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the foundation of the future

Highlights from conference 2013

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• PROFESSIONAL
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COMMUNITY PRACTITIONER

Community Practitioner journal
Unite/CPHVA members receive the journal free each month and have free access to all content from 2004 onwards via the online archive.

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PUBLIC HEALTH NURSING:
The Foundation of the Future

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The big sell-off

When the considered history of the coalition (2010–2015 RIP) and its attempts to demolish and privatise the NHS is written in the decades to come, two questions will jump from the page: why? And how?

It will be clear, with the benefit of hindsight, that David Cameron’s pledge at the 2010 general election that the NHS was safe in Tory hands was a chimera or, in the words of the outrageous Conservative diarist, Alan Clark, that he was ‘economical with the actualité’. Cameron, with his outward polish, smoothly conned the electorate on the NHS.

The new health secretary, Andrew Lansley, had been ‘shadowing’ health since 2004. He knew exactly what he wanted to achieve once in office and hey presto, within two months the substance of what is now the Health and Social Care Act was unveiled. This controversial piece of legislation – not in the coalition agreement – would not have reached the statute book without the acquiescence of a large section of the Liberal Democrats.

‘Health’ is a complex subject, and the twists and turns of policy are difficult for the general public to follow and understand. We have not reached the stage of paying £10 to visit your GP or take out additional health insurance to cover this cost. If/when such a policy comes into being, the public will respond with horror and the reality of government policy will hit home.

‘Privatisation’ is a concept also quite hard to grasp. The hospital is still there – where it has stood for a century – but the local community does not realise that it could be run by a private company from America’s mid-west, with profit as its prime mover. It is a step-by-step process; an incremental dilution of the NHS that we have known since 1948.

So what can be done? The answer is simple – democracy. The same method that Cameron used to hijack the NHS in 2010 can be reversed by voting for the act’s repeal in 2015, as pledged by Labour shadow health secretary Andy Burnham.

Democracy may be a cumbersome, imperfect and messy process – but it works in the end and has the imprimatur of legitimacy. History ebbs and flows unevenly and it is now time for progressive forces to roll back the tide of the NHS sell-off.

Shaun Noble
Unite Senior Communications Officer
WHO review warns of ‘public health time bomb’

The UK is still trailing its European neighbours on female life expectancy, mortality among under fives and child poverty, a landmark review led by a health inequality expert has claimed.

The report, published by the World Health Organization (WHO) and the UCL Institute of Health Equity (IHE), Review of Social Determinants and the Health Divide in the WHO European Region, shows female life expectancy in the UK is 83 years, compared to 85 years in Spain, France and Italy.

Furthermore, the UK has a higher rate of mortality in under fives (5.4/thousand live births) than countries both to the east and west of Europe, including the Czech Republic (3.4/thousand), Slovenia (3/thousand), Finland (2.9/thousand) and Iceland (2.2/thousand).

‘Best buy priorities’ in 12 policy areas have been identified, covering action across the life course in wider society, based on social cohesion, protection and the right to health in relation to economic, fiscal, environmental and other sectors, and in health systems.

The report, chaired by Professor Sir Michael Marmot, revealed that one in four children live in poverty in the UK, with less than half reaching a ‘good’ level of development by the age of five.

In addition, children are less likely to live in poverty in many other countries in Europe including Iceland, Cyprus and Ireland. Professor Marmot says the current high numbers of young people not in employment, education or training (NEETs), particularly if they are unemployed long-term, is a ‘public health time bomb waiting to explode’.

‘We are failing too many of our children, women and young people on a grand scale,’ he said.

‘Health inequalities, arising from social and economic inequalities, are socially unjust, unnecessary and avoidable, and it offends against the human right to health,’ he continued.

Professor Marmot has called for good-quality early years provision to become a priority for all children, and for a broad range of social policies, including improvements in every child’s start to life, adequate social protection ‘that can act as a buffer against low income over the life-course, and provide a minimum standard for healthy living’.

Unite/CPHVA Lead Professional Officer, Obi Amadi, said: ‘This report provides further evidence about the way in which the social determinants of health are impacting on families and their futures. We know about the importance of the first years of a child’s life in shaping its future. Current health policy has changed over recent years to recognise this, but more can still be done to ensure better futures for our children.’

Chief Medical Officer calls for free vitamins to counter rickets ‘comeback’

All UK babies should be offered free vitamins to combat a rise in cases of rickets, England’s Chief Medical Officer (CMO), Professor Dame Sally Davies, has said.

The National Institute for Health and Care Excellence (NICE) has been asked to examine whether it would be cost-effective for all children to receive daily drops or tablets containing vitamins A, C and D. ‘We are offering these vitamins to vulnerable children and the take-up is low, but many children not in these communities need them too,’ Professor Davies said. In the report, the CMO warned the UK has gone from having one of the best records on children’s health to ‘one of the worst’, with five more children dying a day from potentially avoidable causes in the UK compared with those in Sweden – the majority of which occur in the first year of life.

Unite/CPHVA Professional Officer, Dave Munday, said: ‘We welcome the CMO report, especially as it supports the concerns that our members raised at the CPHVA Annual Conference – that in the current targeted approach, the most disadvantaged families miss out.’

Amanda Moss, a health visiting student from Staffordshire (who recently spent ‘A Day with Dave’ (see p. 10 in this issue)), also said: ‘This is a particular challenge with hard-to-reach groups such as traveller communities. A more effective solution might be for health visitors to carry the drops with them, to give out a primary visits, and this should be trialled.’
Fears over rise in swaddling

The resurgence of swaddling has prompted fears of an increase in developmental hip problems in infants.

Swaddling is linked to heightened risk of osteoarthritis and hip replacement in middle age as it is said to ‘force’ the hips to straighten and shift forward, risking the potential for misalignment.

Professor Nicholas Clarke, Paediatric Orthopaedic Surgeon at Southampton University Hospital, said the technique has become ‘fashionable’ due to its perceived ‘calming’ effect.

While the practice has fallen out of favour in many parts of the world, it is estimated the demand for swaddling clothes rose by 61% in the UK between 2010 and 2011.

Writing in the journal Archives of Disease in Childhood, Professor Clarke advises that swaddling can be safe provided ‘it doesn’t prevent the baby’s legs from bending up and out at the hips, because this position allows for natural development of the hip joints’.

He warns: ‘The babies’ legs must not be tightly wrapped and pressed together. Any commercial swaddling products should include a loose pouch or sack for the babies’ legs and feet, allowing for plenty of hip movement.’

Healthcare professionals must also ‘do their bit’ by giving mothers the correct advice about how to swaddle their child safely to ward off hip abnormalities and other potential problems in later life.

Unite/CPHVA Professional Officer, Dave Munday, said: ‘It’s good that this study has highlighted swaddling as an area that requires further thought. It’s also important that in considering this issue our members don’t forget safer sleeping practices, highlighted by the Lullaby Trust and others.’

ONS threatens to stop publishing SIDS data

The goal to halve the number of deaths caused by sudden infant death syndrome (SIDS) by 2020 has been placed in jeopardy after it was announced that the Office for National Statistics (ONS) cannot afford to keep publishing its annual report on unexplained infant deaths in England and Wales.

The ONS claims the report costs between £10,000 and £50,000 to publish and is ‘suggesting’ it will need to stop the publication of the data.

Francine Bates, Chief Executive of the Lullaby Trust, asked for the help of colleagues to persuade the agency to continue releasing the report to highlight how many babies are still dying every year by responding to the online consultation, which closed in October.

‘We want to get across as strongly as possible that this will greatly affect our work and our fight to halve the number of SIDS deaths by 2020,’ said Bates.

‘Without this data we will not be able to track if SIDS is increasing or decreasing and we will no longer have an annual data set to promote in the press – a key route to raising awareness of SIDS.’

Should the report be withdrawn the Lullaby Trust claims it would have to pay to access the data, employ and pay a statistician to help us analyse the data, and negotiate with the ONS to publish the data itself.

‘We believe that infant mortality is a key indicator of public health,’ said Bates.

‘Together with the withdrawal of the Department of Health’s universal leaflet on reducing the risk of SIDS in 2010 and now abandoning publication of national statistics, we fear that national and local agencies will no longer prioritise sudden infant death in the future.’

Unite/CPHVA Professional Officer, Gavin Fergie, said: ‘Our suggestion is that the ONS does not stop the publication of this data unless they have a rationale beyond the expense. SIDS is preventable, but practitioners will be unaware if their intervention is having a positive impact if the statistical evidence is not readily available to gauge the effectiveness of measure.’

Smoking in pregnancy linked to depression

Smoking during pregnancy can contribute to long-term emotional problems in young children, researchers claim.

Children whose mothers had continued smoking during pregnancy had smaller brain volumes, with reduced amounts of grey as well as white matter.

Those babies with smaller brains were at the greatest risk of depression and anxiety, found the study, which analysed brain scans of six to eight year olds who had been exposed to tobacco during pregnancy.

Figures in England and Wales show that 17% of women smoke during pregnancy. Among under-20s the figure is 45%.

Researcher Dr Hanan El Marroun, who works at the Department of Child and Adolescent Psychiatry at Erasmus MC University Medical Center in Rotterdam, said: ‘We see a smaller superior frontal cortex, an area involved in regulating moods, in children exposed to tobacco in the womb. If mothers stopped smoking in early pregnancy there were no differences in the brain structures or behavioural and emotional problems compared to children whose mothers had never smoked.’
Parents and teachers don’t know how to deal with cyber bullying, a survey claims. More than half of young people in England (55.2%) polled admitted they accept cyber bullying ‘as a part of everyday life’ and almost seven out of 10 would turn to their parents for help.

However, 40% of parents said they do not know how to respond if their child is being cyber bullied or how to set up filters on computers, tablets and mobile phones that could protect their children.

Both teachers (69%) and young people (40%) have called for more schools to introduce teaching around cyber bullying and online safety onto the national curriculum.

Luke Roberts, National Co-ordinator of the Anti-Bullying Alliance, who commissioned the survey together with legal experts Slater & Gordon, said: ‘We need a collaborative approach to tackling cyber bullying so children themselves can take responsibility for their own safety online and know where to turn for help when things go wrong. If we get this right and make cyber bullying a thing of the past, our children will be able to enjoy a digital future that is safe, fun and connected.’ Almost a third (32.1%) of young people said that educating schools, parents and young people would have the greatest impact towards combating the problem of cyber bullying.

Netmums publishes maternal mental health research

Mothers-to-be should draw up a ‘wellbeing plan’ during pregnancy in a similar way to a birth plan to open up discussions around their mental health, says a study carried out by parenting website Netmums.

The research into maternal mental health, funded by the Boots Family Trust, questioned around 1,500 mums who had all suffered with depression during or after pregnancy, as well as more than 2,000 health professionals.

Almost half of the mothers polled said they had either depression or anxiety when they were pregnant; two thirds experienced postnatal depression; and 2% had suffered with puerperal psychosis.

Many women attribute their mental health problems to trying to live up to unrealistic expectations. However, less than a fifth of depressed new mothers said they were ‘completely honest’ when questioned about how they were feeling and coping as a new mother, and a third of those questioned said they had never told a health professional that they felt unwell.

More than a quarter of the women surveyed admitted they were worried about admitting their true feelings to a health professional in case their baby might be taken away.

The report recommends that health professionals receive better guidance on what questions to ask to find out how a mother is feeling and coping during and after pregnancy, and urges professionals to dispel the myth that babies are taken away from mothers with depression or anxiety.

Unite/CPHVA Professional Officer, Dave Munday, said: ‘Netmums does really important research in making sure that the voices of mothers are heard clearly, not just to professionals but to policy makers. We know that postnatal depression is an issue for many mums and we hope that with the increase in the number of health visitors, this will help to reduce the prevalence of the condition. We know that there is stigma attached to having depression and the concerns around babies being removed from parents, but we need to work against that misheld belief and ensure mothers are well supported.’

‘It is important that health visitors get the appropriate training, so it is good there is national training in place and we would encourage all our members to make sure they access any training offered locally.’

Chief Executive of NHS Scotland appointed

Paul Gray has been appointed Director General Health and Social Care and Chief Executive of NHS Scotland for the Scottish Government.

Formerly Scottish Government Director General for Governance and Communities, Gray took up his new position at the beginning of December 2013.

Gray said he was looking forward to tackling Scotland’s public health challenges, and, in particular, focusing on tackling health inequalities.

‘It is a crucial time as we drive forward greater health and social care integration, and improvements to the quality of care, while maintaining high standards of performance and delivery,’ he said.

Unite/CPHVA Professional Officer, Gavin Fergie, said Unite Health in Scotland looks forward to working with Gray in addressing the challenges that face NHS Scotland now and in the future.

Gray replaces Derek Feeley, who left the Scottish Government in July 2013.
Common vaccines would prevent two million child deaths globally

One in five children globally still do not receive ‘basic’ immunisations against the main causes of child deaths, a report has shown.

The report published by the Royal College of Paediatrics and Child Health (RCPCH UK), Calling the Shots: A Review of Global Immunisation Initiatives and Future Priorities, argues that with political will and financial backing for global immunisation programmes, a disease such as polio can be completely wiped out.

It states that around 2.4 million child deaths from rotavirus could be prevented over the next 30 years and ‘significant steps’ could be made to meet the Millennium Development Goal of reducing global child mortality by two thirds by 2015.

In 2008, 22 million infants and children did not receive routine measles immunisation, resulting in an estimated 450 deaths a day. By the end of 2010, vaccines prevented an estimated five million deaths from conditions such as hepatitis B, measles, pertussis, polio and rotavirus. In 2011, 700,000 children died from diarrhoea – with a routine rotavirus vaccination, up to 160,000 deaths in children under five years could be have been averted annually.

Foetus thumb sucking ‘could indicate healthy development’

Healthy babies learn how to anticipate touch while in the womb, new research from Durham University suggests.

4D scans showed foetuses were able to predict, rather than react to, their own hand movements towards their mouths as they entered the later stages of gestation compared to earlier in a pregnancy.

Researchers said the results could be a ‘potential indicator’ of how prepared babies are for feeding and improve understanding about babies, especially those born prematurely, their readiness to interact socially and their ability to calm themselves by sucking on their thumb or fingers. The researchers carried out a total of 60 scans of 15 healthy foetuses at monthly intervals between 24 weeks and 36 weeks gestation. Increased sensitivity around a foetus’ mouth at this later stage could indicate they have more awareness of mouth movement, with researchers claiming it could be a sign of healthy development.

‘A Day with Dave’ health visiting student Amanda Moss reflected that with the increase in parents arranging their own 4D scans, ‘this could cause anxiety among expectant mothers who will now be worried if their baby is not sucking their thumb at the right time.

‘There are lots of factors that impact on whether a foetus would suck their thumb in the womb, such as positioning. If a mother is becoming anxious this early on in the pregnancy, the chance of postnatal depression occurring may also be increased.’

Thousands signed up for Stoptober in Wales

Stoptober has seen almost 14,000 smokers in Wales register for support to give up smoking for 28 days.

The month-long campaign, which was supported by a number of businesses and organisations throughout Wales, provides a range of free advice to kick the habit.

Research shows if someone can stop smoking for 28 days they are five times more likely to stop smoking permanently.

Chief Medical Officer for Wales, Dr Ruth Hussey, who launched the campaign, said it is ‘extremely encouraging’ so many people took up the Stoptober challenge in the country.

Unite/CPHVA Professional Officer, Jane Beach, said: ‘It is really encouraging that so many people took up the challenge and shows the value of the stop smoking services to public health.

‘Once smokers have had an attempt to give up smoking, they never go back to being “contented smokers” so even if they were not successful on this occasion they will be in the near future. This, of course, is really good news for babies and children as the chance of them being exposed to the adverse effects of second-hand smoke is greatly reduced.’

