More than just a bath oil

Washing shouldn’t have to be bad for eczema

NICE guidance is clear that emollients should be used for washing and bathing, as well as moisturising, because soaps and detergents can damage the skin barrier and exacerbate symptoms. All children require an essential package of emollient therapy including a topical emollient and a wash product.

Not only do Oiilatum wash products provide an active emollient benefit, rehydrating the stratum corneum and helping to restore the skin barrier, they also cleanse skin effectively, avoiding the need for soap.

To help your patients receive an active emollient benefit even when washing, prescribe a fragrance-free product from the No.1 prescribed emollient wash range – Oiilatum.

Prescribing Information

Oiilatum® Junior light liquid paraffin 63.4% (Bath Additive)

Indications: Contact dermatitis, atopic eczema, seborrhoeic and related dry skin conditions. Dosage and administration: Apply as often as necessary. Apply to wet skin or add to water. Adult bath: 1-3 capsules in an 8 inch bath of water. Soak for 10-20 minutes, pat dry. Infant bath: ½ -1 capsule in a bath of water, apply gently over entire body with a sponge, pat dry. Precautions: Hypersensitivity to any ingredient. Stop use if rash or irritation develops. Side effects: See SPC for full details. Application site reactions including irritation, erythema, rash, pruritus, dermatitis. Legal category: CSL. Presentation and Net wt: 100 ml £2.82, 250 ml £3.55, 500 ml £3.10, 600 ml £3.99. PL 000779/0701. PL holder Stiefel, 980 Great West Road, Brentford, Middlesex, TW8 9GG. Date of revision: February 2014.

Oiilatum® Shower Gel Fragrance-Free (light liquid paraffin 70%) (Bath Additive)

Indications: Contact dermatitis, atopic dermatitis, seborrhoeic and related dry skin conditions. Dosage and administration: All ages: Apply to wet skin, normally as a shower gel. Use as frequently as necessary. Precautions: Hypersensitivity to any ingredient. Test for use on greasy skin. Side effects: See SPC for full details. Application site reactions including irritation, erythema, rash, pruritus, dermatitis. Legal category: CSL. Presentation and Net wt: 100 g £3.13. PL 000779/0704. PL holder Stiefel, 980 Great West Road, Brentford, Middlesex, TW8 9GG. Date of revision: March 2014.

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Stiefel, on 0800 917 9111.


Date of preparation: March 2014. CHSL/CHOL/0016/14C.

Oiilatum is a registered trade mark of the GSK group of companies.
Unite/CPHVA

Existing Unite/CPHVA members with queries relating to their membership should contact: 0845 850 4242 or see: www.unitetheunion.org/contact_us.aspx for further details.

To join Unite/CPHVA, please see: www.unitetheunion.org

Unite/CPHVA is based at:
Transport House, 128 Theobald’s Road,
London WC1X 8TN
Tel: 020 3371 2006

Community Practitioner journal

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

Non-members of Unite/CPHVA and institutions may subscribe to the journal to receive it every month and access the online journal archive.

Non-member subscription rates:
- Individual (UK) £125
- Individual (rest of world) £145
- Institution (UK) £145
- Institution (rest of world) £195

Subscription enquiries may be made to: Community Practitioner subscriptions, Ten Alps Community Practitioner Subscriptions The Barn 6 Abbey Mews Robertsbridge TN32 5AD www.cphvabookshop.com

The journal is published on behalf of Unite/CPHVA by: Ten Alps Publishing 1 New Oxford Street London WC1A 1NU Tel: 020 7878 2300

For editorial contacts, please see the panel over the page.

Advertising queries:
Claire Barber Tel: 020 7878 2319 claire.barber@tenalps.com

Production:
Ten Alps Creative – Design and production
Magazing Printing Company
© 2015 Community Practitioners’ and Health Visitors’ Association
ISSN 1462-2815

The views expressed do not necessarily represent those of the editor nor of Unite/CPHVA. Paid advertisements in the journal do not imply endorsement of the products or services advertised.

Editorial

3 A vote for change
Amy Brewerton

News round-up

4 A look over the biggest stories from www.communitypractitioner.com

Member focus

10 News and opinions from members and their colleagues

Association

13 Latest updates from Unite/CPHVA

Special report

14 Healthy competition
Amy Brewerton

17 Political union
Amy Brewerton

20 Interview: Rachael Maskell
Amy Brewerton

Antenna

22 Research evidence and resources

Clinical features

24 Supporting families with a fussy eater
Dr Emma Haycraft, Dr Gemma Witcomb and Dr Clare Farrow

CPD

28 Reducing dog bites in children
Dr Caroline Furnell and Dr Fiona Finlay

Professional and research

32 The lived experience of homeless women: insights gained as a specialist practitioner
Dr Maria Fordham

38 Students’ and tutors’ perceptions of the use of reflection in post-registration nurse education
Linda Stirling

42 Early intervention for increased antenatal anxiety associated with foetal development risk
Rebecca Balakrishna and Melanie Teixeira

Last word

47 Educating practice teachers and specialist mentors for their new role
Lisa Bayliss-Pratt

ELECTION

Special Report: From healthcare to politics
Our six-page special report looks at how those working in health can use their voice, views and experience to influence and engage with the political process in the run-up to May’s election

p14

p24

p47
Can you reduce the risk of an infant developing eczema?

Tanya Wright BSc Honours MSc Allergy HCPC Registered Dietitian MBDA

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

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

Eczema is a growing modern epidemic

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

Its impact extends to the whole family

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

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. The independent prospective GINI study, for example, enrolled over 2000 infants. 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).

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.

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 breastfed. The decision to discontinue breastfeeding may be difficult to reverse and the introduction of partial bottle-feeding may reduce breast milk supply. The financial benefits of breastfeeding should be considered before bottle-feeding is initiated. Failure to follow preparation instructions carefully may be harmful to baby’s health. Infant formula and follow-on milks should be used only on the advice of a healthcare professional.

Registered Trademark

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

It is nutritionally complete and can be used from birth.

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

Supporting you to support mums

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


ZTC716v03/15
A vote for change

As CPHVA members, you really do have a voice – don’t be afraid to use it

It’s already been a couple of months since I started working on Community Practitioner. The journal’s usual editor, Polly Moffat, began her maternity leave at the start of January and I have been filling in while she takes some time away from the office to get to know her new arrival – a baby boy, if you were wondering!

You might notice a few changes to your journal this month as we try to make you – the members of CPHVA – the central focus. You’ll see that our news pages now include comments from social media and our website, which are fantastic ways to engage and interact in real time. You will also notice new member pages where we showcase some of the interesting, impressive and innovative work you have been involved in.

I’ve really enjoyed meeting and talking to members at the recent CPHVA Awards and Unite/CPHVA Question Time events, and I hope to be able to speak to even more of you as the year goes on. It’s also been great to play more of a role in the weekly #CPHVAtt Twitter Tuesday chats, which help to feed fantastic new ideas into the journal.

Getting to know you better, both as professionals and individuals, will really be one of my main priorities as deputy editor. I really want you to get your voice heard, and help you connect with colleagues, CPHVA and policymakers about the things that really affect you and your service users, day in, day out.

With the general election coming up next month, it’s even more important for healthcare professionals to use their voice - and their vote - to help make a difference.

The CPHVA colours are inspired by the suffragettes, who fought hard to give women the right to vote. Make sure you exercise this hard-won right by registering and using your vote on May 7. It’s vital that your first-hand, front-line experience is represented at the polls.

The election is a bit of a theme for this issue, and we take a look at Unite’s role in politics, and why it’s so important for everyone to get involved.

Unite head of health, Rachael Maskell, has been selected as the Labour candidate for York Central and will be standing in the upcoming general election. She took some time out of her busy schedule to talk to Community Practitioner about her journey into politics.

As ever, we’d love to hear your thoughts and feedback via Facebook, Twitter, the website or face-to-face. If you’d like to be featured on our member pages, then get in touch and tell us a little about what you’re up to, and don’t forget to join #CPHVAtt every Tuesday from 7pm.

See you there!

Amy Brewerton
Deputy Editor
Community Practitioner

April 2015 Community Practitioner
A cross-party government report has recommended that sex and relationship education (SRE) should be given statutory status in schools. The Commons Education Select Committee, who put together the report, also recommend that schools should address the shortage of school nurses, as numbers of nurses have not risen along with the number of pupils.

According to the report, the number of pupils in state schools in England has risen from 6.93 million in 2009 to 7.14 million in 2014, and is expected increase to 8.02 million by 2023. Conversely, the number of school nurses has remained static at around 1,200.

‘We recommend that the Government ensure that there are sufficient school nurses training places, and that the ratio of school nurses to children is maintained,’ the report states.

Findings from the report also suggest that in many cases pupils feel more comfortable receiving SRE from a health professional rather than a teacher, and that schools may choose professionals other than teachers to deliver the information, such as nurses or outside organisations.

The report also highlights the need for children to begin to receive appropriate SRE before reaching puberty, and that the correct names for genitalia should be used as part of the education, as an inability to correctly identify body parts may represent a weakness in safeguarding. It is recommended that this should be a requirement as part of the National Curriculum. Pornography, ‘sexting’ and cyberbullying were all identified as ways in which the SRE needs of pupils have changed in recent years, with younger teens and children having access to sexual material and pressure from an earlier age.

The committee also proposed that SRE should be renamed ‘relationship and sex education’ to emphasise the central role of relationships.

School nurse numbers must increase to meet SRE needs

We asked you
Should school nurses deliver sex and relationship education?

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>70%</td>
</tr>
<tr>
<td>No</td>
<td>5%</td>
</tr>
<tr>
<td>It should be a combined approach</td>
<td>25%</td>
</tr>
</tbody>
</table>

To vote on issues affecting your profession, head over to www.commprac.com.
Parents spend £35,000 in first five years

Parents spend an average of £35,000 on their children by their fifth birthday. A study of 2,000 parents, conducted by insurance firm Aviva, revealed that childcare is the biggest expense for most parents. Families are also spending an average of £47.70 on nappies every month for each child under five, with children’s food and formula costing an average of £41 a month per child. Nearly £700 is spent on clothes every year. This does not include uniforms and school equipment, which add an extra £670 to the annual household budget. Other costs include leisure and family trips, which cost an average of £650 a year per child, and toys, which come in at £640 a year.

The survey also highlighted significant regional variations, with parents in London spending more than twice the amount of those in Wales, with annual costs of £9,711 compared to £4,220. The average overall spend for parents in Scotland is just under £6,000 per child, with parents in Northern Ireland spending slightly less at £5,450.

Nearly £700 is spent on clothes every year. This does not include uniforms and school equipment, which add an extra £670 to the annual household budget. Other costs include leisure and family trips, which cost an average of £650 a year per child, and toys, which come in at £640 a year.

Children to have more say in family courts

Young people involved in family law cases are to have a greater say in issues that affect their future. Justice Minister Simon Hughes has announced that a new system will make it easier for children to voice their views in cases such as living arrangements after family separation or when children are potentially being moved into care.

Children will be given the chance to contribute via meetings, letters or pictures, or having their viewpoints communicated by a social worker or Children and Families Court Advisory and Support Service (Cafcass) officer.

A gaming app to help explain the court system to young people is also being developed. In 2014, there were 90,000 children involved in cases in the family courts. The new proposals will apply to all young people aged 10 and above.

Commenting on the guidance and allocations for 2015/16, members of the Unite/CPHVA Facebook page had plenty to say.

Sherri G
We have been assured we remain employed by the NHS! But who knows?

Yvonne D
CNNs being halved and management under sever threat will leave a massive shortage of skill mix and wealth of knowledge and experience in the HV teams!

Debra B
From a safeguarding of children perspective are we not part of a multi-agency team?

Julie E
In 5 years time there will be few, if any, HV services left in the NHS.

The Department of Health (DH) has issued updated guidance on the transfer of commissioning for 0-5 services. The planning and paying for public health services for 0 to 5 year olds, including health visiting, transfers from the NHS to local authorities in October 2015.

The new factsheet sets out the timelines and responsibilities of the various service providers, including local authorities, clinical commissioning groups and health and wellbeing boards. It also defines which services will be provided by which professionals, and sets out the scope of the health visiting service.

Under the new commissioning arrangements, health visitors will continue to be employed by their current employers and not local authorities, and will still lead delivery of the Healthy Child Programme.

Commenting on the guidance and allocations for 2015/16, members of the Unite/CPHVA Facebook page had plenty to say.

Sherri G
We have been assured we remain employed by the NHS! But who knows?

Yvonne D
CNNs being halved and management under sever threat will leave a massive shortage of skill mix and wealth of knowledge and experience in the HV teams!

Debra B
From a safeguarding of children perspective are we not part of a multi-agency team?

Julie E
In 5 years time there will be few, if any, HV services left in the NHS.

Is this an accurate estimate of the true cost of having a child? Tweet us your thoughts @CommPrac


The full story

April 2015 Community Practitioner 5
Health professionals urged to discuss FGM

**THE GOVERNMENT HAS ANNOUNCED A SERIES of measures to prevent and punish the practice of female genital mutilation (FGM).**

At a summit to mark the International Day of Zero Tolerance on FGM, ministers and leaders gathered to set out how the new rules will help protect those who are victims, or at risk, of this form of abuse.

Public Health Minister Jane Ellison announced that a new system of recording FGM will come into force, with clinicians being able to report on a child’s record that they are at potential risk of being subjected to the illegal and abusive procedure.

An extended programme of training will also be offered to health professionals by Health Education England aimed at improving communication and sensitivity to help recognise and identify this form of abuse. This will include e-learning, pathways and educational materials.

Speaking to Community Practitioner about how public health nurses can help to tackle FGM, Ellison said: ‘I would encourage all healthcare professionals to make sure they raise the issue, have the conversations. I think one of the problems in that past is that we just didn’t talk about FGM, but now we are talking about it and I’m seeing some fantastic leadership in local areas.

‘What we want is for FGM to be mainstream – where everyone knows what to do, everyone knows the referral pathways. There’s still a lot to do but we’re working really hard on it. In a year’s time I hope we’ll be further down the road to erasing FGM in the UK.’

---

Sure Start centres to get Labour boost

**THE LABOUR PARTY HAS PROMISED THAT SURE START centres will receive additional funding and places if the party wins the next general election.**

Shadow Education Secretary Tristan Hunt pledged that the centres will not only operate with double the amount of spaces - bringing them up to 118,000 - but they will provide childcare access and the premises will be available to charity organisations.

The plans aim to re-establish Sure Start centres as community hubs and to engage with families from harder-to-reach areas.

---

Community focus for public health recommended

**COMMUNITY-CENTRED working is the key to reducing health inequalities, according to a new report issued by Public Health England (PHE).**

Responding to the challenge set out by NHS England’s Five Year Forward View to evolve the way health services engage with patients and communities, the publication sets out ways in which services can react and respond to local needs.

The document suggests that ‘place-based approaches’ will offer providers the opportunity to empower communities to thrive by using an evidence-based approach.
BREASTFEEDING IS BEST FOR BABIES

Science & nature
hand in hand

We've used 50 years of breastmilk research to perfect the combination of science and nature and create the only complete range of organic formula milk on the UK market.

Our infant formulas combine natural organic ingredients with PRÆBIOTIK® (GOS), a source of prebiotic oligosaccharides to encourage the growth of friendly bacteria, and Omega 3 & 6 LCPs, needed for brain and nervous tissue development.

To find out more, visit
hipp4hcps.co.uk

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

Figures released by the Office of National Statistics (ONS) show that conceptions among under-18s in England are continuing to fall. Pregnancies occurring in this group have reduced by almost 50% across the whole of England since 1998, with a reduction of up to 60% seen in some local authority areas. Between 2012 and 2013, the conception rate among under-18s dropped by 12.3% to 24.3 per 1,000, the lowest since records began.

Reassurance over pregnancy vaccines

Public Health England (PHE) has issued clarification of the risks of vaccines during pregnancy with the publication of new guidance. Expectant mothers can be assured that while current advice recommends that these vaccines should not be intentionally administered during pregnancy, these measures are precautionary and there are no known risks associated with inadvertently receiving the vaccines in the early stages of pregnancy or before. Despite the apparent safety of these vaccines, infection of these diseases themselves can have serious consequences for the unborn child.

Building Great Britons report released

The All Party Parliamentary Group (APPG) for Conception to Age 2 has published the Building Great Britons report setting out how best to support early years service delivery. The report is in response to the First 1001 Days manifesto which was launched by the APPG in October 2013, and it presents the results of evidence presented by a panel of experts into the factors that affect emotional and social development of children, from conception to the age of two.

Quitting smoking linked to improved mental health

People who smoke are more likely to suffer with anxiety and depression, new research suggests. A study looked at the prevalence of these mental health conditions among smokers and compared them to non-smokers and ex-smokers.

