV star.

‘I don’t think that necessarily means children are growing up too quickly, I just think we are not quite keeping up in terms of supporting young people to cope with these pressures – I don’t think we are good enough at that.’
Human milk science: What makes human milk’s composition ideal for infants?

Human milk is the preeminent source of infant nutrition. Although its precise composition varies depending on the mother’s diet, health, lifestyle and geographic location, its unique properties remain essential for complete nourishment of full-term and premature newborns. The WHO recommends exclusive breastfeeding for the first 6 months, after which breastfeeding can continue alongside other complementary solid foods.

Breastfeeding has numerous short- and long-term beneficial effects for infants and mothers. Human milk has optimal nutritional value and beneficially influences absorption, metabolism, development of the gut microbiota and gut maturation. Breastmilk also plays a key role in reducing the risk of infections and allergies as well as supporting brain and eye development.

“Exclusive breastfeeding for at least 3 months is associated with a lower incidence and severity of diarrhoea, respiratory infection and otitis media. Exclusive breastfeeding for at least 6 months is associated with a lower incidence of allergic disease in at-risk infants.”

Breastfeeding is also associated with a lower incidence of obesity during childhood and adolescence, and of hypertension and hypercholesterolemia in adulthood.

Human milk composition is influenced by gestational and postnatal age. A large review concluded that breastfeeding was associated with a reduced risk of acute otitis media, non-specific gastroenteritis, severe lower respiratory tract infections, atopic dermatitis, asthma (in young children), obesity, type 1 and 2 diabetes, childhood leukemia, sudden infant death syndrome (SIDS), and necrotizing enterocolitis.

Infants’ immune responses are modulated by environmental factors in the first month of life, which may explain why breastfeeding in the first month of life has a protective effect against subsequent infections and atopy.

In addition, breastfeeding is associated with an earlier return to pre-pregnancy weight, and decreased risk of breast and ovarian cancer pre-menopause and of hip fractures and osteoporosis post-menopause.

Besides macronutrients (e.g. lactose, triglycerides and proteins), which provide energy and building blocks to the newborn infant, human milk also contains a large number of compounds that modulate functional aspects of metabolism.

“The key to unravelling the health benefits of human milk is an understanding of the causes and consequences of the variation in its composition.”

Many of the non-digestible factors in human milk contribute to epithelial cell growth, mucosal barrier and immunity. The development and maturation of the gastro-intestinal tract and its specific and digestive functions are of utmost importance. Maturation is a continuous process from foetal development until early childhood. A crucial phase starts after birth with the infant’s first feeds.

Human milk contains low amounts of protein, and a ratio of caseins and whey proteins that is tailored to meet infants’ functional and nutritional needs. It also contains functional proteins such as growth hormones and interleukins inducing cell growth and cell differentiation.
Human milk contains large amounts of human milk oligosaccharides (HMOs) with complex molecular structures that have an important effect on the gut microbiota and the developing immune system including allergy and infection9,10.

Individually, the complex pattern of these HMOs varies depending on the mother's diet, health, lifestyle and on the baby's needs. Each milk group has its own pattern and each lactation period has its own pattern of concentrations of HMOs. These variations are in addition to nutritional regulation of fatty acid synthesis, a very important regulator of LCPs synthesis16.-18.

Additionally, LCPS are known to stimulate differentiation, support gut maturation, reduce transepithelial permeability19, and influence mucin synthesis20, inflammatory and anti-inflammatory effects21.

Another functional lipid class is short chain fatty acids (SCFAs), which can induce specific mucin expression, and have been found to improve the gastro-intestinal extrinsic barrier by enhancing epithelial mucus expression22.

Human milk is a source of anti-oxidative compounds23, and also contains living cells derived from the maternal system.

The relevance and physiological effect of low amounts of bacteria found in human milk samples is currently being explored24.

More recently, a clear association between genotypes of lipid metabolising enzyme and fatty acid levels in diverse human tissues shows that these gene cluster variations are, in addition to nutritional regulation of fatty acid synthesis, a very important regulator of LCPS synthesis16.-18.

Conclusion:

There is an ongoing need to improve understanding of the contribution of specific human milk composition on digestion and absorption; the development of the gut and its microbiota; the immune system and the brain. There is an increased scientific interest to gain more insights into the complex interplay of macronutrients and trace compounds in human milk, which is key to understanding further health benefits.

Further exploration into the many benefits of human milk and breastfeeding behaviour on infant and maternal health must continue, in order to help support breastfeeding, but also to help in understanding the nutritional needs of mothers and their infants in their early phase of life.

References:


IMPORTANT NOTICE: Breastfeeding is best for babies. Breast milk provides babies with the best source of nourishment. Infant formula milk and follow on milks are intended to be used when babies cannot be 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.

This resource is for healthcare professional use only.
Maintaining professional resilience through group restorative supervision

Introduction
Restorative clinical supervision (Wallbank, 2007) is a model of supervision designed to support professionals working within roles where they have a significant emotional demand. The model has been piloted (Wallbank, 2010) and substantially tested with a range of community staff (Wallbank and Hatton, 2011). It has delivered substantial reductions in the stress and burnout levels of over 2,500 staff while supporting their compassion satisfaction (the pleasure they derive from their job) and increasing the attachment they have to their organisations (Wallbank and Woods, 2012).

The programme currently offers a training day, followed by six individual sessions and two group sessions of restorative supervision. Professionals report:

‘Feeling stronger and having greater thinking capacity’ (Nursing Standard, 2013: 21)

post sessions and cite that the programme supports them to:

‘interact more positively in the workplace, which benefits both the rest of the team and the families or patients they are working with’ (Nursing Standard, 2013: 21).

The programme was cited as a positive example of what could be done to support a compassionate NHS service in the government response to Francis (Department of Health (DH), 2013) and the cascade model continues to be commissioned widely to support staff.

Restorative group supervision
To develop the sustainability of the model it became quickly apparent that organisations are not always in a position to support individual sessions. As group supervision had been a consistent feature for the supervisors working within the restorative programme, there was also anecdotal evidence available from these sessions that there were also benefits to this approach.

This paper will discuss the development of the group aspect to the restorative programme and the evidence base that is currently in development to demonstrate the effectiveness of the ongoing group supervision to support professionals’ resilience and compassion within the workplace.

Literature for group supervision
The effectiveness of group supervision has not been widely studied, particularly using a more formal quantitative methodology. Only a handful of studies exist that evaluate the efficacy of clinical supervision using self-report questionnaires (Nicklin, 1995; 1997a; 1997b; Mahood et al, 1998; Berg and Hallberg, 1999; Winstanley, 2001; Hyrkäs 2006). Many other evaluation studies have used approaches that cannot be replicated, such as in-depth interviews or subjective perceptions and experiences of clinical supervision and the numbers involved in the studies would prevent wider applicability of findings (Brunero and Stein-Parbury, 2008).

A small-scale study of six high-level managerial nurses revealed that after six months of clinical supervision, nurses viewed it as positive as they had been able to debrief, reflect and share stressors in their work environment (Cross et al, 2010). Although this study adds to our knowledge about the impact of clinical supervision in the nursing community, the sample size is small and the methodology unreplicable.

Abbott et al (2006) conducted a study where mandatory clinical supervision was introduced to all frontline nursing staff, including health visitors and school nurses working in City and Hackney Teaching Primary Care Trust. On evaluation the researchers found that staff strongly supported the implementation of clinical supervision within their service. Although this study clearly indicated that clinical supervision was effective for the nurses involved, quantitative replicable results were not used and so this study is limited in its effectiveness.
A number of Scandinavian studies have moved towards a more empirical approach using the Manchester Clinical Supervision Scale (MCSS) and the Maslach Burnout Inventory (MBI) (Hyrkas, 2005; Hyrkas et al, 2006). These studies identified that evaluations of clinical supervision were related to a number of factors, including the supervisee's background, the infrastructure at work and job satisfaction. Evaluations of clinical supervision could also predict burnout and job satisfaction.

Gonge and Buus (2011) have undertaken wide-scale research into supervision within psychiatric nursing and identified that factors such as level of education, gender and engagement with the organisation will certainly impact on the effectiveness of supervision. Benefits of the process appeared to be increased job satisfaction and vitality and less stress and emotional exhaustion.

While the evidence for the effectiveness of group supervision was not widely available, there appeared to be a satisfactory amount of early findings to indicate as a strategy for sustainability there would be merit in researching the impact of group supervision with the restorative model.

**Aim**

The aim of this study was to evaluate the effectiveness of group supervision as a tool to maintain the resilience of the professional achieved through individual restorative supervision.

**Design**

The study was a cross-sectional, questionnaire design which aimed to review the impact of the restorative group supervision sessions after up to six sessions.

**Ethical approval**

The research was conducted within the NHS ethical framework and as the questionnaires were evaluating staff responses to the supervision provided, formal ethical approval was not needed.

**Participants**

The study invited all health visitors who were involved in the cascade of the restorative model and had experienced up to six group supervision sessions to participate in the evaluation of the sessions. This paper reports on 174 health visitors’ experience of the group sessions.

**Data collection**

The restorative programme has relied upon the professional quality of life scale (Stamm, 2005) to provide baseline evidence for stress, burnout and compassion satisfaction. Given that baseline and post individual supervision session data were available using this questionnaire it was decided to keep the measure consistent and use this measure again after up to six group sessions.