Number of babies born to older mums falls

Official figures from the Office for National Statistics show 49% of births last year were to mothers 30 and over – a fall of 2% from 2011.

Among those in a marriage or a civil partnership, 148,403 births were to women aged 30 to 34, 78,689 to women aged 35 to 39 and 17,380 to women aged 40 to 44. Women aged 45 and over accounted for a further 1,240 births.

Overall, the average age of mothers was 29.8 years, with the average age for first-time mothers 28.1 years.

Unite/CPHVA Lead Professional Officer, Obi Amadi, said: ‘My concern is that the fall is the result of an increase in teenage pregnancies, although it may reflect the different cultural practices of our populations. Again, we need some real action on school-aged children, the reduced school nurse input and the fact that sex and relationships education is no longer a requirement in schools, which can only increase the negative impact.’
We would like to reassure or by calling 0300 123 1002 or visit the campaign symptom of cancer – over twice as many people know that unexplained bleeding is a more than half of kidney cancers. Only a third their GP earlier. Blood in pee is a key symptom of bladder and kidney cancers. Be Clear on Cancer campaign.

Studies suggest that targets on poverty will be ‘undermined’ by the twin problems of high youth unemployment and falling living standards. Since 2010, there has been a 275,000 rise in the numbers of poor children in absolute poverty. Since 2010, there has been a 275,000 rise in the numbers of poor children in absolute poverty. Projections by the Institute for Fiscal Studies suggest that targets on poverty will be missed by around two million children.

Unite member honoured at Mary Seacole Awards
A Unite member was among six healthcare professionals honoured for their work in improving outcomes for BME communities at the Mary Seacole Leadership and Development awards. Shirley Baah-Mensah, a Modern Matron at the North East London Foundation Trust was presented with a development award for her project around developing black and ethnic minority nurses as leaders in the health profession. Taking place at the Royal College of Nursing headquarters at the Royal College of Nursing headquarters on Thursday 24 October 2013, the awards provided Baah-Mensah and the other winners with up to £6,250 each to undertake their year-long projects.

Government urged to address Britain’s ‘fairness deficit’
The government’s goal to end child poverty by 2020 is likely to be missed ‘by a considerable margin’, a report suggests. In its first report, the Social Mobility and Child Poverty Commission found any progress on social mobility may be ‘undermined’ by the twin problems of high youth unemployment and falling living standards. Since 2010, there has been a 275,000 rise in the numbers of poor children in absolute poverty. Projections by the Institute for Fiscal Studies suggest that targets on poverty will be missed by around two million children.

Be Clear on Cancer campaign
Help save lives by supporting this autumn’s NHS campaign to raise awareness of blood in pee as a symptom of bladder and kidney cancers. Be Clear on Cancer aims to improve early diagnosis of cancer by raising awareness of symptoms and encouraging people to see their GP earlier. Blood in pee is a key symptom of around eight in 10 bladder cancers and more than half of kidney cancers. Only a third of people know that unexplained bleeding is a symptom of cancer – over twice as many people know about an unexplained lump. Order free posters and leaflets through or by calling 0300 123 1002 or visit the campaign website on NHS Choices: nhs.uk/bloodinpee

Poots orders review of NI abortion case
Northern Ireland Health Minister, Edwin Poots, has ordered a review into the case of a woman who was forced to leave the country to have an abortion as her baby had no chance of survival.

Under current law in Northern Ireland (NI), foetal abnormality is not considered legal grounds for an abortion.

Sarah Ewart found out she was carrying a baby with anencephaly – a severe case of spina bifida, where a large part of the skull is not formed – at 20 weeks. She said her only two choices were to let the baby die or deliver it and watch it die. And as an abortion could not be granted in NI, she travelled to England for the procedure. She has since called for the law to be changed publicly.

Poots said he has requested health officials to consider Ewart’s case to ensure ‘everything has been done that we would expect to be done, within the confines of the legal position that exists in NI’. He said the law on abortion in NI and any potential change was ‘a matter for the Department of Justice, the Executive and the Assembly.’

‘Issues around the termination of pregnancy can present hugely difficult issues for families,’ he continued.

‘I am only too aware of that from experience down the years as a local elected representative. It can be a challenging area for trust staff, too. Anyone who thinks these issues are always simple has not given the issue the thought it demands.’

‘At all times, those staff involved must be incredibly sensitive and compassionate. I expect the highest standards of care from our public servants and if there are lessons to be learned in how this, or other cases, have been handled I am keen to know about it and seek to rectify it. I do pay tribute though to the fantastic work our staff do day and night.

‘I want to be 100% assured that everything has been done that we would expect to be done, within the confines of the legal position that exists in NI.’

Formula milk exposes babies to ‘high levels’ of aluminium
Formula milk is still ‘heavily contaminated’ with aluminium, researchers claim.

The authors said the amount of the chemical – linked to cancer and Alzheimer’s disease in later life – could damage an infant’s health.

Professor Christopher Exley from Keele University and a group of researchers studied the aluminium content of 30 brands of formula milk in a follow-up to his 2010 study of 15 products, and concluded that nothing had been done to reduce the amount of aluminium in the three years since.

Professor Exley said: ‘Clearly, the manufacturers of infant formulas are not concerned about reducing their content of aluminium, and the extensive use of aluminium-based packaging for infant formulas seems to confirm this.

‘There are no adequate criteria upon which to base a safety level for aluminium in infant formulas and for this reason it would be sensible to take action to reduce the level of aluminium to a lowest practicable level.’

Researchers said it is time for the government, through the Food Standards Agency (FSA) advisory body, to provide guidance, as well as indicating a maximum allowable concentration as a ‘precautionary step’ to protect infants against chronic aluminium intoxication.

Unite/CPHVA Lead Professional Officer, Obi Amadi, said: ‘There should be concern over these findings, and guidance and minimum levels should be set in the absence of the research. We need to be more cautious and not be complacent.’

However, the FSA recently concluded ‘there was no cause for concern’ after looking into aluminium levels in formula milk products. A spokeswoman for SMA told the Guardian: ‘We would like to reassure parents that all SMA infant formula is safe. Aluminium occurs naturally in the environment and is present in many fruits, vegetables, packaged foods, beverages and water. We take every precaution to ensure the level of aluminium in our products is kept as low as possible.’
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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2014 Regional Update Conferences

Coming to a region near you, between March and May 2014, Unite is running a series of Professional Update Conferences. Issues to be covered are:

- Record keeping
- Duty of care
- Safeguarding
- Domestic violence.

Locations and dates

North East, Yorks and Humber: Tuesday 22 April, Unite Office, 55 Call Lane, Leeds LS1 7BW

North West: Tuesday 29 April, Unite Office Salford Quays, Board Room - Ground Floor, Merchants Quay, Salford Quays, Salford M50 3SG

South East: Friday 7 March, Esher Place, 30 Esher Place Avenue, Esher KT10 8PZ

South West: Friday 25 April, Rooms 202 & 203, Unite the Union, Tony Benn House, Victoria Street, Bristol BS1 6AY

Wales: Thursday 10 April, Unite Regional Office, 1 Cathedral Road, Cardiff, Wales CF11 9SD

West Midlands: Wednesday 7 May, Transport Hall, Transport House, 140 Broad Street, Hanley Stoke-on-Trent ST1 4HP

London: Monday 12 May, Diskus Conference Centre, 128 Theobald’s Road, Holborn, London WC1X 8TN

Scotland, Eastern, Northern Ireland Details of venues and dates to be confirmed

Please register your interest by completing the online booking form at: www.unitetheunion.org/cphva/events

Calling student health visitors: #adaywithdave

As the professional officer at Unite with lead responsibility for health visitors in England, Dave Munday is offering students the chance to come out and spend a day on placement as part of their HV studies. This is combined with the Student HV Question Time (#StHVQT) events taking place throughout the country. There will be approximately 12 placements for Unite CPHVA members over the next 12 months.

Why should I apply?

If you want to spend time thinking about the profession at a national level and be involved in some important work, this is for you. It’ll be a great opportunity to widen your scope of experience and will help you to develop your knowledge.

What will happen on the day?

Professional officers at Unite have a varied workload and can work in any part of the UK. Once a date is agreed with successful applicants, we will try to make sure that the day focuses mainly on health visiting issues, but it might also link in to other areas. Successful applicants will have travel and subsistence paid in line with normal Unite expenses. You’ll need to agree the time from your studies/placement if successful for the agreed day.

As well as successful applicants getting the opportunity to experience something a bit different we will want a few things back from you. Dave will take the opportunity to learn things from you, both about your experiences on the course and out in practice. We will want a write-up of your experience. It won’t need to be a PhD thesis – just a short article that highlights some of the things you did, learned and enjoyed. This might be featured in Community Practitioner or as a blog on our website.

Sounds interesting – how do I apply?

Send an email to cphva@unitetheunion.org with the title ‘A day with Dave’. In the subject of the email include your name, membership number, where you’re studying, your graduation date and a brief paragraph on the subject: ‘I want to spend #adaywithdave because…’.

Dave’s day with Amanda Moss

‘It was great to welcome Amanda to my first #adaywithdave. In the morning we spent time with the team at Community Practitioner and this included Amanda helping me out with the quotes for some of this month’s news stories.

We then met with my MP, Jonathan Reynolds. Students who have attended the Question Time events or have come along to hear one of my university lectures will know that I’m passionate about SCPHNs getting involved with politics and having a good knowledge of how it affects the families they work with. This was a great way of seeing that up close. Amanda was also involved with some of the preparation that Jane Beach and I were doing for a meeting the next day with the Nursing and Midwifery Council. ‘Our day finished with a meeting with Pauline Watts at the Department of Health. Amanda has promised to write up the day so her thoughts and reflections can be shared.’

Unite/CPHVA Student HV Question Time (#StHVQT) London

The next Student HV Question Time will be in London on 12 December 2013, and we want you to come and debate the issues that are important to you! You’ll get access to a panel with national and regional policy makers.

The event will be a great way to think about your future profession, and you will have the opportunity to get your views across to people who are involved with setting policy nationally. It’ll also help with your studies and professional development.

For more information about this and future Student Question Time events being held throughout the UK in 2013/14, visit: www.unitetheunion.org/cphva/events

Amanda Moss (#adaywithdave student) and Dave Munday (Unite professional officer)

Amanda and Dave meet Jonathan Reynolds MP, Shadow Minister for Climate Change
Intention to supplement with infant formula and breastfeeding duration

This study from Canada examined the relationship between a mother’s intention to supplement with infant formula and the risk of discontinuing breastfeeding during the 12 months postpartum. In this study nearly one third of mothers intended to supplement with infant formula. Of those mothers, 69% actually supplemented their baby with infant formula within 12 months postpartum. Intention to supplement was found to be associated with shorter breastfeeding duration. The analysis indicates that a mother’s prenatal intent to supplement may be associated with shorter breastfeeding duration. Further research is required to confirm these findings and to address the underlying assumptions and limitations.


Influence of early regulatory problems in infants

This German study examined the extent to which regulatory problems in infants at four and six months influence childhood development at 12 months. The second aim of the study was to examine the influence maternal distress has on four-month-old children’s subsequent development, as well as gender differences with regard to regulatory problems and development. A total of 153 mother–child dyads enrolled in the family support research project ‘Nobody slips through the net’. These families faced psychosocial risks (poverty, excessive demands on the mother and mental health disorders of the mother. The results reinforce existing knowledge pertaining to the transactional association between regulatory problems in infants, maternal distress and dysfunctionality of mother–child interactions. Easily accessible support services provided by family health visitors (particularly to the so-called at-risk families) are strongly recommended to help prevent the broadening of children's early regulatory problems into other areas of behaviour.


Prenatal smoking cessation and gestational weight gain

Quitting smoking is often associated with weight gain, and prenatal cessation may lead to increased gestational weight gain (GWG). Although previous reports have suggested a link between prenatal smoking cessation and GWG, no studies have examined the relationship between cessation and guideline-recommended GWG, and there is little information about the relationship between the timing of prenatal cessation and GWG. This US study examined GWG among women in a community prenatal smoking cessation programme and assessed the relationship between the timing of prenatal cessation GWG. Pregnant women from care clinics serving economically disadvantaged women who participated in a smoking cessation intervention were offered free of charge, self-reported weight, and provided biochemical verification of smoking. Relationships between duration of cessation and GWG were evaluated in t-tests and regression models. GWG was calculated from self-reported weight before pregnancy and self-reported weight at the last visit before delivery. Quitting earlier in pregnancy is associated with greater GWG, but women who do and do not quit do not differ on total GWG. Despite increased GWG with early cessation, the maternal and foetal health benefits of prenatal smoking cessation outweigh risks of potential risks of excessive GWG.


What cereal advertisements teach children about healthy eating

Marketing that targets children with energy-dense, nutrient-poor foods is a likely contributor to the childhood obesity crisis. High-sugar ready-to-eat cereals are the packaged food most frequently promoted in child-targeted food advertising on television. The authors of this study combined content analysis of product nutritional quality and messages presented in cereal TV advertisements with syndicated data on exposure to those ads. The analysis quantifies children’s exposure to specific products and messages that appear in advertisements and compares it with adult exposure. Children viewed 1.7 ads per day for ready-to-eat cereals, and 87% of those ads promoted high-sugar products; adults viewed half as many ads, and ads viewed were equally likely to promote high- and low-sugar cereals. Given children’s vulnerability to the influence of advertising, the emotional and mixed messages used to promote high-sugar cereals are confusing and potentially misleading.


New resources

Specialist and community public health nursing bulletin

School nurses can sign up to a new Specialist and Community Public Health Nursing (SCPHN) bulletin, which will be published by Health Education North Central and East London once a month. If you would like to post any updates or be added to the distribution list, please contact the SCPHN Team at: SCPHN@ncel.hee.nhs.uk

CPHVA community nursery nurse resources

The CPHVA community nursery nurse online resources have been updated and are now available on the website. Please visit: www.uniteetheunion.org/cphva

Transition to Community Nursing Practice

The Queen’s Nursing Institute’s new educational resource, Transition to Community Nursing Practice, is aimed at newly qualified nurses and those in the process of moving from a hospital to a community nursing setting. It is designed to be used in conjunction with a professional mentor and is now available in print and online. Visit: www.qni.org.uk/for_nurses/transition_to_community

New teenage health and wellbeing survey trial

The ‘What about YOUth?’ survey is aimed at 15-year-olds and will examine topics such as smoking, emotional wellbeing, diet and physical activity. The trial will scope the feasibility of a potential full-scale survey with responses from 150,000 teenagers next year. Visit: www.whataboutyouth.com
Public health nursing: the foundation of the future

The CPHVA Annual Professional Conference took place this year at York Racecourse. Giving delegates an opportunity to network with colleagues and update their professional knowledge, the event was a great success. Chris Cloke, Vice President of the CPHVA delivered the keynote speech, and warned that structural changes in schools may weaken child protection.

Chris Cloke, Head of Child Protection Awareness at the NSPCC and Vice President of the CPHVA, told delegates that school nurses have a ‘vital role’ to play in preventing cases such as Daniel Pelka and Hamzah Khan, but claimed the creation of school academies and free schools ‘may’ mean child protection and safeguarding are afforded ‘less priority’ among school nurses. Concerned by the recent slew of serious case reviews, Cloke said it is ‘little wonder’ practitioners from all disciplines find it hard to learn the lessons of the past when coping with increasing workloads and unfilled posts.

‘We need to make sure this learning is a priority, and that we build it into the work that we do. We also need to ensure this learning happens across disciplines and I’m not sure the way in which structures are set up are conducive to this aim,’ he said.

