INITIATING IMMUNISATIONS

Meningitis B vaccine to be offered to all newborns
Prescribing Information
Oilatum® Junior (light liquid paraffin 63.4%) Bath Additive and Oilatum® Junior Cream (light liquid paraffin 6%, white soft paraffin 15%)

Indications
Contact dermatitis, atopic eczema, senile pruritus, ichthyosis and related dry skin conditions.

Dosage and administration
Use as often as necessary.

Bath Additive:
Apply to wet skin or add to water. Adult bath: 1-3 capfuls in an 8 inch bath of water, soak for 10-20 minutes, pat dry. Infant bath: ½-2 capfuls in a basin of water, apply gently over entire body with a sponge, pat dry.

Cream:
All ages:
Rub in well to affected area.

Contraindications and Precautions
Hypersensitivity to any ingredient.

Bath Additive:
Stop use if rash or irritation develops.

Side effects

Have you considered prescribing Oilatum Junior Cream?
(light liquid paraffin, white soft paraffin)

87% of mums agreed Oilatum Junior Cream soothed their child’s dry skin† (product testing with 150 mums)

Oilatum emollient creams:
☑ Specifically formulated to restore the skin barrier and break the itch-scratch cycle
☐ 70% of mums agreed that Oilatum Junior Cream left their child’s dry skin less itchy† (product testing with 150 mums)

Use with an Oilatum wash product – the No 1 prescribed emollient wash range2 – for complete emollient therapy in line with NICE guidance.3

Oilatum bath emollients:
☑ Proven to maintain the skin’s moisture barrier and significantly improve hydration in healthy, dry adult skin4
☐ Provide an active emollient benefit and an effective cleanser

Prescribe Oilatum Junior Cream in combination with Oilatum Junior bath additive for a complete emollient therapy solution for babies and children with eczema.

References:
1. GSK Data on File (Product testing with 450 mums with children with dry skin aged 6–36 months. Product tested unbranded in 3 cells: cream emollient (n=150), bath emollient (n=149) and both products (n=151). 2015.
2. IMS unit performance data, MAT to May 2015.
4. GSK Data on File (A cosmetic study to consider the effect of Oilatum emollient as a cleansing product on skin barrier function using a forearm-controlled application technique). 2014.

Date of preparation: August 2015. CHGBI/CHOIL/0060/15i.

OILATUM is a registered trade mark of Stiefel Laboratories, Inc.

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Unite/CPHVA
Existing Unite/CPHVA members with queries relating to their membership should contact 0845 850 0242 or see: www.unitetheunion.org/contact-us.aspx for further details.

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

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Supporting women to continue to breastfeed.

We are getting better and better at helping women to initiate breastfeeding, but at the same time, health professionals are becoming more and more stretched in how they are able to offer care to new mothers. Supporting breastfeeding women, especially when clinical concerns have been raised, or Mum is struggling with sore or cracked nipples can be an added pressure.

Here at Lansinoh we are ready to support you in your support of breastfeeding women, from Day 1, for as long as Mums continue to breastfeed.

Our new health professionals’ website is a growing resource, with research, information, quick reference guides, charts and free samples, as well as information about all of our breast ‘Care’ and ‘Pump-Store-Food’ range to help you look after your clients’ breastfeeding needs.

Why Feed Expressed Breastmilk?

As many as 85% of mothers will express breastmilk. This is most often due to a return to employment or to overcome a difficult period in the breastfeeding journey, such as illness, nipple damage or breast refusal.

“Allows baby to switch easily from breast to bottle and back again.”

Options for Feeding Expressed Breastmilk

Expressed breast milk can be fed to baby by a variety of means, including cup, finger-feeding, spoon or bottle. Health professionals generally recommend cup feeding, especially in the early days and weeks, because of the perceived risk of nipple-tee complication and the very small amounts of breast milk a baby takes at a feed. Mothers however, often prefer to use a bottle, especially once the amounts baby needs are larger. After extensive research, Lansinoh has developed a teat which allows baby to easily replicate the peristaltic movements used to breastfeed when using a bottle, which will reduce the risk of nipple-tee complication and is more likely to allow a baby who has well-established breastfeeding to switch between the two.

What is Paced Responsive Feeding?

Current techniques of bottle feeding are known to have associations with over-feeding, and an inability of baby to self-regulate feeds. When expressed breast milk is fed to the term baby via bottle, a feeding technique that facilitates breastfeeding should be employed, using a teat that will allow the infant to regulate milk flow and return to the breast when required. Baby Friendly Initiative currently advocates the use of the paced responsive technique. Parents should be educated to invite the baby to draw the teat into the mouth, pace the feed to ensure the baby is not forced to feed more than required and recognise the baby’s cues when they have had enough. This style of feeding is positively associated with a reduced risk of reflux, over-feeding and colic-like symptoms, whilst also supporting the breastfeeding relationship with increased breastfeeding success long term for mothers who are separated intermittently.

The NaturalWave™ Teat

An evidence based peristaltic teat designed to help the term baby maintain the natural sucking style learned at the breast and preserve established breastfeeding patterns. Studies demonstrated few differences between feeding on the breast and that seen with the NaturalWave™ teat with babies employing peristaltic tongue movements most commonly seen in breastfed babies. Flow rate throughout the feed was found to be much more stable, therefore indicating a reduced risk of over-feeding and colic-like symptoms when actively employed as part of a paced feeding routine.

3 Steps for Successful Breastfeeding

1. Attachment
2. Peristaltic movement
3. Swallowing

Ultrasound studies confirm when using the NaturalWave™ teat the baby uses both “peristaltic” forces and “extractive” action in milk removal, actions most commonly associated with the natural sucking style of the baby at the breast, in order to maintain this natural sucking style the baby must be able to perform the above three key steps.

www.lansinoh.co.uk

References:

Conference season

Now that summer is over and autumn is upon us, we turn our attention here at Community Practitioner to conference season.

The CPHVA annual conference is fast approaching (17-18 November) and promises to be an exciting event.

I have had a sneak preview of the programme and members are in for a real treat. A host of high profile professionals will be sharing their knowledge and expertise in a bid to improve your practice.

Deputy leader of the opposition, the Rt Hon Lord Philip Hunt of Kings Heath, will kick off the conference with a key note address focusing on the current challenges for health and social care. We all know there are many. There will be representatives from organisations including the Care Quality Commission, Public Health England, the Nursing and Midwifery Council and the National Institute for Health Research Clinical Research Network, to name but a few.

They will be joined by a whole host of academics and healthcare professionals who will endeavour to make the conference a roaring success.

I am looking forward to meeting as many CPHVA members as I can and invite you to come and introduce yourself to me during the two days. I am always interested to hear your stories, comments and suggestions and welcome the opportunity to discuss any burning issues you may have.

We are also looking forward to attending the RCGP conference (1-3 October) in Glasgow, Conservative Party Conference (4-7 October) in Manchester and the NICE annual conference (13-14 October) in Liverpool. All these events enable us to bring you the latest policy developments and clinical updates and helps us to champion the community practitioner voice in front of some of the most influential people in the world of healthcare.

Throughout October we will be keeping a very close eye on the commissioning of health visiting services in England as it moves over to local authorities and would welcome your comments and feedback. It is vital that the good work so far achieved, as a direct result of the increase in the number of health visitors over the past five years, is not reversed. Never before has it been so important to focus on the health and wellbeing of children. The results of the government consultation on how to reduce the 2015/16 public health grant for local authorities by £200 million are due this autumn and it is far from certain that services for children aged 0-5 will not be targeted.

This month’s issue of Community Practitioner features the third and final part of our special report on revalidation. We held a roundtable discussion at the beginning of September to focus on some of main issues you raised in our survey. Among those who attended were director of continued practice at the NMC Katerina Kolyva, Queen's Nurse and specialist nurse practitioner Debbie Brown and CPHVA member Angela Lewis. You can see how the discussion progressed in our special report on pages 16 to 25.

In November's issue we will be starting our next special report, which will focus on continuing professional development (CPD) and the issues and challenges surrounding it with regards to the new NMC Code of Conduct.

As always please do get in touch with any ideas, suggestions or comments and I very much hope you enjoy reading October’s Community Practitioner.

Best wishes

Katie Osborne
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deputy editor
NEWS ROUND-UP
A look over the biggest stories from www.communitypractitioner.com

Meningitis B vaccine launch hailed as ‘landmark moment’

THE LAUNCH OF A VACCINE TO PROTECT CHILDREN against meningitis B has been hailed as a ‘landmark moment’ by public health minister, Jane Ellison.

The meningococcal group B (Men B) vaccine will be available for all babies from 1 September as part of the NHS Childhood Immunisation Programme in England.

Meningitis B is the most common cause of meningitis in England, according to Public Health England (PHE). It usually affects babies less than a year old, with infections most likely at five months of age.

Jane Ellison said: “This is a landmark moment. “Men B can be truly devastating and we know the suffering it can cause to families. Now every new baby can get this free vaccine to protect them from this terrible disease,” she added.

A high fever with cold hands and feet, a dislike to bright lights and a red rash that does not fade when a glass is rolled over it are all symptoms of meningitis.

Parents are advised to purchase infant liquid paracetamol for babies after they have been vaccinated, as there is ‘an increased risk’ of fever when other vaccines are administered at the same time.

Care watchdog announces newborn care review

THE CARE QUALITY COMMISSION (CQC) has announced a review into the care of newborn infants.

The review, which began last month (September 2015) will look at 20 different services across the UK.

It will examine how fetal medicine, obstetrics, neonatal and community services work together to care for newborn babies with health concerns.

Edward Baker, deputy chief inspector of hospitals at the CQC said: “Everyone has the right to care which is safe and effective, but we know from our inspections of maternity services there is a marked difference in the quality of care provided.

“While this review will not give us a national picture of the quality of care, we hope that it will identify if there is a need to develop clinical guidelines to ensure there is consistent care across England.”

Flu immunisation toolkit launched

A toolkit for healthcare providers planning the resourcing and delivery of the extension of the national flu immunisation programme has been published by Public Health England. It aims to inform workforce and resource planning for the programme and outlines approaches to delivery and different models used.

The toolkit can be accessed by visiting: https://www.gov.uk/government/publications/flu-immunisation-toolkit-for-programme-extension-to-children
New oral health guide for homeless launched by QNI

THE QUEEN’S NURSING INSTITUTE (QNI) has launched guidance for community nurses on how to support homeless people improve their oral health.

‘Oral Health and Homelessness: Guidance for Community Nurses’ covers the specific oral health risks and needs of people who are homeless and includes useful advice nurses can give to re-connect patients with community dentists, to address fears and phobias, and to give practical advice for patients about looking after their teeth.

The ten page guide highlights information about the three major preventable oral health conditions – periodontitis, oral cancer and caries – to help patients who may have concerns about seeing a dental professional.

A free PDF of Oral Health and Homelessness: Guidance for Community Nurses is available by contacting lauren.knight@qni.org.uk

Unexplained infant deaths increasing

THE NUMBER OF UNEXPLAINED infant deaths in England and Wales has increased for the first time in five years.

Data from the Office of National Statistics (ONS) highlighted that there were 249 unexplained infant deaths in 2013, a rate of 0.36 deaths per 1000 live births.

Between 2008 and 2012 the number of unexplained infant deaths fell steadily year on year from 0.41 to 0.32.

The data also revealed that the rate of infant deaths for mothers aged under 20 rose from 0.93 to 1.27, with the North East and North West of England being the worst affected regions.

Francine Bates, chief executive of The Lullaby Trust said: “We are deeply concerned to see that the number of unexplained deaths has risen in 2013, the first increase in five years. “It is shocking that the UK has one of the highest infant death rates in Europe. We call on government and all agencies to urgently develop a national strategy to reduce these deaths and reinforce safer sleep messages to all parents, especially young parents.”

Pregnant women encouraged to get whooping cough vaccine

PUBLIC HEALTH

England is urging pregnant women to take up the whooping cough vaccine.

Data published on 3 September showed that whooping cough vaccine coverage in pregnant women had reached just 56.4 per cent in the UK.

The vaccine has been given to pregnant women since 2012 after research suggested babies born to women vaccinated a week before giving birth had a 93 per cent reduced risk of becoming ill with the infection.

Whooping cough can be fatal, particularly to young babies before their first dose of vaccine at two months.

NMC to finalise policy on English language tests for EU nurses

THE NURSING AND MIDWIFERY COUNCIL (NMC) is to finalise the policy and guidance on new English language checks for nurses and midwives who trained in the EU at its council meeting.

Council members will consider the 722 responses received as part of the 12-week consultation, which closed on 21 August.

Once the new language checks are in place, nurses and midwives from the European Economic Area who apply to join the register will need to satisfy the NMC that their knowledge of English equips them to practise safely and effectively in the UK.

See Unite/CPHVA’s response to the policy proposal by clicking on the submission tab in the Unite in Health webpage - part of the Unite the Union website.

Smoking ban leads to drop in stillbirths

RESEARCHERS AT THE UNIVERSITY OF Edinburgh have found the number of stillbirths dropped by almost eight per cent in England in the years after the smoking ban was introduced.

The findings suggest that almost 1500 stillbirths and new-born deaths were averted in the first four years after the smoke-free legislation was introduced in July 2007.

DH consultation on public health grants closes

A Department of Health (DH) consultation on how the 2015/16 public health grant for local authorities (LA) should be reduced by £200m has ended.

Questions on how the DH should save £200million across LAs and how the department could ‘assess and understand’ the impact of savings were included as part of the consultation exercise.

The consultation included examining the possible effects on services for children aged 0-5, when the planned transfer of commissioning public health services for children aged 0-5 to LAs takes place in October.

The consultation ended on 28 August.
Meet your reps...
Benedicta Lashley, nurse, midwife, health visitor and practice educator

Tell us a little bit about yourself
I work in Barking and Dagenham and I love my job. I am also particular about health visitors and their daily work as it impacts positively on children and thus society. So I am passionate about representing them to enable them to feel secure and be more productive.

How long have you been a CPHVA rep?
I have been a rep since 2007, during which time I have supported many colleagues. In this role I have instilled confidence in them to join Unite.

What made you want to become a rep?
As a newly qualified nurse, I became scared of going to work thanks to a senior practitioner I worked with who always made me feel inadequate and lost. I also found that some of my colleagues were also facing similar problems but did not know what to do until someone introduced Unite to us.

What’s the biggest challenge?
This particular rep sat down with me and explained the importance of knowing about HR and Trust policies, and how they are applied in the workplace. I started feeling safe and two years down the line, some of my colleagues called me and asked if I was able to take on the role. That is how I started my rep journey.