Levels of anxiety and depression reported by long-term ex-smokers were indistinguishable from people who have never smoked and much lower than current smokers, suggesting that quitting smoking could help people combat anxiety and depression and improve mental health. More than 18% of smokers reported suffering from anxiety or depression, compared to 10% of non-smokers and 11% of ex-smokers.

Teenage pregnancy at all-time low

Figures released by the Office of National Statistics (ONS) show that conceptions among under-18s in England are continuing to fall. Pregnancies occurring in this group have reduced by almost 50% across the whole of England since 1998, with a reduction of up to 60% seen in some local authority areas. Between 2012 and 2013, the conception rate among under-18s dropped by 12.3% to 24.3 per 1,000, the lowest since records began.

Reassurance over pregnancy vaccines

Public Health England (PHE) has issued clarification of the risks of vaccines during pregnancy with the publication of new guidance. Expectant mothers can be assured that while current advice recommends that these vaccines should not be intentionally administered during pregnancy, these measures are precautionary and there are no known risks associated with inadvertently receiving the vaccines in the early stages of pregnancy or before. Despite the apparent safety of these vaccines, infection of these diseases themselves can have serious consequences for the unborn child.

Building Great Britons report released

The All Party Parliamentary Group (APPG) for Conception to Age 2 has published the Building Great Britons report setting out how best to support early years service delivery. The report is in response to the First 1001 Days manifesto which was launched by the APPG in October 2013, and it presents the results of evidence presented by a panel of experts into the factors that affect emotional and social development of children, from conception to the age of two.

Quitting smoking linked to improved mental health

People who smoke are more likely to suffer with anxiety and depression, new research suggests. A study looked at the prevalence of these mental health conditions among smokers and compared them to non-smokers and ex-smokers.

Levels of anxiety and depression reported by long-term ex-smokers were indistinguishable from people who have never smoked and much lower than current smokers, suggesting that quitting smoking could help people combat anxiety and depression and improve mental health. More than 18% of smokers reported suffering from anxiety or depression, compared to 10% of non-smokers and 11% of ex-smokers.
BREASTFEEDING IS BEST FOR BABIES

Less is more: the UK’s first reduced protein infant milk, now with alpha-lactalbumin

High protein intake in the first two years of life has been linked with an increased long term risk of being overweight or obese.1 Our new infant milk with 1.89g protein/100kcal, and added alpha-lactalbumin, is the first formula in the UK to contain less than 2g protein/100kcal (Figure 1).

The BeMIM (Belgrade-Munich Infant Milk) study2

Aim: to prove the safety and suitability of the reduced protein formula for healthy term babies aged 0-4 months and non-inferiority compared to a standard formula.

Results

- Adequate growth: no significant difference in weight gain between formula groups
- Good tolerance and acceptance: both formulas were well accepted and tolerated. No differences in stool consistency and colour, colic, flatulence, regurgitation or vomiting
- Protein intakes closer to that of breastfed babies for those on the reduced protein formula (Figure 2)
- Positive influence on satiety: no compensatory increases in formula intake for babies on the reduced protein formula. In fact, these babies consumed significantly less energy of 90 days and 120 days of age compared to the control-fed group. This was explained by lower meal frequency, which might indicate higher satiety
- Improved energetic efficiency: Weight gain per 100kcal and length gain per 100kcal were significantly higher in the 4th month for the intervention group compared with the control group. This could be due to the improved protein quality of the intervention formula.

To find out more, visit hipp4hcps.co.uk


Important Notice: Breastfeeding is best for babies. Breastmilk provides babies with the best source of nutrition. Infant formula milks and follow on milks are intended to be used when babies cannot be breastfed. The decision to discontinue breastfeeding may be difficult to reverse and the introduction of partial bottle feeding may reduce breastfeeding supply. The financial benefits of breastfeeding should be considered before bottle feeding is initiated. Failure to follow preparation instructions carefully may be harmful to a baby's health. Infant formula and follow on milks should be used only on the advice of a healthcare professional.
THE FIRST PROJECT I WORKED WITH-IN

Cameroon was with a vastly disadvantaged group: orphaned children, for whom access to education - a crucial social determinant to health - is difficult. The school serves orphans, child prostitutes and street children, attempting to change the course of their current trajectory. Although it is difficult to attain accurate quantitative data regarding the incidence of child trafficking, due to inaccurate birth records, the reality of its occurrence is abundantly clear. The school provided two vital services - safety and education. However, the provision of these services was limited to school hours during term time only, leaving homeless children vulnerable overnight. Through negotiation and donation of numerous blankets I established a child protection initiative, which manifested as a safe haven named 'Gabriels Gateway' where a classroom was utilised as a safe overnight area. Over the duration of my voluntary work this initiative broadened. Community support and engagement increased, enabling them to offer childcare to mothers/caregivers who prostituted themselves, providing safety to children while their caregiver worked.

I was also able to spend considerable time working as a team member within the International University Bamenda Outreach Service in Kumbo Town. This service was partially government funded, but primarily supported by means of charitable funds. A large proportion of orphaned children had HIV and had been orphaned by AIDS. However, I found that the extreme stigma still associated with AIDS within this community causes the epidemiological prevalence rates to remain artificially low; precipitating a downward spiral wherein undiagnosed HIV+ individuals have staggering misconceptions regarding transmission and unknowingly spread the virus. I set about initiating a 'Stop the Stigma' HIV/AIDS screening drop-in day, which would provide culturally sensitive health promotion to those who sought it at a private (and free) drop-in centre.

We conducted a door-to-door promotional survey to advertise the drop in day and establish an estimated attendance. The focus on what HIV/AIDS is, primary prevention, secondary screening and tertiary healthy behaviour/lifestyle changes were explained. To my absolute surprise, the majority of households were interested. I was even asked to promote the initiative within the local church, mosque and school. A total of 187 people were screened using HIV point-of-care test kits which analysed a sample of saliva or blood. This method was chosen for many factors; primarily because results were available within a few minutes, rather than a few days. This enabled counselling, which focused on de-stigmatisation, health promotion and referrals to the treatment centre (if appropriate) on the same day. Further, everyone who attended was provided with a leaflet detailing modes of transmission, which had been translated to their native ‘Lamnso’ and condoms. To my astonishment, many of the women who attended, some of whom were prostitutes, confessed to have been given condoms by volunteers in the past, yet reported having never been shown how to use them. Some had been attempting to use them as femidoms, clearly without success. I found this discussion very powerful, it reinforced the paramount importance of sustainability in both voluntary work and health promotion.

Members start advice line

CPHVA member Vicki Stennett has been involved in developing an out-of-hours health visitor advice line to extend the reach of the health visiting service in Kirklees, West Yorkshire. She explains a little bit about the initiative.

‘We came up with a telephone advice line because there was less disruption for staff, it covered the whole of the area, is accessible for everyone and people wouldn’t have to bring their baby out to an evening clinic. Plus we already had the technology to do it, including instant access to online medical records, which made it different to NHS 111.

‘We wanted more flexibility for working families who can’t attend normal clinics, reduction in GP attendances and inappropriate A&E attendances, and for health visitors to engage with fathers.

‘Mobile working allows the health visitors manning the line to work from home if they wish. Figures show that without the line, people would have gone to the GP, called NHS 111 or have waited to see a health visitor or midwife. Two would have even gone to A&E. Feedback has been really positive and there’s been nothing negative.’
CPhVA Question Time: Salford

The first of this year’s Question Time events addressed revalidation, local commissioning concerns, the use of social media and integrated working.

CPHVA QUESTION TIME CAME TO SALFORD ON
23 February, giving attendees the opportunity to put their burning questions to a panel of experts.

Josephine Johnson, Project Officer for Public Health at NHS England; Eustace de Sousa, National Lead for Children, Young People and Families at Public Health England; Dave Munday, professional officer and lead on health visiting at Unite/CPhVA; and Jane Beach, professional officer for regulation at Unite/CPhVA were all on hand to field questions from the audience on a range of burning topics.

The evening kicked off with a presentation on revalidation from Jane, looking at the ins and outs of the process that all registered nurses, including SCPHNs, will be required to undertake every three years from 2016. Linking this to the amended NMC Code, which was released earlier this year and comes into force this month, Jane explained how portfolios, CPD, appraisals and personal reflection will need to be collected as early as possible to ensure the revalidation process runs smoothly.

Attendees – a combination of CPhVA members and non-members – were particularly concerned about how they would be able to show evidence of reflection and whether this would increase workloads, and there were concerns that the NMC hadn’t been forthcoming with information about the revised Code or the revalidation requirements.

Participants posed questions about the transfer of commissioning to local authorities, with some confused about whether this would change who they were employed by and if this would affect their indemnity cover. Panelists were on hand to reassure the audience that it wouldn’t affect the employment of NHS staff, although Josephine pointed out that local commissioning may affect the structure of workforces.

On the topic of social media, the majority of attendees admitted to not being active in a professional capacity, with some worried about breaking policies and guidelines. All of the panelists explained that they are heavy Twitter users, finding it a useful professional tool, provided guidance – such as that issued by the NMC, CPhVA or local trusts – was adhered to. Some audience members found that social media, such as closed Facebook groups, can be a useful way of contacting hard-to-reach groups.

The role of multidisciplinary teams was discussed by the panel, with members unpicking what they felt did or did not fall within the health visitor or school nurse remit, with a feeling that with additional time and support, SCPHNs would be able to take a more holistic approach to health and social needs.

Just as the session adjourned for a warm supper of vegetable chilli, the feeling of evening was summed up by Eustace, who concluded that ‘in the words of Keith Lemon – I’d say that’s bang tidy.’

WHAT MEMBERS THOUGHT

Rachel Scrafton, student health visitor
‘I’ve been qualified as a nurse for 5 years but I only found out about the new Code a week ago. Revalidation I didn’t know about beforehand but it seems doable, it’s not stressing me out! As a student health visitor you have to do all that anyway, so it’s just continuing it.’

Margaret Koller, health visitor
‘It’s been very useful coming here, especially as I’ve been chosen in one of the pilots. It’s given me information that I can use if people are asking why I am doing this or that. It’s definitely been very useful.’

Jackie Smith, health visitor
‘Doing more additional CPD in addition to mandatory training should be useful and interesting, better than just doing fire safety or information governance. I’m feeling much happier about it.’

Helen Gundy, student health visitor
‘I wasn’t aware of the revalidation process at all. I’ve heard about it but didn’t realise to what extent it would have an impact on what I do. It was interesting to hear about commissioning and how people view that is going to impact the service.’

April 2015 Community Practitioner
Twitter has a wealth of opportunity for health visitors. People use Twitter for different reasons; some people use it for personal use, to follow celebrities and catch up with friends. I used Twitter for these reasons until I saw how I could use it professionally and academically.

Twitter can develop skills necessary for being a health visitor, such as communication, negotiation and open-mindedness. It helps you to write concisely, formulate your arguments and encourages you to look at the bigger picture. A health visitor has a number of important roles from leading and delivering child and family health, providing additional services through health centres or Sure Start centres, and perhaps the most important; to enable vulnerable children and their families to develop and be safeguarded, with the help of other health and social care professionals. Having 140 characters to express your thoughts and feelings teaches you to think before you speak, which allows you to consider how you feel and how to convey that in the best possible way.

Twitter chats are another valuable resource. These are live chats on a particular subject. The topic can be general or specific, for example looking at a particular policy or guidance. They can help you learn about a particular area and allow you to communicate professionally with people who may or may not have the same opinion as you. These ‘debates’ motivate you to think about your own opinion and certainly challenge your thoughts and feelings.

Twitter also offers a chance to connect with people locally, nationally and even internationally, expanding your network. You can learn about practice in your local area and within other settings. It opens up opportunities for jobs, projects and research. I’ve been offered a lot through Twitter. Perhaps there is a gap in your knowledge, you want to identify good practice or want to find a new job - all of these opportunities can arise through Twitter.

Research is prevalent on Twitter, so you could be a part of that research. Many people share resources and research with their followers so this permits you to be able to maintain research-focused, so your practice is up to date.

Lastly, Twitter is a great support network. Perhaps you are struggling with work, or are confused in relation to an aspect of your practice. There will be people on Twitter who have experienced the same as you. People support one another on Twitter as we are a community - you can discuss your problems (maintaining confidentiality, of course).

Social media has many benefits professionally. The health and social care sector is utilising social media a lot more because of it’s many benefits, so why not take the plunge. There are people that can help you find your feet and it’s easy to sign up - so go for it and you’ll never look back!
Unite’s head of health becomes Labour candidate

RACHAEL MASKELL, HEAD OF health at Unite, has become the new Labour candidate for York Central.

She was named following the final selection from an all-female shortlist of election hopefuls.

Rachel will be looking to retain Labour’s parliamentary seat in May’s general election, against York Central candidates standing for the Conservatives, Liberal Democrats, UKIP, Green Party and the Trade Unionist and Socialist Coalition.

Posting on Twitter after learning the news of her selection, she said: “Thank you to York Labour Party for putting your trust in me to ensure we secure a Labour victory in May.”

The general election will take place on 7 May. To read more about Rachel’s hopes and plans for the election and beyond, turn to our interview on page 20.

Catch-up with…

Kevin McAdam

KEVIN MCADE IS STEPPING INTO RACHAEL MASKELL’S SHOES as head of health at Unite while she takes a step back to focus her pre-election activities. Community Practitioner caught up with him to find out more.

Tell us a little bit more about your background with Unite

For last 16 years I’ve been a full-time officer covering a range of industries. The last 12 years I’ve worked mainly on the health side, representing 4,000 members in Northern Ireland, including health visitors, school nurses and district nurses. I’m also the chairperson of the Trade Union Forum in Northern Ireland, which is the group for health trade unions, and that brings me in direct contact with the health minister and the Department of Health at a range of levels.

How long are you serving in Rachael’s absence?

I’m really glad Rachael has had the opportunity to stand for a Labour party seat in York Central, and I really wish her well. My role will be to fill in for her as national officer for – at this stage – probably around four months. What happens after that is for the organisation to decide, but I’ll be giving my full support during that period.

What do you hope to achieve while acting as national officer?

I think one of the main priorities for everyone in Unite is to look towards the general election, to provide support wherever possible. One of the things we’re looking at in health is what would happen in the event of a Labour government and how we can best interface with that government to benefit the health service and it’s workers.

What would you say is your proudest professional achievement?

I’m not sure that one is any more important than the other. Our goal year-on-year is to keep the health service public, and for every year we do that to some extent, that’s an achievement. It’s a long-term goal, so the longer we work at it we’ll achieve it in different ways.

Unite in Health Regional Events

Unite in Health are continuing their regional training sessions following the success of last year’s events

The programme of training events for this year focuses on continuing professional development (CPD) and raising concerns. The events will talk you through what CPD is, why it is important, how to demonstrate evidence and information on the e-portfolio.

Attendees will also take through a step-by-step process of how to raise professional concerns, including whistleblowing.

The events are free for members (£75 for non-members) including lunch, and will be held from 10am to 4pm in the following locations:

Somerset 8 April 2015
Bristol 9 April 2015
London (Moreland Street) 16 April 2015
Leeds 22 April 2015
Crawley 21 April 2015
Newcastle 23 April 2015
Slough 23 April 2015
Derby 8 May 2015
Londonderry 11 May 2015
Belfast 12 May 2015
Salford 13 May 2015
Cardiff 2 June 2015
London (Holborn) 4 June 2015
Birmingham 9 June 2015

To read more about the agenda and to register your interest for a particular event, visit: www.unitetheunion.org/how-we-help/list-of-sectors/healthsector/healthsectorrepstraining

eRedbook receives CPHVA endorsement

Unite CPHVA are delighted to support and endorse the digital development of the Personal Child Health Record in the form of the eRedbook. Our members support parents and families on a daily basis in addressing the health needs of their children, and the addition of an accessible digital record will only enhance this working relationship.

Unite CPHVA look forward to participating in this development and will ensure that progress reflects the needs of community practitioners, health visitors and families.
Healthy competition

With one in seven politicians reported to have never had a ‘proper’ job, Amy Brewerton examines the minority of MPs who have come from a healthcare background.

It’s not a career path for everyone, but a small number of MPs started off their professional lives as frontline health workers before moving into politics. Although under-represented in Westminster – only 1.4 per cent of MPs who were successful in the last general election had a healthcare background, compared to 25.1 per cent from business and 13.8 per cent from the legal professions – there are several politicians who have made this transition.

It’s easy to see why some practitioners have followed this path; after all, healthcare professionals are the best placed of all when it comes to imparting knowledge about the inner workings of the health and social care sector, as well as their own experiences and ideas about what the NHS needs to do to improve.

They also have a number of transferable skills that could be as useful in political situations as they are in healthcare scenarios.

The ability to talk and listen to people from all sections of society and work towards shared goals is a skill that all MPs ought to have, and that healthcare professionals clearly possess.

