Clinical feature
School health matters

Professional
Dental health barriers

Last word
Professor Judith Ellis

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Revalidation
Members’ fears exposed
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August 2015 Community Practitioner
From the leading experts in organic infant nutrition, comes the UK's lowest protein infant milk.

Ours is the first infant milk in the UK to contain less than 2g/100kcal protein, making the protein level and quality closer to that found in breastmilk. High protein intake in the first two years of life has been linked with an increased long term risk of being overweight or obese.

With prebiotic oligosaccharides (GOS) for healthy digestion, and Omega 3 & 6 LCPS for brain and tissue development, our formulas combine all the natural benefits of organic ingredients, with 50 years of breastmilk research.

Discover more at hipp4hcps.co.uk
@hipp_for_hcps

1 Contains 1.89g/100kcal of protein, including α-lactalbumin, making the protein level and quality closer to that found in breastmilk (1.7g/100kcal). Nommsen LA et al. Am J Clin Nutr 1991; 53: 457–465.

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

A Fond Farewell

I’m writing my final editor’s letter on my last day working at Community Practitioner. Over the past six months in this role, I’ve really enjoyed getting to know the fantastic health visitors, school nurses, community nursery nurses, community staff nurses and colleagues that make up the Unite/CPHVA membership. I’ve been so impressed by their dedication and determination, passion and professionalism and I’m in awe of how hard you work and how much difference you make - often in less than ideal circumstances.

I particularly want to thank all the members I’ve met, both in person and virtually via Twitter during my time here. Kerry and Lynne, the nurses I was fortunate to shadow over the past couple of months, were so incredibly warm and welcoming when I followed them around for the day - I came away from both visits wishing I could do their jobs! Of course, I’ve also come to realise that everyone works very hard indeed - and for many of you, your jobs are set to become even more challenging as commissioning of health visiting services in England moves over to local authorities from this Autumn.

The Unite/CPHVA awards back in March were also an inspirational highlight of my time here. It was a privilege to attend and to present the Student of the Year award to Karen Heggs on behalf of Community Practitioner. It was so good to see so many rewarded for their hard work and dedication.

The weekly #CPHVAtt Twitter Tuesday chats have been a fantastic way to get to know members, and they will continue to take place every Tuesday from 7-8pm. It’s become such a lovely part of my week that I expect I’ll still pop along for the chats every now and then when my schedule permits.

It’s so great to see how well received and respected Community Practitioner is and how passionate readers can be about the journal and articles within it. I’ve lost count of the number of times I’ve spoken to members at events who have started the conversation with ‘there was a really interesting article the other month about...’ once I’ve told them what my job is.

We’ve made a few changes to the journal over the past few months, the biggest of which is probably our three-part special reports. These run over the course of three months - in the first part we research the topic and find out what is happening on the ground, the second part looks at what members are currently doing to manage the issue, and the third part attempts to offer advice or a solution. The July issue concluded the caseloads special report, and in this issue we look at Nursing and Midwifery Council (NMC) revalidation.

Results from our research were quite surprising with several members not having even heard of revalidation until we approached them to take part in the survey. Less than half of you agree that revalidation will achieve its primary aim of protecting the public, and the vast majority are particularly worried about finding time.

I hope you enjoy this issue as much as I’ve enjoyed working on it. Last but not least I want to thank all the Unite/CPHVA professional officers for being so kind and supportive and for sharing my goal to make Community Practitioner the best it can be.

Amy Brewerton
@Amy_Brewerton
Acting Editor

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Babies to receive Men B vaccine

INFANTS IN ENGLAND AND SCOTLAND ARE TO BE OFFERED a new vaccine at two, four and 12 months of age.
From September, Bexsero will be given to protect babies against Menigitis B.
Every year in the UK, around 1,200 people contract the infection, which is responsible for more than 100 deaths annually.
Other serious complications from the disease can include brain damage, blindness, deafness and loss of affected limbs.
Babies and young children are most vulnerable to Meningitis B, which is passed from person-to-person through close contact.
It is thought that Wales and Northern Ireland will announce plans to introduce the vaccines later this year.
Students are also at risk from the infection due to living in close quarters in university accommodation.
As part of the plans, a combined vaccine against the A, C, W and Y strains of meningitis will be offered to 17 and 18-year-olds in England and Scotland, as well as young people aged 19 to 25 who are starting university.

Child sex offences increase by more than a third

FIGURES PUBLISHED BY THE NSPCC reveal that three child sex offences are committed every hour.
The charity’s How safe are our children? report shows that there was a total of 31,238 sexual offences reported in in England and Wales in 2013-14.
Offences reported to the police included rape, sexual assault and grooming. Most victims were aged 12 to 16, however, 8,282 were younger than 11.
This includes 2,895 aged five and under, and 94 babies.
Offences recorded against girls were nearly five times higher than those in boys, with 24,457 compared to 5,292.
Recorded sexual offences against children increased by 40 per cent across the whole of the UK from 2012-13 to 2013-14.

Half of children eat no veg

JUST 56 PER CENT OF CHILDREN in Wales eat vegetables every day, according to information published by the Welsh government.
The Welsh Health Survey examined the health and lifestyle of adults and children living in Wales in 2014.
Intake of fruit is slightly higher, with two-thirds reporting to eat some form of fruit on a daily basis.
Fruit and vegetable consumption has however increased over the past few years.
Other results showed that just over a third of children partake in more than an hour of physical activity a week.
This falls far below official recommendations, which stipulate that five to 18-year-olds should be aiming for at least an hour of exercise per day.
Data also showed that one in five children suffer with a long-term condition, including six per cent whose condition is debilitating.
A third of adult respondents reported that their daily activities were limited due to health problems or disability, and there has been an increase in adults receiving treatment for diabetes or mental health conditions.
Young people at highest risk for STIs

THOSE AGED 16 TO 24 experience the highest rates of sexually transmitted infections (STIs), according to official figures released by Public Health England (PHE).

The most commonly diagnosed STI last year was chlamydia, with 206,774 reported cases. Despite chlamydia screening being routinely offered to young people, just 14 per cent of males and 35 per cent of females took the test in 2014.

Syphilis diagnoses increased by a third compared to the previous year, with cases of gonorrhoea up by a fifth.

Overall diagnoses for STIs across all age groups decreased very slightly, with a drop of 0.3 per cent.

New regulations aim to reduce liquitab ingestion

MANUFACTURERS WILL NOW HAVE TO ADHERE TO NEW rules from the European Commission on the production of laundry ‘liquitabs’.

Laundry liquid capsules are responsible for poisoning around 1,500 children in the UK every year. Under-fives are attracted by the bright colours and packaging that make them look like sweets or toys. Once the tablets come into contact with water, the membrane containing the detergent dissolves.

This can cause burns or poisoning if the liquitab is put into a child’s mouth.

Producers must now ensure that the capsules are impregnated with a bitter flavour to prevent children from sucking or swallowing them. The membrane casing must also withstand contact with water for more than six seconds, to reduce the chance that it will leak into a child’s mouth.

The new rules also mean that manufacturers must use packaging that is not transparent, with child-resistant closure and clear warnings of the danger to children.

The regulations came into force from 1 June, however, they only apply to the production, rather than the sale, of the products. This means that tablets currently on sale may not adhere to these rules, and it may be months before retailers are only selling the new versions.

Substance use higher in young offenders

YOUNG PEOPLE IN CUSTODY are ‘substantially’ more likely to smoke, drink and use illegal drugs than non-offenders. A new report issued by Public Health England (PHE) into the health and wellbeing of people in prison reveals the extent of the problem.

As many as 37 per cent of persistent young offenders have a drug problem of some kind. More than a third of young people in children and young people’s secure estates (CYPSEs) also suffer from mental health issues, according to the report. Half also have problems with speech, language and communication.

Children up to the age of 15 are generally detained in secure children’s homes for the duration of their sentence.

Secure training centres provide detention and education for those aged up to 18, while young offender institutions are usually for those aged 15 to 20.

Offenders move to an adult prison at the age of 21.

NMC consults on English language requirements

THE NURSING AND Midwifery Council (NMC) is seeking responses to its consultation document on how it plans to ensure English language competency in nurses from the European Economic Area (EEA).

The document proposes that all EEA nurses and midwives who apply for registration will have to prove their ability to communicate fluently before they can register, or in order to re-register.

Language incompetence will also become an issue that could result in fitness to practise referrals.

Potential registrants will need to provide evidence that they are able to read, write, listen and speak in fluent English. This could include passing an International English Language Testing System (IELTS) examination, holding a nursing qualification which was gained mostly in English, or having worked for more than two years in a country where English competency is required.

The consultation is open until 21 August 2015. The full documents and further information on the consultation process are available from the NMC website.
Members attend Buckingham Palace garden party

FLYING HATS, DELICATE
sandwiches and Royal Family spotting were the order of the day for Maggie Warner when she attended a garden party at Buckingham Palace.

The health visitor from the south east of England was nominated to attend the event because she is an active member of the CPHVA’s national executive committee.

She attended with fellow CPHVA member Naledi Kline – look out for Naledi’s blog on www.communitypractitioner.com.

After getting through tight security checks, the pair enjoyed a brief tour of Buckingham Palace before joining guests on the main terrace and gardens for afternoon tea.

Maggie said: ‘The gardens were exquisite. You wouldn’t believe you were in the middle of London because it was so quiet. ’The tea was wonderful and everything was miniature – the sandwiches, the cakes and éclairs – and all beautiful quality. ’It was a sunny but windy day and I spent a lot of time chasing after my hat, as did everyone else. The highlight of the day was when the Queen, Prince Philip, Prince Charles and the Duchess of Cornwall arrived on the terrace to wave at the guests, before being escorted down to their own private tea tent.

You wouldn’t believe you were in the middle of London because it was so quiet.

‘The tea was wonderful and everything was miniature – the sandwiches, the cakes and éclairs – and all beautiful quality.

‘It was a sunny but windy day and I spent a lot of time chasing after my hat, as did everyone else. The highlight of the day was when the Queen, Prince Philip, Prince Charles and the Duchess of Cornwall arrived on the terrace to wave at the guests, before being escorted down to their own private tea tent.

Twitter Tuesdays

AS PART OF CHILD SAFETY WEEK, OUR weekly #CPHVAtt Twitter chat on 2 June focused on how accidents in the home can be reduced. The Child Accident Prevention Trust (CAPT) was also on hand to give advice to members.

@childsafetyweek From about age 10 the roads are the big danger. Big injury reductions in last few decades but stalling now?

@sudavis Need early intervention to educate so that behaviour becomes habit #keepchildrensafe

@angelabinkee2 baby walkers v laminate floors and steps very dangerous

@StudentHVA We do have a home safety scheme but postcode lottery if families are eligible

@CAPTcharity Emerging issues: button batteries, nappy sacks, hair straighteners, blind cords.

@FiWoodhead can start by advising parents not to allow babies to sleep on the sofa—even when newborn and immobile :-(

@jilly249 we offer 1st Aid classes to all our new parents. Also think the British Red Cross apps are a really useful tool.

@sudavis need to use positive messages also ‘Keep your balance’ instead of ‘don’t fall’

@loftyjen having a small stuntman, would be hovering constantly if preventing all his falls, but do best to stop/ready to catch

@StudentHVA Bringing back 4 mth contact would be helpful, get to see parents before baby is becoming more mobile and discuss safety

Twitter Tuesdays take place every Tuesday from 7-8pm using the hashtag #CPHVAtt
Our Voice, Our Direction

THE UNITE-CPHVA ANNUAL
Professional Conference is coming to the Manchester Central Convention Complex on the 17-18 November, bringing community practitioners the chance to network and discuss the latest changes in policy, society and how these impact upon practice.

The 2015 event will explore the latest insight and guidance on topics that are encountered in the diversity of roles that delegates undertake on a daily basis. The conference programme has been put together by a specially selected committee of CPHVA representatives to cover all areas of practice and practitioners. You can study the developing annual conference programme on the event website at www.cphvaconference.co.uk.

Among the confirmed speakers and sessions at this year’s annual professional conference we have Jo Dickson, CNIO and Lead Nurse, Informatics at Leeds Teaching Hospitals NHS Trust. Jo will explore the role that you can take to encourage use of informatics among peers and clients and how technology can be used to positively influence healthy outcomes and decision making.

In addition, this year’s conference will identify how you can build a stronger practitioner with an insightful talk from Ben Fuchs, psychologist, who will be discussing strengths-based leadership. He will explore how you can build your self-awareness and confidence to support the development of others and successfully work together towards a common goal.

Our annual conference presents a great opportunity to meet Unite the Union representatives and discuss with them other issues that impact on your clinical role. Barrie Brown, national officer for health, will be offering expert guidance on escalating concerns and whistle blowing in one of our event master classes. Other topics being explored include the increasing concern of teenage health and pornography with journalist and former ‘Lads Mag’ editor Martin Daubney.

Attendees at the two-day conference will also have the opportunity to discuss the role of community practitioners in research. Dr Susan Hamer, from the National Institute for Health Research, will look at your professional responsibilities for clinical research and how you can involve clients, carers and the wider public to participate.

