The right start
Free school meals for children

PROFESSIONAL
Health ministry through local faith communities

CLINICAL
Respiratory tract infections
Cetraben® Emollient Cream and Cetraben® Emollient Bath Additive. White Soft Paraffin, Light Liquid Paraffin

Prescribing Information: Please refer to Summary of Product Characteristics before prescribing.

Presentations:
- Cream – a thick white cream containing white soft paraffin 13.2% w/w and light liquid paraffin 10.5% w/w.
- Bath additive – clear liquid containing light liquid paraffin 82.8% w/w.

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

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

Contra-indications:
Hypersensitivity to any of the ingredients.

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

Side Effects:
Very rarely, mild allergic skin reactions including rash and erythema have been observed, in which case the product should be discontinued. (Refer to the SmPC for full list)

Marketing Authorisation Numbers:
- Cetraben Emollient Cream: PL 06831/0259
- Cetraben Emollient Bath Additive: PL 06831/0260

Basic NHS Price:
- Cream – 50g pump dispenser £1.40, 150g pump dispenser £3.30, 500g pump dispenser £5.99, 1050g pump dispenser £11.62
- Bath Additive – 500ml plastic bottle £5.75

Legal Category: GSL. Date of Preparation: June 2013

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

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.mhra.gov.uk. Adverse events should also be reported to Genus Pharmaceuticals. CETAPI.V13

Date of preparation: June 2013 CET05131757

For patients of all ages and stages of eczema and dry skin

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The right start
Free school meals for children

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Community Practitioner | Community Practitioner

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I am writing this piece reflecting on 2013 and the significant events that have happened in the past year. We achieved some great things, which were all chronicled in the journal for all time for others to read, consider and decide on whether our actions made services better.

As I write these lines I am reflecting on a person who I believe has had an amazing impact on this world and from whom I have learned much – Nelson Mandela, Mandiba, a father to his people, who as you all know has sadly left this world. He fought for justice, freedom and equality; values we also hold dear. He was principled and fought against racism and for social justice, and so will we. Although, unlike him, we do not have the world stage, my commitment to you is that I will continue to work for the interests of our members to ensure our legacy is not forgotten and is positively viewed by those who know us or those that want to.

2014 is a year where we will continue our efforts to have an impact on the issues that are important to you and your work, and we will respond to the unknown challenges that will inevitably come as the year progresses. We do this because it is important. We do this with you, and we can’t progress without you. I believe that, because of us, things have changed and we have a legacy to be proud of. For that I thank you for your support and involvement. Long may it continue.
Just 6% of Local Safeguarding Children Boards are complying fully with government guidance on tackling sexual exploitation.

A report by the Office of the Children’s Commissioner (OCC) has found the structures tasked with the co-ordination and oversight of child protection at a local level are failing to protect vulnerable children from being groomed and abused by men in gangs across the UK.

A two-year study by researchers at the University of Bedfordshire found ‘significant levels’ of gang-associated sexual violence, including young people’s knowledge and experience of individual and multiple perpetrator rape.

It is reported that sexual violence is seen as ‘normal’ and ‘inevitable’ in gang environments with young women often getting blamed for their own abuse.

The report proposes a child-centred framework for professionals who commission, plan or provide services to tackle child sexual exploitation.

See Me, Hear Me aims to ensure that agencies can no longer ignore child victims. It is claimed that by posing a series of questions developed with young people who have been victims of sexual exploitation, it ‘forces’ professionals to ‘focus relentlessly on the child and ensure the right actions are taken to make them safe, keep them safe and support them through to recovery’.

It is said that the questions place the focus of attention firmly on the child and their needs, and identify the essential support professionals require if they are to do this complex work effectively.

Sue Berelowitz, Deputy Children’s Commissioner for England, said organisations have largely focused on sexual violence perpetrated by adults against children and, as such, the understanding and recognition of peer-on-peer abuse and sexual violence in gang environments has remained ‘below the radar’.

‘The evidence gathered for this inquiry over the last two years has shown the country the stark and grim reality of child sexual exploitation in gangs and groups,’ she said. ‘The reality is that children, including young women who are associated with gang members, are at high risk of rape and other forms of sexual violence. The task now is to bring about a sea change in the culture of professionals working with children so that they truly focus on the needs of the child who is already a victim or is at risk of sexual exploitation.’

“Our report, If only someone had listened, seeks to do this by providing a framework for professionals to use when commissioning or planning services for or working with children. We believe implementing See Me, Hear Me will achieve that.’

A study commissioned by the OCC and carried out by London Metropolitan University also found young people understand what is meant by giving consent or agreeing to sex, but that they have a very limited understanding of what consent means, with ‘narrow concepts’ of rape, including where the definition only involves explicit force between strangers.

Professor Liz Kelly, Director of Child and Woman Abuse Studies Institute, London Metropolitan University said: ‘Our study shows that the emphasis and responsibility remains on young women to give consent with little expectation that young men seek and get it. This needs to become a more balanced negotiation. We also have to shift the cultural norms, which label young sexually active women as “slags” and “skets” whereas for young men they are considered “legends”.

Berelowitz has again called for sex and relationship education to be made compulsory in schools and said its absence means ‘young people’s access to accurate information and spaces to explore the complexities of their lives and decision-making are limited’.

Unite/CPHV Lead Professional Officer, Obi Amadi, said: ‘This is an escalating concern and it will need an approach that educates and empowers girls and boys. ‘PHSE and SRE must be made compulsory in schools with teachers and school nurses available to teach them, the inappropriate internet content they access must be restricted. Communities need to have more clubs and activities that children can access with role models who they can talk to. As adults and professionals we need to be more alert to this issue when working with children.’

Councils ‘failing to act’ over child sexual exploitation

NEWS ROUND-UP

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Parents who buy alcohol for underage children should face community service, a left-wing think tank has said.

In a report, Demos demanded the government introduce ‘tougher’ punishments for ‘adult enablers’ of teenage drinking in a bid to crack down on underage alcohol consumption. Other ideas include social shaming and being banned from shops.

A third of 11–15 year olds (33%) admitted obtaining alcohol recently, with one in five (19%) saying they were given the drinks by their parents and the same number claiming they received it from their friends.

Around one in seven teenagers (13%) had also asked someone else to buy alcohol for them, compared with only 3% who had illegally purchased it from a shop themselves.

Health experts have been tasked with targeting information campaigns specifically at parents to shift their attitudes on the dangers of underage drinking and it is suggested drunken individuals are charged a levy towards policing and NHS costs.

The think tank also argues police should do more to both enforce on-the-spot fines for law breakers, as well as using their powers to prosecute as figures show only 16 people were successfully prosecuted for purchasing alcohol on behalf of a child in the past four years.

Jonathan Birdwell, Head of the Citizens Programme at Demos and author of the report, said: ‘The majority of teens get their alcohol from parents, friends and older siblings, rather than buying it themselves. However, these proxy-purchasers aren’t facing the consequences for the harm they are doing.

“Our research suggests tackling certain high-strength drinks, or just test purchasing shops is not sufficient. We need a tougher, smarter approach. This includes threatening parents who buy alcohol for their children to drink unsupervised with “social shaming” like community service.

‘Giving drunk and disorderly people entering city centres a “yellow card” and denying them entry or forcing them to sober up would also moderate excessive pre-loading by denying people the fun night out they had planned.”

Unite/CPHVA Professional Officer, Dave Munday, said: ‘It is all well and good considering shaming parents; but even if we ignore the potential impact of that on them as individuals, you cannot unlink the parent to the child. That shame would automatically transfer onto the child too, and surely that is something we would not want to see happen.’

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**Mental health risk linked with steroid use in pregnancy**

Steroids given to pregnant women to help premature babies develop have been linked to mental health risk in childhood, a study has claimed.

The drugs are often administered to help those babies at risk of a premature birth accelerate lung development.

However, a study published in the journal *PLoS One* showed there was a higher risk of attention disorders at age eight among those children born to mothers who had received the steroids.

Researchers at Imperial College London and the University of Oulu in Finland found the drugs may affect the developing brain of an infant after comparing 37 premature children whose mother was injected with steroids with 185 premature children who were not exposed to the drugs.

Professor Vivette Glover, of Imperial College, told the BBC: ‘These are really important and lifesaving drugs. These findings shouldn’t affect clinical practice and parents shouldn’t worry.’

Professor Glover also said stress, anxiety and depression in pregnancy increase levels of cortisol and may be having a similar effect on the developing brain as glucocorticoid steroids among the study participants.

‘Unite/CPHVA Professional Officer, Dave Munday, said: ‘It is important that our members are aware of this study, especially for any parents that are concerned about its results. It is always important to reinforce the message that parents shouldn’t worry, although we realise that may be difficult.’

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**BMA calls for easier access to domestic violence support**

More investment in support services for domestic violence victims is needed, the British Medical Association (BMA) has said.

One in nine women are severely physically abused every year in the UK and two women die at the hands of their abusers every week.

The BMA said access to support services ‘must be made easier for victims of domestic abuse’.

It also called for health professionals to gain more confidence and skills in identifying and supporting victims, and for better working arrangements with other services to provide earlier detection of domestic abuse.

Professor Sheila Hollins, Chair of the BMA’s Board of Science, said: ‘In light of funding and resource cuts we need an end to the unstructured investment and overlapping of resources, which make it much more difficult for victims to access services, and instead move towards a more proactive detection of the early signs of domestic abuse.’

Unite/CPHVA Professional Officer, Obi Amadi, said: ‘Health professionals should be confident to deal with this issue sensitively. There does remain the issue of support for those who are abused, but it is not consistent. It should be more accessible.’
SNP launches independent vision

The Scottish National Party (SNP) has launched its ‘mission statement’ for an independent Scotland, putting childcare at its heart.

On 18 September 2014, the Scottish public will be asked to answer ‘yes’ or ‘no’ to the question ‘Should Scotland be an independent country?’

The 670-page paper, entitled Scotland’s Future: Your Guide to an Independent Scotland was launched by Scotland’s First Minister, Alex Salmond, and sets out a series of policy pledges, including 30 hours of childcare per week in term time for all three and four year olds, as well as vulnerable two year olds.

Other pledges promise the abolition of housing benefit reforms – otherwise known as the bedroom tax – and a halt to the roll-out of universal credit.

Mr Salmond said: ‘The most comprehensive blueprint for an independent country ever published will reverse the damage caused by the vast social disparities, which have seen the UK become one of the most unequal societies in the developed world. This guide contains policies that offer nothing less than a revolution in employment and social policy for Scotland, with a transformational change in childcare at the heart of those plans.’

‘Our proposals will make it far easier for parents to balance work and family life and will allow many more people, especially women, to move into the workforce, fostering economic growth and helping to boost revenues, which will in itself help pay for the policy.’

Unite/CPHVA Professional Officer, Gavin Fergie, said: ‘The SNP’s White Paper is their vision for the future of Scotland and members may agree or disagree with it. People may wonder why some of the issues raised in the paper are not being addressed now, as there is so much in health and social care that has been devolved. The devil is still in the detail, some of which is missing from both sides of the debate, and which will have the biggest impact on people’s day-to-day lives.

‘As many as 30% of Scottish citizens are undecided about which way they will vote in September, so it is still all to play for. ‘We encourage members from whatever political persuasion to become involved in the debate because it is their vote, their country and their future.’

Wales struggles to control superbug outbreak

Hospitals in north Wales are battling against an outbreak of the superbug Clostridium difficile (C. diff).

In October 2013, 47 cases were reported by the Betsi Cadwaladr University Health Board (BCUHB). According to a report, BCUHB claimed that seven patients across the region had died as a result of the increase in cases during the months of September and October 2013. The rate of C. diff cases rose to 5.90 cases per 1,000 hospital admissions in north Wales in October, compared the Welsh average of 3.76 cases per 1,000.

BCUHB said it is working with Public Health Wales to ‘understand infection control issues’, with extra staff being brought into the infection control team and rapid-review audits on hand hygiene being carried out.

Unite/CPHVA Professional Officer, Jane Beach, said: ‘It is alarming to see that there has been such a rise of C. diff cases in the trust. BCUHB needs to do all it can to bring the situation under control. We will be watching closely in monitoring the outcome of its work.’

NCT launches more affordable, ‘bitesize’ antenatal courses

The National Childbirth Trust (NCT) is making its antenatal courses shorter and more affordable for busy parents on a budget.

‘NCT Essentials’ courses are said to be ‘more structured’ than traditional NCT courses, designed to equip new parents with important information and tips for early parenting.

The charity wants to reach out to parents in new areas, whatever their background or income as evidence shows antenatal education leads to higher levels of satisfaction with the experience of giving birth, can improve maternal wellbeing and increase the confidence of parents with their baby.

Belinda Phipps, CIO at NCT, said: ‘Everyone wants to be the best parent they can be. Evidence shows that preparing for the birth of your baby and being a parent with an NCT course improves your confidence and helps give you skills you need.

‘Not everyone is able to spend as much time and money as they would like on preparation. We’ve designed a course that is the same NCT quality, but covers the basics over a shorter number of hours and is more easily affordable.’

The six structured two-hour sessions will include the impact of birth on relationships, feeding and nutrition, and birth and labour. The cost of the course starts from £110 for a couple or £70 for a new mother attending alone.
Unite criticises government’s Francis response

Unite has blasted the government’s response to the Francis report as ‘inadequate’.

While the union welcomed transparent, monthly reporting of ward-by-ward staffing levels, it criticised the Health Secretary, Jeremy Hunt, for failing to reverse the current programme of cuts to frontline staff.

Unite’s concerns are not just focused on the acute sector and A&E departments, but also on ‘inadequate’ staffing numbers in community nursing, which it claims puts families ‘at risk’.

Hunt said the acceptance of Francis’ 290 recommendations act as a ‘blueprint for restoring trust in the NHS, reinforcing professional pride in NHS frontline staff and above all giving confidence to patients’.

New measures introduced include a statutory duty of candour on providers and professional duty of candour on individuals, through changes to professional codes as well as a new criminal offence for wilful neglect, with a government intention to legislate so that those responsible for the worst failures in care are held accountable.

Unite Head of Health, Rachael Maskell, said: ‘What Jeremy Hunt outlined won’t disguise the fact the public and staff can see there are not enough nurses.

‘The toxic meltdown of the NHS is caused by cuts and privatisation, and therefore Hunt’s response can’t be used as a sticking plaster to obscure the real nature of the crisis.

‘It is clear that that we need strong mechanisms in place for enabling staff and patients to freely whistleblow when they witness alleged abuses.’ She criticised Healthwatch – a body designed to represent patients’ interests – for having ‘no teeth’

NI health service compensation costs soar

Almost £150 million has been paid out in compensation by Northern Ireland’s health service over the past four years.

The Traditional Unionist Voice (TUV) party leader, Jim Allister, said he was ‘astounded’ by the amount. Health Minister, Edwin Poots’ department told the Assembly that it spent £17.5m on legal costs and £21.5m on compensation last year alone – up 60% from three years ago.