Most MPs also run weekly ‘surgeries’ where members of the public from their constituency can come along to air and share their complaints – a setup not exactly alien to most nurses, doctors and other healthcare staff.

As many MPs will attest to, it also helps to have a thick skin and to not be offended or shaken by criticism – another thing that the majority of nurses and health visitors will also have experience in.

Politicians are frequently criticised for being out of touch with the needs of ordinary people, and the fact that one in seven MPs have reportedly never had a job outside of politics hardly helps their cause.

Yet there are a handful of MPs who have worked on the front line of health and have first-hand experience of working in caring settings.

We examine some of the current members of parliament who have made the move into politics from the broader spectrum of health.
Former care worker, miner and Labour MP Dave Anderson represents the Blaydon constituency in Tyne and Wear. Prior to becoming a member of parliament in 2005, Anderson held a number of roles, including working as a carer for the elderly in Newcastle-upon-Tyne. He made the move into politics after the local council changed the provision for the elderly care service, and he became trade union officer within the council that eventually led him to parliament.

Labour MP for Darlington Jenny Chapman was elected to her seat at the last general election in 2010. Prior to her move into politics she studied psychology which led to her caring for prisoners through her role as a prison psychologist. Using the experience she gained, Chapman is currently Shadow Prisons and Probation Minister.

Doctor and fertility expert Lord Robert Winston is a Labour peer in the House of Lords. Prior to joining the House of Lords in 1995, Lord Winston gained eminence in fertility medicine, having led improvements in IVF technology including pre-implantation genetic screening. He has worked in a number of NHS hospital settings since qualifying in medicine in 1964, and led the House of Lords Select Committee on Science and Technology. He speaks frequently in the House of Lords on education, science, medicine and the arts.

Labour MP Liz McInnes won her seat in the 2014 by-election for the Heywood and Middleton constituency, following the death of the incumbent MP. She has worked for the NHS since 1981 and was employed as a senior biochemist at Pennine Acute Hospitals NHS Trust before prior to being elected. McInnes was previously a branch secretary for the Pennine Acute Branch of Unite.

Leading surgeon and Labour peer Lord Ara Darzi joined the House of Lords in 2007, following his appointment as Parliamentary Under-Secretary of State. His background is in minimally-invasive and robotic surgery, and has developed new techniques and technologies in these areas. As a peer, he led a national review to plan the direction of the NHS over a ten-year period, recommending the development of academic health science centres and polyclinics.

Labour MP for Easington Grahame Morris spent his early career working in a research capacity for the NHS. His role as a medical laboratory scientific officer in Sunderland led him to become an active member of his trade union and serve on a national advisory committee for the NHS. Morris' move into politics came in 2010.
What is lactose intolerance and how can it be managed?

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

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

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

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

Although temporary, it may take weeks rather than days for lactase secretion to be adequately re-established. Formula fed infants may require a lactose free formula as a temporary substitute for standard cows’ milk formula.³ Studies have shown that infants with diarrhoea fed on lactose free formula milk recovered in significantly less time than those fed on a lactose containing formula.¹⁵

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

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

---

**SMA LF Lactose Free Formula**
SMA LF Lactose Free Formula is designed specifically for the dietary management of primary and secondary lactose intolerance. It is nutritionally complete and can be used from birth.

- The only whey dominant LF formula available in the UK and Ireland*
- Omega 3 and 6 LCPs
- Fortified with iron to help support normal cognitive development²
- Halal approved and suitable for vegetarians

Available on prescription or to buy in supermarkets and other pharmacies

---

**Supporting you to support mums**
Visit us: smahcp.co.uk or smahcp.ie

---

*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 breastfeeding may be difficult to reverse and the introduction of partial bottle-feeding may reduce breast milk supply. The financial benefits of breastfeeding should be considered before bottle-feeding is initiated. Failure to follow preparation instructions carefully may be harmful to babies health. Infant formula and follow-on milks should be used only on the advice of a healthcare professional. This product must be used under medical supervision. SMA LF is a lactose-free milk based formula for the dietary management of babies and young children who are intolerant to lactose or sucrose, or who are suffering from symptoms such as diarrhoea, abdominal discomfort or wind caused by temporary lactose intolerance. It is suitable as the sole source of nutrition up to 6 months of age, and in conjunction with solid food up to 18 months of age. SMA LF is not suitable for those who are allergic to cows’ milk protein, or who suffer from galactosaemia or require a galactose free diet.

*Registered Trademark

---

¹As of November 2014, as checked via company communications

Political Union

As a CPHVA member, you play an important part in informing national strategies, policies and priorities.

**CPHVA HAS A LONG AND ILLUSTRIOUS HISTORY OF** influencing and campaigning on a national level. From its beginnings in 1896, right through the current general election, the organisation and its members have been instrumental in affecting policy, guidelines and initiatives that have had a positive effect on generations of families and health visitors.

In the earliest days of the profession, women involved in health visiting were closely aligned with the women's rights movement, since charitable and caring professions were among the very few areas where women were given a level of social responsibility in any way comparable to that of men.

While the struggle for equal rights and votes for women rumbled on, social reform facilitated the development of services that began to resemble the health visiting service we have today. The CPHVA logo colours are based on the original green and purple colours of the suffragette movement, signifying this close tie and the battles fought and won by early pioneers of the profession.

Times may have moved on, but the ethos of campaigning, influencing and improving remains. For the CPHVA of today, politics isn’t just about politicians. Any issue, big or small, can be political - and members have the ability to inform themselves, campaign for, or change things which they feel, on some level, can be improved.

You might not feel particularly ‘political’, but just by reading through your copy of *Community Practitioner* or attending conferences, and engaging with and sharing any of the topics raised, you are becoming part of the process. But your involvement, and that of the CPHVA, doesn’t end there.

Behind the scenes, CPHVA officers and executives represent the profession of their members in a number of ways that have affected your professional, and probably even family, lives. They do this by representing you and voicing the things you tell them to those with the power and influence to action change. Some of the most significant ways in which Unite/CPHVA have been influential are described ahead.

**PRINCIPLES OF HEALTH VISITING**
The four principles of health visiting were first defined by the CPHVA in 1977, and to this day are used to guide training of health visitors and the development of the profession. They appear most recently in the 2015/16 National Health Visiting Core Service Specification used by NHS England.

The principles are:
- Search for health needs
- Stimulation of an awareness of health needs
- Influence on policies affecting health
- Facilitation of health enhancing activities

The third point in particular might be one that not all health visitors feel falls under their remit, but it remains central to the role of the health visitor if they are to be truly effective in their mission to deliver the other three principles.

**HEALTH VISITOR IMPLEMENTATION PLAN**
The development of the Department of Health (DH) Health Visitor Implementation Plan was led largely by Unite/CPHVA and their work on the Action on Health Visiting programme. At the time of the last general election in 2010, the priority for the incoming government in terms of the health visiting service was to maximise the numbers of health visitors and optimise their effectiveness and reach.

CPHVA were heavily involved with this process, representing health visitors and the profession to policymakers through campaigning, meeting with civil servants and discussion at the national conference. Members were included in these discussions and informed of their progress through events run by the organisation and articles in *Community Practitioner*.

The end result of this work and campaigning was the 2011-15 Health Visitor Implementation Plan, which led to a sizeable increase in the health visiting workforce.

The CPHVA logo colours are based on the original green and purple colours of the suffragette movement.
and improved understanding of the importance of the profession. As the implementation plan approaches its end, and commissioning for services transfers to local authorities a few months later, it is still as important as ever that the achievements and progress made over the past four years continue to be felt, to ensure an enduring and efficient programme of specialist public health nursing.

1001 CRITICAL DAYS
The period between conception and age two was flagged as a crucial stage for influencing the health and social outcomes that affect individuals for the rest of their lives. A cross-party manifesto setting out suggested interventions was established, agreed on by politicians from across the political spectrum.

CPHVA were heavily involved in campaigning for and enforcing the representation of best practice in this manifesto, getting involved with the all party parliamentary group and meetings with key figures, pushing for the best – rather than the cheapest – solutions, and ensuring that the importance of early intervention and the crucial role of health visitors were flagged throughout.

The follow-up to the original manifesto, Building Great Britons, sets out how these aims and objectives can be achieved, and along with a number of other stakeholder organisations, the CPHVA have been vital in ensuring that the experiences and interests of members are heard.

NMC CODE
CPHVA have played an important role in The Nursing and Midwifery Council (NMC)’s updated Code and the development of the upcoming revalidation process. Consultation on the draft version of the document resulted in significant changes to the final version, and Unite/CPHVA worked closely with the NMC to ensure that both the Code and the revalidation process were applicable to specialist community public health nurses (SCPHNs). CPHVA professional officers are taking part in the NMC revalidation pilot which will help to flag and iron out any difficulties in the process.

UNITE IN HEALTH
On a broader level, Unite’s health branch has been instrumental in campaigning for fairer pay for NHS workers, through lobbying the government and balloting members for strike action when solutions can’t be reached. NHS workers have received ‘real terms’ pay cuts for the past eight years, and pay has been cut by 12-25 per cent since 2010.

Since the government ignored recommendations from the independent pay review body that NHS workers should receive a cost of living rise, Unite have been in discussions with politicians including the secretary of state of health, Jeremy Hunt, to secure a fair living wage for members.

Pay offers suggested by the government have been voted on and acted upon by Unite, which culminated in October 2014 in the first strike of NHS workers for over 30 years. Negotiations over pay are ongoing, with your views and ballots being used to inform priorities and discussions.

USING YOUR VOICE
With the election approaching, this really is your chance to have your say on the future. Party politics is ever further removed from the daily lives of ordinary workers, and many voters feel understandably disengaged from the process. It might be hard to feel involved in this process, but it’s impossible not to be involved if you want things to change.

It’s unlikely that the thoughts, priorities and values of any individual will align completely with that of a political party; even MPs rarely agree with everything put forward by their own party. Unite professional officer Dave Munday advises that members shouldn’t feel too torn when choosing who to vote for. He suggests that the electorate should base their decision on a main issue that is important to them, and campaigning for change in the issues that don’t reflect their own views.

One of the reasons CPHVA exists to represent you and to make sure you are heard. The more you can feed into this process, the more you are likely to get out.
RENault CAPTUR
CAPTURE LIFE

Renault Captur Dynamique MediaNav ENERGY dCi 90 S&S

Multimedia Touchscreen with Integrated Navigation
With only 95g/km CO₂, 78.5 combined mpg and 15% BIK
P11D price £16,540

Visit renault.co.uk/business or call the Renault Business Team on 0800 040 7344.

The official fuel consumption figures in mpg (/100km) for the Renault Captur Dynamique MediaNav ENERGY dCi 90 S&S are: Urban 67.3 (4.2); Extra Urban 83.1 (3.4); Combined 78.3 (3.6). The official CO₂ emissions are 95g/km. EU Directive and Regulation 692/2008 test environment figures. Fuel consumption and CO₂ may vary according to driving styles, road conditions and other factors.

Car shown has optional metallic paint, available at an additional £495 (or £995 for I.D. paint), plus £100 for painted roof. All information correct at time of going to print.
Special report

Rachael Maskell

Labour candidate for York Central and head of health at Unite speaks to Amy Brewerton about her election plans

UNITE’S HEAD OF HEALTH RACHAEL MASKELL has had a busy few months, and things don’t look like they’re going to calm down for her any time soon.

As well as leading 100,000 Unite in Health members through one of the most turbulent times for their sector, Maskell has also been working hard behind the scenes to secure her place as a parliamentary candidate for the Labour party.

The day we spoke, she was still caught in the whirlwind of activity that had followed her selection as Labour’s candidate for York Central earlier the same week. In the weeks and months to come, she will be tirelessly following the campaign trail to defend the constituency’s seat in May’s general election – and, if successful, for the duration of her tenure in parliament.

Physiotherapist Maskell still practices one weekend a month in between her Unite and pre-election duties, and feels that this patient contact is vital to get a picture of the issues on the ground in the health service. Having represented so many Unite in Health members, including the CPHVA, she also values the insight she has gained into the opinions and thoughts of those working on the front line in all areas of health.

She took some time out of her busy schedule to talk to Community Practitioner about her path into politics, how CPHVA members can mobilise themselves to change the NHS, and why it is so important to have a health presence in parliament.

How did you first come to be involved with Unite?

I started, like so many people, as a member of a health union. I was a physiotherapist working in the NHS and became the rep at the hospital I was working at, and became the convener for the hospital. I then went to work for the union. I’ve held various roles - I headed up the equality portfolio to start with, then the not-for-profit sector for seven years. When this government came in I led for the NHS. I was a regional official before leading for health, so I’ve always had a strong footprint in health.

What inspired you to make the move over into politics?

I believe that health workers are best placed to set out the future of the health service and therefore it’s important to have people with health experience actually working in parliament and changing policies. We have seen a real dismissal of the value of the NHS.

We’ve seen this government condemn NHS staff, we’ve seen them reorganise the NHS when of course they said they wouldn’t, introducing cuts and privatisation. If this government were to get back in, the NHS would be unrecognisable from where it is now – and we will lose our NHS, it’s a very simple fact. We will see such privatisation that we will not have a health service.

We’ve also seen a dumbing down of the preventative agenda. We know that investment in prevention is an investment in people’s lives. I’ve been working with Andy Burnham for about the last three years in putting together Labour’s health policy. I’ve been very much about setting out the future of what health and care should look at, and again really focusing on ensuring that prevention is central to that.

How do you think your experiences working in healthcare have helped you?

I continue to practice. I work a weekend a month in the NHS, and I think it’s kept me very grounded with what’s happening in the NHS. Not just with patients - working with my members across the health sector has really kept me grounded with what’s happening in the NHS.
helps workers to determine what’s happening and what should happen in the health service, and I continue to want those voices to be heard in parliament.

Do you think people are put off by the word ‘politics’?
I think politics itself has become quite a passive exercise for so many people - so many people are disfranchised - but I think we’ve really brought forward the experience of members, and we really do engage them as a union. That’s what Unite’s political strategy is all about – it’s really ensuring that working people are heard, are listened to, and influence policy. If we don’t listen to people who are working on the front line then we are never going to get policy right.

Can there be more engagement among healthcare professionals?
I think that this election is going to be so crucial, and would encourage all health workers to play a very active role. I think that health workers deliver the best message to the electorate about the state of the health service, so I would be encouraging all Unite’s NHS workers to go out and campaign in their constituencies and to talk about what they experience and see all around them in the NHS. Obviously I believe that Labour has got a strong plan moving forward and will support patients and clients in a far better way than anything we’ve got at the moment – particularly the integration between physical health, mental health, and social care. Bringing that holistic approach back into the heart of the NHS will be crucial. Making sure that the patient drives the finances and the structures around them, rather than the structures determining what happens to patients.

Who inspires you most in terms of politics, past or present?
I’m totally inspired by the 1945 government. At a time of economic austerity, where we had so many people coming back from serving our country and needing jobs, our government renationalised so many services, built the welfare state, including the NHS. As a result they created the jobs, economic growth, and a welfare state to support us. I think if it can be done in 1945, it can be done now. We should take the spirit of 1945 into this election - 70 years on - to ignite hope again across our country.

What advice would you give to those who are disillusioned with politics, or who would just like to become more involved?
I would encourage all Unite members to look at what’s happened in Greece recently. The power is in their hands. If they want to make a difference and they’re frustrated with the situation and how things are, it’s when workers join together and organise that they can bring about change and make a difference. I believe that the future of politics is about people taking a collective stake in the political system. Politicians need to make sure they’re listening and engaging with people – and I believe that Labour are best placed to do that, hence our historic links with the trade union movement.

Do you think the nature of political campaigning is changing?
I think there are so many ways of campaigning and I think what campaigning does is to make politicians go further, faster. Of course we have the ability now to campaign online, but there is nothing more effective than when a health worker is standing before a member of parliament telling their story. We have an amazing story in the NHS, but we also have a story where things have got really difficult in the past few years. We think about the cuts to NHS pay, we think about cuts to terms and conditions, we think about cuts to services - I think people need to hear the real story about what is happening in the NHS. There is a real alternative out there, and Labour, I think, their health policy is probably the most exciting policy that they’ve put forward, therefore it’s something to really get out of the armchair for, to campaign for and to fight for.

How important is it to have health workers in parliament?
We don’t have many clinicians - there’s never been a physiotherapist in parliament - but we do need people who have been there from all different parts of the service. I always think that the health service is like a human body and you need all the parts there for it to be able to work. On the parliamentary benches I think we need to have people with a range of experiences in the NHS to work together to make sure we can build a health service that is fit for the future. We’ve got nobody with a clinical experience in that sense. So I think this is real opportunity to make sure we’ve got somebody there, but also representing people with such a spread of professions. We’ve got over 100,000 Unite members working in the NHS – I am already well versed in the arguments and know the challenges facing so many of our members. Thinking of our CPHVA members in particular we need to make sure we’ve got a safe skill mix, staffing levels so we’ve got safe caseloads, if we look at school nurses, the average child just gets 12 minutes a year of school nursing, we need to make sure we’ve got enough top health professionals. I think that background I’ve got as front line clinician but also a representative of 100,000 health workers will be so useful for the Labour party but also for building the NHS of tomorrow.