**Data analysis**

Data were analysed using ‘SPSS version 21’. T-Tests were conducted to compare means of the baseline and post-supervision data.

**Results**

The average number of group sessions was 5.46. The results showed the group supervision continued to reduce levels of stress (t (139)=-11.564; p=0.00) and burnout (t (139)=-1.414; p=0.01). It also showed that the group supervision maintained and increased levels of compassion satisfaction (t (139)=7.480; p=0.00).

**Discussion**

The quantitative results show that the model of restorative supervision (Wallbank, 2007) is able to offer professionals the individual experience that they need to reduce their stress and burnout levels. It can also be used as a sustainable tool within organisations to ensure that the change is maintained through group supervision. Group restorative supervision is an efficient and effective way of maintaining professional resilience. Organisations can have confidence that the training programme offered is able to deliver change through the individual sessions and then this is continued once in the group phase.

The process of restorative group supervision also appeared to have inadvertent benefits to the groups within it. As part of the programme’s ongoing evaluation, supervisors who were facilitating the group were asked for themes within the supervision. These were regular topics coming up for discussion within the groups where organisations’ decisions were potentially having a negative impact on the capacity of the individual to work at their best. Confidentiality is always strictly maintained and any information fed back to an organisation was done with permission from the participants involved within the group. The themes showed how the group members were able to use the restorative sessions to support their resilience within the workplace.

**Insight into my group role**

Through the process of group restorative supervision, the supervisors within the programme team were able to learn more about how the individual professional engages within a group dynamic and this further enhanced their ability to function as a dynamic team member outside of the sessions. By supporting the professional to understand not just the content of the group supervision but the process of being within a group, the professional was able to learn about themselves. By noting the group dynamics and where these may be mirrored within the workplace, professionals were able to think about the wider impact of their individual style and support any changes they needed to make.

**Helping me deal with conflict situations**

Dealing with conflict was and remains a consistent issue within restorative supervision

<table>
<thead>
<tr>
<th>Area</th>
<th>Baseline (before any restorative intervention)</th>
<th>Post six individual sessions</th>
<th>Post up to six group sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compassion satisfaction</td>
<td>44.20 (4.18)</td>
<td>44.72 (4.17)</td>
<td>45.21 (4.12)</td>
</tr>
<tr>
<td>Burnout</td>
<td>42.81 (4.23)</td>
<td>24.71 (5.13)</td>
<td>22.81 (6.15)</td>
</tr>
<tr>
<td>Stress</td>
<td>43.85 (4.12)</td>
<td>16.86 (4.02)</td>
<td>15.81 (3.02)</td>
</tr>
</tbody>
</table>
and while the individual sessions have been useful in talking this through and developing strategies, group supervision has enabled live situations where conflict has developed and presented an ideal opportunity to think about the impact in the moment. This opportunity has been used by the supervisors to support individual professionals thinking around how they deal with conflict but also to pull on others experience and watch how they may exacerbate or mediate in particular situations. The group sessions allows participants to play with ideas around how would you deal with this particular situation and given the psychological safety of the space that has been developed, this enables professionals to practice potential solutions without the fear of getting it wrong.

Others feel this way
Normalising demands on the professional and having an opportunity to understand that others are feeling the same way is a critical part of the process. Structural changes in organisations lead to professionals not spending enough time working together and sharing experiences. This means that they can be more vulnerable to thinking that the way they are experiencing their workload or difficulties within their organisation are not shared by others. By working together to understand the aetiology of issues and, more importantly, how these can be resolved, professionals are learning to work in a more constructive and supportive way with each other. Although team-working skills are already strong within most professionals, it is the opportunity to utilise them within the restorative space that is regarded as valuable by the supervisees.

Motivating, creating and bringing together ideas
Post individual sessions, most supervisees are more energetic, creative and able to think more clearly. Bringing together groups of professionals who are high functioning and full of ideas can only encourage the innovation for services that needs to happen within the NHS.

During one recently observed group session there was a clear organisational difficulty occurring. Rather than focus on the negative aspects of what was happening, several members of the group were able to reflect different perspectives of their reality and represent the system in a more balanced way. This enabled the professional who was most impacted by the difficulty to really think about how she was viewing the situation.

Sharing the session with the supervisor
The experience of delivering individual and group restorative supervision does demand a high degree of emotional involvement on behalf of the supervisor. The group sessions were described as both enjoyable and challenging but all the supervisors appreciated the opportunity of drawing on different perspectives within the room and bringing together that thinking. This opened up the learning from the supervisees and supervisors perspectives, which will no doubt enhance the abilities of the supervisor.

Conclusion
Embedding the restorative model within an organisation means adopting a flexible approach to individual and group sessions once the initial six sessions have been delivered. The group restorative experience seems to enhance the progress that has been made within the individual sessions and brings a new dimension to the learning that occurs within the restorative experience. Group restorative supervision is both an efficient and effective way of delivering the restorative model and will further enhance the capacity of organisations to sustain the benefits of the sessions.

References
A lecturer–practitioner’s contribution to the Health Visitor Implementation Plan in East London

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Abstract
Before 2011 the UK saw a decline in the number of nurses coming forward to undertake a postgraduate programme in specialist community practice. In addition to financial constraints and an aging nursing demographic, existing health visiting teams have struggled to meet the complex health and social needs of parents with pre-school children. The Health Visitor Implementation Plan published by the Department of Health in England in 2011 aimed to expand and strengthen health visiting services nationwide. This plan is in conjunction with developing new ways of working incorporating the Healthy Child Programme. This model of working was piloted in 26 areas around the UK, commencing in 2011 as an Early Implementer site. The Community Trust in Hackney in East London was one of three trusts within London chosen by the DH in recognition that the health visiting service demonstrated good practice and had the infrastructure to build further sustainable community links. My entry into the role of lecturer-practitioner, on a two-year contract, coincided with this exciting and challenging time of lecturer–practitioner, on a two-year contract, coinciding with the change in the health visiting service in Hackney. The article describes the development of a Learning in Practice (LiP) programme and the trust's health visiting teams. The role of lecturer-practitioner arose in the 1980s in an attempt to bridge the perceived theory–practice gap (Hancock et al, 2007). Initially established in the clinical acute setting, the role continued to develop into the community arena. The role can be described as being suitable for a senior nurse who demonstrates specialist knowledge in the areas of practice, education, management and, ideally, research.

My nursing background, predominately in health visiting, captured the role prerequisites for a lecturer-practitioner, offering credibility to the dual aspects of teaching and being a practitioner. A dual role that straddles both education and health necessitates a joint and clear focus of how the role should work so there is no confusion or ambiguity in the expectations of the role. The demands of a dual role (academic vs practice) and being able to combine both cultures is a challenge (Fairbrother and Mather, 2004).

I was fortunate that there was a strategic desire to blend the contribution between academia and practice, and an intrinsic foundation of support in working within the boundaries of the Implementation Plan, both at university and in practice. At University London, I taught on the specialist community public health nurse (SCPHN) programme, and I got to know my Hackney SCPHN students very well, being visible programme, and I got to know my Hackney SCPHN students very well, being visible, accessible and respected by them both at university and in practice. This was an advantage as I possessed knowledge of their progress academically via the classroom and being their link tutor, and I understood their practice environment and the challenges that this presented to them.

I worked closely with the director of the SCPHN programme and the trust’s health visiting head of service (HOS), meeting quarterly to review my progress as a lecturer–practitioner, setting new objectives as necessary. It was here that my idea of ‘learning in practice’ (LiP) was put forward.

My primary designated objective was to contribute to the Implementation Plan’s aspect of ‘growing the workforce’. For the academic year 2011/12 the organisation was committed to significantly increasing the number of SCPHN students that could be accommodated from two to nine, requiring a corresponding increase in practice teachers (PTs). Working in collaboration with the trust’s education lead and three existing experienced PTs we were able to support a further six student PTs who were recruited internally from a pool of experienced health visitors.

Figure 1 shows how each experienced PT would oversee two student PTs, each having a student, including the experienced PT, enabling the proposed nine SCPHN students to be supported in practice by three experienced PTs.

Undoubtedly, the increase in PTs’ workload impacted upon the health visiting teams, and increased the pressures in being able to deliver the service – a new way of working – to our clients. Nursing and Midwifery Council (NMC) guidance (NMC, 2008) requires PTs to maintain their competencies as a teacher in practice, meet the requirements for their triennial review and to attend regular study days at university, as well as being able to facilitate the learning of their assigned student and manage an active caseload with the demands of an increase in practice teachers who were managing complex caseloads, whilst at the same time offering support to practice teachers who were managing complex caseloads, whilst at the same time offering support to practice teachers who were managing complex caseloads.
workload. This, in part, was achieved by raising the profile of PTs and their essential role in facilitating students in the context of their team. Discussions with PTs and their colleagues assisted in adapting to different ways of being a team with a SCPHN student. For a number of years, before it became an Early Implementer Site (EIS) in 2011, a low number of SCPHN students were being placed in Hackney so the expectations of the nature of learning and the benefits of having students needed to be restated. They would, after all, be our future colleagues. The PTs were balancing the demands of complex workloads in one of the most deprived boroughs in the country, adapting to new ways of working and I was asking them to share their own knowledge and skills in a supportive environment, coming together on a regular basis, which benefited the SCPHN students. Having previous experience as a PT, I possessed a real understanding of the student without duplicating the input per se.