In a statement, Allister questioned the oversight and efficiency measures of the organisations, including the department of health, the Health and Social Care Board, the five health trusts and other ‘arm’s-length’ bodies, following the soaring costs.

The largest of the five health trusts in the country, the Belfast Health and Social Care Trust, spends the most on legal proceedings, paying out an average of almost £5m every year since 2009/2010.

Unite/CPhVA Professional Officer, Gavin Fergie, said: ‘It would be far more usual if politicians were part of the solution, rather than being part of the problem in revealing why there is so much money spent on compensation claims. Is it because there aren’t enough people doing the job any more because the department have cut essential services and that is why more errors are being made? We also must not forget that this is all happening against a backdrop of a far more libellous society.’

Perinatal mental health midwifery services expansion plan

The number of midwives specialising in perinatal mental health is set to grow under government plans.

Health Minister, Dr Dan Poulter, announced the increase to help new and expectant mums affected by a mental illness.

Health Education England (HEE) has been tasked to make sure there is enough training available to ensure there are specialist perinatal mental health staff available for every birthing unit by 2017. Mental health issues are said to affect 10% of all women either when pregnant or after their baby is born, yet according to a recent report by the NSPCC, only around half of the country currently has access to such specialised staff.

Head of Strategy and Development at the NSPCC Chris Cuthbert said: ‘Specialist midwives can make a crucial difference to the well-being of new and expectant mums suffering from conditions such as depression or anxiety, supporting them and their families so that they get personalised care and their children can thrive.

‘Provision of specialist midwife services in this country is currently widely inconsistent from area to area. That’s something which urgently needs addressing and we want the same standards of care implemented across the whole of the NHS.’
NEWSINBRIEF

Change4Life Healthy Eating Campaign
Change4Life will be launching a new healthier eating campaign in January, with free materials to help schools and teachers engage children and parents with this important subject. Look out for your Change4Life box – addressed to your healthy school lead – which will be delivered to your school via your fruit and vegetable delivery from 6 January. More information will be available at: www.nhs.uk/C4Lschools in the new year.

ChildLine tackling sexting with Internet Watch Foundation
Young people are taking huge risks making and sending sexual images of themselves, also known as ‘sexting’, says the NSPCC, ChildLine and the Internet Watch Foundation (IWF). The charities are joining forces to ensure young people know where to turn to get sexually explicit images removed online. ChildLine has also developed an app for young people to provide tools to defuse the pressures to send an explicit image. Called ‘Zipit’, the app offers witty images to send instead of explicit ones, advice for how to engage in safe chat, and a direct link to call ChildLine. Visit: www.nspcc.org.uk

New waistline measure means more teenagers are obese than first thought
The waist of the average 15-year-old girl has expanded nearly 13cm (5in) in the past two decades, according to a study by Leeds Metropolitan University. It found six out of 10 girls are obese by the time they reach 10 and one in 10 are obese even by adult measurements, with waists larger than 88cm (35in), according to a measure that looks at waist size rather than body mass index (BMI).

Teenagers ‘falling through gaps’ in HIV services
More than two million adolescents between the ages of 10 and 19 years living with HIV do not receive the care and support that they need to stay in good health and prevent transmission, says the World Health Organization. It claims the failure to support ‘effective and acceptable’ HIV services for teens has resulted in a 50% increase in reported AIDS-related deaths in this group compared with the 30% decline seen in the general population from 2005 to 2012.

‘National debate needed’ on internet use by children
More than half of children are using the internet without any parental supervision, a poll suggests.
Research by a children’s charity shows almost one in four parents are concerned their child has been bullied online and 33% suspect their child could be a cyber bully themselves. An estimated 53% of children go online in their own bedroom – 46% on a games console and 66% on a personal smartphone.
A third of parents surveyed by the Anti-Bullying Alliance admitted to not having had a single conversation with their children about online safety. Furthermore, some parents could be said to be unintentionally exposing their children to inappropriate behaviour and cyber-bullying by setting up children’s access to social networks. Half (46%) of the parents polled have set up their children’s social profile for them, and 45% have set up a Facebook account for their children aged under 13, despite the age restrictions in place on the site.
Raj Samani, online safety expert at McAfee, the company that jointly commissioned the survey, said: ‘As a father myself, it’s worrying that parents are unknowingly enabling their children’s bad behaviour online. This is alarming, as setting up these social profiles without installing parental controls or even having conversations about how to stay safe online means children are ill-prepared to understand and deal with online issues such as cyber-bullying.’
A third (32%) of parents surveyed admitted that better personal knowledge of the internet and social networks would make them feel more equipped to keep their children safe online, with one in six (18%) parents saying that their own knowledge of the internet and social media platforms is ‘not adequate to match the online behaviours of their child’.
Luke Roberts, National Co-ordinator of the Anti-Bullying Alliance, said: ‘Currently, there is no clear leadership, no co-ordination and no adequate educational model in place to tackle the growing issue of cyber-bullying.
‘The Anti-Bullying Alliance is calling for a national debate on children and young people’s use of the internet, and their online safety in the 21st century, focusing specifically on cyber-bullying, which will bring together children, parents, industry, providers, NGOs, government, and educators.’
To help parents, McAfee and the Anti-Bullying Alliance have published an online paper: Digital Deception: The Online Behaviour of Teens to give parents and children the tools they need to better protect themselves and their family. The paper can be downloaded from: www.anti-bullyingalliance.org.uk

CPHVA concerns over Kent children’s centre closures
Unite/CPHVA has warned that the quality of help given to parents bringing up babies and young children could be ‘badly hit’ in Kent if the council goes ahead with its plan to axe around a quarter of the county’s children’s centres.
The warning came as parents joined community groups to demonstrate outside county hall in Maidstone on 2 December 2013 over the debt-ridden local authority’s proposal to close 23 of the 97 children’s centres across the county.
The union has called on the council to ‘rethink’ its actions.
Unite Professional Officer, Dave Munday, said: ‘There is little doubt that the advances in child welfare and increasing awareness among parents of their child’s developmental needs will be badly affected if the county council goes ahead with these plans. Children’s centres provide a wide range of activities, clinical advice on such issues as postnatal depression and educational opportunities, as well as access to professionals such as health visitors and social workers. They provide an opportunity for young parents, who are often isolated, to have a focus that can help them through those vital early years in a child’s development.’
‘We would urge the council to rethink its proposal to axe these centres – if a centre is closed it will mean parents having to travel quite long distances to access these services, which may not be possible.’
Kent county council’s restructuring plans are the result of a deficit of £240 million.
Sustain STEPS®
to Excellence in the NHS

Health visiting staff have spoken of the immense benefits which an inspirational personal effectiveness and behavioural change course has brought to their team after they became the first service in the country to pilot the unique programme.

East Coast Community Healthcare (ECCH), which provides services in Great Yarmouth and Waveney, started piloting Sustain STEPS® to Excellence in late 2012.

Specifically adapted for NHS health visiting services by business consultancy Sustain, the three-day course is designed to ensure staff are well placed to respond to the challenges of the health visiting ‘call to action’. It aims to:

• give health visitors the confidence to deal with change, embrace leadership and take responsibility for driving the healthy child programme and call to action
• increase motivation and ensure staff are able to work successfully in partnership, in turn helping them provide high quality services

Four senior members of ECCH staff have also now completed a further ‘train the trainer’ programme, which has accredited them as Sustain STEPS® facilitators and gives them the opportunity to run the course internally. As well as ensuring consistency and quality, this additional element provides value for money and a better return on investment during times of squeezed budgets.

The facilitators are now taking responsibility for rolling out the popular course to all 100 members of ECCH’s health visiting and associated support team. And feedback so far has been excellent, with every participant recommending the course and 99.5% agreeing it delivers its aims.

“The course was absolutely brilliant, and has had a big impact on my work, helping me cope with the pressures of my job much more effectively,” said ECCH community nursery nurse Rachel Moody. “I’m more positive, more relaxed and don’t let things get to me – instead of panicking, I take stock and talk myself through things. This has been reflected in the workplace and is benefiting the children I care for and is also helping us relate to each other better as a team.”

For health visitor Carey Roberts, the course has helped her make positive permanent changes both inside and out of work.

“Sustain STEPS® is designed to empower you so you can visualise these changes;” she said. “It does this by opening up the way we think and breaking down the thought process to help us understand why we have predisposed thoughts.

“I would recommend the training to everyone. It will stretch your comfort zones safely, raise confidence and self-esteem and enable you to be more open to change.”

Pamela Agapiou, ECCH’s Director of Universal Children’s Services, has also spoken highly of the benefits the programme has bought the service.

“The course gives you back the ability to remove yourself mentally and really focus on what you’re doing rather than just diving in and doing;” she said. “This is ideal for health visiting where, whenever possible, we should take the time to stand back and think rather than feeling the need to do things right now.

“Sustain STEPS® is a thought-provoking, mindful life skills course which is about valuing yourself, your staff and your clients so that you support others to find their own solutions. It opens people’s minds in a caring, nurturing and creative way while giving them transferrable skills they can apply to both their personal and professional lives.

“By setting goals and focusing on positive affirmations, this powerful course helps you learn to deal with the negative voices we all have in our head and get the drive we need to move forwards. I would highly recommend it to anyone.”

Sustain STEPS® has been specifically adapted for the NHS from an acclaimed programme created by The Pacific Institute®. In addition to the health visiting adaptations, Sustain has also contextualised the STEPS® course for delivery to healthcare assistants as part of a national pilot to strengthen pre-nursing education. The newly adapted course will be launched in January to a cohort of 43 healthcare assistants across East Anglia.

For more information, contact Sustain on 01603 897415 or email steps@sustain-improvement.com
Unite launches credit union service

Unite has launched a new credit union service, in a bid to take on payday lenders, encourage saving and offer members finance without fear.

The new credit union service, launched at Unite’s sector conference, arrives in the week the union released figures showing the extent of Britain’s cost of living crisis. Independent research shows that the disposable income of Unite members has fallen by £129 a month, with households being forced to borrow an average of £660 over the same period.

The new Unite credit union service is open to all Unite members in England, Scotland and Wales, who will be able to open instant access savings accounts, offering low cost borrowing, including payday loans. Supporting members to save, even low amounts, will open up more affordable loan opportunities.

The Unite credit union service uses a panel of carefully vetted, existing credit unions, so ensuring that members can link up with a credit union that is already established in their region. Members can find out more and start the joining process by calling 0333 0110 450 or visiting www.unitetheunion.org/CreditUnion

Commenting, Unite general secretary Len McCluskey said: ‘We are determined to wipe out rip-off payday lenders and ensure that they can’t make profits by exploiting victims of the financial downturn. Unite’s new credit union service ensures our members can access finance without fear and helps keep them out of the clutches of parasitic lenders.

While the government stands on the sidelines and allows the quiet crisis to intensify, Unite is taking firm action: fighting for better wages and conditions in the workplace, while offering members a new credit union service that puts them and their families first. This is a clear embodiment of Unite’s values.’

Unite credit union will operate in partnership with Unite Debt Management and initiatives such as the Unite4Jobs website (www.unite4jobs.co.uk).

Those interested in finding out more about the credit union network and joining should call 0333 0110 450 or visit: www.unitetheunion.org/CreditUnion

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The Past, Present and Future of Health Visiting: What it Means to Me

A poem about health visiting by Sharon Dawson, Unite CPHVA member

Sixteen and pregnant, that was me
Input from a health visitor there probably
should’ve been
But with cousins, aunts, nans and a mother
They’d have to be brave to try and bother!

‘You don’t need them interfering
busybodies telling you what to do
What the heck do they know, they ain’t got
a clue!’

‘If you need to know ‘owt about kids’, said
my nan
‘Look no further than me or your Mam’.

‘A wealth of knowledge we have between
us
No nosy parker knows more than we does’!
Giving me advice with a Woodbine on
lips
While holding my baby upon her hips.

My historical ideas of health visiting, as you
can see
That they were not needed, nor wanted by
my family!
Yet another statistic I could have been
But instead, determination for a better life
I was keen.

I know we were lucky, my baby and me
To have family support, although some may
disagree.

So one to be one of those interfering
busybodies is why I am here today
And yes, stood here telling you this I am
afraid!
Building relationships, therapeutic they
have to be
Let’s get it right for children and Build some
Community Capacity.

To help children be healthy, enjoy and
achieve
To stay safe and have economic wellbeing
Making a positive contribution is one we
can do
Breastfeeding, teething, antenatal, birth
visits, too.

Domestic violence safeguarding, maternal
mood
Toileting, nappy rash, to ‘When can I give
‘em food?’
Health visitors recognise what needs to be
done
But this government’s bright ideas amount
to none.

All these guidelines to help us through
Early intervention, yes that’s what we
should do!
From Healthy Lives and People, and the
Implementation Plan
To the Healthy Child Programme, yes I am
a fan!
We need to ‘Prevent poor children from
becoming poor adults’ (if only we could)
Because Every Child Matters and of course
they should.

My future as an interfering busybody is
exciting … I think
Four weeks in my training I think I’m just
about back from the brink!

Helping teenagers to become good
mothers
Would be an achievement for me above all
others
My own experience of being a teenage
mum
I can give something back to help them
along.

To offer advice and to be there to lend an
ear
To be an advocate for those most in fear
And say ‘Come on, young ladies, you know
you can
Be good mummies, cos statistics don’t
mean a damn!’

What’s going to happen in the future, we
don’t really know
Especially if these economic times don’t
grow
But perhaps with imagination we can all be
Able to help the vulnerable and those most
in need.
#adaywithdave:
Amanda Moss

In November 2013, student health visitor Amanda Moss spent the day shadowing Unite Health Sector Professional Officer for Health Visiting, Dave Munday

Agenda for the day

My day with Dave started with a visit to the Community Practitioner journal office to meet the Editor and to talk through the content of the journal; in particular its relevance to student health visitors. I was given three brief articles to read relating to health visiting practice, and was invited, along with Dave, to contribute my thoughts on some of the news stories for the next issue, including foetal thumb sucking, the provision of free vitamins and the practice of swaddling babies. My comments were included in the December edition and it was great to see them in print.

The next item on our agenda was a visit to Westminster for a meeting with Dave’s local MP, Jonathan Reynolds, to discuss his priorities for his constituency (one of which he stated to be mental health) and where his political interests lie. Dave and Jonathan discussed the progress of submitted funding bids from various undisclosed agencies for money from the Department of Health, to be used specifically within the domestic abuse arena, and the progress of the 1001 Critical Days cross-party manifesto. Pauline felt this would be a significant piece of international work that the UK would be well placed to contribute to, given the progression seen in practice in relation to the Family Nurse Partnership and the Health Visitor Implementation Plan, and the recognition of the importance of neuroscience and early brain development on attachment and life chances.

Reflections

My youthful optimism about embarking on a fabulous career as a nurse, where I would care for people in a supportive, well staffed environment to meet patient needs within a national health system that would value my contribution and would recognise my training needs through continuing professional development and a progressive salary, was perhaps somewhat naïve.