Unite/CPHV Lead Professional Officer, Obi Amadi, said: ‘I cannot promise there will not be any more child deaths – but in a more resourced service where staff are able to be more up to date and reflective, I think we would be quicker to react to risk with the co-operation of other multi-agency colleagues. There is learning to be had from serious case reviews and, often, that part of safeguarding is overlooked.’

The Nursing and Midwifery Council (NMC) has issued a call to the community nursing workforce to help draw up plans for its revalidation framework.

NMC registrant member and a member of the previous NMC Council, Judith Ellis, admitted that the regulator’s greatest challenge is introducing an ‘affordable and proportionate revalidation programme’.

‘We are looking to see how it should work in the community and are talking through the all the difficulties. When fitness to practise is related to specialist community public health nursing, the CPD has to be relevant and we need to look at the area of appraisals when practitioners are self-employed,’ she said.

‘Nothing is definite; we need your help to get the consultation right.’

The formal consultation for nursing revalidation starts in 2014. While acknowledging the NMC has had a ‘traumatic’ couple of years, Ellis reassured delegates the organisation was ‘back online’ and ‘is getting there’.

‘The improvement plan is working,’ she said.
Community nursery nurse (CNN) redundancies are a ‘perverse impact’ of the health visitor growth programme, a senior nursing leader told delegates.

Professor Viv Bennett, Director of Nursing at Public Health England and the Department of Health, said it is important to protect the skill mix ‘we have worked so hard to build up. We have had the CNN redundancy issue raised previously and we are working on this,’ she said.

‘In single workforce growth targets we have to be careful that we don’t get perverse impacts; however, we know there have been some. That is one of them.’

Professor Bennett urged delegates to ensure they talk about health visiting teams and health visiting services, rather than just the numbers, as well as making sure the profession can demonstrate it cannot deliver the priorities without necessary skill mix within the teams. She encouraged practitioners to feed back all concerns and promised she will continue to do what she can in ‘trying to influence commissioners and providers about the importance of diverse teams’.

‘In a lot of places the CNNs are a part of the local community in enabling local services to deliver in a way that is appropriate for that community; and in some cases in the languages that is right for that community,’ she said.

‘What we need to do is talk up this whole child health agenda and all of the professions delivering it as we go forward.’

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Bennett vows to protect CNN role

Conference gala dinner: from day to night

Day one of the conference ended with a fantastic evening of dinner and dancing at York Railway Museum. Delegates attended to unwind from the day’s events and network with colleagues and the Unite Health Sector team.
Early collaboration vital in safeguarding children

Vicki Lant, UK Head of Children’s Centre Development at Barnardo’s, emphasised the importance of collaboration, sharing practice and combining talents in order for every child to get the best start in life.

She said, ‘My natural move into the world of children’s centres and Sure Start has been an opportunity to open up this world of collaboration.’

A large proportion of audience delegates stood up to show that they were involved with working with Sure Start centres; however, few could admit that they had a fully functioning data sharing agreement with those centres. Ms Lant concluded that this is something that needs to be improved.

The Caldicott review in April 2013 recognised that data sharing protocols should only be applied where there is a distinct problem for a family. ‘If data sharing enhances the relationship between people, then, truly, we should be sharing,’ Ms Lant said.

‘Children have one chance for the best start in life. We are a large provider of children’s centres and we have a responsibility to ensure our teams can offer that best start.’ The message that needs to be shared is that collaboration is key to improving outcomes.

Record keeping, ownership and digital transformation

Dr Susan Hamer, Organisational and Workforce Development Director at the National Institute for Health Research, explained the importance for community practitioners of keeping up with the digital age. She said simply, ‘If you don’t do digital, you’re not a nurse’.

Dr Hamer emphasised the importance of sharing information and safer practice through the use of technology and sharing evidence.

The presentation also covered online professional identity, including the use of social media websites such as Twitter and Facebook. Previous examples of the misuse of these sites by health professionals highlight the need for caution around what is being talked about online, particularly with regard to details about patients or their treatment. It is vital to remember to apply professional responsibilities in digital spaces and understand the boundaries when speaking freely online.

Dr Hamer asked delegates to bear in mind that digital skills demand new ways of thinking and being. The most important factor in any move towards digital records and the sharing of key information is confidence, she said.
Structural change ‘distracts’ from public health job

Public health success is dependent on how people work rather than structural change in the system, Dr Jane Atherton, President of the Association of Directors of Public Health has said.

Dr Atherton told the CPHVA conference that each of the health and social care systems across the UK ‘have their merits and their challenges’; and while none are perfect, she would advocate against huge structural change ‘in any of them’.

‘It isn’t about structures; I think it is about people and the emphasis on how they work and serving the population,’ she said.

‘It is not about changing systems, it is about how we work together. To be successful in public health depends on whether we are able to work across organisational boundaries.

‘Integration has very little point if all you are going to do is join up structures and not change the model of care to a more preventative one. Prevention has to be at the heart of any changes, and this will make the difference needed.’

Dr Atherton warned that public health professionals have been ‘distracted’ by structural change ‘for too long’ and it is ‘important to reap the rewards’ of sitting on local government in looking at the social determinants of public health.

‘Public health can be characterised as “pink and fluffy” – but actually what we do is deadly serious. This is about improving people’s lives and making sure that we can afford to provide that care into the future,’ she said.

Sharing information is a professional duty, the Children’s Commissioner for England has said.

Sharing information is about power not safety

Dr Maggie Atkinson told Unite/CPHVA members the duty to share information is about ‘secrecy’ and ‘power’ rather than ‘patient safety’ and ‘confidentiality’.

‘I am telling you, when it matters, you should share,’ she said.

‘It is not rocket science. It is harder than rocket science, because boy are you stepping on dangerous and difficult territory if you insist that sharing information is a professional duty.

‘If only more of us had a conversation over a cup of tea, children like Daniel Pelka and Hamzah Khan may still be alive.’

She also warned that members ‘may well be the voice of prevention in locality areas’ as local authorities have retreated to what is statutory after they, she claimed, closed ‘an awful lot of their preventative activities’.

Dr Atkinson also encouraged the creation of a shared language of prevention.

‘We need to put the child in the middle and stop calling it nine different things,’ she said.

The concept of hope: recession and suicide

Catherine Johnstone, Chief Executive of The Samaritans, warned that in times of recession the number of suicides increases and that health professionals need to be aware of the signs so that anyone at risk can be identified and signposted to the right support.

Ms Johnstone said, Suicide is a health inequality. It is well documented that the unavoidable differences in health and length of life that result from being poor and disadvantaged lead to a higher level of suicide. Unemployed people are two to three times more likely to commit suicide than those who are in work, and workplace support initiatives can mitigate that risk – but we need more interventions to help.

The Samaritans works with schools to provide support during the aftermath of a suicide, which can lead to copycat deaths and serious emotional consequences for all those involved.
Health visitors and school nurses safe from NHS ‘crippling’ efficiency savings

The health visiting profession is on the verge of a ‘renaissance’, the Unite/CPHVA Lead Professional Officer told delegates at the conference.

Obi Amadi said the increase in health visiting numbers proves there has been change, but it cannot be said to be mirrored across the different English regions. She urged members to ‘keep pushing for more change and to keep an eye on what the change is’.

She reassured attendees that the CPHVA Professional Officer team is ‘working hard’ to make sure that the ‘crippling’ NHS efficiency savings do not derail the plans for health visiting. She continued, ‘In terms of what we have done so far I think health visiting and school nursing are going to be OK’.

She also renewed the call for one school nurse to be appointed for every secondary school and one school nurse for ‘every primary feeder’, and made a commitment that the campaign was UK-wide.

‘It is important that school nurses do not have to fight this fight on their own, as thanks to the new local authority commissioning arrangements they are more isolated than ever before. They need everyone’s support in their efforts lobbying and campaigning for what is right.’ She said it is ‘scary’ that health visitors consistently report low morale in staff surveys and cited a trust in London reporting that 38% of staff were being bullied.

‘We need to turn this around. Low morale undermines good services. Hopefully, the increase in numbers will help that.’
BREASTFEEDING IS BEST FOR BABIES*

Can you reduce the risk of an infant developing eczema?

Tanya Wright BSc Honours MSc Allergy HCPC Registered Dietitian MBDA

Tanya Wright is a specialist dietitian who is passionate about working with healthcare professionals and patients to promote the practical aspects of food allergy management.

Breastfeeding has many benefits for both the mother and infant and should always be recommended as the first choice of feed.

Eczema is a growing modern epidemic¹,²

The occurrence of eczema is greatest in young children,¹ but the prevalence of allergic diseases worldwide is rising dramatically in both developed and developing countries.² Eczema can occur from birth, on introduction to formula milk, or when weaning commences.

Its impact extends to the whole family³

Apart from the visible effects on the baby, eczema can also affect the whole family socially, psychologically, and financially.³ Sleep deprivation, low self-esteem, exclusion from activities, along with inconvenient time schedules for treatments, are often the reality faced by these families.

“What is important to understand there are things we can do to help babies at risk of eczema and reduce the burden of this condition”

What are the options for feeding infants?

Breastfeeding is best for babies and should always be recommended as the first choice of feed. If exclusive breastfeeding is not possible however, reducing the impact of allergy (including eczema) in bottle-fed infants has been a major focus of research.⁴ The independent prospective GINI study, for example, enrolled over 2000 infants.⁴ It found that certain formulas containing hydrolysed proteins reduced the risk of eczema by over 50% in babies with a family history of the condition (those with at least one parent or sibling with allergy).⁵

What the guidelines recommend

Not all hydrolysed formulas have been found to reduce the risk of developing eczema. Therefore clinical guidelines, such as the European Academy for Allergy and Clinical Immunology (EAACI), suggest choosing a formula that has been clinically proven.⁶

IMPORTANT

SMA H.A. Infant Milk should NOT be used if a baby has already been diagnosed with allergy to cows’ milk proteins or is suspected of already having an allergy to cows’ milk protein. SMA H.A. Infant Milk should be used as the first formula feed, before babies have been exposed to intact cows’ milk proteins.

*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.

New SMA H.A. Infant Milk - designed to specifically reduce the risk of developing allergy (e.g. eczema) to cows’ milk proteins.

It is nutritionally complete and can be used from birth.

- Clinically proven to reduce the risk of eczema by over 50% in ‘at risk’ infants⁵
- Use from first formula feed
- Omega 3 and 6 LCPs
- Easy to digest

Available to order over the counter at Boots and other pharmacies

Supporting you to support mums

Visit us: smahcp.co.uk or smahcp.ie

6. EAACI Food Allergy and Anaphylaxis Guidelines 2013.
Nursing across the borders

All four of the UK’s Chief Nursing Officers took to the stage at the CPHVA’s 2013 Annual Conference in York. *Community Practitioner* sat down with the Welsh and Scottish CNOs to find out their priorities for the public health nursing workforce for the coming years.

Louise Naughton
Assistant Editor

Professor Jean White  Chief Nursing Officer for Wales

Q: What are the biggest challenges facing health visitors in Wales?
A: We have challenges of social deprivation like everywhere else – we have a very aged population. We have very high public health challenges around child obesity and lack of exercise, drug and alcohol use. All those sorts of social determinants are in pockets of Wales like they are everywhere, so the challenge for health visitors is how do you actually fit into that particular role. We have a programme called Flying Start, which is one of the top five priorities of the Welsh government and a flagship activity because it tackles child poverty, and looks at socially deprived areas and the most challenged families in Wales. This government has committed to doubling the size of this programme, which means we have had to double the number of health visitors involved and have had to recruit far more.

Q: How will the education and training models change in order to support the health visitor growth in Wales?
A: One of the things we have tried, I think quite successfully, is to allow the newly completing adult nurses to do another year – almost a dual qualification in a four-year period – and come out as a health visitor. We have never done that before, but it has worked very well and they have come out and got jobs as a consequence. We are also thinking about skill mix within the health visiting teams and what the roles are for other people working alongside registered health visitors. If we go to a part-time work-based training for health visitors in the future, rather than the full-time degree that we use currently, perhaps the role of the staff nurse could almost be part of work-based training – they work alongside the health visitor in order to get to be a registrant that way. So if you create a staff nurse role as part of the health visiting team, it might be a cheaper education model for the future and that means we can train more faster.

Q: It has been suggested that health professionals weigh children at every contact to stem the obesity epidemic in the country. What’s your view?
A: There is a debate to be had over the language used when talking to parents about their child. The media tells us not to use the word ‘obese’ but we have to use words to educate parents on healthy eating for children and the health consequences for that child when it goes wrong. Even if you are weighing each child at each point, what do you say to parents? I think it is tied up with how do we have constructive conversations with parents that don’t alienate them or make them feel stigmatised and actually get across the healthy eating model rather than saying ‘your child is obese, you have done bad’. It is a very different conversation to finger pointing and saying ‘I’m the professional, I know what is best’.

One of the things Public Health Wales is leading on for me is how you have multi-public health motivational interviewing conversations. Whereas in the past we have had alco-chats, which is motivational interviewing techniques used to stop people drinking too much, we can transfer these skills to have the same short conversations about changing behaviours and acting more healthily.

Q: Are there any plans to review health visitor caseloads in Wales?
A: There is such a variability of caseload across Wales. One of the 10 recommendations we are working through under the health visitor review is to come up with a workforce acuity tool to determine the ‘right’ caseload. If we are expanding from 18,000 to 36,000 of children from the most socially deprived backgrounds moving into a Flying Start arrangement – which is capped at 110 cases per health visitor – that is going to have a knock-on effect for the generic workforce. Therefore, the generic workforce should see more balance in their caseload, however I’m not entirely convinced it is happening like that, which is why I want a tool that can configure how your team should work.

Q: Has the Francis Report into Mid Staffs had any impact in Wales?
A: It certainly has and it has confirmed that setting minimum standards is too dangerous quite frankly. We have seen it happen in the social care world where people just do the minimum required. That is not a drive for excellence as far as I’m concerned, that is a drive for safety and I would rather drive for excellence as a stance.
Francis confirmed that a lot of what we are doing and planning is the right thing to do. Whether the report penetrates right down to the bottom of organisations I don’t know – it might do. Some things would be obvious; staff will know we are looking at numbers and ratios, as well as other quality indicators around data entry. But we were doing this before Francis came out, looking at training standards for healthcare assistants; we already planned to do that work.

Q: Will there be any changes to health visitor/school nurse training programmes to facilitate an increase in numbers?
A: In November 2013 I will be launching the CNO’s education review, which is about making sure people are educated, because there has been a reduction in programmes available across the UK for health visiting and school nurses. The review sets out six strategic priorities; one of which is to develop a national framework for post-registration education that will include public health nursing. So we have a long-term strategic plan for the numbers we need lasting until 2020, as opposed to working through a ‘boom and bust’ cycle. It may well require an increase in the number of student health visitor places, but that will be driven by workforce planning tools and demand. It is about getting all the bits together to support the increase that we are going to need in health visiting – to make sure there is always a business case and they are funded and educated in the right way as well as having jobs available for them.

Q: How has the Francis report impacted health visitors and school nurses in Scotland?
A: I don’t think there is any nurse that looked at Francis and didn’t feel something. It has impacted all nurses in Scotland in that it is our duty to look and understand the circumstances that allowed that and created that sort of situation to happen.

Q: How much do the UK CNOs share information?
A: We are all still facing the same global drivers, but the flavour is slightly different. There are a number of things that unite us as a family of nurses – organisations like the CPHVA are UK-wide, regulation is UK-wide, we are all part of Europe etc. The four UK CNOs meet every four months and share and lead things for each other. If any of us are doing anything new or innovative, we will all watch, learn and share and we do bring things across the border – why wouldn’t you?
Two recent headlines in the *Guardian* newspaper alarmed me: ‘Recession has led to spending on food falling’ (Clark, 2013) and ‘Number of homeless families with children in B&Bs highest in a decade’ (Gentleman, 2013). These are two public health concerns that need concerted action; but who, pray, is in charge of improving health outcomes for these families?