Where possible the timing ie, the date for each session was aligned with the modules at university and what the students were doing in practice. The sessions were usually led by a PT or speakers with a specialist interest who were offered a remit to fulfil. The first session was felt to be particularly important as it set the scene for the coming academic year, and provided the opportunity for the SCPHN students to be introduced to each other (outside of the university) and other key staff members of the health visiting service. See Table 1 for a list of the workshops held.

Learning in Practice workshops
To develop a learning culture is to recognise the challenges to be overcome and, importantly, the potential to increase staff motivation and commitment. Working closely with the PTs, the responsibility lies with the lecturer–practitioner to constructively align theoretical input with experience in practice placements to ensure students have a smooth transition to a new way of working. A major consideration for PTs was that they were not having to provide all the experience and learning. They could share their own knowledge and skills in a supportive environment, coming together on a regular basis, which benefited the SCPHN students.

The LiP programme was developed in agreement with the director of the SCPHN programme at the university and the trust education lead. The HOS provided an overview of what was being developed under the guise of the Implementation Plan. The overall aim was to blend the growing newly acquired knowledge, skills and expertise of the student without duplicating the input of the university or their PT through a series of LiP workshops. Each workshop was planned with a theme, with the choice of topics arising from feedback provided by the previous year’s SCPHN students and as identified by the current cohort. This included perceived gaps in theoretical input, primarily around child development and referral systems.

A series of 10 2.5-hour informal workshops were developed, running every five to six weeks, aiming to be inclusive of both the health visitor (HV) and school health SCPHN students.

Although school nurses are not part of the Implementation Plan, it was felt that they were an integral part of the community nursing family. They worked closely with their HV colleagues and this promoted an exchange of ideas and perspectives. The workshop sessions were themed, with their duration and frequency agreed with the university. This ensured that the sessions did not negatively intrude into practice time, met the requirements of practice and provided sufficient time to be meaningful and worthwhile to attend.

The sessions were held in a variety of accessible venues across the trust, including HV bases and an assessment centre for children with special needs. The workshops were also aimed at those new to being a PT, offering the opportunity to develop teaching and presentation skills. As Hackney lecturer–practitioner I co-ordinated the workshops and oversaw the running of each session, booking in-house speakers and venues. This was intentional as I felt that although I was competent to teach or present, the focus should be upon the PTs or other specialist practitioners, sharing their knowledge and skills rather than academic input per se.

Evaluation by students
The students were asked to evaluate at the end of each session using a standard trust evaluation sheet. Towards the end of the workshops the students were also asked to evaluate their overall experience of the LiP sessions, to gauge whether the students’ needs were met and what could be improved for future cohorts of students. Students were asked to complete an anonymous
questionnaire regarding their views about:
- What they liked about the sessions
- How the sessions could be improved
- What could be undertaken differently
- The frequency and duration of the sessions
- Any other points.

The workshops were well evaluated by the students and it was clear from their comments that they viewed the sessions as being complimentary to their academic work and to be able to relate their experiences to practice.

‘The sessions were really relevant to my practice placement experience and the theory to practice.’

The initial ‘meet and greet’ as an afternoon tea, timed for the second week in practice, proved useful in welcoming the students to Hackney, away from the university. This was attended by the HOS, education lead, other team leaders and myself.

‘It was good to have the meet and greet as it made me feel welcome.’

An unexpected positive outcome was the value placed on meeting the managers within the health visiting and school health services. The students were interested in the role of managers as leaders and were already contemplating the possibility of future opportunities, whether:

‘This was somewhere I could work when I completed the course.’

The trust also recognised the value in the sessions as potential for retaining new members of staff by demonstrating a keen commitment to learning.

The sessions led by the head of service provided the opportunity to understand how the wider public health role was being developed in the context of the Implementation Plan, which the students were beginning to feel an integral part of:

‘Good to see how current practice is implemented.’

The planning of the sessions considered the appropriate time, duration and frequency of the sessions that required a blending of theory and practice without being intrusive into the NMC requirements regarding teaching and practice hours (NMC, 2008). Interestingly, the students would have liked the sessions to have been held more frequently:

‘The sessions were insightful.’

‘Once a fortnight would be better as we could have more sessions including reflective practice.’

Other comments included:

‘It has been good to meet up with other students in practice as they are my future colleagues, and therefore good for working relationships.’

‘It is good to hear other people’s experiences.’

‘Very good programme to be continued with other students.’

**Conclusion**

The balance between developing a new idea in practice, adhering to NMC requirements for SCPHN students and working collaboratively with all stakeholders was achieved. However, developing the LiP sessions was not without its challenges. Managing demanding workloads and meeting the needs of their student, coupled with staff shortages, would prove difficult for the PTs. They found it a challenge to maintain a sense of continuity in attending the sessions when they were not leading on a session, while actively encouraging their student to attend.

This was a particularly successful year in terms of recruiting and retaining staff, with all but one of the students upon qualifying securing posts within the trust. This student accepted a post nearer to where they lived, thus reducing their travelling time. For the following academic year, three student PTs achieved their award resulting in the service having six PTs with sign-off mentor status and accountable for stating that a SCPHN student is fit to practise. This allayed fears about the PTs being able to manage their workloads and their teaching responsibilities. Anecdotal feedback from the teams around the students reported that, overall, they welcomed a SCPHN student within the team, not least because they offered new insights into the Healthy Child Programme (2009).

In reflecting upon the planning for future cohorts of students and in meeting their needs to embed ‘best practice’, the LiP model allows for a degree of flexibility to meet identified learning needs. This can enhance the experience for SCPHN students examining local and national issues. The increase in PTs offers the opportunity to further strengthen the learning environment for students and to progress the LiP model, demonstrating leadership skills. In addition, there is scope to embed real joint learning between health visitors and school health students.

**Acknowledgements**

I cannot conclude without acknowledging the support and understanding of the HOS and team managers, as without this the LiP would not have been successfully completed. I would like to acknowledge the support of the director of the SCPHN programme who understood and approved the LiP and was excited by this development in practice.

**References**


**Key points**

- Health Visitor Implementation Plan: Growing the Workforce
- Lecturer–practitioner role in supporting practice teachers and an increase in SCPHN students within practice placement areas
- Supporting a SCPHN student network in practice
- Learning in Practice

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A survey of antenatal advice and education by the Sedgemoor Health Visitor Team

Introduction
In recent years there have been considerable cutbacks in the provision of antenatal education by the NHS in the UK. In 2006, the National Perinatal Epidemiology Unit claimed that 88.5% of primiparous women were offered classes at their local hospital or clinic (Redshaw et al, 2007).

Many women who are pregnant for the first time will seek to attend antenatal classes (Redshaw et al, 2007) and may be distressed if not offered them. Some women who can afford it will seek classes in the voluntary or private sectors (Singh et al, 2002).

Studies of childbirth education have universally failed to take into account the quality of the education provided to women and their families, and whether its content and style of delivery meet women’s preferences and needs. A woman’s education about childbirth is influenced by the society in which she lives and its cultural expectations. Kitzinger (2000) has illustrated the ways in which birth is perceived in different cultures – and the experiences of these women suggest that there is a large divide between professional and lay perceptions. MacVicar (1990) also recognised that the information provided and the expectations of women during pregnancy were at odds.

There has been a dearth of research in the last 30 years looking at antenatal education meeting women’s needs and attendance at such sessions (Coombes and Schonveld, 1992; Rees, 1982; Roch, 1992). The effectiveness of antenatal education by systematic review remains unknown (Gagnon, 2004).

It has been acknowledged that classes suffer from a number of problems, including a low attendance rate and a high dropout rate. Murphy-Black’s (1990) review of the literature included the following factors as reasons of poor attendance:

‘Clients did not want to go; did not know about them; classes not worthwhile; felt confident without attending; poor timing; transport problems; attended in previous pregnancy; no childcare provision’. [If this is a direct quote please provide a page number]

Studies also indicate that, at their best, antenatal classes encourage and develop lasting supportive friendships, and that parents want balanced, honest and realistic information so that they know what to expect and can then make informed decisions (Shearer, 1993; Cliff and Deary, 1997; Nolan, 1997).

Schott and Priest (2002) found that the women whose needs are least likely to be met by standard antenatal classes are young, single, working class women and those from minority groups. Women who are socially isolated or concerned about housing, money or domestic violence may have little time or energy to explore antenatal classes. Women learn about birth and parenting from their mothers, sisters, extended family and community (Nolan, 1997; Kitzinger, 2000).

Background
Antenatal classes were running very successfully in parts of Somerset but it was identified by the health visiting team in South Sedgemoor that there was a particular need to look at the antenatal provision in the local area. Previously, health visitors had run an antenatal parenting session as part of the parentcraft/antenatal education provided by the midwives. This was stopped for a number of reasons, including health visitor shortages in South Sedgemoor, health visitors working to vacant caseload policy and the dwindling numbers of parents attending the third antenatal session run by the health visitors.