I have no regrets about my career choice, and although my experience of working within the health service has become a little less idealistic, it remains entrenched in high-quality patient care, and a commitment to ongoing performance improvement to ensure sustainability of the NHS for future generations.

My experience of shadowing Dave has opened my eyes to the fact that union membership is much more than an ‘insurance’ policy to deal with legal or employment matters; rather, it is a forum that links the individual practitioner with the wider organisation, and also to government policy. I feel this experience has expanded my knowledge and understanding of the relationship between health visiting and policy development, and of how the standards of proficiency underpin the 10 key principles of public health practice outlined by the NMC.

Much of the work health visitors carry out is focused on political issues that often divide families and communities. It is important that health visitors take a political interest within the community, and have the skills and knowledge to work within current policy, and disseminate the important work we carry out if we are to influence the development of future policies affecting health within the communities in which we practice. I feel empowered to arrange to meet my local MP and discuss the local political agenda. Although I don’t feel my knowledge on current affairs is vast, I now realise I have the knowledge and confidence to talk about and share examples of health visiting practice.

Before my day with Dave I did not consider the role of local members of parliament as significant to routine health visiting practice, but I now realise it is the responsibility of all practitioners to raise the profile of health visiting and public health.

I feel a key skill I learned from Dave was to ascertain local priorities and the personal and political interests of local MPs. This information can be a springboard to facilitate a meaningful discussion about the valuable contribution of health visiting. Health visiting practice is intertwined and relevant to many public health topics so it is likely that some common ground will be reached. My aim is to arrange a meeting with my local MP as soon as I am in post as a health visitor.

For more details about #adaywithdave, visit: www.unitetheunion.org/adaywithdave
Bio-Oil® is a skincare oil that helps improve the appearance of scars, stretch marks and uneven skin tone. It contains natural oils, vitamins and the unique ingredient PurCellin Oil™. Bio-Oil is the No.1 selling scar and stretch mark product in 11 countries. £8.95 (60ml).

For comprehensive product information and results of clinical trials, please visit bio-oilprofessional.co.uk.

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Research evidence

Why talk with children matters
This US article reviews basic features of infant- or child-directed speech, with particular attention to those aspects of the register that have been shown to impact profiles of child language development. It discusses concerns that arise when describing adult input to children with language delay or disorder, or children at risk for depressed language skills. The article concludes with some recommendations for parent counselling in such cases, as well as methods that speech and language practitioners can use to improve the quality and quantity of language input to language-learning children. Semin Speech Lang 2013 34(4): 203–14.

Peers and the emergence of alcohol use
This study addresses not only influence and selection of friends as sources of similarity in alcohol use, but also peer processes leading drinkers to be chosen as friends more often than non-drinkers, which increases the number of adolescents subject to their influence. Analyses apply a stochastic actor-based model to friendship networks, assessed five times from 6th through 9th grades for 50 grade cohort networks in Iowa and Pennsylvania, which include 13,214 individuals. Results showed definite influence and selection for similarity in alcohol use, as well as reciprocal influences between drinking and frequently being chosen as a friend. These findings suggest that adolescents view alcohol use as an attractive, high status activity and that friendships expose adolescents to opportunities for drinking. J Res Adolesc 2013 23(3)

Effectiveness of electronic aids for smoking cessation
Tobacco use continues to be the leading cause of preventable death in the world, and though current evidence-based approaches have substantially reduced rates of smoking, these rates remain disturbingly high. Two recent technological advancements, the electronic cigarette (e-cigarette) and mobile health (mHealth) interventions, may offer smokers an alternative way to quit smoking. E-cigarettes continue to be fiercely debated. Preliminary evidence suggests that e-cigarettes are likely to be much safer than normal cigarettes and are helpful to some smokers as a means of reducing or quitting smoking. Questions, however, still remain as to how they will affect overall public health-if they will be used as a gateway product or reduce motivation to quit smoking, to name but a few. Similarly, mHealth interventions appear to be effective and accepted by users. However, mobile ‘apps’ have yet to be tested in randomised trials and there are concerns about violations of users’ privacy. Carr Candianes Risk Rep 2013 7(6)

Nurse–parent interaction to promote healthy weight gain
In this Swedish study researchers conducted semi-structured interviews with 15 nurses working at child health centres (CHCs) in south-west Sweden in 2011–2012. The findings resulted in 332 codes, 16 subthemes and six main themes. The subthemes identified and described barriers and facilitators for the prevention of childhood obesity at child health centres. Main themes included assessment of child’s weight status, the initiative, a sensitive topic, parental responses, actions and lifestyle patterns. Obesity was a sensitive topic. For the most part, nurses initiated discussions of a child’s overweight or obesity. CHCs in Sweden provide a favourable opportunity to prevent childhood obesity because of a systematic organization, which by default conducts growth measurements at all health visits. The BMI chart yields greater recognition of overweight and obesity in children and facilitates prevention of obesity. In addition, visualisation and explanation of the BMI chart helps nurses as they communicate with parents about a child’s weight status. Inconsistent use and lack of quality assurance regarding the recommended BMI chart was a barrier to prevention, possibly delaying identification of overweight or obesity. Other barriers included emotional difficulties in raising the issue of obesity because it was perceived as a sensitive topic. Some parents deliberately wanted overweight children, which was another specific barrier. Concerned parents who took the initiative or responded positively to the information about obesity facilitated prevention activities. BMC Nurs 2013 12(1): 27

New resources

No Smoking Day campaign
The British Heart Foundation is calling on healthcare professionals to use the annual anti-smoking campaign, which last year encouraged a million people to attempt to quit smoking, as an opportunity to promote quit aids in their practice and signpost smokers to local support services. The day will take place on 12 March 2014. Visit: www.nosmokingday.org.uk

Resource to support young people with substance misuse problems
‘Healthy Development in Young People: for professionals working with substance use in young people’ aims to improve the way youth workers, nurses, social workers and adults working in targeted and specialist substance misuse services work together. The short online course has been developed jointly by the Royal College of Paediatrics and Child Health, Public Health England and the Cambridgeshire Adolescent Health Service. Visit: www.rcpch.ac.uk

Specialist Mental Health Midwives
A new report from the NSPCC says that specialist mental health midwives have a crucial role to play in effective perinatal mental health care. There are many maternity services without this important position, and where specialist mental health midwives do exist there are differences in their role, skills and experience. It is hoped that the report will aid discussions and lead to improvements in local provision. Visit: www.nspcc.org.uk
Giving children the best start: free school meals

Deputy Prime Minister, Nick Clegg, recently announced that free schools meals will become available for all infants in England at the start of the next school year. However, the details around the universally welcomed initiative are painfully vague. Louise Naughton reports

All school nurses will have come into contact with children who turn up to school having had no breakfast, with lunchboxes scarcely filled with more than chocolate bars and packets of crisps. Poor diets mean two out of every 10 children are obese when they leave primary school at the age of 11 and the related illnesses that stem from obesity in later life are said to cost an already strained NHS around £10 billion a year. Speaking at a Westminster Food and Nutrition Forum event, Sharon Hodgson MP, the former Shadow Minister for Children and Families, now working as the Shadow Minister for Women and Equalities, described the rate of childhood obesity as a ‘national scandal’.

It is for this reason that all six and seven year olds in England will become eligible for free school meals from September 2014, Deputy Prime Minister Nick Clegg has announced. Currently, pupils are entitled to free school meals if their parents have an annual income of less than £16,190 and claim means-tested out-of-work benefits (such as Income Support) or Child Tax Credit. It is estimated 80% of children eligible for free school meals live in out-of-work
households or with earned incomes of less than £1,000. Under the policy – which is estimated to cost around £600m – Reception, Year 1 and Year 2 students will still be able to bring in packed lunches; but it is hoped the universal availability of free hot dinners will boost uptake to ensure ‘every child gets the chance in life they deserve’.

‘My ambition is that every primary school pupil should be able to sit down to a hot, healthy lunch with their classmates every day,’ said Clegg. ‘We will start with infant school pupils because teaching healthy habits young, and boosting attainment early, will bring the biggest benefits. Universal free school meals will help give every child the chance in life that they deserve, building a stronger economy and fairer society.’

Head of the Children’s Food Trust’s Research Programme and Nutritionist, Jo Nicholas, said the need to update current rules around free school meals and ensure they are universally available to every pupil means we will be able to bridge the gaps between those some 400,000 pupils who are eligible for free school meals but decide not to take part in the scheme, as well as for those children who are living in poverty but whose parents just miss out under the current eligibility criteria.

Pilot programme
The benefits of hot cooked meals over packed lunches have been well documented, most recently by a recent two-year review of school food by two founders of the Leon restaurant chain, Henry Dimbleby and John Vincent, on behalf of the Department for Education in 2012 following criticism from TV chef Jamie Oliver over the state of school meals and packed lunches. Dimbleby and Vincent evaluated the success of pilots operating in three local authorities (Durham, Newham and Wolverhampton) between the autumn of 2009 and summer of 2011 in extending entitlement to free school meals. As well as the extension of the barriers to free school meals, the pilots also included a range of supporting activities in each area designed to encourage take-up of school meals and to increase parental awareness of school food, such as holding talks and taster sessions.

It was estimated by the end of the pilot that around nine in 10 primary school pupils were eating at least one school meal per week, compared with the average of six in 10. Take-up increased both among pupils who were not previously eligible for free school meals, and also for those who were already eligible. It was said the pilots had a ‘significant positive impact’ on attainment for primary school pupils at Key Stages 1 and 2, with pupils making between four and eight weeks’ more progress than children in comparison areas.

Some have dubbed Clegg’s announcement as nothing more than ‘a gimmick’ and doubt whether it will indeed become a reality for England’s schoolchildren; but Nicholas insists the review has given the policy move a ‘great foundation’ from which to build.

‘There has been a gradual building of the evidence base for universal free school meals and this announcement is the natural next step,’ she said. ‘It is also a very pragmatic roll-out, starting with younger children. In an ideal world, all children in primary and secondary schools would be included, but you have to remember this is all happening at a time where the purse strings are being tightened on public spending. You have to start somewhere – and this is a very good starting point.’

Although the review found no evidence of any impact of increased take up of free school meals on children’s health, Nicholas encouraged school nurses to get involved in the initiative to ensure there is a ‘whole-school approach’ to the school meals agenda, as it is these professionals who most understand the benefits to public health that hot, cooked meals can bring to pupils.

Despite the overwhelming success of the pilots, Hodgson said she was surprised by the move.

‘We have taken a big stride forward in terms of free school meals for all Key Stage 1 pupils, which is something I never expected that John and Henry would ever manage to get past ministers, let alone watch the announcement from Nick Clegg during party conference. It was so exciting, and those of us who have been campaigning for this for a number of years never thought it would have happened so soon. There is still a long road to go, but it is going to happen, which is great.’

School Food Plan
The School Food Plan – launched in July 2013 – has thrown down the gauntlet to schools and catering organisations to ensure 70% of children are eating ‘tasty and nutritious’ school meals; currently the average take-up of school meals is around 48%. Linda Cregan, Chief Executive of the Children’s Food Trust praised the work of schools, catering organisations and local authorities for ensuring school meals have moved on from the now infamous ‘Turkey Twizzler’ days.

‘We should never underestimate what has already been achieved through the work of a many great people,’ she said. ‘We know that by limiting the range of foods to healthier options, children now take healthier food at school. The average school meal in primary schools now contains over two portions of fruit and vegetables and is lower in fat, salt and sugar. In secondary schools, meals eaten in 2011 had nearly 50% more vitamin A than they did in 2004. Pupils were eating fewer chips and at least 30% less fat, saturated fat, sodium and sugars.

‘After many years of campaigning we’ve finally got more practical cookery back on the curriculum and even if all schools don’t have to follow the national curriculum, it’s a really clear statement from government of the importance that food plays in a child’s overall educational experience.’

Health and safety
Schools are concerned that teachers don’t have the training and confidence in their ability to teach practical cooking skills to pupils and Cregan warned not enough schools are thinking about how to change this before the next school year.

Glyn Owen, a teacher from Ashton Vale Primary School in Bristol, has called for more consultation from the government and schools on the new national curriculum and said there are still a lot of unanswered questions.
We need advice on appropriate health and safety requirements – teachers are very worried about health and safety. Can I use knives in the classroom? Can I teach outside of a cooking room? Teachers are overly worried about these sorts of things. Teachers are not experts in nutrition, they need to be trained up. Many teachers don’t feel confident when teaching cooking and nutrition, so if things stay as they are, then [the Plan] is not necessarily going to be delivered perfectly. You can’t just expect this to go and be wonderfully delivered.’

Cregan said Clegg’s announcement is ‘undeniably hugely welcome’ but raised concerns that there are still no details on how schools will be supported to prepare for the implementation of the plan before the next school year.

‘The last annual survey we did showed that a quarter of primary schools don’t have a full production kitchen. Most of the schools that contact us at the trust want help with ageing equipment, out-of-date equipment and kitchen facilities, which are just too small. Schools will see take-up rise considerably from next September, they are going to need to make sure that they have got systems in place to cope with that and handle it.’

She said the Children’s Food Trust has recently launched an online learning network specialist training designed to help those involved with school meals address those children with specific nutritional needs.

The School Food Plan is described as the ‘blueprint for the next stage in school food improvement’. It has 16 action points – 17 if you include the delivery of infant free school meals.

Malcolm Clark, Co-Ordinator for the Children’s Food Campaign, Sustain, said the Plan has made a ‘clear commitment’ to mandatory standards for school food. However, the standards will not be compulsory for the 3,364 academies that have been created since 2010.

‘We are particularly concerned about this because there has been anecdotal evidence of worsening standards in academies,’ he said.

And it seems academies are already deciding to work outside of the standards. A survey by the School Food Trust of academies in 2012 found nine out of 10 polled were selling at least one kind of snack food high in fat, sugar or salt that wasn’t permitted in vending machines under the standards.

Nicholas agrees there should be some compulsory standards in place for schools when it comes to food provision but argues against being too prescriptive: ‘All schools are different – they have their own local needs, a particular balance of pupils, different challenges and funding levels. There is no model that will suit all schools.’

**Dietary culture**

Anne Bull, National Chair of the Local Authority Caterers Association (LACA) said headteachers are the only people who can truly lead the revolution in school food. She welcomed the news that Ofsted has recently announced revised guidance advising inspectors to consider the food on offer at school, and the atmosphere in the canteen, to help move school meals up the priority list for many headteachers. Inspectors will be asked to consider how lunchtime and the dining experience contribute to good behaviour and the culture in the school, and after spending time in the lunch hall they should ask school leaders how they are helping to ensure a healthy lifestyle for their children and meeting their dietary needs.

Universal free school meals for infants in England has proven to be a popular move by Clegg. Schools now need to be properly supported if they are to be given the chance to reverse the tide in childhood obesity rates and equip their students with the life-long cooking skills they need to lead healthy lives.