It is not unusual for there to be tears at the end of conference and this year should be no exception. To close the Unite-CPHVA Annual Professional Conference this year we have Elaine Miller who will give her unique professional perspective as a physiotherapist on pelvic floors and offer first-hand advice on how you can better support women who are suffering with incontinence. Uniquely, Elaine is also a successful stand-up comedian, who has performed on the Edinburgh Festival Fringe.

‘You’ll go home with a smile on your face, guaranteed’, said Gavin Fergie, Professional Officer, Unite-CPHVA 2015.

Inbox

Multi Agency Safeguarding Hub (MASH) safeguarding nurse support and networking

“We are two newly appointed safeguarding nurses working within a multi-agency safeguarding hub in Hertfordshire. This project is currently being set up to ensure effective multi-agency working and information sharing to secure improved safeguarding outcomes.

“We anticipate that we will be going live soon and hope to talk to any practitioners that already have experience representing health within a MASH team with the aim to share good practice ideas and consider setting up a support network.”

Please contact Tracy O’Brien and Tracy Bullot via email: MASH@hchs.nhs.uk
Healthy schools London: event report

By Ros Godson

THE LONDON HEALTHY SCHOOLS celebration event, which took place on 4 June started with all the delegates engaging in a ‘mindfulness’ session; which was led by an art therapist, so we knew that this event wasn’t going to be a standard trawl across healthy eating days and tackling bullying, although both of those were covered. The great and the good were there as well as representatives (staff and children) from more than 80 schools.

Dawn Taylor from the Department of Education (DfE) talked with knowledge and feeling about the importance of pupil’s emotional health and wellbeing in school, and referred to the fact that around 18 per cent of pupils with mental health problems will not achieve academically. She proposed teaching about mental health to reduce stigma, school-based counselling and linking to the voluntary sector.

John Connolly from the Office of the Children’s Commissioner (England) spoke passionately about the UN Rights of the Child: to be safe, healthy, have access to education, play and leisure; and to have their views taken into account. However, he pointed out that the general ‘mood music’ coming from the narrowed curriculum and education policies: longer school days, more homework, more exams, drilling in maths and English, is leading to stressed out children and young people and working against the objective of improved mental health: the school system itself is becoming the problem.

The next theme of the day was on building resilience by using mindfulness training and other techniques to help girls understand gender stereotyping and to be able to negotiate fulfilling (not abusive) relationships and to make friends. Some commercial brands and voluntary organisations are supporting the work to strengthen girls’ body image and to empower them to concentrate on themselves. Young Londoners showcased their campaign on positive relationships, which covers domestic violence, sexting and keeping safe. Called ‘Oii My Size!’ which is apparently what the boys shout out when they are attracted to a girl, they have presented to over 6,000 young people and have talked to MPs and others.

There was a poignant ‘vox pop’ film with children talking about their experiences of bullying but the emphasis was on developing resilience and ‘moving on’.

School nurses will be familiar with growing and cooking food at schools, but not many have the resources and facilities. However, where this is embedded into the curriculum, children learn about the environment, maths, cooperation, teamwork and health and safety. This particular school invited lonely elderly people to join them for lunch, thus teaching children about their responsibility for the wider community. They run a bank account, act as waiters (with uniforms), have a newspaper, and have links with schools in Europe and Nepal.

The World Health Organisation concept of ‘health promoting schools’ has sadly not reached its potential in Britain, but when you see what can be done, and how it enhances children’s wellbeing and development, it is difficult to understand why the government is so lukewarm about the idea; it should be one of the main criteria against which schools are assessed. However, in England, despite many attempts, we have not even managed to get Personal Health and Social Education (PHSE) onto the national curriculum, and nowadays Academy schools do not even have to follow a national curriculum.

It was left to Professor Chris Bonell to put forward the results of the Institute of Education, University of London’s Cochrane style review, which shows that those with better physical and mental health perform better academically, and that schools are wrong to think that time devoted to health is at the expense of learning.

And finally, an alarming thought from Janet Palmer defending Ofsted: five-year-olds today will join the workforce after 2030 and will live into the 22nd century.
How common are infant feeding problems and how can they be managed?

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

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

Modifying standard infant formula to help digestion

Adaptations can be made to standard first infant formula which may help alleviate the challenges faced by an immature GI tract.

**Partially hydrolysed whey protein**

Breast milk provides a very fast gastric emptying time that reduces the risk of digestive disturbances. For formula fed infants, partially hydrolysing the proteins to form smaller peptides makes the formula easier to digest.2

**Reduced lactose**

In the immediate weeks after birth a young baby’s body is often unable to efficiently digest lactose, and this can cause discomfort due to wind.3 The symptoms of colic; fussing, crying and wind, can be difficult for both baby and mother.

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

**SN-2 enriched fat blend**

An SN-2 enriched fat blend structurally resembles that found in breast milk and is well absorbed by infants.4 As the fats are more easily absorbed, formula using an SN-2 enriched fat blend is proven to reduce soap formation in stools and help make stools softer.5

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

**Practicalities of preparation and feeding**

Some comfort formulas contain thickeners which require the use of a fast flowing teat. They have a thicker texture which can become more viscous as the liquid cools and have the potential to block normal flow teats. SMA Comfort milk has been designed to be easily digested and therefore there is no need for a thickener.7


*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
Unite tackling race inequality

UNITE THE UNION WANTS TO PUT tackling and challenging race inequality in the NHS at the centre of its agenda for the thousands of members working in health and social care and is committed to making progress on this issue, so the race inequality gap can be demonstrated to be narrowing.

The Snowy White Peaks of the NHS report highlighted that:

- The proportion of black and ethnic minority (BAEM) senior and very senior managers in England has fallen from 64 per cent in 2010 to 5.9 per cent in 2013
- The proportion of BAEM Trust board appointments in England fell from 8.5 per cent in 2010 to 5.8 per cent in 2013
- In London, trust board BAEM executive membership fell from 9.6 per cent in 2006 to 7.4 per cent in 2014
- BAEM nurses have to work longer to reach higher of management than white nurses – 15.1 years compared to 11.8 years
- BAEM NHS employees are almost twice as likely to be disciplined than white employees.

Smoke and mirrors

Recent press reports regarding a health visitor and community nursery nurse who were forced to remove a child from his home due to parents’ smoking shocked the public and caused quite a stir in the media. When the member mentioned in the reports got in touch with Unite/CPHVA, Dave Munday, professional officer for health visiting, was straight on the case to find out what really happened – and found that all was not quite as had been reported.

Dave’s full investigative blog can be found at: www.commprac.com/blog/smoke-and-mirrors

Shape of caring roundtable

Leading figures from the world of nursing gathered at Unite the Union’s London offices in June to discuss the future of nurse education.

The roundtable debate, chaired by lead professional officer for Unite the Union Obi Amadi, was prompted by the publication of Lord Willis’ Shape of Caring Review in March 2015.

Following a ten month review of the current four-branch model of pre-registration, Lord Willis recommended a shift to a two-year whole person core training model followed by one year in a chosen field, such as mental health, learning disabilities or health visiting. All newly qualified nurses would then be expected to undertake one year’s preceptorship.

A fifth branch, which would introduce a pre-registration course for community nurses and practice nurses is also being considered.

But delegates at Unite’s event, who included mental health nurses, school nurses, community nursery nurses and health visitors, overwhelmingly felt the 2+1+1 model was not ‘fit for purpose’.

Professor Judith Ellis, chief executive of the Royal College of Paediatrics and Child Health (RCPCH), called on specialist nurses to stand united in opposing the introduction of the new model.

She said: ‘You cannot train a specialist nurse in a year. Nurses cannot be Jack of all trades because they will be incompetent in everything’.

Unite the Union will make submissions to Health Education England following the debate.

Downbanding and appraisals factsheets launched

The NHS Job Evaluation Process under Agenda for Change was established to comply with the principles of equal pay for work of equal value, and to end discrimination. Although the scheme has been challenged in the courts, it stands up to scrutiny as the only systematic way to measure NHS jobs against each other, and determine the correct pay band for staff undertaking different roles. Unite representatives have been active on job evaluation schemes and evaluation panels, and continue to work to protect the scheme, and our members’ grading.

To advise members facing down banding, Unite in Health has put together a factsheet that can be downloaded from the ‘resources’ section at: www.unitetheunion.org/how-we-help/list-of-sectors/healthsector

Changes to your terms and conditions under Agenda for Change have led to performance-related pay progression in the NHS. Unite opposed these changes, however, they are now being implemented locally. Employers must work with trade unions to discuss their local systems and undertake an equality impact assessment before the appraisal system is introduced, and review this at least yearly thereafter. To help with this process, Unite in Health has developed a factsheet for employers and staff.

The Unite in Health Good Appraisals factsheet can be downloaded from the ‘resources’ section at: http://www.unitetheunion.org/how-we-help/list-of-sectors/healthsector/healthsectoryourprofession/cphva
What is lactose intolerance and how can it be managed?

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

**Common symptoms**

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

**Primary lactase deficiency**

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

**Secondary lactase deficiency**

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

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

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

**Lactose free vs. lactose containing formula**

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

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

**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

² As of November 2014, as checked via company carelines

² Heyman MB. Pediatrics 2006; 118: 1279–86.

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 development
- Halal approved and suitable for vegetarians

Available on prescription or to buy in supermarkets and other pharmacies
Other findings from the survey reveal...

- More than half (52 per cent) are worried about understanding the requirements for revalidation, while two in five (39 per cent) are concerned about keeping a portfolio.
- A quarter are anxious about providing evidence of their professional indemnity arrangements, with the same proportion also concerned about the reflection and discussion elements.
- Other areas of concern include their revalidation application being refused (17 per cent), going through the appraisal process (21 per cent), gaining CPD (21 per cent), providing a health and character declaration (15 per cent), and completing practice hours (13 per cent).
Some people may feel anxious about the introduction of a new system and that is understandable. We have started publishing a comprehensive range of materials to support both nurses and midwives, and their employers, through the process (NMC).

required to revalidate every three years to remain on the register that allows them to practice.

As part of the revalidation process, all nurses will be required to complete 450 hours of nursing practice plus 40 hours of continuing professional development (CPD), collect five pieces of feedback from patients and colleagues, and provide five written reflections relating to the NMC Code. They must collate this, along with other evidence and information, in their professional portfolio.

Asked about their worries relating to the process, 57 per cent say that they are anxious about finding the time, with more than a quarter (27 per cent) concerned about making errors.

Managing their already heavy workloads to make extra time emerged as a huge concern for the nurses surveyed. Just 37 per cent say that they were confident they would be supported in their workplace while they undertake the necessary steps for revalidation.

MEMBER VOICE
One respondent said: ‘I think it is unfair to expect individual nurses to do this, I barely find enough time to record clinical notes let alone complete this.’

Another commented: ‘There is no time to do this in work and I often bring work home to complete. What happened to work/life balance? I think this could cause practitioners a great deal of stress.’

A health visitor said: ‘Day-to-day working is stressful and allows no time to reflect or gather evidence for revalidation. This will need to be undertaken during precious time at home, which will add more pressure on individual practitioners.’

A spokesperson for the NMC said: ‘Some people may feel anxious about the introduction of a new system and that is understandable.’

“We have already started publishing a comprehensive range of materials to support both nurses and midwives, and their employers, through the process. Although the final process has not been signed off there is information on the NMC website to guide registrants, make sure you register with NMC Online.’

But chief executive of the Patients’ Association, Katherine Murphy, said the results of the survey were ‘extremely worrying.’

‘It is concerning that so many people felt they needed more information about revalidation. The public need to have confidence that nurses are fit to practice.’

“We acknowledge concerns around finding the time to complete the tasks related to revalidation, but from a public confidence point of view it is important for patients to know that those caring for them can demonstrate that they are practising safely and effectively throughout their career.’

If registrants act now and prepare at a steady pace, the impact will be less. Nobody can deny it will take extra time but our advice is to start early (Unite/CPHVA)

STARTING EARLY
Health Education England (HEE), the body responsible for the education and training of healthcare workers, welcomed the survey and said it would continue to work with the NMC and employers to raise awareness of the revalidation process.

‘It is good to see the importance of revalidation is recognised but also shows more can be done to raise its profile among the profession,’ a spokesperson said.

Obi Amadi, lead professional officer at Unite/CPHVA, said: ‘It is encouraging that the survey results show some awareness about what is going to happen in terms of revalidation – although many are not fully aware of what they need to do.

‘Change, even when welcomed, still creates a certain level of anxiety and apprehension. This is understandable, but if registrants act now and prepare at a steady pace, the impact will be less. Nobody can deny it will take extra time but our advice is to start early’

Unite/CPHVA is keen to hear registrants’ experiences and what initiatives are being used in their organisations, she added.
How much do you know about revalidation?

- 9.28% quite a lot
- 22.81% a fair amount
- 52.17% a little
- 12.73% nothing

Are you confident you know what revalidation involves?

- 43% yes
- 26% no
- 30% not sure

Do you know when you are due to revalidate?

- 39% yes
- 58% no
- 2% not applicable

Do you feel confident that you will be supported in your workplace while you undertake the necessary steps for revalidation?

- 38% yes
- 21% no
- 41.5% not sure

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DO YOU AGREE REVALIDATION WILL IMPROVE PUBLIC PROTECTION?

- **19.32%** Most confident
- **12.11%** Least confident
- **32%** Neither agree nor disagree
- **48%** Agree
- **15%** Neither agree nor disagree
- **48%** Agree

MEMBERS ARE WORRIED ABOUT...