What’s the best thing about the role?
The best thing about being a rep is how you can make the workplace exciting and safe for everyone. It is also very enlightening in the way that your awareness in the workplace is heightened. I like the fact that I can organise staff in to come together for a common cause. I am also very excited about discussing the benefits of joining Unite – the opportunities and education Unite gives is unique. Moreover, I also have access to my regional and professional officer thus making accessing information easier.

What’s the biggest challenge?
The IPB was developed to provide up-to-date evidence combined with practical delivery options to prevent falls, burns/scalds and poisoning injuries in young children. It includes unintentional injury information, key messages and links to child development, checklists, quizzes etc.

It is designed so that a range of practitioners can use its information to support families with young children in a variety of contexts and is freely available as an interactive pdf (http://www.nottingham.ac.uk/research/groups/injuryresearch/projects/kcs/index.aspx).

One element of being able to access this free resource is that we would like to discover how useful it is to yourself and other practitioners and the families that you/they support. Therefore, if you download it, please tell us and send us your contact details! We will contact you six months later with a short, five minute, online questionnaire for your feedback.

Thank you very much!
MUMS ADVISED ‘DON’T AVOID EGGS’

Eggs are a nutrient dense convenient food, ideal for weaning infants, with evidence suggesting that early introduction can be beneficial.

EGGS AND ALLERGY
Current government advice is that weaning should start at around 6 months and that eggs and other potentially allergenic foods can be introduced from this time. Emerging evidence suggests that delayed introduction (beyond 4-7 months) of potential food allergens, such as eggs, during weaning may actually be counterproductive. Yet confusion among mothers over historic advice means that many babies are not given eggs until after 12 months or more.

Dr Juliet Gray, registered nutritionist, says, ‘Having reviewed the current evidence, I am happy to encourage parents to introduce eggs from six months as an early weaning food. This could have a positive effect in terms of nutritional intake and may also help promote immune tolerance of eggs in the babies.’

Two major research studies are testing the hypothesis that the early introduction of potentially allergenic foods could protect against developing allergies to these foods. Results published earlier this year from one of these, the LEAP (Learning Early About Peanut Allergy) study, showed that the early introduction of peanut in a child’s diet could serve as an effective strategy for the prevention of peanut allergy.

NUTRITIONAL BENEFITS
Eggs are highly nutritious, containing key nutrients for a growing child including high quality protein, vitamin D, selenium, choline and omega-3 fatty acids.

UNNECESSARY AVOIDANCE
A secondary analysis of UK infant feeding data suggests that only 9% of babies are currently given eggs at six months, the recommended age to start weaning. Even at 12 months, only 36% are given eggs, with allergy concerns given as the main reason for avoidance. Data from the latest UK Infant Feeding Study of more than 10,000 mothers also showed that three quarters largely avoided eggs and 40% cited allergy as their major concern. More than one in ten avoided giving eggs to their babies altogether.

EGGS AND SAFETY
The British Egg Industry Council’s Lion Code of Practice, introduced more than 15 years ago, has effectively eliminated salmonella from British Lion eggs. Around 90% of British eggs are now produced within the Lion scheme, which requires vaccination of hens against salmonella and stamping a best-before date on each egg shell and box.

For more information visit egginfo.co.uk

References:
2. EAT (Enquiring About Tolerance) and LEAP (Learning Early About Peanut Allergy).
Conference delegates show ‘passion and desire’ to improve wellbeing of young people

By Wendy Nicholson, professional officer for school and community nursing, public health nursing team, Department of Health

THE 18TH BIENNIAL SCHOOL NURSE International Conference, which took place between 27 and 31 of July in Greenwich, brought together more than 300 international delegates to discuss, debate and share their experiences as school nurses and leaders of public health for children and young people.

The conference, which was co-hosted by Public Health England (PHE) and School and Public Health Nurses Association (SAPHNA), attracted school nurses, researchers, educators, commissioners and wider stakeholders. Despite their varying roles everyone had one shared objective – the passion and desire to improve the health and wellbeing of children and young people.

The conference hosted an excellent line up of expert speakers who provided a wealth of international evidence, data and research. The packed agenda addressed complex and sensitive issues including Female Genital Mutilation (FGM), Child Sexual Exploitation (CSE), young carers, military families and complex vulnerability. School nurses from across the globe shared examples of good practice and there was a collective international agreement for the need to tackle key public health issues including obesity, mental health and sexual health.

Young people shared their personal experiences, which deeply moved the 300 delegates, by providing a glimpse into their lives and how they deal with the challenges of growing up.

The conference was opened by a group of young people storms the stage with pleas for their voice to be not only heard but acted upon to dispel common myths about the way children and young people lead their lives. They told us the misperceptions and negative media portrayal of young people was ‘pants’ – and to close the conference the ‘pants’ switched to positives – a show stopper without a doubt (see picture left).

The professional networking, fellowship and sharing of good practice at the conference was not only experienced by those in Greenwich - the hashtag #SNIC15 trended on Twitter. So those who could not be there were drawn in via social media.

School nursing might have a small workforce but it certainly does make a big difference!
By Ros Godson, Unite/CPHVA professional officer, School Nursing

SO WHAT STOOD OUT FOR ME?
One over-arching theme about School Nurse International conferences is the cultural angle and the involvement of young people. This year the British Youth Council (BYC) brought their pants (labelled with stereotyped words about young people) and throughout the week presented different topics in different ways.

One of the young people, Iqra Ali was inspired to write this poem:

---

WHAT ARE WE?
A LABEL, A WORD,
GIVEN BY YOU AND
EVERYONE AROUND US.
THEY SAY WE
ARE THE LABEL OF
ARROGANT
LAZY
GANGS.
THEY SAY WE ARE,
THE LOST GENERATION,
THAT ARE LOST IN SCREENS
WE ARE HERE TO WASH THEM AWAY,
CHANGE THE WAY YOU THINK ABOUT
US, BECAUSE WE ARE NOT ARROGANT,
WE ARE NOT LAZY, AND
WE WANT TO MAKE A DIFFERENCE.

I was very impressed by Helen Lowey who brought us up to date with the ‘Adverse Child Experiences’ study and explained how early sexual, physical or emotional abuse or neglect has been shown to lead to disrupted neuro development. She explained how bereavement, homelessness and bullying can compound the problem, and highlighted the links to deprivation.

There are ongoing studies, but there is no doubt that adversity in early childhood is a predictor of poor learning and involvement in the criminal justice system.

Julia Egan, from the Scottish government explained a review which has concluded that there will be a school health team to deliver universal services and a specific role for qualified school nurses who will specialise in leading on public health issues. The decision to have standard assessment and reporting tools across the country was music to our ears. They are fortunate that the Scottish government has a strategy for child health ‘Getting it Right for Every Child’ which is a reference point for action.

It was remarkably refreshing to hear from Prof Ram Weiss about the International Strategy on childhood obesity. He emphasised there is no effective, sustainable treatment for severely obese children, as the body was capable of making adjustments to cause them to regain weight which they lost. Consequently, we need to throw all our resources at public health – ‘an ounce of prevention is worth a ton of management,’ he said. Prof Weiss highlighted statistics that show that an overweight child has far more likelihood of becoming an overweight adult, and this trend increases as the child grows older: a child who is obese at 10 has a 69 per cent chance of becoming an obese adult.

No one who attended this conference will ever forget David Evans’ hilarious graphics on teaching and learning about sex education. Even those delegates who had a rudimentary grasp of English were left in no doubt about the message from the lecture! This was followed by an exploration of what it means to be masculine, and what sex means to young men.

We heard from school nurses working in international schools about the particular problems of working with an itinerant population and concerns that children from military families might not get the support they need on returning to mainstream schools.

The issue of young carers was comprehensively explored; we need to ask young people: ‘do you help look after anyone at home?’ However, Unite/CPHVA thinks the policy response should be that there should be no such thing as a young carer. We should however support the emotional health of those living with a sick or disabled family member.

One theme was gender based violence, which is a human rights issue, and includes female genital mutilation (FGM). Obi Amadi spoke on this to a rapt audience. The advice was to ‘be professionally curious and encourage children and young people to talk’.

There was plenty more, but you had to be there! Seriously though, attending conferences lifts morale and makes you think, so talk to your manager and colleagues and get hold of a ticket for the CPHVA conference in Manchester on 17/18 November.
NMC chief executive Jackie Smith to deliver keynote address at Unite/CPHVA annual conference

THE UNITE-CPHVA ANNUAL
Professional Conference 2015 is bringing together essential clinical updates and the latest insight into policy changes affecting the roles of healthcare professionals. Combining incisive seminar content, with dynamic exhibition and networking time, the Unite-CPHVA Annual Professional Conference taking place on 17th – 18th November will give community practitioners the opportunity to share best practice with peers.

Over the course of two days, delegates will enjoy a lively mix of sessions including cutting-edge plenary talks, inspirational presentations by successful entries from the ‘call for papers’ process, and educational and informative masterclasses designed to give delegates the opportunity to explore topics of significance to their role in the community.

This year, due to popular demand, the number of masterclasses has increased, enabling attendees to tailor a programme that suits their professional interests. The presenters will include a range of leading experts who will be on hand to share their experiences and offer insightful advice to support the learning and skill development of attendees.

Highlights from the masterclass programme include Dilyse Nuttall from the University of Central Lancashire, who will explore the current role of prescribing in the community. Using examples of common facilitators and barriers, she will show delegates how to use standards, protocols and current frameworks to develop successful strategies for community practitioner prescribing.

Jackie Smith, chief executive and Registrar for the Nursing and Midwifery Council (NMC) will deliver the keynote address on the second day of the conference, focusing on revalidation - a process that is causing much concern in the profession. Unite Professional Officer, Jane Beach and Angela Lewis, independent consultant will be taking us through the challenges of revalidation and will be on hand to answer any queries from the delegates as they explore the practical solutions and tools to support the new registration process.

For the first time in 2015, we will be welcoming Francine Bates, chief executive of The Lullaby Trust, who will be giving an interactive workshop on co-sleeping, exploring which advice is best to give to parents. She will be looking at the latest evidence for the relationship between Sudden Infant Death syndrome (SIDs) and co-sleeping, and how you can best explain this to parents who are demonstrating behaviour for concern.

Safeguarding and risk to children is a subject that remains integral to the community practitioner’s role. Christopher Cloke, honorary vice president of CPHVA, and head of professional reputation and local campaigns at the NSPCC, will be presenting a masterclass on the key safeguarding issues frequently encountered in professional practice. His informative session will help delegates to quantify the risks in order to prioritise safeguarding, and will give useful advice on how to maintain perspective and prioritise caseloads based on potential risk.

The full programme contains many other insightful and inspiring sessions and speakers, relevant to the current challenges that delegates are facing on a day-to-day basis. Further information can be found on the Unite-CPHVA Annual Professional Conference 2015 website at cphvaconference.co.uk.
Adverse Effects: Balneum Plus Cream has been reported to cause a burning sensation, erythema, pruritus or the formation of pustules, aggravation of eczema if applied to inflamed skin areas. Contact allergy has also been reported.

Legal Category: GSL.

Marketing Authorisation Number(s): PL 33016/0010.


Marketing Authorisation Holder: Almirall Hermal GmbH, Scholtzstrasse 3, 21465 Reinbek, Germany.

Further information is available from: Almirall Limited, 1 The Square, Stockley Park, Uxbridge, Middlesex, UB11 1TD, UK. Tel: (0) 207 160 2500. Fax: (0) 208 7563 888. Email: almirall@professionalinformation.co.uk.

Date of Revision: 10/2012.

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CALLING ALL CPHVA MEMBERS!

There is an opportunity for you to apply for a supported place to attend your annual professional meeting. This meeting is open to all members - you do not have to be a Local Accredited Representative to apply. This event will be held at the Manchester Central Convention Complex, Manchester, on Monday 16 November from 5:30pm. Registration and refreshments will be available from 5pm.

The meeting will give you the chance to express your views and influence the agenda for the professional executive team for 2016. The executive will also feed back to you on the work that has taken place over the last year and issues that they feel are important for the association for the coming year.

Whilst attendance is open to everyone in membership, the supported places are limited to 10 per region, so early application is recommended. The supported place will include transport costs to and from the venue, as per union rules, and a maximum of £50 towards an overnight stay where this is necessary. This does NOT include entrance to the Annual Professional conference. If you wish to attend conference we advise you to contact your branch for support or contact your regional office to establish a local branch facility.

Applications should be made ONLY via your professional regional representative (see box right), using the form found on this link http://tinyurl.com/unite-cphvaapr2015 by Friday 16 October 2015.

Please share this with your colleagues and encourage applications from across all the disciplines.

Your CPHVA needs you!

CPHVA HAS BEEN TASKED BY THE MEMBERS to produce a set of factsheets on the 5 core commissioned Health Visiting contacts (England) and review and update the existing ones. In order to do this we need help from members across the country.

The factsheets will be about quality and reflect Health Visiting across the profession. They should be evidence based and should reflect what we do out there in the real world!

We want the factsheets to reflect the art of Health Visiting, as well as the core requirements of each contact in context of our professional expertise, our adaptation to the needs of our children, families and communities.

So that’s where you come in. We need evidence from a wide range of experience. We require a team of 6-8 Health visitors who would be happy, with support to contribute to the compilation of 3 of the factsheets.

The team would be supported by an Executive member, a meeting could be arranged at conference but otherwise we expect the contact would be via emails so it would not be too difficult to hit our deadline!

If you are keen and want to contribute to CPHVA’s commitment to promoting quality professional advice and guidance, then please send your comments to cphva@unitetheunion.org by close of business on 23rd October 2015.

LAR of the Year Award 2015

Do you know a Local Accredited Rep who deserves special recognition?

CPHVA members are invited to nominate local accredited representatives for LAR of the Year Award 2015.

Unite/CPHVA is calling for nominations for this year’s LAR of the Year Award, which is due to be presented at the Unite/CPHVA Annual Professional Conference 2015 in Manchester on 17th and 18th November.

Members are encouraged to nominate suitable candidates for this important annual award, using the online nomination form at http://tinyurl.com/CPHVA/ALAR15

All nominations must be submitted by Friday 9 October 2015.
Renault MOTABILITY

The official fuel consumption figures in mpg (l/100km) for the cars shown are: Urban 40.4 (7.0) – 80.7 (3.5); Extra Urban 57.6 (4.9) – 91.1 (3.1); Combined 50.4 (5.6) – 85.6 (3.3). The official CO₂ emissions are 130-85g/km. EU Directive and Regulation 692/2008 test environment figures. Fuel consumption and CO₂ may vary according to driving styles, road conditions and other factors.