**Unite/CPHVA Professional Officer, Ros Godson, said:**

‘School nurses (and teachers) could help with the take-up of school lunches by participating themselves and setting a good example; it should be possible to arrange (and pay for) this once a week when the nurse is in. That would also give schools a good opportunity to monitor the nutrition and presentation of the meals, and discuss food values and eating habits with children. It needs to be borne in mind that good nutrition is a public health end in itself, as it leads to good lifelong habits and will help prevent much dietary-related poor health, such as heart disease, renal disease, dental caries and diabetes. If we place all the emphasis on obesity, we will miss the bigger picture. School nurses could build on this initiative to help primary schools develop good food policies to cover packed lunches, drinks brought into school, vending machines, sweets brought into school for special occasions, tuck shops, and prizes and competitions at school fairs.

It is also an opportunity for community development work reaching out to families and linking them into the government’s Change4Life programmes in England and Wales.

http://change4lifewales.org.uk   www.nhs.uk/Change4Life
Q: What has been your highlight of 2013?
A: The fact that we have grown our influence and reach, as well as providing new resources this year. We have been moving forward, have done better and have been able to deliver on the promises we have made.

Q: What has been your low point of 2013?
A: That not all of Francis’ recommendations were accepted by government; in particular, the regulation of healthcare support workers and the issues concerning safe staffing levels. The community was not really included and the conversations were very hospital-centric, and that was a bit of a disappointment.

Q: What is your New Year’s resolution for 2014?
A: Next year I would like to do more joint work with other like-minded organisations.

Q: What are your priorities for 2014?
A: One of my priorities for all CPHVA professional groups is that we pay attention to safe staffing levels and caseloads in the community. Also, following the intercollegiate document on female genital mutilation (FGM) that was published by Unite/CPHVA, the Royal College of Nursing, the Royal College of Midwives and others in December 2013, which the government has promised it will take on board, we want a systematic approach to the adoption of its recommendations across health, education and social care systems so that everybody has a common understanding. I am also very interested in how black and minority ethnic (BME) staff have been affected by the financial cuts to the health service – when the cake is smaller, sometimes one particular group has a disproportionately small slice.

Q: What are the biggest challenges facing the CPHVA membership?
A: For health visitors, it will be about demonstrating the positive impact they are making as a result of the Health Visitor Implementation Plan, because that will be what is needed to confirm what a worthwhile investment it was. It will also be important to ensure that we are ready for the changes in 2015 after the Plan and the transition to local authorities. School nurses will need to make sure they move forward in 2014 and develop positively in terms of their working arrangements and making sure they have the opportunity to increase their scope and numbers.

Q: What has been your highlight of 2013?
A: The anniversary of my first year in the role was certainly a highlight! The time went very quickly and I had to hit the ground running. I have especially enjoyed getting to know the OPCs that I am the lead for and working with them on professional issues. I am also really pleased to have finished the year with a new record-keeping book and a duty of care book in production, as members have been asking for support in relation to these areas of practice. I think the 2013 CPHVA Annual Conference was a big highlight. I thought there was a really good feel about the event this year and I enjoyed delivering some of the sessions.

Q: What has been your low point of 2013?
A: It has to be hearing from members about the difficult circumstances many of them are working in as a consequence of the changes taking place under the Health and Social Care Act, and the impact this is having on them professionally.

Q: What is your New Year’s resolution for 2014?
A: To achieve a better work–life balance, related to the previous question. There is so much to do that it can be all consuming at times.

Q: What are your priorities for 2014?
A: To release both the record-keeping and duty of care book to members. We want to build more of a presence in Wales, and are delivering some record-keeping ‘train the trainer’ training early in 2014 as part of that. I would also like to work on having some more Welsh entrants to the CPHVA Awards and at conference. My focus will be on building better relationships with some of the regulators and, of course, the consultation on revalidation will begin in January so I will be working with members on our response. Responding to the Law Commission’s report is on my priority list as well.

Q: What are the biggest challenges facing Wales and regulation in 2014?
A: The Welsh government is looking to increase its health visitor numbers, and school nurse numbers have also reduced in the country, which is certainly an issue given the public health challenges that exist. Revalidation, resisting any suggestion of another fee increase and continuing to pursue regulation of community nursery nurses and other groups in the health sector will be also be challenges.
###PROFILE: CPHVA PROFESSIONAL TEAM

<table>
<thead>
<tr>
<th>NAME</th>
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<tbody>
<tr>
<td>Dave Munday</td>
<td>Lead on Health Visiting in England</td>
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<td>Gavin Fergie</td>
<td>Lead on Scotland and Northern Ireland</td>
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####Q: What has been your highlight of 2013?

**A:** The work that I have really enjoyed and found rewarding this year has been the package that I have developed for student health visitors, including the Student Health Visitor ‘Question Time’ events, the lectures I have been doing in universities across England on the politics of health visiting and the #adaywithdave initiative. What’s really nice about it is being able to see the tangible results of the Implementation Plan.

####Q: What has been your low point of 2013?

**A:** The thing I am most depressed about is the result of the coalition government’s austerity measures. It’s an uphill struggle to convince people at large that austerity has such a damaging effect on our society. Some people seem to think spending money on health is a bad thing, but all the evidence I’m aware of is contrary to that. To invest more heavily in health has such a fiscal multiplying effect that it seems absolutely daft that we are not doing that.

####Q: What is your New Year’s resolution for 2014?

**A:** I will not apologise for maintaining a laser focus on health visitor numbers during 2013, but 2014 has to be about the shift towards health visitors further influencing the strong development of a number of professional issues.

####Q: What are your priorities for 2014?

**A:** The number of serious case reviews that we have seen during 2013 shows there is still so much to do around safeguarding and integration of people. This work will never be done, but there really needs to be a focus on that this year. There is a confidence that the health visitor plan numbers will be achieved and the focus has to be on reclaiming the professional ground in the profession. It is so important that the 35% of the new health visiting workforce in England who have trained in the past five years are ready for the things that will happen post-2015.

####Q: What are the biggest challenges facing health visiting in England in 2014?

**A:** NHS employees are working against a narrative that is anti-investment in people; yet the people who are hardest hit are our poorest brothers and sisters. We all need to fight against false truths about situations in which people find themselves.

####Q: What has been your highlight of 2013?

**A:** The best times have been when I have supported, advocated and articulated for and on behalf of our members. Big projects come and go, but they mean nothing if a CPHVA member feels that their phone call or meeting with a Professional Officer has made no difference or offered no additional reflection to their area of concern.

####Q: What has been your low point of 2013?

**A:** Thankfully, these have been few and far between. Why dwell on negatives? Learn from the experience and move on.

####Q: What is your New Year’s resolution for 2014?

**A:** A large proportion of my time in 2013 was dedicated to strategic work streams that benefited the wider UK membership. 2014 should see a redress in my work balance, with more time for Northern Irish and Scottish members and their issues. I want to engage with members in their locality on a greater basis and I would encourage members from the two countries to get in touch with me to re-establish that link.

####Q: What are your priorities for 2014?

**A:** Holding country-specific CPHVA conferences in Northern Ireland and Scotland is something I want to get back into the CPHVA calendar. However, my main priority has to be member engagement, and I would encourage members from both countries to contact me (gavin.fergie@unitetheunion.org) and offer an invitation to their next meeting. Colleagues may read within the pages of Community Practitioner about initiatives that are being offered to our colleagues in England and most of these will not work outside England in their present form. I am working on how to scale these to reflect the reality of numbers, governance and logistics in Scotland and Northern Ireland. Member feedback and communication are important if I am to be successful in doing so.

####Q: What are the biggest challenges for Scottish and Northern Irish members in 2014?

**A:** The continuing challenges are supporting members working in ever-tougher conditions as public service financial constraints impact upon their practice and their clients’ daily lives; as well as the challenges that exist as a result of legislation moving through Stormont and Holyrood, and how this will impact on practice and practitioners.
PROFILE: CPHVA PROFESSIONAL TEAM

NAME: Ros Godson

ROLE: Lead on Public Health

Q: What has been your highlight of 2013?
A: The CPHVA Awards ceremony was a highlight for me. It demonstrated that our members are able to carry out tremendous work every day that makes a difference to all the children, young people and families they work with, despite the cuts. It is lovely to be able to give some of these practitioners due recognition.

Q: What has been your low point of 2013?
A: The passing of the Health and Social Care Act in England and seeing its effects. It is so awful seeing the NHS fragmented into hundreds of competing private organisations, with no overall structure or strategy. The goal of improved public health across the population as described by Professor Marmot is now further away than ever.

Q: What is your New Year’s resolution for 2014?
A: I will visit as many school nurses and community nursery nurses (CNNs) as I can, in their clinics and meetings, to make sure that they are up to date with current public health issues in a fast-moving political and social agenda.

Q: What are your priorities for 2014?
A: The priority for school nursing in England is to continue with the 121 Campaign to activate school nurses to work with their local authority and relevant managers, so that the service is appropriately commissioned and resourced. I will liaise with my colleagues to support school nurses in Scotland, Wales and Northern Ireland. The priority for the CNN workforce involves ensuring that the practice documents that were re-launched at the CPHVA Annual Professional Conference in 2013 are being used to promote the CNN role appropriately across the UK and that the value of the workforce is understood.

Q: What are the biggest challenges for school nurses and community nursery nurses in 2014?
A: The biggest challenge facing school nurses is the fact that commissioners and managers would like them to deliver on a lot of public health outcomes, but there aren’t enough school nurses to do this in any of the UK countries. Particularly challenging will be the roll-out of the flu immunisations to school populations across the UK for school nurses. For CNNs, it is so important for their qualifications and experience to be recognised within a fragmented health system in England.

NAME: Ethel Rodrigues

ROLE: Lead on Education

Q: What has been your highlight of 2013?
A: Having to organise the Unite CPHVA London one-day update conference from scratch in June, which I was very proud of and was very successful. I am very privileged to work within the professional team during these very challenging times in the health service.

Q: What has been your low point of 2013?
A: I cannot recall a low point in 2013 but there are lots of continuing challenges facing everyone in this austerity climate. Cuts and money-saving initiatives are affecting service provision and how care is being delivered by practitioners, as well as how we respond.

Q: What is your New Year’s resolution for 2014?
A: My New Year’s resolution is to never give up. As the saying goes: ‘When the going gets tough, the tough get going’!

Q: What are your priorities for 2014?
A: Building on existing relationships and establishing new ones with the relevant learning and educational organisations and institutions, as well as engaging, involving and supporting our members are some of my top priorities for this year. Identifying our members’ learning and educational needs, and developing learning and educational resources that are member- and user-friendly, and fit for purpose are also goals I would like to achieve in 2014. Additionally, I will lead on the establishment of the Unite in Health Academy to foster growth and expansion of learning and training resources for members; and co-ordinate the various regional one-day update conferences, which are planned for 2014.

Q: What are the biggest challenges facing education in 2014?
A: The ongoing re-organisation and restructuring of the NHS, fuelled by increasing cuts and savings, together with the outsourcing of some services to the private sector, has huge implications, not only for education but also service provision, employment and employment sustainability. Education needs quality investment and commitment. Practitioners need time to learn and reflect, practise safely, feel well supported, be confident and competent in delivering high-quality care, and advance further in their careers.
The CPHVA Awards will take place in the stunning setting of OXO2, overlooking the River Thames in London on Friday 28th March 2014, at a lunchtime ceremony that is the annual opportunity to recognise the achievements of the profession at your own national awards.

The lunchtime ceremony will begin with a reception where those shortlisted for each award will be invited to attend and have the opportunity to meet and share their practice informally with their peers, our supporters and invited guests. The awards presentation will form the finale of the afternoon.

Now, the moment has come for you to nominate or be nominated for the awards – your awards – to celebrate you, your colleagues, your teams, and the positive work you accomplish.

How to get involved
Study the categories and list anyone you believe should be nominated for their outstanding professional contribution.

Prepare your nomination(s)
You can complete the online entry form on the Community Practitioner journal website (www.communitypractitioner.com/awards) and send us information about your nominated person or team.

- You need to make sure your nominations are submitted online no later than 15 January 2014.
- Your entries will be assessed by a CPHVA judging panel throughout February 2014.
- The judging panel will release a shortlist of finalists with no more than three finalists in each category.
- All those shortlisted will be invited to attend the awards ceremony, when the winners will be announced.
- Profiles of the finalists and winners will be published in Community Practitioner journal.

Nomination criteria
You will need to visit the Community Practitioner journal website to enter your nomination(s) online.

You may nominate any colleague or team demonstrating exceptional work performance. Self-nominations are permitted, but you must provide a supporting endorsement from a senior officer, senior employer’s representative, or college lecturer.

You need to briefly describe the nominee’s activities, achievements, or contributions that you believe qualify them for an Award. Please limit this description to 500 words.

These guidelines are intended to help focus your thinking when completing the nomination form. They are not all-inclusive nor are they intended as categories.

Nominations should describe the qualities nominees have displayed in their chosen area of professional practice.

The deadline for nominations has now been extended to 15 January 2014. Visit www.communitypractitioner.com/awards to nominate a colleague or team you think deserves recognition.
They could demonstrate:
- outstanding care within their practice setting
- an ability to be an advocate and professional role model
- an ability to instigate, develop, co-ordinate and/or participate in projects and programmes that have a positive outcome for the health and wellbeing of the community
- active participation in professional and/or community organisations that foster and advance the health and wellbeing of the community
- a willingness to share their personal philosophy of community and public health nursing practice
- a vision for community practice
- a commitment to safety and quality
- a personal commitment to continuing education for themselves and/or others.

2014 Award Categories
- Community Practitioner of the Year
- School Nurse of the Year
- Community Nursery Nurse of the Year
- Community Practitioner/Health Visiting Team Leader of the Year
- Health Visitor of the Year
- Community Practitioner Team of the Year
- Student of the Year
- Healthcare Support Worker of the Year
- CPHVA Advocate of the Year
- Educator of the Year
- McQueen Travel Bursary for Public Health

To enter the awards or nominate any colleagues and/or a team please visit: www.communitypractitioner.com/awards
If you have any questions, call 020 7878 2404

For sponsorship enquiries please contact Claire Barber: claire.barber@tenalps.com
020 7878 2319
I hope some of you managed to attend the Public Health England (PHE) regional school nurse events (there are now only four strategic health authorities in England: North, Midlands, South and London). I was at two of the meetings and, although the speakers were excellent and the workshops constructive, there was still a feeling from some delegates that there was no joining up of rhetoric and reality.

At both events, school nurses voiced their concern that they wanted to do further public health work, but that they simply didn’t have the time or the resources, particularly given the amount of safeguarding work they are expected to carry out. This is known and understood by PHE, and they have presented the Treasury with the need for more funding, particularly because of the plans to roll out the flu immunisations to all children up to 16 years from next September.