1. Understanding the requirements 52.48%
2. Gaining CPD hours 22.02%
3. Completing practice hours 12.66%
4. Obtaining feedback 32.39%
5. Applying the NMC Code 10.00%
6. Keeping a portfolio 39.36%
7. Reflection and discussion 23.67%
8. Health and character declaration 16.15%
9. Indemnity arrangements 24.68%
10. Finding a suitable confirmer 36.33%
11. Appraisal process 21.83%
12. Application being refused 17.61%
13. Making errors 27.34%
14. Accessing information 19.54%
15. Finding time 57.98%
16. None of the above 11.01%
Responses to our survey findings

The info on NMC website is very comprehensive.

I don't feel there will be protected time to complete the new revalidation which means it will be another thing to add to my list of work that I do in my own time.

The revalidation process is something that I know little about, I am unsure about when I need to start collecting this information and when it requires to be submitted. As a health visitor in an area that has high vulnerability and at least 94 hours down for HV hours, the day-to-day working is stressful and allows no time to reflect or gather evidence for revalidation. This will need to be undertaken during ‘precious time at home, which will add more pressure on individual practitioners.

The guidance documentation was essential and supported the process. Additional support from professional officers was very useful.

A little daunting at first however having taken part I feel the evidence required will ensure nurses make a conscious effort to keep up-to-date with practice and continue to reflect on practice.

Not as onerous as I thought although it took quite a bit of time. I particularly found the professional discussion useful.

I found that the process wasn't difficult but the evidence plus someone to say that it is correct doesn't give me the confidence for the safety of the public.

I found it helpful. It's certainly made me think more about how to record my CPD and reflect on my practice. I do have a supportive manager however so wonder if experience could have been worse if I didn’t have that support.

Much easier that expected. There was a lot of support, before and during the process.

I do hope that if there are concerns colleagues will be confident regarding ‘raising concerns’ processes.

I found that the process wasn't difficult but the evidence plus someone to say that it is correct doesn't give me the confidence for the safety of the public.

Compiling the information was interesting and I have learnt so much about myself. I know the benefits of gathering feedback and reflecting and will be more systematic in this pursuit from this point forward.
I am committed to the principle of revalidation especially in the wake of some of the adverse publicity and recent news (eg. Victorino Chau in Stepping Hill and the midwives at Furness General). I would like to think that had these practitioners been subject to properly executed revalidation it may have saved lives. My worry is that revalidation will become a tick box exercise with no real currency in ensuring safe practice.

If too onerous it will make me take early retirement. I've had enough of being treated like an idiot by an incompetent organisation that is not fit for purpose. I am a professional.

I am concerned that at a time when resources are so stretched, both in terms of time and money, it will be a paper-based exercise causing anxiety for hard working conscientious nurses and will not achieve it aims.

Our trust have explained it to us - I need to sit down and spend time looking at what is needed and then hope that what I produce is what is expected. Finding time is the biggest issue for me.

I hope revalidation will root out lazy, unkind, uninformed, unsafe nurses.

Had I not attended the CPHVA regional training session I would have had little knowledge or understanding of revalidation.

I need to sit down and spend time looking at what is needed and then hope that what I produce is what is expected. Finding time is the biggest issue for me.

I have had some useful basic info from my employer but it was this Community Practitioner revalidation survey that prompted me to visit the NMC website and find out more.

One leaflet from the NMC is hardly enough. I pay £120 per year to the NMC. What for? How are they going to support me in revalidation?

I received no information when I failed to renew my registration.

I received no information when I failed to renew my registration.

I am concerned that it will be a requirement but other than that I know nothing about how it will work or how it will differ from simply recording CPD activity as I have always done.

I am leading on revalidation in my trust, I feel well informed but only because I go looking.

I am aware that it will be a requirement but other than that I know nothing about how it will work or how it will differ from simply recording CPD activity as I have always done.

I hope revalidation will root out lazy, unkind, uninformed, unsafe nurses.

Not received any info. I did not even know this was happening until I read the email to take this questionnaire regarding revalidation.
A study has concluded that there is no available evidence that children of same-sex parents experience negative effects from their family setup. Published in the journal Social Science Research, the US-based study sought to compare a range of social and behavioural outcomes of children in same-sex parent families with those of heterosexual or single-parent families.

Examining thousands of peer-reviewed articles that looked at children in families where both parents are the same sex, researchers looked at patterns in citations to establish whether there was a consensus. By the 1990s, there was a definite shift in the published research towards there being no negative affects of this type of family arrangement. From 2000 onwards, the consensus was described as ‘overwhelmingly’ in favour of there being no negative outcomes associated with same-sex parenting. Authors concluded that there was an agreement among scientists that same-sex parents do not present any additional negative impact to children.

The Office of National Statistics (ONS) found that in 2013, there were approximately 13,000 same-sex couples in the UK, either in a civil partnership or co-habiting, who had dependent children.

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No negative impact of same-sex parents found

Children exposed to 80 per cent less smoke

Exposure to second-hand smoke in children has decreased by 80 per cent since 1998, according to research published in the scientific journal *Addiction*. In 1998, 68 per cent of children in the UK were reported to live in smoke-free homes. By 2012, this figure had risen to 87.3 per cent.

The study looked at 35,000 children, using saliva samples to detect nicotine traces that would indicate exposure to tobacco smoke. Cotinine is derived from nicotine but stays in the body much longer, giving a longer-term picture of recent smoke inhalation. In the 1980s, children had an average of 0.96 nl/ml of cotinine in their saliva, while in 1998 this had reduced to 0.52 nl/ml. Samples taken in 2012 gave an average of 0.11 nl/ml, with more than two-thirds registering no cotinine at all.

Researchers suggested that one of the reasons for this change is that parents who smoke are now more likely to recognise that smoking in the home poses a health risk to children. The ban on smoking in indoor public spaces may also have played a part. The government’s tobacco control programme, released in 2010, aimed to have two-thirds of homes smoke-free by 2020. Authors have suggested that it is likely this target will be met ahead of time.

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The National Institute for Health and Social Care Excellence (NICE) has published guidance on assessing babies with bronchiolitis.

The viral lung infection, which affects a third of babies under one year, can cause feeding and breathing difficulties. In the majority of cases it is a mild condition, but in some cases it can become severe. In 2009-10 in England, there were 72 recorded child deaths from bronchiolitis.

Guidance recommends that healthcare professionals should take into account that the condition is most common in babies aged between three and six months, but that symptoms will mostly resolve within three weeks. Recommendations also flag that infants under three months, those who were born prematurely, or suffer from immunodeficiency, neuromuscular disorders, chronic lung disease or congenital heart disease are among those most at risk.

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Public health profiles published

Public Health England (PHE) has updated its public health profiles, which provide summary health information across England by local authority.

They are designed to help commissioners make decisions and plans to improve local people’s health and reduce health inequalities.

The profiles present a set of health indicators that show how the area compares to the national average.

To search and view profiles, go to: www.apho.org.uk
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.

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.

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

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.

Supporting you to support mums

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


Registered Trademark

SMA Staydown Formula

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
School Health Matters: Teenagers want online health services

RUTH BUTLER (ORIGINATOR OF HEALTH MATTERS)
Senior School Nurse, Queens Nurse Central London Community Healthcare NHS Trust

With a national shortage of qualified school nurses and school nurse time stretched to the limits, priority has to be given to those most vulnerable in our school communities. This often means that most young people have little or nothing to do with the school health service and the school nurse’s public health role is limited.

The British Youth Council research (BYC, 2011) clearly showed that young people want to engage with a school health service that was visible, accessible and confidential. They want early help and advice on key issues and wanted school health teams to consider the use of technology to make services more accessible.

FOCUS GROUPS
With this in mind, the author led a series of focus groups in a large, diverse, inner-city secondary school, consisting of students aged 11-16 years. The participating students confirmed the findings of the BYC and went on to outline what an online school health service should offer. This included a way for students to contact the school nurse without going through a teacher, a problem page and information about common health topics. The focus groups were presented with a list of 30 health topics, which they scored as to how important the information on these topics would be for teenagers. The participants agreed that there was plenty of health information available on the internet but they either questioned its reliability or, with reliable sites such as NHS Choices, they felt it was not aimed at a teenage audience.

As well as student focus groups, school staff were asked what they wanted an online school health service to offer. For staff, knowing who the school nurse was, when she was in school and having an easy efficient way to refer students was important. They also wanted to be relieved of finding and photocopying health forms for students who...
had lost them. Staff who were responsible for first aid and supporting students with medical conditions wanted concise information that was quickly and easily accessed.

SITE DEVELOPMENT
The head teacher and senior staff were very supportive of the school nurse’s work in school and made every effort to enable the creation of Health Matters (Butler, 2013), an online school health service, on the school’s intranet system. In response to the focus groups, Health Matters provided a visible, accessible school health service to the students 24 hours a day, seven days a week. Students were able to request appointments with the school nurse, post anonymous questions on the problem page and access reliable health information on topics that commonly interest young people (as highlighted in the focus groups). For staff, the site offered concise information about medical conditions, healthcare plan templates and an easy, efficient way to refer students.

LAUNCHING HEALTH MATTERS
In 2013, the school nurse presented Health Matters to all school staff during a staff meeting. Tutors were instructed to introduce it to their students the following week during one of their tutor periods and, as part of this introduction, the students were encouraged to complete an online feedback questionnaire.

RESULTS OF FEEDBACK
There were a total of 588 respondents to the feedback questionnaire. Of these, 69 per cent knew who their school nurse was and 56 per cent knew how to access the service but only 41 per cent knew when she was in school. These results are relatively high and do not reflect the norm. This is because there had been a period of three years where the school nurse was in school for two days a week and was able to maintain a high profile within the school.

Of the total number of respondents, 32 per cent went on to comment on the things they particularly liked about the site, the most popular aspect being the problem page. Students also commented positively about being able to confidentially contact the school nurse on-line, out of school hours, and also that the health information was presented in a ‘teenage friendly’ way. A number of students noted that the appearance and functioning of the site was poor, although it was recognised that much of the problem was due to the limitations of the system we were using.

The feedback questionnaire asked students to make further suggestions for the Health Matters site and, although most students made no comment, 31 per cent of respondents put forward their suggestions. Unsurprisingly, most of these related to the appearance and functioning of the site or additional content that would be helpful. Predictably, the top ten topics requested were related to sexual health, substance misuse and mental health, with healthy eating and medical conditions also fairly popular.

IMMUNISATIONS AND HEALTH MATTERS
About three weeks before delivering an immunisation programme, the school nurse speaks to the students about the vaccination being offered and is based on a power point presentation. Due to the large number of students (around 200) and time limitations, there is little opportunity for questions but, at the end of the session, students are given an information leaflet and a consent form to be completed and returned to school.

In the past it had been a real challenge for the school nurse to get these immunisation consent forms back from students, and school staff had expressed their frustrations about finding or photocopying spare forms. Staff have also felt inadequately prepared to answer the questions that students ask about the immunisations and other health related matters.

Soon after the launch of Health Matters, the immunisation power point presentation and consent form, along with the dates of the immunisation sessions and links to the NHS Choices immunisation page were added to the site. This meant students and their parents could view the presentation shown in school, they could link to other reliable information sources and easily replace any lost consent forms.

In January 2014, a presentation was given to 210 students about the Teenage Booster and Meningitis C immunisations, and at the end of the session they were shown the immunisation section on Health Matters and reminded how they could use it. Each student was given

<table>
<thead>
<tr>
<th>Return Date</th>
<th>Original Consent Forms</th>
<th>Downloaded Consent Forms</th>
</tr>
</thead>
<tbody>
<tr>
<td>30.01.14</td>
<td>68</td>
<td>2</td>
</tr>
<tr>
<td>11.02.14</td>
<td>26</td>
<td>8</td>
</tr>
<tr>
<td>15.02.14</td>
<td>12</td>
<td>11</td>
</tr>
<tr>
<td>24.02.14</td>
<td>9</td>
<td>36</td>
</tr>
<tr>
<td>25.02.14</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>115 (65%)</strong></td>
<td><strong>61 (35%)</strong></td>
</tr>
</tbody>
</table>

Figure 1: Return of Consent Forms
a consent form to return prior to the immunisation session on 26 February. As the consent forms were returned, the author recorded how many forms were the original consent forms and how many had been downloaded from Health Matters. Figure 1 shows the number of consent forms returned in the weeks and days prior to the immunisation session. It was noticeable that the number of consent forms that had been downloaded from the Health Matters site rose significantly as time drew near to immunisation day and by 25 February, 176 (84 per cent) consent forms had been returned, 35 per cent of which had been downloaded from Health Matters. More consent forms were downloaded on the day of immunisation but these were not counted in the final figures.

As well as the success of the consent forms, three further contacts were made through Health Matters. One was an appointment request from a student; one was a telephone contact with a parent after she had viewed the information on Health Matters and one student submitted an anonymous question on the problem page. Staff were also positive about how Health Matters had helped the immunisation process in school with one member of staff writing ‘It’s much easier now, we don’t waste time trying to get information or replacement forms for the students. We just direct them to Health Matters.”