To qualify for the Motability Scheme you must be in receipt of the Higher Rate Mobility Component of the Disability Living Allowance, the Enhanced Rate of the Mobility Component of Personal Independence Payment, the War Pensioners’ Mobility Supplement or the Armed Forces Independence Payment. Advance Payment offers are only valid for Motability applications between 1 October and 31 December 2015, are correct at time of going to press and subject to acceptance of Motability application. The Motability Contract Hire Scheme is administered by Motability Operations Limited (Registered Company No. 1373876), City Gate House, 22 Southwark Bridge Road, London SE1 9HB. Full written details, including terms and conditions, of the Motability Scheme are available on request from Motability. Please note 60,000 miles over 3 years are allowed on the Motability Contract Hire Scheme.

Contact your local dealer or call the Renault Motability Team on 0800 387 626.

Book your test drive at renault.co.uk

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KO: Community Practitioner carried out a survey on revalidation that has been extremely well received with more than eleven hundred responses from members. More than half of our respondents felt that revalidation would not improve public protection, which is incredibly concerning. The Patients Association has said revalidation is a very important tool in ensuring public confidence in our healthcare professionals and the NMC itself puts public protection as the main purpose of this whole process so I think the first question we would like to ask is how do we bridge that gap between the NMC’s idea that revalidation is the main focus to public confidence, patient value it and the perception of the process from nursing staff.

JB: There is definitely a mis-match between what we all want from revalidation, and what patients, providers and service users expect from revalidation and the view of practitioners on the ground. We were particularly interested in how you put the message across about revalidation and how the focus is on patient safety and how we can kind of change that perception and I don’t know what the answer to that is really.

We’ve found as we go through the pilot that it does refocus you on your own professionalism and there are certain aspects of revalidation that do that more than others. The reflective discussion is a valuable part of revalidation, but equally the risk is that for those people who haven’t been part of the pilot it could become part of the tick box thinking where its value is questioned.

KO: How do we get that message across to registrants that revalidation is not a test, exam, punitive thing, and that this is how we demonstrate to the public that we are safe practitioners?

KK: Those individuals who hear about revalidation for the first time tend to reply to it and respond to it in a very process driven approach. Once they go through it they experience a totally different thing and the majority of the 2,100 nurses that have taken part in the pilot have confirmed that once you go through and see that the process makes sense that the outcomes become clearer. Revalidation will have added value in terms of reflection. So what is different from prep and any other system to-date in terms of the ability to practice, is that...
for the first time in nursing there will be a regulator putting in a regulatory process so we are saying “Jane, you are an individual senior nurse but we do believe you should be telling us what you are doing, we believe you should be doing that with another professional or your line manager and that adds value in that you're going to do that in line with peer pressure”.

**NETWORKING ENCOURAGEMENT**

**KO:** And in terms of patient safety reducing that professional isolation and sharing with colleagues is key to preventing something like Mid-Staffs.

**KK:** Reflection is a key word. Jane already alluded to the fact that the majority of the patients and their families are the most important aspect of revalidation and I hope we prove that when we publish the reports – but reflection highlights the culture within the organisation.

**DB:** I’m also part of South London Network and we meet up to talk about guidance about revalidation. What we found was of the eight CCGs, four of them felt revalidation was nothing to do with them. A lot of CCGs feel they have bought the licences in but the other four CCGs said “no, not interested”. Having spoken to colleagues across the country, quite a few CCGs are saying it’s not their responsibility, it’s down to the general practice and the nurses themselves to make sure they fulfil the requirements. I think it is a golden opportunity for the first time for many CCGs to know how many hours nurses are working especially if you have part time, agencies or bank nurses or it’s a friend of the family coming in to help out a lot.

It is also about who do we as nurses talk with. Some of the nurses say: “well actually I have a really good friend that I have been discussing things with, but I am not sure about her qualifications and I have never worked with her.” Surely there is a responsibility to prove that they have fulfilled the requirements. The QNI carried out a questionnaire for 3,300 nurses and found that a third of practice nurses claim to have never had an appraisal.

**UNDERSTANDING THE SYSTEM**

**DM:** There have been supervisors of midwives who have felt uncomfortable with changes that the NMC have brought in around midwifery and health visitors, and they felt they had to put extra checks and balances in place because they didn’t agree with what was the NMC had done it right. But actually for that midwife that needed their certification to practice signing off they needed that signature to prove that they had done what the NMC had tasked them to do not what the individual thought they should do. How many of the 48 per cent of people who felt revalidation would improve public protection knew a lot about the system and how many people of the 52 per cent knew nothing or very little about the system? How many people don’t know about it and just assume that it is going to be bad?
It could just be people’s normal nature; being worried about things that are being brought in that it is going to make things worse. The relationship the NMC has built up in the past few years hasn’t exactly been exceptional so people are automatically thinking that anything the NMC is bringing in are automatically bad and it might be that people just need to get over that issue and see revalidation as being positive and making people believe in the confidence to just give it a go.

**KK:** The only two individuals that can remove someone from the register are the nurses and midwives themselves or the NMC registrar, so we just want to make that very clear and it is something you may want to use as part of your messages there is none else that can remove from the website. That means that if a confirmer or a reflective partner in the discussion challenges or raises issues or doesn’t sign the document, the individual nurse or midwife would raise this with us because the alarm system asks - if you don’t have your confirmation then why? Is it because you don’t have the appraisal or don’t have the network system to pick that up and as a result of that in that particular case we would try and see where the issues are.

**JB:** So what would happen to their registration? Would it lapse?

**KK:** It is clear in the guidelines that there are routes we will take but what we’re not going to do is to remove people from the register.

**GUIDANCE**

**KO:** Are you expecting revalidation processes to be up to scratch in individual organisations when it comes to individual registrants revalidating?

**KK:** There are two parts of the process. In 2014 as you know we held a very lengthy consultation. As a result of that consultation we were able to get a very clear picture about who the nurses were that would be easy to revalidate and what kind of context – we’re talking about those who have appraisals, who have a line manager, who work in large organisations or in a networking capacity. Then there are those who are in that harder to revalidate group. In 2015, we ensured our selection was overrepresented with the harder to revalidate than the easy to revalidate. We deliberately did not select a large number of easy to validate NHS trusts or large organisations – we over-represented the others, practice nurses, health visitors, GPs, school nurses as professional advisors and army nurses.

**ND:** It will be crystal clear what the requirements are that I’d like to approach. You will need to make it very clear what you are required to do to revalidate and what you need to do to prove that. There will also be guidance for confirmers. If confirmers are given a very clear checklist from the very start, then we will produce professional confirmers who take responsibility for introducing that process.

**KO:** On the issue of guidance, 68 per cent of CPHVA members felt they hadn’t received enough information about the revalidation process and 58 per cent had no idea it was that they were supposed to revalidate.

**KK:** All of that process is available on our website and we have already sent out a postcard, which actually generated so many responses that registrations online spiked. Those who are registered got the postcard by post and were told to go online to get the information and as a result of that we got a dramatic increase in our online applications and the last month was higher than the normal amount.

It’s not about the information that is available to organisations but is about the individual taking control of their professional development, showing that they can work with us being able to talk to somebody else and to interact.

I have not seen a single nurse or midwife who is not able to do that. I haven’t met a single one that has said to me “you’re getting it wrong”.

**JB:** We do have a core group of people who are very negative about anything to do with regulation anyway but actually they kind of mix up revalidation with regulation and they eventually realise that it’s not about “they’re making us do this”.

**DM:** The problem is that if the employers don’t get wise to the fact that actually you know I pay you to be registered, not to help you be registered therefore any training you need – and you need forty hours of training in order to be registered – you have to self-fund because I am paying you to be registered to have it. It’s that danger of employers always trying to find ways around revalidation. Will that emphasis on guidance give more power to employers to say well actually the NMC say we don’t have to do this for you, you have to do it yourselves?

**KK:** No – let’s just be clear - training on average will be 12 to 13 hours a year so for somebody who is employed full-time and even for somebody who is

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Nobody should be using revalidation as a way of raising problems because by then it is too late

*Katerina Kolyva*
The smallest victories over eczema start with QV

For eczema and dry skin sufferers, simply stopping scratching is not an option. Food, perfume, clothes, temperature — anything can trigger a flare-up. An effective way to help manage the itch-scratch cycle is to encourage complete emollient therapy. And QV makes compliance easy.

QV has a range of cost-effective products that are free from colour, fragrance, lanolin, propylene glycol and sodium lauryl sulphate (SLS), which can irritate skin. It's also one of the few brands to use glycerin, a naturally occurring humectant that helps skin to retain moisture, without blocking pores.

Because QV feels so light and comfortable on skin, patients are much more likely to keep on using it morning, noon and night. Which means they can enjoy their own personal victory over eczema, thanks to QV.
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.\(^7\)


\(^{4}\)Carnielli VP et al. Structural position and amount of palmitic acid in infant formulas: effects on fat, fatty acid, and mineral balance. JPGN 1996; 23: 553–60.

\(^{5}\)Yao M et al. High 2-palmitate and oligofructose in lower protein alpha-lactalbumin-enriched term infant formula: effects on stool characteristics and stool composition. JPGN 2010; 50: (Suppl 2).


\(^{7}\)Registered Trademark
employed part-time, I'm sure 10 hours, 12 hours a year can be met even with no employer input. For me, out of our 1,200 people going through the pilot, meeting the CPD requirements was the least contentious.

**JB:** I think in some ways that is a slight concern that actually it might be the other way then that employers will say, well actually because most people more than meet the requirements, we can pull back on the training so we do need to be really careful of messages around CPD.

**DM:** If you want revalidation to be a positive thing then what we want is for employers to say we want you to do forty hours of really good training every three years to mean that we have good staff - and I'm paraphrasing here - but saying that well anyone can do that takes it away from it.

**KK:** The NMC strategy has to be about the requirements and we ensure that the ownership is with the individual and they know what they need to have. Although we are saying in the guidance that employers should aim to help nurses get what they need and why this is important, I think there is a role for you here and for the other professional bodies to push the agenda.

**STOP PANICKING**

**DB:** People regard reflection as what do I do? But really you do it every single day when choosing what to wear, what to buy when you go to the shops and throughout your nursing career, really you are doing it all the time but when it comes to revalidation it's about when you've finished, just write a few lines - what have you got from here, what you'd do differently, have you shared that with your colleagues have you gone back and said? Just write two lines, we're not being asked for a whole assignment just to say what benefit it has been and if it hasn't been a benefit why hasn't it?

This should be arms open wide, this is fantastic as we've now got something that we can work with, so for the first time its a negative thing having an appraisal, now its a positive because now if you don't fill those requirements you will now potentially lose your pin number, you will not be able to work and your GP will not be able to have their nurse. We've had to do it that way and when we've gone to GP federation meetings we've had to say to them that you've got to support your nurse or else she will not be able to work with you, you will not be able to get your QOF and payment accrued and it is as simple as that.

Instead of looking at it negatively - and we should all be doing some prep anyway - practice nurses for the first time could actually go to their employer and say "I would like my appraisal done and its my time to shine and highlight what I've been doing," because the GP might not actually have known all the courses they have been on. It gives us an opportunity to talk about pay rises and to use revalidation as a way into looking at supporting practice nurses to fulfil the criteria.

We've asked every nurse to stop panicking, take a deep breath and look at how this is going to benefit you because it is not against you.

**JB:** We've had people who are on more than one part of the register think that they have to do five reflections per each part or if they are in a management role they have to pull out the hours when they are working in the code and say "well does your job description require you to be a nurse and a registrant?" and they go yes and you just count the whole role then, you don't sit there thinking, well I've been doing something that is purely management then so I can't count this as part of that.

**KK:** It doesn't have to be written in your job description as a nurse because I think there is a risk that individuals who think that they are revalidating against their job description, but essentially they are actually revalidating against the code so what we're saying with this code of practice is that you are registered with the NMC and you are a registered nurse or midwife with any additional skills or qualifications that you may or may not have you are a skilled and within that you are doing that against the code.

**JB:** We would recommend that over the three years you should have at least one reflection per year rather than five reflections in the last year so are you saying you should have a reflection from each of your different roles?

**KK:** From the pilot we were talking about CPD and reflection in terms of saying there has to be a reflection on the practice as a whole so if you had something that happened in your practice that significantly influenced you then surely you would want to include that so revalidate as a result of the targets.

So an individual could have accounts on a combination of things. It could be CPD from a conference they went to, it could be that they received feedback from a colleague or a patient, but another individual on the other extreme could have five on CPD only and both would be OK - obviously which one you would say was most valuable.
Cow & Gate Friends are designed to make vegetables an essential part of the weaning journey. This unique range of savoury food pouches helps parents start weaning with single vegetables and gradually introduce combinations of flavours, a process that helps create a love of vegetables for life.

Find out more about the ‘Start, Vary, Repeat’ approach to weaning at www.in-practice.co.uk/weaning.
we can all make a judgement call on that but for us now at the NMC the important thing now is to not overdo it. It would be great if we could have a cross section of variety, and if you spoke to your members that would be nice but it’s not mandatory. You can’t say to people.

DATA PROTECTION
KO: Does this raise data protection issues and governance concerns if we’re talking about patient feedback?

ND: We took a lot of legal advice about data protection issues and one thing that we found was that there were ways around patient feedback, how to store information and we provide a whole separate sheet of information at the back of the guidance including case studies in there so an example would be – we saw this patient, they had this treatment and this is what happened to give practical examples while getting around the data protection issue so that no-one who follows the instructions we give will be in breach of data protection rules.

KK: It doesn’t have to be you naming people as part of revalidation.

KO: So using anonymised case studies means nurses don’t have to gain consent?

KK: No

KO: So what would be the situation where you would obtain consent?

ND: According to the processes we have in place you shouldn’t have to take consent because you won’t be recording the details in any way that can identify the patient.

The emphasis isn’t on the feedback itself, it’s what you took from that which is the template that we have given people to use. They can come up with their own way of doing it which will follow straight from that concept of what did you learn from this, how will you improve your practice, how did you learn from the code and that’s what we are trying to get at and I really hope that someone would see this as a chance.

KK: I see the regulator as sitting at a distance. There is the employer, the organisation and governance policy making - so many layers of management between us and the nursing and midwives. We regulate that and we must not undermine those and use them in a positive way. The CCG, NHS England, the chief nurse, there are so many people and structures between us and the register, so I see us as sitting here almost pushing buttons and then the butterfly effect means things happen as a result of the decisions we make here. It’s not about us going through every single layer of that process - we could have a process and I think it is similar to the regulatory process where you say I implement the policy and set the code but manage every single layer of that until I get down to the registrar that I regulate and I am confident that it works or I set the tone, evaluate and see the change in behaviour because I trust the individual person at the end of it and I do whatever I can to engage with the layers between me and them.