I still believe that health workers are best placed to set out the future of the health service and therefore it’s important to have people with health experience actually working in parliament and changing policies.
RESEARCH EVIDENCE

Energy drinks increase hyperactivity in children
A study has found a strong link between sweetened beverage consumption (including energy drinks) and hyperactivity or inattention in school-aged children.

The study, undertaken by researchers from Yale University, was conducted on a sample of 1,649 children with a mean age of 12.4 years. Participants were asked to record the drinks consumed in the preceding 24 hours, and completed a five-item hyperactivity and inattention subscale questionnaire to measure symptoms.

Results showed sweetened beverage consumption was higher among boys compared to girls. Children in the study consumed up to seven sweetened drinks per day, with an average of two drinks per child.

Researchers found the chance of a child being hyperactive or inattentive increased by 14% with each additional sugary drink consumed, once other variables were taken into account.

Those who had consumed energy drinks were 66% more likely to report hyperactivity than those who had not.

The authors recommend that children should not consume sweetened energy drinks and that more research is needed into the link between such beverages and hyperactivity disorders.


Alcohol messages should focus on social consequences
Results from a study of university-aged students examining the effects of alcohol warnings has found that those who are aware of the potential social consequences are likely to drink less.

Undertaken on a sample of 211 students with a mean age of 18.9 years, researchers supplied participants with materials that described an episode of drinking, framed as having been written by a recent graduate.

The materials either described positive outcomes or negative consequences as a result of their personal drinking experience.

After reading the accounts, participants were then asked to record their future intentions with regards to their own alcohol consumption.

Students who had read about positive social consequences were more likely to state an intention to consume less alcohol.

Those who had read about negative health consequences were also more likely to state an intention to consume less alcohol.

The authors conclude that public health messages highlighting the social and health outcomes of drinking alcohol are likely to be more effective in this population.


Naps affect sleep quality in children over two
A systematic review of original published research has found evidence that napping may be associated with later and shorter duration of sleep in children aged over two years.

Researchers examined existing published evidence regarding the effect of napping in children aged 0-5 against measures of child development and health.

The 26 papers identified in the study looked at development outcomes such as night sleeping, cortisol, behaviour, obesity and accidents.

A consistent theme among the studies was that napping was associated with later onset of night-time sleep, which was also shorter in duration and of poorer quality, particularly in children more than two years old.

Authors however noted that there were limitations of the studies, including the fact that in most cases, behaviour and development was reported by parents or carers rather than health professionals.

Although more research is required into the link between napping and behaviour, health and cognition, the study found evidence to indicate that napping negatively affects night-time sleep.


Child Feeding Guide app launched
A smartphone app for iPhone and Android devices has been launched to help parents manage mealtimes with a fussy child.

Developed by a group of psychologists from Loughborough University Centre for Research into Eating Disorders (LCURED), who are also parents of pre-school children, the app offers strategies and tools that can be used to help tackle fussiness in a positive way. The accompanying website, www.childfeedingguide.co.uk, aims to help to assess and monitor feeding behaviour, learn about common feeding problems, and access tips and tools that can be used to implement changes.

NICE updates guidance on gestational diabetes
The National Institute for Health and Care Excellence (NICE) has updated guidance for the diagnosis and postnatal care of women with gestational diabetes. Nearly 90 per cent of women who have diabetes during pregnancy have gestational diabetes, which may or may not resolve after pregnancy.

The new recommendations suggest that pregnant women should be diagnosed with gestational diabetes if they have a fasting plasma glucose level of 5.6 mmol/litre or above, or a two-hour plasma glucose level of 7.8 mmol/litre or above.

This new threshold is intended to standardise the current variation in glucose levels currently used to diagnose the condition, and is likely to lead to an increase of diagnosed cases.

The guidance also states that women with gestational diabetes whose blood glucose levels have returned to normal after birth should also be offered lifestyle advice that includes weight control, diet and exercise, and a fasting plasma glucose test 6–13 weeks after the birth to exclude diabetes.

The full guidance is available at: www.nice.org.uk/guidance/NG3

NICE updates guidance on gestational diabetes
The National Institute for Health and Care Excellence (NICE) has updated guidance for the diagnosis and postnatal care of women with gestational diabetes. Nearly 90 per cent of women who have diabetes during pregnancy have gestational diabetes, which may or may not resolve after pregnancy.

The new recommendations suggest that pregnant women should be diagnosed with gestational diabetes if they have a fasting plasma glucose level of 5.6 mmol/litre or above, or a two-hour plasma glucose level of 7.8 mmol/litre or above.

This new threshold is intended to standardise the current variation in glucose levels currently used to diagnose the condition, and is likely to lead to an increase of diagnosed cases.

The guidance also states that women with gestational diabetes whose blood glucose levels have returned to normal after birth should also be offered lifestyle advice that includes weight control, diet and exercise, and a fasting plasma glucose test 6–13 weeks after the birth to exclude diabetes.

The full guidance is available at: www.nice.org.uk/guidance/NG3
Help parents teach healthy habits from the start

Cow & Gate Friends are designed to make vegetables an essential part of the weaning journey. This unique range of savoury food pouches helps parents start weaning with single vegetables and gradually introduce combinations of flavours, a process that helps create a love of vegetables for life.

Find out more about the ‘Start, Vary, Repeat’ approach to weaning at www.in-practice.co.uk/weaning.
Supporting families with a fussy eater

WE ALL KNOW CHILDREN WHO ARE fussy eaters. Half of all parents report having a child who is fussy or eats a limited diet (Reau, Senturia, Lebailly & Christoffel, 1996). These fussy or difficult eating behaviours are often significant, persisting for months or years (Farrow & Blissett, 2012), and a poor diet in childhood frequently continues into adulthood and is linked to obesity and various preventable diseases, such as cancer and diabetes (Nicklas & Hayes, 2008). How this fussiness is managed early on affects whether children outgrow it or if it will continue as they get older and this is why parents and caregivers have such a vital role in helping children to develop healthy eating habits.

While information about milk feeding and weaning is abundant, practical advice about child feeding once weaning has occurred is lacking (Schwartz, Scholtens, Lalanne, Weenen & Nicklaus, 2011). Our own research confirms that parents find available resources about feeding young children and promoting healthy eating to be “too basic” and that parents often resort to searching for information independently (Mitchell, Farrow, Haycraft & Meyer, 2013).

The five most common pitfalls encountered by parents are:
- Food refusal
- Children’s unhealthy food preferences
- Pressuring children to eat
- Using food as a reward
- Parental use of restriction

A common child eating behaviour which lots of parents find worrying is food refusal. Many children go through a phase known as ‘food neophobia’, or fear of new foods, typically around 18-24 months, where they become wary of new foods or of foods that they previously liked (Birch & Fisher, 1998). During this phase, children often appear fussy and many parents are unsure how to respond to this. There is good evidence that a food may need to be offered up to 15 times before children trust it and are willing to taste it (Wardle, Carnell & Cooke, 2005). Once the child deems a food to be ‘safe’, it can take a further 15 offerings, or ‘exposures’, before the child develops a liking for it (Wardle et al., 2003). This means that it is vital that parents continue to offer foods that their child dislikes, as only by increasing children’s familiarity with a food will it become likely to be eaten (Aldridge, Dovey & Halford, 2009).

These food exposures can be part of a meal or snack, or they can occur outside of meals when children may be more relaxed, for example, playing with food (e.g., messy play with cooked pasta or dried beans), singing songs about foods, or encouraging children to pick out and touch different foods when out shopping or at a market.

In the UK, daily consumption of five portions of fruit and vegetables is recommended. However, only around one in five children achieve this (Health and Social Care Information Centre, 2014). The Child Feeding Guide has a whole section devoted to ways that parents can increase children’s fruit and vegetable intake. For example, using real fruits and vegetables in messy play, ‘growing your own’, or getting children involved in food preparation and cooking. By making a food more familiar, it is much more likely to be subsequently eaten (Aldridge et al., 2009).
Difficulty swallowing?
Feel good about food again.

If you need mashed or puréed food, mealtimes might not be so enjoyable. Our award winning Softer Foods range will help. Used in more than 250 hospitals nationwide, they are approved by hospital dietitians and recommended by speech and language therapists for people who need a softer diet. Softer Foods are created to look and taste like ordinary food, and quick frozen for convenience. Delivery to your door is free. They are appetising, nutritious, easy and safe. So you can relax and begin to feel good about food again.

To order your copy of our free brochure call 0800 066 3733 softerfoods.co.uk
When is infant regurgitation a cause for concern and how can it be managed?

Uncomplicated regurgitation is a developmental issue, but it is normally nothing to worry about.

Virtually all infants will experience some symptoms of gastroesophageal reflux.

Gastroesophageal reflux (GOR) is the effortless passage of gastric contents into the oesophagus, with or without regurgitation and vomiting.

Symptoms peak at 3 months of age, usually resolve between 12 and 14 months of age, and do not require further assessment by a specialist.

Gastroesophageal reflux disease (GORD) occurs when reflux leads to complications and/or troublesome symptoms.

Guidelines recommend considering pre-thickened formula to reduce GOR.

The European Society of Pediatric Gastroenterology, Hepatology and Nutrition recommend parental reassurance and education when trying to help resolve reflux. They also recommend considering anti-regurgitation formula for uncomplicated GOR in formula fed infants. These formulas help to minimise regurgitation by thickening on contact with the stomach acid.

The benefits of thickening with cornstarch

Since children under 6 months of age can digest cornstarch, it is an appropriate carbohydrate to use as a thickening agent in formula. Cornstarch provides a valuable source of calories and, importantly, it does not interfere with the absorption of other nutrients.

Several studies have demonstrated the advantages of using cornstarch as a thickener. In one study, 86% of infants with GOR who were fed anti-regurgitation formula pre-thickened with cornstarch demonstrated an improved reflux index – this is a measure of how long oesophageal pH was most acidic (pH4).

As a result of this improved reflux index, formulas thickened with cornstarch may also help to reduce silent reflux. Pre-thickening with cornstarch also led to significantly fewer daily episodes of regurgitation and vomiting compared with infants fed on regular formula.

The effects of using non-digestible thickeners in infants is unclear

Carob bean gum is one such thickener. It passes undigested into the colon which may impact on the digestion and absorption of certain nutrients such as calcium, iron and zinc. Further studies are required to evaluate the effects of such thickeners in regurgitating infants.

SMA Staydown Formula is designed for the dietary management of babies with significant reflux. It is nutritionally complete and can be used from birth.

- Clinically proven to reduce reflux in infants with GOR
- Thickened with easily digestible cornstarch
- Omega 3 and 6 LCPs
- Halal approved and suitable for vegetarians

Supporting you to support mums

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


*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 breastfeeding may be difficult to reverse and the introduction of partial bottle-feeding may reduce breast milk supply. The financial benefits of breastfeeding should be considered before bottle-feeding is initiated. Failure to follow preparation instructions carefully may be harmful to babies health. Infant formula and follow-on milks should be used only on the advice of a healthcare professional. This product must be used under medical supervision. SMA Staydown is a special formula intended for the dietary management of bottle-fed babies when significant reflux (regurgitation) is a problem. It is suitable as the sole source of nutrition up to 6 months of age, and in conjunction with solid food up to 12 months of age. If the baby’s reflux does not improve within 2 weeks of starting SMA Staydown, or if the baby fails to thrive, the GP, Health Visitor or other healthcare professional should be consulted.

*Registered Trademark
We developed a free app for tablets and smartphones called Child Feeding Guide, which provides evidence-based information and practical support for anyone who is concerned about children’s eating behaviours.

In addition to supporting parents and caregivers (henceforth referred to as ‘parents’), it is also a useful resource for health professionals to use and share with families that they work with who are encountering these common feeding difficulties.

The app helps explain the science behind children’s eating behaviour, allows parents to assess and monitor their own and their child’s responses around food and mealtimes, and provides strategies to address fussiness in a positive way.

One unique feature of the app is that it describes the five most common feeding pitfalls that families encounter. It explains what they are, why they occur, and advises parents about what to do when they are encountered.

REFERENCES


Mary Seacole Awards 2015-16

For nurses, midwives and health visitors

From 27 February applications will be invited to participate in the prestigious Mary Seacole Awards programme for 2015-16.

These awards, funded by Health Education England, provide the opportunity to undertake a specific health care project or other educational/developmental activity that benefits and improves the health outcomes of people from black and minority communities.

Want to find out more? Visit one of our workshops taking place on 19 March in London and 26 March in Birmingham.

Book a workshop: Email amy.cole@rcn.org.uk

Publication code 004 808
Reducing dog bites in children

**INTRODUCTION**

Dog bites cause a significant burden of injury to society with a particular impact on children. Data published by the Health and Social Care Information Centre revealed that there were 6,740 hospital admissions specifically for dog bites and strikes in England and Wales, a 6 per cent increase from the previous year.

The data also showed a worrying increased risk related to deprivation with an admission rate three times higher for the 10 per cent most deprived areas compared to the 10 per cent least deprived areas (241 admissions per 100,000 compared to 8.1 per 100,000). Rates of admission were highest in the north of England and lowest in the South West. Dog bite admissions were highest in the Summer months and in the 0-9 year old age group.

Children suffered more injuries to their head compared to other age groups where the main injuries were to the wrists, hands and forearm (HSCIC, 2014).

Studies by Bernardo and colleagues (2002) and Reisner and colleagues (2011) have shown that >50 per cent of children bitten are under the age of seven, and many are bitten by either the family dog or a dog that they know. Meints (2010) has shown that young children may misinterpret dog’s facial expressions. Four, five and six-year-olds, and adults were tested on neutral, aggressive and happy human and dog facial expressions.

While <1 per cent adults made mistakes, 69 per cent of four-years-olds interpreted aggressive dog faces as smiling and happy. 35% of five year olds and 25% six year olds misinterpreted dog expressions but gave correct interpretation in >90% human expressions. This lack of interpretation may contribute to the high incidence of bites in younger children.

Bites may have serious consequences for children and adolescents and a review of the literature revealed that a range of interventions have been considered to try and reduce dog bite injuries. Studies have looked both at dog bite awareness and the effectiveness of specific educational prevention interventions.

**RESULTS OF LITERATURE REVIEW**

Presutti (2001) emphasises the important role that a dog can play in family life, but stresses the need for education programme providing clear boundaries for a dog within the family. Families should avoid ‘humanising’ their dog (e.g. allowing it to sleep on furniture or beg at the dinner table), as this type of behaviour can confuse the animal making it difficult to distinguish between animal and master, increasing the risk of biting.

Presutti also stresses that children need to learn to avoid running and screaming in the presence of a dog, and dogs should not be greeted by presenting an outstretched hand. Hugging or kissing a dog expresses submission and is confusing to the animal, which may lead to more aggressive behaviour.

Dixon and colleagues (2012) conducted a cross-sectional study sampling three hundred 5-15 year olds and their parents presenting to a US paediatric department with non-urgent complaints or dog bites.

Eleven per cent of children participating had a current dog bite, 23 per cent had prior dog bites and 72 per cent currently or previously owned a dog. The parent/child pairs completed surveys and knowledge-based scenario tests, 43 per cent of children failing the test.

Older children had higher odds of passing the test than younger children, as did children with white parents versus non-white parents. More than seven out of ten of children had never received dog bite prevention education - although 88 per cent of parents desired it, the majority not knowing where to go receive this education.

Dixon (2013) went on to evaluate a video-based prevention intervention in a paediatric emergency department. In a cross-sectional, quasi-experimental study 120 five to nine-year-olds and their parents completed a 14-point simulated scenario test, with ‘yes’ or ‘no’ answers, about safe dog interactions pre/post a video intervention. The video lasted approximately 20 minutes and was called ‘Dogs, Cats and Kids’. The test pass rate was 58 per cent pre-intervention and 90 per cent post-intervention, younger age being the only predictor of failing the post test.

Knowledge scores increased in 83 per cent of children. The greatest increases were in questions involving stray dogs or dogs that were eating or fenced. The authors concluded that video intervention would be helpful in addressing the dog bite problem, but recommend further studies on effectiveness by measuring dog bite incidence or injury severity.

Chapman and colleagues (2000) also designed an educational programme for primary school children called ‘Prevent-a-Bite’. The intervention consisted of a 30-minute lesson conducted by an accredited dog

**Children need to learn to avoid running and screaming in the presence of a dog, and dogs should not be greeted by presenting an outstretched hand.**
handler who demonstrated various ‘do’s and don’t’s’ of behaviour around dogs. Children practised patting the dogs in the correct manner and were shown protective body postures to adopt when approached or knocked over by dogs.