HEALTH MATTERS IN PRACTICE
Health Matters is now part of the school health service in one secondary school. Because the site is part of the school’s large intranet system it has not been possible to collect data regarding the number of hits, but students and staff are starting to access the school health service through Health Matters and, over a four month period, 21 questions were submitted to the problem page (see examples in Figure 2). Concerns that students may submit questions that required immediate responses (such as safeguarding issues) had been raised so it was made clear on the site that questions would not be answered immediately and appropriate signposting was added (ChildLine). The school nurse re-posts the question with a short answer attached, which is viewable by all who access the Health Matters site. Signposting to further support is also included in the answer and this may involve advice to see the school nurse, referral to other professional services (such as the young person’s sexual health services) or links to other reliable websites (such as Young Minds). Over time, as questions have been submitted, common themes have emerged. The school nurse has responded to these by writing about these topics in a ‘teenage friendly’ format and making this information available on the Health Matters site.

In October 2014, in response to the Department for Education’s advice, Supporting Pupils At School With Medical Conditions (2014), the author-led workshops where senior school nurse practitioners came together to develop a series of standardised healthcare plans, which could be customised for individual pupils. These healthcare plans, which include ones for asthma, anaphylaxis, epilepsy, diabetes and sickle cell anaemia, are now available on Health Matters and are being completed collaboratively by the school nurse, the school welfare officer, the parents of students who have a medical condition and relevant specialist nurses.

FUTURE DEVELOPMENT
Although Health Matters is proving to be a successful addition to the school nursing service in one secondary school, it is yet to be seen how it can be expanded to offer the same service in other secondary schools. The author’s employing Trust expressed an interest in pursuing the concept of an online school nurse and have now invested in the development of a new Health Matters site, which will be accessed publicly through any search engine. This site will be officially launched in September 2015.

If health professionals are to connect with young people, we need to understand not only what they are interested in knowing, but we also need to offer support and information in a way that teenagers will access it. This means that, in spite of our natural reluctance to embrace technological and social media solutions, school nurses must offer a service based on what young people tell us they want.

References
British Youth Council, 2011, Our School Nurse: Young people’s views on the role of the school nurse
Butler, R., 2013, School Health Matters: A web-based health resource for the school community. Community Practitioner, 86(10), 30-32
Five simple steps: #CPHVAtt Twitter Tuesdays

Every Tuesday from 7-8pm, Community Practitioner (@CommPrac) and Unite/CPHVA (@Unite_CPHVA) join forces on Twitter to host a live chat on issues affecting young people and healthcare professionals.

Below are five simple steps to help get you started with Twitter Tuesdays:

1. **Sign up for Twitter!**
   Simply go to www.twitter.com and follow the instructions to sign up for an account. You only need to supply the minimum required information if you’re worried about online security. You can use Twitter through the web or via an app.

2. **Follow people**
   You can see what people are saying on Twitter by ‘following’ them. Try searching for and following @Unite_CPHVA and @CommPrac as a starting point. People can also ‘follow’ you, which means they get to see what you post.

3. **Write a tweet**
   Messages on Twitter are called ‘tweets’. When you post a tweet, it is potentially visible to everyone, and will show up on the home page of anyone who follows you. Tweets have to be 140 characters or less, so use them wisely.

4. **Use hashtags**
   Hashtags are words that start with the ‘hash’ (#) symbol. They are used on Twitter to link similar content together. For example, the Twitter Tuesday hashtag is #CPHVAtt. Anyone who searches or clicks on this hashtag will see all the tweets related to the chat. You can use popular hashtags or even make up your own.

5. **Join our chat**
   Log into Twitter from 7-8pm on a Tuesday and make sure you’re following @Unite_CPHVA to find out the theme for this week’s discussion. Any tweets you send during this time that include #CPHVAtt will form part of the chat. Click or search #CPHVAtt to view all the tweets in the chat.

And finally...

Don’t forget that everything on Twitter is public, so be mindful of this when sending tweets. The Nursing and Midwifery Council (NMC) and Unite/CPHVA both provide guidance on the responsible use of social media. Other than that, get stuck in and don’t be shy – everyone is helpful and friendly! Twitter Tuesday chats are fun, informative and can even count as self-directed continuing professional development (CPD).
HAVING RECENTLY RETIRED FROM MY role as a specialist health visitor and infant feeding co-ordinator in both community and hospital settings, I was keen to continue to support work in the important area of infant feeding and child health, but in a voluntary capacity. I was already familiar with the national child health charity Best Beginnings, because I have used their resources extensively within my professional role.

Best Beginnings was set up in 2006 and became a registered charity in 2007. It works to ensure every baby born in the UK has the best start to life and focuses on the ‘window of opportunity’ from pre-conception to three years of age where the foundations for a healthy childhood are laid. The charity is guided by the principles of innovation, collaboration and evidence.

These discussions helped mothers to make informed choices that felt ‘right’ for them and their baby

UK has the best start to life and focuses on the ‘window of opportunity’ from pre-conception to three years of age where the foundations for a healthy childhood are laid. The charity is guided by the principles of innovation, collaboration and evidence.

The resources Best Beginnings produce are designed to give every baby born in the UK the best start to life and help to diminish health inequalities. These are endorsed by the Department of Health, royal colleges, and many professional organisations, including the CPHVA, and underpinned by a rigorous evidence-base and developed in collaboration with multi-disciplinary health professionals and parents.

In my work as an infant feeding coordinator, we introduced Best Beginnings ‘From Bump to Breastfeeding’ DVD, which was endorsed by the Department of Health, into local service provision. These DVDs were given out free to every pregnant woman, supported by a discussion with their midwife or health visitor, and were customised for our local service,
‘Baby Buddy’ is a dynamic, interactive and engaging resource that places new and expectant parents at the centre of their pregnancy and the transition to parenthood

This DVD uses real mothers’ stories, from different social settings; including young parents, to encourage new and expectant mothers to consider breastfeeding as their preferred method of infant feeding. It gives a realistic view of how to start breastfeeding and keep going, including practical information and guidance designed to help overcome the challenges commonly encountered during the early days and weeks. It has subtitles in Polish, Somali, Bengali, Urdu and British Sign Language. We found that health visitors were able to refer to these stories when talking to parents and that these discussions helped mothers to make informed choices that felt ‘right’ for them and their baby. I also think that using ‘From Bump to Breastfeeding’ in service provision was instrumental in helping our Trust achieve full UNICEF Baby Friendly Accreditation within both the hospital and community trust settings.

The hospital went on to become a pilot site for another of Best Beginnings’ resources, its ‘Small Wonders’ DVD, which supports parents of sick and premature babies to be at the cornerstone of their baby’s care in ways that improve maternal and child health outcomes.

‘Small Wonders’ promotes family-centred care and NICU babies receiving breast milk/breastfeeding while in the neonatal unit. As with ‘From Bump to Breastfeeding’, Small Wonders follows real families on their babies’ journeys through the neonatal unit and a year following their babies’ transition home. Where Small Wonders is used as part of local care provision, this has been found to enable more parents to be involved in their baby’s care, increase the numbers of babies receiving skin-to-skin contact (‘kangaroo care’) and leaving hospital totally breastfed, or breast milk feeding their babies. Parents who have watched the DVD report feeling more confident in handling and caring for their babies before they take them home; feeling better supported and prepared for what lies ahead. Within my unit, maternity and neonatal staff ‘gift’ the DVD to parents with babies on NICU, so that they have their own copy to watch while in hospital and to also take home with them once their baby has been discharged. Small Wonders covers the period from pre-birth and the baby’s admission to NICU, through the early weeks and months, to their baby’s transition home and then a year afterwards.

An exciting new resource that Best Beginnings launched at the end of last year is their ‘Baby Buddy’ phone app; a free resource that can be downloaded onto both Android and iOS devices via the Google Play and the Apple App Store.

‘Baby Buddy’ is a dynamic, interactive and engaging resource that places new and expectant parents at the centre of their pregnancy and the transition to parenthood. The phone app is designed primarily, but not exclusively for young and vulnerable parents, who may be difficult to engage through traditional methods. It is designed to build self-confidence and self-efficacy; and promote good parenting that encourages parental-infant bonding and attachment. The phone app delivers personalised pregnancy and parenting information with prompts for ‘reflection’ and ‘action’ in the voice of a chatty, knowledgeable friend – an avatar the user creates who then becomes their ‘Bump Buddy’ or ‘Baby Buddy’. Although the app was initially designed for young parents and those with low levels of literacy (it has a reading age of 11 years), Best Beginnings have found that many older mothers find it equally informative and fun to use.

Best Beginnings have developed Baby Buddy with significant input from midwives, doctors, health visitors, breastfeeding specialists, speech and language therapists, psychologists, voluntary sector workers and teenage pregnancy specialists. It has been created to offer non-judgemental, evidence-based information and support from pre-conception, throughout pregnancy, and during the first six months’ post birth; specifically supporting young parents to:

• Improve their physical, emotional and social health and encourage positive lifestyle behaviour choices
• Increase self-confidence, knowledge and understanding on how to cope as a new or single parent
• Encourage realistic expectations about life as a ‘new mum’
• Understand their baby’s world to better tune into their baby’s physical and emotional needs

Best Beginnings have developed Baby Buddy with significant input from midwives, doctors, health visitors, breastfeeding specialists, speech and language therapists, psychologists, voluntary sector workers and teenage pregnancy specialists. It has been created to offer non-judgemental, evidence-based information and support from pre-conception, throughout pregnancy, and during the first six months’ post birth; specifically supporting young parents to:

• Improve their physical, emotional and social health and encourage positive lifestyle behaviour choices
• Increase self-confidence, knowledge and understanding on how to cope as a new or single parent
• Encourage realistic expectations about life as a ‘new mum’
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So far, around 800 health visitors are already using the app. I’ve seen for myself how easy to use the app is, so why not download the app yourself, get to know it and share it with colleagues and clients.

In addition to all these functions, the films from the ‘From Bump to Breastfeeding’ and ‘Small Wonders’ DVDs are included within ‘Baby Buddy’. I think that delivering these vital resources through the app will make them more accessible and useful for mothers and mothers to be. Best Beginnings are currently busy producing over 200 new film clips for the app, these include films about maternal mental health. This is another very important programme of work that Best Beginnings is involved with. The films are designed to promote better understanding of maternal mental health problems and show how mothers’ moods may vary and impact on their relationships with their babies. The in-app films will offer positive suggestions, and discuss antenatal and postnatal mental health problems openly; including practical guidance about why it is important to seek help earlier rather than later.

An in-depth, academic evaluation is being done at the moment, but the initial feedback from users showed more than 80 per cent of the users were learning more about their pregnancies, feeling closer to their babies; and more confident as parents. More than 60 per cent of young mums also report that Baby Buddy helps them to look after their own health. Most importantly the feedback from users was that the app was fun and easy to use. I think that Baby Buddy can really support you as a health visitor in your antenatal and postnatal contacts; so that new and expectant parents in your care have easy access to reliable, evidence-based information. So far, around 800 health visitors are already using the app. I’ve seen for myself how easy to use the app is, so why not download the app yourself, get to know it and share it with colleagues and clients. If you want to help us promote it you can order leaflets and posters through the Best Beginnings website.

Don’t forget to provide in-app feedback as this gives Best Beginnings valuable information that supports future development and improvements, and above all it will help us to give every child in the UK the best start in life.
Supporting rehabilitation of traumatic brain injury sufferers in the community

INTRODUCTION
NICE (2014) defines head injury as any trauma to the head other than superficial injuries to the face. Each year, 1.4 million people attend emergency departments in England and Wales with a recent head injury. In the UK, traumatic brain injury (TBI) [leading to acquired brain injury (ABI)] due to head injury sustained is the most common cause of death and disability in young people aged 1-40 years. Although most patients with head injuries recover without any specific or specialist intervention, a (small) proportion of patients will experience long-term disability (needing continuous support) or death following TBI.

At the time of initial discharge from hospital, the patient may have physically recovered, however, long-term complications are known to manifest post discharge after severe TBI. Personality changes, memory and judgement deficits, lack of impulse control, and poor concentration are commonly seen in the recovery phase of head injury.

Health professionals working in the community need to remain aware of these issues as the effects of complications can be potentially minimised or avoided with early detection and initiation of appropriate treatment (NICE 2014). Follow up is of benefit in patients with moderate/severe TBI in terms of reducing reporting of symptoms, reducing anxiety and reducing behavioural changes (SIGN 2009). This article aims to provide an overview of the different specific psychosocial difficulties that community practitioners may pick up while dealing with such patients.

<table>
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<th>Physical</th>
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<th>Cognitive</th>
<th>Behavioural/ emotional</th>
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<td>Psychosis</td>
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Table 1. Categories of the deficits arising from acquired brain injury (adapted from RCP [2003]. Rehabilitation following acquired brain injury, National clinical guidelines)

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to occur and rehabilitation should be aimed at individual patient needs to reintegrate them back in the society. Table 1 highlights the different categories of deficits encountered.

**EFFECT OF DEFICITS FOLLOWING ACQUIRED BRAIN INJURY**

Depending on the severity, the combination of deficits and other associated injuries, limitation of activities and social participation will vary to varying degrees. Patients with ABI may face wide-ranging long-term restrictions (RCP 2003) in their ability to:

- live independently
- drive a car or use public transport
- return to work or education
- participate in leisure and social activities
- fulfill family roles and maintain personal, sexual and family relationships.