It comes back to the original point that we have to let it go and see, let it show us how revalidation is working. We at the NMC are committed to not making this process misleading to those midwives on the registers so we will do anything we can in terms of our processes and support that we are offering through our online system, our call centre that we are adding resources to.

Nobody should be using revalidation as a way of raising problems because by then it is too late.

JB: If they haven’t met their requirements in three year, they’ve lapsed and it doesn’t become a fitness to practice but would have to be a return to practice.

ND: There are reasons why people cannot meet these requirements for revalidation. If there are particular reasons why people can not meet the additional criteria then between the employer and the individual there will be measures but into place so that the individual does not lapse on a technicality. We don’t want our process to get in the way of nurses and midwives practising professionally. If there is a perfectly good reason for this, they can get in touch with us.

JB: Going back to the subject of feedback, I don’t see the point in saying that you have to have five pieces of feedback if you don’t have to keep a record of it or that you don’t have to show to your confirmer evidence that you’ve got five pieces of feedback. So either you say you want all of the reflections to be based on feedback or your reflections of CPD feedback because it is part of the process that the confirmer had to tick that we had five pieces of feedback so he hadn’t had our reflective discussion with us so he wanted to see where is the five pieces of feedback.

I supposed we could have just discussed those, but if you are gathering those over three years, you aren’t going to remember what they are unless you store them as they come up.

DB: I’ve got some GPs that when you look at the documentation, and you dig round a bit further, you find that all their confirmers are family members.

If every single registrant actually had their template looked at and going back to then that may be the only way that it is ever going to be a real safeguard that every single registrant is actually working and going through this process.

KK: To do this within the cost of the registration fee is not possible and we don’t want to have to increase the fee as a result of this process. You know there is something around how much do you want the NMC to check and how much financial burden you want to add.

The emphasis isn’t on the feedback itself, it’s what you took from that which is the template that we have given people to use

Natasha Dare
If you fail to prepare for revalidation you put your NMC registration at risk!

By Karen Kessack, revalidation lead, Kent Community Health NHS Foundation Trust

I HAVE BEEN WORKING AS REVALIDATION lead for Kent Community Health NHS Foundation Trust, one of the largest community trusts in the country, which covers a large geographical area with staff spread across numerous bases.

This means we have to make sure we reach staff in all corners of our area. Our staff include nurses, health visitors and school nurses.

When I first came into role I felt my first task was to make sure that staff had heard of revalidation, were not scared of it and saw it as a positive change. We set up revalidation awareness sessions, which were well attended across our area – and in some cases we had to put on extra sessions. The aim of the sessions was to increase understanding of:

• why revalidation is being introduced;
• how the revised Code links to revalidation;
• what provisional guidelines suggest is required to renew NMC registration (revalidation);
• what the benefits of revalidation are;
• what staff should be doing now;
• what our trust plans are to support staff.

We outlined at the beginning of each session how they were designed as an introduction to revalidation rather than in-depth training. They were 45 to 60 minutes long, which allowed for multiple presentations to be given at the same venue and made sure staff did not have to take much time out of practice.

Our communications team designed an A5 sized card with info graphics in a checklist style (see opposite page) to share and the design of this used in our presentation. This has given a clear identity to our revalidation activities, making it easier for staff to recognise. It was used as a screensaver to publicise our sessions and raise awareness. We also have a generic revalidation email address that staff can use as a point of contact. I have also written a blog and narrated a version of the presentation.

We are very keen to make sure meeting the requirements of revalidation are incorporated into everyday practice. I think a good example of this has been looking at clinical and safeguarding supervision sessions that our school nurse and health visiting teams take part in. We have worked with our safeguarding team and the team that facilitates clinical supervision to make small adjustments that highlight how supervision supports revalidation. Supervision can cover CPD, feedback and the reflection elements of revalidation. Small changes to the documentation can act as a helpful prompt, for example the addition of the question: ‘Which part of the Code does this link to?’

I have found that, as a group, school nurses and health visitors should be very well prepared for revalidation as they are already experienced in linking their reflective pieces to the SCPHN Domains and Proficiencies, therefore linking this to the revised NMC Code should be fairly simple. Practice teachers in particular already have a requirement to have a comprehensive portfolio including reflective pieces, which fits very well with revalidation.

Reassuring staff that revalidation does not mean you have to have an extra portfolio has been helpful. Using a mock portfolio with some examples of reflection and completed templates has been very well received, as it shows how simple it can be. Putting a copy of a job description highlighted the importance of understanding scope of practice, which varies greatly across roles. We have also put together some FAQs for non-NMC line managers and those staff who do not have direct patient contact.

We plan to discuss revalidation with staff at all appraisals whether it is their revalidation year or not and it is important to have support in place for SCPHN students. Those due to revalidate during their SCPHN training need to be identified when they begin the SCPHN course and our plan is that SCPHN students will have a discussion around their revalidation readiness at an agreed 1:1 during the SCPHN programme. For those students due to revalidate during their SCPHN programme the SCPHN manager will act as their confirmer.

Overwhelmingly staff seem to agree that we do need to change how we remain on the NMC register and while revalidation is not perfect it is a good start. Our organisation’s view is that we will do our best to support our staff through revalidation, however we are being very clear that the responsibility to be ready for revalidation belongs to the individual staff member. The reality is if you fail to get ready for revalidation you are putting your registration at risk.
Your revalidation checklist – what you need to demonstrate for the last three years of your practice.

1. Have you logged 450 practice hours?

2. Do you have at least five pieces of practice-related feedback?

3. Have you recorded at least five written reflections on the NMC Code, your CPD, and practice-related feedback?

4. Have you had a professional development discussion on your reflections with another NMC registrant?

5. Have you recorded at least 40 hours of continuing professional development (CPD) relevant to your scope of practice as a nurse?

6. Do you have confirmation from a third party that you are fit to continue practising? This should be discussed and evidenced during your appraisal with your line manager.
Mindfulness classes trialled in secondary schools

A ‘MAJOR TRIAL’ TO ASSESS THE EFFECT of mindfulness on teenagers has been launched by the Wellcome Trust. The study will investigate the most effective way to train teachers to deliver mindfulness classes and how mindfulness improves the ‘mental resilience’ of teenagers.

The £6.4m research programme is being carried out by the University of Oxford, University College London and the Medical Research Council.

Mindfulness is a form of meditation that is thought to bring about long-term changes in levels of happiness and wellbeing.

The study will involve almost 6,000 pupils in 76 schools in the UK.

More than 10 per cent of children aged 11-16 has a mental disorder, according to the Office for National Statistics. One in ten children aged between five and 16 have a mental disorder, data has shown.

The trial is expected to begin in late 2016 and will run for five years, which includes a two year follow up period for each student.

Professor Willem Kuyken, from the University of Oxford said mindfulness was a form of ‘mind exercise’.

He said: ‘Just as brushing your teeth or going for a run are well known ways of protecting general physical health, mindfulness exercises develop mental fitness and resilience.’

Pregnant women encouraged to get whooping cough vaccine

Public Health England (PHE) is encouraging pregnant women to take up the whooping cough vaccine.

Data published on 3 September showed whooping cough vaccine coverage in pregnant women reached 56.4 per cent in the UK.

The vaccine has been given to pregnant women since 2012 after public health research suggested that babies born to women vaccinated a week before giving birth had a 93 per cent reduced risk of becoming ill with the infection.

Whooping cough can be fatal, particularly to young babies before their first dose at two months.

Diabetes UK welcomes guidance for diabetic children

A LEADING DIABETES CHARITY HAS welcomed new guidance published by the National Institute for Health and Care Excellence (NICE) for diabetic children.

The guidance recommends diabetic children adhere to stricter blood glucose levels of 48 mmol/mol (6.5%) and below to reduce the risk of stroke, blindness and amputation in later life.

But Diabetes UK warns this can only be achieved if government puts in place appropriate support to help children achieve this.

The guidance also recommends same day referral for children suspected with Type 1 diabetes and access to continuous glucose monitors (CGMs) and insulin pumps.

Barbara Young, Diabetes UK chief executive said it was ‘critical’ diabetic children received emotional support to achieve these targets.

‘While the technology, such as pumps and increased access to CGMs, is available to support children with Type 1 diabetes reach blood glucose targets, it is critical they receive the emotional support, such as improved access to specialist psychological care they and their families need to feel empowered to achieve these new targets,’ she said.

Diabetes UK, with the Juvenile Diabetes Research Foundation (JDRF) and INPUT Patient Advocacy, has released a guide to Type 1 diabetes technology today.

Type 1 Technology: A guide for young people and families aims to help families become more aware of healthcare options available to them.

Sarah Johnson, JDRF director of policy and communications said the new ‘family friendly guide’ would make life easier for people living with Type 1 diabetes.

The NICE guidance can be viewed at http://www.nice.org.uk/guidance/ng18

Smoking in cars containing children outlawed

Motorists in the UK will face fines of £50 if they are caught smoking in a car containing children under 18. Under the new legislation, which came into force on 1 October 2015, it will be illegal to smoke in the car and also to not stop someone else from smoking in the same circumstances. Each offence carries a fixed-penalty fine of £50.

New resources for young people affected by pregnancy loss

A set of resources aimed at providing specialised information and support for young people who have experienced a miscarriage or ectopic pregnancy has been launched.

The resources, produced by the Miscarriage Association, include a leaflet, several short films and written stories from young people.

To access the information in full go to: www.miscarriageassociation.org.uk/support/feelings-after-pregnancy-loss/support-for-young-people

DH Blog in run up to HV transfer of commissioning

THE DEPARTMENT OF HEALTH IS starting a series of blogs in the run up to the transfer of commissioning public health services for 0-5 year olds on 1 October 2015.

The first has been written by Alison Morton, professional advisor for health visiting at Public Health England.

Alison has blogged about how health visitors help children get ready for school and improve outcomes.

To access the blog go to: https://vivbennett.blog.gov.uk/2015/08/14/ready-to-learn-ready-for-life-the-central-role-of-health-visitors-by-alison-morton/
Perinatal Care: reflections on dads’ engagement

SALLY HOGG
NSPCC lead for babies and vice chair of the UK maternal mental health alliance

Last year my professional and personal lives collided. I was leading NSPCC’s work on pregnancy and babies when I became pregnant. This collision has been an interesting and challenging experience – one which many readers of this journal will have encountered.

In some ways my work was helpful. I knew why different professionals were there, why they asked the questions they did, and how they might help me. But there was definitely more pressure. Every parent frets about whether they are doing a good job; it is even worse when you understand just how much early parenting matters!

My role exposes me to the best and the worst of services. I’ve seen good practice, but I also know of problems and gaps in services from my research and campaigning. I was intrigued about what I would experience as a service user, and early on had to consciously try to engage with services as a ‘normal’ parent, and not some sort of mystery shopper!

When I became pregnant, I was half way through a big project about how to work with dads in pregnancy and infancy – so I was particularly interested in how services treated my husband.

We all know dads matter. It is so simple, but so easily forgotten. Dads matter in their own right. Whatever your gender, new parenthood is a time of emotional turbulence; stress, sleeplessness and enormous changes in your roles, relationships and responsibilities. Dads also matter because they make a huge contribution to babies’ wellbeing. A wealth of research demonstrates that when fathers are sensitive, supportive and involved, it has a hugely positive impact on babies’ life chances. And dads matter because they are usually mums’ primary supporters. Dads influence the wellbeing of their partner and the likelihood that she will maintain healthy behaviours that benefit their baby. More detail on the research on the importance of dads can be found in our NSPCC ‘Dad Project’ report (look closely, you can also see a photo of my husband on the cover!).

Before I wrote this article, I talked to my husband (it would be wrong to write about how dads should be more directly involved without involving a dad!) I asked him how he felt he had been engaged by professionals since I became pregnant. His first response was: ‘I haven’t! He felt he had always been treated as an observer to my or my son’s care. Some professionals were friendly and warm, some polite, and some completely ignored him. No one ever talked to him in his own right, as a parent with his own insights and perspectives on how things were going, his own questions and concerns, and his own, hugely important, contribution to our son’s life.

My husband remembered warmly those professionals who had actively included him and given him a role – the midwives, for example, who encouraged him to dress our son after his birth and after his postnatal check. We both also remembered times where he was totally excluded by professionals. Two examples stood out.

The first was our 20 week scan. A chance for both of us to learn about how our baby was developing. The letter about the scan was addressed only to me. Its tone was official, and it contained the sentence “If you feel that you need a chaperone for this procedure you may bring someone with you or if you would like us to provide one please let us know …”. There was no mention of my husband being welcome or even encouraged to come along and this sentence almost suggested he was there only as my chaperone – a role which others could easily substitute. The welcome he got from the sonographer in person was no better. She never once addressed him directly.

The second example was the home visit after our son was born. When the midwife arrived, I was feeding him on the third floor of our home. As she walked into the bedroom she said: “Now, you are doing that wrong…” she grasped my baby and moved him across my chest. “He or she should be like this!” There was so much wrong with this. The lack of greeting, the immediate criticism, the uninvited physical contact. But it also revealed something else: between meeting my husband at our front door and getting to my bedroom, the midwife had not asked him about our baby. If she had, she would have known his gender, at the very least, before she arrived at my bedside.

I know many people reading this will be angry because this is not reflective of their practice. There are professionals who are doing a fantastic job working with dads. But sadly I do not think our experience is unusual. It is 25 years since Professor Michael Lamb described dads as the “forgotten contributors to child development”, but in many places, this quote still feels very relevant.

The difference that can be achieved by involving dads was illustrated to me in our experiences of feeding our son. When I was pregnant, my husband and I went to an evening workshop on breastfeeding run by the NCT. As a result, he was able to give me very practical support in the early days of breastfeeding; he could look at our position and help me to get the latch right. When I was tired and emotional, he could remind me of the information we had learned together.

Sadly the same was not true when it was time to wean our baby. The local health visitors ran a workshop on weaning which was held mid-morning on a Monday, so difficult for many fathers to attend. The workshop included a film of a child gagging on food and I asked if there was a link for my husband to watch this online but they could not give one. When the right time came I gave my son a finger of toast to eat, which he gagged on. My husband expressed concerns about the danger he might be in, and I – thrown by the experience – questioned whether we should be giving him finger foods or just stick to puree. This was a simple illustration for me about how much harder it is for mums to stick to professionals’ advice without dads also being informed and on-side.

Austerity continues to bite and services are cut, the contacts that professionals have with families must have maximum impact. Without reaching out to dads, we are leaving 50 per cent of parents unsupported and unengaged. That is an enormous missed opportunity.