A resource kit for teachers was also distributed. Seven to ten days after the intervention the children were let out to play unsupervised in the playground with a dog tethered nearby, with a videotape recording their actions. Those children in the intervention group displayed much better precautionary behaviour when compared to controls.

Wilson (2002) also found that a dog safety programme resulted in a significant increase in the ability of children to identify high risk situations involving dogs, with the benefits being even greater in those children whose parents were also given dog safety information.

Prevention interventions targeted solely towards parents have shown mixed results. Shields and colleagues (2012) enrolled 901 parents attending a paediatric emergency department with young children in an urban area in USA, where there was a high exposure to stray and dangerous dogs.

The parents completed a kiosk assessment and received a report which contained information aimed at increasing knowledge about either dog bite prevention (n=453) or other safety behaviours (n=448). Participants were phoned two to four weeks later for a follow-up interview to measure knowledge differences. Those who had received information about dog bites scored significantly higher on two of the three dog bite knowledge questions, although only 13 per cent of respondents answered each of the questions correctly.

The authors concluded that tailored written material, designed for low literacy audiences, may effectively communicate with families, although it is unclear how the knowledge gained is translated into preventative behaviours.

Researchers have looked at the impact of the ‘Blue Dog Programme’, an educational resource which started as an interactive CD-rom with a printed parent guide. It contains information with stories and scenarios to educate children about safe dog interactions. It was developed by a team of professionals from multiple disciplines and is administered by a charitable trust.

Since its inception in 2005 various studies have assessed its effect. In 2009, Meints and de Keuster looked at its impact in children under seven. In this age group the intervention was successful and showed that children were better equipped to make safe choices after viewing it.

This was taken further in 2012 by Schwebel and Morrongiello. They offered children aged three and a half to six years the same training programme and then assessed their knowledge in three different ways. They looked at pictures of risky behaviour, simulated behaviour with a dolls house and then introduced children to a live dog. The study found that although children were successfully taught knowledge about safe engagement with dogs, the intervention did not influence recall or implementation of safe behaviours.

Meints and colleagues went on to do a longitudinal study to assess the impact of the Blue Dog story modules on DVD, particularly looking at whether acquired knowledge changed behaviour with their own dog. Children were shown a set of 15 different interactive child-dog scenes and asked to choose a safe or unsafe outcome for the story. Children were then tested at eight weeks, six months and one year.

Some were allowed to take the DVD and booklet home while a second group received only the booklet. Those children with the DVD did show more correct responses and they were able to retain this information. Younger children benefit from using the DVD especially. Parental questionnaires at eight weeks showed 38 per cent of children interacted more safely with their own dog and 50 per cent behaved better with dogs in general.

Morrongiello and colleagues (2013) conducted a pre/post intervention/control study to assess whether exposure to the Blue Dog positively impacted upon parent behaviours. The authors found no difference in behaviour pre and post intervention with parents showing risky reactions and encouraging children to interact with the dog despite knowing little about its disposition. They highlight the need for effective interaction with children.

UK legislation targeting ‘dangerous dogs’ has not been shown to reduce the number of dog bites.
interventions targeting both parents and children.

**CONCLUSION**

Orritt (2014), writing in the BMJ, points out that politically driven UK legislation targeting ‘dangerous dogs’, has not been shown to reduce the number of dog bites, and a review of the literature has shown that there are few studies looking at the effectiveness of educational intervention programmes. In an effort to reduce the number of dog bites in children and adolescents medical and veterinary professionals need to work together to develop effective, evidence based management strategies promoting safe interactions with dogs.

**REFERENCES**


---

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

1. Rates of admission for dog bites are highest in
   - London
   - The North
   - South West

2. Where do children suffer most injuries?
   - Head
   - Leg
   - Forearm

3. What age of child is most likely to be bitten?
   - 0-7
   - 7-10
   - 10-14

4. Admission rates for dog bites
   - Are highest in the winter months
   - Are highest in deprived areas
   - Have shown a steady decline in the last 5 years

5. Young children
   - Are less likely to be bitten by a dog they know
   - Are good at interpreting the dogs face
   - May think an aggressive dog is smiling

6. It is good for your dog to
   - Be humanised

---

**Sleep on the furniture**

Be greeted with an outstretched hand

None of the above

---

**7. Dog safety programmes**

- Are more effective if parents are also given safety information
- Have little effect in teaching precautionary behaviour
- Are not suitable for the under-fours

---

**8. The Blue Dog programme**

Implements implementation of safe behaviour in over 90% of children

Was shown to be effective in children over 7

Is only effective when children can take the booklet home

---

**9. Dog bites**

- Have a low risk of infection
- Are usually from male dogs
- Are routinely treated with trimethoprim

---

**10. The following are true**

- UK legislation targeting dangerous dogs has not significantly reduced the number of dog bites
- Over 70 per cent of 10-year-olds have received dog bite prevention education in school
  - The Blue Dog Programme is delivered by health visitors
"Give me peace, how long will this irritation last?"

Spread Calm
Soothing, calming and protecting, Diprobase has been helping people with eczema to hydrate their skin, relieve symptoms and live more peaceful lives for over 30 years.
The lived experience of homeless women: insights gained as a specialist practitioner

**INTRODUCTION**

The home reserves a very special space experience which has something to do with the fundamental sense of our being. Home is where we can be what we are. We feel a special sorrow for the homeless because we sense there is a deeper tragedy involved than merely not having a roof over one’s head (Van Manen, 1990:102).

Van Manen (1990) articulates how home is intrinsically linked to a sense of being in the world (Heidegger, 1962). But what happens to the ‘being’ of a homeless person? How do they live in the world and who are they? In this paper, I draw insights into the lived experience of homeless women, drawn from a PhD reflexive narrative study on health and homelessness (Fordham, 2012). When I ventured into specialist community public health nurse (SCPHN) homelessness practice in 2006 there was little national or local guidance on homelessness that I could draw on for public health nursing practice. There were few UK qualitative studies on the way homeless people experienced ill health, or how they felt poor health had contributed to becoming homeless. There was substantial literature on why homeless people may not participate in research, highlighted by Dasqui (2007), including distrust of authority (Brealy, et al 2001, Smith et al, 1991), chaotic lifestyles (Power et al, 1999) and prioritisation of addiction needs over research engagement (Hills, 2007). I found engagement with homeless women and men highly successful, contrary to the literature cited above. Respondents articulated how focus group dialogue contrasted with the often dehumanising experience of repeated attempts to access health services. In them, they expressed their experiences of healthcare and were able to constructively contribute to local service improvement. Similarly, therapeutic engagement in homeless outreach clinics reflected the stories of disengagement by mainstream health services. Having always visited women in their homes as a SCPHN, hearing stories of being homeless told by homeless women particularly intrigued and challenged me. The insights I gained were developed through reflective practice and guidance beyond my former understanding of homelessness in generic practice. These insights are the focus of this paper. In it, I present a story text from the narrative study and a synopsis of seven core texts which illuminate

**Key points**

• Homeless women are a heterogeneous group of people of varying ages and included professional women

• Housing ‘priority need’ pregnant rough sleepers who are deemed as ‘intentionally homeless’ are not eligible for social housing

• Mainstream health services are often ‘hard to reach’ for homeless groups. This prevents complex health issues being effectively addressed

• Childhood trauma is a significant feature in homelessness

• Dialogue around ongoing generic SCPHN support for mothers who have children taken into care should be considered in ongoing service development to prevent some women becoming homeless
the experience of homelessness and women’s feelings about their health and wellbeing.

AIM
The aim of this paper is to illuminate the lived experience of homeless women who attended outreach clinics or lived in hostels where insights were developed through a process of reflective practice and self-inquiry (Johns, 2013).

METHODOLOGY
The narrative study was constructed using reflective practice guidance (Johns, 2009; Schon, 1983).

NARRATIVE CONSTRUCTION
The research method drew on Johns’ (2009) Six Dialogical Movements, which evolves from reflective journaling towards narrative performance using reflective guidance and extant theory. Coherence is woven through each movement. This is important as narrative research positioned in the constructivist paradigm seeks to understand meaning rather than provide a scientific explanation. Coherence made the narrative study plausible and believable. Richardson & St Pierre’s (2005) Creative Analytical Practices (CAP) was used to determine criteria for aesthetic merit regarding reader/audience engagement: i.e. narrative should make a substantive contribution to an understanding of social life; invite interpretative responses through the way it is written, be artistically shaped and complex.

Seven texts in my narrative study centred on women. The stories of these women were shocking and thought-provoking. The specialist role of the SCPHN in homelessness enabled therapeutic intervention at crucial points and ensured effective multi-agency collaboration. The outcome of this often resulted in the prevention of rough sleeping and evictions when ill health was present.

ETHICS
Ethical approval
With the proviso that identifying details were removed and pseudonyms (Morse, 2002) used in the study, the chairperson of the local ethics committee and the clinical effectiveness lead of the Trust confirmed that the submission of a research proposal to the PCT research governance committee and the local ethics committee was unnecessary. Developing self in professional practice does not require ethical approval (Carson, 1994; Johns, 2002; 2009). However, I did obtain oral consent from patients whom, without exception, wholeheartedly agreed that I should write their personal stories into the narrative. Indeed, it seemed to form part of their empowerment story. As such, it became a joint study with those whose lives had been affected by homelessness and warmly encouraged me on.

ANALYSIS OF REFLECTIVE DATA
The ‘Being Available Template’ (BAT) (Johns, 2009) was used in the study as an organising framework towards a deeper understanding of holistic care. Figure 1 shows its development in relation to homelessness. Within it, the core therapeutic of holistic practice with homeless people is irreducible; unfolding insights contributed to the whole of my homelessness SCPHN practice.

NARRATIVE TEXT
Mary’s Story – a homeless pregnant woman:
• Despair and Delight
• Winter Rough Sleeper Clinic

It’s freezing again. Val, the homeless centre manager, is impatient for me to meet a vulnerable, young rough-sleeping couple, two of the six rough sleepers on my clinic list. Mary and Cain shyly enter the room. Both look underweight and cold. I ease their discomfort, moving chairs into place to welcome them, seeking engagement. The couple have slept rough whilst applying for social housing in this area. Mary speaks slowly through stray strands of dark hair. Her borderline learning disability becomes visible as we dialogue together. Her list of medical and social problems grows, edging my concern towards despair:
• Raised by a mother with a heroin addiction
• Mother imprisoned for stabbing her father
• Childhood sexual abuse
• Learning disability
• A heroin user - unknown hepatitis status
• Asthma - no inhalers
• Epilepsy - no medications

Figure 1: Model of effective therapeutic engagement with homeless people and homeless families

Holding and intending the realisation of a vision of practice towards effective inclusion of homeless people in health services

• History of psychosis
• Possible pregnancy

Everything is disclosed so easily. I ponder on this couple’s relationship. A few minutes later Cain raises his sleeve to show me bruises and a slash mark on his arm. Domestic violence added to my concerns. Whilst domestic violence is recognised as a leading cause of homelessness (Buck, 2002; Quilgars & Pleace, 2010) a strategy for coping with domestic violence in rough-sleeping couples is undeveloped.

Just when my professional anxieties are at their highest Mary discloses that she had a young baby taken into care last year and she thinks she is pregnant again.

“No-one would take my child away”, Cain mumbles. I note the protective warmth in his naïve reply.

“How would you feel about being pregnant again?” I ask.

“Oh, great” she replies “really great.”

We watch the pregnancy test indicator. Slowly, silently the + sign appears. The room becomes filled with their delight. For awhile they remain totally unaware of the effects of the issues revealed to me on future child-rearing. I muse on the very few pleasures that greet homeless people and engage within-the-moment in their delight. It has a huge pleasurable impact on their present life circumstances.

Mary begins to reminisce about Ruby, her daughter, who was taken into care at six-months of age. From her navy track-suit pocket she pulls a creased photograph of a bonny-faced baby. The trauma of sudden removal, Mary’s most significant mark on his arm. Domestic violence added to her bereavement as well as her delight in this vulnerable group?

Or are these areas excluded - marginalisation carried into education, feeding exclusion of vulnerable groups?

Allowing Mary to therapeutically express her bereavement as well as her delight in this pregnancy secures effective engagement.

There is an enormous amount of partnership

April 2015 Community Practitioner 33
actions I have to initiate networking towards their ongoing care (Figure 2).

Supporting this young couple to engage with services underpins my advocacy role. Prompted in reflective guidance I consider ‘advocate’ Gadow (1980) identifies existential advocacy as unique to nursing. Rather than consumerism advocacy, “a trouble-shooter willing to intervene when systems violate an individual’s rights” (p.84), she argues that existential advocacy is.

The concept of professional involvement as a unifying and directing of one’s entire self in relation to another’s need .. in order that patient and nurse can participate as unified selves in the patient’s process of self-determination (Gadow, 1980:90-99)

Yet, I do feel like a troubleshooter in Mary’s struggle for self-determination. I ponder on Hebblethwaite et al’s (2007) note that learning disability makes survival in homeless environments difficult. Reduced capability results in fear, anxiety and despair, at a time when, despite increased physical and mental health needs, access to health services is difficult. Michael (2008) also describes how, People with learning disabilities can find it more difficult to identify and describe symptoms of illness, and much harder to navigate the health system to obtain treatment. These problems also make it more difficult for NHS professionals to deliver treatment effectively (p.16).

I negotiate the balance between acting as a trouble-shooter on their behalf and working in partnership towards self-determination, a way of enablement. Drawn from Mary’s past experience, their values towards self-determination are clear; they want to engage services to be able to parent effectively.

But, I spend two hours trying to engage services – a three hour time commitment with this couple today, confirming under-service – a three hour time commitment. Service access issues shock me: determination are clear; they want to engage services underpins my advocacy role. Prompted in reflective guidance I consider ‘advocate’ Gadow (1980) identifies existential advocacy as unique to nursing. Rather than consumerism advocacy, “a trouble-shooter willing to intervene when systems violate an individual’s rights” (p.84), she argues that existential advocacy is.

The concept of professional involvement as a unifying and directing of one’s entire self in relation to another’s need .. in order that patient and nurse can participate as unified selves in the patient’s process of self-determination (Gadow, 1980:90-99)

Yet, I do feel like a troubleshooter in Mary’s struggle for self-determination. I ponder on Hebblethwaite et al’s (2007) note that learning disability makes survival in homeless environments difficult. Reduced capability results in fear, anxiety and despair, at a time when, despite increased physical and mental health needs, access to health services is difficult. Michael (2008) also describes how, People with learning disabilities can find it more difficult to identify and describe symptoms of illness, and much harder to navigate the health system to obtain treatment. These problems also make it more difficult for NHS professionals to deliver treatment effectively (p.16).

I negotiate the balance between acting as a trouble-shooter on their behalf and working in partnership towards self-determination, a way of enablement. Drawn from Mary’s past experience, their values towards self-determination are clear; they want to engage services to be able to parent effectively.

But, I spend two hours trying to engage services – a three hour time commitment with this couple today, confirming under-service – a three hour time commitment. Service access issues shock me:

• Social Services refuse to see Mary until 28 weeks of pregnancy. I challenge them about addressing parenting issues early in the ante-natal period, perhaps through residential schemes, but funding for an assessment is unavailable.

• Housing teams stress that despite the pregnancy and subsequent priority need category she will only be offered time-limited temporary accommodation. If assessed as intentionally homeless, she will not be eligible for social housing. My previous health visitor belief, held within our local health visiting teams, is incorrect - pregnancy and parenting does not confer social housing rights and Mary was later assessed as ‘intentionally’ homeless.

• The learning disability team will not accept Mary because she is not registered with a GP. I have to wait for the consultant to contact me later. (Later, Mary’s IQ test score was 71. The criteria for Learning Disability service inclusion is 70. Mary was not offered services. Arguably complex disabilities and homelessness makes people more vulnerable and borderline criteria should be assessed holistically with criteria lowered in complex need).

• It takes four attempts to find a GP who will see Mary today; despite not having any medications or prior history. Even then she will only be offered temporary registration, denied preventative interventions such as the asthma clinic which she requires.

The very care which I regard as my role to coordinate is limited. Mary is seen through a particularly lens which conspires against equity and practically at a strategic level to change perceptions and policy.

Public authorities should never be allowed to treat their duties towards adults with learning disabilities under the Human Rights Act 1998 and the Disability Discrimination Act as optional (including their positive duties under the Disability Equality Duty. (A Life Like Any Other, Committee on Human Rights [HL/HC 2008:95]).

Ongoing story

• I lead two professional strategy meetings. The third strategy meeting is attended for the first time by social services when Mary is 28 weeks pregnant

• I arrange an introductory visit between Mary and her health visitor – the health visitor does not attend

• Mary’s baby was removed at birth. She had a severe psychotic episode and was admitted to an acute mental health unit. Having lost their accommodation when hospitalised, Mary and Cain returned to rough sleeping following her hospital discharge several weeks later.

