Invisible backbone
Members come together for CPHVA conference 2015

Member Focus
The latest #daywithdave recounts a trip to Parliament

Clinical
A guide to FGM support for members

Professional
Educating the profession on domestic violence
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 skin1 (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 itchy1 (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/00860/15.

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

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
See SPC for full details. Application site reactions including erythema, rash, pruritus, dermatitis.

Legal category
GSL.

Presentation and NHS cost
Bath Additive: 150 ml £2.82, 250 ml £3.25, 300 ml £3.89. PL 00079/0708.
Cream:

PL holder Stiefel, 980 Great West Road, Brentford, Middlesex, TW8 9GS.

Date of revision
May 2015.
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Louise Naughton

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From the leading experts in organic infant nutrition, comes the UK’s lowest protein infant milk.

Ours is the first infant milk in the UK to contain less than 2g/100kcal protein, making the protein level and quality closer to that found in breastmilk.

High protein intake in the first two years of life has been linked with an increased long term risk of being overweight or obese.

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

Discover more at hipp4hcps.co.uk

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

1 Contains 1.89g/100kcal of protein, including α-lactalbumin, making the protein level and quality closer to that found in breastmilk (1.7g/100kcal). Nommsen LA et al. Am J Clin Nutr 1991; 53: 457–465.
At the time of going to press, conference 2015 is being packed away. Exhibition stands collapsed, microphones stored, and speeches delivered. It was a hugely positive, busy and inspirational two days. I hope you thought so too.

The main stage saw Unite general secretary Len McCluskey, the NMC’s Jackie Smith, Labour leader for health in the House of Lords, Lord Philip Hunt, PHE’s Richard Janowski and The Guardian and CPHVA’s very own president, Polly Toynbee, among others. Each were full of pride for CPHVA members and the wider community nursing workforce, speaking about how crucial you all are to the sustainability of the health service.

One of the most valuable sessions for myself and for members was an intimate Q&A session with Viv Bennett, director of public health nursing at Public Health England. Members were very vocal in their concern over communicating with their new commissioners in local authorities. Tales of disciplinary action being taken against those who dare to converse with commissioners, and the familiar story of practitioners being asked to do more than they are commissioned to do were put on the table. Viv called for those present to question why lines of communication were unclear and evidence the consequences of under-commissioned services to the outcomes of children and families. Community Practitioner will be working with Viv next year on articles to help you communicate and influence the commissioning agenda. There are lots of positives and benefits to harness, and we will seek to support you in doing just that.

Myself and CP’s professional editor Professor Jane Appleton hosted a session on Writing for publication on day two. It was wonderful to see experienced and budding writers who got up early to find out tips on getting published in CP. I hope you all found the session useful and it has helped you develop your ideas to put forward for publication. For those of you that missed the session, highlights from our presentation is online at www.communitypractitioner.com As always, myself and Jane are on hand to support you in your writing journey and will always answer any questions you have – big or small – so please get in touch! As I mentioned in the session, the purpose of the journal is to connect the members with Unite/CPHVA and each other – help share best practice and communicate with your colleagues.

We had a record number of nominations made already for the CPHVA Awards 2016 at the Community Practitioner stand so thank you all for stopping by and I hope you enjoyed our yummy cakes. Nominations are open on the website so please get yours in early.

Have a very happy and healthy Christmas, see you in the new year.
CHILDREN’S DOCTORS ARE WARNING that the decline in the amount of child health research being conducted presents a risk to the health of current and future generations.

The survey of almost 2,000 paediatricians, conducted by the Royal College of Paediatrics and Child Health (RCPCH), reveals more than 80 per cent of consultant paediatricians have no programmed activities in their job plan for research, and more than half undertake no research work at all.

Of those undertaking research, doctors spend almost the same amount of time on unpaid as paid research work, and almost 90 per cent do not receive grants for research.

Professor Anne Greenough, vice-president for research at the RCPCH, said: “The level of research being undertaken into child health is worryingly low. We know there are huge pressures on the paediatric workforce but without time allocated to generating evidence to advance treatment and care, we risk not giving children and young people the level of healthcare they deserve. This will affect not only today’s children, but ultimately the health of the nation.”

The RCPCH is making a series of recommendations, which it says should be implemented urgently to reverse the trend. These include:

- Ensuring that training in research methods and associated disciplines in undergraduate and postgraduate curricula is effectively delivered, so that all paediatricians have the opportunity to get involved in research and the skills to understand evidence-based practice.
- Highlighting and promoting key research successes by paediatricians, particularly where research has led to change and produced better outcomes for children.
- Improved communication to paediatricians and their employers about the routes to obtain funding research, and the encouragement of collaborative work between organisations.
- Studying the processes for paediatric research activity overseas to learn from models of best practice that could be replicated in the UK.

Virgin wins £64m contract bid

Virgin Care has won a £64 million contract to run community child health services for the NHS, reports The Financial Times.

According to the broadsheet, the privately-owned company has won a five-year contract providing children’s specialist community nursing, health visits, speech and language therapy in Wiltshire.

It is claimed the Wiltshire services are currently being provided by five NHS providers but the new contract will start in April 2016.

Jayne Carroll, regional director at Virgin Care, told the FT: “The changes made will help children’s community health services in Wiltshire to continue to meet its statutory duties.”

Neglect “the most common reason” for adults to contact the NSPCC

FEW ADULTS CONTACT THE NSPCC helpline with concerns about teenagers suffering from neglect, despite neglect being the top reason for contacting the charity when it comes to younger children.