The Healthy Child Programme (Department of Health (DH), 2009), which is being implemented in South Sedgemoor, includes an antenatal contact with the health visitor between 28 and 36 weeks gestation. The decision was made to survey expectant parents to determine their views on how best this contact could be achieved.

Setting up the project
Local needs assessment

The questions in the survey were designed to identify a number of key issues: when and where the clients would like the antenatal contact [with the health visitor or midwife?] to take place; what they would like to discuss at this contact; who they would like to share this contact with and how they currently get their antenatal advice.

Due to the time constraints set for the project, we could only survey parents for two consecutive months [please provide the months and year]. As the midwives were already seeing these parents it was felt that a higher response rate to completing the questionnaires would be achieved if the midwives handed out the questionnaires at antenatal appointments. Midwives working in Bridgwater handed out the questionnaires to antenatal parents who were 28–34 weeks gestation over a two-month period. This did result in a potential bias in that we did not include in the survey those parents who had pregnancy complications and were having hospital antenatal appointments.

After the results had been collated, it was decided that a pilot antenatal group was to be run in a local children’s centre at a time that the majority of respondents had requested.

Results

Sixty questionnaires were handed out by the midwives and 44 replies were received (73%). It was evident from the findings that the vast majority of parents [do you mean women?] questioned (82%) wanted individual, face-to-face to contact with health visitors and midwives, with only 27% wanting to attend a small group. However, it was interesting to see that the majority of respondents felt that it was ‘moderately important’ that they met other expectant parents. Most of the respondents wanted to see the health visitor in private and there was an equal division between the respondents as to whether it was important that their partner attended this contact or not.

There was a clear request for this contact to be done in the surgery (59%), although 36% felt that home or the children’s centre would be an appropriate place. The parents mostly felt that the best time for this to happen would be during the day (48% of respondents) [please provide number] or at the weekend (30% of respondents) [please provide number].

When asked what topics they would like to know about, development of the baby, feeding, health, safety, basic care and role of the health visitor were requested by over a third of the respondents. Setting up the project proved to be very challenging but rewarding. Due to staff shortages within the health visiting team, it was difficult to find the time to meet with colleagues to discuss which questions should be included in the survey and to prepare the questionnaire. Due to logistics, only those women who were seeing community midwives could be included in the survey. It also resulted in a mistake being printed in one of the possible answers on the questionnaire which was not spotted until the results were being collated.

The midwives were very supportive and agreed to hand out the questionnaires during their antenatal appointments with the parents. [How long was the questionnaire? Was it composed of closed and open ended questions? Did you get Trust approval to send out the questionnaire?]

Figure 1. How would you prefer antenatal advice and information to be provided?

Figure 2. Where would you prefer antenatal advice and information to be provided?

Figure 3. What information would be helpful?
Preparedness related to initial mentor preparation, annual updating and triennial review. A range of experiences was identified. However, most participants were ambivalent about the adequacy of their training due to its lack of currency and the quality of the course they attended being:

‘Terrible, I did very little work.’

‘Adequate, but tick-boxy.’

Annual update is compulsory and online updating was regarded as:

‘Quick and easy, I didn’t learn anything.’

The experiences of participants in relation to triennial review also appeared to lack rigour and one participant felt:

‘You can do it as well or as badly, you know.’

Emotional support reflected participants’ views that they were inadequately supported by managers who failed to acknowledge the difficulties associated with the dual role.

‘There is no reduction in case load…in fact, at some points I was covering two caseloads…my manager understood but I was never offered time away to do anything to do with mentoring.’

While support groups were available to some mentors the effectiveness of them was varied. In some, but not all cases Pts were considered helpful.

‘I would have appreciated a phone call just to say are you OK?’

Little mention was made of the role of university staff in the support of mentors.

The final theme was compromising, which reflected the tension between the mentors’ duty to care for clients and students while trying to minimise the impact on their own and their families’ wellbeing:

‘Sadly, our clients have suffered. We haven’t been able to provide them with even the core programme.’

‘It’s not the students’ fault they have been given us and it’s not fair for us.’

Discussion
Laschinger and Finnegan (2005) identify that empowerment can be used in the workplace to build trust and respect. Work place empowerment is defined by Kanter (Purdy et al, 2010: 902) as:

‘Having the power to access the structural factors within the work environment that enable the employee to get work done’.

Laschinger identifies the value of structurally empowered workplaces where feelings of justice, respect and trust in management are more likely to be evidenced with consequential increased job satisfaction, organisational commitment and increased patient satisfaction (Angermeir et al, 2009).

Hegar and Hunzeker (1988, cited in Gibson, 1991) observe that a lack of empowerment may be understood as the presence of feelings of powerlessness, hopelessness, alienation and a loss of control over one’s life. These concepts align significantly with participants’ statements where fear, anger, isolation unhappiness, frustration, loss of confidence, failure, resignation, poor communication, lack of support, worry and exhaustion were acknowledged.

Kanter (1977, cited in Purdy et al, 2010) identifies access to opportunities; information and resources may improve individuals’ perception of control. Participants appreciated a choice of online or face-to-face updating. The provision of support from an educational forum run by a Practice Education Facilitator (PEF) was regarded highly by two participants, while other mentors appreciated the opportunity to assert control over their situation by running their own support group. Information provision regarding organisational goals appears to have been in short supply, while lack of time was the resource most consistently referred to by participants and constituted their main concern. Lack of practical facilities aggravated a difficult situation requiring creative thinking to enable physical space to reflect upon the day’s work as desks, computers and office space were in some cases in short supply.

Preparedness
The standard of mentor training is articulated by the NMC (2008a), incorporating the length of training and clear standards mentors should be able to demonstrate through a range of eight domains. The quality of courses is overseen by the Quality Assurance Agency for Higher Education. However, in some cases due to the historical nature of their training, mentors felt they were unfit for this purpose. A range of views informs this discussion; Gainsbury (2010) and Duffy (2003) identified a lack of adequate preparation was a concern to mentors with particular reference to failing students when appropriate. Yonge et al (2007) recognised the need for community nurses to receive a higher level of training to support the practice of specialist practitioners.

The quality of mentors’ annual updates was identified as requiring attention. Time constraints and geographical location determined the mode of delivery, but some participants felt online training was not in sympathy with their learning style and many considered the quality of the training to be poor. Triennial review is an opportunity for mentors to bring together evidence enabling them to remain on the live mentor register. Gopee (2010) regards this occasion as an opportunity to celebrate success reflecting upon the previous three years learning. This process is, however, conducted by managers who may not be sufficiently conversant with teaching and learning to maximise the opportunity. While the documentation relating to this procedure is audited by the NMC and the HEI the quality of the portfolios of evidence is the responsibility

Key points

- Powerlessness emerged as the overarching theme within the data. Three sub-themes emerged of preparedness, emotional support and compromise
- Managers might consider the impact of the dual role of the mentors and ensure mentors are located in shared offices where informal support networks can develop
- Mentors may benefit from continuing professional development undertaken in co-operation with the HEI and Pts. Triennial review would benefit from being undertaken by Pts using quality standards benchmarked across a range of trusts
- Support groups facilitated by Pts may empower mentors if they can set their own agenda
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Dear Sarah,

First, I want to say what a pleasure it was to have you as my health visiting student. You told me how my enthusiasm and ability to teach potential health visitors had encouraged you to apply for the specialist community public health nursing (SCPHN) course and I was so delighted when I learned that I was to be your practice educator and you were to be placed within our team.

We discussed the need for you to have support and a designated study area as well as attaining a healthy work and life balance. Even so, with all your family support and my advice, when we met up in the office after your first three weeks at university I remember how overwhelmed you felt about all the assignments, the exams and the portfolio. I encouraged you to initiate your own learning needs using the ‘strengths, weaknesses, opportunities and threats’ self-analysis tool from your university documentation, and we then compiled a comprehensive list of achievable learning objectives.

We talked through your anxieties about practice; the concerns you had about the academic side of the course and we looked at the numerous opportunities that would help you gain the necessary skills and confidence. In removing ourselves from the distractions of the office and sharing some time analysing and discussing your concerns, I was able to put a stop to you telling me what you felt you did not know and changed the focus to highlighting your many transferable skills, given you had a military and nursing background.

My role was to ensure that by the end of the 52-week course you were a competent, safe practitioner, deemed fit to be signed onto the Nursing and Midwifery Council register. Over a period of weeks we established and developed an effective professional partnership; and with such a positive team around you and a comfortable learning environment, effective learning could occur. You felt relaxed, able to ask questions, listened carefully and shared your concerns about families in allocation meetings. You were making real progress and enjoying placement.

The joint ongoing partnership with your university and your tutor’s placement visits assured me that you were progressing well and listening to you give a synopsis of your research into domestic violence, while clearly linking it to practice, made me as your mentor feel very proud.

As the year progressed, you were confidently doing complex primary visits, follow-up visits, referrals to other services, liaising well with other professionals and jointly attending case conferences. The more time you spent in practice the more your confidence grew and you learned through observation of how the team interacted with each other, with parents and their children, and with everyone they encountered.

Everyday interactions were dealt with respectfully; a simple reassuring phone call to an anxious parent, clinic contacts and home visits to clients. No matter how that client was in terms of mood or even in the complexity of their problems the team approach was to try and make a little difference to their lives.