Figure 2: Partnership actions for ongoing care

Community Practitioner April 2015
We are delighted to announce the 2015 CPHVA Awards shortlisted finalists:

Community Practitioner of the Year
Alison Lewis
Carol Sibbald
Catherine Nixon

Community Practitioner Team of the Year
Early Years Mental Health Specialist Team – South Tyneside
NINES, Northern Ireland New Entrance Service
South Warrington 0-19 years Team

Health Visitor of the Year
Niamh Hanlon
Shakila Shah
Sheila Lally

School Nurse of the Year
Angela Lovatt
Yvette Bynoe

Community Nursery Nurse of the Year
Amelia Wilton
Becky Sears
Sarah Rowland
Sue Patterson

Team Leader/Manager of the Year
Alison Waite
Ruth Chittenden
Sharin Baldwin

Educator of the Year
Jennifer Kirman
Martha Gibbons
Ruth Heffernan

Student of the Year
Emma Cummings
Karen Heggs

Thank you to everyone who submitted nominations for these awards

Thank you to our prestigious group of sponsors this year

For more details about the finalists and winners, visit www.communitypractitioner.com or see the May issue of Community Practitioner
Mary’s story shows the complex nature of homelessness and the plight of some homeless pregnant women who may be rough sleeping. It also raises issues about the support offered to mothers with children taken into care and the nature of disengagement by health and other services in homelessness. Other stories giving insight into the lived experience of homeless women were equally as poignant as Mary’s. In Figure 3, I offer a synopsis of those women who featured in the narrative study. Their health needs and their journeys into/out of homelessness are illuminated as well as the SCPHN role either as an advocate and/or enabler in partnership working towards ongoing health and well being.

**DISCUSSION**

Mary’s story shows the complex nature of homelessness and the plight of some homeless pregnant women who may be rough sleeping. It also raises issues about the support offered to mothers who have children taken into care and the nature of disengagement by health and other services in homelessness. Other stories giving insight into the lived experience of homeless women were equally as poignant as Mary’s. In Figure 3, I offer a synopsis of those women who featured in the narrative study. Their health needs and their journeys into/out of homelessness are illuminated as well as the SCPHN role either as an advocate and/or enabler in partnership working towards ongoing health and well being.

**BEING AVAILABLE TO EFFECTIVELY ENGAGE WITH HOMELESS WOMEN**

Fig 3 does not illuminate the intensity of the women’s experiences as much as stories do. In

<table>
<thead>
<tr>
<th>The women</th>
<th>Presenting health needs</th>
<th>Homelessness trigger [Homeless status]</th>
<th>Housing outcomes</th>
<th>SCPHN role towards a positive health outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mary</td>
<td>Asthma, epilepsy, borderline learning disability, infant in care, pregnancy, substance misuse, domestic violence. H/o childhood trauma and psychosis</td>
<td>Evicted from social housing accommodation - categorised as intentionally homeless [Rough sleeping]</td>
<td>Cold-weather temporary accommodation (TA), followed by Registered Social Landlord (RSL) accommodation. RSL tenancy was lost during hospital stay following psychotic episode after her infant was taken into care at birth. Returned to rough sleeping.</td>
<td>Advocacy where possible</td>
</tr>
<tr>
<td>Pamela</td>
<td>Traumatised by being sectioned under the Mental Health Act. Subsequently diagnosed with a brain tumour</td>
<td>Illness, loss of employment leading to loss of house [Rough sleeping]</td>
<td>Night-shelter; Sofa-surfing; Post narrative: Hospice until her death</td>
<td>Enablement</td>
</tr>
<tr>
<td>Heidi</td>
<td>Sprained ankle, alcoholism, estranged from adult children, H/o childhood trauma, adult torture; personality disorder</td>
<td>Released from prison following first offence [Rough sleeping]</td>
<td>Rough Sleeping; referred to a hostel where she stayed for 2 years</td>
<td>Enablement</td>
</tr>
<tr>
<td>Dora</td>
<td>Sprained ankle, alcoholism, fear of hospital. H/o children taken into care as a young mother</td>
<td>Unknown [Rough sleeping]</td>
<td>Rough Sleeping</td>
<td>Advocacy</td>
</tr>
<tr>
<td>Lucy</td>
<td>Severe self-harm, H/o childhood trauma including presence of maternal mental health illness and a sibling with learning disability</td>
<td>Escaping parental and sibling violence in family home [Hostel]</td>
<td>Hostel; then lived with partner’s family</td>
<td>Enablement</td>
</tr>
<tr>
<td>Ros</td>
<td>Huntington’s Chorea; alcoholism. H/o childhood trauma</td>
<td>Unknown [Night shelter]</td>
<td>Night shelter [prevention of imprisonment following breach of ASBO]</td>
<td>Advocacy</td>
</tr>
<tr>
<td>Ariella</td>
<td>Feeling alienated and frightened by hostel culture. H/o childhood bereavement</td>
<td>Loss of relatives family home. Limited family support following mother’s premature death. [Hostel]</td>
<td>Hostel and then onward into Social housing</td>
<td>Enablement</td>
</tr>
</tbody>
</table>

**Figure 3: Synopsis of women involved in the narrative study**
stories, their daily struggles, suffering, courage, knowledge and their search for peace and well-being was illuminated. Having concern for the person meant knowing the person as I worked with them therapeutically, often in dramatic circumstances. A key insight was seeing each person as a unique human being, without prejudice. Like Sycamore (2006), I found that most women wanted a home. However, some did not. Ironically, Pamela found her home with the homeless, being an advocate and living simply in a deep spirituality which, may or may not, have been an associated symptom of her undiagnosed brain tumour. Heidi also had a precarious relationship with accommodation; feeling at times it was safer to ‘sleep under the stars’, a reference to the extreme violence she experienced living at home.

In therapeutic spaces of being available to homeless women, I found the ‘genre of women’, noted by Pope John Paul II (1995), despite their enduring hardship.

In every time and place... women’s dignity has often been unacknowledged; they have often been relegated to the margins of society. This has prevented women from truly being themselves... reflect carefully on what it means to speak of the ‘genre of women’ in order to let this genius be more fully expressed in the life of society (p.10) Krumen-Nevo and Benjamin (2010) in their paper on poverty knowledge, show how social distancing occurs through ‘Othering’.

‘...Othering cushions middle-class people leaving their values unviolated and protected from any potentially impinging cultural relativism...

I challenged myself, do I or other health professionals, protect ourselves through Othering? Fitzpatrick et al (2011) notes a rise in “middle-class” homelessness. I chose two professional women (Fig 3) to illuminate how homelessness can affect professionals. My hope was to prevent Othering which I believed contributed to exclusion of homeless women and men from health service engagement and promote instead compassionate engagement. Being available to therapeutically engage with homeless women including homeless families, issues surrounding engagement and compassion are highly transferable into all areas of public health work. Further support for parents who have had children removed and taken into care was raised as a key issue for ongoing SCPHN dialogue.

CONCLUSION

In this paper, I have presented insights into the lived reality of being a homeless woman as seen through my specialist SCPHN role through a process of self-inquiry (Johns, 2009). I have noted how advocating and enabling homeless women in their health care requires effective engagement. The Effective Engagement with Homeless People and Homeless Families’ therapeutic model is presented to guide SCPHN teams towards compassionate engagement with homeless people including homeless families. Issues surrounding engagement and compassion are highly transferable into all areas of public health work.

The Effective Engagement with Homeless People and Homeless Families’ therapeutic model is presented to guide SCPHN teams towards compassionate engagement with homeless people including homeless families. Issues surrounding engagement and compassion are highly transferable into all areas of public health work.

IMPLICATIONS FOR PRACTICE

Through stories of practice, I hope to enable other health professionals to grasp the experience of homelessness in which complex health needs are often evident. The challenge for professionals is to engage effectively. The homeless women in this study were not ‘hard to reach’; health services were. The Effective Engagement with Homeless People and Homeless Families’ therapeutic model is presented in this paper to guide SCPHN teams towards effective engagement with homeless people including homeless families.

Beyond health services, the study findings have implications for social services, housing, police, probation and the voluntary sector.

REFERENCES


Fordham M. (2014) Reflective Practice: Health and Homelessness - Weaving the Net of Care as a Specialist Practitioner Community Practitioner 87 6 29-33


April 2015 Community Practitioner 37
Students’ and tutors’ perceptions of the use of reflection in post-registration nurse education

INTRODUCTION
This is a small-scale, qualitative study looking at students’ and tutors’ perceptions of the use of reflection in post-registration nurse education. The study involved a purposive sample of six post-registration nurse students and three tutors. The benefits of reflection have been highlighted in a number of studies (Langley and Brown, 2010; Glaze, 2002; Smith & Jack, 2005; Asselin, 2011; Bulman, 2008) however, there is a paucity of literature on students’ perceptions of the use of reflection in post-registration nurse education. This paper refers to the type of reflection that Schön (1983) describes as ‘reflection on action’. Practitioners reflect on actions, judging their success and whether any changes to actions could have resulted in different outcomes. Reflection increases students’ confidence in justifying actions and supports decision making in professional practice (Glaze, 2002).

As post-registration nurses have to engage in complex decision-making processes (QAA, 2010) as an integral part of their everyday practice it is important to investigate their perceptions of reflection as this could influence the education of post-registration nurses. Reflection also enhances professional practice and improves patient care (Gustafson and Fagerberg, 2004), which is the major premise of nurse education (NMC, 2004). Therefore, it is important to explore students’ perceptions surrounding its use in education so that its full potential to improve professional practice and patient care can be realised. The main aims of this study were to determine post-registration nurses’ and tutors’ perceptions of the usefulness or benefits of reflection on the learning process and the opportunities available to undertake reflection, examining both support and barriers experienced by students.

THE BENEFITS AND EFFECTIVENESS OF REFLECTION
Reflection was found to improve students’ self-awareness and self-confidence (Smith & Jack, 2005; Glaze, 2002). Reflective journaling is a written record that students create as they think about various concepts learned, about critical incidents involving their learning, or about interactions between students and teachers, over a period of time for the purpose of gaining insights into their own learning (Thorp, 2004). Reflective journaling enabled students to examine their own attitudes, such as fear of exposure and self-doubt (Langley and Brown, 2010; Kerka, 2002), and to see problems from the perspectives of others (Langley and Brown, 2010). However, studies have shown that nurses can be selective when remembering experiences and this plus vulnerability or fear of reprisal can make reflection seem like a negative experience (Newell, 1992). Reflection benefits professional practice. Glaze (2002) found that reflection improves nurses’ confidence in justifying their actions and supporting their decision making (Glaze, 2002), although empirical evidence has questioned the use of reflection to explore the nuances of professional practice and decision making (MacJaren et al., 2002; Langley and Brown, 2010) found that empowerment was a positive outcome of reflective journaling as individuals took control of their circumstances, achieving personal desires and goals. Empowerment is necessary for innovation and imaginative problem solving. Following reflection, students were found to become more assertive and their thinking was more strategic and politically astute (Glaze, 2002). Being politically astute is a requisite for post-registration nurses (QAA, 2010).

Reflection was found to have benefits for the students’ learning. Glaze (2002) found that critical reflection enhanced students’ learning through the process of perspective transformation (Mezirow, 1991), a process through which adult learners develop different frames of understanding and action, which results from a transformative learning experience. Reflective journaling was also seen by students as a vehicle to narrow the theory-practice gap (Langley and Brown, 2010), a more favourable perception expressed by the students than the tutors from the same faculty. Reflective journaling was found to improve the students’ writing skills (Langley and Brown, 2010). However...
some studies report that reflective journaling does not necessarily result in higher levels of reflection (Chinmaya, 2007; Van Horn & Freed, 2008). Although guided reflective journaling was found valuable in assisting students to achieve higher levels of reflection and learning (Lasater & Nielsen, 2009).

**BARRIERS TO THE USE OF REFLECTION**

The literature highlighted internal and external barriers to reflection. External barriers were seen by students to be the greatest barriers, including a lack of time (Langley and Brown, 2010; Smith & Jack, 2005, Glaze, 2002) and grading by the University (Langley and Brown, 2010; Glaze, 2002). Smith & Jack (2005) suggested the introduction of protected time for reflection. Students need time to develop reflective skills and overcome barriers (Platzer et al., 2000, Glaze, 2002) and a safe environment to foster reflection (Glaze, 2002). A safe environment is one where students can trust their peers and tutors (Glaze, 2002; Langley and Smith, 2010); because a lack of trust and freedom of expression were seen as barriers to reflection. Fears were also raised about the legal implications of documenting thoughts; this illustrates influences in nursing practice that relate to a blame culture (Smith & Jack, 2005). Frequent interruptions from staff and clients in the clinical area provided the students with a barrier to reflecting with their mentor (Langley and Brown, 2010), a view shared by Smith & Jack (2005). As adult learners competing family and work commitments, frequent interruptions at home were also cited as a barrier to reflective journaling by students (Langley and Brown, 2010).

The literature highlighted a number of internal barriers to the use of reflection. Some students showed a lack of insight presenting a barrier to reflective development (Glaze, 2002) and some students found difficulty in discarding early nursing socialisation. Other internal barriers included a lack of interest in reflective journaling (Langley and Brown, 2010) and a lack of understanding of the purpose, goals and benefits of reflective journaling that was seen to lessen the students’ motivation to engage (Langley and Brown, 2010). Students found reflection difficult and required personal discipline (Smith & Jack, 2005). Finally, students also found it difficult to associate themselves with writing down reflection (Smith & Jack, 2005). Therefore, students found it difficult and required personal discipline (Smith & Jack, 2005). Finally, students also found it difficult and required personal discipline (Smith & Jack, 2005). Finally, students also found it difficult and required personal discipline (Smith & Jack, 2005). Finally, students also found it difficult and required personal discipline (Smith & Jack, 2005). Finally, students also found it difficult and required personal discipline (Smith & Jack, 2005). Finally, students also found it difficult and required personal discipline (Smith & Jack, 2005).

**THE NEGATIVE ASPECTS OF REFLECTION**

Reflection can lead to a flawed perception of one’s own self and can be a selective and misleading process (Newall, 1992; Smith & Jack, 2005). Some students are cynical about the value of reflection (Langley and Brown, 2010; Smith & Jack, 2005). Although the sample was not representative of the larger population due to size and convenience sampling. Some students believed there was not necessarily a correlation between reflection and good nursing practice (Smith & Jack, 2005). Research could further explore this viewpoint, which appears to be synonymous with the view of flawed self-perception.

**RESEARCH DESIGN**

The study employed an interpretive approach to explore in-depth the complexities of the perceptions of a small number of participants (Bast, 2010). A qualitative approach was employed to provide depth rather than breadth of information. The researcher aimed to explore the reality of a small number of participants to ascertain their perceptions on the use of reflection in post-registration nurse education. Semi-structured interviews were used to collect data for this study; the most favoured type of interview in health research (Polit and Beck, 2006). A series of semi-structured questions were formulated in advance of the interviews and the same questions were asked of tutors and students. Freedom of expression about their perceptions enhanced the richness of data collected; the in-depth discussion provided high validity. The aim of the semi-structured interview was to promote self-disclosure of participants’ thoughts and feelings (Morse and Field, 2002). The interviewer probed participants to explore their answers discovering information that had previously not occurred to the researcher. The target population for this study was post-registration nurses (from various nurse backgrounds including critical care, A&E, palliative care and midwifery) undertaking current education at a specific university and tutors/lecturers working with the university. A purposeful sample was selected, which maximised the richness of information obtained. Six out of 10 proposed students and three out of the proposed five tutors were interviewed. Sample triangulation between students and tutors perceptions was used to check the credibility of data (Basit, 2010). The interviewer attempted not to influence the interview process. Confidentiality of information was maintained throughout the study (BERA, 2004). Before proceeding with the study ethical approval was gained from the local ethics committee.

All interviews were recorded and then transcribed by the researcher. Transcripts were analysed using guidance from Graeme and Lundman (2004). Transcripts were read several times to ensure immersion in the data and to obtain a sense of the whole. The text was divided into meaning units; which are key phrases or sentences which contain one idea. The meaning units were abstracted and labelled with a code (see table 1). The various codes were compared based on differences and similarities and sorted into categories and themes (see table 2).