However, even if further funding is released, there is no existing mechanism whereby the (English) government can direct local authorities to commission increased numbers of school nurses, as they are not a statutory requirement. That decision will be made by each local authority through the Health and Wellbeing Board, according to the evidence presented in the Joint Strategic Needs Assessment.

Developing partnerships

Consequently, I urge you to redouble your efforts this year and pick up and run with the 121 Campaign, which is designed to influence your local commissioners. If you can spare half an hour, look back over the last six months of Community Practitioner issues or the 121 webpage (www.unitetheunion.org/cphva) to see where you could influence locally.

To reiterate, you (or your manager) need to have a robust partnership with:

- The elected member of your local council who has the lead for children
- The lead for children’s services within the local authority (usually director)
- The Director of Public Health (this post may be shared across more than one local authority)
- The lead GP for children from each Clinical Commissioning Group (CCG) that relates to your local authority.

In addition, you need to have a partnership relationship with:

- The chair of governors in each of your schools and/or the governor with the lead for safeguarding
- The headteacher of each of your schools
- The lead for children in the local GP practice (nearest the school).

Where you have corporate working arrangements you will need to divide up the task between you, but you do need to get out there and explain how school nurses can improve health outcomes for young people. More than this, you need to explain how this can be measured. The easiest way for us to find out whether or not what we do makes a difference is to ask children and young people themselves – so do consider using questionnaires and online tools to collect user views. It is an advantage that school nurses deal face to face with clients; many professionals and organisations are reliant on second-hand information.

In Scotland, Wales and Northern Ireland the system has not changed recently, but there is less money within the NHS so, undoubtedly, there will be pressure to reduce services. It is important to influence decision makers that money needs to be spent ‘upstream’ on children’s services to prevent problems later.

The PHE regional seminars were attended by a mixture of school nurses, public health leads and local authority commissioners, so the ideas from discussions were wide ranging. I mentioned above that you need to make yourselves known to the lead child health GP for the local CCGs, and particularly ask them how school nurses can engage better with their priorities, and offer a more joined-up service for young people.

It may well be that your GPs haven’t realised the extent of the role of the school nurse, so when you are showcasing your work, don’t forget to invite them. We heard from one part of the country where trainee GPs are
routinely told about school nursing. Could you volunteer to do that? You would need to approach your manager and the university.

By the time you read this, the Children’s Public Health Outcomes Framework should have been published, so your commissioners will want to align what they are doing with this. We will examine this in detail in a future issue of CP.

It was pointed out at one of the PHE events that local authorities are more likely to commission school nurses if they can be persuaded that doing so will save them money, rather than saving the NHS money. The general advice given was to find out what is important to local decision makers that you have a passion about, also and follow that through.

School nursing is a preventive social health model, but some nurses have raised concerns that they are being pushed towards a medical model. You need to be clear that only an holistic universal service will deliver improved health outcomes, and individual task work will not. For example, public health is to prevent young people from becoming overweight, not to deal with the problem once it has occurred.

Evidence-based practice
There are 13 pieces of National Institute for Health and Care Excellence (NICE) guidance that relate to schools, but judging from responses in the room very few areas are using this guidance. This is a pity, because we describe ourselves as ‘evidence-based practitioners’, so again we will put some information on this in this journal over the next few months.

I realise you have to work according to your employers directions, but I am a little perturbed by some non-evidence-based practice that is still going on in several areas: namely, audiology tests. All children born in Britain entering school now will have been eligible for newborn hearing screening, so there is no requirement for routine testing. Where there are concerns about a child’s hearing, they need to be seen by someone who can carry out the test in a sound-proofed room and can diagnose the problem. If school nurses can do this, they are the appropriate person, but if not, you will need to refer. I hope local protocols are reflecting this.

Online resource
There is a new website for you to read, and I’m afraid you need to set aside a bit of time to look (www.chimat.org.uk/schoolhealth). The site is currently being populated and will eventually be added to the gov.org website. Let me know what you think.

Catch-up sessions
I’ve been delighted to meet with school nurses throughout the country recently, so do continue inviting me to your meetings (rosalind.godson@unitetheunion.org). I’ve also managed to do a few ‘Lunch & Learn’ and ‘Cake & Catch up’ sessions with smaller groups of nurses on particular topics, so will be rolling these out through 2014.

Happy New Year.

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**CPHVA Education and Development Trust MacQueen Travel Bursary for Public Health**

Applications are open for a one-off sum of up to £1000 to cover travel connected with undertaking a public health project abroad. The award will allow the winner to:

- Share expertise gained with others
- Learn from other countries
- Promote partnerships between people from different cultures
- Broaden knowledge and understanding of other cultures
- Broaden knowledge of the working practices of others
- Personally develop as a result of the experience

The year’s award will be presented at the annual CPHVA awards to be held in London 28th March 2014.

Closing date 17.01.14

Please contact Deborah Rountree (email:deborahrountree@live.co.uk) for an application form.
Health ministry through local faith communities: a European perspective

Helen Wordsworth RN RM RHV RNT MTh DMin
Chief Executive Officer, Parish Nursing Ministries
UK

Correspondence: helen.w@parishnursing.org.uk

Abstract
Before the introduction of the NHS, faith communities were involved in health promotion and public health. Deaconesses often had nursing training as well as their theological study and visited homes where there were health needs. Over the last 10 years this role has re-emerged in the UK and now in 80 churches of various denominations parish nurses help to promote health generally, often engaging with hard-to-reach groups. With the help of the 2012 MacQueen Travel Award, Revd Dr Helen Wordsworth visited nurses in four different European countries to understand how other faith communities are involved in health promotion and spiritual care. This article describes the practice of parish nursing in the UK and reports on how similar ministry happens through churches in Finland, Ukraine, Georgia and Germany. The common presenting issues are: the ways in which the availability of the parish nurse is made known; its impact on ecumenical relationships; the potential for effective deployment of volunteers; and the need for resources to support these activities. The implications for the UK are that more promotion for resources to support these activities. The place of faith in contemporary health care has been a controversial issue, although throughout history faith groups have had a major role in the founding of hospitals and engagement with public health.

Over the last 30 years, led by the late Dr Granger Westberg of Chicago, faith communities have begun to reconnect with health through appointing registered nurses with community experience to lead various health and wellbeing initiatives. The practice has spread to 25 countries, including Canada, Australia, and New Zealand.

In the UK, parish nursing has been developing slowly over the last 10 years in a variety of churches. Most appointments are voluntary, for one or two days a week, but some are paid part-time posts. This article describes that practice and then reports on similar initiatives encountered in four different European countries.

The following definition of parish nursing was proposed and accepted by 600 parish nurses at an international symposium in Chicago in October 2000:

‘Parish nursing is the intentional integration of the practice of faith with the practice of nursing so that people can achieve wholeness in, with, and through the community of faith in which parish nurses serve.’ (Patterson, 2008: 34)

Solari-Tweedell and McDermott (1999) describe parish nursing as having seven functions:

- Personal health counsellor
- Health educator
- Trainer of volunteers
- Developer of support groups
- Integrator of faith and health
- Referral agent
- Health advocate.

As the practice has evolved it has become clear that the role is more complex, and following her latest research this new definition has recently been offered:

“The practice of parish nursing includes care that supports: physical and psychological functioning, protection against harm, the family as a unit, effective use of the health care system, the health of the congregation and community as well as facilitating lifestyle change with particular emphasis on coping assistance and spiritual care. All this is dependent on the parish nurse being able to effectively mobilise volunteers in the congregation to support this model of health ministry.’ (Solari-Tweedell, 2013)

Parish nursing is so termed because the care is offered to anyone, living in the community around the church, of whatever faith or belief. It is founded on Judaeo-Christian principles. In some countries it is called ‘faith community nursing’ (Patterson and Slutz, 2011).

UK parish nurses do not carry out invasive treatments or prescribe medications, but through the activities outlined above they seek to improve health in their local communities. Hard-to-reach groups, such as asylum seekers or the homeless, have been encountered and signposted to appropriate NHS or third-sector care, often accompanied by effective monitoring as the parish nurse maintains an ongoing relationship with the client group.

People attending toddler groups and lunch clubs in faith buildings have benefited from health education activities, often involving visiting speakers such as health visitors and nutritionists. People at risk of falls, or who have just been sent home from hospital, have been followed up either as part of their regular faith-related activities, or as clients of a home-from-hospital or visiting scheme, potentially resulting in considerable savings to the NHS. Volunteers have been recruited, co-ordinated and trained to offer neighbourly care under the supervision of the parish nurse. Service users have become service deliverers and found a sense of identity.
Salvation Army congregations.

encouragement towards pilot projects and seven the churches. A visit to the Department of attended by representatives from nursing and group and organised three regional seminars, to which this specialty might be relevant to an masters-level dissertation examining the extent that, and a study trip to the USA, I completed a of parish nursing was introduced. Following in Birmingham, England, at which the concept Historical development in the UK In June 2001 a parish nursing conference was held in Birmingham, England, at which the concept of parish nursing was introduced. Following that, and a study trip to the USA, I completed a masters-level dissertation examining the extent to which this specialty might be relevant to an English context. I then re-activated the planning group and organised three regional seminars, attended by representatives from nursing and the churches. A visit to the Department of Health (DH) in London in 2003 resulted in encouragement towards pilot projects and seven volunteers emerged from Baptist, Anglican and Salvation Army congregations.

and new purpose. Businessmen and women have been invited to breakfast events with talks by GPs on various health issues, raising awareness of the need to check for early signs of cancer, or have regular blood pressure checks. The most common intervention has been active listening beyond that which could be given at a surgery or hospital appointment.

All clients are made aware that the nurse is working for the faith community and that, if they wish, they may receive spiritual support or prayer as part of their care. Approximately half take up this offer, whether or not they are church attenders (Wordsworth, 2011). There is no requirement to change faith or join a particular group to access a parish nurse; the care is offered to people of all faiths or none, within the time available, and clients can be referred to someone from their own faith community if they so request. A five-day introductory course, study days and professional support are offered to registered nurses with community experience who are appointed and line-managed by the church.

The introductory curriculum offered by the International Parish Nurse Resource Centre was adapted for a UK context. The practice has slowly but steadily developed under the auspices of a registered charity, Parish Nursing Ministries UK. There are now 90 practising parish nurses in Scotland, Wales and England in most denominations. Many work volunteer hours for the church in addition to paid employment in the NHS, but at least 20% also have paid employment with the church. They are encouraged to build good relationships with local health services so that the work they do does not compete with, but rather adds value to what may be offered through the NHS.

The 2012 MacQueen Travel Scholarship, awarded by the Unite/CPHVA Education and Development Trust, enabled an exploration of the way in which faith communities are engaging with public health in four further European countries (see Table 1). The purpose was to see whether there were ways in which learning could be mutually shared and a European network for parish nursing established.

Faith communities and public health in Europe

Finland

The first visit was to Finland: the ‘best place in the world to be a mother’ (Save The Children, 2013). It also happens to be the one country where parish nursing has existed as ‘diakonie’ nursing since 1867. Many Finns belong to the Lutheran church and pay the optional church tax of 1.25% of earnings. Around 80% of all young people receive confirmation, but only 10% of the population are active members.

In Helsinki I met with a Lutheran representative who explained that within the ‘diakonie’ there are two orders: nursing and social work.

In Helsinki around 40% of the diakonie are nurses; but in Oulu, a city to which I travelled, the ratio is greater and 65% are nurses. As Northern Finland is so sparsely populated some of these nurses can travel 60 miles in one day and the co-ordinators can travel up to 600 miles. Diaconia University of Applied Sciences (Diak) in Oulu trains nurses over three years with an optional extra year of theological preparation if they wish to join the diakonie. Educational exchanges with this university are available through the Erasmus scheme.

The state-run health centre in Oulu serves around 16,000 people. It has doctors, a laboratory, two diabetic nurses and public health nurses. Although it offers a more secular approach, relationships with the diakonie are usually good and annual meetings are arranged. If the client requests, the diakonie may accompany them to case conferences.

Hospitals in Finland are also state-owned and during one visit there the chaplain did a short service in the dining room of each ward to which patients were invited. The Finnish nurses were shocked to discover that this would not now be common practice in the UK.

The nine diakonie, based in the churches, take referrals from the state-funded public health nurses and hospital chaplains, and refer clients to them. Each diakonie nurse has a specialty: for older people, for sight-impaired or hearing impaired people, for mental health, for prisoners, for drug and alcohol addiction, for families for students and internationals, and there is one volunteer coordinator and one team leader. Sixty volunteers work with the nine diaconal nurses in the parish of Oulu. They are trained, supervised, and matched to the needs and ages of the clients.

Table 1. Parish nurses in Europe

<table>
<thead>
<tr>
<th>Country</th>
<th>Number of active parish nurses (as at Nov 2013)</th>
<th>Denomination</th>
<th>Type of care most commonly offered by nurses and volunteers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finland</td>
<td>700</td>
<td>Lutheran</td>
<td>Health advocacy and promotion, spiritual care</td>
</tr>
<tr>
<td>Ukraine</td>
<td>15</td>
<td>Orthodox, Catholic and Free Church</td>
<td>Health promotion, hands on care, spiritual care</td>
</tr>
<tr>
<td>Georgia</td>
<td>16</td>
<td>Baptist</td>
<td>Hands on care, spiritual care</td>
</tr>
<tr>
<td>Germany</td>
<td>15</td>
<td>Lutheran, Baptist</td>
<td>Health advocacy, home visiting, spiritual care</td>
</tr>
<tr>
<td>UK</td>
<td>90</td>
<td>Anglican, Baptist, Catholic, Church of Scotland, Church in Wales, Independent, Methodist, New Churches, Pentecostal, Salvation Army</td>
<td>Health promotion, health advocacy, home visiting, spiritual care</td>
</tr>
</tbody>
</table>

Ukraine

Although there is health care available in Ukraine, it is by no means universally accessible and many of the sick people in this community are nursed at home, either by members of their family or by friends.

Kiev stood in stark contrast to Finland. The city had not encountered faith community nursing until 2012, when an American nurse introduced the concept with the Orthodox church in a poor suburb of concrete apartment blocks, surrounded by potholes and mud roads. She worked from a modest church building and conference venue, which bore no similarity to the very ornate buildings in the city centre.

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In the teaching room 30 nurses, nuns and priests were listening to an Orthodox priest speaking in Russian on the spiritual journey that people may make. This was followed by a lecture from a doctor at the university hospital about how the church can seek to meet the health needs of the people who live around them. ‘This kind of work will not be easy,’ he said. ‘It requires sacrifice of time and energy, but we have the example of Jesus. God calls us to follow Him and we will support one another.’

The next morning there were sessions on the history and philosophy of parish nursing. The ecumenically-mixed audience had travelled many miles. For some it was their first encounter with people from another denomination. There were Russian Orthodox, Catholics, Ukrainian Orthodox and Free Church nurses debating the practical application of the principles in a Ukrainian context, and linking with parish nurses in other countries through Skype. Later, the steering group directors discussed charity structure and function, training courses, finance, and quality standards. Almost all of the nurse attendees volunteered for further training. Several months later, 10 new parish nurses were given certificates and commissioned to work with their various churches.