Martha Gibbons
Health Visitor and Practice Educator, Central Manchester Foundation Trust

A practice educator highlights how a collaborative approach between the university, the student, the practice educator and a supportive team during placement allows the student to flourish, be inspired and achieve success.
You saw that there was excellent open communication within the team. You witnessed how each member felt totally appreciated and their opinions were both encouraged and valued. There was a real sense of belonging in the team, loyalty, pride, genuine warmth and a calm nurturing approach. There was a ‘can do’ rather than a ‘cannot do’ attitude. You would comment on the willingness to help one another out and ‘pitch in’ and assist struggling neighbouring teams.

You often said you were in awe of my strong commitment to my profession after over 25 years of service and had admiration for my ability to conduct my duties in the fast changing pace of society; and I would reply that I felt truly privileged to be doing this work. Training the health visitors of the future and sharing my experience simply adds to my satisfaction with my role.

You were surprised by my knowledge of every single road in the district, my networking skills and my recall of all the families, their connections and the funny stories I would tell you about the most delightful characters I had the pleasure of meeting.

I would tell you of the families who will remain in my heart for ever because of their ability to survive when faced with real adversity. Families who suffered the heartache of late still births, loss of children through illnesses or accidents and children born with severe disabilities. We visited foster parents, who at a moment’s notice would step in to care for a child, these quiet, unsung heroes among the community in which we work. We visited families that had children removed because their own formative years had been so damaged, so devoid of real love or any positive parenting model.

We were seeing generations of families who had never worked and where there was not only financial poverty but a poverty of aspiration for themselves and their children. Some parents accepted our help and were up for the challenge and willing to change and some sadly were so entrenched in putting their own needs ahead of their children’s that they were beyond help, shunning our attempts and reacting abusively.

In your 10-week consolidation period it was so rewarding to see you empowering one particular family whose first baby was removed a few weeks after birth. This was her second child and she was now with a more supportive partner. This mother accepted our health visiting guidance that she had previously dismissed years before. Her little girl was thriving and through your consistent visiting and the building up of trust, she gained added confidence and she bonded with her child and had a renewed belief in the practitioners involved in her care. You see, it is possible to make a difference even with some of our most damaged clients if they themselves are willing.

The key to effective health visiting has always been about the building of relationships through regular consistent visiting to address problems before they become insurmountable. This concept was very much part of the ethos when I qualified.

Over the past 10 years due to significant staff shortages and underfunding, a leaner model of health visiting became accepted practice. Unfortunately it was so 'paired down' that health visiting as a profession was in danger of becoming extinct.

I believe that with the advent of an increased workforce, health visiting will once again become a profession where we can form supportive bonds with families and return to our child development focus and our health promotion roots. Indeed, this is echoed throughout a raft of government plans to increase the health visiting workforce to deliver the preventive and proactive work that once formed the core values of our profession.

Overtime, Sarah, your confidence and competence grew and I watched you mature from that fledgling student status to a practitioner ‘ready to fly’. You were building up relationships, liaising, using your initiative, planning your work, leading allocation meeting, conducting the full range of visits and consistently doing your best. You embodied all one would ever want in a future health visitor and your infectious enthusiasm spread throughout our team.

We continued with our regular one-to-one support sessions away from the bustling office discussing, reflecting and reviewing cases and while I sat observing you, listening to you, you were confirming to me that you were a safe and competent practitioner. The days became weeks, then months and before we knew it your training was nearing completion.

This in itself was a pleasure to see yet further accolades and total appreciation came from you in recognition of all those who had helped you along that journey, the team around you, the university, your employer and our partnership.

I do hope you are enjoying your six months preceptorship and are benefiting from this excellent innovation. I make no secret of the fact that the usual inner city problems exist in this challenging and diverse city, but the experience and training for students here in Manchester is outstanding and all the practice educators, university tutors and the trust need to be commended for what we are being tasked to do. Health visiting is flourishing once more and Manchester is proving a popular place to train as we are inundated with applicants.

Sarah, we had a fabulous mentor–student partnership. I have thoroughly enjoyed our year together, playing a small part in your success and in sharing my genuine passion for health visiting. I wish you many years of happiness in a most unique and fulfilling career.

Martha Gibbons is a practising health visitor and practice educator with Central Manchester Foundation Trust (CMFT).

Martha works at Northenden Health Centre, recipient of the CPHVA Team of the Year Award 2013.

Sarah Jane Mills is a practising health visitor with CMFT and was a finalist for the CPHVA Student of the Year Award 2013.
School nursing: the picture in Sweden

A recent trip to the UK provided Pernilla Garmy with the opportunity to compare her profession with the picture in her home country.

While staying in Oxford for an English language course during a week in April, I had the opportunity to meet with school nurses working at the East Oxford Health Centre, and with PhD students and researchers interested in children’s health (all of them nurses) at Oxford Brookes University. I was a bit nervous before meeting with them, but soon realised that, all being nurses, we shared a strong interest in the health and wellbeing of children and adolescents. I also realised that, although there are similarities between school nurses in Sweden and in the UK, there are a few differences. This article aims to provide a picture of what school nursing is like in Sweden, including the successes we experience and the challenges we face.

Qualifying as a school nurse
To become a school nurse in Sweden you are required to undertake three years of study to obtain your bachelor’s degree in nursing. I had heard that in the UK, in contrast, you can choose a programme of study leading directly to becoming a nurse for children, or a nurse with some other specialty. In Sweden, there is only one option initially – that of studying to become a registered nurse (RN). Most Swedish universities require you to have worked as a RN for one or two years before you are allowed to enter a 1–1½ year graduate studies programme to obtain a master’s degree in nursing.

If you want to become a school nurse you can select one of three types of master’s degree programmes: one dealing specifically with child and adolescent health; another dealing with public health in general; and the third being a programme devoted entirely to school nursing.

School health service
All schools in Sweden are required to have access to a school nurse and to a school physician. A school nurse is commonly on duty at the school in question every week day. Generally, the school physician visits the school either once or twice a month, depending upon the size of the school. Although the Swedish Association of School Nurses recommends that a school nurse should not be responsible for more than 400 pupils, in many areas the number of pupils involved can be twice that.

The school health service provides each pupil with the opportunity not only for spontaneous visits with the school nurse, but also for an individual health examination at least once every three years. In addition to the pupil’s height, weight, spine and vision being checked, the pupil is given the opportunity to talk with the school nurse about matters of health and lifestyle (Fagerholt, 2009).

Health dialogues
The most common type of intervention undertaken by school health services in Sweden is individual visits with the school nurse, who discusses with the pupil matters of health, after obtaining her bachelor degree in nursing in 1998, Pernilla worked at the Children’s Hospital in Lund for three years before taking her master’s degree in child and adolescent health in 2002. She has worked as a school nurse in Lund for 10 years, and has now been enrolled in a four-year PhD programme. Her PhD project is an evaluation of a school-based programme aimed at preventing the development of stress and depressive symptoms in adolescents. She received the school nurse of the year award in Sweden in 2010 and in 2012 she received an award from Her Royal Highness Queen Silvia of Sweden for her research on sleeping habits in school children.

Pernilla (front row, second from left), with school nurses in her home town of Lund, Sweden
lifestyle and wellbeing (Golsäter et al., 2012). Subjects commonly brought up include eating, sleeping and media-consumption habits, as well as emotional difficulties, which may sometimes be linked with stress, lack of self-confidence or problems with social interaction.

Evaluations have shown most pupils to be satisfied with the health dialogues they have with the school nurse (Golsäter et al., 2010; Borup, 1998), although Bodén et al. (2013) showed recently that adolescent girls with endometriosis (pain during menstruation being the most common symptom) found that school nurses failed to live up to the expectations they had in terms of the support provided to them and the degree of competence shown.

At the same time, Borup and Holstein (2010) found that in Denmark (which has school health services very similar to those in Sweden) overweight boys perceived a dialogue with the school nurse as having very positive effects. The pupils are encouraged to focus on the strengths and resources they possess to make the healthiest choices possible. In the Danish study, overweight boys, to a greater extent than boys of normal weight, were found to reflect on health dialogues of this type, to discuss them with their parents, follow the nurse’s advice and to visit the nurse again. Such an association was not found among girls of different weight groups, but the girls were found, in general, to be more ready to visit the school nurse than the boys in the first place (Borup and Holstein, 2007).

All school health visits must be recorded, but school nurses in Sweden sometimes find it difficult to document in detail confidential talks with a pupil regarding certain matters, fearing that parents, future caregivers or even the pupil in question could misinterpret what has been written down (Clausson et al., 2008).

A school nurse’s day

When one of the school nurses in Oxford showed me her weekly schedule of different activities I could easily recognise myself in her schedule. I would say that most of the things we do in Sweden are similar: immunisations, meetings with school head teachers and members of staff and parents, training of staff regarding conditions such as allergies and epilepsy, individual meetings with pupils with special needs, and classroom discussions concerning topics related to health, hygiene and puberty, for example.