October 2015 Community Practitioner 27
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Educator winner – 2015
“I’m honoured, overwhelmed, surprised and proud. Just great to share it with so many deserving colleagues”

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Infant Mental Health: Health visitors as key partners

ANNE CHITTY
Specialist health visitor, infant mental health, Parkside community health centre

INTRODUCTION
The field of infant mental health has grown dramatically over the past few decades and its increasing importance is now widely accepted. This is due in part to the supporting evidence in babies’ neurological development that demonstrates how crucial early childhood experiences and the vital role of caregiving relationships are in shaping babies’ brains. Secure attachment relationships have a positive effect on babies’ emotional and social well-being and development resulting in fewer behavioural problems, better peer relationships and less affective disorders e.g. depression and anxiety. Where there are concerns in the attachment relationship, early intervention, even before the child is born, is known to prevent the development of mental health problems in later life. (Building Great Britons, 2015).

BACKGROUND
The Infant Mental Health Service (IMHS) began in South Leeds during 2002 as part of a local Sure Start programme. ‘The Baby Bonding Early Attachment project’ was aimed at first time parents with a risk of attachment difficulties. A Consultant Clinical Psychologist worked together with health visitors, (HVs) community midwives and other members of the Sure Start team to promote secure attachment relationships between infants and their primary carers. Various interventions were used from pregnancy up to the infant’s first birthday focussing on maternal mood and wellbeing, attunement in interactions and emotional and social support. The ‘Understanding your Baby’ (UYB) booklet was developed as a city wide provision for parents and was handed out by HVs either during the antenatal period or at the birth visit.

Following the mainstreaming of Sure Start, the Clinical Psychologist together with a part time specialist health visitor, (HV) provided the IMHS which included a referral service plus training and consultation. A training day ‘Supporting parents to understand their Baby: applying attachment theory’ (UYB training) was developed predominantly for HVs supporting them to use the UYB booklet with families to establish sensitive and attuned parenting in the early weeks and months of a child’s life.

From April 2012 Leeds IMHS was commissioned as a city wide service with a clear structure promoting awareness of Infant Mental Health across the city. With the emphasis on prevention and early intervention the aim is to achieve optimal mental health outcomes for children by providing advice and support to practitioners and parents in meeting their infants’ emotional needs. Delivery of training and ongoing consultation works to underpin and improve the skills of the workforce in health and social care, including Early Start teams, (HVs, nursery nurses and children’s centre staff) community midwifery and the Family Nurse Partnership. The Service operates at universal level, universal plus through to a targeted, and specialist level of care. Referrals are accepted where there is concern regarding the attachment relationship and direct work with families is offered from conception to the child’s second birthday.

TRAINING
The ‘Infant Mental Health : Babies, Brains and Bonding’ training is a basic provision of the IMHS and was initially aimed at Early Start practitioners but continued to roll out across the city. Leeds children’s social workers, foster carers and third sector workers have received the training and currently it is provided for Local Authority nursery staff and children’s Guardians. The day includes infant neurodevelopment, attachment theory and how to support caregivers in understanding their babies. The emphasis is to link all three sections so that practitioners appreciate the importance of focussing on infant states and cues when supporting parents/carers to be attuned, sensitive and responsive in their caregiving. In turn this promotes secure attachment relationships with a positive impact on their babies’ brain development and consequent healthier emotional and mental health outcomes.

All training sessions are evaluated and both quantitative and qualitative data is collected which inform the annual review where changes have been made. The training consistently evaluates positively, with 98% of participants reporting that their personal objectives were met, 99% that the training was relevant to their job and 99% that they would recommend the course to others. The IMHS provides a summarised version of the training for HV students at Leeds Beckett and Huddersfield Universities including a module on maternal mood for Leeds students.

The UYB training remains a core component of the IMHS and is offered to a range of professionals supporting families with babies and young children including professionals working outside Leeds. Currently it is expected that all Leeds HVs access this training and HVs new to Leeds access it as part of their induction.

REFERRAL SERVICE
The IMH referral service is for families where there are concerns about the quality of the attachment relationship between infant and caregiver from conception to the age of two. Currently referrals are accepted from health professionals, predominantly HVs and midwives of those families who may benefit from direct intensive therapeutic support. Intervention is provided as early
as possible to enable formation of therapeutic relationships, provision of vital information about the importance of early relationships and promotion of attachment and sensitive caregiving.

Using genograms, assessment focusses on family history, childhood experiences, emotional history, significant relationships, obstetric history and the caregiver’s thoughts and feelings about their infant. Observation of the caregiver and infant interaction is crucial in providing vital information not only regarding the caregiver’s ability to meet their infant’s needs but more importantly regarding the infant’s response. Close observation using an NCaST parent/child interaction assessment scale reveals caregiver’s sensitivity, promotion of social, emotional and cognitive growth and response to their infant’s distress together with the infant’s responsiveness to their caregiver and environment providing necessary detail of their emotional wellbeing.

A diverse range of therapy options are offered to improve the quality of the parent-infant relationship, including psychoeducation, parent-infant psychotherapy, cognitive analytical therapy and cognitive behavioural therapy. Owing to the mix of skills and modalities within the team, families can benefit from team members working, which can be particularly beneficial when parental mental health difficulties are present.

The majority of referrals into the service are appropriate, suggesting that referrers are skilled in identifying concerns around attachment relationships and have a good understanding of the service. Quantitative outcome measures are routinely collected using validated self-report questionnaires such as the Patient Health Questionnaire (PHQ-9) and the Generalised Anxiety Disorder scale (GAD-7) and MORS, (Mother’s Object Relation Scale, Short Form). More qualitative outcomes are obtained by verbal report, observation and Child and Adolescent Mental Health routine ‘Experience of Service’ questionnaires administered on discharge.

Results are positive, demonstrating visible and often significant improvements in parental mental health, parent-infant relationships and the wellbeing of infants.

CONSULTATION/REFLECTIVE CASE DISCUSSION

Working intensely with infants and their families in addition to the complexity of attachment relationships evokes strong emotions. The IMHS offers Consultation to teams, groups and individuals either face to face or by telephone. Early Start teams are provided with regular on-going support from the IMHS in the form of ‘Reflective Case Discussion’ (RCD) sessions.

Reflective supervision in IMH and early intervention supports best practice (The Wave Report 2013) and issues around confidentiality are negotiated in advance. A practitioner, typically a health visitor or children’s centre outreach worker, will have a family in mind to bring for discussion having thought about key issues. The family is presented using a genogram. This provides a focal point to aid understanding when families are typically complex. The same IMH practitioner facilitates the discussion at regular intervals and times to suit team members but usually every 6-8 weeks for 1hr - 1 1/2hrs.

Cases brought for discussion are the complex families that practitioners worry about; families with chaotic life styles, relationship problems and where parents express concerns regarding their children’s behaviour. The aim is to:
• Provide a safe, reflective space for practitioners to think about their work with families focussing on early attachment relationships.
• Hold in mind the importance of the infant’s emotional experience
• Improve understanding and increase confidence
• Improve practice
• Relieve stress and anxiety
• Help build team cohesion and positive working relationships.

A brief evaluation questionnaire measures the effectiveness of the RCD’s which are found to:
• be helpful in reflecting about families,
• improve understanding of the infant/child/family’s experience
• improve practitioners’ confidence when working with families.

DEVELOPING THE SERVICE

Additional investment into the IMHS has allowed the Service to develop by increasing the number of consultant clinical psychologist sessions and appointing new team members bringing the total number of health visitors in a team of six permanent practitioners to three. Health visiting is very much a core component of the IMHS and plans are underway to introduce a city wide universal screening by HVs for attachment concerns at the 6-8 week contact, alongside maternal mood.

References


WHE Trust (2013): Conception to age 2 – the age of opportunity. Supporting Families in the Foundation Years. Department for Education

30 Community Practitioner October 2015
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

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"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.

⁷Registered Trademark

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ZTC685a/01/15
INTRODUCTION
Eating and drinking are an important part of life, both physically and socially. Where swallowing is difficult, people may become isolated, under-nourished and frail. Dysphagia may be caused by pathology in the mouth, pharynx or oesophagus. The following paragraphs will focus on the mouth and pharynx, and outline the swallowing process, the frequency of swallowing problems, complications and their management.

NEUROLOGY
Swallowing is essentially a reflex involving 55 muscles, five cranial nerves and two cervical nerve roots. The swallowing control centre is situated in the medullary area of the brain stem and receives inputs from the mouth and pharynx regarding the bolus size and consistency, the respiratory centre to coordinated swallowing and breathing and from cortical and subcortical areas of the brain all of which result in the modulation of and duration of different phases of the pharyngeal swallow, but the sequence of events remains consistent (Smithard, 2002; Kendall et al, 2000; Molfenter, 2014).

The pharynx is a common pathway for ingested food/ liquid and inspired air. As they pass through the pharynx, air enters the larynx and food/ liquid passes over/ around the larynx and continues to the oesophagus. When this relationship is disturbed, swallowing problems/ dysphagia occurs (Matsuo, 2008).

DYSPHAGIA
Dysphagia is always abnormal, irrespective of age. The only difference being the timing of the different components is more critical (Lelsie et al, 2005). Dysphagia is a symptom, not a diagnosis, very much like cardiac failure and falls. Once identified the underlying aetiology needs to be sought (Table 1).

EPIDEMOLOGY OF DYSPHAGIA
Oropharyngeal dysphagia in the general population varies between 2.3% and 16% (Chiocca et al, 2005; Cho et al, 2005; Eslick et al, 2008; Mansson et al, 1991; Watson et al, 2009; Ziólkowski et al, 2013). The data is based on self-reported questionnaires or surveys. Dysphagia is frequently under recognised and under appreciated. Medical/nursing staff often do not inquire as to whether their patients have difficulty swallowing unless weight loss is evident, yet a proportion of people living in the community, let alone institutions, will have previously unreported swallowing problems. For many this is gastro-oesophageal reflux.

Dysphagia is a common problem with increasing age; frequently because of accompanying medical problems. Using the Standardised Swallowing Assessment (Perry and Love, 2001; Yang et al, 2013) describe in a Korean longitudinal study an overall prevalence of dysphagia of 33.7% (95% CI, 29.1-38.4%) for people above 65 years living independently. Barczi and Robbins (2000) found prevalence rates near 15% in community dwelling and more independent individuals, and upward of 40% of people living in institutionalised settings such as assisted living facilities and nursing homes.

This is even more so in those people who are frail. In the presence of frailty, the swallow may be intact on a day-to-day basis, until medication is changed (side effects causing drowsiness, confusion or dry mouth) or illness occurs, then dysphagia will occur. With the multiple possible aetiologies of dysphagia in this age group it is high time that dysphagia was added to the list of Geriatric Syndromes or Giants.

Dysphagia will occur in many disease situations, not just in the presence of neurological disease. Swallowing requires
a period of apnoea, and where this is not possible (lung disease, cardiac failure) dysphagia will occur (Table 1).

**PRESENTATION AND IDENTIFICATION IN THE COMMUNITY**

The presentation of dysphagia will often depend on the context in which it occurs. The most common complaints will be that food/liquid goes down the wrong way, may regurgitate through the nose, may cause coughing or a change of diet. In others where they cannot recognise or communicate their problem, food refusal, regurgitation, and spitting may be the presenting complaint by carers. In those who are frail, swallowing only becomes a problem when another stressor such as infection or prescribed (or non prescribed) medication wipes out their physiological reserve resulting in dysphagia and the risk of aspiration.

Signs of dysphagia will be a changed/wet voice, recurrent chest infection, hypoxia, a grumbling pyrexia or weight loss. Coughing is frequently a sign of airway penetration (food/liquid not going below the vocal cords), then the airway is cleared with a cough and aspiration does not occur.

**MANAGEMENT**

The management of dysphagia is a multidisciplinary problem. First the problem has to be identified by a clinical history and a swallow screen (Hinchey et al, 2005; Donovan et al, 2013) (such as the water based Bedside Swallowing Assessment BSA). Any member of the clinical team can do this. Once the problem has been identified, referral to the local expert should occur, in the United Kingdom this will be the speech and language therapist. The speech and language therapist will then fully assess the patient looking at the anatomy of the swallow as well as the functional aspects (Ramsey et al, 2003; SIGN, 2010; Speyer, 2010). Following the clinical assessment, recommendations will be made to ensure that nutrition can be provided safely, and, in some situations, further assessment is required.

Various guidelines suggest that instrumental assessment of the swallow should occur where indicated, different countries have different approaches. In the UK, the speech and language therapist will recommend videofluoroscopy and/or Flexible Endoscopic Evaluation of Swallowing (FEES), the approach is often dictated by local availability. Other investigations that may be required include manometry and pH monitoring where reflux is considered to be the aetiology of oropharyngeal dysphagia (European Society 2013; Kelly et al, 2007).

The management of swallowing is to encourage a safe swallow and ensure that the patient receives adequate nutrition (Wright et al, 2005) and is able to take their medication. From a nutrition point of view there are two basic approaches, one is to modify the diet (i.e. consistency

### Table 1: Aetiological factors for dysphagia

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of food taken (Cichero, 2013) and the other is to modify the swallowing physiology (swallowing manoeuvres) (Ashford et al, 2013).

Where it is not possible to swallow safely or it is not possible to ensure someone’s nutritional needs are met, enteral feeding needs to be considered. In the acute phase nasogastric feeding is the route of choice, and where necessary a nasal loop or bridle is used to keep the tube in place (Bevan et al, 2010). Longer term, depending on patient choice and acceptability a gastrostomy may be placed, either endoscopically or radiologically (Gomes et al, 2010). Some, usually younger patients, may prefer to repeatedly pass a nasogastric tube.

There is at the present time a lot of hope and expectation around the management of swallowing disorders, particularly in those due to neurological disease with otherwise no health problems, this is termed presbyphagia.

In the case of brain injury (including stroke), there are opportunities with transcranial stimulation, pharyngeal stimulation and neuromuscular stimulation. Where there is reduced tongue strength, either due to brain injury, post-surgery or sarcopenia, muscle resistance training may be beneficial, not only in strengthening the tongue but also improving the swallow. Where laryngeal elevation is a problem, neuromuscular stimulation or muscle strengthening of the hyoid musculature (Shaker exercise and chin tuck against resistance) offers hope (Shaker et al, 1997; Smithard, 2013; Steele et al, 2012).

**LIFESTYLE**

Living with dysphagia can prove to be problematic, not only for the person with dysphagia but also family members. Dysphagia can lead to social isolation and embarrassment. Enterostrymal feeding may take over one’s life as feeding is often done over many hours, usually at night. Nasogastric feeding may affect body image. Enteral tubes are not without their complications. Even where swallowing problems are not overt, such as in presbyphagia (Lelsie et al, 2005; Reginelli et al, 2008), dietary changes may have taken place subconsciously and people may not wish to attend events that involve eating.