Georgia

The old city of Tbilisi is punctuated by newly built parkways and elegant buildings among contrasting concrete apartment blocks, a reminder of the back streets of Kiev. It was a tense election time, among large but seemingly peaceful demonstrations. The work of the Baptist mission is based in a complex on the other side of town, a spacious but not elaborate building with views across the valley, home to around 40 senior citizens and displaced people, administrative offices and a teaching room.

It was very different to the massive new Orthodox cathedral, which was alive with people kissing icons, lighting candles, making confessions and having their weddings blessed. Around 93% of the population are Orthodox Christian, so Baptists, atheists, Moslems and Pentecostals are in the minority.

The order of St Nino was formed about 17 years ago by the Georgian Baptist church to reach out to the poor and needy. They have about 400 clients across the country, most of whom do not attend church but have been referred by people who knew of them. Medication and hospital treatment in Georgia is very expensive and so for the poor, basic nursing care is needed.

The first visit was to a basement room, where a deeply depressed young man of 21 was caring for his bedridden aunt and blind grandfather. He had started to train as an engineer but could not afford his fees so had to stop. Proper medical care could have prevented the aunt from being bedridden. The old man seemed quite fit and hearty apart from his sight limitation.

The role of the St Nino volunteer was to visit twice a week to befriend and help them. She did the same for a family in a nearby flat with an elderly dying mother whose son was recovering from a prostate operation, in one tiny room surrounded by all their belongings. The mother had been offered a place at the Baptist centre but the neighbours had said they would do the caring in return for the ownership of the flat. This is a common way of treating vulnerable people and the volunteer has to ensure that care really does happen; the neighbours appeared very quickly when they realised she was visiting.

The evening was spent discussing how pastoral education might be improved. It was proposed to commence a library which would include medical and health-related textbooks for the order of St Nino.

The Baptist ’cathedral’ is very different from a Baptist church in the UK. The bishops wear robes and the service is liturgical. Bishop Rosyda is a mother of pre-teenage children with a theological degree and gifts in linguistics, youth work and pastoral care. About 150 people attend, of all ages. At the end of the service many come forward for a blessing with oil, and afterwards they file out with a truly Biblical kiss for each person.

A total of 25 staff and volunteers from the church attended a lecture and discussion about Parish nursing. Four were sisters – equivalent to parish nurses – and one was a medical doctor. They go to the government and ask to be referred to the poorest of the poor. Each sister has five volunteers whom she trains and supervises. These volunteers speak with deep commitment about their work. They have between three and seven patients each, most of whom need end-of-life care.

One problem they often encounter is mistrust; people want to know why they are doing this for free. But where their offer of care is accepted, they begin to visit. There are monthly training days for the sisters but most of the resource material they use is medical. It does not include spiritual, theological, professional or community health topics. They would like a link with parish nursing internationally, in order to access resources. Clearly, however, they would need to contextualise the material.

Germany

Germany is often quoted as the historical inspiration for Parish nursing. Florence Nightingale, a theologian and statistician as well as a public health nurse, was deeply influenced by the work of Pastor Fliedner in Kaiserswerth (Macdonald, 2001).

German citizens have to pay health insurance (15% of income plus 15% from their employer). They choose from 60 different insurance funds, which pay for Lutheran or Catholic hospitals with corresponding theological foundations. Patients can go to any one of these, or a state hospital, regardless of faith connection. Those without insurance or a European card have to pay. In addition there is new form of insurance for home care, costing 2-3% of income. Assessment is made by the insurance company and any professional help needed is provided by home care agencies. More than half of these have Christian foundations but have to compete. They can only provide care to the extent that it is paid for either by the insurance company, a charity, or private means. There is little extra time allowed for listening or attention to spiritual needs.

There is no equivalent to the UK health visiting service, and no continuing state registration, just a final examination. Some nurses have extra training as diaconal nurses, usually in a ‘motherhouse’ (like a convent) close to the hospital. They form a spiritual community but their practice is usually confined to their state-funded place of work.

The main churches are Lutheran and Catholic. Around 70% of population are members of one of these but only 5% attend church. There is a small church tax, only paid by those who are members of the church. That results in the expectation that everything offered by the church should be free of charge.

A German nurse had come to a Parish nursing introductory course in England and established a ministry in Southern Germany entitled ‘Vis a vis’ (face to face). She has developed a team of volunteers, a prayer ministry and, at the entrance to the church buildings, a shop called ‘Treff Punkt Hoffnung’ (meeting place of hope).

It is a well stocked room where people can buy health related books, cards, gifts, and pick up leaflets on various health conditions. This showcases the work of a parish nurse to the
congregation and community. There is space for conversations and prayer and GPs refer their patients for ongoing support.

Fifteen Lutheran nurses practice around Speyer and one Baptist nurse works in Hagen. Researchers, medical consultants, and chaplains take part in the day-release training, the costs being currently borne by the Lutheran church. I contributed several sessions over two days.

Conclusion

In each of these countries faith communities have a role to play in supporting the public health services. In the Ukraine and Georgia this is more often hands-on care. But in all four countries there is space for church involvement, using the medical and disease process knowledge of the nurse to bring reassurance, to monitor, to refer, to pray, to educate, to co-ordinate volunteers, to identify appropriate resources, and to offer advice. All of the nurses are prepared to offer care to anyone, regardless of denomination or faith, and although spiritual care is integral to the practice, I did not witness any attempt to proselytise.

The issues common to all are:

- Increasing public awareness of the role
- Recruitment and training of volunteers
- Building ecumenical relationships
- A need for increased funding.

I will take some of the ideas I encountered back to UK parish nurses. From Speyer the concept of a resource shop in the church building as a showcase for health ministry; from Tbilisi the addition of health-related books and journals to theological libraries and the effective deployment of volunteers; from Kiev the power of parish nursing to bring together women and men from different denominations that have never talked to each other; and from Finland the possibility that one day every church will have someone on their ministry team whose task it is to enable the church to reach out to its community in unconditional service and health ministry.

The benefit has been mutual and the development of continuing relationships will enable a strengthening of health and wellbeing programmes from faith communities in our five countries. It will hopefully also mark the start of a European network for Parish nursing, linked to the International Parish Nurse Resource Centre.

References


Voices from the heart: the use of digital storytelling in education

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Abstract
Digital storytelling has emerged as a powerful teaching and learning tool, which presents personal narratives, images and music to create a unique and sometimes emotional snapshot into another person’s experience. By offering a platform for sharing and understanding such narratives, professionals may gain insight into a perceived experience and construct their role accordingly. Used effectively, they can engage the listener and offer opportunity to reflect and consider the impact of their professional role on the storyteller. This article looks at how digital storytelling can enhance professional practice and enable vulnerable voices to be heard.

Key words
Voices, education, user involvement, empowerment

Introduction
People who tell stories have a need to share their thoughts, feelings and information with others, and to create meaning about an event. Individuals may tell their stories to come to terms with or understand their experience, legitimise their behaviour or share with others the emotional experience. The use of these stories gives the teller a voice, empowering and enabling vulnerable individuals, and offering the professional an ideal vehicle with which to really listen to and engage with their clients.

Digital storytelling is the practice of people using digital tools to share their stories. These stories are often powerful, use emotionally engaging images and can cover a wide range of digital formats. This can include web-based stories, interactive stories and computer games and films, which may be used for education, promotion, advertising and charitable enterprises. With the advent of new technologies and accessible equipment, such as mobile phones and digital cameras, individuals can now make and share their experiences across the internet to a global audience. These digital stories may include photographs, animation, video, sound, music and the storyteller’s own voice to convey an intimate insight into a lived personal experience.

Legislation and professional practice
The Equality Act (Department of Health (DH), 2010) and the Health and Social Care Act (DH, 2012a) have been instrumental in the government’s legislation to drive forward patients’ inclusion in their care. No Decision About Me Without Me (DH, 2012b: 4), the ‘Big Society’ and the government’s declared desire to promote research, recruiting and involving patients in their care to give them a ‘voice’, puts them at the very heart of the NHS and decisions about planning care.

The government’s aim is to increase democratic accountability and public voice, and embedding research is seen as a core function of the health service. The Health Visitor Implementation Plan (2011) feeds into this drive for public health improvement and the specialist community public health nursing course (SCPHN) has trained health visitors and school nurses as ambassadors to build on social capital, resilience and family wellbeing.

Digital storytelling in education
Digital storytelling can be a valuable tool for education in health as a means of enhancing understanding to help practitioners reflect on their communication skills and positively improve their practice. Figure 1 illustrates how digital storytelling can be used in education in health.

Individuals may wish to attribute responsibility, praise or blame following an experience; for example, women’s birth experiences can provide insight for students and midwives to explore their role and to give the women a ‘voice’ with which to influence policy makers, thereby improving maternity services (Merrc and Brannigan, 2012). Digital storytelling has been a vital and successful part of the current SCPHN course (Holloway and Freshwater, 2007).

As a teaching aid, the narrative of an individual’s story is a useful form of feedback in being able to let ‘people know the score’ (Rock, 2006), offering an opportunity to improve their professional nurturing skills by practising discourses. Robin (2008) lists the seven elements of digital storytelling (see Box 1) as a potent way to expose students to the human experience. These elements aim to encourage the development of sensitive, individualised and compassionate practice, enabling professionals to engage in reflective and meaningful learning, keeping the storyteller (client) at the centre of care.

However, Judge et al (2004) warn that their use in the classroom may be dependent on the teacher’s own technological expertise. In education, the term ‘technological
pedagogical content knowledge’ (TPCK) focuses on the relationship between knowledge about content, pedagogy and technology. Good teaching with technology requires an understanding of the concepts of constructively using multi-media to the best advantage for the subject.

An example of digital storytelling used in healthcare education can be found on the website ‘Patient Voices’ (www.patientvoices.org.uk), which was funded by the NHS Clinical Governance Support Team, with ongoing research into making healthcare education and delivery more ‘patient-shaped’.

**Communication**

While working as a medical volunteer with the international charity Operation Smile (www.operationsmile.org.uk) in Mexico in November 2011, I was involved in assessing and caring for Mexican children with cleft lip and palate. My experience of working in a multinational team of volunteers was challenging on many levels. Communication was key, so written and verbal information given to the patients was in their language. The mission was televised and the patients’ stories were used for educational and fundraising purposes.

On reflection, the experience of being part of their stories was hugely influential and caused me to question my priorities and personal values. Similarly, the Patient Voices programme (Hardy and Sumner, 2001) aims to facilitate the telling and hearing of some of the unwritten and unspoken stories of ordinary people, informing professionals to provide their care in a more informed and compassionate manner.

Holloway and Freshwater (2007) state that human beings ‘narrate past events and experience throughout their lives for a diversity of reasons’ (p. 703) including information giving, ‘sharing thoughts and feelings, justifying their actions or beliefs or by way of giving meaning to their experience’ (p. 703). How do professionals ensure they hear their clients’ voices in order to gain a greater understanding of individual needs and include clients in their assessments? Digital storytelling provides a lens through which we can look at personal life experiences, and how the stories we tell to, and about ourselves construct and define us. We reflect on our own stories and those of our clients, and how we relate accordingly.

**User involvement**

Chase (2005) suggests that during the 1960s and 1970s, the liberation and political movements (feminism and women’s rights, gay pride, trade unions) influenced the importance and re-emergence of personal narrative. Today’s social media culture, with instant access to people’s lives, their stories and experiences, and their willingness to share these narratives, gives healthcare providers a rich and powerful insight into exploring their world and a privileged opportunity to reflect on our practice for the good of each individual. However, there is a known risk that personal and potentially delicate information may not be censored, nor treated with the respect for confidentiality it warrants (NHS England, 2013). The danger is that unscrupulous individuals can use the internet as a scam for deceiving the vulnerable.

With the current political climate of promoting empowerment, the patient-as-consumer influence and expectations of healthcare, it would appear that the narrative approach to encourage an individual’s story allows the person at the heart of the issue to make a distinctive contribution to future development of services. Nettleton (2009) describes patients as ‘prosumers’ who both ‘produce and consume knowledge’; while Bury (2001) acknowledges the power and value of their ‘lay knowledge’, realising the potential for the ‘patient experience to inform better healthcare’.

However, these stories should not be limited to confessional, ‘self-indulgent’ accounts (Bleakley, 2000) but serve to enhance the listener’s experience through insight into living with their experience, emotionally, practically and spiritually. Bleakley (2005: 538) writes of the challenge of analysis of these narratives and states the reader should have ‘high levels of ethical and critical engagement and the cultivation of narrative sensibility’.

To achieve greater participation, patients are now involved in user involvement strategies.

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**Box 1. The seven elements of digital storytelling**

- **Point of view:** What is the main point of the story and what is the perspective of the author?
- **A dramatic question:** A key question that keeps the viewer’s attention and will be answered by the end of the story.
- **Emotional content:** Serious issues that come alive in a personal and powerful way, and connects the story to the audience.
- **The gift of your voice:** A way to personalise the story to help the audience understand the content.
- **The power of the soundtrack:** Music or other sounds that support and embellish the storyline.
- **Economy:** Using just enough content to tell the story without overloading the viewer.
- **Pacing:** The rhythm of the story, and how slowly or quickly it progresses.

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**Figure 1. The convergence of digital storytelling in education**
For example, the Patient Experience Framework (National Institute for Health and Care Excellence (NICE), 2011), patient forums, survivor groups, the INVOLVE project (2004, 2013) and access to local and global information via the internet mean that technology is now widely available and used across most socio-economic, cultural and environmental groups in society. Coulter (2012) wrote that when clients are asked for feedback and to give their story, the most common complaint is that they have failed to receive clear written and verbal information.

Good involvement practice is inclusive and participatory, describing a wide range of ways of working to involve the public and to give them a ‘voice’, including web chat, e-panels, surveys, interviews and workshops. Schwartz (2010) states the importance of the professional ‘giving voice to vulnerable people’ (Schwartz, 2010) by enabling them to express their story and to facilitate it being heard. Examples of this might be the health visitor working with vulnerable families at risk, recording their stories and representing them in a professional context; for example, by contacting other agencies on their behalf, such as housing or their GP.

By moving from passive recipients to active participants, and being enabled by telling the stories of what health care, illness and recovery (survivorship) have meant to each individual, the public has become empowered. This individual empowerment feeds into the capacity-building ethos promoted by the government, both at an individual and a community level.

Actively listening to how people describe their own journey shows respect from the professional, following Rogers’ (1961: 116) humanist approach: ‘Unconditional, positive regard involves showing complete support and acceptance of the person’. This would indicate a shift in power to a more participatory continuum between patient (client) and professional (Hickey and Kipping, 1998). In practice, this is being encouraged and effectively used in health visiting: the action plans for targeted family care are co-constructed around the family’s needs, then discussed and agreed by both client and professional with accurate, contemporaneous documentation of paramount importance.