The article on food refers to a depressing survey from the Institute of Fiscal Studies, which shows that in the face of squeezed budgets and rising prices, poorer families are buying more energy-rich, processed foods, high in sugar and saturated fat, and less fruit and vegetables. The second story makes it clear that families in temporary and overcrowded accommodation will be unable to buy, store and cook fresh nutritious meals; two thirds of the B&B families interviewed said they had no table for the children to eat at.

A third worrying headline related to the joint Royal Colleges, Unite union and Equality Now report on female genital mutilation (FGM) (RCM, 2013). This places awareness of the crime of FGM in the same category of other forms of child abuse; therefore, by definition, school nurses must be alert to symptoms and behaviours, and report their concerns.

Children in need
The Department for Education (DfE, 2013) has published statistics on the characteristics of children in need in England in 2012–13. Findings include:

- There were 378,600 children in need at 31 March 2013
- A total of 43,100 were the subject of a child protection plan
- There were 593,500 referrals to children’s social care services.

Chris Cloke, Head of Child Protection Awareness at the NSPCC and CPHVA Vice-President, spoke at the CPHVA Annual Professional conference this year and said that school nurses have a vital role to play in preventing child neglect. The NSPCC ‘Underwear Rule’ campaign (www.nspcc.org.uk), which encourages parents to talk to their children about keeping private those parts of their body normally covered by underwear, needs to be publicised more widely to children generally. It may well also be significant in teaching British-based children and families that FGM is wrong.

All of the above shows the tremendous amount of public health work that is going to be needed over the next 10 years if we are to prevent the next generation from lifestyle-related ill health.

As public health nurses we must act as advocates for families – and as school nurses we must ensure that those children who are living in difficult circumstances at home receive the best possible health promotion at school.

Engaging with commissioners
Public Health England (PHE) is running four events this autumn under the title, *Delivering Excellence: Maximising the Health and Wellbeing of School Aged Children*. Encouragingly, the first was well attended by commissioners, public health directors/strategists and healthy living nurses.
SCHOOL NURSE CAMPAIGN

schools representatives, as well as nurses and students. Several of you have said that you are discouraged from talking to commissioners, but I still suggest, again, that you set up a day of your achievements and good practice, and invite all local partners. At the very least, invite them to mince pies one afternoon near Christmas.

Chief Medical Officer report

You may have read the report from England’s Chief Medical Officer (CMO), Professor Dame Sally C Davies, entitled Prevention Pays – Our Children Deserve Better (Department of Health, 2013). There are many references to school nurses (especially in chapter seven) and much of PHE’s work has been incorporated into the report.

It is gratifying to read that the CMO appreciates ‘the efforts of school nurses in health promotion and co-ordinating health and wellbeing services in school’.

She goes on to say: ‘The school nursing service is ideally located to deliver an assets-based public health agenda. The potential of the school nurse to adopt a leadership role in the promotion of health and wellbeing among the school-aged population has recently been reasserted, with new policy guidance on school nursing.

‘Identified as key public health professionals, school nurses are intended to lead, co-ordinate and provide services to deliver the Healthy Child Programme to the 5–19 years population and ensure a smooth transition from the health visiting service for the school-aged population.’

Make sure you read and learn the relevant passages by heart so that you can advocate at all meetings for increased resources for school nurses in your area. If you would like a ‘Lunch & Learn’ or ‘Cake & Catch-up’ session on this or any of the topics I have talked about, then do get in touch.

Voluntary work

I have received a couple of emails about something I wrote in the August issue of Community Practitioner. I mentioned that all NHS England (and PHE) staff are allowed to have five days a year to do voluntary work; however, this applies only to directly employed staff, ie, civil servants. School nurses in England are variously employed by trusts, private companies and social enterprises. Most of you are under Agenda for Change terms and conditions regarding holidays, but some trusts are trying to introduce local (inferior) conditions.

By the way, we had a speaker from the Trades Union Congress (TUC) at our conference and they are fully behind the 121 campaign!

References


Royal College of Midwives, Royal College of Nursing, Royal College of Obstetricians and Gynaecologists, Equality Now, Unite. (2013) Tackling FGM in the UK Intercollegiate recommendations for identifying, recording and reporting. London: Royal College of Midwives.

Call for Advisory Board members

Community Practitioner journal is seeking new members for the Editorial Advisory Board. All applications will be considered but we would particularly welcome those from the following disciplines/areas:

- School nursing
- District and practice nursing
- Representatives from Wales and Northern Ireland.

Editorial Advisory Board members assist the editor in ensuring the content of Unite/CPHVA’s monthly journal is topical and relevant to clinical practice. You need to be able to demonstrate enthusiasm, knowledge and experience, and dedicate the time to assisting the editorial team where needed. You will also be required to review professional research articles. If you feel you fit the bill and would like to help us take the journal forward into 2014 and beyond we would love to hear from you. The deadline for applications is 31 December 2013.

Please send your application (CV and brief covering message outlining your suitability) to the Editor, Polly Moffat, at polly.moffat@tenalps.com
FGM: A hidden crime

A new report into female genital mutilation (FGM) highlights that, despite the barbaric practice being illegal in the UK, not one single person has been held to account for their involvement in the act.

Louise Naughton reports

Charities estimate that 66,000 women in England and Wales are living with the consequences of female genital mutilation (FGM) and a further 24,000 girls from African communities under the age of 15 are said to be potentially at risk of the cruel and inhumane practice.

Legislation in the UK has banned FGM since 1985, with offenders facing a prison sentence of up to 14 years if found guilty. However, to date there has never been a conviction in any of the UK’s four countries against anyone involved in FGM. This is compared to France, which has convicted around a hundred people associated with the practice.

FGM comprises all procedures involving the partial or total removal of the external genitalia or other injury to the female genital organs (pricking, piercing, incising, scraping and cauterisation) for non-medical reasons. Many falsely believe FGM to be a cultural ‘ritual’ or ‘rite of passage’, which has allowed the practice to stay hidden and largely ignored for too long. Increased migration has meant more girls in the UK are at risk of being cut every day; yet we are still failing to integrate FGM into the child protection system. However, a new report says no more.

There was not a dry eye in the House of Commons on a bitterly cold November evening in 2013 as FGM activists gathered to formally launch a landmark intercollegiate report into the barbaric crime.

Alimatu Dimonekene – a survivor of FGM – bravely stood in front of health professionals, senior police officials, MPs and journalists to tell her story. At 16 years old she was brought to her grandmother’s house in Sierra Leone, a place she trusted and in which she felt safe. ‘That place was my world, it held everything I ever wanted’, she said. She then recounts how she was held down by her aunts, the very women she loved and looked up to, with her legs splayed open ready for a drunk, uneducated and unprofessional woman to take a dirty blade to the most private part of her body.

‘I was thrown to the ground and stripped of everything I had. As I lay there, I knew straightaway what was about to happen, because I knew the screams and they rang loudly in my head. I knew it was only a matter of time for me – and that day was my time.’

Alimatu broke down as she recalled that she then suffered the indignity of being left in her own blood after being cut.

‘I lay there thinking, “This is the end of my world” – and indeed it was.’

Alimatu came to England shortly after her ordeal, and was helped and counselled by NHS professionals.

Louise Naughton
Assistant Editor
The report, *Tackling FGM in the UK: Intercollegiate Recommendations for Identifying, Recording and Reporting*, makes it clear that any babies, children or young people suspected of being at risk or presenting with FGM should be considered as potential victims of crime and referred to support services and the police.

Under the report’s nine recommendations, FGM is to be considered as child abuse and integrated into all UK safeguarding procedures ‘in a systematic way’, with the performance of frontline professionals in addressing FGM to be measured by the NHS and local authorities. The government has also been tasked with implementing a national FGM awareness campaign, similar to that of previous domestic abuse and HIV campaigns.

Historically, there has been little urgency in empowering frontline professionals to take a stand against FGM. However, the intercollegiate group behind the report, made up of Unite/CPHV A, the Royal College of Midwives, the Royal College of Nursing, Royal College of Obstetricians and Gynaecologists and Equality Now has made its intention to take people’s fingers out of their ears and force them to listen.

Lead Professional Officer for Unite/CPHV A, Obi Amadi, said: ‘We are really pleased to have been partners in this important work. This is “joined-up” thinking and we are all committed to acting together on this issue. FGM devastates the lives of girls and young women, and needs to be stopped. This is an important project for health visitors because they need to get good information from midwives about FGM. This project is also about safeguarding vulnerable children, and information about FGM should be collected sensitively and as routine practice.’

‘School nurses are with children during a key formative period in their lives and are advocates for children potentially impacted by FGM. An alert about FGM risk for a child should come with school handover. Above all, children should be listened to sensitively.’

Alimatu warned attendees at the launch of the report in London that FGM happens in the UK in everyone’s neighbourhoods and all around them: ‘You may not hear the screams, but it happens.’

She urged people to support the recommendations and touched everyone in the room when she spoke of FGM’s lasting consequences and the very real impact it has had on her life. ‘I am constantly in pain. I have no emotions, I have no love, I have no care; but I have had the support of NHS practitioners. This is the time and we need to drive on. No more turning back. It is not a cultural practice, it is evil, it is barbaric, it is inhumane, it is a human rights violation. I can never go to my gynaecologist and feel comfortable, I always have to let them know they are about to see something they are not familiar with. As a woman, it takes every pride and dignity away from me. ‘I didn’t ask for this. It is too late for me, but there is another little girl out there who needs your help.’

### Key points from *Tackling FGM in the UK: Intercollegiate Recommendations for Identifying, Recording and Reporting*

- **Treat it as child abuse**: FGM is a severe form of violence against women and girls. It is child abuse and must be integrated into all UK child safeguarding procedures in a systematic way.
- **Document and collect information**: The NHS should document and collect information on FGM and its associated complications in a consistent and rigorous way.
- **Share that information systematically**: The NHS should develop protocols for sharing information about girls at risk of – or girls who have already undergone – FGM with other health and social care agencies, the Department of Education and the police.
- **Empower frontline professionals**: Develop the competence, knowledge and awareness of frontline health professionals to ensure prevention and protection of girls at risk of FGM. Also ensure that health professionals know how to provide quality care for girls and women who suffer complications of FGM.
- **Identify girls at risk and refer them as part of child safeguarding obligation**: Health professionals should identify girls at risk of FGM as early as possible. All suspected cases should be referred as part of existing child safeguarding obligations. Sustained information and support should be given to families to protect girls at risk.
- **Report cases of FGM**: All girls and women presenting with FGM within the NHS must be considered as potential victims and should be referred to the police and support services.
- **Hold frontline professionals accountable**: The NHS and local authorities should systematically measure the performance of frontline health professionals against agreed standards for addressing FGM and publish outcomes to monitor the progress of implementing these recommendations.
- **Empower and support affected girls and young women (both those at risk and survivors)**: This should be a priority public health consideration. Health and education professionals should work together to integrate FGM into prevention messages (especially those focused on avoiding harm).
- **Implement awareness campaign**: The government should implement a national public health and legal awareness publicity campaign on FGM, similar to previous domestic abuse and HIV campaigns.
The CPHV A are immensely proud of the professionalism, passion and creativity that community practitioners and health visitors are undertaking throughout the diversity of environments in which they practice.

This practice is being undertaken in extremely difficult times, often without thanks and appreciation.

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The 2014 CPHV A Awards ceremony will take place in the stunning setting of the OXO2, overlooking the River Thames in London on Friday 28th March 2014.

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Winners at the CPHVA Awards ceremony 2013
The role of the school nurse in child protection

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Abstract
School nurses are the only health professionals with a remit specifically to address the health needs of school-aged children and young people in the UK. However, evidence within one Scottish city suggests that the health needs of vulnerable school-aged children are not always identified or met by the school nurse. Using a qualitative approach, a purposive sample of six school nurses was selected to explore their perceptions of their role in child protection and to identify training needs. Data collection comprised semi-structured interviews and the data were analysed thematically. The school nurses in this study perceived that there was confusion and lack of clarity in relation to their role and involvement in child protection. Report writing, child trafficking, and legal issues were identified as training needs.

Key words
School nurse, school-aged children, child protection, training needs, continuing professional education

No conflict of interest declared

Introduction
Promoting and safeguarding the health and welfare of children and young people have been identified as key issues for the Scottish and UK governments (Scottish Government, 2008; Department of Health (DH), 2013). In the UK, child protection and safeguarding policy and legislation are different across the four devolved countries due to strategic and operational differences in the delivery of services. However, the principles are the same: the needs of the child are paramount and it is everyone’s responsibility to safeguard children (DH, 2013; Scottish Government, 2010).

The school nurse has been identified as having a key role in safeguarding the needs of school-aged children (DH, 2013; Scottish Government, 2010). This article will focus on the role of the school nurse in child protection within the context of Scottish policy. Better Health, Better Care is the action plan for NHS Scotland (Scottish Government, 2007). It details a programme of actions to offer all children the ‘best possible start in life through integrated cross-government approaches’ focusing on early intervention and partnership working (Scottish Government, 2007; 26).

Getting It Right For Every Child underpins the practice of all professionals involved in working with children and young people in Scotland (Scottish Government, 2008). It builds on universal services and aims to improve outcomes by ensuring that the needs of children and young people are met and that they are given the chance to achieve their full potential (Scottish Government, 2012a). A central tenet is the need for professionals to work together effectively. More recently, the report of the Health and Wellbeing in Schools Project has highlighted the importance of partnership working and the early identification of health needs for the most vulnerable children and young people (Scottish Government, 2011).

Background
Evidence from one Scottish city suggests that the health needs of vulnerable school-aged children and young people are not always identified or met by school nurses (HM Inspectorate of Education, 2010). An extensive review of the literature revealed a dearth of published research on the role and involvement of the school nurse in relation to child protection practice.

Nine studies were included in the review as they met the inclusion criteria: primary research published in English after 1997 and papers with school nurses in the sample relating to their role in child protection issues and training/education. Only one study sought to specifically explore school nurses’ perceptions of their role in protecting children (Clarke, 2000). This qualitative study set out to explore workers’ perceptions of the handling of child protection issues over a 10-year period between 1984 and 1994. The findings revealed that expectations of the role and involvement of the school nurse in child protection increased as these nurses became more visible to other professionals; in particular, head teachers and social workers (Clarke, 2000). Clarke (2000) concluded that school nurses have an important role to play in child protection and suggested that training and experience were key factors enabling school nurses to develop their role in the child protection process (Clarke, 2000).

Land and Barclay (2008) contend that lack of education and opportunities to participate in continuing professional development are factors that influence nurses’ understanding of their role in child protection (Land and Barclay, 2008). However, this study was conducted in Australia and the perceptions of only two school nurses were obtained, which limits the transferability of the findings. Nonetheless, these findings are similar to those of Crisp and Green Lister (2006), who explored nurses’ perceptions of their training needs in child protection issues. The findings suggest that practitioners perceive the importance of education and training in child protection in relation to its relevance for their professional practice. However, this study was excluded from the review as the researchers do not specify if school nurses participated in the research. Nevertheless, the findings of these studies suggest that the role and involvement of the school nurse in child protection might be associated with training needs.

To investigate the role of the school nurse in child protection and their training needs for child
protection practice, a small-scale qualitative study was carried out as part of the dissertation module of a Master’s in Nursing and Applied Education. This article first reviews the methodology, and presents some key findings followed by the implications for practice, education and research.