**MEDICATION**

Medication can pose a particular challenge in people who have an abnormal swallow. The pharmacist is key to assisting the patient and clinical staff to make the right decision. The first question should be, is the medication necessary? Is it making the swallow worse (dry mouth, confusion, reduced alertness). If it is, how can it be administered? Some medications can dissolve (e.g. statins), others may come as liquid/syrup formulations, and some are available as wafers/melts or skin applications.

**THE ROLE OF THE COMMUNITY NURSE**

It is most likely that district nurses and their teams eg community staff nurses and also practice nurses working with adults with dysphagia. Whatever the context, community nurses have an important role to play in the identification and management of people with dysphagia.

Nurses work in specialty areas, intermediate care teams and as part of the matron teams for long term conditions. They will need to be aware of the effect that many long term conditions can have on swallowing, and many of these are not neurological (Table 1). Community nurses will need to support families when patients with dementia refuse to eat and drink, which is often part of the terminal phase of dementia.

Dysphagia will be present in many neuro-degenerative conditions as the disease progresses, and for many, this will be part of the terminal decline. Being able to recognise this and implementing end of life care is very important (Palecek et al, 2010). This will prevent unnecessary and distressing transfers to hospital.

Community nurses need to be able to spot when people are likely to be having difficulties with swallowing and questions about swallowing should form part of the holistic assessment undertaken in the community.

Screening for swallowing problems can be part of the general assessment. Watch someone eating/drinking. Do they cough or choke? Are they unintentionally losing weight. Is uneaten food left around?

One area that is very neglected is mouth care. Poor oral care (including teeth/ denture care) increases the risk of aspiration pneumonia. Failure to inspect a dental plate may make the treatment of oral thrush pointless, as the mouth will just be re-infected.

Many people are enteral fed in the community, and although they are supported by community nutrition teams, nurses will have opportunities to review the position of a nasogastric tube, insert a PEG tube site or attempt to unblock PEG tubes if trained to do so. Most trusts have guidelines and protocols around blocked tubes.

**SUMMARY**

Swallowing problems are common and may occur in non neurological conditions. Swallowing problems are often insidious and ignored in older people; dysphagia should be recognized as a geriatric syndrome. It is important to identify this to ensure appropriate intervention and management is put into place. A Community Nurse is ideally placed to do this.

**References**


1. The brain stem swallowing centres receives information from?
   a. Mouth
   b. Pharynx
   c. Cortex
   d. Respiratory Centre
   e. All of the above

2. To be able to swallow safely you must be able to?
   a. Stop breathing
   b. Stand up
   c. Walk
   d. Have a gag reflex
   e. Talk

3. The most common cause of aspiration pneumonia is?
   a. Difficulty swallowing
   b. Poor mouth care
   c. Nasogastric tubes
   d. Percutaneous endoscopic gastrostomy (PEG)
   e. Medication

4. How many muscles are involved in swallowing?
   a. 10
   b. 55
   c. 90
   d. 40
   e. 22

5. Which of the following is not used in the assessment of swallowing?
   a. Manometry
   b. Drinking a yard of ale
   c. Videofluoroscopy
   d. Flexible endoscopic evaluation of swallowing
   e. pH monitoring

6. Dysphagia may be caused by?
   a. Stroke
   b. Heart failure
   c. Head injury
   d. Cancer
   e. All of the above

7. Which of the following may not indicate a swallowing problem?
   a. Spitting food out
   b. A sore mouth
   c. Difficulty in swallowing
   d. Loss of taste
   e. Poor appetite

8. Dysphagia is indicative of:
   a. Difficulty in eating
   b. A sore mouth
   c. Difficulty in swallowing
   d. Loss of taste
   e. Poor appetite

9. Dysphagia is a geriatric syndrome because
   a. Has many different aetiologies
   b. Is associated with frailty
   c. Associated with a poor outcome
   d. Occurs with increasing age
   e. All of the above

10. Which of following is not a form of enteral feeding
    a. Sip feeds
    b. Pureed diet
    c. Nasogastric tubes
    d. Subcutaneous fluids
    e. Gastrostomy
Comfort for babies, relief for mums

95% of Paediatricians* reported an improvement in common infant feeding problems with a formula like Cow & Gate Comfort.

Evidence shows these partially-hydrolysed formula milks containing oligosaccharides (GOS/FOS) improve the symptoms of colic in bottle-fed babies.† So if a bottle-fed baby’s colic is more than mum can manage with practical tips alone, put digestive care first with Cow & Gate Comfort.

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*Out of 96 paediatricians


Comfort for babies, relief for mums
Empowering health visitors: a multi-faceted approach

INTRODUCTION
This paper reports an evaluation of a project to empower health visitors. Empowerment is a concept that has been widely used in nursing and health visiting. It emerged in the late 1960s in the context of movements to promote political awareness and self-help among minorities (Manojlovich, 2007). Chandler (1992) stated that ‘to empower is defined as to enable to act’ (p. 54), distinguishing empowerment from power, which is ‘to have control, influence, or domination’ (p. 65). Hawks (1992) added that the ability to act requires ‘the correct information, support, resources and environment’ (p. 609). An empowerment approach is considered to be a key aspect of health visiting practice both with individuals and communities (Cowley and Houston, 2004; Kenyon 2015). Research has demonstrated that empowered nurses experience less burnout and less job strain, while the inability to act creates feelings of frustration and failure (Manojlovich, 2007).

Health visitors working in Tower Hamlets, a deprived inner London borough, face a large and growing under-5 population, and caseloads with disproportionate numbers of vulnerable families and child protection concerns. This paper reports an evaluation of a project to empower health visitors. Baseline data about their activity (primarily derived from observation and interviews) showed that health visitors would benefit from improved resources (e.g. leaflets, books, training packs), enhanced knowledge of local borough and third sector services, and support for their own wellbeing and morale. After the programme that was implemented to provide these, seven health visitors were interviewed for evaluation purposes. They reported feeling empowered by the project: the training had been invaluable in providing affirmation, reassurance, and the opportunity to reflect; the new sleep information packs were very helpful for families, as was the new leaflet explaining their role; and restorative supervision had been useful in helping individuals think through how to deal with particular challenges in life or work. The project was thus successful in helping the health visitors interviewed to feel more supported and thus empowered in their work with families.

KEY WORDS
Health visitors, Empowerment, Evaluation, Reflection

Box 1: Topic guide for interviews

Which events in the Toolkit project did you experience (training, networking, supervision, awaydays)?
About each component:
What was most useful?
Have you used what you learnt then since? How?
Has it affected your work? If so, how?
Has the training added to your knowledge and use of evidence in practice?
Any effects on your colleagues / teams?
General questions:
Do you use the poster / leaflet / website about health visiting when working with clients / other professions? Do they help? How?
Have you looked at any of the books? Are they useful?
of health visitor activity in the identified areas by collecting data from observation, from reflective diaries from health visitors and from interviews with staff and service users. The clinical project manager (Barts Health) met health visitors and staff in local NHS departments, Children’s Centres and local voluntary organisations, in order to understand current service provision, referral pathways and barriers to effective working. The baseline data showed that health visitors were generally aware of the evidence base, but were not always able to maximise use of their knowledge through skilled communication due to a range of barriers (e.g. pressures of time, feeling stressed). It was therefore decided that a broader concept of a “toolkit” would be more useful. The third phase therefore included the following range of provision:

- physical resources (for staff and client use): e.g. checklists, guidance, forms, leaflets, books, equipment, training packs;
- virtual resources (for staff and client use): web pages (http://www.bartshealth.nhs.uk/health-visiting), links, evidence briefings;
- training (by a variety of local agencies), to enhance staff knowledge, skills and team working;
- networking, to enhance staff’s knowledge of the local resources provided by the borough and third sector organisations; and
- support for staff’s own wellbeing and morale (supervision and team development, and awaydays, which combined work-related discussions with ‘pampering’ such as massage and supportive supervision).

These are described in detail in Davis (2014).

In the fourth phase, CUL evaluated phase 3, and it is that evaluation which is reported here.

**METHODS**

Qualitative semi-structured interviews were chosen as the method of gathering data. The topic guide appears in Box 1. Relevant team leaders were asked to facilitate contact between the evaluator and those health visitors who had taken part in the project. These were contacted by e-mail, and those who responded either straight away or after prompting were interviewed at their workplaces. Interviews were audio recorded. Research ethics committee approval was not necessary as this was an evaluation, but the principles of informed consent, anonymity and confidentiality were observed throughout.

**FINDINGS**

Seven health visitors from two localities (all female) were interviewed. They described their responses to many of the components of the project. Table 1 itemises which health visitors had experienced which components of the project. Only those data that relate to empowerment are reported here. Two interviews were not recorded, one because of equipment failure, and one because of the preference of the health visitor interviewed: detailed notes were taken during these interviews, and typed soon afterwards.

Health visitors identified a number of ways in which they felt empowered by the project:

- knowledge;
- materials; and
- psychological support.

They also identified aspects of the project that had tended to make them feel less rather than more empowered.

**KNOWLEDGE**

Some knowledge gains were reported. Two mentioned that they had been introduced to some new ways of helping families of children with sleep problems, while another who had not previously worked in the locality valued ethnic-specific information relating to speech and language development. Two had been to the networking event and had been introduced for the first time to a number of local third sector organisations that supported families with young children, to which they or their colleagues had since referred clients. Another health visitor had learnt a new and useful technique from the communication skills training.

- Generally, however, the health visitors had not themselves acquired significant amounts of new knowledge from the project and its components. Much more commonly, though, those interviewed spoke of the value of the training as a ‘refresher’, which both reminded them of what they already knew and provided an opportunity to reflect.

  - It’s always good to refresh with speech and language what is good for a year, fifteen months and so on…. You don’t see these children routinely any more. Suddenly one pops up at say fifteen months and you think, How many words should that child have? (HV2)

  - The attachment stuff is always good to go over again. It refocuses you and it makes you think about it more. (HV2)

One, who had also particularly valued the day on perinatal health and attachment, added that though for her, the training was more a refresher, this was not necessarily true for her colleagues:

  - Any study day that you do, you come away and you think, Right, let’s really hone our skills back on it again. I think that it is good to get you re-focussed. But certainly for junior members of the team, they thought that it was invaluable. (HV4)

However, another felt that, as more junior colleagues were the target audience for a lot of the training, attendance by more experienced health visitors was not the best use of their time.

**MATERIALS**

Health visitors were full of praise for the information packs that came as part of the sleep training, and which they could give to families.

- We have got like little packets of information about different sleep training techniques, which have been very useful to give out to parents (HV5)

  - Lots of them [parents] were using the leaflet and they would say: ‘I used the leaflet, and I tried this and I tried that, and it is working.’ (HV1)

Similarly, all the health visitors were pleased to have the new leaflet (Barts...
Table 1. Project components experienced by those interviewed

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Health, 2014) explaining their role:
I always give out the health visiting leaflet because I think that the general public really
don't have a clue about what health visitors are. I always give them a verbal explanation
on what a health visitor is, but... It makes us look a bit more professional I guess, and it
validates our role a wee bit. (HV4)

The books provided were thought to be
well-selected. Generally, they did not
provide the health visitors themselves
with new information, rather, they
supported them in giving information
to others. One who ran a sleep clinic
sometimes lent relevant books to clients,
and others recommended them to
student health visitors on placement
with them.

We have students in the office, and if
there's a quiet moment before they are
waiting for us to go out on a visit, they are
always looking at them…. They were very
much appreciated. (HV2)

The website was another resource that
those interviewed did not use much
themselves, but did mention to others,
including to student health visitors and
to clients.

PSYCHOLOGICAL SUPPORT
Though the training had not exposed the
health visitors to much new information
or ideas, it had been invaluable in
providing affirmation and reassurance.
It was inspiring, and reassuring that the
work we are doing counts – empowering:
you to believe in yourself a bit more. (HV6)

Sometimes when you work with families
where you are struggling with emotional
and mental health, it is about recognising
that we can’t always fix it... What came
out was really that there is no magic phrase
that you can say. And sometimes you
need to hear that, because you think ... I
am not doing something that I should be
doing. But actually it is because these are
very complex situations, often with very
vulnerable families and there is no magic
fix, it is about long term work ... That was
such a good thing to hear, actually. (HV5)

One talked about being more motivated
to pay attention to perinatal mental
health at every contact with a mother,
whereas before she had tended to do so
only at the six-week check. She also felt
more motivated to provide follow-up
appointments.

If a client has got a problem, it means
sitting back and just listening. If I cannot
provide a solution there at the clinic, I will
actually make an appointment... When it is a
busy clinic what I will do is a follow up home
visit, so we can talk about this more. (HV3)

The health visitor who ran the sleep clinic
had evidence suggesting that other
health visitors, not interviewed as part
of the evaluation, were also feeling more
confident in their practice.

I am definitely getting referrals for the
more complex mothers and not [any more]
for the bread and butter management
stuff. So that is good, definitely good. (HV4)

Restorative supervision was provided
by the local psychology service, and
had been useful not just in helping
individuals think through how to deal with
particular challenges in life or work, but
more widely.

Very helpful – it was about boosting
self-belief, reminding you that the work is
worthwhile. (HV6)

One health visitor spoke of the service
providing the supervision as follows:

I always think that having a day with a
psychologist is like being wrapped up in a
blanket and looked after. Because they are
really skilled. They are really skilled and they
really understand health visiting. So they
are realistic about what we can do and about the
reality of our workloads and of the challenges
some of our families face, so it is very
grounded in reality... We have supervision
with them once a month with them and it is
by far the highlight of the month. (HV5)

WHAT WAS DISEMPOWERING?
Aspects of some parts of the project were
experienced negatively, and these are worth
mentioning here as an illustration of how
administrative and organisational decisions
can sabotage the good intentions behind
projects such as this.

First, some awaydays that were designed
to make staff feel ‘pampered’ were perceived
to have been badly organised, which had
therefore been irritating rather than nurturing.

Second, as already mentioned, some health
visitors felt that the training had been more
useful for less experienced and qualified
members of their teams, and were therefore
not the best use of their own time. On the
other hand, some valued the sense that
teams now knew that they shared the same
knowledge base.
Third, although the experience of restorative supervision was very positive, even for those who had been resistant to the idea, the experience was marred by a Trust plan for health visitors to themselves be trained to provide restorative supervision to colleagues. This felt like a cause of additional work and hence of additional stress.