Despite this, one thing was different. The school nurses I met in Oxford appeared to be responsible for many more pupils and schools than any school nurse I know of in Sweden. It is regarded as particularly important in Sweden for pupils not to have to schedule a visit with the school nurse in advance. This is facilitated by the school nurse having an office in the school and being available at least several days a week. I could also see advantages in the way school nurses in Oxford worked, as they had the opportunity to meet with one another more often. Even if they are out on visits to different schools, most of the time they have an office at a health centre where they can meet and discuss things with colleagues. Swedish school nurses are more likely to feel isolated as they are the only health professional present on a daily basis at the school in which they work.

Conclusion

Being a school nurse, whether in the UK or in Sweden, means being able to work independently. A great deal of experience is called for, with school nurses needing to be able to communicate effectively with school staff, parents and, above all, with the children and adolescents.

Morberg et al. (2012) have shown how school nurses in Sweden experience their work in terms of Bourdieu’s concepts of capital, habitus and field. The experiences during my visit to the UK made me feel highly confident that the results obtained in that study would likewise be very applicable there. In both countries, the work of school nurses is highly important and makes a difference every day.

References


A guide to home visiting in child protection cases

A considerable amount of a health visitor’s time is now spent working with families where there are child protection concerns, collaborating with social workers and other professionals, attending child protection conferences and core groups and visiting the family home. Joanna Nicholas explains how to make the most of these visits.

Joanna Nicholas
Independent Child Protection Consultant and Trainer

Home visits may be carried out alone or with other professionals but, either way, it is essential that as a health visitor you make maximum use of your time with the family.

The most important point is to make sure you are clear what your role is. Social care will always be the lead agency in child protection cases, but your role as a health visitor is fundamental as one of social care’s partner agencies. If the child is subject to a child protection plan there should be a clear strategy in place, with individual roles and practicalities, such as the frequency of home visits agreed.

In practice, social workers sometimes feel it is their role to tell other professionals what is expected of them. In reality, that is not their role and you do not have to do as you are told. As a professional member of the core group you need to ensure that you have been part of the planning, and that you have agreed what your role is from the beginning.

You have equal responsibility, along with the other core group members, to ensure the child protection plan is being adhered to and it is your responsibility, again along with other core group members, to be clear about what will happen if there is deviation from the plan or if other core group members are not fulfilling their roles. All of this you will do with the support of your safeguarding supervisor. You will not be working in isolation.

Getting in touch with the family
If you are working on a case where you know there are child protection concerns, find out as much as you can about the family before you visit. This is important for your own personal safety and so that you can assess who should be living in the home when you visit. Apart from health records, social care would be the place to start gathering this information.

If a child is on a child protection plan, plan social care will always be involved. If the family has moved into your area with the child already on a child protection plan, there will be a receiving-in/transfer-in child protection conference. You will be invited to this conference but if you are unable to attend or do not receive the invitation make sure you speak to social care before you do a visit.

In many child protection cases, social workers are seen as the ‘enemy’ by the family, while the health visitor is regarded in a more positive light, although this is not always the case. If you have any concerns about your personal safety discuss them with your supervisor or manager before you visit.

In the home
Your role in ensuring the protection of the
children you work with is essential. When you are in the home you will need to make sure that you are observant and record what you see. Make sure you know who all the adults are and don’t be afraid to ask people to identify themselves. You may not feel confident to challenge them but if someone is in the home who, in your opinion, should not be there, make sure you let the social worker know as soon as you leave the property – or the police, depending on the depths of your concerns.

What to look out for
As part of your role you should always be considering and weighing up what you see in a home. Is there evidence of drug-taking, excessive use of alcohol, filth or chaos? Is there evidence of food, bedding, sanitation and good hygiene?

On an emotional level, how is the toddler responding to the adults in the home? Do they seem frightened or withdrawn? Have you seen them flinch with a particular adult? Is their development delayed? What might be causing that? We often wait for a medical or psychological diagnosis when a child’s development is delayed but these diagnoses often come too late for the child. Neglect is very often a cause for developmental delay and we need to use the evidence we find to support our claims.

Many children who have learning difficulties are children who have been neglected and your observations in the home will all help you, as a group of professionals, to come up with a clear picture of that child’s life and what it is that child needs.

When it comes to working with older children, make sure you speak to the child. We often tick a box saying ‘child seen’, but what does that mean? Use your time in the home meaningfully.

One of the most crucial factors in child protection work is that agencies work well together and communicate with each other. Some families will try to play one professional off against another but they will not be able to do that if we are working well together. That is our best chance of protecting children.

Conducting the Home Visit in Child Protection, by Joanna Nicolas, was published by Open University Press in May 2012.

Case study: a neglected child

‘I was working with a single mother with five children. All of the children were subject to child protection plans because of neglect. There was also domestic abuse. I arrived at the home one day and the eight-month-old baby was lying in her pushchair, feeding herself from her bottle. I was in the home for 1¼ hours and during that time uniformed police arrived. There was a domestic incident, the other children were coming in and out, and the baby lay there. She fed herself until she fell asleep. When she woke 20 minutes later, she found her bottle that she had dropped. She carried on sucking until it was empty and then dropped it again and for the rest of my visit she just lay quietly, watching. She asked nothing of anyone. In addition to this she was unable to sit up and rarely babbled.’

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Delivering Solihull Approach training in Pakistan

Linda Norman SRN ONC HV
Health Visitor, Islamabad, Pakistan

What do you do when your husband comes home and asks if you would like to move to Pakistan for three years? This was the question I was asked in 2010. The outcome was that I left work, my grown-up children, ageing parents and friends. We arrived in Islamabad in February 2011.

Having worked since 1973 as a nurse and health visitor I was not about to sit still in my new and exotic surroundings. Fortunately, I had been introduced to the Solihull Approach some years ago and had delivered training across the UK. I was about to face one of the many challenges I embraced during my life in Pakistan.

After some months I found a contact who was able to help me recruit Pakistani women to receive Solihull Approach training with a view to them delivering a parenting course to local parents. The volunteers came from the local community and a variety of backgrounds, including a teacher and three nurses. In April 2012 I was informed there were eight women interested in running 10-week parenting courses in their own areas of Pakistan. As my Urdu is limited I was not able to offer much help during the sessions. We agreed I would visit towards the end of the sessions to support the facilitators and meet the delegates. Three groups ran the Solihull Approach ‘Understanding Your Child’s Behaviour’ course. They completed nine sessions, with the 10th being a ‘Celebration Day’ on the 19 May 2013. A total of 42 of 47 women completed the course. This equated to a retention rate of 89%.

The groups
Group One (Islamabad): 19 registered, 17 received certificates
These women were from a more affluent background. One of the delegates was a qualified Doctor of Medicine. Feedback from this group demonstrated how communication had improved between spouses and parents to their children. ‘Feelings’ was a new concept for them to understand because, traditionally, Pakistani children do as they are told without question or hesitation. The course helped change those views, resulting in better relationships within the families.

Group Two (Abpara): 15 registered, 13 received certificates
This group encountered the most difficulties due to language problems, travel and ongoing load-shedding or power cuts due to a...
national shortfall in energy production, in some areas for up to 20 hours in a day. The two facilitators had to rewrite the homework sheets as the official interpreter had translated them literally. Load-shedding meant no fans or light and, as there was also a lack of furniture, it was not the best environment to facilitate learning.

Many delegates had to keep their children with them, as spouses either could not, or refused to, look after them. There were a few toys but no childcare facilities at the venue. However, it was interesting to witness how quiet these children were. Most delegates used public transport that did not always arrive on time – or not at all – resulting in sessions that started late.

The group developed during the weeks. It was noted how confidence improved and women who were, initially, not contributing at all, gradually became more involved. This culminated in one woman helping with role play – something that surprised everyone – and one delegate even volunteered to present during the ‘Celebration Day’.

Many of the delegates appeared to struggle with Pakistan’s male-dominated society. Education was something that they hoped to offer their children, both male and female. Hitting children was the only form of control the delegates had recourse to until they had attended the course. They now intend to think about feelings, both their own and those of their children, many of them having five or more offspring. During the weeks they had been able to deal with situations in a more positive way, not always resorting to hitting. One lady made the group laugh as she had missed one session, only to be asked by her child when was she going back because she had been much nicer after attending the session on the previous Saturday.

**Group Three (Rawalpindi): 13 registered, 12 received certificates**

The facilitators reported it took until Week Three for things to settle and for them to gain the group’s confidence. Homework was completed and by Week Nine all delegates had contributed. The facilitators believed that the delegates expected solutions and, although changes were being seen, more work was needed before they fully understood the concepts.

The group realised their confidence had increased and being able to speak in public was something they had not been able to do previously. They were now able to socialise and believe they have new friends that they hope to maintain relationships with. Delegates reported they were recognising their own feelings, leading to thinking about the children and how they perceived different situations. They now try to give time and listen to the children; before the course they were quick to become angry often resulting in shouting and often hitting. The feedback from training has been overwhelmingly good. Communication, confidence and parent–child relationships have all improved.

**Celebration Day on course completion**

During the ‘Celebration Day’ three separate speeches were delivered, in Urdu, by a delegate from each group. Interestingly, they were three very different talks given by women who have never previously presented to a large audience before. They had composed their own speeches that were delivered well.