Aims
The aims of this study were to:

- Explore school nurses’ perceptions of their role in child protection
- Identify skills required to undertake this role
- Identify training needs.

Methodology
A qualitative approach was used.

Participants
Recruitment of participants commenced in September 2011 following receipt of ethical approval. The chief nurses provided lists of school nurses working in their area. Study invitation letters and participant information sheets were sent to all school nurses on the lists (n=36). Eleven school nurses volunteered to participate in the study; however, due to time constraints to complete the study, six participants were purposefully selected. The final sample comprised three school nurse team leaders and three school nurse staff nurses from two geographical areas. Length of experience since initial nurse qualification ranged between five and 37 years, while experience in school nursing ranged between three and 19 years. Five participants were educated to degree level; one participant was educated to diploma level; and two participants possessed the Specialist Practitioner Qualification (SPQ) in Public Health Nursing.

Ethical approval
Ethical approval was not required as the study was considered to be service evaluation. Permission was granted by the local NHS, and the university research and ethics committee.

Data collection
Interviews were semi-structured and conducted between February and March 2012 at various health board premises. A topic guide was used to shape the interviews (see Box 1). Interviews were digitally recorded and ranged between 45 and 90 minutes. To ensure accuracy each interview was transcribed verbatim by the researcher. Notes were made at the end of each interview to assist in the identification of themes and to reflect on the interview experience. Two sample questions were:

What is your role and responsibility in relation to protecting children and young people?

| What do you consider are your education/training needs for identifying and responding to child protection issues? |

Data analysis
The data were analysed thematically. Data analysis commenced at the end of the first interview when notes were made and transcription began. The completed transcriptions were read several times to aid familiarity and reduce the data aiding the identification of themes. Upon completion of this stage a coding index was developed and applied to the transcripts. Subsequently, thematic charts were developed for each of the initial themes. The final stage involved mapping out the key themes and interpreting and making sense of the data (see Table 1 for development of Theme 2).

Findings
Three key themes and several sub-themes emerged (Table 2).

Theme 1. Role Confusion
This theme emerged from participants’ perceptions of their role and responsibilities in relation to child protection issues. Participants were clear that education is the main agency in regard to child protection issues. All participants were aware of the need to follow child protection procedures when they had a cause for concern. However, there were differing thoughts and opinions on their role as a school nurse. One participant described being unsure of her role:

‘I said that I was quite clear what my role is, safeguarding and disease prevention, and then sometimes I act like I am unsure about what my role is, you know what I mean, because I am pushed somewhere else.’ (SN3)

All participants talked about the need for clarity in regard to their role and responsibilities. They felt familiar with varied professional and managerial expectations of what the school nursing service could provide, particularly in relation to child protection practice. Participants’ accounts of school nurse involvement in child protection issues identified varying perceptions, with some expressing strongly held views:

‘I think the fact is that it depends on how far you want to be involved with child protection … when a child protection case conference comes up that is my devotion to that case and to see it through.’ (SN4)

‘… it is not social concerns. We are very much I think physical health … we don’t do home visits.’ (SN5)

Theme 2. Learning in Practice
This theme emerged from questions seeking participants’ views of their current child protection knowledge, skills and experience, and perceptions of their training needs. All participants provided accounts of the importance of having life experience before taking up a position as a school nurse:

‘If I had come into school nursing straight as a newly qualified nurse without a load of life experience, I probably wouldn’t have the same ability to pick up on little things.’ (SN2)

However, one participant felt that personal attributes are more important:

‘I think it is more their personality and their skills in that they are open to learning and they are not quick to judge.’ (SN5)

Experiential learning was perceived as the most effective method of learning. One participant suggested that, although experience and attending training is important, it is vital to be able to integrate theory and practice:

‘I don’t think experience alone is enough but I think the experience is actually putting everything that you have learned into practice and learning from that.’ (SN6)

Teaching activities that used small group work and problem-based scenarios were perceived as effective for their learning. Participants also held the view that training should be more regular and annual updates were suggested. Additionally, they felt training should be relevant, meaningful, set at the right level, multi-agency and school nurse specific.
The school nurses in this study highlighted confusion and lack of clarity surrounding their role in child protection and felt that it required clarification. This finding is not surprising as the Royal College of Nursing (RCN) (2012) contends that commissioners and planners of services lack understanding and appreciation of the school nurse role in promoting the health and wellbeing of school-aged children and young people.

The revised National Guidance for Child Protection in Scotland (Scottish Government, 2010) emphasises the need for professionals to attend child protection training to develop skills in identifying, assessing and responding to child protection issues, and to increase understanding of their and other agencies’ roles and responsibilities. Lack of time and resources have been cited as constraints to practice development (Croghan et al, 2004) while financial and organisational constraints have been associated with difficulty accessing training (Banning and Stafford, 2006; Crisp and Green Lister, 2006). School nurses in this study identified these factors as constraints, but cost to the individual in terms of their personal time was also perceived to be a barrier, which concurs with a census conducted by the RCN (2009).

A key theme emerging from data analysis was experiential learning. Educational research has identified that learning is an active process whereby knowledge is constructed through experience, and reflection on that experience (Brookfield, 1986; Race, 2004). Participants in this study perceived that life experience before taking up a position as a school nurse is important as it assists in the identification of abuse. This is mirrored in an exploratory study, which sought to explore the perceptions and training needs of health visitors, school nurses, nursery nurses and practice nurses in relation to parental alcohol misuse (Lacey, 2009). However, Pakieser et al (1998) found no association between previous experience and decision making in child protection.

Active learning was perceived as the most effective method of learning and the importance of integrating theory and practice was highlighted. It is acknowledged that active learning methods are associated with deeper approaches to learning (Biggs and Tang, 2009). Those felt by participants to be the most effective included the use of case scenarios, small group work and child protection supervision. A study by Hall (2007) has also identified that child protection supervision is perceived as useful to help school nurses reflect and learn from practice.

### Table 1. Extract of development of Theme 2: Learning in Practice

<table>
<thead>
<tr>
<th>Data charting using coding index</th>
<th>Elements identified in thematic chart</th>
<th>Theme/sub-theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.3. Importance of experience</td>
<td>Life experience seems to be important for the identification of child protection issues</td>
<td>Learning in practice/ Importance of experience</td>
</tr>
<tr>
<td>'You might have looked on it differently without the experience or not be able to pick that up the same. So that’s where I think life experience comes in’ (SN2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>'The more times you have to deal with situations, the more that you learn and you develop skills and strategies to help you cope based on what went well and what didn’t go well’ (SN6)</td>
<td>Feels that learning through experience gained on the job is important</td>
<td>Learning in practice/ Learning from experience</td>
</tr>
</tbody>
</table>

### Table 2. Key themes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role Confusion</td>
<td>Lack of clarity</td>
</tr>
<tr>
<td></td>
<td>Variation in practice</td>
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<tr>
<td></td>
<td>Competing demands</td>
</tr>
<tr>
<td>Learning in Practice</td>
<td>Importance of experience</td>
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<td></td>
<td>Learning from experience</td>
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<tr>
<td></td>
<td>Learning from others</td>
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<tr>
<td>Moving Forward</td>
<td>Self-development</td>
</tr>
<tr>
<td></td>
<td>Supporting child and young person</td>
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<tr>
<td></td>
<td>Practice development</td>
</tr>
</tbody>
</table>

'... something a bit more specific just for school nurses.' (SN1)

'... unless it is directly relevant to you, you are not going to remember it ... it would have to be meaningful, it has to make sense why the nurse would need that level of knowledge.' (SN5)

One participant suggested that the content of training has to be different from current training to ensure that it offers a new way of looking at child protection issues:

'It has to have a different angle so that it is meeting your needs.' (SN2)

Participants provided accounts of learning in different learning environments. These included multi-agency training, attending child protection case conferences, child protection supervision and informal peer supervision. Topics identified as current training needs included report writing, child trafficking, and legal issues in relation to looked after children:

'... a mentor, you know, that has to facilitate a workbook.' (SN3)

Workload, time, lack of staff and cost were perceived as barriers to uptake of child protection training by all participants.

### Theme 3. Moving Forward

This theme emerged throughout the interviews, particularly in relation to participants’ perceptions of the skills and training required to identify and take forward a child protection concern. Confidence and communication skills were perceived by all participants as the key factors required:

'Knowing who to speak to and the right people to speak to, knowing, having the confidence, I suppose, to speak to certain people as well.' (SN3)

Two participants in particular stressed the importance of listening skills and made a distinction between hearing and listening, and seeing and listening:

'... hearing and listening are probably slightly different, but it is being open to hear what they are saying ... take it step by step.' (SN2)
Length of experience did not appear to have a bearing on perceived training needs. In fact, legal issues, report writing and child trafficking were identified as training needs by most participants. Crisp and Green Lister (2006) identified similar findings as participants in their study also wanted training in legal issues tailored to meet the needs of different occupational groups and workforce setting. More regular training in child protection and annual updates were perceived as important by the majority of participants which is consistent with the findings of Crisp and Green Lister (2006) and Paavilainen et al. (2000). Moreover, in common with the findings of Hall (2007), support for nurses new to school nursing included an induction pack and allocation to a mentor.

Professional confidence and communication skills, in particular the confidence to air personal views and to challenge the views of others, were perceived as important for taking forward a child protection concern. This finding is congruent with the recommendations of the Scottish Government (2012b). In addition, the ability to communicate effectively with children, young people and professionals was perceived as essential. An extended literature review identified that a range of communication skills, including listening skills and the ability to establish a rapport with parents, were important for all practitioners involved in child protection practice (Keys, 2009).

Implications and recommendations

Inter-agency training programmes should highlight the role of the school nurse to increase awareness and understanding of their role and responsibilities in child protection. Child protection trainers should ensure that teaching and learning activities that promote active learning are incorporated into training material, including lesson plans. Child trafficking, legal issues and report writing are topics that the school nurses in this study identified as training needs. This training could be delivered by child protection trainers in addition to the current single and inter-agency training. Within the local area, report writing workshops for the school nurses have been developed and delivered by child protection advisors. Due to demand for this training it has been extended to include health visitors and student health visitors. In addition, a team of multi-agency trainers deliver training in child trafficking and legal issues.

Nurses new to school nursing may benefit from an induction package based around the essential skills and competencies outlined in the National Framework for Child Protection Learning and Development in Scotland (Scottish Government, 2012b). The allocation of a mentor could support achievement of the required competences.

Conclusions

Although the school nurses in this study highlighted confusion and lack of clarity surrounding their role and involvement in child protection, they were quite clear about their responsibility to follow child protection procedures if they had a cause for concern about a child or young person. In addition to child protection training, case supervision was perceived as important to meet their learning and training needs.

Multi-agency training in particular was felt to benefit their child protection practice due to an increased understanding of the roles and responsibilities of other professionals. However, lack of time and increasing workload were identified as barriers to school nurse involvement in child protection and ability to undertake child protection training.

Acknowledgements

I would like to thank managers for their support, and the school nurses who gave their time to participate in this research study, as without them it would not have been possible.

References


When a child is distressed with a fever parents want to turn to a medicine they can trust.

Fortunately the makers of Calpol® also make Calprofen®. It gets to work on a temperature in just 15 minutes and gives relief for up to 8 hours, allowing a child to get the good night’s sleep they need.
A cognitive behavioural approach to working with parents and families

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Abstract
This article examines the difference between cognitive behavioural therapy (CBT) and the cognitive behaviour approach (CBA) in relation to its use in health visiting practice and school nursing. Two areas of practice are illustrated: support in postnatal depression; and support with positive parenting. The ‘Five Areas’ approach to assessment and intervention is discussed alongside behavioural activation, cognitive restructuring and problem solving to reduce avoidance strategies.

Key words
Cognitive behavioural therapy, CBT, cognitive behavioural approach, health visitor


No conflict of interest declared

Introduction
Cognitive behavioural therapy (CBT) is an evidence-based psychological intervention and the Department of Health (DH) in England is committed to increasing patient access to cognitive behavioural interventions using a stepped care model to organise services (National Institute for Health and Care Excellence (NICE), 2011). Step 1 of the model refers to the identification and assessment of common mental health disorders; Step 2 outlines interventions for mild-to-moderate conditions such as depression; and Step 3 for mild-to-moderate conditions such as depression that have not responded to low-intensity intervention at Step 2.

Low-intensity interventions are delivered by psychological wellbeing practitioners (PWPs) trained in a cognitive behavioural approach (CBA); interventions include facilitating self-help, group-based peer support and psycho-educational groups. High-intensity therapists trained in CBT provide interventions at Step 3. Both the high-intensity therapists and PWPs are trained to deliver therapies in NHS Increasing Access to Psychological Therapy (IAPT) services; however, while the IAPT guidance appears to recognise that perinatal groups are particularly vulnerable to depression, it does not explicitly indicate that postnatal depression (PND) should be a priority for the roll-out of the IAPT programme. With 13% of women experiencing depression during the first postnatal year, the health visitor maternal mental health pathway (DH, 2012a) identifies CBT as an intervention at Universal Plus level and recommends that the health visitor works in partnership with IAPT services.

This article will look at the existing skill set of the health visitor (HV) and argue that, with further skill development, the HV can integrate a CBA-informed approach to listening visits for PND to ensure early intervention (NICE, 2007).

Parental stress can also be supported using a CBA (Furlong et al., 2012). Early intervention is important where parental stress is discovered, particularly if there is partner violence. Research has found that harsh, inconsistent parenting is associated with child behaviour problems; if this is not addressed antisocial behaviour may develop (Scott et al., 2012). The CBA can be used to support parents to help regulate their family’s negative emotions and interactions and, in turn, build resilience (Centre for Excellence and Outcomes in Children and Young People’s Services (C4E0), 2010).

The Health Visitor Implementation Plan (DH, 2011a: 19, 30) suggests that health visitors use the skill of CBT; yet it takes a long time to train in CBT and there are quality issues. Currently, psychological therapies are unregulated in the UK. This means there is no legal standard of qualification and training in place for this area. However, the British Association for Behavioural and Cognitive Psychotherapies (BABCP) is recognised by the NHS and has developed a standard of accreditation for experience and training. Some CBT courses can be completed in one year full time, which is unrealistic for most HVs to achieve. Therefore, it may be acceptable for qualified HVs to enhance their current skills and practice in an informed manner with a CBA, using the evidence-based process for goals and interventions similar to the PWP. Some Step 2 interventions are within the scope of practice of the qualified HV; for example, HVs were trained in the CBA in a few days in a pragmatic cluster trial and were reported to deliver clinically effective outcomes (Morrell et al., 2011).

This article will explore the difference between CBT and the CBA and it will apply the CBA to health visiting in two main areas: first, supporting women identified with mild PND; and second, supporting positive parenting.

Cognitive behavioural theory
CBT is a psychotherapy that uses both cognitive (thinking) and behavioural (acting) techniques. Aaron Beck is considered by many to be the father of CBT. He proposed that emotional disorders, in particular depression, are maintained by a thinking
disorder, where a set of cognitive distortions known as the cognitive triad (negative view of oneself; current experience; and the future) commonly exert an influence over day-to-day functioning (Beck, 1995). The claim is not that negative thinking causes depression, but that it exacerbates and maintains emotional disturbance.

Behavioural factors also serve to exacerbate the condition, so cognitive therapy seeks to test out negative automatic thoughts (NATs) with the aim of changing unhelpful thoughts and beliefs. Behaviour therapy works on symptoms by changing behaviour and environmental factors that control behaviour (Kinsella and Garland, 2008). Kinsella and Garland (2008) outline that within the CBT model there are three levels of cognition: automatic thoughts; rules for living; and core beliefs.