<table>
<thead>
<tr>
<th>MEANING CODE</th>
<th>CONDENSED MEANING CODE</th>
<th>CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I think I had more insight in how far I had come</td>
<td>More insight on how far I had come</td>
<td>Insight into progress made</td>
</tr>
<tr>
<td>I learned more about myself and the journey rather than the learning</td>
<td>Learned more about myself</td>
<td>Self-awareness</td>
</tr>
<tr>
<td>Reflection has helped me organise my thoughts</td>
<td>Organise my thought better</td>
<td>Improving decision making</td>
</tr>
<tr>
<td>Reflection has helped me to make decisions</td>
<td>Helped make decisions</td>
<td>Reflect on practice</td>
</tr>
<tr>
<td>Reflection has helped me improve my practice</td>
<td>Helped improve practice</td>
<td>Reflect on practice</td>
</tr>
<tr>
<td>Definitely enables student to think about practice</td>
<td>Assists students to think about practice</td>
<td>Reflect on practice</td>
</tr>
<tr>
<td>Helps student link theory to practice</td>
<td>Student links theory to practice</td>
<td>Reflect on practice</td>
</tr>
<tr>
<td>Has a positive influence on future practice</td>
<td>Positive influence on future practice</td>
<td>Enhances future practice</td>
</tr>
<tr>
<td>Yes it helps you unpick some issues</td>
<td>Helps unpick some issues</td>
<td>Improves problem solving</td>
</tr>
<tr>
<td>I don’t think I learn academically</td>
<td>Don’t learn academically</td>
<td>No academic learning</td>
</tr>
<tr>
<td>I learn more about myself</td>
<td>Learn about self</td>
<td>Increases self-awareness</td>
</tr>
</tbody>
</table>

**Table 1: A sample of data analysis to identify codes**

April 2015 Community Practitioner 39
Professional and research

RESEARCH FINDINGS AND DISCUSSION

The results are presented alongside the discussion to enhance the narrative and provide context. The freedom of expression during interviews offered a rich source of data, providing recommendations for improvements in practice and further research. This qualitative approach created a depth of information, providing a greater understanding of the social world as it is lived by post-registration students and tutors. The research findings are presented under three themes identified from analysis of the data. Using direct quotes from participants shows some of the data from which the results emerge, helping to illustrate the meaning and feeling of participants. Pseudonyms are used in place of participants’ names to maintain confidentiality. The three themes are:

1. Benefits of reflection
2. Barriers to reflection

Students’ preconceptions of reflection based on previous experience, shaped their perception of the benefits of the use of reflection in their current course. However, all six students felt that through the process of reflection they learned more about themselves.

Karen: ‘I learn more about myself and my own attitude and perhaps the attitudes of others.’

A view supported by the literature (Glaze, 2002; Smith & Jack, 2005) and by all three tutors.

A strong argument for the benefit of reflection was the ability to empathise with others.

Rachel: ‘more about the attitudes of others… stepping into others shoes being empathetic… looking at other people’s perceptions of things’

A view shared by all students and tutors. Evidence shows that empathy is reported as an integral component of the patient-nurse relationship (Innes et al, 2006). Reflection was also thought to identify the ‘students’ strengths and weaknesses, which is a useful skill when identifying learning needs. The value of identifying and addressing individual learning needs through reflection is documented well (Perry, 2009). Each student and tutor believed that reflection assisted in the identification of hidden areas of a student’s practice that required change. A view not reported in the literature reviewed. Further research could unlock this potential for reflection to improve students’ practice in areas unknown to them. Students only know what they have experienced or been taught. They do not know what they do not know, and reflection can be used to unlock these hidden areas of practice for students. This would create safer and more effective practitioners.

All students and tutors believed that reflection improved nursing practice and one tutor included benefits to future practice; although literature questions the correlation of the use of reflection and being a good nurse (Smith & Jack, 2005). Participants alleged an improved ability to problem-solve and make decisions.

Chloe: ‘It has helped me organise my thoughts better and helped me make decisions’

However, questions can be raised about the validity of self-report as a method of data collection as it leaves room for response bias (Moskowitz, 1986). Further qualitative research could be used to investigate the validity of reflection and improved decision making. However, Glaze (2010) reported reflection improves the nurses’ confidence to justify actions and support decision making in professional practice.

One student and one tutor reported that reflection helps students’ link theory to practice, a view shared by literature (Langley and Brown, 2010; Schutz, 2007). Participants believed that reflection helped them to focus on the process of learning rather than the product of learning. A view supported by anti-behaviourist theorists, who believe that setting learning outcomes can limit learning (Perry, 2009). However, one student questioned the use of reflection to improve academic learning.

Megan: ‘I don’t think I learned academically’

A view that is not supported by the literature (Glaze, 2002). However, all tutors did highlight the benefits that reflection had in assessing students’ understanding and decision making, a view shared by Smith & Jack (2005).

BARRIERS TO REFLECTION

All student and tutors thought previous negative experiences of reflection impacted upon students’ perception of reflection. Four students reported too much reflection in post-registration nurse education, which was burdensome. One student questioned the value of reflection due to flawed self-perception, a view reflected in literature (Smith & Jack, 2005; Langley and Brown, 2010). One tutor believed that the student’s personality and experience affected their ability to cope with the negative aspects of reflection.

All students felt they had a good knowledge of the use of reflection and that it was a process they used to improve their practice. However, all students acknowledged that the only time they undertook academic reflection was as a part of the summative assessment process on post-registration courses. In their experience they felt that the faculty had not adequately prepared them for this reflection; a view shared by all three tutors.

One of the greatest hurdles expressed by students to the use of reflection was the lack of time; a view expressed in the literature (Glaze, 2002; Smith & Jack, 2005; Langley and Brown, 2010). Although the literature highlighted the benefits of reflective journaling (Langley and Brown, 2010) one participant questioned whether students really kept a reflective diary.

‘Not many people keep a reflective diary, do they?’

Other external barriers to reflection were believed to be imposed by the faculty, including restricting students’ freedom to select a reflective model and making the reflective exercise too prescriptive. Students had been prevented from using Gibbs model of reflection and some students reported difficulty in choosing a reflective model that was acceptable to tutors. An internal barrier to reflection expressed by one student was their own state of mind. If the participants had a positive self-perception, reflection would be an effective and balanced process; however, if the participant had a negative self-perception then reflection became an ineffective process that was unbalanced. A number of students found it difficult to write down negative experiences, a view synonymous with the findings of Smith & Jack (2005).

SUGGESTION FOR IMPROVEMENTS

All students believed that reflection would be more

| Table 2: A sample of data analysis to identify themes |
|---|---|---|
| Theme | Category Code | Benefit to Practice | Benefit to Learning |
| Personal Benefits | Self-awareness | Improved practice | Importance of process over product |
| More insight into progress made | Improved Organisation of thought | Reflection on practice | No academic learning |
| Self-awareness | Improved Decision Making | Links theory to practice | Enhances learning |
| Improved Organisation of thought | Improved Empathy | Enhances future practice | Honest reflection on difficulties enabled further progression through course |
| Identification of weaknesses | Identification of strengths | Improves problem solving | |

No academic learning

Links theory to practice

Enhances learning

Honest reflection on difficulties enabled further progression through course

Multiple reflections to improve academic learning.
beneficial if students were given time to reflect on something they identified as important, a view shared by Smith & Jack (2005). Reflection should take place in a venue that provided privacy and space, a view supported by Glaze (2002). All students and tutors expressed the need to explore different models of reflection to maximise effectiveness. Both believed the faculty could facilitate this by delivering a lesson or module on reflection. All tutors felt that the student should be able to identify which model they found most effective.

All students wanted tutors to be available each week for open tutorial support or include a 15 minute reflective session at the end of a weekly lesson. Students believed they would benefit from guided reflection by tutors; guided reflection has been reported as superior to personal or unaided reflection (Duffy, 2008). Most students and all tutors felt their suggestions for change would be easy and cost effective to implement. However, one student felt sceptical about these changes, believing that education was about outcomes and not quality. Rachel: ‘It’s a product world not one that is interested in developing the individual. Organisations would not allow the time for reflection’.

CONCLUSION

Overall this study set out to explore students and tutors’ perceptions on the use of reflection in post registration nurse education and as a result a number of recommendations have been made which aim to improve the use of reflection in post registration courses. Although the sample size of this study was small the recommendations are an excellent starting point for tutors to consider when using reflection as a form of assessment or to enhance learning.

LIMITATIONS

Although tutors perceptions on the use of reflection were used to validate those of students further analysis could explore the relationship between their perceptions.

KEY FINDINGS AND RECOMMENDATIONS

The key findings not found in previous literature were the use of reflection to identify the students’ strengths and weaknesses; a useful skill when identifying students learning needs. Tutors could implement a reflective activity at the beginning of a learning experience to identify students learning needs. Also participants believed that reflection could be used to identify hidden areas of practice requiring change. Dedicated time set aside for reflection could allow both tutor and student to explore areas in the students practice requiring change, ensuring safe and effective practice.

The benefits of reflective practice and journaling help improve nursing care through empathy, improved decision making and critical thinking; therefore time should be set aside to undertake reflection. This may involve tutors reducing other learning or assessment activities in favour of reflection. Tutors should also allow students freedom to select a reflective model of their choice following exploration of different models, this would enhance student’s engagement in the reflective process. Tutors should take notice of other barriers to reflection found in this and previous studies when using reflection in education. Faculties could improve students’ preparation for reflection and offer regular support through guided reflection enabling students to reach a higher level of thinking. These recommendations could improve the use of reflection in post-registration nurse education and subsequently professional practice and patient care (Gustafsson and Fagerberg, 2004), the major premise of nurse education (NMC, 2004).

REFERENCES


Key points

• The use of reflection in nursing post registration education improves practitioner’s ability to empathise; make decisions; and bridge the theory practice gap.

• Tutors and practice teachers should support students through guided reflection using guided reflective models to enhance higher level thinking.

• Those designing curriculums should ensure sufficient time is given to supporting reflection, including reflective tutorials.

• Tutors should allow students the freedom to select their own model of reflection to enhance engagement.

• Tutors should use reflection to assist students to identify their learning needs and gaps in their practice.
Early intervention for increased antenatal anxiety associated with foetal development risk

INTRODUCTION

Findings published in 2002 from the Child of the 90s Study, revealed the detrimental effects on the developing foetus of prolonged heightened states of maternal anxiety (O’Connor et al. 2002). By identifying correlations between maternal stress levels and several childhood cognitive and emotional conditions, links between foetal neurological development and maternal perinatal mental health were established. Ongoing research has continued to provide supporting evidence and increasingly more specific information about the adverse consequences of intrauterine exposure to maternal stress to the infant and child. Links between conditions such as Attention Deficit Hyperactivity Disorder (ADHD) have been identified and documented (Rodriguez et al. 2005) alongside autism (Beversdorf et al. 2005), schizophrenia (Malaspina et al. 2008), child depression (Van den Bergh et al. 2007), delayed language development (Laplante et al. 2004) and atypical motor development (Glover et al. 2004).

The identified association between maternal anxiety during the gestational period, and lower levels of maternal-foetal attachment, also presents serious mental and social health implications for infant and child (Alhusen, 2008). Raised levels of cortisol produced in women with exposure to excessive and enduring psychosocial stress and the conditions discussed, have been reliably linked. The placental barrier enzyme 11-betaHSD2 (specifically its role in metabolising cortisol) is key in regulating the placental environment, therefore impacting the neurological development of the foetus (O’Donnell et al. 2009).

High levels of maternal anxiety during the 12-22 week period are identified as particularly likely to predict outcomes of Attention Deficit Hyperactivity disorder symptoms, externalising problems and self-report anxiety in 8-9 year olds (Van den Bergh et al. 2004). The period of 25 – 28 weeks of gestation are key in predicting incidence of autism (Beversdorf et al. 2005), and the first trimester when identifying links to schizophrenia (Malaspina et al. 2008). The length and timing of exposure to intrauterine maternal stress is an important factor, although any reduction may aid limitation of undesirable consequences (Buss et al. 2012). Investigation into the effects of specific forms of stress is inconclusive, but research suggests that the relationship with partner can be a significant factor (Talge et al. 2013) in infant outcome. Reducing maternal anxiety as early as possible during pregnancy (or, more ideally, before) will have a positive impact on physical, mental and social health for ‘at risk’ infants and children.

The NSPCC 2013 All Babies Count Spotlight report on perinatal mental health (Hogg, 2013) has championed preventative interventions over reactive ones, highlighting how timely identification of antenatal mental ill health and provision of care is vital in reduction of harm to both mother and child. The report identified 29% of midwives received no content on mental health in their pre-registration training, and no training on perinatal mental health services available (e.g. Improving Access to Psychological Therapies (IAPT) (www.iapt.nhs.uk), or their role in signposting to these services. Another key finding is the current ‘postcode lottery’ inequity of care.

In his 2011 report to the government, informing future policy in health and social care, Graham Allen (Allen, 2011) draws particular attention to the importance of prioritising perinatal mental health in women in order to reduce many of the previously discussed conditions identified in their children. The report includes evidence of the potential effect of raised anxiety on the developing foetal neurological system, and also addresses the practical issues of funding intervention within the public sector. Allen compares the cost of early intervention to lifetime costs of...
the noted conditions, championing the cost effective nature of early intervention. Whilst focusing on government fiscal cost reduction, he also recognised the considerable personal and social cost reduction that could be achieved by early intervention.

Allen identified a current bias toward late intervention due to financial and institutional obstacles, despite the expense and limited success. He proposed that the NHS gives priority to early intervention driven by local action. NICE guidelines on antenatal mental health, which already recommend the use of the ‘Whooley questions’ for the early identification of depression (National Institute for Health and Clinical Excellence. 2007), are currently under review and are expected to reflect this refocus. Guidelines for the commissioning of public health services for children (Department of Health. 2014) reiterates the importance of identification of a broader range of mental health issues during the perinatal period and call for stronger links between midwifery and health visiting to aid both identification and service provision.

The 2013 Report for the All Party Parliamentary Sure Start Group (All Party Parliamentary Sure Start Group. 2013) identified a need for stronger links between midwifery, health visiting and children’s centres, for effective early intervention, ideally delivering all perinatal services ‘under one roof, with midwifery, health visiting and children’s centre services all being accessed from the children’s centre’. A refocus on the ‘age of opportunity’ (the period from conception to age 2) was called for, based on evidence provided by The Wave Trust (The Wave Trust. 2013), who, commissioned by the Department of Education, recommended that midwives and health visitors should be using questionnaires to identify potential mental health and relationship issues. Another key recommendation of the report was ensuring early intervention is at the heart of the 2016-2018 Comprehensive Spending Review, with a commitment to a 2-3% shift in spending from late to early intervention.

The ten key messages in the 2012 Guidance for Commissioners of Perinatal Mental Health Services made by the Joint Commissioning Panel for Mental Health (Joint Commissioning Panel for Mental Health. 2012) include similar themes, emphasising the importance of developing regional strategies and pathways focusing on this area of health, to deliver an effective and equitable service, with all health care professionals participating and compliant. The importance of training health care professionals, particularly midwives, health visitors and GPs in perinatal mental health and regional pathways is highlighted, as well as recommending that maternity services have access to perinatal mental health teams and to designated specialist clinical psychologists. They also recommend improved availability of timely treatment for pregnant women and that related data should be collated with regularity.

**DEVELOPMENT OF THE ANTENATAL MENTAL HEALTH AND ATTACHMENT CARE PATHWAY**

In 2006 a pilot to develop a postnatal maternal mental health and attachment care pathway was driven by the local CAMHS team in conjunction with the Health Visitors and a core team of other agencies. Following completion the pathway was rolled out across the county (Milford et al. 2009). The same CAMHS team and multi agency core group then responded to the emerging research on antenatal maternal distress and planned a further pilot focussed on delivering an antenatal pathway involving the local midwifery team as the lead.

The partnership between PCT and local authority in North Somerset at the time of the pilot inception clearly outlined a key objective of ensuring the best possible start for all babies and young children and their families, particularly ensuring the most vulnerable families receive support as early as possible. They suggested strengthening links with the midwifery teams to ensure all families are aware of their local children centres before their baby is born and those most in need of services are referred by their midwives. Midwives therefore were key in developing early assessment and referral. Increasing the awareness of midwives of the potential lifespan consequences of high levels of antenatal maternal anxiety was the initial focus and increasing their confidence in identification of the most vulnerable women. An identification process was created and a menu of services to refer onto, to support them in this task. The group also focused on local mental health services, raising their awareness and encouraging them to prioritise pregnant women. Current services were assessed and developed to include specifically targeted facilities. The intention was that this would inform the process of developing a formal pathway, and improving the equity of service throughout North Somerset.
The percentage of women identified was predicted to be 10-12% based on figures previously collated for women experiencing high levels of anxiety postnatally (Milford et al 2009).