DISCUSSION
The initial motivation behind the Toolkit project was to ensure that health visitors were using evidence-based practice to enable them to provide the highest quality care for families in Tower Hamlets. Once it had been established that in the main their knowledge base was up-to-date, the focus of the project became the support that the health visitors needed. Research on the use of evidence in practice, over many decades, has shown that barriers to research utilisation need to be addressed (Bero et al, 1998, Bryar and Griffiths, 2003). This project has reinforced the evidence that health practitioners may be very skilled and knowledgeable but do not have the time, resources and support to make best use of their knowledge in practice. The wide range of interventions used in the Toolkit Project was shown in this evaluation to have empowered health visitors in their work with families. Refresher training in topics key to health visiting practice, for example, had succeeded in reasserting and motivating them, not least by emphasising the importance of their role. As another example, the provision of relevant and recent materials to give to clients supported them in making effective contact with clients: the materials endorsed the advice that health visitors gave warmly and in that way empowered them.

The study had some limitations. The size of the sample was small, and included only experienced health visitors. However, one could argue that if such a group felt empowered by the project, then those with less experience, knowledge and confidence would be as or more likely to feel empowered. Another limitation was that it was not possible, due to limited resources, to test the self-reports of health visitors by observation, consultation with colleagues and clients, etc.

Hawks (1992) argues that a key factor in empowerment is the existence of a nurturing and caring environment. The mixture of relevant materials, refresher training and supportive supervision that the project comprised was successful in helping the health visitors interviewed to feel more supported and thus empowered in their work with families. Evidence from the health visiting early implementer sites (Department of Health, 2013) and other projects which have used innovative methods to develop and sustain health visiting services (for example, James et al, 2015) indicate that empowerment of health visitors through a multi-faceted approach is most effective. One thing that those commissioning and managing health visiting services may wish to take from this project is that the value of training is not just the receiving of knowledge and acquisition of skills. Staff may feel more affirmed and motivated by the provision of relevant training and support that might not be indicated by a strict needs analysis. Keeping morale and commitment high may benefit from a more nurturing model of training than is often the case.

ACKNOWLEDGEMENTS
We are grateful to those who agreed to be interviewed, to The Burdett Trust for funding, and to Claire Davis, the clinical project manager.

Key points

- A project to empower health visitors provided improved resources, training and restorative supervision
- Training had provided affirmation, reassurance and the opportunity to reflect
- New printed and online information about health visiting and child care issues were very helpful for families
- Restorative supervision had provided support for the wellbeing and morale of health visitors
- Overall, health visitors reported feeling empowered by the project

COMPETING INTERESTS
Neither author has any competing interests.

References
**Can you reduce the risk of an infant developing eczema?**

*Tanya Wright BSc Honours MSc Allergy HCPC Registered Dietitian MBDA*

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

**Eczema is a growing modern epidemic**

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

**Its impact extends to the whole family**

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

> "It is important to understand there are things we can do to help babies at risk of eczema and reduce the burden of this condition."

**What are the options for feeding infants?**

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

**What the guidelines recommend**

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

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- Use from first formula feed
- Omega 3 and 6 LCPs
- Easy to digest

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6. EAACI Food Allergy and Anaphylaxis Guidelines 2013.

**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.

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Exploring the support mechanisms health visitors use in safeguarding and child protection practice

JUSTINE ROOKE  FHV
Health Visitor - Practice Teacher
Harrogate and District Foundation Trust

ABSTRACT
Health visitors lead the Healthy Child Programme (HCP), a universal public health service designed to give children the best start in life. Running through the HCP are responsibilities to safeguard and protect children. Supporting the role of the health visitor is essential to ensure quality interventions and improved outcomes for children.

This article describes an empirical study. It explores the experiences and views of health visitors on the mechanisms of support they use for working in child protection and safeguarding. A qualitative approach was used to collect data from two focus groups. The data produced was transcribed and a thematic analysis used to produce the results.

The results demonstrate that health visitors gain the majority of their support from their colleagues and from supervision processes. Also identified from the data analysis were three factors which health visitors felt supported their role. These were support for managing the emotions associated with child protection work, feeling safe and effective in practice and having time to reflect and evaluate casework.

KEY WORDS
Safeguarding, Child protection, Support, Health visitor

INTRODUCTION
Safeguarding and child protection practice has been acknowledged as having a fundamental role in the health visiting service (DH, 2011). Being a universal service, health visiting is ideally placed to identify vulnerable children and those at risk of abuse (DCFS, 2008). Recent socio-political influences affecting health visiting (DH, 2011) as well as recommendations from reports such as Laming (2009) have suggested health visitors require good support to fulfil their role. Further recommendations (Munro, 2011) advocate that safeguarding practice should be based on sound professional judgements and partnership working with families. The Munro Report (2011) particularly criticised the procedural and task orientated systems entering child welfare services. If health visitors are to use their professional judgement and remain responsive and attuned to the needs of children then support is essential. It is also important to gain knowledge and understanding on this support and how it occurs in practice.

Health visiting has been acknowledged as a profession which is exposed to high levels of stress and anxiety (Wallbank and Hatton, 2011). Anxiety has been acknowledged to run throughout the safeguarding role (Morrison 2006). If health visitors are to use their professional judgement and remain responsive and attuned to the needs of children then support is essential. It is also important to gain knowledge and understanding on this support and how it occurs in practice.

DEFINITIONS OF SUPPORT
Support is defined by the Oxford dictionary as; “To keep something from falling, to give strength, help and encouragement” (Oxford Dictionary 2011 p595). Cohen and Willis (1985) acknowledge support as having two main functions, that of providing another with strength and connection, and increasing self-efficacy or the belief in one’s ability to cope. Plews et al (2005) illustrate a taxonomy of support and its benefits in Box 1;

STUDY AIMS
The specific aims of this study:
• To examine the experiences of health visitors who work in child protection and safeguarding.
• To discover what health visitors view as supportive in their role.
• To understand the impact of support on health visitors.

METHODOLOGY
The study used a qualitative approach to collect data from a sample of health visitor participants. Participants were emailed and asked to express an interest in taking part. Ten health visitors expressed interest, so two focus groups were compiled with five participants in each. The participants were a homogenous group of white British women. Diversity occurred in

Box 1 Taxonomy of support

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<tr>
<td>Emotional support allowing the person to feel cared for.</td>
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<tr>
<td>Social integration or being part of a network.</td>
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<tr>
<td>Bolsters self-esteem.</td>
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<td>Offers advice.</td>
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<td>Provides information as part of a network of reciprocal help.</td>
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<td>Instrumental aid.</td>
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terms of their age and the length of their practice experience, this ranged from very experienced to newly qualified.

Focus groups were chosen as the method of data collection as these are known to facilitate discussion on feelings, experiences and opinions (Denscombe, 2012). Data was collected by asking open questions and then analysed using a thematic approach which included recording, transcribing and coding the 'raw data.' The results were later checked with the participants for accuracy.

Ethical approval was gained from the university’s ethics approval panel and Trust research governance agreed and followed. The ethical issues relevant to this study were to protect the psychological well-being of the health visitor participants and to ensure no harm was done whilst undertaking the study. Self-disclosure was a large part of the study and efforts to ensure safety were maintained by following professional guidance and the Nursing and Midwifery Council (2008) Code of Professional Practice. A debrief session was used to discuss emotive issues raised in the focus groups.

RESULTS
The results suggest that health visitors gain support through both formal and informal mechanisms of support. Box 2 describes a thematic analysis of the transcriptions that the participants viewed as supporting their child protection and safeguarding role. These are broken down into themes and sub themes.

SUPPORT FOR MANAGING EMOTIONS
The results suggest that health visitors gain the majority of their emotional support through contact with their colleagues. This occurs in both day to day interactions and through organised supervision forums. Anxiety was noted to increase for health visitors when clinical risk increased or isolation occurred, and more so if both occurred together. Health visitors’ anxiety was reduced by having contact with someone who could talk through their safeguarding concerns. Health visitors felt supported by speaking to experienced colleagues, the Safeguarding Children team, and social workers if involved.

“‘There is nothing worse than needing help and it not being there. You think to yourself what am I going to do now?” (HV6).

‘It makes your practice different when you have spoken to someone. More clear in your mind (HV6).

‘Some things are anxiety provoking. We are accountable for what we do and don’t do. So if harm comes to a child because of a failure on our part, you’ve got to take that into consideration’ (HV2)

The effects of experiencing negative emotions such as anger, fear, and sadness in child protection cases were identified by all the health visitors. The participants explained they coped with these feelings in a variety of different ways. Coping mechanisms ranging from the use of humour, described within a professional context and as a means of distancing and reframing the experience (Moran, Hughes, 2002), to the need to talk with colleagues, to share feelings and to make contact with the Safeguarding Children Team. The cases described which required the most emotional support were those which left the health visitor feeling powerless to prevent.

Examples included families exhibiting disguised compliance and emotional neglect, or when the health visitor held intuitive feelings for the parent or child and felt unable to evidence their concerns.

‘It makes you feel overwhelmed for starters, not being able to deal with the issues causing stress’ (HV 6).

‘At times you’re seeing situations that are beyond your control and you can’t change it, you can’t always make it better’ (HV 2).

In contrast the emotional effects of being involved with physical and sexual abuse, although difficult and having an impact created less need for support as these cases were generally prioritised and actioned by Children’s Social Care.

SUPPORT TO PROVIDE SAFE AND EFFECTIVE PRACTICE
The results of this theme were dominated by the health visitors’ opinions of their own contribution and whether they felt they were providing a quality service which protected children. It is succinctly illustrated by the words of a participant.

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‘Ultimately you want to know that your practice is good. You could be thinking I may end up in court’ (HV 7).

Day to day interactions with colleagues were again defined as an important and beneficial aspect for delivering safe and effective practice. Discussions with colleagues enabled the health visitors to share learning and advice and make sense of their experiences. Health visitors described the importance of predictable and consistent advice between colleagues to remove uncertainty and doubt in practice.

Being an authoritative practitioner who was able to challenge both families and other professionals, was connected to safe and effective practice. Assistance and support to challenge in child protection work was identified as important for maintaining accountability and improving the assessment process in multi-agency working. Newly qualified health visitors found this aspect of the role more difficult to undertake, especially if their decisions ran at a tangent to other agencies.

‘Support to challenge is really key. Newly qualified staff have said to me ‘I am glad you went with me [child protection conference], I don’t think I could have done that’ (HV 3).

Gaining regular feedback on casework and debriefing sessions with an experienced practitioner, was reported to be of benefit to the delivery of safe and effective practice. This was cited as very beneficial to health visitors especially after they had been involved in a critical incident or where a case had escalated or a child had been harmed. The need to contact someone more senior or experienced for immediate support was reported to happen informally, in both an official and private manner. Having access to informal support such as peers, to discuss case work allowed health visitors to explore the intuitive feelings and hunches the health visitors associated with the responsive and relational aspects of their practice. When health visitors did not access supervision or training they described feeling caught in a ‘spiral of demand’ and found it hard to problem solve and think clearly.

‘Doing, doing, doing and not taking the time out to think, when do we think what am I doing here?’ (HV 8).

‘It was great to have time out to breathe and it brought up a few issues which I had never thought about, which I could address’ (HV3).

‘It’s great, I could not see the wood for the trees, but it has opened up an opportunity to think’ (HV6).

DISCUSSION

Support for health visitors working in safeguarding and child protection was generally required in connection to the management of risk and the containment of emotions. Health visitors required increased support if the children they are responsible for were perceived to be at risk of either harm, significant harm or if their concerns were difficult to evidence, prevent or were ongoing. The anxiety health visitors described came mostly from worries about failing to protect.

Support was accessed from a number of sources. Having access to informal support such as peers, to discuss case work allowed health visitors to think, plan and evaluate cases and it was cited as important to embed learning in practice. Having protected time out was reported to allow space to explore the intuitive feelings and hunches the health visitors associated with the responsive and relational aspects of their practice. When health visitors did not access supervision or training they described feeling caught in a ‘spiral of demand’ and found it hard to problem solve and think clearly.

‘Doing, doing, doing and not taking the time out to think, when do we think what am I doing here?’ (HV 8).

‘It was great to have time out to breathe and it brought up a few issues which I had never thought about, which I could address’ (HV3).

‘It’s great, I could not see the wood for the trees, but it has opened up an opportunity to think’ (HV6).

The requirement of clear lines of individual accountability and responsibility limit the effect of peer support in risk management. In practice, as clinical risk increases health visitors contact their Safeguarding Children team to support their decision making and to ensure correct Trust procedures are followed. It was cited as important for health visitors to access this support in a timely manner for it to be beneficial to practice.

Formal supervision mechanisms were reported to be highly effective for supporting child protection and safeguarding practice. Child protection group supervision was reported to provide structure, reflection and guidance on dealing with accountability and risk.

The results did suggest a distinct when the benefits health visitors gained from group child protection supervision and individual supervision. Individual clinical or restorative supervision reported to be more informal and useful for dealing with the emotional elements of the role, whereas, child protection group supervision reported to be beneficial for accountability, outcomes and actions. These results would suggest the need for both types

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of supervision to continue to adequately support health visitors in practice. In relation to multi-agency working, health visitors described feeling supported by policies and procedures which helped them to challenge. Challenge was connected to the health visitor being able to articulate assessments of need and escalate concerns. Differing thresholds for intervention were identified as the main barrier to this, with health visitors feeling their preventative role was limited if their referrals were not acted on by Children’s Social Care or Children’s Centres. Despite evidence of the detection of risk factors improving (Brandon 2005), feedback from other reports (Laming 2009) has suggested that children can be known to agencies prior to harm occurring. When referrals were not acted on, health visitors described feeling responsible for monitoring and continuing to review the child, this subsequently affecting the delivery of the universal functioning of the Healthy Child Programme.

RECOMMENDATIONS
The knowledge gained has informed a number of recommendations to support health visiting practice locally. These are identified in Box 3. They include the development of forums, which allow peers to meet and discuss cases after incidents. Peer support sessions would create additional opportunities for learning to take place in practice and may be required more with the onset of mobile working. Looking to the future an integrated approach to training and supervision may also help to overcome the problems attributed to organisational barriers such as thresholds and referral criteria. The support of student and newly qualified health visitors should be given priority. Emotive reports came from the transcriptions of newly qualified health visitors after being exposed to child protection. At times this was reported to make them feel shocked and question whether they wanted to be part of the profession. ‘The first meeting I went to I nearly cried. It made me question whether I wanted to be a health visitor’ (HV 5).

A robust period of preceptorship is recommended for all newly qualified health visitors teams who have had limited exposure to previous child protection practice work. This transition between qualifying and entering the SCPHN register is now recognised as an extremely sensitive time for practitioners (DH, 2012). Preceptorship is becoming fully embedded in practice and the importance of this is highlighted and recommended to continue.