While managing a patient it will be necessary to identify the areas where support will be necessary and community practitioners are best placed to support them in the community.

**IDENTIFYING BEHAVIOUR PROBLEMS**

Head injury survivors may experience a range of neuro-psychological problems following a TBI. Depending on the area of the brain affected and the severity of the injury sustained, the manifestations will vary between individuals. Behavioural changes in TBI sufferers may be stressful for families. The family members may consult health professionals as they fail to understand the sudden change in behaviour of their relative. Caregivers need to be explained about in TBI sufferers may be stressful for families. The family members may consult health professionals as they fail to understand the sudden change in behaviour of their relative. Caregivers need to be explained about the need for aiding with memory problems and or amnesia related to certain periods of time (Marshman 2013).

Personalities changes are often an exaggeration of the person’s pre-injury personality in which personality traits become intensified. Some changes can be quite striking. For example, the TBI survivor who used to be easy going, energetic, and thoughtful may suddenly appear to be easily angered, self-absorbed, and unable to show enthusiasm for anything new. It is important not to criticise them but provide positive environment that will aid recovery and reduce chronic behavioural problems (Li 2013).

**LEARNING AND MEMORY PROBLEMS**

Survivors of TBI may experience short-term memory problems and/or amnesia related to or amnesia related to certain periods of time (Marshman 2013). Generally, new learning presents the greatest challenge to memory or remembering. In contrast, pre-injury knowledge (memory) is more easily retained. The ability to focus and concentrate is the key to address some short-term memory problems. This might be a particular problem in children and adolescents where there is a high demand for learning newer skills and knowledge (Middleton 2001).

It is important to keep distractions (e.g. music, loud noise) to a minimum and focus on one task at a time. Repetition of the name of a person or object may be helpful if the memory impairment is severe. Writing down key information (e.g. appointments, phone messages, list of chores) is helpful. A structured routine is important for activities of daily living. It is helpful to keep to routines. Family members may be advised to keep household objects in the same place and keep dangerous items away from the individual sufferer undergoing rehabilitation in the community. If the person is an adolescent or an adult who are living independently, and keeps getting lost, some useful suggestions to help mobility could include labelling doors or colour code doors inside the house, hang arrows to indicate directions. When going out, the person should be accompanied initially to ensure the route is understood and remembered. A simple map can be sketched from the bus stop to the house with important landmarks e.g. a corner shop, a telephone booth, etc. It is important to ensure that the person always carries his/her address and emergency phone numbers with them. Community practitioners may need to work with schools to reintegrate the child to the school environment but need to emphasise the need for aiding with memory problems and problem-solving skills (Jennekens 2010).

**EMOTIONAL PROBLEMS**

It is not uncommon for a person who survived a moderate/severe TBI to exhibit a lack of emotional responses such as smiling, laughing, crying, anger, or enthusiasm and their responses may sometimes appear to be inappropriate. This may be especially the case during the earlier stages of recovery. The main emotional needs that will need supporting are with ‘one’s mood’, mood swings and learning how to deal with stress (Jennekens 2010). Post traumatic stress disorder, obsessive compulsive disorder and panic disorder may also be seen in the survivors, and nurses may be able to identify these early and make early referral (Gracey 2002). The family members should be explained that this is part of the TBI recovery and the need for patience and emotional support during the phase of emotional lability. There may not be any reciprocated appropriate emotion exhibited by the TBI sufferer and this may cause emotional upset among the family members.

**AGGRESSIVE BEHAVIOURS**

Aggression is one of the most common consequences seen after a TBI with a prevalence ranging from 11 per cent to 34 per cent (Rao 2009). It is important to screen survivors for aggressions early as studies have found that this can be associated with new-onset major depression, poorer social function and increased dependency on others for activities of daily life.
INAPPROPRIATE SEXUAL BEHAVIOUR

While recovering from a TBI it is not uncommon to show inappropriate sexual behaviour. A community-based survey in Australia identified a prevalence of 8.9 per cent for inappropriate sexual behaviour over previous three months: inappropriate sexual talk (57.9 per cent) followed by genital and non-genital touching behaviours (29.8 per cent) and exhibitionism/public masturbation (10.5 per cent) (Simpson et al, 2013). The TBI sufferer may also exhibit sexual disinterest and this may cause emotional issues among partners. The causes could be a result of brain dysregulation of hormonal activity or an emotional response to the injury.

Helpful strategies that may be discussed with partners include: allowing time to resume sexual activity, helping the person dress appropriately and practicing good personal hygiene, gentle reminders that inappropriate sexual talk/behaviour is not acceptable, making friends/acquaintances aware of the problem so that a certain tolerance level is exhibited and avoiding being aggressive to the person. A sexually aggressive person may need to be isolated from others when inappropriate behaviour is not controlled. Support groups may be useful in helping the person realise the consequences of inappropriate sexual behaviours.

LEARNING TO COPE/GETTING SUPPORT

Coping with behaviour problems after a head injury requires identification and acknowledgment of the impaired individual’s deficits. A comprehensive neuropsychological assessment is recommended in sufferers of moderate/severe TBI. This may help both the survivor and the family to understand better the neurological and cognitive deficits.

In some cases, it may be necessary for the family to recognise the personality changes and be given strategies to deal with it rather than to resolve the problem behaviour. Targeted strategies may be used to deal with specific behavioural issues.

ROLE OF COMMUNITY PRACTITIONERS

Caring for a TBI suffer can be challenging at times and family members may need support for their own emotional issues. It is vital the health professionals working in the community support the family members and the patient. Following strategies may be useful (Stejskal 2012; NICE 2014; RCP 2003; Keightley et al 2009; Khan et al 2003).

- Support rehabilitation and reintegration of sufferers of TBI in the community keeping in mind the family’s cultural and social practices.
• Recognise new onset symptoms or deterioration in mental status and arrange appropriate assessment early
• Chalk out an individualised plan for each patient taking into patients’ needs and the support available within the family
• Ensure children and adolescents are closely supported in the school environment e.g. extra time to finish school work, easy accessibility to school nurse and the medical room
• Arrange respite care for carers to enable a balanced life for them
• Arrange provisions of adaptation to the home environment to enable better and safe care e.g. ramps, hoists, etc.
• Ensure appointments at hospitals and with other professionals are attended regularly
• Ensure repeat prescriptions are available easily to allow continuation of therapy at home and avoid ill health (e.g. break through convulsions in a patient who developed epilepsy post TBI)
• Support family members when they seek help for themselves
• Provide guidance about assistance and financial support available e.g. carers allowance, disability living allowance, wheel chairs, mobility scooters, etc
• Liaise with social services where abuse to the vulnerable TBI sufferer is suspected.

References
The Tameside and Glossop Early Attachment Service: Meeting the emotional needs of parents and their babies

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ABSTRACT
Parent-infant emotional health is probably one of the most complex arenas in which mental health, maternity and health visiting services operate. This critical period can be highly emotionally charged, not only for the infant but also for the parent. While most parents essentially get it right, severe ruptures in the parent-infant relationship can occur, and can have serious consequences. This paper describes a comprehensive and cost-effective parent infant mental health service based on a psychodynamic model. The service aims to meet the needs of all parents from those with a high level of need through to a universal provision. Strategic and theoretical underpinnings of the service model are described.

KEY WORDS
parent-infant, perinatal, early intervention, prevention

THE IMPORTANCE OF PARENT-INFANT MENTAL HEALTH SERVICES
The health and care of parents and their babies are usually provided by a range of services and professionals who not only have different focuses and training, but who also may have different understandings of mental health. Some of this care may focus on the health and development of the infant and some may focus on the parent’s problems and anxieties. No arena is more complex than that of parent-infant mental health. Infants start to be influenced by their emotional and physical environment from the moment of conception, and the two years following birth is fundamental to the subsequent development of the individual (Schore, 2004; Stroufe et al. 2005; Wave Trust, 2012).

The fact that many different professionals and agencies are inevitably involved during this period presents a challenge to provide a coherent, shared understanding, and a seamless, integrated service for families. There is the question of how much of these resources should be devoted to the help and guidance for all parents and infants, compared with the amount that should be allocated to those who have specific emotional or mental health problems.

Holding the baby in mind
The overarching principle of the Tameside and Glossop Early Attachment Service (EAS) is holding the baby in mind, from a universal level to targeted individual parent-infant relationships, from the antenatal period, across services, and with all professionals and families, placing it at the centre of everyone’s thinking in the community. Holding the baby in mind means also holding the parent-infant relationship in mind. When things go awry, the central focus is neither solely on the parent/s nor the baby, but on their relationship. Winnicott (p88, 1964) was one of the first to point out the interdependence. ‘At this early state it is not logical to think of an individual. If you set out to describe a baby, you will find that you are describing a baby and someone. A baby cannot exist alone but is essentially part of a relationship’ One cannot think of physically holding a baby without thinking about the psychological meaning for the infant and the parent. The way we hold a baby reflects how we understand his/her state of mind, and his/her feelings, thoughts and needs. Sometimes, our own experiences of being ‘held interferes with holding our own baby. The experience of being held physically and psychologically allows the baby to feel contained within his/her own body and mind. ‘We know that as babies the way we are held, talked to, and cared for each teaches us about who we are and how we are valued. This profoundly shapes who we will become’ (Brazelton, 2013).

The importance of parents’ own early experiences
Our service focuses on both the inner and outer worlds of expectant and new parents and how they adapt to the changes and react to the emotions that are stirred...
during the perinatal period. Neither parent nor infant is a passive recipient of what is going on. While the infant is affected by the parent, the parent also is deeply affected by infant. We were all once infants ourselves and we carry unprocessed residues of our own childhood experience (Raphael-Leff, 2000). Fraiberg, Adelson & Shapiro (1975) referred to the experience as ‘Ghosts in the nursery’, where a parent’s current issues, as well as their own unresolved experience of childhood, may be stirred and interfere with the relationship to the infant. Thus intergenerational factors, the antenatal experience, and the mental health of both parents are intrinsically linked. While during the perinatal period there is potential for breakdown, there is also potential for breakthrough. It is a time when both the parent and infant are open to new learning and change, making parent-infant intervention vital.

**THE TAMESIDE AND GLOSSOP EAS**

The service is jointly run by two NHS Trusts. EAS is led by the clinical manager who is a consultant clinical psychologist. There is another clinical psychologist and two infant mental health specialists who come from health visiting and midwifery backgrounds, and a child psychotherapist. We also have a senior mental health practitioner who is based in primary care in adult mental health. We have a partnership with Home Start and have appointed a parent-infant mental health coordinator who supports volunteers working with families with babies.

The service works with families from pregnancy through to the child’s third birthday. Although our staffing contingent is relatively small (4.77 WTE), EAS has been able to develop a strong service through building links with partner agencies, and training staff. In particular, we have developed close working partnerships with midwifery and health visiting, raised their awareness and skills in parent-infant mental health, enabling them to become proficient in the use of a range of universal interventions, and also in identifying early when problems emerge. Also, we provide consultation to many staff. The general principle is for the less qualified staff to deal with many of the universal interventions, and work with families whose problems are less severe, enabling the core staff to work with those who have serious parent-infant mental health concerns.

**THE INTEGRATED PARENT INFANT MENTAL HEALTH (PIMH) CARE PATHWAY**

Central to the operation of the EAS is the Integrated PIMH care pathway, which was developed in 2011 to provide an early, comprehensive assessment of parent mental health problems and infant attachment problems, appropriate to individual needs, and accessible to all who need it. Parents with mental health difficulties during the perinatal period are prioritised in primary care adult mental health for psychological therapy (IAPT) services. The PIMH pathway was developed through a multi agency working group which consisted of representation from adult mental health (both primary and secondary), children’s social care, health visiting, midwifery, GPs, and early attachment. Unlike other perinatal pathways around the country there was a focus not only on adult mental health but parent-infant mental health (Hogg, 2013).

All mothers and fathers who present during the perinatal period are asked the three Whooley questions. In addition they are asked, ‘Are you worried about bonding with your baby?’

Depending on the parent’s history and response to the questions, their care follows one of three pathways: green, amber or red. The majority of families, while potentially able to benefit from information and guidance, basically ‘get it right’ (Svanberg, 2006) and fall in the green pathway. The amber pathway is triggered for families who have problems that are judged to be mild to moderate, of a less pressing and less severe nature, while the red pathway is for those with more serious issues.

**Evaluation of the pathway**

In 2012, we evaluated the pathway and asked both professionals and parents to complete a brief survey on their experience. In particular, the performance indicators were: effective multi-agency care planning for parents on the red pathway, effective communication between maternity and health visiting for parents on the amber pathway, and service user experience of ante- and post-natal provision. The results indicated that there was very good multi-agency care planning for parents. Discussions in the group were helpful in gaining experience of the pathway, how each service works, enhanced multi-agency working and communication, and also learning from the experience of service users. The PIMH pathway is currently under review in consideration of the new NICE guidelines for antenatal and postnatal mental health (NICE, 2014).

The earliest possible intervention

Proactive interventions beginning either ante-natally or at birth have the greatest most sustained effect (MacLeod & Nelson, 2000). EAS has worked closely with midwifery colleagues to better support them in providing ante-natal education to parents, so that not just the physical preparation, but psychological preparation and adjustment, is shared and communicated.