Conclusion
A personal story may be unexpected and distressing (Gregory, 2016: 634) and uncomfortable to hear. In practice, health professionals need to safeguard their own emotional health by seeking supervision and self-reflexivity: digital storytelling facilitates an insight into another’s lived experience (Denscombe, 2003) and we should not underestimate the effect this knowledge might have. Reissman (2008) wrote of the many layered expressions of human thought and imagination, and by embracing these with flexibility, empathy and a humanistic approach we endeavour to cultivate a respectful and democratic experience.

Frank (2000: 354) and Pennebaker (2000) write of the cathartic effects of storytelling, allowing narrators to ‘reaffirm, possibly to create and possibly to redirect the relationship within which the story is told’. Establishing relationships and trust to enable the narrator to express themselves in this way highlights issues of potential exploitation and therefore increased vulnerability, Professionals may also experience vulnerability within their role, and seek a mentor to support them and listen to their story. This a key part of our responsibility as professionals and colleagues; empowering and enabling our clients, working reflexively and collectively, and listening out for the hidden messages. It is our privilege to be part of another’s story, to listen to their voices and enable them to be heard.

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Key points
- Digital storytelling is an educational tool for sharing stories and enhancing practice
- Giving a voice to the vulnerable and enabling their story to be told
- Building on social capital, resilience and wellbeing through effective communication
- How health visitors and other professionals can be ambassadors for the government’s drive for user involvement through improved understanding of an individual’s needs, professional growth and reflexivity.
Can you reduce the risk of an infant developing eczema?

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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 epidemic**\(^1\)\(^2\)

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 family**\(^3\)

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.

"It 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.\(^5\) 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).\(^6\)\(^5\)

**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.\(^6\)

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

- Clinically proven to reduce the risk of eczema by over 50% in 'at risk' infants\(^6\)
- Use from first formula feed
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**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.

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6. EAACI Food Allergy and Anaphylaxis Guidelines 2013.
Specialist community public health nurses: readiness for practice

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Abstract
This article outlines the perceptions of specialist community public health nurses (SCPHN) (health visitors, school nurses and sexual health advisors) on their readiness for practice as a qualified health visitor, school nurse or sexual health advisor entering part 3 of the Nursing and Midwifery Council register. It discusses overall development of students who have completed the BSc(Hons)/Postgraduate Diploma SCPHN programme using the medium of art to depict students’ thoughts on readiness to practice as a SCPHN. A thematic approach was taken to identify that a transformative change had taken place for students as a result of completing a 52-week SCPHN programme. Discussion included return on investment for the NHS organisation and student, alongside the development of the SCPHN attributes. The article concludes that SCPHN students had subtly transformed their perception of their future role and there was a difference between SCPHN perceptions of the role at the beginning of the programme in comparison to that at the end of the programme.

Key words
Nurse education, public health, SCPHN


No conflict of interest declared

Introduction
This article will provide an insight into the perceptions of student specialist community public health nurses (SCPHN) of their impending public health role, indicating their readiness for practice. It considers student SCPHN who are in the final stage of their SCPHN programme, having completed 52 weeks of a blend of theory and practice in relation to their chosen discipline (health visiting, school nursing, sexual health advising).

The focus for discussion is a comparison between initial perceptions of the role and final perceptions of the role given that the students have reached the end of their programme. Key themes were taken from class-based student drawings, which depicted perceptions of their role, collected at the start and end of their programme of study. Consideration was given to the notion of return on investment in relation to new knowledge and new insights developed into the role as a result of completing the programme; and readiness for SCPHN practice having achieved the Nursing and Midwifery Council (NMC) public health proficiencies with a comparison to the Department of Health (DH) vision for health visiting (DH, 2011a).

Findings will be used to support subsequent deliveries of the SCPHN programme to maintain a high-quality and contemporary nature. The paper was written as a result of classroom-based teaching activity looking at the links between theory and practice and is not intended to be a research paper. What it does identify is the students’ theoretical and clinical journey, providing insight into this complex myriad of thoughts and ideas by drawing on student capacity to reflect, analyse and conceptualise the SCPHN role using drawings (MacPhail and Kinchin, 2004).

As previously alluded to by Coates and Gilroy (2012) and with 130 years of health visiting as a landmark (DH, 2012) SCPHNs are at the forefront of delivering a well established public health service. School nurses and sexual health advisors are also key to individual, community and family positive public health outcomes (Coates and Gilroy, 2012). Therefore, it is important to consider the impact of educational programmes on future development of SCPHN. One of the reasons for this is to maintain a suitably robust educational programme in line with NMC requirements and to develop a workforce that is equipped with the knowledge and skills to undertake the role. With collaborative partnerships with our local trust organisations already in place (DH, 2011b), activity such as this demonstrates return on educational investment for the programme team and the trusts involved.

Rationale
The rationale to explore students’ perceptions was to gain a better understanding of their views on their impending SCPHN role and consider the educational impact of the programme.

Establishing how exposure to the experience of public health practice and theory had potentially changed their perspectives was crucial in order to identify how personal schemas (Smith, 2005) may have altered and taken on new meanings. These meaning perspectives or transformative learning referred to by Mezirow (2000: 7–8) as ‘the process by which we transform our taken for granted frames of reference (meaning perspectives, habits of mind, mind sets) to make them more inclusive, discriminating, open, emotionally capable of change, and reflective so that they may generate beliefs and opinions that will prove more true or justified to guide action’ were exposed by the students as they visually represented their roles through drawings. This enabled both the student team and the trusts involved.

No conflict of interest declared
considered the notion of return on investment which is something that has been widely used in industry and commerce, only more recently emphasised in relation to nursing education.

Francis (2013) highlighted the need for programmes to equip practitioners with the necessary skills and knowledge to provide high quality care (Francis, 2013). With the above in mind, we as module tutors are required to demonstrate that our students have developed as a result of access to the programme and that the programme demonstrates value and worth to key stakeholders including, commissioners and providers. Evaluating the learning that has taken place for our students is a vital part of the programme and its ongoing development.

Process: gathering and interpreting student transformational journeys

To gather their views on completion of the programme, students worked in small groups to depict, using drawings, their view of the generic role of the qualified SCPHN (school nurses, health visitors and sexual health advisors). We were explicit about the rationale for the students in that we were aiming to compare their perceptions as they exited the programme in comparison with those gathered at the start.

On completion of the group work, students articulated their ideas, thoughts and feelings about what their new SCPHN role would hold using their drawings. This enabled us, in partnership with the students, to identify key themes and descriptors. These were then validated by the students and aligned to the three distinct areas that had been identified by the same students at the start of the programme.

The themes were: personal attributes, practical tools and role activities. Subsequently, as module tutors we carried out a further thematic analysis to compare and contrast themes and descriptors from the initial exploration of the SCPHN role at the start of the programme (2012) and this final evaluation of the SCPHN role at the end of the programme (2013). Although the discursive material and drawings gathered could be construed as subjective, it was validated for meaning by the students during the session. This strengthened the analysis and assisted accuracy of the information presented within this article.

Alongside this evaluative process for transformative practice the students also completed an in-house evaluation based on the national student survey. Overall, 100% of 43 students indicated student satisfaction with the SCPHN programme as a whole. In relation to personal development 90% of 43 students gave a positive response in that they felt the programme had helped them develop on a personal as well as academic level. This is important as it indicates that students had developed wider skills over and above those thought of as purely academic, such as the ability to search and critically analyse literature.

The descriptors from the drawings and discussions are show in Tables 1, 2 and 3. These depict both original (Coates and Gilroy, 2012) and new or developed perceptions of the role alongside each other. Where the original descriptor from 2012 was not repeated by the students, a blank space has been left. Where the descriptor was repeated, an arrow indicates this, and where it has been developed the new and additional descriptors have been added.

Discussion

As with the first review of the role descriptors, three key themes were identified relating to personal attributes depicting the qualities the students felt they would need to develop to fulfil the role (Table 1), practical tools associated with the role (Table 2) and role activities (Table 3), which described what they would be doing.

As with the initial explorations (2012) of personal attributes, qualities and skills that students identified as necessary for their future role, emphasis remained on the emotional and psychological nature of these. In 2012, students demonstrated some of the key elements believed to be required to be a successful SCPHN such as ‘caring, listening, open and a good communicator in all ways’, alongside the ‘ability to balance and juggle’ the role (Coates and Gilroy, 2012: 29).

In 2013 there was a subtle shift in some of these concepts, with new descriptors being introduced; for example, ‘empathetic’ and ‘non-judgemental’ had been added to the notion of ‘having a big heart’. This demonstrated that students were able to think more deeply about the personal attributes they had and what this meant for them in a more detailed and pervasive way.

It appears that SCPHN students had begun to understand the value of life-long learning, rather than being preoccupied with knowledge required to see them through the current programme of academic study. This demonstrated that they appreciated the value of life-long learning, linked to their developing SCPHN clinical practice and future SCPHN role. They envisioned themselves as politically aware, transformative and reflective SCPHN practitioners.

Leadership also featured more prominently than before and this was firmly associated with catalytic change. In relation to the personal attributes identified above (caring, listening, open, a good communicator in all ways, empathetic, non-judgemental, the ability to balance and juggle and having a big heart) these are key attributes of the SCPHN (NMC, 2004) and concepts that are explored in depth during the programme. It would be interesting to review these in greater depth to establish the reality of their application in practice.

In the students’ first expressions of their role in 2012, practical tools took a prominent position, with both drawings and articulation of those drawings focusing on what was needed to support the students perform their new role. In the second review (2013), practical tools did not feature as highly and were given less importance in both the drawings and subsequent discussions.

Benner (1984) built her model on the work of Dreyfus and Dreyfus (1986), and argued that expertise becomes ‘embodied’ so that an expert’s skill becomes part of them and any tools of the trade become extension of their expert practice. In relation to the SCPHN students this could signify the transition the students have made, with less reliance on practical tools, a foci of discussions in 2012 the students have more insight into the role and increasing confidence in their ability to use a body of practical knowledge and skills instead.

In relation to role activities (Table 3), students continued to demonstrate a good understanding of groups and individuals they would be working with, and appeared to have a greater understanding of the intricacies of the broad remit of their role. At the start of the programme we noted that the SCPHN students were not specific, preferring to identify broad areas of practice rather than give specific examples of the type of work they may be involved with in any great depth (Coates and Gilroy, 2012). For example, reviewing information gathered at the start of their programme in 2012, it was noted that SCPHN students did not appear to include or consider risk assessment, planning and strategic working as part of their future public health role.

Initially, it was felt that this could be due to these elements being difficult to depict using...
drawings. However, it is pleasing to see that these crucial elements of the role were now articulated and translated within the 2013 drawings and verified by ensuing discussions.

Students now captured the broad concepts of surveillance, safeguarding, partnership working, and multidisciplinary working, which all feature in the Health Visitor Implementation Plan (DH 2011a). It was interesting to note that drawings by the school nurse students in 2013 identified safeguarding as a prominent feature, and this is reflective of work carried out by Coates (2011), which highlighted that increasing safeguarding and child protection, and hefty pupil–school nurse ratios had prevented public health activities from taking place as part of the daily role of the school nurse.

Building community capacity (BCC), advocated in the Health Visitor Implementation Plan (DH, 2011a), was a concept that was not articulated in the discussion or the drawings in an explicit manner. However, there was a shift towards co-ordination and partnership, which are key principles of BCC (DH, 2011a). Perhaps the rationale for this could be that the concept of ‘BCC’ as a term remains elusive to both SCPHN students, and SCPHN practitioners do not recognise this activity within their practice, despite the fact that they may be building community capacity in reality as part of their role.

Since writing our last article, the notion of BCC has been strengthened within the programme, with emphasis placed on building and using community capacity to improve health outcomes. It will be interesting to see if future students recognise this concept more easily as a result.

In the 2013 drawings there was a clear shift to more specific elements of the role, including supportive frameworks; for example, Solihull (Johnson and Wilson, 2012) the Healthy Child Programme (DH, 2009) and Common Assessment Frameworks (Department for Education, 2013) now referred to in some areas as Early Help Assessment. This may appear self-explanatory in that as students develop the practical elements of the role, they should be able to articulate and consider the policy and frameworks that underpin this. This indicated to us that students had developed and constructed learning that widened their capacity as SCPHNs and bridged the theory and practice gap present at the start of the programme.

**Conclusion**

This evaluation of one cohort of students’ perceptions of their future role has proved to
be both insightful and thought provoking. The use of creative methods to capture student learning is paramount within competitive healthcare and education sectors to demonstrate the effectiveness, efficiency and efficacy of programmes such as this one (DH, 2011b; Academic Integrity Service, 2010).

In terms of return on investment and readiness for SCPHN, when we map the competencies achieved by the students on this programme there is a clear correlation between their final perceptions and the NMC standards for SCPHN (NMC, 2004). It was reassuring to note that personal attributes remain a key focus in light of the recent Francis Report (2013), alongside leadership skills and attributes, which have been advocated by organisations such as the King’s Fund (2011). We acknowledged that this activity had its limitations in the way that themes were generated; however, it outlines that the SCPHN students had a specific knowledge base upon which to continue to build their future public health roles, and scope to develop their initial ideas on the role they were about to undertake (Coates and Gilroy, 2012). Through re-evaluation of the students’ perceptions we feel that a subtle transformation in their broader perceptions of the role has evolved. There is now a greater emphasis on role responsibilities and attributes, as opposed to tools of the trade, which become a by-product of the whole practitioner rather than a core focus. As emphasised in our previous article, preceptorship will need to continue to be a key feature of the newly qualified SCPHN journey.

References

Key points
- The medium of art is a useful tool to elicit students’ perceptions of future roles
- Student specialist community public health nurses’ (SCPHN) transformation during the programme to focus on broader role responsibilities as opposed to the tools of the trade
- Educational programmes for SCPHNs should consider the perceptions of students at the start and end of courses to develop Nursing and Midwifery Council (NMC) SCPHN standards

DH. (2010b) Equity and Excellence: Liberating the NHS. London: DH.
The start of a new year is often a time of celebration, in which we hope that the new year will be better than the last. However, instead of passively wishing for better things, we can proactively make it better. Many of us use this period to reflect and set resolutions for the year, and we may find ourselves setting the same resolutions that we set the previous year. Perhaps life or work got in the way of achieving your expectations. So how can you make 2014 different? How will you make the next 365 days count?

Learn from 2013
To go forward, we sometimes need to look back. When you reflect on what you did and who you were in 2013, how do you feel? Did you achieve the resolutions you set at the start of the year? If you find that you didn’t, don’t despair. View it as learning. What can you learn from it? Often, we learn how not to do something before we learn how to do it. I remember making a drug error many years ago and I learned so much from it. Failure to achieve a goal often brings with it learning.