CONCLUSION
This study has highlighted the importance of support for maximising the impact health visiting has on outcomes for children. Peer support has been identified as one of the main sources of support in safeguarding and child protection practice. This support is limited, however, in terms of its responsibility and accountability in decision making processes. Support mechanisms therefore, have to be part of a wide network, which include processes for dealing with escalating risk, evidencing professional judgement, and evaluating practice. There is emerging evidence to suggest that supporting staff leads to improved outcomes for children (Glissen and Green, 2011, Hamama, 2012). However, the challenge for the future exists on how health visitors demonstrate to commissioners that support can impact on child health outcomes. Staff support is closely aligned to the ability to safeguard and protect but it is a topic that requires further evidence to substantiate and demonstrate it. Building and evaluating practitioner support is an essential requirement for all organisations employing child protection practitioners.

Key points
• Health visitors are exposed to anxiety when working in child protection and this can increase if they work in isolation.
• Health visitors identified their peers as the main source of support for dealing with issues in child protection practice.
• Different support mechanisms are being used for the restorative elements of child protection practice and for the management of clinical risk.
• Health visitors identified a need for additional support in their child protection or safeguarding role when challenging other agencies.
• Newly qualified health visitors should be supported through a preceptorship process.

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A Preceptorship Model for Health Visiting

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ABSTRACT
Many new qualified health visitors may find the transition from being a student to an accountable individual practitioner a daunting prospect. Although competent and knowledgeable, they may feel the need for support and guidance of more experienced professional colleagues as they find their feet in professional practice. The same may apply to those who have returned to practice after a break of five years or more. It may also apply to those who move from a different area of practice by virtue of a new registerable qualification, for example a registered nurse who subsequently qualifies as a health visitor. Feeling valued and invested in by the employing organisation does have benefits to the children, families and communities with whom we work. Building professional resilience and developing and maintaining up-to-date knowledge will inevitably provide a high quality delivery of equitable services. This paper discusses the findings from a six month pilot of the HEE/iHV (2014) National Preceptor Framework for health visitors, exploring the impact of the implementation of the health visitor Preceptorship framework. Whilst the pilot lasted just six months, early indications suggests a positive impact on the staff and the children, families and communities we serve.

KEY WORDS
Health visitor, Preceptee, Preceptorship, CPD, Retention

WHY DO WE NEED TO SUPPORT NEW HEALTH VISITORS?
The profile of health visiting education has been raised considerably since the Health Visitor Implementation Plan 2011–15: A Call to Action (Department of Health, 2011), which presented a real opportunity to strengthen and grow the health visiting workforce. The result of this rapid expansion of the health visiting workforce is that there is a large percentage (46%) HSCIC (Sept 15) in some areas of new and recently qualified practitioners, each requiring robust preceptorship and support in their first two years of practice. Just as education in the first two years of practice is important, having access to continuing education throughout professional careers is vital (McInnes 2013). “A Health Visiting Career” (DH, 2012a) highlights that completion of the Specialist Community Public Health Nursing (SCPHN) health visiting qualification, is only the start of the journey for continuous learning, growth and for the profession. All health visitors must be enabled to access and demonstrate achievement of continuing professional development (CPD) to meet the revalidation requirements for future registration to practice (Nursing and Midwifery Council, 2011). Evidence also indicates that care and the retention of staff is compromised if staff are not provided with access to professional education and training (Francis, 2013; Whittaker et al 2013). Willis (2015) in the Shape of Caring review, identified that further focused reviews are needed on the purpose of preceptorship and whether, in addition to being provided during the transition period, it should also be offered as a formalised follow-on programme. In this way, newly qualified health visitors (NQHVs) would be encouraged by preceptors to consider their future career pathway and create an appropriate foundation for this in their personal development plan.

THE PRECEPTOR FRAMEWORK
The Preceptorship framework aims to provide the basis for local organisations to develop a custom-made preceptor programme appropriate for the local area profile and priorities. It is outcomes focused and intends to:
- Set out best practice in health visitor preceptorship and consolidation of learning in the first two years of qualifying.
- Promote an understanding of the need for protected time for new or returning health visitors, preceptor period and activities.
- Promote an understanding of the need for protected time for managers and other staff responsible for organising preceptorship.
- Ensure organisations provide an equitable structure for all employees.

A 3-STAGE MODEL FOR DEVELOPING A SUCCESSFUL LOCAL PRECEPTOR PROGRAMME
The framework follows a simple 3 stage approach with the focus on best practice.
1. Preparation 2. Embedding 3. Sustainability

Stage 1. Preparation of a Preceptor Programme
Preparation is key to the success of a preceptorship programme. Forward planning by organisations to allocate preceptors to preceptees should occur in advance of the new practitioners starting in practice. Deciding which model of preceptorship to use depends on the local organisational structure, geographical spread and most importantly the number of new practitioners arriving.

Stage 2. Embedding the preceptor programme
Embedding the preceptor programme involves regularly undertaking reflective practice and building resilience to ensure good health as well as access to supervision on a regular basis. Having an action plan defined by a learning contract will enable the preceptee to take ownership of their development.
Stage 3. Sustainability of the individual’s accountability
The sustainability phase should enable the preceptee to prepare for revalidation of their NMC registration and to provide continued protection of the public.

PRECEPTORSHIP MODELS
The Nursing Midwifery Council (NMC 2009a) suggests a period of preceptorship when moving to a new and different role. During the induction period the new health visitor (preceptee) should be introduced to their preceptor and be ready to start a preceptorship programme. During this period the new health visitor should work through a self-directed programme with a named preceptor.

Models available for organisations to consider are:
- 4-6 weekly meetings 1:1 with a practice teacher (PT)/HV;
- 4-6 weekly facilitated by a HV/PT- group (recommended up to 8 NQHVs);
- Combination of both.

A pilot study was conducted in eight different organisations across England employing health visitors (Rural, urban, city and London) funded by Health Education England to look at the implementation, usability and value to not only the families with whom we work but to individual practitioners and their organisations. During the pilot, the eight test sites were evenly divided between the different models of preceptorship. Figure one demonstrates the favoured model over the six months. A combination of both 1:1 with a practice teacher/manager and group facilitated support was the preferred model. The reasons for this included: the importance of involving the manager and practice teacher in meetings; preceptees benefited from group facilitated meetings where they discussed specific topics relevant to practice with a preceptor present; building up peer support networks (see Figure one).

Preceptees comments on the models of preceptorship included several about how the arrangements work in practice:
“Sometimes (it’s) difficult for staff to meet up for group sessions because of the geography of the area and time taken to travel to meetings/fit in with caseload requirements, especially if working part time.” (Newly Qualified Health Visitor)

“The Preceptor is usually in the same base, so has daily contact with time set aside for completing the more formal parts of preceptorship.” (Practice Teacher)

SAFEGUARDING CASELOADS
During the focus groups and interviews the anxieties around when and in what format taking on safeguarding cases was discussed. The participants all felt the preceptorship framework required to have a statement added to provide clarity around this area. We devised a statement which was then tested with all eight pilot sites. The final framework (2015) has this added:
“Co-working is recommended for families with known safeguarding issues (section 17 and 47) within the first 6 months. Naturally arising safeguarding issues should be taken back and discussed with the preceptor and line manager. Ideally, NQHVs should experience safeguarding families in the first 6 months. However for best practice the ideal time should be discussed between the NQHV and their manager” (HEE/ iHV (2015))

A preceptee commented:
“My main anxiety was taking on safeguarding clients. I co –worked families in the beginning, had help in writing reports and attending my first conference. Now I am doing this on my own. Having a ‘buddy’ has helped hugely”

The pilot process provided the opportunity to make any necessary amendments to the preceptorship framework. We listened to the feedback and added in 3 (validated) important statements:
1. 10 top tips for organisational leads on implementing and embedding the framework.
2. A statement to support the role of the new health visitor whilst waiting for the NMC PIN number for families with safeguarding concerns.
3. 10 top tips to developing resilience in practice.

EMERGING THEMES
During the six month pilot three themes emerged:
Communication
We asked: How effective is communication with your organisation and manager?
We heard: Tripartite meetings were very useful. The preceptor met with the preceptee and team manager 3 times during the preceptor programme. The meetings were for 2 hrs and all relevant staff involved felt this was a suitable length of time. This was found to be very valuable for the following reasons:
- Highlighted to the manager the importance of providing a ‘buddy’ to co-work safeguarding clients rather than just focusing on KPIs.
- Participants felt this 3 way meeting would have a positive impact on staff retention.
- Allowed the Practice Teacher to step in if the preceptee felt pressurised to take on too many safeguarding clients.
- Allowed a 3 way conversation to meet the service and the practitioner’s needs at an early point.

“I understand the pressures on managers but I felt sometimes they were ‘papering over the cracks’. Having the tripartite meeting allowed the manager to understand the longer term benefits of putting the right support in from the start.” (Practice Teacher)

Support
We asked: What support do you have from your manager and teams?
We heard: Good support from the team is very important; new staff welcomed it. On reflection, interviewees wondered if the introduction of mobile working may adversely affect capacity for team support when welcoming new staff.

“When you first arrive you feel quite vulnerable in a team where there is a lack of positive support. I moved base after 4 months and now feel more confident in my role and have a great ‘buddy’.” (Newly qualified health visitor)

“This year is much better with the ‘buddy’ arrangement. This is having a positive impact on experienced staff. We are beginning to see the benefits of ‘call to action’” (Practice teacher)

Benefits
The benefits of preceptorship for children and families
We asked: Do you think preceptorship will benefit the children and families in our communities?
We heard: Every respondent felt Preceptorship would positively benefit children and families, relating the benefits to support within the teams.

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“Supervision, daily support from a ‘buddy’ and planned meetings means I feel a confident practitioner.” (Newly qualified health visitor)

“If we provide a safe meeting place where they [preceptee] can share anxieties, they feel restored and allows them to do their job 100%.” (Practice Teacher)

The benefits of preceptorship for staff retention

We asked: Do you think preceptorship will benefit staff retention?

We heard: Perceptions of the impact on staff retention from the practice teachers were positive, although it is too early to provide numerical data to support perceptions. They indicated that in relation to this time last year they were experiencing fewer anxieties from the new staff, and experienced staff were beginning to feel the benefits from additional staff.

“Last year, before we had a preceptor programme in place, staff were leaving due to heavy caseloads and stress. Newly qualified staff not being supported in the right way had a knock on effect on experienced staff, making them feel exhausted. I notice a positive difference already this year. Providing the right support, a ‘buddy’ to co-work safeguarding families in the beginning means at this 6 month point all staff are beginning to feel the benefits.” (Practice Teacher)

“I asked at interviews if the organisation has a preceptor programme in place. I chose the organisation who had invested in this programme” ( Newly qualified health visitor)

WHAT DOES A SUCCESSFUL PRECEPTORSHIP PROGRAMME LOOK LIKE?

There are key components to a successful programme for organisations to consider:

- Provide a buddy system is key to daily support.
- Provide a system of co-working for safeguarding clients from day one.
- Change the culture - to embrace and embed CPD into the business plan.
- Include staff in developing the service delivery plan.
- Provide workshops between local authorities and health visitor teams to brainstorm integrated working.

RECOMMENDATIONS

Conduct further evaluation: From this short evaluation involving eight pilot sites further urgent research is now required to evaluate and compare the impact of local preceptorship programmes in those areas outside the pilot sites. Additional evaluation is recommended to measure the value of embedding CPD into organisations business planning. This evaluation identifies that preceptorship will be taken more seriously if it is included as part of the overall training model and better linked to more formal systems.

Sustainability

Best practice standards

Two key elements of preceptorship are: maintaining good communication between preceptors, preceptees and line managers and mutual support through group meetings for newly qualified staff. Senior managers should hold responsibility for creating the right conditions, as far as is practically possible, for best practice. We recommend that organisations and teams allocate a preceptor on Day 1 or before a new health visitor begins employment. Caseloads should be acquired gradually, starting with a small generic caseload from 2 weeks into new employment and building up to a full and more complex caseload after 6 months of employment. Newly qualified and return to practice health visitors’ shadow or co-work safeguarding cases from day one, and only take on named person responsibility for safeguarding cases when they feel competent to do so and on discussion with their line manager and preceptor. Equal emphasis is given to encouraging health visitors new to a role or an area to use the frameworks, in order to challenge the assumption that the Frameworks are for newly qualified staff only.

Culture change

Develop Best Practice Toolkits: As we enter a period of significant change and a shift from health led to that of joint health and social care led, we must work swiftly with organisations to develop skills in leadership for all Band 6 health visitors in order for them to be able to lead the early year’s teams across health and local authority staff groups. Enhance understanding of Outcome Measures: From this evaluation it is clear there is still work to be done in understanding the importance of the Public Health Outcomes Framework and how to use profiling effectively in the local communities.
CONCLUSION
Preceptorship should not be seen as a training course (i.e. is something that follows the education programme). Instead it should consist of at least 1 year including regular supervision both child protection (3 monthly) and clinical supervision (4-6 weekly). The end of the first year flows into the second with the preceptee organising peer supervision groups and support as required from a mentor. From day one of a career in health visiting, practitioners are encouraged to keep reflective journals both to support their practice and provide evidence for revalidation (iHV, 2014). It was clear through the stages of the pilot that we have very high quality health visiting being delivered in many areas around the country. However whilst the framework goes some way to highlighting the benefits of a preceptor programme we must do more. Urgent further research must be commissioned to evidence the effectiveness of providing a more formal preceptorship period of continuing practice development on the retention of high quality reflective health visitors.

Key points

- All health visitors must be enabled to access and demonstrate achievement of continuing professional development to meet the revalidation requirements for future registration to practice (Nursing and Midwifery Council, 2011)
- Preceptorship should include a buddy system for daily support
- Preceptorship should include a system of co-working for safeguarding clients from day one
- Organisations should consider a change in the culture to embrace CPD into the business plan
- Research must be commissioned to evidence the effectiveness of providing a more formal preceptorship period of CPD on the retention of high quality reflective health visitors.

References
Health and Social Care Information Centre (HSCIC) http://www.hscic.gov.uk/workforce
The aim of the Queens Nursing Institute (QNI) is to support the delivery of high-quality nursing care for people at home, in the community and in primary care settings. We do this in a number of ways – including the direct support of innovative projects in practice, influencing policies which impact on the delivery of high-quality care and the development and support of a cadre of outstanding nurses who are awarded the title of ‘Queen’s Nurse’.

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The QNI has for the past three years been campaigning for significant improvements in the workforce plan in order for nursing to meet the changing needs of our communities. Our activity is not limited to campaigning however – we also take practical action to make a difference.

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Dr Crystal Oldman is chief executive of the QNI

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