- NATs are the simplest form of spontaneous thoughts that may be accurate; however, the conclusion is dysfunctional because it may lead to low mood or anxiety. For example, a new mother may acknowledge that her baby is not rolling like the other babies she knows of the same age (accurate part), and think that her baby is not intelligent, which makes her feel sad.
- Deeper than the surface thoughts is a person’s ‘rule for living’ such as ‘shoulds’ and ‘musts’.
- At the third level are core beliefs that relate to domains about the self (‘I am bad’); the self in relation to others (‘I am inferior’); other people (‘people are not to be trusted’); and the world (‘the world is not fair’).

The practitioner using a CBA will only support a client to identify and challenge their NATs and unhelpful behaviours, whereas work with rules for living and core beliefs may require CBT to facilitate change. Roth and Fonagy (2005) outline how CBT has been found to be high in effectiveness and efficacy for most psychological disorders in adults. The government has acknowledged this evidence base (DH, 2001) and provided guidelines for psychological problems, such as antenatal and postnatal depression (NICE, 2007), which advocates CBT for mild-to-moderate depression.

Many reviews have found that psychological treatments specifically designed for depression (eg, CBT or interpersonal psychotherapy) are equivalent to drugs in terms of their efficacy (National Collaborating Centre for Mental Health (NCCMH), 2004). However, Dobson and Dobson (2009) state that the effectiveness of CBT is dependent on the practitioner adhering to a manual; this ensures there is fidelity in the delivery of the intervention, which ensures that it is effective. For example, with cognitive behavioural group-based parenting programmes (Furlong et al, 2012), it is essential that key ingredients are not lost. Nevertheless, Dobson and Dobson (2009) caution that there is a temptation, due to public demand for CBT, for practitioners to use the therapy to treat problems for which there is little evidence of its success.

The CBA is evidence based because it is about applying the process and principles of CBT without conducting activities, such as thought records, to elicit core beliefs. An example for the HV would be to inform practice with the manual written by Mågrom et al (1999) on leading groups for postnatally depressed mothers. Sessions are planned to help women understand the relationship between behaviour, thoughts and feelings. Easy to understand language is used for feelings, which are labelled as As (awful feelings) and Bs (beautiful feelings). It is explained that life has some As, such as chores to be done, but that a balance is needed, and ideas are given for pleasurable activities.

Dobson and Dobson (2009) outline three main principles of CBT.

- The ‘access hypothesis’ emphasises the benefit of educating clients in the value of understanding their own thinking.
- The ‘mediation hypothesis’ emphasises the interconnection between human thoughts, emotions and behaviour.
- The ‘change hypothesis’ emphasises that once clients understand the first two principles, they can change the way they respond and so become more functional.

The three principles above are the basis of CBT, although Beck (1995) spreads them out as 10 principles (see Table 1).

Critics of CBT describe it as an ‘interiorising approach’ that undermines the role of environmental (ie, social/political) factors. Supporters of this approach criticise CBT for ‘blaming the victim’, suggesting it is a person’s thoughts and beliefs that are problematic, not poverty, discrimination and limited opportunity.

Other critics of CBT appear to be those affected by the political nature of the commissioning of services, particularly highly qualified psychotherapists who are dubious about the suitability of low-intensity therapists (House and Lowenthal, 2009). This should not be a problem for HVs as they practice at Step 1 of the ‘stepped care model’ and know who to refer to when clients need to be ‘stepped up’ to more intensive forms of therapy (NICE, 2007). Referral to other services, such as adult or child mental health services, is always essential when progress is not being made at the HV service level.

Before starting CBT an assessment or cognitive behavioural analysis occurs. This requires the therapist to engage the client in a collaborative, respectful, empathetic manner to maintain a therapeutic alliance (Kinsella and Garland, 2008). HVs also have this skill (see Table 1). While the majority of therapists rate a good therapeutic...
alliance to be the *sine qua non* of effective therapy; Roth and Fonagy (2005) demonstrated in treatment trials that the client's degree of participation determined the outcome rather than the quality of therapeutic relationship. HVs are taught to practice with a collaborative strengths-based approach (DH, 2011b). The strengths-based approach is similar to the values-based approach found in mental health care; Kuyken et al (2009) explain that 'any common daily activity maintained during distress is symbolic of some value the client holds that can be viewed as a strength' (Kuyken et al, 2009: 99).

The advantage of building on values ensures the individualisation of therapy and can be incorporated at each stage of therapy (Kuyken et al, 2009). Beck (1995) asserts that the structure of a CBT session starts with agenda setting (see Principle 8 in Table 1). Agenda setting has been outlined by Kinsella and Garland (2008) to provide structure while maintaining ‘collaborative flexibility’ (Kinsella and Garland, 2008: 23). HVs are taught to ‘agenda match’ when providing advice (DH, 2011b); guidance on agenda setting would particularly enhance listening visits (Milgrom et al, 1999). However, clients new to the CBT process may struggle to contribute to an agenda. Kinsella and Garland (2008) illustrate that interpersonally sensitive clients may perceive therapists as trying to humiliate them or catch them out. This highlights the need for the therapist to be non-judgemental, accepting and warm in their approach; again an attribute of the HV (DH, 2012b).

Before any intervention can occur it is important to check that the client has sufficient motivation to change and to use a collaborative conversation (such as motivational interviewing) to motivate clients (Miller and Rollnick, 2012). HVs are increasingly competent in motivational interviewing and are, thus, capable of supporting behaviour change (Table 1). The main limitation of CBT is that it is not a panacea, and it doesn’t work for everyone. Appleye et al’s (1997) research concluded that both pharmacology and CBT delivered by HV are equally effective as treatments, so the choice of treatment may be made by women themselves. Interestingly, Morrell reported (personal communication) that some of the HVs and some of the mothers in the trial (Morrell et al, 2011) preferred and were comfortable with either CBA or person-centred counselling. This illustrates the need for choice, and emphasises that if one approach does not work then the other may be more helpful.

**Cognitive behavioural approach**

The CBA follows the structured process of CBT, valuing a holistic assessment; for example, using the ‘Five Areas’ approach (Williams and Garland, 2002) and formulating a hypothesis in partnership with the client to identify the maintaining factor of the problem and choose the correct intervention, be it cognitive or behavioural, group work or one-to-one (Morrell et al, 2011) for PND. It can also be used to support parenting (Wiggins et al, 2009) as it is about evaluating thoughts and finding a more balanced alternative. For a good summary of helpful thinking styles, visit the Psychology Tools website (www.psychologytools.org) and download a worksheet.

Jenny had a number of unhelpful thinking patterns. She demonstrated ‘all or nothing’ thinking that is typical in depression and was catastrophising. She considered that their financial situation would never improve and she would never cope with Jake’s behaviour. Jenny needed help to test out her thinking ‘traps’ (unhelpful thinking) to build resilience. This was done by asking her, ‘If that’s true, what does it mean?’ (Neenan and Dryden, 2013: 8). This helped her identify an underlying assumption that she felt she was a useless mother.

Jenny was able to come up with some of her own behavioural experiments to reassess if Jake’s behaviour helped them to understand themselves better. Homework is an essential feature of CBT because it helps the client use the psychological understanding and practical skills learnt during the contact session in problem situations in their everyday lives. The HV and client work together to identify how the problem developed and what maintains it. Diary sheets can often help here. Another word for this conceptualisation is ‘formulation’, which enables the practitioner to tailor the right intervention for the individual.

**Formulation**

In Jenny’s case, a problem list was constructed together. Maintaining factors included unhelpful thinking, avoidance of people who make her feel useless, avoiding paying bills and alcohol use. Formulation can help the client make the decision as to whether theirs is a helpful behaviour or a maintaining factor (Dudley and Kuyken, 2006). As Jenny identified that alcohol use was a maintaining factor she was then more motivated to do something about it.

**Intervention**

The intervention could be cognitive and/or behavioural (Kinsella and Garland, 2008). The first goal for Jenny was a cognitive goal – to change her thinking. It was evident that Jenny’s NATs about her son influenced her attitude towards him, which made her feel irritable with him. Changing thinking to be more realistic is called cognitive restructuring and is about evaluating thoughts and finding a more balanced alternative. For a good summary of unhelpful thinking styles, visit the Psychology Tools website (www.psychologytools.org) and download a worksheet.

Jenny could easily provide answers for Areas 3, 4, and 5, but the HV needed to use open questions to elicit what was going through her mind at the time she felt stressed (Area 2). Clients often report that thinking about the five areas between visits helps
Interventions found on the Psychology Tools website. Again, Jenny decided which solution and action to take.

**Evaluation**

The role of the practitioner is to guide the client in a step-by-step process, supporting progress by regularly reviewing and evaluating thoughts. This helps the client to see thoughts as not absolute, but fluid, and helps them to re-frame their thoughts and coaching them to use problem-solving skills reduces stress and increases positive parenting.

**Relapse prevention**

The fifth element of the structure of CBT is relapse prevention. Mindfulness-based CBT is recommended by NICE (2011) to prevent the recurrence of depression. Techniques drawn from meditation and cognitive therapy help people become more aware of their bodily sensations and feelings associated with depression relapse. Neenan and Dryden (2013) assert that mindfulness helps a person to develop resilience as they learn to acknowledge the presence of unhealthy negative thoughts and feelings without getting entangled in them. Such an intervention would take place within the mental health service.

To summarise the case study, Jenny progressed well. She stopped drinking so much alcohol and adopted an age-appropriate expectation for Jake who improved his behaviour at home. Finances did not improve quickly but Jenny changed her perspective and felt she could cope.

**Conclusion**

The CBA is an effective approach when clients choose to engage. This article has used one short case study to give a sample of the CBA. In relation to professional development it may be worth HVs doing a short course on the CBA before using the approach in practice.

**References**


DH. (2012b) Health Visiting Attributes. London: DH.


What is lactose intolerance and how can it be managed?

Lactose is a sugar found in milk and dairy. A deficiency in the enzyme lactase stops the body breaking down the lactose sugar.1

Common symptoms
Undigested lactose remains in the intestine and can cause diarrhoea, abdominal distension, nausea, flatulence and bloating.1,2

Primary lactase deficiency
Lactose intolerance can affect any infant but primary lactase deficiency is genetic and more common in Hispanic, Asian and black populations, with around 20% of children under 5 affected.2

Secondary lactase deficiency
A common, but temporary, cause of diarrhoea, it often occurs because of damage to the intestinal brush border, where lactase production takes place. It is brought about by untreated coeliac disease, Crohn’s disease and severe gastroenteritis caused by infections, such as Rotavirus.1,2

Although temporary, it may take weeks rather than days for lactase secretion to be adequately re-established. Formula fed infants may require a lactose free formula as a temporary substitute for standard cows’ milk formula.1

Studies have shown that infants with diarrhoea fed on lactose free formula milk recovered in significantly less time than those fed on a lactose containing formula.3,4

Lactose free vs. lactose containing formula
Lactose free formula has been shown to provide comparable growth and key nutrient absorption; when tested it showed no significant differences for magnesium, phosphorus, calcium and nitrogen.5

Lactose free formula is well accepted and tolerated and maintained growth at a comparable level to that in infants receiving lactose containing formula.6

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"Lactose free formula is well accepted and tolerated and maintained growth at a comparable level to that in infants receiving lactose containing formula."
Educating health visitors for their new role: psychological interventions

Introduction
In 2011 the Department of Health (DH) published the *Health Visitor Implementation Plan* (DH, 2011a). This document pledged to increase the health visiting workforce by 4,200 by 2015 and deliver a new and enhanced model of support to families. *Educating Health Visitors for a Transformed Service* (DH, 2011b) endorsed this and set out a detailed plan to support the preparation of future practitioners, in order for them to fulfil the needs of this new service vision.

These requirements are in addition to, and do not affect, regulatory body requirements (Nursing and Midwifery Council (NMC), 2004). Many of the content areas highlighted (DH, 2011b) are included in current health visiting programmes and will be familiar to practising health visitors; however, the document included a number of new elements designed to enhance the model of support offered to families. All areas link health visiting practice to the goals and evidence of the Healthy Child Programme (DH, 2009).

In December 2011, a group of 45 health visiting practice teachers from across West Yorkshire were asked to review the new requirements as set out by the DH (2011b). Their views were sought on what they considered to be the greatest gaps in knowledge and skills within the current health visiting workforce.

Practice teachers have a significant role in the preparation of health visiting students and are responsible for co-ordinating a complex programme of student experiences in clinical practice. They contribute greatly towards the summative assessment of student health visitors (NMC, 2004). These expert practitioners are well placed to review and assess current health visiting practice. Their needs are a priority in terms of developing their own knowledge and skills to reflect the requirements of the new service vision (DH, 2011a) as they are required to role model best practice to student health visitors. Feedback from the practice teachers consistently suggested gaps in knowledge and skills around psychological interventions (see Box 1).

This article discusses a training programme that was designed to introduce some basic psychological interventions to qualified health visitors within the Yorkshire and Humber region. It discusses the evidence base of the training programme, the interventions taught and the evaluation that took place following completion of the programme.

Past training initiatives
In recognising the potential of health visitors to support the perinatal mental health of mothers there have been previous attempts to equip them with the skills to carry out psychological interventions (Holden et al, 1989; Appleby et al, 1997; Turner et al, 2010; Morrell et al, 2011). Morrell et al (2011) described a programme with the intention of developing person-centred counselling and cognitive behavioural skills in health visitors. This programme lasted for five days and was evaluated very positively; although the article did not describe whether such an investment resulted in benefits for the mothers and their families.

Designing the training programme
Yorkshire and Humber commissioned a two-day training programme based on the curriculum

<table>
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<th>Box 1. Health visitor skill and knowledge gaps (psychological interventions)</th>
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<td><strong>Motivating depressed mothers.</strong> Depressed mothers frequently lack the inclination to engage with their babies and activities that people normally find rewarding. Both solution-focused and motivational interviewing were explored in the workshop</td>
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<td><strong>Person-centred approaches.</strong> The need to work collaboratively with mothers according to their individual needs</td>
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<td><strong>Cognitive behavioural approaches</strong> including behavioural activation and working with negative thoughts</td>
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topics identified in *Educating Health Visitors for a Transformed Service* (DH, 2011a). Previous research on postnatal depression suggested that psychological interventions may be of use to mothers with depression (see Sockol et al, 2011 for a review). Previous training has focused on various psychological interventions, ranging from training in how to conduct listening visits with an emphasis on non-directive counselling (Turner et al, 2010), through to brief cognitive behavioural counselling (Appleby et al, 1997; Morrell et al, 2011).

Other psychological interventions that are recommended in the National Institute for Health and Care Excellence (NICE) guidelines (NICE, 2007) are quite complex or lengthy (for example, interpersonal therapy) and are not considered as an intervention that can be taught as part of a two-day programme for health visitors. Senior health visitors were asked what they considered to be the greatest gaps in knowledge and skills within the current health visitor workforce. Feedback consistently suggested the areas in Box 1.

A pilot two-day programme was run with a group of experienced health visitors who had the role of practice teachers and confirmed the appropriateness of the content and method. This workshop was well received and helped identify the constraints on health visitors in performing the more complex behavioural interventions. These constraints are discussed later in this article. Following this and with minor adjustments, additional workshops were facilitated and over 300 health visitors attended and positively evaluated the workshops. A follow-up suggested some application of learning to client work, with some benefits experienced.

**Workshop content**

The workshops consisted of a balance between theory and practice, both of which had a firm rooting in empirical research. Given the lack of research involving health visitors and psychological interventions, the content was informed by considering research on therapeutic alliance and what works with people who are depressed. Content was designed by considering what works with people who are mildly or moderately depressed and what may be considered as appropriate strategies for health visitors to use, given their time constraints and limited contact with mothers. O’Mahen et al’s recent qualitative study (O’Mahen et al, 2012) suggests the areas that many depressed mothers found of help.