In the period of 2014-2015, 41 per cent of our referrals were parents presenting ante-natally. 80 per cent of infants were seen at eight weeks or younger, 96 per cent infants were seen at one year or younger. In general, we continue to see parents and infants very early in the perinatal phase. This is a stable trend that has been reported over the past few years. It suggests professionals are recognising problems in the parent infant relationship very early, and are also acknowledging the importance of early intervention and support.

Most consultations and referrals to EAS come from health visiting, midwifery and children’s social care, but consultations are also conducted with a range of other services. The consultation service has become an effective and essential method of ensuring that the limited availability of the EAS team for direct clinical work is used most effectively. It also represents another opportunity to influence professionals’ thinking. Many families seen by EAS are overburdened with risk and in these cases, with so many professionals involved; it can be so easy for the baby to get lost in people’s minds. EAS has devised a parent-infant risk assessment that is used at all consultations.
and with all families seen by the service. The risk assessment looks at parent/s, the infant and the parent-infant relationship, it focuses on both risk and protective factors.

Specialist training of staff
We place great emphasis on the need for staff who work routinely with infants and parents to be proficient in promoting and facilitating the parent-infant relationship and also in identifying, at the earliest possible stage, problems in the parent/infant relationship. This has partly been achieved through training sessions conducted by the EAS to health visitors, midwives, community nursery nurses, social workers and early years workers.

The Brazelton Influence
It is particularly important to mention training in the Brazelton (Neonatal Behaviour Assessment Scale - NBAS, Brazelton, 1972 and Newborn Observation System, NBO, Nugent et al. 2007) interventions. Since the 1960s, Brazelton has recognised the fundamental role babies themselves play in cementing the relationship with their parents. Babies from the earliest age communicate with their parents through their behaviours and individuality. The Brazelton interventions are first and foremost interactive, and provide a way to understand the infant, and how it must feel to parent the baby, thereby promoting the development of the parent-infant relationship. While ultimately we can never know really what a baby is thinking, the Brazelton interventions provide a way to provide meaning to what parents are observing, and facilitate their understanding and contribution to the development of the baby’s mind (thoughts and feelings) (Brazelton and Cramer, 1990).

EAS commissioned training in the NBO and NBAS for all health visitors, community nursery nurses, a representative group of midwives, Home-Start coordinators, community nursery nurses and specialist perinatal adult mental health workers. The NBO is offered universally to all families in Tameside and Glossop. It is recommended in the Healthy Child Programme (Department of Health, 2009) and also in the national 2015-2016 Health Visitor Service Specification (NHS England, 2014).

While the NBO/NBAS provides an important framework to help professionals facilitate increased sensitivity between parents and infants, EAS provides additional learning and support to health visitors to help them further tune into and understand the emotional register between a parent and infant, and between themselves and the parent-infant relationship. We also seek to help health visitors understand emotional stirrings in themselves that may emerge as a result of the contact with the family.

Pyramid of support and intervention
Figure 1 illustrates parent-infant mental health provision in Tameside. It is a guide on the different levels of support and intervention we provide. Interventions need to be tailored to the specific needs of the parent-infant relationship to ensure better outcomes (Shonkoff & Phillips 2000), so the model is flexible and inclusive and services are guided by the individual parent-infant needs.

Each tier represents a different level of intervention and level of access. The EAS has placed a strong emphasis on promoting understanding of parent-infant mental health from the ‘bottom up’, rather than providing a service from the ‘top down’. Culture change can be achieved through communities owning, valuing and sharing an understanding of infant communication, and the importance of that first relationship between infant and parent. This has meant developing resources for parents that are universally available, and organising and facilitating training for practitioners from a wide range of settings. Health visitors and midwives take responsibility for the less serious parent-infant relationship difficulties and, through receiving support from EAS in this work, grow in confidence, knowledge and skill in this vital area. This frees up the time of more specialised clinicians to see those parents who are most in need of their attention.

EXAMPLES OF THE THREE INTERVENTION LEVELS
Green: Universal
EAS has developed a universal post-natal programme, ‘Early Start’ for parents and infants up to one year of age, that is evidence based and focuses on enhancing the parent-infant relationship. The programme is based on key theoretical concepts in parent-infant mental health: sensitivity, reflective functioning, regulation of affect, and self and mutual interactive regulation (Slade, 2005; Beebe, 1998).

All new parents in Tameside and Glossop receive our purpose-designed DVD and booklet, ‘Getting it right from the start’ at their 20 week scan. The resource was
developed to promote sensitive and responsive early parenting and infant communication. The resource is based on evidence from research and clinical studies in infant development and infant mental health (Brazelton, 1972; Schore, 2004; Douglas & Ginty, 2001). A recent evaluation of the resource (Lee et al, 2013) indicated that ‘Getting it right from the start’ represents an effective method of reaching all parents during the perinatal period.

Since 2011, Tameside has invested in training in NBO to ensure it is offered universally. In 2013, an evaluation of the NBO was conducted in Tameside and Glossop to explore its use in the everyday practice of health visitors. The majority of health visitors reported marking changes to their working practice as a result of the NBO training. For some health visitors, the NBO as an intervention has freed them to refocus their attention on the parent-infant relationship.

Also offered is the Solihull Approach. This approach to supporting families is based on the principles of containment, reciprocity and behaviour management (Douglas & Ginty, 2001). More recently, Tameside has invested in Solihull Parenting, offering it to all parents with children from 1-2 years of age. Preliminary findings suggest parents are significantly benefitting from the groups and are reporting reduced levels of stress.

Amber: Mild to Moderate Intervention
Families placed on the Amber pathway are typically those with mild to moderate mental health concerns and/or parent-infant relationship concerns.

Since 2012, EAS has formed a close partnership with primary care adult mental health. We appointed a perinatal adult mental health specialist whose role includes: consultation with professionals, liaison, prioritising assessment and treatment of pregnant women and their partners who were presenting with mental health concerns, and raising awareness of parent-infant mental health in adult services. The perinatal specialist has also expanded her work to focus on groups for parents with mental health problems during the antenatal period and also parents and babies post-natally.

In 2015, Tameside established a ‘Babies Can’t Wait’ agreement, which means all pregnant women or those with children under the age of two years and their partners can access Healthy Minds (IAPT) service directly following referral, avoiding any wait. This has meant it is possible for parents to receive support for their own mental health. With the close partnership between adult mental health and EAS, we have raised the importance of parents needing to access help for their mental health during the perinatal period, and also raise the importance of the parent-infant relationship.

While specialist support from mental health, maternity, health visiting and EAS is available for these parents, we have found that what was particularly missing was low level support for parents individually and to engage them into local children's centre and other community provision. To try to meet this need, we appointed a coordinator based in Home Start to work with the volunteers to support parents and infants. The partnership with EAS has meant together we provide parent-infant mental health training and supervision to staff and volunteers in Home Start. Health visitors also have a key role in training Home-Start volunteers in parent-infant mental health for their work as befrienders with vulnerable families.

For health visitors, any concerns raised through carrying out a routine NBO with a parent-infant may then be referred on for a more in-depth Brazelton intervention, namely the NBAS. In addition, if a baby is identified with additional needs, a NBAS may be provided first.

Red: Direct Specialised Clinical Intervention
EAS offers a direct clinical service across Tameside and Glossop. The team also works closely with the post-natal ward and neonatal intensive care unit at the local hospital, attends the ante-natal clinic as needed, has provided and influenced change in ante-natal classes, works with specialist midwives for mental health, safeguarding and young parents, and offers support to the fostering and adoption team.

The service offers a wide range of interventions that include: interaction guidance, video feedback, adult psychotherapy, and parent-infant psychotherapy. There is a particular focus on parent-infant psychotherapy. The therapy typically shifts back and forth on several registers. It focuses on present concerns and also moves back and forth between past and present, between parent and infant, and back to the parent’s own past, hopefully helping the parent understand what they are feeling, but also what the baby is feeling. Together, the clinician and parents explore both the ‘ghosts’, the painful memories that can upset the parent-infant relationship, and the ‘angels’, the early benevolent experiences with parents that can be protective factors (Leiberman et al, 2005). The therapy provides a space to contain and treat the parent’s anxieties and distress, and also supports the infant at a time when the parent may be finding this more difficult to do so. The clinician can also be the voice of the baby especially, when the parent cannot see the baby in his/her own right.

It is not unusual for families to receive a range of interventions depending on their individual and changing needs. There is no restriction on the length of time a family receives an intervention.

More recently, Tameside has invested in Mellow Parenting. We have trained staff from EAS, Home-Start, health visiting, CAMHS, and early years. All the staff meet as a group to discuss and plan the delivery of Mellow groups which are co-facilitated by two staff, one of whom is a senior mental health clinician. Mellow Parenting is for families who have experienced serious adversity.

![Figure 2: Example of 3 questions asked in the service questionnaire](image)

<table>
<thead>
<tr>
<th>Question</th>
<th>Percentage Agreed</th>
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<td>I learned something new about my baby/child</td>
<td>100% agreed</td>
</tr>
<tr>
<td>I feel more tuned in to my baby/child</td>
<td>90% agreed</td>
</tr>
<tr>
<td>I feel more confident about my ability to care for my baby/child</td>
<td>100% agreed</td>
</tr>
</tbody>
</table>

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to the extent that they are struggling to establish or maintain a positive relationship with their children.

SERVICE EVALUATION

EAS has a wide range of data, evaluations, and performance measures to demonstrate the impact of its work with families. All families who are seen receive pre and post measures. These include: PHQ-9, GAD-7, Mothers’ Object Relations Scale, Parenting Stress Index, Parent-Infant relationship - Global Assessment Scale, and Parent Infant Relational Assessment Tool. Parents presenting during the ante-natal period are given a series of different measures looking at their thoughts and feelings towards the unborn infant.

The following are some brief extracts from our annual report.

Mothers’ Object Relations Scale (MORS)

This is a 14 item questionnaire, which assesses a mother’s representation of her infant. A mother’s perceptions of her infant derive partly from the infant’s characteristics and behaviour but also from the mother’s projections, which stem from her own inner world (e.g., her feelings, behaviour, identification and attachment). Based on the completed scales there was 80 per cent of the families showed improvement by two categories, and 24 per cent showed improvement by three categories.

Experience of Service Questionnaire

All parents who receive a direct clinical service are given a service questionnaire asking about their experience of the service and the impact of the intervention. This service evaluation has been used since 2009.

CONCLUSION

It clearly makes sense to focus attention on the fundamental bedrock of child development – the parent-infant relationship. From this basic union stems every relationship that the person makes in the rest of life, and how the person interacts with the wider society. There is a recognition of this in current research and service development, and it is to be hoped that this will translate into the setting up of many more such services in the future.

The importance of a broad workforce and service development and collaborative approaches in sustainability, rather than investing only in a high degree of specialism.

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Every child has the right to smile! – A qualitative study exploring barriers to dental registration in a SureStart area in Northern Ireland

INTRODUCTION
Dental caries remains the most prevalent childhood disease and affects the most vulnerable. (Mouradian et al., 2003). It has been referred to as the ‘silent epidemic’ of childhood characterised by marked disparities and confers severe multi-level effects on children, their families, communities and the health system (Casamassimo, et al., 2009). Oral disease reduces quality of life and has multiple impacts on physical and psychological wellbeing (DHSSPS, 2007) while oral health enables an individual to speak, socialise and eat without active disease, discomfort or embarrassment (WHO, 2003). Although the average dental health of children has significantly improved over the past few years, the population averages mask the oral health inequalities in socially disadvantaged areas (Kengne Talla et al., 2012). Children living in these communities are three times more likely to experience dental decay than those living in more affluent areas (Robertson et al., 2011). SureStart is a government-led early intervention initiative that targets 0-4 year old children living in geographically defined areas with high levels of deprivation. SureStart aims to give every child the best possible start in life by bringing together health, early education, childcare and family support (SureStart, 2002).

SureStart is currently expanding services into the top 25 per cent most disadvantaged wards. The electoral ward chosen for this research study is part of this new expansion programme and within the local healthcare Trust has the lowest rate of dental registrations for both the 0-2 and 3-5 year age groups. In the 0-2 year age group only 15.2 per cent are registered with a dentist and 44.1 per cent of 3-5 year olds compared with the Northern Ireland averages of 30.6 per cent and 74.7 per cent respectfully (CYSP, 2013). These statistics are of particular relevance and interest to the author who currently manages a local SureStart project and is trying to influence registration rates.

This study aimed to explore parents’ perceptions of factors influencing the dental registrations of their children 0-4 years, within this electoral ward given the poor dental registration rates identified.

METHOD
Given that dental care is free in Northern Ireland for all children the researcher believed that before attempting to suggest strategies for improving access to dental care, it was necessary to understand cultures and explore, with parents, the barriers they encounter in registering their children for dental care. The author chose to adopt a qualitative approach to address the proposed research question namely ‘what are the factors that parents perceive effect dental registrations for their children age 0-4 years.’