The first group talked about the increased confidence of each delegate; the second discussed improved communication; and the third talked about anger management, including how they now think before they act and considered feelings that had not been thought about before, including those of their children and other family members.

The Council Chief spoke next. His wife had attended the course. She noticed a change from Day One when she returned home: ‘After greeting the adults she went to their son, not an easy child, and greeted him’. He said that now a compromise is often reached as a solution to problems. Pakistani women live in a patriarchal society and some of the women attending the 10-week course could not read or write. Some were attending without their husband’s knowledge and consent, but all wanted to learn.

Official statistics released by the Federal Education Ministry of Pakistan give a desperate picture of education for all, especially for girls. The overall literacy rate is 46%, while only 26% of girls are literate. However, independent sources and educational experts believe these figures are inaccurate. They place the overall literacy rate at 26% and the rate for girls and women at 12%, contending that the higher figures include people who can handle little more than a signature. There are 163,000 primary schools in Pakistan, of which merely 40,000 cater only for girls.

Of 14,000 lower secondary schools and 10,000 higher secondary schools, 5,000 and 3,000 respectively are for girls. There are around 250 girls colleges and two medical colleges for women in the public sector of 125 districts. About 1.5 million and 0.5 million girls respectively go to higher secondary schools/colleges and universities.

Poverty is also a big hurdle to girls’ education. According to UNICEF, 17.6% of Pakistani children are working and supporting their families. Indeed, children working as a domestic help are a common phenomenon in Pakistan and this sector employs more girls than boys.

**Conclusion**

The Solihull Parenting Course ‘Understanding Your Child’s Behaviour’ gave 42 women, plus the 10 delivering the training, the opportunity to think about their parenting and how it can affect their children’s future. They have been part of a group where their thoughts and feelings were listened to and understood. They have made new friends who will support each other and, more importantly, they realise they are important and they can make a difference.

**Acknowledgement**

I would like to thank the Solihull Approach Team who supported me in introducing the Solihull Approach to Pakistan where there are still many millions of women who would welcome and benefit from a chance to receive
Nutritional requirements in pregnancy and use of dietary supplements

Introduction
The maternal diet plays a crucial role in determining foetal health and development, and a healthy, varied diet is of critical importance during pregnancy. Pregnancy is also a key opportunity for health professionals to encourage women to make dietary improvements, as they tend to be more motivated to change aspects of their diet and lifestyle during this time.

Dietary recommendations for pregnant women are very similar to those for other adults, but there are a few notable exceptions. There are two supplements of critical importance during pregnancy – folic acid and vitamin D. This article will look at current recommendations with regard to supplement use during pregnancy and current issues in this area, such as low uptake in vulnerable groups.

Health visitors and other health professionals working in primary care and community settings have a vital role to play in encouraging women to follow the appropriate guidelines to help ensure a healthy pregnancy and optimal birth outcome.

The British Nutrition Foundation (BNF) has recently published a new Task Force report entitled ‘Dietary requirements for pregnant women’ (BNF, 2013), which looks at the health and nutrition of pregnant women and where improvements in the maternal diet could be made. This article focuses on the report’s findings with regard to the essential nutrients folic acid and vitamin D, including current intakes and status, uptake of supplements and vulnerable groups that are falling short of dietary guidelines.

No conflict of interest declared.

Nutritional requirements during pregnancy
All pregnant women should be advised to follow a healthy, varied diet based on the 'Eatwell Plate' model (www.nhs.uk/Livewell/Goodfood/Pages/eatwell-plate.aspx). There is an increased requirement for a number of essential nutrients during pregnancy, including protein, vitamins B and B₁₂, folic and vitamins A, C and D. Although maternal physiological adaptations during pregnancy, such as increased absorption, can help achieve adequate nutrient levels, dietary advice around the time of pregnancy is still required.

Pregnant women should be encouraged to consume plenty of iron- and folate-rich foods, as levels of these nutrients are often low in the diet. While there is no recommendation for extra calcium in pregnancy, foods rich in calcium should be encouraged as calcium intake can be low, particularly in adolescence when the maternal skeleton may still be developing and calcium stores are insufficient to meet both maternal and foetal needs (see Williamson, 2006).

Some additional energy is required during pregnancy to support the development of new tissue for the foetus and placenta, for the growth of maternal tissues including breast and uterus, and for additional maternal fat deposition. However, some of these energy costs are met by a reduction in physical energy expenditure and, therefore, on average there is only an extra requirement of approximately 200kcal per day during the third trimester (Scientific Advisory Committee on Nutrition (SACN), 2011; Department of Health (DH), 1991). This is equivalent to a medium bowl of cereal with semi-skinned milk or a small jacket potato with baked beans.

There is a small additional requirement for protein during pregnancy of 6g per day, but as average protein intakes (65 g in women aged 19–64 years) are already well above the Reference Nutrient Intake (RNI) (45 g for women aged 19–50 years), most women do not need to consume additional protein during pregnancy (Bates et al, 2012).

Folic acid
In the early 1990s research showed that daily consumption of folic acid (400 µg per day) around the time of conception could reduce the risk of neural tube defects (NTDs) (Medical Research Council, 1991). Since then, governments and health organisations around the world have made recommendations for women to take folic acid during early pregnancy. However, government policy in the UK has recently moved towards a new period of mandatory folic acid fortification of flour in bread and ready-to-eat cereal products (Hartley et al, 2011). This change in policy is expected to improve the prevalence of women taking folic acid before pregnancy and may translate into a reduction in the risk of NTDs. However, it is also important that women are encouraged to follow their healthcare professional’s advice on the use of dietary supplements in pregnancy.
pregnancy. In the UK, the government advises pregnant women who may become pregnant to take a daily folic acid supplement of 400 µg, continuing up to the 12th week of pregnancy, and to consume foods providing folate/folic acid in the diet. Women who have already experienced an NTD-affected pregnancy are advised to take a 5 mg folic acid supplement daily (SACN, 2011).

While awareness of the need to take folic acid appears to be high, compliance with this recommendation is not necessarily reflected in practice. Recent evidence shows that uptake of folic acid supplements can be low, particularly in certain population groups. In a study of 296 women from Northern Ireland, 84% reported taking folic acid supplements in the first trimester, but only 19% had started before conception, despite NTD rates being among the highest in the world (McNulty et al., 2011). A study in Southampton that included 238 women of child-bearing age reported that only 2.9% of those who became pregnant were already taking folic acid (Inskip et al., 2009). As over half of all pregnancies in the UK are unplanned (SACN 2011) greater awareness of the importance of folic acid supplements and improvements in the nutrition and lifestyle of women of child-bearing age is required.

Higher parity is also associated with increased NTD risk and women appear to be less likely to take folic acid after their first baby (McNulty et al., 2011). In a survey of 211 mothers from Fife, Scotland, 31% reported taking folic acid as recommended; 56% said they only took the supplement during pregnancy and 12% indicated not taking folic acid at all. The main barriers to uptake that women reported included morning sickness, competing priorities for concern, busy lives and not remembering (Barbour et al., 2012). Most women not taking them did not appear to be aware of the potential health consequences of not doing so.

There is evidence of ethnic and social disparities relating to use of folic acid supplements. For example, a study of over 400 newly pregnant women in East London found that 42% of Caucasian mothers had taken folic acid supplements before the critical time when the neural tube closes, compared to only 19% of West Indian and Asian mothers (Brough et al., 2009). Pre-conceptual use of folic acid also appears to be low among teenagers (Baker et al., 2009).

Obesity in pregnancy is an increasing problem. As NTD affected pregnancies are more prevalent among women with a raised body mass index (BMI) >30, it has been suggested that obese women should take a higher dose of folic acid from before pregnancy until the end of the first trimester (5 mg/day) to help minimise the risk of NTDs (CMACE/RCOG, 2010). However, currently there are no specific recommendations about folic acid supplements for obese pregnant women. Overweight and obese women (BMI >27) have been found to be less likely to take nutritional supplements and also have a lower folate intake from the diet (Mojtaba, 2004).

There is a requirement for extra folate (the form of the vitamin found naturally in foods) throughout pregnancy, as the RNI increases from 200 µg per day (the amount for all adult women) to 300 µg per day. This extra folate can be provided by the diet and women should be encouraged to consume folate-rich foods throughout pregnancy. Foods containing folate include fruit, green vegetables, such as broccoli, and pulses (beans, lentils). It is also found in milk and meat – and foods fortified with folic acid (such as breakfast cereals) provide an important source. However, it is difficult to obtain enough folate from the diet to meet the extra requirement around the time of conception, hence the importance of taking a folic acid supplement up to the end of the first trimester.

Health professionals have a key role in raising awareness of the importance of folic acid in preventing NTDs and there is some evidence that pre-conception care can have a positive impact on folic acid uptake. As around half of all pregnancies in the UK are unplanned (SACN, 2011), health professionals advising women of childbearing age need to look for opportunities to provide advice before women actually become pregnant. This includes physicians in obstetrics and gynaecology and family medicine, who can advise women during annual, family planning or infertility visits. Health visitors and other health professionals working in the community also have an influential role, as they may often see women who already have a child/children and are thinking about a further pregnancy. Pharmacists also have an important role in delivering this message as they may be among the first health professionals that a woman sees when she is planning to have a baby.