It made sense to start the workshop by re-examining what helps with relationship building, particularly among mothers who may have their own attachment difficulties, which can be insecure, ambivalent or disorganised (Ainsworth et al, 1978). Bordin’s work on establishing a focus through agreeing a purpose is still relevant today and is helpful for health visitors who have a desire for structure in their work (Bordin, 1979).

A recent review by Smith and Horne (2012) emphasised the benefits of focus through collaborative work. This part of the workshop validates what many health visitors already do and provides a good base to extend the health visitor’s knowledge and skills. The oft-mentioned skill of empathy, which many health visitors demonstrate, is receiving increased interest due to research revealing that neurological changes are facilitated through the provision of empathy. Switched-off parts of the brain associated with attachment are triggered within a context of an empathic relationship (Shore, 2011).

In addition, focus and purpose are facilitated through the application of the ‘Five Areas’ approach to working with mothers who are depressed and anxious. This approach was elaborated by Greenberger and Padesky (1995) and applied to postnatal depression by Williams et al (2009) (see Figure 1). If nothing else, health visitors have found this model particularly useful for their work with depressed mothers. The use of simple models increases the likelihood of engagement as it allows both health visitors and mothers to share and understand their experience of postnatal depression and anxiety.

Sharing and understanding the Five Areas model is often enough to generate a ‘sudden gain’ – where there is a sudden improvement in mood in mothers who are depressed and often predicts future improvement (Hunnicutt-Ferguson et al, 2012; Tang et al, 2007). Research points towards early work as the facilitator of this sudden shift and has appeal to the ‘time-poor’ health visitor. The message is that work can be undertaken by a health visitor very early in the relationship that potentially steers the client to maintain improvement on their own.

The workshop covers cognitive and behavioural parts of the cognitive behavioural approach. Behavioural activation as an intervention has a strong evidence base (Cuijpers et al, 2007; Martell et al, 2010) and one that has much to offer health visitors in their work with mothers (O’Mahen et al, 2012). Behavioural activation is recognised as a particularly important strategy in helping postnatal depression as it is associated with reduced activity. When depressed mothers stop doing things they get even more depressed. Health visitors easily see the link between reduced activity and depression, and can share this with mothers.

Encouraging mothers to ‘pick up activities where they left off’ can result in a positive shift in mood. It is a relatively safe and effective intervention which, although simple to understand requires a certain amount of health visitor effort in motivating mothers to get active. Thus, the workshop also covers methods of motivating people, including a consideration of the thoughts that block behaviour or task completion (Beck et al, 1979).

Health visitors and their clients are quick to grasp the various types of thoughts that demotivate their clients and these have a long history of being described in depression (Beck et al, 1979; Beck, 2011; Burns, 1998). These thoughts lead to avoidance because they usually involve predicting something awful is about to happen that will make them feel worse. O’Mahen (2012) articulates well the circumstances around birth that generate particular negative thoughts such as, ‘I expected to immediately fall in love with baby and this didn’t happen’ and ‘Other mums cope much better than I do’.

At this point, the health visitor enters the most complex part of the workshop where they are taught to facilitate a counter-argument to the negative thoughts that ‘swamp’ a mother’s mind which, if left alone result in depression and anxiety. The interventions taught are cognitive approaches. At the simplest level, health visitors can use their questioning skills to invite scepticism and, if undertaken diplomatically, can help mothers question their own beliefs. Box 2 provides examples of useful questions.

Another useful intervention is to write down a client’s thoughts as this operationalises the Five Areas model. When writing down clients’ responses, the health visitor can note unrealistic thoughts under a ‘thoughts’ column. Seeing these thoughts under a ‘thoughts’ column. Seeing these thoughts and negative mood. Physical effects

**Figure 1. Five Areas model**
distance herself from her thoughts and this also invites scepticism or ‘mindfulness’; for example, ‘Is this thought about being a poor mum really true?’ Such distancing or ‘decentring’ has been found to be very helpful in both depression and severe anxiety (Butler et al., 2008).

A more advanced process for working with cognitions is the use of thought records. There are various models for recording and challenging thoughts, some of which are quite complicated and some that are easy to follow. Used correctly they can greatly improve a person’s mood (Greenberger and Padesky, 1995; Beck, 2011) and once learned, mothers can use them to improve their mood in the absence of the health visitor.

Health visitors sometimes question whether they have the level of training to use these, but the argument for supporting their use lies in the knowledge that many respected self-help books contain chapters advocating their use (Burns, 1998; Greenberger and Padesky, 1995; Williams, 2009) and with the input of a professional this can only be more beneficial. Some health visitors are already making use of self-help books and self-help websites that facilitate this. The implication is that health visitors should be accessing advanced skills training to use thought records effectively, with a minimum of risk to mothers.

There is also a neuroscience behind encouraging health visitors to engage in cognitive work. Parts of the brain associated with stress (the limbic system) are overactive in the presence of those parts of the brain (the cortex) that give mothers a sense of control, resulting in a depressed and anxious mother whose attachment hormones (oxytocin) are displaced by stress hormones (Kamsta and Heinrichs, 2013; Pierrehumbert et al., 2012). The aim is to eliminate, or at least reduce, negative thoughts and in so doing improve mood and reduce stress, putting a mother in a better position to attend and attach to their infants. This shift between the different parts of the brain (‘mind over mood’) is made possible through cognitive interventions (Bannink, 2012).

The neuroscience aspects of the workshop were well received. There is emerging research that considers the impact of low oxytocin and dopamine on the mother’s attachment behaviour and the corresponding impact on the child. Hughes and Baylis (2012) offer fascinating insights into brain changes after childbirth and how various psychological interventions can stimulate parts of the mother’s brain associated with empathy, attention and an empathic and caring capacity. These aspects are covered, albeit briefly, in the workshop.

Unsurprisingly, the practical approach in the workshop is popular with health visitors. Problem-solving therapy (Nezu et al., 2013) offers health visitors insights into the benefits of working productively with mothers whose minds are crammed with countless and often poorly articulated problems. The liberating process of clearly defining and prioritising problems can, in itself, improve a person’s mood and reduce anxiety. Problem-solving therapy has a good evidence base (Nezu et al., 2013) although not as yet considered specifically with postnatal depression.

Problem solving and solution-focused work sit well with each other. Solution-focused work offers a hopeful and empowering approach, and has been employed within a community setting (Simm et al., 2011). Goal setting in itself is motivational (Reeve, 2009) and the set of techniques described under the banner of motivational interviewing are often embraced by health visitors. Health visitors are often practical in approach and undertake complex challenges that transpire from working with poorly motivated mothers.

Problem-solving strategies employed with mothers can also offer opportunities for decentring from painful thoughts. Health visitors helping mothers to externalise what is going ‘round and round’ in their heads are helping them de-clutter their client’s minds are freeing up energy to be invested in parenting (Nezu et al., 2013). Simply working with a mother to prioritise her problems and to brainstorm solutions can lead to a sudden improvement in mood and a reduction in anxiety.

Methods of training

A variety of teaching methods are employed over the two days. The start of the training models a collaborative approach where health visitors’ expectations are brought into the open. PowerPoint presentations offer the evidence base for many of the interventions described. The most engaging part of the workshop is the employment of service users in role play and presentation. Service users help demonstrate the Five Areas model and offer insights into what mothers with postnatal depression find useful.

The personal journey from depression through to recovery is quite an emotional one and health visitors evaluate this section as being very helpful. Service user input requires sensitive and ethical management, but is more than worth the effort, participants are afforded a powerful insight and service users gain from knowing that their painful experience has been listened to and made a difference.

Evaluation

At the time of writing, one of our colleagues is progressing a robust evaluation of the impact of this training. This will further consider what practical benefits such training has had on the work of the health visitor.

Conclusion

Despite its positive evaluation there are flaws in the training. Two days is far too short a time to deliver the competencies required to deliver in-depth psychological interventions for helping depressed or anxious mothers. Cognitive behavioural approaches alone consist of a wide variety of techniques and it is still not known which particular ones have the greatest effect.

In their feedback health visitors reported all the techniques to be of use; but it is noticeable that their level of interest is at its highest when problem solving and solution-focused techniques are covered.

In a meta-analysis of treatments for perinatal depression, Sockol et al (2011) are unable to conclude whether cognitive behavioural therapy is any more effective than other psychological approaches with mothers. However, it is difficult not to conclude that the workshops are a very useful introduction to the potential benefits of training in psychological interventions.

References


Are you struggling to cope with the continuous change that is happening within the NHS? If you are, you are not alone. It’s not easy to adapt to change, especially if you feel that it is imposed on you. How can you keep thriving and not just surviving amidst continuous change?

Change your outlook
We may try to categorise the change that is happening to us as positive or negative. However, giving it a label does not alter what it is. It’s best to accept that change is the only constant in the age we live in, and that the pace of change will only get faster as time goes by.

If you find you do not like change, you may need to change your attitude towards it. Avoid a pessimistic outlook. Instead of viewing change as pointless, turn it on its head. Change can be refreshing – and it is an unalterable fact of life.

Sometimes we thrive on changes in our lives, but usually this only applies to the changes we like or believe will yield potential benefits for us personally. For example, if someone offered you a million pounds today, you probably wouldn’t refuse it, despite the enormous changes it would make to your life. So get to love change.

In the first year after birth a baby continuously develops and experiences many development milestones – and is eager to do so. We were all babies once, and couldn’t wait for the next change. Learn to enjoy it and get proactive. Don’t let change control you by reacting negatively to it. Adjust your perception to change and watch how your reality changes in response.

Embrace change
Even if you do not like change, you can’t afford to ignore it. Neither should you resist it. Imagine you were sailing in rough seas. Blaming the strong winds or moaning about them would not stop them from blowing; neither would fighting them, which will exhaust you. Doing nothing would not work either, as you’ll end up where you least expect. The only way to stay afloat and prevent capsizing would be to adjust your sails and steer your boat in the direction in which you want to sail. That’s the same attitude we as community practitioners should have towards change. We need to embrace it!

Influence change
Organisations often communicate proposed changes to their staff and offer them opportunities to engage in consultations. Rather than adopting the cynical view that such discussions are pointless exercises and that senior management has already decided on the outcome, get informed about the proposed change and endeavour to influence it.

Whatever you look for, you will find. So during a time of change, look for the positives. Ask yourself: how will this change benefit me, my colleagues and my patients? Get colleagues and staff on side and empower them to influence change. It may not be easy at first, but with practice it will become easier and you might even grow from it and develop your skills.

It is often said that ‘necessity is the mother of invention’. Change can afford you the opportunity to get creative and innovate new ways of delivering services and improving standards of care, but only if you embrace it.

So when the winds of change next blow your way, be proactive; adjust your sails and try to steer the course. It may just be to the benefit of both you and your clients.
Can infant formula innovation help digestion in formula fed infants?

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

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

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

Modifying standard infant formula to help digestion

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

**Partially hydrolysed whey protein**

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

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

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

**Reduced lactose**

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

Reducing the levels of lactose is one potential strategy to help reduce the amount of wind babies produce. For some colicky babies, decreasing the concentration of lactose in formula has been found to result in a reduction in crying and wind.3

**SN-2 enriched fat blend**

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

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

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

At SMA we understand that the first few months can be hard for babies with mild digestive troubles which in turn can be difficult for their parents. That’s why for bottle-fed babies we have designed our new SMA Comfort Infant Milk to be easy to digest and gentle on infant digestive systems.

Specially formulated, it contains partially hydrolysed 100% whey protein, an SN-2 enriched fat blend and lower levels of lactose compared to standard first infant milk.

Designed to be easy to digest, SMA Comfort Infant Milk is also nutritionally complete.

**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 baby’s health. Infant formula and follow up milks should be used only on the advice of a healthcare professional.

Support for children living with HIV

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In the UK today an estimated 100,000 people are living with HIV and in 2011, a total of 809 children and adolescents aged under 15 were living with HIV. (This figure does not account for undiagnosed children) (Health Protection Agency (HPA), 2011). The frequency of mother-to-child transmission of HIV has reduced in the UK in recent years – of all children born to diagnosed and undiagnosed HIV-infected women from 2005–2010, an estimated 2% were HIV-infected. However, babies infected with HIV are born in the UK every year and 35 HIV-infected babies were born between 2007 and 2012 (Tookey, 2013).

While the physical prognosis for people living with HIV in the UK has improved considerably since the beginning of the epidemic 30 years ago, children and adolescents living with and affected by HIV remain highly vulnerable. Aside from the physical impact of HIV and HIV medication, these children are likely to have shorter childhoods and, as a result, limited choices and opportunities for successful future lives (Lyons, 2008).

Dispelling myths

Many of the prevailing myths, misconceptions and stigmas surrounding HIV stem from a widespread misunderstanding of the virus; specifically around transmission and the prognosis of those living with HIV. HIV can be passed from one person to another through perinatal transmission (mother to baby, also called vertical transmission) or horizontal transmission (through unprotected sex, blood transfusions or sharing needles with someone who is HIV positive). HIV is not transmitted through kissing, saliva, sweat, hugging, sharing cups or clothes, touching or toilet seats and does not discriminate due to age, race, sexual orientation or gender. It is not possible to tell if someone is living with HIV just by looking at them.

An HIV-positive child poses no risk to other children or adults in the school or community environment. Professionals and institutions have a duty of care to children living with HIV as with all other children, and a responsibility to support them to the best of their capabilities. All instances where transmission could potentially occur (for example, if a child is bleeding heavily) should be dealt with using universal precautions for blood-borne pathogens, regardless of what the child’s HIV status is assumed to be.

How HIV affects children

The impact of HIV on a child’s life is profound. For many, HIV becomes a defining part of a child’s identity. The indisputable stigma surrounding the virus in this country, accompanied (and compounded) by the public’s lack of basic knowledge around HIV often means that those living with HIV, including children, are forced to deal with the consequences in secrecy.

Beyond the physical effects, which can be managed but also complicated by powerful antiretroviral drugs (ARVs), a diagnosis of HIV has a far-reaching psychological and psychosocial impact. People living with HIV can have a near-to-normal lifespan, and while there is no cure a positive diagnosis is not what it once was.

However, we cannot overemphasise the impact an HIV diagnosis can have on an individual or family and the extent to which it can jeopardise familial and community functionality. The World Health Organization (WHO) states: ‘HIV/AIDS is a disease that affects families in a profound and tragic way. When a family member, particularly a parent, becomes sick and weakened or dies, everyone in the family suffers. HIV/AIDS has greatly and disproportionately affected family structure and functions, increasing the vulnerability of families living in poverty.’ (WHO, 2011)

A child infected with HIV perinatally may have additional barriers to overcome, as there will be at least one family member (their mother) who is living with the virus, or who may even have died as a result of it. Children and adolescents closely affected by HIV (under the age of 19 with at least one close family member or carer who is HIV positive) are at increased risk of early bereavement, carer responsibilities, poverty, exploitation and subsequent HIV infection. A 2010 study estimated that there were 16,324 such children and adolescents in London, equating to an average of 6.5 children affected by HIV in each London primary or secondary school (Smith Barnes, 2012).

HIV compounds and multiplies poverty, dysfunction and cycles of depression; it exacerbates the difficulties associated with life transitions and can make the intricacies and setbacks of everyday life seem insurmountable.

Poverty is absolutely linked to HIV both in the UK and worldwide. Poverty contributes to poor health outcomes and lower baseline life expectancy. HIV is linked to increased exposure to violence, lower educational attainment, greater likelihood of teenage pregnancy, higher rates of sexually transmitted
infections, poorer mental health and family dysfunction (Salway et al., 2007). Poverty in the UK disproportionately affects lone parent households, people living with disability, minority ethnic groups, workless households and people with low qualifications (Ghate and Hazel, 2002). Many people living with HIV in the UK belong to several of these groups. Poverty compounds risk factors that lead to child maltreatment, including neglect and physical violence (Cawson et al., 2000).