A purposive sample of twelve parents currently known to SureStart services and not yet registered with a dentist was identified to participate in the interview process. Potential participants were identified from data stored on the ‘SureStart Play’ database by their electoral ward postcode and the information disclosed on the registration form that their child was not registered with a dentist. The Sure-Start Coordinator (CCN) RN (Adult), RN (Child), Specialist Practitioner (CCN) Sure-Start Coordinator (DOWN Sure-Start) South Eastern Health and Social Care Trust

CORRESPONDENCE: clare-marie.dickson@setrust.hscni.net

ABSTRACT
The aim of this research study was to explore parents’ perceptions of factors influencing dental registrations of children, age birth to four years, living within a SureStart area. The electoral ward identified had the lowest rate of dental registrations for both the birth-two and three-five year age groups in a local healthcare Trust in Northern Ireland. The author chose to adopt a phenomenological approach to explore the lived experiences of parents in relation to dental behaviours. A purposive sample of eight parents currently known to SureStart services and not yet registered with a dentist was identified. Face-to-face, semi-structured interviews were conducted. The interviewees were aged between 20-41 years with a dentist and 44.1 per cent of 3-5 year olds compared with the Northern Ireland averages of 30.6 per cent and 74.7 per cent respectfully (CYSP, 2013). These statistics are of particular relevance and interest to the author who currently manages a local SureStart project and is trying to influence registration rates.

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years and the number of children in the family ranged from one to three, with their age range spanning from one month to three years. Face-to-face, semi-structured interviews were conducted using an interview schedule. Seven interviews took place on a one-to-one basis within the home setting and one was facilitated by telephone at the mother’s request. The interview schedule contained thirteen questions, all of which were open, to allow the interviewee to probe the interviewee to elaborate on experiences relevant to the research question and capture as much information as possible. The questions were based on those previously used in focus groups in an American qualitative study (Kelly et al., 2005). Although not a validated tool, the findings were significant uncovering multiple barriers for caregivers attempting to access dental care for their children.

Ethical approval was received from a university ethics committee and the National Research Ethics Committee (Reference: 14/NS/0044). A Participant Information Sheet was issued and written, informed consent obtained. None of the participants were known to the interviewer. Participants were assured of confidentiality and had the right to withdraw at any stage. In order to protect anonymity, the participants were given an identity number rather than disclose their personal details and client confidentiality (Watson et al., 2008) was assured. Data held by the researcher, including all electronic information, was stored securely at all times according to the Data Protection Act (1998).

The analytical process for this study began during data collection, as data is shaped and refined as the researcher pursues emerging avenues of inquiry in greater depth (Pope et al., 2000). All interviews were recorded and then transcribed as soon as possible (Sandelowski, 1994) after the event to ensure that data available for analysis was an accurate record of the interview. To capture any additional information notes were made during the interview process. The researcher used Colaizzi’s (1978) phenomenological seven step framework for data analysis and the following themes were identified: age of first dental attendance; childhood experiences, behaviours and attitudes.

**FINDINGS**

The aim of this study was to explore the factors affecting dental registrations for children aged 0-4 years within one electoral ward in Northern Ireland, given the poor registration rates already highlighted. The four main objectives were to understand the reasons why families of children aged 0-4 years residing in an area of disadvantage have not registered their child/ren with a dentist; to explore parental factors that might impact upon decision-making in relation to dental registration, including their own dental experiences; to explore what measures parents currently use to prevent oral disease and to explore how dental registration rates could be improved in the future. The following themes emerged from the study through systematic thematic analysis (Colaizzi, 1978).

**AGE OF FIRST DENTAL ATTENDANCE**

The first theme that emerged from the interviews was the age of first dental attendance. Research suggests children who have their first preventative dental visit by age one are more likely to have subsequent preventative visits and less restorative or emergency visits (Savage et al., 2004). Conversely, children who have their first preventative visit at age two or three years are more likely to have subsequent restorative and emergency visits (Savage et al., 2004). During the interview, parents were asked what age a child should start attending the dentist? Although two respondents initially stated between 18 months – 2 years and 3 years respectively they later clarified that this was their personal opinion, but they had been advised by professionals to register their children earlier. The remaining six interviewees gave responses similar: ‘as soon as his wee teeth come through, to get him used to the dentist’.

This is reflective of the information issued to all parents resident in Northern Ireland through primary care services (antenatal clinics, health visitors or GPs) in the Birth to Five publication (Public Health Agency, 2013), which is also used by midwives and health visitors as a tool or resource to advise parents:

‘You can take your child to a dentist as soon as they are born, even before they have any teeth. HSC dental treatment for children is free’ (PHA 2013, page 71)

It also indicates that this group of parents had a general awareness of the age recommended by primary care staff. Coincidentally, two of the above parents disclosed that their children had four teeth and twelve teeth respectively and yet they still had not ‘got round’ to registering them with the dentist.

All interviewees were aware that dental treatment was free for children and the majority knew how and where to register their child. One parent was motivated enough to attend the dentist before her baby’s teeth erupted, but subsequently decided during the dental visit that it was a pointless exercise until teeth appeared.

‘They said they wanted the baby up for an appointment and I just thought, this is pointless me bringing her up there because she had no teeth…’

This could simply be explained by a sudden change of heart by the mother, however, I got a sense from her recounting the event that it was more about her own experience, or treatment, that made her start to question why the baby needed to be with her for registration and latterly why a baby with no teeth would need to attend at all. This raises the question of visits potentially taking place too early’ causing parents to view this as a futile exercise.

<table>
<thead>
<tr>
<th>Table 1: Dental Registration Rates</th>
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<tr>
<td>Percentage of Children Registered With A Dentist 2012</td>
</tr>
<tr>
<td>NI Average</td>
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<tr>
<td>Electoral Ward involved in research study</td>
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*Children & Young People Strategic Partnership (CYPSP), (2013)*
Although the research evidence clearly indicates a need for early anticipatory advice to parents before their children's teeth erupt, this advice may be best delivered by non-dental healthcare providers who are more likely to see infant and toddlers before early childhood caries manifests clinically (Goldfield et al., 2003) for example health visitors and SureStart staff.

The most significant experiences in relation to age of attendance or registration were shared by two mothers. At the time of the interview, one mother had twins of two and a half years and a fifteen month old. When the twins were eighteen months she was at her own routine dental appointment and asked when she could register them:

“He [the dentist] told me to come back when they were about two.”

They are now only attending for their first dental visit next week. She has enquired if she can bring along her fifteen month old and has been told: ‘No! he’s too young.’

The other parent revealed a similar story when she took her child to the dentist at 1½ years old and although the dentist put him on the chair and looked at his mouth, she was told to come back at school age.

INCONSISTENCIES IN ADVICE OR INFORMATION GIVEN ACROSS PROFESSIONS

At least two of the parents who participated in the study reported a similar experience where the health visitor advised them to register their child early with the dentist and the dentist told them the children were too young:

’Actually she [health visitor] told me earlier. Maybe that’s why I went to them [the dentist] when they were a year and a half. But as I say, it was the dentist that told me No! they don’t see them until they are at least two.’

This contradictory advice may cause professionals to lose credibility as parents may interpret this as one person giving the correct information and the other incorrect advice. It also leads to confusion for parents who are trying to secure the best outcomes for their child’s healthy teeth.

PREVENTION

Parents were asked during the interview process what a parent can do to maintain their child’s healthy teeth. It was interesting to note that none of them mentioned taking their child to the dentist as a preventative strategy. However, their answers in relation to why a child should attend the dentist did provoke a preventative response:

’Just to keep his wee teeth healthy and clean.’

Seven parents mentioned brushing their child’s teeth while the eighth participant’s child was in the process of teething and waiting for their first tooth to erupt.

School environments have a significant impact on sustainable, healthy behaviours, a key success factor for Health-Promoting Schools (WHO, 2003). It is important to encourage positive dental health behaviours from an early age and the pre-school setting provides an ideal opportunity to do this. The pre-school ‘3-2-1’ dental health education scheme, which has been operational in Northern Ireland since 2002, involves three discreet elements; dental health education, healthy break time snack policy and supervised daily tooth brushing. In addition to this, the most deprived wards are also provided with toothbrushes and fluoride toothpaste for use at home four times a year. Only one of the mothers mentioned reducing the use of a dummy and bottle to maintain healthy teeth:

“She has actually come off the dummy lately, I know about sucking on the dummy and bottle but, she doesn’t take sweet stuff or anything. I do minimise that because that would rot her teeth.”

This is consistent with the guidelines that recommend no sugar should be added to food or drinks, infants from six months should be introduced to a free-flow cup and from one year discouraged feeding from a bottle (Public Health England, 2014). The British Dental Health Foundation (2014) discourages parents from using dummies or thumb-sucking as these can both affect how the teeth develop and grow. There were a range of responses given when parents were asked how they had learned to look after their baby’s teeth. Several discussed receiving their knowledge from health visitors although two participants stated they had never received any information from professionals.

Two participants suggested they learned dental care for their children from their own childhood experiences:

“My mummy – just what she taught me.”

However, one parent suggested it was:

’Just common-sense, really! Isn’t it?’

This ‘common-sense’ theory was an
overarching theme in a recent research study (Roberts & Condon, 2014), which may provide a rationale for why some parents don’t actively seek information or advice or indeed access dental services at an early stage.

BARRIERS/REASONS FOR NON-ATTENDANCE

Barriers to dental care are related to a mixture of beliefs, perceptions, emotions and practicalities relating to the individual or some external factors in relation to service provision. The themes discussed earlier (which affected four children in this small cohort) in relation to registration age and inconsistencies of advice are compounded by dental practices deeming children ‘too young’ and denying early access. This has significance for children’s oral health and parents eager to follow the recommendation (PHA, 2013) given by other health professionals and introduce their child to the dentist as early as possible.

Fear of dental treatment and associated anxiety, often stemming from childhood experiences, was identified by over half the mothers as a reason for avoiding the dentist:

‘I’m scared of them [dentists]. I don’t like people in my mouth. I just don’t like the dentist. I don’t go as often as I should. I’ve still that fear.’

Parents were keen to point out that this maternal dental anxiety had not affected them taking their other children to the dentist nor did they believe their children experienced fear. This is consistent with previous research that suggested that mothers’ personal fear can have a positive influence on their behaviours as they strive to ensure appropriate dental registration and attendance (Morrison et al., 2000).

One mother discussed a variety of reasons that she perceived may affect children’s dental registration including parental dental attendance pattern, lack of awareness or education and a fear of being reprimanded. While another mother stated that although she just hadn’t got round to registering her child for others perhaps dental opening hours conflict with parent’s work hours.

CHILDHOOD EXPERIENCES, BEHAVIOURS AND ATTITUDES

Six of the mothers interviewed for this research study claimed to be regular dental attenders, all having visited the dentist within the past year. The two mothers who discussed more significant fears only attend if treatment is needed and last attended around eighteen months and two years ago. Five parents also reported that they attended the dentist regularly in childhood and the following participant believed that this affects her behaviours now as a mother:

‘I think it’s just, to me it’s just we were brought up that way… just to become a healthy part of the day, brushing their teeth and things like that.’

Not all parents interviewed experienced a positive attitude towards the dentist in childhood or regular attendances; however, this has made them more resolute to ensure that their children have a totally different experience.

Many parents mistakenly believe that milk teeth are less important than permanent teeth because they are just going to ‘fall out anyway’. However, primary teeth serve a very important purpose in growing mouths maintaining the proper structure of the mouth in preparation for permanent teeth, speech production and development, eating and drinking and promoting self-confidence (British Dental Health Foundation, 2014). Cavities in primary teeth cause children discomfort, pain and abscesses if left untreated. They also promote the onset of childhood periodontal disease.

DISCUSSION

All of the participants involved in this research were aware that dental treatment was free and the majority knew how and where to register their child with the dentist. All participants were aware that children should be registered with the dentist at an early stage. For at least half of the mothers interviewed there was a dichotomy in terms of what they said and what they did. They could verbalise clearly the recommended age of registration, however when the researcher probed further to ask if their child had any teeth, they would answer ‘yeah, he has four’ or ‘he has about twelve’. There appeared to be a lack of connection or understanding that that their responses contradicted each other. One mother who did make the association quickly clarified that she ‘just hadn’t got round to it yet’.

The inconsistencies around age of registration mirror closely the inconsistencies across professions and are, in effect, barriers to dental registration. The contradictory advice leads to professionals losing credibility but also reduces the impact of an early intervention approach to improving oral health.
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Key points

- Children living in disadvantaged communities are three times more likely to experience dental decay than those living in more affluent areas.
- Several barriers exist including inconsistencies in advice across professions that influence a parent’s ability to register their child with the dentist.
- A collaborative approach between health professionals, dental professionals and relevant voluntary, community and statutory organisations, including SureStart will provide a platform for promoting the oral health of children in disadvantaged communities.
- A widespread campaign should be initiated to encourage early dental registration and promote good oral health practices.

IMPLICATIONS FOR PRACTICE

The findings illustrated in this research study have highlighted the lived dental experiences of parents residing in an area of social disadvantage. Parents have revealed several barriers that they perceive have influenced their ability to register their child with the dentist. Parents require encouragement and support to overcome these barriers and achieve early registration. From a research perspective, further investigation is required to explore the issue of dental access being denied to young children, which may adversely affect their oral health outcomes.