Vitamin D

Insufficient vitamin D during pregnancy can have long-term effects on infant bone health. Roles for vitamin D, including protection against diabetes, cardiovascular disease and some cancers, and in optimising immune function, have been proposed recently (BNF, 2013). The main source of vitamin D is exposure to sunlight during the summer months and there are relatively few dietary sources. However, there is evidence that low vitamin D status is common among many people in the UK, including pregnant women. There is no RNI for vitamin D for children and adults aged four to 65 years, as it is assumed that summer sunlight will provide enough vitamin D. However, for pregnant and breastfeeding women, the RNI is 10 µg per day and a daily dietary supplement providing this amount is recommended.

There are few significant dietary sources of vitamin D and average intake in women from foods is only 2.6 µg per day, which is well below the recommended 10 µg. Oily fish is the richest food source but only 28% of adult women actually consume oily fish (Bates et al., 2011). Fortified foods, such as fat spreads and some breakfast cereals, also contribute to intakes of vitamin D in the UK (see Table 1). For example, a small can (200 g) of mackerel will provide 7.4 µg of vitamin D; a boiled egg will provide 3.2 µg; and spreading a slice of bread with fortified margarine/spread will provide 0.6 µg of vitamin D.

Low vitamin D status is particularly evident in the UK population, for example, in young adults (especially women 19–24 years), in people aged over 65 years living in institutions and in two-year-old children of Asian background (see Figure 1). Furthermore,

<table>
<thead>
<tr>
<th>Table 1. Dietary sources of vitamin D (BNF, 2013)</th>
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<tr>
<td><strong>Dietary source</strong></td>
</tr>
<tr>
<td>Oily fish eg, salmon, trout, mackerel</td>
</tr>
<tr>
<td>Fortified margarine/spreads</td>
</tr>
<tr>
<td>Fortified breakfast cereals</td>
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<tr>
<td>Lean beef</td>
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<td>Eggs</td>
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</tbody>
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the re-emergence of rickets has been seen in some population sub-groups in the UK, predominantly in people of African–Caribbean and South Asian origin (Lanham-New et al, 2011).

Low vitamin D status has been found to be common in pregnant women. In a study in Southern England 18% of pregnant white women had low vitamin D status (serum 25(OH)D <25 nmol/l) and 31% had a vitamin D level that was less than 50 nmol/l (Javaid et al, 2006). In a study of UK pregnant women from ethnic minorities, more than 50% had a low vitamin D status (Datta et al, 2002). Pre-pregnancy weight is inversely associated with a lower serum vitamin D concentration, causing obese women to be at greater risk of vitamin D deficiency. Other risk factors for poor vitamin D status are multiple births, short intervals between births and darker skin. People with darker skin require longer in the sun to make sufficient vitamin D. Furthermore, keeping the skin covered up with clothing throughout the year (such as when wearing a veil for religious reasons) has a significant impact on the ability to make vitamin D, making such women at higher risk of vitamin D deficiency.

The vitamin D status of newborn babies and infants is dependent upon maternal vitamin D status; so a poor maternal status will have an impact on that of the offspring and their long-term bone health (BNF, 2013). Therefore, current advice in the UK is for pregnant and lactating women, as well as infants, young children and those over 65 years to take a daily vitamin D supplement.

The National Institute for Health and Care Excellence (NICE) issued antenatal guidance on vitamin D in 2008, which advises on the need to inform pregnant women about the importance of maintaining adequate vitamin D status during pregnancy and taking a daily 10 μg supplement. Women of South Asian, African, Caribbean or Middle Eastern origin (and those who are housebound) are considered to be at particular risk (NICE, 2008). However, there appears to be widespread lack of awareness of the need to take vitamin D supplements during pregnancy and while breastfeeding.

Health professionals have an essential part to play in advising pregnant and breastfeeding women about the importance of vitamin D. Healthy Start vitamins (www.healthystart.nhs.uk) are available free of charge for pregnant/breastfeeding women and children up to the age of five years, for mothers under the age of 18 years or on income support, via the Healthy Start scheme. The vitamins for women contain folic acid, vitamin C and vitamin D and they should be available from baby centres and children’s clinics.

There have been reports from some health professionals in the past of problems in the supply and availability of these vitamins. Since 2010 they have also been available from pharmacists in order to try and address issues with uptake and availability. Although a more recent study suggests that uptake remains low, which is suggested to be due to a lack of availability and low promotion from healthcare professionals (Jessiman et al, 2013).

Evidence suggests that many healthcare professionals also need to be made aware of the importance of vitamin D supplements for women of childbearing age. A study conducted in 2010 reported that over 50% of health visitors and over 80% of GPs did not advise women about vitamin D supplementation during breastfeeding and only 10% of GPs and 24% of midwives advised women about vitamin D supplementation during pregnancy (Jain et al, 2011). A letter from the UK Chief Medical Officers to health professionals was issued in February 2012 to raise awareness of the risk of vitamin D deficiency among at-risk groups (www.gov.uk/government/publications/vitamin-d-advice-on-supplements-for-at-risk-groups).

### Conclusion

A healthy, varied diet is of vital importance for optimal birth outcome and this includes taking a folic acid supplement from before conception to the 12th week of pregnancy, as well as a vitamin D supplement throughout pregnancy. However, evidence from a new BNF Task Force report on early life development (see BNF 2013) shows that many women are not following these guidelines and there are concerns about vulnerable groups, including women from low incomes, those from some ethnic minority groups, overweight/obese women and teenagers who become pregnant.

School nurses and health visitors have an important role to play in encouraging healthy eating habits among these groups. Health professionals who come into contact with women both before and during pregnancy can play a key role in raising awareness of the importance of diet and other lifestyle factors in ensuring a healthy pregnancy and birth outcome. Appropriate supplement use in pregnancy is a simple measure that can make all the difference to the health of the mother and of the next generation to come.

### Further information and resources

To support the findings from the Task Force report, the BNF has produced a new resource for consumers and health professionals – a ‘four-week planner’ with useful information and practical advice on healthy eating and physical activity, including healthy food swaps. The planner includes four goals each week for women to achieve and build on. Specific information and advice for women planning a pregnancy and for women who want to get back into shape following a pregnancy is also available. The Healthy Life Planner for Women is available free to download from the BNF.
Further information on diet and pregnancy for consumers and health professionals is available on both the BNF website (www.nutrition.org.uk) and BNF’s Nutrition4Baby website (www.nutrition4baby.co.uk).

References


CPD questions (please visit www.communitypractitioner.com/CPD to submit your answers)

1. Approximately how many extra calories should pregnant women consume in the third trimester?
   - A. 50 kcal
   - B. 100 kcal
   - C. 150 kcal
   - D. 200 kcal

2. Which of the following foods is rich in folate?
   - A. Pasta
   - B. Bread
   - C. Broccoli
   - D. Lemons

3. Current advice in the UK is for pregnant and lactating women to take a daily supplement of what?
   - A. Vitamin D
   - B. Cod liver oil
   - C. Iron
   - D. Zinc

4. What percentage of pregnancies in the UK are unplanned?
   - A. A quarter
   - B. Half
   - C. A third
   - D. Two thirds

5. What is the recommended intake of vitamin D for pregnant women per day?
   - A. 4 μg
   - B. 10 μg
   - C. 15 μg
   - D. 20 μg

6. Which of the following foods has the lowest amount of vitamin D per 100g?
   - A. Eggs
   - B. Lean beef
   - C. Oily fish
   - D. Fortified cereals

7. In a recent study, what percentage of UK midwives reported that they advised women about vitamin D supplementation during breastfeeding?
   - A. 24%
   - B. 37%
   - C. 63%
   - D. 82%

8. Most women need to consume extra protein in their diet while pregnant – true or false?
   - A. True
   - B. False

9. What are the UK recommendations for folic acid supplements per day (up to the 12th week of pregnancy)?
   - A. 200 μg
   - B. 300 μg
   - C. 400 μg
   - D. 500 μg

10. What percentage of women surveyed in Scotland reported that they did not take folic acid during their pregnancy?
    - A. 7%
    - B. 12%
    - C. 25%
    - D. 40%
Included within the course:

- Secure Attachment
- Observe babies cues in communication
- Identify and offer techniques in remedial touch to relieve intra-uterine and birth trauma
- Introduce holding, stroking and gentle stretching prior to 'tummy time' and massage.

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The Correct Use of Baby Massage to:

1) Develop circulatory and breathing rhythms
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3) An easy introduction to 'tummy time'
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7) Elementary motor delay and correction
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High quality resource: Peter Walker's DVD 'Developmental Baby Massage' and a copy of his international best selling book 'Developmental Baby Massage' together with a full set of course notes given to all students.

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

I would like to add just how much I enjoy teaching the Developmental Baby Massage program. I have witnessed such positive results, not only with the babies and development but also with the parents and their responses. It really makes a difference in terms of attachment, parenting and building confidence.

'My working practice within the NHS is using The Solihull Approach; I strongly believe that Developmental Baby Massage complements this approach.'

'Peter Walker is well known in the baby massage field. It was therefore to him that we turned when setting up training days during which health visitors could learn more about the value and technique of baby massage. These days have been a huge success and resulted in baby massage being offered free to parents in health centres and clinics throughout the country'.

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