The combination of HIV, poverty and unstable family environments can negatively affect a child’s mental and emotional health and development. HIV can impact a child’s ability to attain other physiological needs, such as adequate nutrition (largely due to some of the side-effects of ARVs, like chronic diarrhoea) and sleep (including abnormally excessive sleep patterns or inability to sleep because of depression or anxiety).

As a result of the isolating effects of HIV-related stigma on families, children living with and closely affected by HIV may not enjoy the same quality of social interaction as their non-affected peers. This can threaten their future potential and basic development because there is less access to social stimuli.

Families affected by HIV can experience dysfunction, with a reduction in access to required services including school, nursery or health and social support appointment attendance. This dysfunction can lead to early caring responsibilities and exacerbate low socio-economic status (King et al., 2009).

All of these compounding factors can place a substantial amount of stress on a child or adolescent, which may be severe enough to overwhelm their capacity to cope effectively. Intensive and prolonged stress can lead to a variety of short- and long-term negative health effects, including disrupting early brain development and compromising nervous and immune system functionality. Childhood stress can then lead to health problems later in life, including alcoholism, depression, heart disease, eating disorders, cancer and other chronic diseases (Middlebrooks et al., 2008).

The health professional’s role
Those working with children in a professional capacity should be equipped with a thorough understanding of the impact of HIV on children living with HIV and those who are affected to best support these vulnerable individuals and families. Such an understanding should filter through organisations and work places so all colleagues are equipped with accurate and non-prejudicial information about HIV, especially about transmission and the physical, mental and psychosocial impact of HIV infection.

Children and young people living with HIV, and their parents and carers, are under no legal obligation to inform health, education or social care professionals of their HIV status. Community practitioners’ knowledge of the potential physiological, mental and social impact of HIV is important as, first, practitioners are unlikely to know if there is a child living with HIV in their care; and second, it is likely that younger children may not be aware of their own HIV status. There is no fixed age when a child is required to learn about their HIV status but the WHO recommends that a child should learn about how HIV affects them at school age (six to 12 years). A concerted effort to reject HIV-related stereotypes and myths, and the confidence to challenge publicly those that continue to enforce them, will act as a future preventive measure to infection and also help to dismantle the stigma surrounding the virus.

The chief constraint to adequately supporting children who are living with and affected by HIV within healthcare, social care and educational settings is that professionals in these environments may not be aware of which individuals are HIV positive unless the scope of their interactions specifically addresses the impact of HIV. In addition, it is unlikely that pre-adolescent children in the UK will be aware of their own HIV status.

As a primary support provider for vulnerable children and adolescents, community practitioners play an invaluable role in improving and shaping the lives of children and families living with and affected by HIV. Enhanced HIV knowledge and thorough understanding of the psychosocial impact of HIV on the wellbeing of families will equip professionals and ensure successful outcomes.

References


Understanding, identifying and supporting speech, language and communication needs in children

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Abstract
Communication is a fundamental life skill and acts as the foundation on which many other areas of development are based. Any child who is not developing their speech, language and communication skills in the expected way is considered to have speech, language and communication needs (SLCN). These range from children who are not reaching communication milestones at the age that would be expected, to children who have long-term and persistent SLCN.

It is estimated that 10% of all children will have persistent difficulties with speech, language and communication. Some SLCN are transient and children will ‘catch up’ if they get the right support at the right time. Studies have shown that in some areas of social deprivation, 50% of children have delayed speech, language and communication development at the time of school entry (Locke et al, 2002). Whether SLCN is persistent or transient, all children will make progress with the correct support in place.

Difficulties with communication can have a far-reaching impact, as being able to communicate effectively is a crucial life skill and central to children’s development. Almost everything we do involves speech, language and communication. Healthcare professionals working with children and young people have a very important role in understanding what SLCN is and the potential impact of SLCN. It is crucial that we are able to identify children who have speech, language and communication needs, and that we know who and when to refer children to if they need more specialist support.

It is also important we know how these skills can be supported and can pass on information to parents and carers. However, there continue to be challenges in ensuring that SLCN are adequately identified and supported.

Understanding SLCN
To begin to understand SLCN it is important to make a distinction between the terms ‘speech’, ‘language’ and ‘communication’. SLCN can include the following difficulties with speech:

- Not pronouncing words correctly so that speech is difficult to understand by others
- Difficulties with hearing the difference between speech sounds
- Stammering or stuttering (these terms are interchangeable)
- Unusual voice quality
- Difficulty using intonation.

SLCN can include the following difficulties with language:

- Not using the correct sentence structures, ie using language that seems appropriate for a younger child
- Difficulties building more complex sentences due to not using linking words such as ‘and’, ‘then’ and ‘because’
- Being unable to organise a sequence of events in order to tell a story or speak about a past event
- Problems with learning and remembering new words
- Difficulties finding the word to use – the child will know the word but is unable to retrieve it from their ‘word store’ in the brain
- Difficulty understanding sentences or instructions
- Difficulties understanding ambiguous language; for example, idioms such as ‘pull your socks up’.

SLCN can include the following difficulties with communication:

- Difficulty making eye contact
- Poor turn taking
- Difficulties interacting with peers, showing little interest in play with others
- Finding conversations difficult – this may include being able to ‘to and fro’ in a conversation, not being able to ‘repair’ if there has been a misunderstanding,
A child with SLCN may have difficulties in one of the above areas only, or they may have a combination of difficulties affecting all of the above areas and with varying degrees of difficulty.

There are a variety of factors associated with SLCN. For some children there will be a definitive reason for their difficulties. For others, there may be no known cause. Figure 1 illustrates some of the factors that may be linked to a child’s SLCN.

It is important to note that children who are bilingual or who are learning English as an additional language are no more at risk than any other child of having SLCN. It can be more difficult to identify SLCN in children who are learning English as an additional language, and gathering information about the development of the child’s home language is very important.

The consequences for children who have difficulties with speech, language and communication are many and varied. Children who have SLCN are more likely to have behavioural, emotional and social difficulties. Research has shown that children with SLCN find it more difficult to establish and maintain friendships, and engage in prosocial behaviour, and are more at risk of developing emotional difficulties. In addition, children with SLCN rate themselves lower in general wellbeing measures, such as social acceptance, moods, emotions and being bullied (Lindsay and Dockrell, 2012).

Further research has linked speech, language and communication skills to educational attainment. A recent study indicated that speech, language and communication skills at the age of five are a predictor of later academic success, with pupils identified as having poor language and literacy scores at age five being more at risk of low achievement at age seven (Snowling et al, 2012).

In addition, children with SLCN are at a higher risk of exclusion from school (Clegg, 2004) and 60–90% of young people in the youth justice system have SLCN. In many cases, these needs are not identified until after the young person has offended (Snowling et al, 2012).

**Identifying SLCN**

Early identification of SLCN is crucial to minimise the potential impact and allow children to receive the support they require to achieve their potential. As children grow up, the speech, language and communication demands placed on them increase; therefore, it is paramount that children are identified as requiring support with their communication as soon as a problem becomes apparent. Many children with SLCN have needs that may be undetected for years, misinterpreted as an academic, emotional or behavioural difficulty, or missed altogether.

Identifying children with SLCN is not always easy and requires a holistic approach, taking into account the ‘whole child’ across a number of observation sessions, both spontaneous and planned.

The Communication Trust has developed two main tools for anyone working with children and young people to support the identification of SLCN; ages and stages resources and indicators checklists. Details about both tools can be found in Box 1. Both approaches mentioned in Box 1 are very useful tools to begin the process to identify children who have SLCN. These are not diagnostic tools, but are useful to support onward referral to allow any children identified as having possible SLCN to receive a specialist referral.

**Box 1. Communication Trust tools (www.thecommunicationtrust.org.uk/resources)**

<table>
<thead>
<tr>
<th>Type of tool</th>
<th>How it can be used to support identification of SLCN</th>
<th>Examples</th>
</tr>
</thead>
</table>
| Ages and stages resource | These resources provide information about typical speech, language and communication milestones at different ages. The resources can be used to check if children are developing skills at the age expected | - Universally Speaking  
- Talking Point ages and stages  
- Primary Milestones poster  
- Secondary Milestones poster |
| Indicator checklists  | These resources highlight difficulties to look out for that may indicate SLCN. They describe behaviours that may be observed in children who may have SLCN | - Misunderstood – Appendix 1 checklist  
- Talking Point ‘Things to look out for’ |
assessment where required. All practitioners working with children should be aware of local processes and procedures to refer children who are identified as having SLCN to specialist services for further detailed assessment of their needs.

It is important to remember that it is never harmful for a child to have a full speech and language assessment; however, the potential harm for a child whose speech, language and communication needs are missed can be great.

Supporting SLCN
All children benefit from being in environments and surrounded by adult interactions that support and nurture the development of their speech, language and communication skills. For those children who are not developing their skills at the same time or in the same way as other children, this support is even more important.

The following tips are useful to consider as strategies that support children’s speech, language and communication development.
- **Speak a little more slowly than you usually do.** Allow time after asking a question for them to listen, think and work out what has been said.
- **Demonstrate.** Use gestures, pictures or anything else visual to help understanding.
- **Clarify.** Ensure they understand your instructions by asking them to repeat what they think they have to do.
- **Use shorter sentences and simpler language in instructions.** For example, say: ‘Find your jigsaw’. Pause. ‘Bring it to the table’. Pause. ‘Then we can look at it together’. Say ‘trousers’ instead of ‘jeans’ and ‘car’ instead of ‘vehicle’.
- **Cut down the amount you talk.** Allow children time to talk so that you both get a fair share of the conversation. This may mean waiting for a while for a response, or waiting for the child to initiate the interaction using eye contact, gesture or words – all of these are communication and should be rewarded as such.
- **Comment on what children are doing and be careful with questions.** This is less pressured than asking questions and encourages children to join in. For example, ‘You have a robot on your T-shirt’ rather than, ‘What’s that on your T-shirt?’
- **Give specific praise about what they’ve done well.** ‘You really joined in well there’ or ‘Well done, you got dressed all by yourself today!’ Praise for effort is useful.
- **If they can’t think of what to say, help them.** Give the words and phrases they need to use. For example, when a child wants to join in a game being played by his friends: ‘Ben, you could say “Can I join in?”’
- **Avoid colloquialisms, sayings and...**

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

1. What percentage of children will have persistent difficulties with speech, language and communication?
   - A. 2%
   - B. 4%
   - C. 6%
   - D. 10%

2. In some areas of social deprivation, what percentage of children have delayed speech, language and communication development at the time of school entry?
   - A. 30%
   - B. 40%
   - C. 50%
   - D. 60%

3. At what age did a recent study indicate that speech, language and communication skills are a predictor of later academic success?
   - A. 5
   - B. 4
   - C. 3
   - D. 2

4. Children who are bilingual or who are learning English as an additional language are no more at risk than any other child of having SLCN. True or false?
   - A. True
   - B. False

5. What percentage of young people in the youth justice system have SLCN?
   - A. 20–30%
   - B. 40–60%
   - C. 60–90%
   - D. 70–80%

6. Which of the following factors are linked to the development of SLCN?
   - A. Family history
   - B. Genetic
   - C. Structural
   - D. All of the above

7. Which of the following is an indication of difficulties with speech?
   - A. Problems with learning and remembering new words
   - B. Difficulty understanding sentences or instructions
   - C. Difficulties interacting with peers, showing little interest in play with others
   - D. Difficulties with hearing the difference between speech sounds

8. Which of the following is an indication of difficulties with language?
   - A. Being unable to organise a sequence of events in order to tell a story or speak about a past event
   - B. Unusual voice quality
   - C. Difficulty using intonation
   - D. Poor turn taking

9. Which of the following is an indication of difficulties with communication?
   - A. Difficulty understanding sentences or instructions
   - B. Difficulty making eye contact
   - C. Not pronouncing words correctly so that speech is difficult to understand by others
   - D. Stammering or stuttering (these terms are interchangeable)

10. A useful strategy to support children’s speech, language and communication development is to ask children and young people what helps them. True or false?
    - A. True
    - B. False
idioms. They can be confusing and children may take them literally. For example, ‘Pull your socks up’.

- **Demonstrate how to say a word or sentence.** This is instead of telling them they’ve said it wrong. For example, if they say, ‘Car blue school’ you can continue the conversation by adding, ‘So you saw a blue car on the way to school?’

- **Expand on what children say.** This helps them build bigger sentences. For example, if they say, ‘Daddy going shopping’ you could say, ‘Yes, Daddy’s going shopping to buy some bread’.

- **Follow the child’s lead.** Show an interest in what the child is interested in. You’ll find they are able to maintain their concentration for longer and will be more motivated to communicate.

- **Ask children and young people what helps them.** Sometimes the results are surprising!

It is crucial for parents and caregivers to be informed and involved in their children’s speech, language and communication development and the majority of parents would like to receive timely information about speech, language and communication development (Bercow, 2008). The above information should be shared with parents and carers where possible to allow for children’s speech, language and communication development to be supported on a daily basis, during everyday routines within the home environment, which in turn will have an impact on language acquisition (Roulstone et al, 2011).

Community practitioners working closely with children and their caregivers are in the key position of being able to identify and promote the importance of speech, language and communication development within everyday practice at a much earlier stage than specialist speech and language colleagues. Early identification and support of SLCN maximises children’s potential and minimises the impact on their individual future academic, behavioural, social and emotional achievements.

Where to go for help

The Communication Trust website (www.thecommunicationtrust.org.uk/resources) has several free, downloadable resources for both practitioners and parents aimed at developing awareness and understanding of speech, language and communication development. In the parents’ section of the Talking Point website (www.talkingpoint.org.uk) there are ‘Ages and Stages’ resources, as well as tips to support speech, language and communication development at different ages. There are also resources and information for practitioners working with children and their families.

**References**


Lindsay G, Dockrell L. (2012) The relationship between speech, language and communication needs (SLCN) and behavioural, emotional and social difficulties (BESD). London: Department for Education.


For more information or to advertise in Community Practitioner’s recruitment section, call our advertising team on 020 7878 2319
Alternatively email: claire.barber@tenalps.com
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1) Holding Reassurance Programme Birth to eight weeks
   a) Secure Attachment
   b) Observe babies cues in communication
   c) Identify and offer techniques in remedial touch to relieve intra-uterine and birth trauma
   d) An easy introduction to ‘tummy time’
   e) Reduce the occurrence of ‘flat head syndrome’

2) Developmental Baby Massage Eight Weeks to Standing
   The Correct Use of Baby Massage to:
   a) Secure Attachment
   b) Observe babies cues in communication
   c) Identify and offer techniques in remedial touch to relieve intra-uterine and birth trauma
   d) An easy introduction to ‘tummy time’
   e) Reduce the occurrence of ‘flat head syndrome’

3) High quality resource: A copy of Peter Walker’s international best selling book ‘Developmental Baby Massage’ and a DVD given to all students.

Comments from UK Centre Staff / Managers

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

Since having massages regularly they have really helped him relax and he sleeps better than he ever has. His body spasms are not so painful and we are so very pleased that something finally has helped him sleep for longer. This alone has made me realise just how amazing your massage techniques are as I have seen it for myself over these last few weeks. I can’t thank you enough……

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……

Peter Walker is well known in the baby massage field. It was therefore to him ‘Making friends with Gravity’ the correct way to teach sitting and standing

3) High quality resource: A copy of Peter Walker’s international best selling book ‘Developmental Baby Massage’ plus a full set of course notes and a DVD given to all students.

Diary

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