**PILOT INVESTIGATION**

A small scale pilot was conducted to assess the likely effectiveness of the proposed implementations. The reviewed literature suggests that the earlier high levels of maternal stress are identified and reduced, the more positive the outcome for the infant (Buss et al 2012). Guided by this and current timings of antenatal appointments, it was decided that mothers would be screened at their routine 12 week midwife appointment. Three community midwives from the core group were recruited to apply the screening process over a three month period. The process needed to be simple to encourage usage by midwives in their already time pressured appointments. It also needed to fit well with current tools used in both ante natal and post natal care by midwives and health visitors, to ensure usefulness and ease of information transfer. Current ante natal questions focusing on mental health tend to focus on depression (or a combination of anxiety and depression), so the following question, visual analogue tool and subsequent possible pathway (Box 1) was implemented alongside them. For women answering ‘yes’ to the initial question, a Visual Analogue Scale was devised to encourage mothers’ scaling of their anxiety levels. A score of over 5 was made. Two midwives provided feedback on the visual analogue scale, provided by the pilot regarding the impact on the unborn foetus, increased their understanding of the important implications, which encouraged them to make the time to assess and refer on, when appropriate. They found the 15 week appointment most suitable for asking the question and making the assessment, as the 12 week booking in visit was often too busy. The question and scale were found to be useful in raising the issue in clinic and for quicker referral of pregnant women.

**CARE PATHWAY DEVELOPMENT**

Several additions were made to services already in place, specifically targeting pregnant women:

- Provision of the Mellow Bumps (Macbeth et al 2013) course, led by the CAMHS consultant nurse and the health visitor. The HAD was used at the beginning and the end of the course, and three months later, for mothers who chose to attend, to assess the effectiveness of the course at aiding the reduction of Anxiety and Stress during this period. Using an identical system of anxiety level identification in screening and appraisal of service minimise confounding variables and enables comparisons to be made. Four members of the core group provided the Mellow Bumps course, led by the CAMHS consultant nurse and the health visitor. The HAD was used at the beginning and the end of the course. The percentage of women presenting with heightened anxiety at 15 weeks was 23%, or 61% dependant on criteria used. Four members of the core group provided the Mellow Bumps course, led by the CAMHS consultant nurse and the health visitor. The HAD was used at the beginning and the end of the course. The percentage of women presenting with heightened anxiety at 15 weeks was 23%, or 61% dependant on criteria used. This suggests that the criteria is too broad, the midwife who used only ‘over 5 as her criteria found 17% of those scoring 5 needed further referral due to further information gleaned in conversation. This suggests that a score of ‘5 or over’ may be a better trigger for further assessment. One woman scored 0 but had low mood, was known to mental health services already, and refused to be assessed with the HAD. This demonstrates the need to use the visual analogue scale as an aid to identification of need rather than a definitive process. Judgment using
other information available will also be of great value.

**DISCUSSION AND RECOMMENDATIONS**
The pilot has been very effective in meeting the objectives of increasing the midwives’ awareness of the important potential lifespan consequences, of high levels of antenatal maternal anxiety. There is a clear need for training to raise awareness and confidence for all midwives to encourage assessment and referral for support as soon as possible. Risk factors to the unborn foetus must be discussed as well as increasing knowledge of current government requirements and cost implications. Participating midwives suggested training include Mental Health First Aid and Solution Focus Brief Therapy, having attended these two courses themselves and finding them informative and empowering. These courses are already available in North Somerset, being run by members of the core team. Health visitors as well as midwives are now being offered Mental Health First Aid and Solution Focus Brief Therapy training as well as Attachment Training to increase awareness and confidence. All midwives should use the question and analogue scale routinely at 15 weeks and in future, the midwifery lead should consider earlier identification of need as ideal, including these questions in Early Bird clinics (targeting newly pregnant women or those wishing to become pregnant) as this may provide a way of assessing women even earlier.

The pilot has also provided encouragement and motivation for engagement from other local mental health services and agencies in providing immediate support. Engagement has included pregnant women being prioritised by mental health services (faster appointment times), the care pathway being extended (e.g. Thrive drop in combining many resources in a one stop shop) and improved provision of extra facilities (e.g. Mellow Bumps group (Macbeth et al 2013). Pregnant women are also being encouraged to utilise children’s centre services. There remain identified gaps in the care pathway, due to lack of geographically similar services and services not fitting women’s needs.

**Box 2: Example of referral pathway**

Strategic planning must take place to replicate new services that have been found to be effective at regular time and geographic intervals, ensuring greater equity of service. Reasons given for women not engaging with support offered were
- Lack of suitability due to preferring 1:1 conversation rather than group sessions
- Lack of child care
- Length of time waiting for support
- Need for improved social networks
- Reluctance to self-refer online.

Two of the new initiatives (Mellow Bumps (Macbeth et al 2013) and Thrive) have addressed these issues well, and need to be rolled out at regular time intervals (possibly 2-3 times a year) and in varying locations. Mellow Bumps provided a course specifically for pregnant women aimed at reducing anxiety, promoting self care and maternal sensitivity. This group also increased their social networks and provided childcare. Thrive was developed at two Children’s Centres, combining...
several previously provided groups. These included a 1:1 mental health drop in for support and signposting, weaning/breastfeeding groups and a new rolling programme of sessions on mental health self help techniques and giving information on other health and social needs (e.g. housing/finance/health and safety etc.). Child care was provided, increased social networks encouraged and waiting times were short, due to running the group twice weekly.

Following pilot feedback, the HAD will be replaced with the GAD7 and PHQ-9 as a tool for measuring anxiety and low mood because IAPT services, GP services and health visitors have already moved to these tools, and it will ease cross service evaluation and continuity of care between midwives and health visitors. They were also considered by midwives to be worded more usefully.

Percentages of ‘at risk’ women were higher than expected, implying a greater need for support services than previously thought. However, further data needs to be collected to assess whether this is a typical percentage and an extended pilot will include a wider geographic area and a larger sample of women. The pilot will continue to assess the efficiency of the current service additions, extensions and prioritisations, whilst extending them. It will also include formally linking the antenatal and postnatal pathways (The Wave Trust. 2013), used by the health visiting team, to move away from the current ‘goodwill’ based cooperation between professionals. This will aid health visitors in identifying ante natal visits which need prioritisation. During the pilot, health visitors will identify whether anxiety levels are effectively reduced in the ensuing postnatal period.

CONCLUSION

In conclusion, the pilot highlighted the need for specialist training, appropriate tools for identification of ‘at risk’ women and referral menus of current local services. This resulted in increased confidence in midwives in addressing the issue of prolonged heightened levels of maternal anxiety. It also highlighted training needs of other key workers, health professionals and service providers in understanding and meeting this specific need. This service development is in line with the current Governmental shift toward early intervention. Evaluation of current service provision (including pilot additions) revealed a notable geographic inequity of service and highlighted services users obstacles to engagement. Commissioners’ participation will be key in resolving the gaps in service and providing appropriate and useful future resources. Two of the pilot additions to services (Thrive and Mellow Bumps) were successful in addressing some of the issues raised by service users. The expected number of women reporting heightened levels of anxiety was higher than anticipated, and evidence suggested that a score of ‘5 or more’ might be more useful rather than ‘over 5’ to trigger the application of mood scores. GAD7 and PHQ-9 mood scores were found more appropriate than the HAD.

A pilot extension has been approved by service leads to assess whether findings are consistent over a larger and geographically different population and will develop a formal handover procedure to health visitors by linking the antenatal and postnatal pathways. It will also assess the usefulness of adjustments made following the initial pilot.

REFERENCES

MacLachlan A et al. (2013) A Pilot Evaluation of Mellow Bumps – An Attachment Based Antenatal Intervention, University of Glasgow.
O’Donnell K et al. (2009) Prenatal stress and neurodevelopment of the child: focus on the HPA axis and role of the placenta. Institute of Reproductive and Developmental Biology, Imperial College London, London, UK.
Van den Bergh B et al. (2007) Neuropsychopharmacology 33(3) 536-545.
Since the Health Visitor Implementation Plan 2011–15: A Call to Action (Department of Health, 2011), the profile of practice teachers and specialist mentors has been raised considerably which presented a real opportunity to strengthen and grow the health visiting workforce. This drive to increase numbers has placed unprecedented pressure upon health visiting practice teachers to manage the educational preparation of a greater number of students, which has resulted in the emergence of mixed placement models. In addition to this, the newly expanded health visiting workforce includes a high percentage of new and recently qualified practitioners who require robust preceptorship and support.

In February 2014, Lynne Hall, Health Education England (HEE) Clinical Advisor, initiated and then co-led with Pauline Watts, the Department of Health Visiting Professional Officer, a broad reaching Task and Finish Group. The purpose of this was to enhance quality and consistency of student placement and student support through the development of common standards and expectations, and promotion of clearer understanding of roles and responsibilities and educational preparation.

The goals were to examine current models and experience of learning in practice, review the evidence base related to effective learning in this milieu, and develop standards and recommendations commensurate with excellent health visiting practice education.

In October 2014, the Task and Finish Group produced a long-awaited set of resources that will help the health visiting profession to deliver placement excellence, and services that are underpinned by access to high quality practice learning environments.

These resources were successfully launched at the CPHA Annual Conference in November 2014 via an end of project report that was well received and has gone on to attract much national and international interest.

For the first time ever, we have a good understanding of what a good and indeed a bad practice placement looks like from the collective views of student health visitors, practice teachers and mentors, service managers and clinical leads. This engagement has enabled HEE to access qualitative information from every geographical area of the country that has been used to enhance the quality and consistency of student placement learning and student support through the development of common expectations and standards. It also gave a clear understanding of the educational roles, responsibilities and educational preparation that will enable the best use of the educational and clinical expertise of practice teachers and mentors both now and in the future.

Practice teachers and mentors represent a group of educationalists whose clinical and educational expertise expands over a number of specialist community nursing practice disciplines, and it is therefore important that any proposed changes or developments in how the roles are defined and developed are considered in this context.

Consequently, while the primary focus of the report is centred on health visiting education, the findings presented have resonance across all specialist community nursing practice disciplines, nursing and other non-medical practice learning situations. In order to establish current practice and experiences, a nationwide survey was undertaken of over 700 practice teachers, mentors, clinical managers and health visiting students. While the respondents indicated a generally positive response to the evolving models of practice learning, the expectations associated with these emerging roles and the educational preparation and support provided for them was unclear.

Consequently, the report presents national role descriptors for practice teachers and specialist practice mentors offering employers a framework to inform person specification. A competency framework for practice teachers and specialist practice mentors is also described with related recommendations for future education, training and continuing professional development.

Given the plethora of evidence indicating the impact of the socio-cultural learning environment on the development of professional practitioners, HEE have developed a number of organisationally focused standards for assuring quality in practice placements, also detailed in this report. They facilitate the strategic managing of practice learning at all levels within the host provider and have the potential to form part of the annual quality monitoring applied to all commissioned education. Finally sharing best practice and using evidence as a basis for practice is an important foundation for effective practice-based learning. The potential to exploit technology to support this critical engagement across the wider health visiting community is also considered.

The report can be accessed from http://ow.ly/CNAYX

This drive to increase numbers has placed unprecedented pressure upon health visiting practice teachers to manage the education of a greater number of students.
Practice Lead (Early Years)

Agenda for Change Band 7 (£31072-£40964)

Are you an experienced qualified Health Visitor ready for an exciting leadership challenge?

Highland Council has two vacancies for full time (37.5 hrs) Practice Leads (Early Years) to work alongside Practice Leads in School Years and Care & Protection services as part of an integrated Family Team. The Practice Lead (Early Years) will lead a group of Health Visitors and Community Early Years Practitioners with a responsibility to deliver universal and early intervention services to families with children aged 0-5 years. We are looking for experienced Health Visitors with excellent communication and team working skills and who are keen to develop the benefits of integrated services to achieve better outcomes for children and their families. This is an opportunity to become a leader at a time when the Scottish Government is implementing the Scottish Health Visiting Review recommendations with an increase in Health Visitor training places and additional posts across Scotland.

Practice Lead (Early Years) posts are currently available in the Sutherland and the East Ross districts of Highland. (Posts for Band 6 qualified Health Visitors are also available in various locations across Highland)

For further information contact Susan Russel, Principal Officer (Nursing) on 01463 702870 or email susan.russel@highland.gov.uk

ARE YOU LOOKING TO RECRUIT HEALTH VISITORS AND OTHER COMMUNITY PRACTITIONERS?

Call us today to get your role seen by the people best qualified for the position.

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

To enquire about advertising & vacancy call 020 7878 2319
**PRACTITIONER**

**COMMUNITY**

**www.communitypractitioner.com | www.uniteetheunion.org/cphva**

---

**Community**

- Full set of course notes and DVD given
- ‘Developmental Baby Massage’ plus a primary preparation for sitting and using gravity for stronger foundations

3) Standing

- Developmental including elementary secure potential at each stage of development
- Eight Weeks to Standing

2) c) Making Tummy Time Easy

- Postnatal from Birth to Eight weeks
- Can be taught both Prenatal and
- A Holding Reassurance Programme
- A four-day training course including
- A take home written assignment
- A regular newsletter

Membership of the IAIM UK

- A local, national and international support network
- Continued professional development
- Access to relevant articles, information and the latest research on our website
- A regular newsletter

- Our training courses are run regularly at centres nationwide and are facilitated by experienced IAIM Trainers.

- Further details please visit www.iam.org.uk
- IAIM (UK) Chapter
- O208 989 9597
- info@iam.org.uk
- www.iam.org.uk

---

**Learn Baby Massage with the International Association of Infant Massage**

Train to become a Certified Infant Massage Instructor with the International Association of Infant Massage (IAIM), the largest and longest standing worldwide association solely dedicated to baby massage. Our curriculum is taught in more than 45 countries and has been developed and refined over 30 years through research, reflective practice and practical experience. This has resulted in a widely endorsed and implemented parenting programme.

Our highly acclaimed comprehensive training comprises:

- A four-day training course including supervised practical teaching of a parent/baby massage class
- A take home written assignment
- Further practical teaching and reading

By training with our highly respected organisation you will join a worldwide network of instructors offering a supportive environment to teach life-long parenting and relaxation skills.

---

**CPD accredited events for healthcare professionals**

All our seminars and webinars are free to attend for those who are registered with the Hipp Hub healthcare professional website. Places are limited so register early to avoid disappointment.

**Feeding infants – is less more?** – with Professor Atul Singhal.

- Professor Singhal will review current evidence and thinking on early nutrition, particularly in relation to protein levels in formula milk and feeding practices.

**Dates:**

- Tuesday 28th April at the Royal College of Surgeons of England, London at 6pm
- Wednesday 17th May at the Solent hotel and spa, Fareham, Hampshire at 6pm
- Wednesday 3rd June at Cotswick Hall, Nottingham at 6pm

**Register at** www.hipp4hcps.co.uk

**Child development – with Juliette Francis**

- An appreciation of child development can help us to meet the needs of children, as well as understand what might happen if we don’t use this knowledge to its best advantage. While responding to the many and varied challenges they experience, it can be easy to lose sight of neuro-typical development. This webinar will explore the development stages and transitions experienced by young children as well as recent research concerning brain development.

**Wednesday 7th October online at 6pm**

**Register at** www.hipp4hcps.co.uk

---

**Millpond Children’s Sleep Workshop – Training NHS professionals since 2007**

100% of delegates would recommend to a colleague

**London:**

- Tuesday 15th September 2015

- Our popular one-day interactive workshop, designed for professionals working with families with babies through to school age children.

- A range of sleep techniques
- Evaluate intervention

£175 EARLY BIRD PRICE £160 before end July ‘15

T: 020 8444 0040
E: sleep@millpondsleepclinic.com
W: www.millpondsleepclinic.com

---

**TO ADVERTISE**

**CONTACT:** Claire Barber dl 020 7878 2319 e claire.barber@tenalps.com
NEW MyNutilis

Nutilis Clear has been designed to maintain the original appearance of drinks, which may support compliance and improved fluid intake.

The new MyNutilis.co.uk website aims to inspire patients and carers to cook delicious meals with Nutilis Clear.

Visit the website for recipes, news items and videos of Chef Neil making meals that look and taste appealing to patients.

<table>
<thead>
<tr>
<th></th>
<th>Tin Size (g)</th>
<th>FP10 Price*</th>
<th>Cost per Stage 1 drink**</th>
<th>No. of Stage 1 drinks** per tin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutilis Clear</td>
<td>175</td>
<td>£8.46</td>
<td>£0.15</td>
<td>58</td>
</tr>
<tr>
<td>Nutilis Powder</td>
<td>300</td>
<td>£4.92</td>
<td>£0.13</td>
<td>37</td>
</tr>
<tr>
<td>Thick &amp; Easy™</td>
<td>225</td>
<td>£5.06</td>
<td>£0.20</td>
<td>25</td>
</tr>
<tr>
<td>Resource ThickenUp™ Clear</td>
<td>125</td>
<td>£8.46</td>
<td>£0.16</td>
<td>52</td>
</tr>
</tbody>
</table>

*MIMS, February 2015; **200ml drinks as per manufacturer dosage instructions.

Transparent results
MyNutilis.co.uk