RECOMMENDATIONS

- Optimum age of dental registration should be agreed across professions. This information must be communicated to parents.
- As children are dependent on their parents (or caregivers) for oral health in their early years, a campaign should be initiated to encourage early registration and promote good oral health practices.
- A targeted preventative programme should be implemented to address high-risk groups including children in lower socio-economic groups.
- Children must never be denied dental access particularly on the basis that they are ‘too young’.
- A family-centred approach to oral health delivery, education and promotion should be encouraged. This will address the conflict in practices between the main care-giver and well-meaning relatives.
- Acknowledge and address the issue of dental anxiety while educating parents to promote the oral health of their children.
- Promote positive dental experiences. This has the potential to convert dentally needy children into preventively-minded, asymptomatic adult attenders.

CONCLUSION

Although it is widely known that oral health is a determinant of general health and quality of life, there are many children, particularly those living in areas of social deprivation, who are not given the opportunity to register with a dentist or to access dental services (DHSSPS, 2007). Sure-Start can offer the opportunity to provide additional support to core health and dental services.

If our aim is to influence oral health and subsequent general health for future generations, then the ‘silent epidemic’ of dental caries needs to be addressed. A collaborative approach between health professionals, dental professionals and relevant voluntary, community and statutory organisations will provide a platform for promoting the oral health of children in disadvantaged communities. All too often dental health programmes have been developed in isolation from other health initiatives, which at best leads to duplication, but more often leads to contradictory and conflicting messages being delivered to the public. One of the major criticisms of clinical preventative measures and dental health education has been the ‘narrow, compartmentalised approach adopted, separating the mouth from the rest of the body’ (Watt, 2005). Clinical preventative and education approaches can only achieve limited short-term effects and often widen health inequalities (Schou & Wright, 1994). Therefore a mix of complementary public health approaches is required focusing on high risk individuals and communities creating supportive environments for all, conducive to sustained good health.

References


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Strong links for Public Mental Health

WOODY CAAN MA, DPhil, FacSS, FRSPH
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ABSTRACT
The new, national Public Mental Health Network offers health visitors and school nurses an opportunity to gain more of a voice within policy. The Network is hosted by the Royal College of Psychiatrists and works closely with Public Health England and NHS England to improve population mental health and to prevent mental illness. The CPHVA, RCN and other professional bodies have a vital role to fill in shaping development of the Network, including sharing good practice, inter-professional education and innovative public health research. In the past, the public health community has often been slow and uncoordinated in responding to either grassroots needs or government imperatives. In particular, voices advocating for better mental health for children and families have not been heard. In particular, voices advocating for better mental health for children and families have not been heard. Trade Unionists know that solidarity amplifies the voice of individuals. My own interest as a professor is to build on all we know that makes families, schools, neighbourhoods (and groups of practitioners) more resilient – and capable of more and more.

KEY WORDS
Public Mental Health; Policy; Children and Families

BACKGROUND
Back in 1997, when Chief Medical Officer Sir Kenneth Calman had his vision for a public health ‘family’ of many professions working together in creative ways, I was lucky to represent ‘researchers’ in primary care for his Project to strengthen the Public Health Function. This was around the time Sheelah Seeley (1996) and our colleagues across Cambridge had demonstrated the value of home visits for post-natal depression: the very first research evidence submitted for the influential Health Technology Assessment review (Elkan et al, 2000) and subsequently included in the planning for the Sure-Start programme. The mental health legacy of that research on health visiting continues in some children’s centres (Northrop et al, 2008). Mental health inequalities in the UK show a steep ‘social gradient’, and school nurses play a unique role in improving access to help for socially excluded young people (such as adolescents from ethnic minorities: interview, 2009). Almost a million young people are not in education, employment or training, and these forgotten NEETs are likely to accumulate multiple problems unless school health services pick them up before they leave education. Encouragingly, our international review of schools as an ‘asset’ for health found the most consistent area of health that depends on supportive, responsive relationships depends on supportive, responsive relationships and mastering a set of capabilities that can help us respond and adapt (Walsh, 2015).

THE CHALLENGE NOW
Gleeson et al (2015) report that public health nurses ‘lack input and control in the policy process’ and that there is a need to harness their ‘untapped potential’ in policy development and implementation. This is not just a challenge for nurses and health visitors – even the new chair of the Academy of Medical Royal Colleges, Professor Dame Sue Bailey, seems unable to sway policy in England: ‘It is clear that children and young people are not receiving the care and support they need. We know that if they receive effective help at an early stage they probably won’t reach a mental health crisis in the first place’ (Bailey and Atkinson, 2015)

Perhaps the most rewarding association I ever had with the CPHVA was joining its special interest group for Looked After Children, and thanks to school nurses like Kathy Dunnett and health visitors like Imelda Callowhill, that group was able to share ways in which the health of children in care could be improved (Caan, 2006). A case that had strongly influenced my public health thinking back then was a 14 year old girl who went ‘missing’ from care and the first we knew she was being exploited by pimps was when one of her abusers murdered her near the entrance to Kings Cross Station. This week, as I happened to enter Kings Cross, my heart sank to read the Evening Standard’s estimate that more than a thousand London children disappeared in 2014, ‘missing from care’ (Cierar, 2015).

When Prime Minister David Cameron came to power in 2010, he promised a more caring, Big Society. The reality now for young people in the UK is very different and self-harm is at a five-year high (News, 2015).

PULLING TOGETHER
As a child in occupied France, Cyrulnik (2009) survived the Holocaust. As a child therapist he developed the useful concept of ‘knitting’ together different life experiences over time to create greater resilience. Many different disciplines have contributed to our understanding of mental resilience and nurturing this aspect of wellbeing goes hand-in-hand with greater capability (Anonymous, 2013). Trans-disciplinary networking for education already proved useful across the public health family (Caan, 2007) that is now faced with challenging situations: ‘resilience depends on supportive, responsive relationships and mastering a set of capabilities that can help us respond and adapt’ (Walsh, 2015).
This Spring, a Public Mental Health Network began to knit itself together, hosted by Peter Byrne at the Royal College of Psychiatrists. (For details see http://www.rcpsych.ac.uk/policyandparliamentary/publicmentalhealthevent.aspx). During my working life I have seen two previous attempts to form such an inter-professional network that did not survive long, because those networks lacked either a stable institutional base or members who were policy-makers. The new PMH Network includes senior policy-makers from Public Health England and NHS England, and hopefully the Royal College will be around for many years to come! I represent the interests of the Royal Society for Public Health. The Network is steadily connecting with varied stakeholders across many parts of the UK. At this point I declare a hope that many school nurses and health visitors will contribute your ‘specialist community’ input and shape future policy for mental health.

Over the years, I have observed readers of Community Practitioner enlivening special interest groups, learning circles and research networks: the research in different settings suggests that belonging to groups (and groups of groups) proves ‘a good thing’ (Jetten et al, 2015). When faced with difficult challenges, such as the interaction between alcohol problems, domestic violence and safeguarding children (Caan, 2013), a single profession on its own does not make headway, and practitioners quickly become discouraged. However, precisely those issues (plus divorce, stigma and population mental health) also came up across professions, in the most recent planning meeting for the Network – and they will input collectively to policy-makers, shortly. Young voices also need to be heard, and for me the most promising development of 2014 was when the National Health Service Youth Forum took over BMA House for its first conference, Celebrating Positive Young Mental Health (Caan, 2015).

I am indebted to Barnardo’s for showing that one of the first things we can all share is evidence of effective practice (via http://www.rip.org.uk). Many people reading this are employed by local authorities, and large numbers of staff in local government should have access to datasets like ‘What Works for Troubled Children’ (http://www.rip.org.uk/resources/what-works-for-troubled-children-content/). Sadly, it appears the present chief medical officer Sally Davies doubts that is enough evidence to support Public Mental Health initiatives (Mehta et al, 2015). I am sure health visitors and school nurses could share some of their existing knowledge with her, but her doubts illustrate the way future research needs to relate to practical public health problems, and needs to be communicated to the right decision makers.

SPREADING THE NET WIDER

Sometimes our horizons may be too limited, too local. There is valuable experience way beyond our frontiers, as I learned from small projects on child mental health with the World Health Organisation (Caan and Jenkins, 2008). Compared to even our European neighbours like the Netherlands or Denmark, Britain has failed to create family-friendly communities, with youth who are likely to flourish (Caan, 2011). Currently the European Commission is funding ten countries including the UK for its ADOCARE project on teenage mental health (Caan, 2014). The lessons from that collaborative research should be reported back this October (shortly after World Mental Health Day).

DISCUSSION

In relation to improved mental health, both health visitors and school nurses have contributed to practice development and its evaluation. Nonetheless, over the past 20 years, initiatives from single specialisms or professional bodies have had only limited impact on mental wellbeing at a population level. At a conference on 24 June 2015 the Secretary of State for Health (Jeremy Hunt) addressed delegates from most clinical commissioning groups and their local authority neighbours. Hunt spoke passionately about major changes to general practice (GP) and the wider primary care workforce. The Secretary of State seemed surprised when I informed him that around 30 per cent of GP time is taken up with psychiatric problems, and that the quality of care for mental illness in children and parents was, especially, a cause for concern. On reflection, he responded that he would delegate this ‘awkward problem’ to a think-tank.

Based on long experience, I believe that is a slow way to form policy and by the time any solutions are offered, different policymakers will be in post, with new concerns. Meanwhile, in the words of Sue Bailey, thousands of distressed young people will have deteriorated to a mental health crisis.

One of the essential public health competences is ‘collaboration for health’. Mental health needs have been neglected for a long time in public health education, practice and resources. The time is ripe now to mobilise all the assets that could develop better public mental health. Learning from Kenneth Calman, building a ‘family’ of public health expertise that brings together a whole spectrum of practice and knowledge might be more effective than uncoordinated initiatives. Expertise is not just a matter for professionals: young people may have a better perspective on how the whole system operates than the practitioners who only encounter them for a brief period. The recent television programme Kids in Crisis (Channel 4, 1 July 2015) showed one way give a voice to young people’s own concern about their quality of care.

WHERE NEXT?

At an event for the PMH Network this June, participants heard that just 17 per cent of local authorities’ Joint Strategic Needs Assessments gave consideration to mental health and the current proportion of public health spending on mental health is only 1.4 per cent. Given that local authority funding is simultaneously being cut by the Departments of Health, Education and Communities & Local Government, there is an imperative to keep population mental health on their agenda. Some of the best advocacy has been coming from the voluntary sector (Mental Health Foundation and MIND) but there is a need now for all professional stakeholders to speak with one, clear voice. The government has said it is prioritising developments around perinatal mental health, prevention of adverse childhood events and support for young people in special circumstances. These areas sound right up the street of the CPHVA, and providing ‘input and control in the policy process’ (Gleeson et al, 2015) would strengthen public health across the whole nation.
Few would disagree with the notion that giving children the best start in life – regardless of where they live, their family income or their parents’ upbringing – is vitally important.

But there are major challenges when it comes to making that a reality. The impact of inequality on children and young people’s health in the UK is startling, with the Department of Health estimating the poorest children are almost twice as likely to be obese than the richest. Why Children Die, a joint report by the RCPCH and the National Children’s Bureau published in May 2014 showed that even before a child is born, the impact of health inequalities is felt. For example, evidence points to mothers from poorer families being more likely to smoke during pregnancy, which significantly increases the risk of prematurity and stillbirth. Rates of low birthweight are higher in less advantaged socio-economic groups and are particularly linked to a number of negative health behaviours such as poor prenatal care, substance abuse and poor nutrition. We also know that breastfeeding is less common in less advantaged socio-economic groups. Although post-neonatal mortality makes for only a small proportion of deaths in more advantaged households, it makes up a higher proportion of deaths in the least advantaged households.

That is why it is crucial that during the early years of a child’s life, parents and carers are given the right support to set their children on the right track. And that is where the health visitor workforce plays such a key role.

When the coalition government committed to increasing the number of health visitors by 4,200, it was welcomed across the child health sector.

Health visitors can have a profound impact on the lifelong health and wellbeing of young children and their families, covering key areas such as maternal mental health, breastfeeding, safeguarding including domestic violence and sensitive family relationships, reducing obesity, managing minor illness and accident prevention, and school readiness.

So when the Conservative Party manifesto included a pledge to strengthen the health visiting programme for new mothers, it was again met with strong approval by those working in the field of child and maternal health.

But it seems that this promise is now under serious threat. George Osborne’s proposal to cut local authority public health budgets by £200 million means health visiting services are very likely to be targeted for review.

The RCPCH, and colleagues across the sector including GPs, nurses, midwives and public health professionals, are gravely concerned. Cuts to health visitors would represent a serious backward step, and it is no exaggeration to say any reduction in the workforce could potentially put the health of current and future generations of children and their families at risk.

Public health experts and world economists strongly advocate for investment, not disinvestment, in early years and new families. Indeed, in the UK, investment in early years health is crucial and health visitors are key to leading this, not least because from October this year they will key players in delivering the early years elements of the Healthy Child Programme – the main universal health service for improving the health and wellbeing of children and their families.

The government’s consultation on the proposed public health cuts is due to open shortly. We need a strong sector-wide response to ensure health visiting is given the protection it needs – to give all children and families the support they need from the very first days of life.
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Adverse events should be reported. Reporting forms and information can be found at http://www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Jenson on 01271 334 609. Date of preparation: June 2015. FUL-286.