Know your outcome
Interestingly, many people know what they don’t want but not necessarily what they want. What about you? What do you want to achieve? Why do you want it? When do you want it? What will you do to get it? Who will you need to be to get it? How will you feel if you don’t get it? How committed are you to getting it? Pleasure and pain are often good motivators; there is pleasure in getting the desired outcome and pain if we don’t. Athletes often use positive ‘pre-play’ to achieve an outcome. They imagine themselves crossing the line in first place and this motivates them to take action. So begin with the end in mind and fast forward to 31 December 2014 – what would you like to have achieved by then? How would your personal and professional life be?

Set goals
Life will not go according to plan if you don’t have a plan. Organisations and employers know this, and set objectives and write business plans. Make time to create a plan for the new year and set some goals. Without goals, we stop growing. We initially stagnate and eventually start to rot! Don’t be deceived into thinking that you remain the same. We are either green and growing or ripe and rotten! If you don’t set personal goals, others will set them for you. It is important to write your goals down. When using a satellite navigation system, you need to enter your destination for the device to help you to navigate the best route. Similarly, goal setting sets a command for your subconscious to help you achieve that goal. Consider a goal as a promise to yourself. If your goal is to achieve more work/life balance, you are promising to look after yourself. Writing your goal ensures that you are accountable for honouring the promise you made to yourself. Envision yourself achieving your goals. Imagine how it would make you feel. Then imagine how you would feel if you didn’t achieve them. Then set goals and take action. Track your progress and make adjustments as required. Employ supporters who will hold you to account. Celebrate your achievements but, most of all, enjoy making the next 365 days count. Remember that if you keep doing what you’ve always done, you’ll keep getting what you’ve always got. So do something different and take responsibility for your actions. Choose to make 2014 the best year of your life and remain green and growing.
Setting out: reflections of a newly qualified health visitor

Natasha Morris-Day RHV RGN
Health Visitor, Worcestershire

Over the last year I have written two reflective pieces on my experiences as a student and newly qualified health visitor. As I approach the end of my first 12 months of consolidated practice, I have taken some time to consider how my practice has evolved and changed over this period.

Taking responsibility for your own caseload can be daunting for even the most confident of newly qualified staff – and ours is a role where you simply cannot avoid reflective practice (Thornbury, 2013). However, it can be easy in the midst of such a steep learning curve to simply reflect on individual instances. I would urge anyone in my position to try to review your wider progress as a practitioner on a regular basis; you will be astounded at how much you are learning and this will, in turn, boost your professional self-esteem in what can be an overwhelming time, even with the greatest level of support (Department of Health (DH), 2012).

Focus

The Health Visitor Implementation Plan envisages a career path for health visitors that involves a period of preceptorship and consolidation for newly qualified staff that eventually moves through to specialisation over two years (DH, 2011; DH, 2012). An area of special interest may be the last thing on your mind when adapting to your new role; however, I can now say that I understand how important it is to have these interests as you gain more experience. Focusing on an area of expertise can improve career satisfaction for the employee and staff retention for the employer. It can also enable practitioners to improve outcomes for children and families (DH, 2011; DH, 2012).

Health visiting requires us to be dynamic and react to differing situations from client to client, meaning that our skills in assessment and communication are always growing and changing to meet the complex needs of families in our care. These complex needs can provide unique challenges, particularly when searching for unexpressed needs and dealing with child protection issues. It is easy to become emotionally exhausted and accessing support is key to managing this level of stress (Cowley et al, 2013).

Peer support

All newly qualified practitioners should now be accessing preceptorship programmes within their trusts. Peer support within these programmes is vitally important and is a unique opportunity to discuss the concerns of your new caseload with practitioners who are in the same situation as you. The formality of preceptorship can also provide you with more structure when reflecting on areas of your practice that you would like to improve upon as well as being able to identify where you are doing well.

Never underestimate the skills and experience your colleagues have. Access your wider team to talk through cases that may have previously been theirs – they may be able to provide you with further insight into family dynamics or previous support that has or has not worked for them.

Formal safeguarding supervision is also something all practitioners should access, newly qualified or not. Specialist safeguarding nurses are able to provide detailed and objective advice on complex families to ensure that the health visiting service is doing all it can to safeguard children in vulnerable families (DH, 2012).

Confidence

Despite being overcome at times, I feel that having a fantastic team to support me and taking part in a robust preceptorship programme has really allowed me to flourish as a practitioner. I feel more confident in my health visiting skills but I am also excited to continue on a journey where new learning opportunities are constantly being presented. I am extremely proud of how much I’ve learned so far and now feel ready to embrace the new challenges that lie ahead.

References


Recognising respiratory tract infections in children

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Abstract
Respiratory tract infections are common in children and diagnosis is usually made from the history and presenting symptoms, which can include cough, wheeze and fever, among others. Community practitioners assessing children with respiratory tract infections should always consider symptoms and associated risk factors, such as prematurity and congenital heart disease, as these children will benefit from early referral and specialist management. Community practitioners have a role to play in encouraging uptake of immunisation for children and smoking cessation in parents.

Key words
Respiratory tract infection, children, community acquired pneumonia, bronchiolitis, immunisation

Introduction
Respiratory tract infections (RTIs) are common in children and symptoms usually include cough, cold and wheeze. RTIs are the most common reason for parents to seek assistance from healthcare professionals (Schaad, 2005). The vast majority of children will be managed in the primary care setting but, occasionally, children can deteriorate and will need a hospital admission.

Acute RTI is one of the leading causes of childhood mortality. In England and Wales such infections accounted for about 4% of all deaths (in 2008 and 2009) in children aged 0 to 14 years (Paul et al, 2011). Community practitioners working with children can play an important role in identifying children early who may need referral to a medical professional or can be managed safely with reassurance and advice in the community.

RTIs are more common in the winter months due to the close proximity children have with one another as people tend to stay indoors (NHS Choices, 2011; Paul et al, 2011; Harris et al, 2011). It is important to remember that a child’s respiratory rate and heart rate vary with age and are different from a level that is normal in an adult. Health professionals need to compare a child’s vital parameters to the levels highlighted in Box 1 before labelling that these are abnormal.

When to refer
Presence of one or more of the following signs should prompt community practitioners to refer children to a medical professional and, in some cases, directly to secondary care services (SIGN, 2006; Harris et al, 2011; Paul et al, 2011):
- Rapid respiratory rate (compare with Box 1)
- Difficulty in breathing, recessions in chest wall or substomial recessions
- Intermittent apnoea (cessation of external breathing manifested by pauses in chest wall movement) or grunting (protective mechanism of the body to keep air in the lungs so they will stay open, heard in expiration)
- Children with risk factors for RTI, which will make them deteriorate faster (see Box 2)
- Feeding less than 50% of daily requirement or deemed to be clinically dehydrated (fast heart rate, minimal or no urine output, vomiting)
- Family adjudged being unable to safely observe or supervise the child appropriately during the illness.

Types of RTI
This article describes the commonly encountered types of RTI that a community practitioner may come across in their practice.

Community acquired pneumonia
Community acquired pneumonia (CAP) is an inflammatory condition of the lungs acquired in the community (outside of the hospital environment) by a previously healthy child. In a prospective population-based study in 13 hospitals in the north of England the overall incidence rates for CAP were found to be 14.4 per 10,000 in children aged 0 to 16 years per

Box 1. Respiratory and heart rates of children at rest

<table>
<thead>
<tr>
<th>Age</th>
<th>Respiratory rate (per minute)</th>
<th>Heart rate (per minute)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 28 days (neonate)</td>
<td>30–50</td>
<td>140</td>
</tr>
<tr>
<td>Between 28 days and 1y</td>
<td>20–30</td>
<td>130–140</td>
</tr>
<tr>
<td>Between 1y and 3y</td>
<td>20–30</td>
<td>110</td>
</tr>
<tr>
<td>Between 3y and 12y</td>
<td>15–20</td>
<td>95–100</td>
</tr>
</tbody>
</table>

(Adapted from Gill and O’Brien, 2007)
Bronchiolitis

Bronchiolitis is an inflammation of the bronchioles (the smallest air passages of the lungs). It is most commonly seen in infants and young children aged <2 years. Viruses most frequently encountered in clinical practice are:

- Respiratory syncytial virus (RSV)
- Para-influenza and influenza viruses
- Human metapneumovirus.

The most common bacteria causing CAP is *Streptococcus pneumoniae*, while *Mycoplasma pneumoniae* are not uncommon in children over five years of age. Combinations of viral and bacterial pathogens are also common (Harris et al, 2011).

Children with CAP should be referred for assessment by a medical professional and most cases can be safely managed in the community with advice regarding fluids and antipyretics, and a clear plan as to what to do if the child deteriorates. Some children will need antibiotics.

Childhood vaccinations with *haemophilus influenzae* B and pneumococcal vaccine are considered to be preventive and community practitioners should encourage parents to get their children (and their siblings) fully immunised even after an episode of pneumonia (Paul and Bains, 2012).

**Viral-induced wheeze**

Viral induced wheeze (VIW) is an intermittent airway obstruction presenting with cough and wheeze. Wheezing is a common symptom in pre-school children and most cases are not due to asthma. It may be noted that almost half of children have at least one episode of wheeze by the age of six years (Bhatt, 2013). VIW commonly occurs in children under five years of age. Cough and wheezing may be associated with fever and coryzal symptoms and coughing may be so severe that this can induce vomiting (Paul et al, 2011). RSV causes most cases of VIW; other viruses are adenovirus, influenza, parainfluenza or rhinovirus. Most children can be managed with parental reassurance, adequate hydration and symptomatic management. Factors that have been known to be beneficial in preventing recurrences of VIW are childhood vaccinations and avoidance of tobacco smoke (Bhatt, 2013).

**Croup**

Croup is an upper airway disorder that often develops in the second year of life, with symptoms of a brassy, seal-like, barking cough, alongside a hoarse voice and restlessness (Bjornson and Johnson, 2013). This may be preceded by a few days of mild upper RTI with a low-grade fever, coryzal symptoms and a mild cough. Some children may develop a stridor during inspiration, which becomes prominent when the child cries or becomes upset (Bjornson and Johnson, 2013).

If the child has a raised temperature and is drooling saliva or appears toxic, bacterial tracheitis or epiglottitis should also be considered and immediately transferred to the hospital. Cases of epiglottitis have been substantially reduced since the introduction of *Hemophilus influenzae* type B vaccine.

It is important to enquire about the child’s immunisation history, especially where the child may have recently immigrated to the country or appears extremely unwell with croup symptoms. Children who have a barking cough with no other symptoms may be managed safely at home with rehydration and antipyretics. Children with stridor or other risk factors (see Box 2) should be reviewed by a medical professional. Any missed immunisations should be encouraged once the child is back to normal health (Paul et al, 2011).

**Tonsillitis**

Tonsillitis is an inflammation of the tonsils and is a common upper RTI in children. It is usually caused by a viral infection; however, it can also be caused by a bacterial infection. It usually presents with a sore throat that can feel worse when swallowing; a high temperature (>38°C); and coughing and headache (NHS Choices, 2011). These symptoms usually last for three to four days before the child recovers. Although mostly caused by a viral pathogen; group A Streptococcus remains the most common bacterial pathogen causing tonsillitis. Most children with tonsillitis need symptomatic management with adequate fluids, antipyretics and re assurance.

Children with tonsillitis who have prolongation of symptoms (>4 days) or are unable to eat or drink properly or have other risk factors (see Box 2) should be reviewed by a medical professional (NHS Choices, 2011).

It may be noted that in previously fit children and young people who suffer an intensely
painful sore throat with high fever lasting a few days, along with swollen neck glands, Lemièrre’s syndrome should be suspected – this is a re-emerging condition and has been seen more commonly in recent times (Hawes et al, 2013).

Conclusion

RTIs in children are common in clinical practice. Community practitioners play an important role in managing children with assessment reassurance, guidance on symptomatic management and referring early where necessary. They also play an important role in ensuring immunisations are completed as this has a protective role in preventing serious RTI, such as epiglottitis. The community practitioner should be able to:

- Reassure parents and provide guidance on symptomatic management (fluids and antipyretics) as a large proportion of children with RTI can be safely managed in the community
- Encourage completion of childhood immunisations as this helps in minimising serious RTI
- Encourage and provide guidance on smoking cessation to parents.

References


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

1. In which season are RTIs most common?
   A. Spring
   B. Summer
   C. Autumn
   D. Winter

2. Immunisation is an important strategy to prevent RTIs in children. Community practitioners should...
   A. Encourage uptake of vaccines
   B. Provide correct information to parents
   C. Remove any myths about vaccines
   D. All of the above

3. At what age is a child considered to be at greater risk of RTI?
   A. Under 12 weeks
   B. Under 16 weeks
   C. Over a year
   D. Over two years

4. Bronchiolitis is most commonly seen in infants and young children with a peak noted between what ages?
   A. One and two months
   B. Two and four months
   C. Three and six months
   D. One and two years

5. Most cases of wheeze in children under five years of age are not due to asthma – true or false?
   A. True
   B. False

6. Croup is an upper airway condition presenting with barking cough and stridor, and often develops in which year of life?
   A. First
   B. Second
   C. Third
   D. Fourth

7. Most cases of community acquired pneumonia can be safely managed in the community with the support of medical professionals – true or false?
   A. True
   B. False

8. What is the recommended respiratory rate (per minute) of a child at rest under 28 days old?
   A. 10–20
   B. 20–30
   C. 30–50
   D. 40–50

9. What is the recommended normal heart rate (per minute) of a child at rest between the ages of 1 and 3 years?
   A. 120
   B. 130
   C. 140
   D. 110

10. Community practitioners should encourage and provide parents of children with RTIs with guidance on smoking cessation – true or false?
    A. True
    B. False
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All of the above posts attracts a High Cost Area Supplement of 5% of basic salary subject to a minimum payment of £942 and a maximum payment of £1,632 per annum (pro rata where applicable) and a 10% recruitment and retention premia which will match outer London salaries.

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

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

Manuscripts should be submitted with full author contact details to the editor via email: polly.moffat@tenalps.com

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

- Where either ‘s’ or ‘z’ can be used, use ‘s’ (e.g. organisation)
- One to nine should be in words, 10 and over in figures
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Articles should be written with our readers in mind – health visitors, school nurses and community nursery nurses, and others working in primary care and community settings.

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

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Papers should be between 2000 and 3500 words in length (including references), and are subject to double-blind peer review following submission. Papers should begin with an unstructured abstract of 150 to 200 words, and up to five key words or terms that reflect the article’s subject and focus accurately.

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

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

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

Referencing

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

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- **Date of preparation:** February 2012.

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- **Marketing Authorisation Number:** N.V. Organon, Molenstraat 110, 5342 CC, Oss, The Netherlands.
- **Marketing Authorisation Holder:** MSD Consumer Care, Inc, 3030 Jackson Avenue, Memphis, TN 38112, USA.
- **Legal Category:** Medical device.
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- **Dosage:** Apply to affected area as often as required.
- **Package Quantities:** 300ml pump pack, 50ml tubes. **Recommended Retail Price:** 300ml £6.25, 50ml £2.29.
- **Date of preparation:** September 2013.

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