The NSPCC has called on adults to be more alert to teenage neglect after the charity released new figures in its Hurting Inside Report, which revealed just 16 per cent of the 23,037 children reported by the public and referred by the NSPCC helpline to police or children’s services because of serious concerns about neglect last year, were regarding children aged 12-18.

At the same time, less than one per cent (1,016) of the children who contacted the NSPCC’s ChildLine service last year directly indicated that they were being neglected by their parents or carers – despite it being the UK’s biggest child protection concern.

The NSPCC believes its figures show there may be an underreporting of older children suffering from neglect and that thousands of adolescents may not be receiving the support they need at a crucial time in their lives.
Support breastfeeding to reduce effects of poverty, says new report

LOCAL AUTHORITIES ACROSS
London should support breastfeeding to tackle food poverty, according to a new report.

Beyond the Food Bank: London Food Poverty Profile 2015 recommends implementing the Unicef UK Baby Friendly standards on infant feeding and nurturing, which would have a particular impact on those living in the worst deprivation.

While breastfeeding improves the wellbeing and health outcomes of mothers and babies in the long and short-term, low-income women who leave school early are least likely to breastfeed, compounding the effects of poverty.

As deprivation levels rise, women are less likely to initiate breastfeeding;

just three-quarters of women (73 per cent) living in the most deprived areas in England, compared to nine out of 10 (89 per cent) women living in the most affluent areas – a difference of 13 per cent.

The Baby Friendly Initiative has been shown to be effective at reaching mothers from disadvantaged backgrounds and increasing the likelihood of them breastfeeding for longer.

Crucial developmental checks “may have been missed”

There is no evidence that 46 per cent of premature babies receive a two-year developmental health check, the Royal College of Paediatrics and Child Health’s latest neonatal audit has shown.

Premature babies could be missing out on vital developmental health checks at age two, increasing the likelihood of missing significant disabilities being missed and delaying specialist care.

Doctors say the findings raise “major concerns” that disabilities caused by impairments such as cerebral palsy, visual impairment and intellectual developmental delay could be missed, only to become apparent later in childhood.

The Annual Report of the National Neonatal Audit Programme also identified communication worries, with 11 per cent of families not recorded as having a consultation with a senior member of clinical staff within 24 hours of their baby’s admission to the neonatal unit.

Consultation open on scope of whistleblower guardian role

HEALTH PROFESSIONALS are being invited to help shape the National Guardian role specially created to support whistleblowers and improve reporting culture.

The National Guardian has been created as a result of recommendations from Sir Robert Francis’ Freedom to Speak Up review and will be based at the Care Quality Commission (CQC).

The independent role will provide national leadership to a network of Freedom to Speak Up Guardians across NHS Trusts.

Open until the 9 December 2015, the consultation will help shape how the National Guardian will operate, and its scope and specific functions.

New mothers feel uncomfortable about breastfeeding in public

MORE THAN ONE-THIRD OF BREASTFEEDING mothers shy away from doing so in public, with one-in-five feeling people do not want them to breastfeed in public.

Start4Life, Public Health England’s parenting advice service, released the findings as it launched new animated short films supporting the campaign for breastfeeding in public.

The Start4Life poll showed 72 per cent of people support public breastfeeding. Despite this, six out of 10 mothers who breastfeed hide it in public and more than one-third feel embarrassed or uncomfortable.

One in 10 who choose not to breastfeed said the worry of doing so in public influenced their decision.

Dr Ann Hoskins, deputy director, health and wellbeing, healthy people at Public Health England, said: “Anxiety about breastfeeding in public certainly shouldn’t be a barrier to breastfeeding in general.

One of the great benefits of breastfeeding is that it can be done anytime and anywhere, so as a society we need to help new mothers feel comfortable in feeding their babies wherever and whenever they need to, and we all have a role to play in that.”

500k households could be out of poverty if they quit smoking

More than 1.4 million households with a smoker are living below the poverty line, according to analysis from Action on Smoking and Health (ASH).

The national data shows that, of the five million households in England that include an adult smoker, 1.4 million (27 per cent) are below the poverty line, and an estimated 418,000 households could be lifted out of poverty if they quit smoking.

Mike Hobday, director of policy at the British Heart Foundation, said: “These figures are a timely reminder of how this deadly addiction is contributing to thousands of people living below the poverty line, as well as doubling their risk of suffering a heart attack or stroke.”

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Making an impression

The latest #adaywithdave recruit recounts her trip to Unite HQ and Parliament for an audience with the Minister of State for Community and Social Care

Jennifer Harmer

HAVING DAVE MUNDAY AND
Ros Godson speak to our cohort at university, reading other students’ experiences on #adaywithdave in Community Practitioner and becoming more engaged with CPHVA via the weekly twitter chats, all contributed to me applying for my own day with Dave. My aims were to gain further insight into how the CPHVA works both with and for its members within a local and national context. The day started with a bit of reminiscing for me being back in the capital, having completed my original paediatric nursing diploma in London for which I had lectures at St Bartholomew’s Hospital. Walking through the city to Unite HQ in Holborn took me back to my student days wandering to lectures among the throng of city workers.

It was great to meet Dave properly, and good to chat without being limited to 140 characters. Dave explained the plans for the day – we were to spend the morning in the office meeting some of the team, and in the afternoon we had been invited to attend a seminar by the National Children’s Bureau. It was great to discuss how the CPHVA works both with and for its members within a local and national context.

The presentations on integrated reviews were also very interesting. The Islington and Warwickshire sites featured in the discussion had different approaches to integration. Warwickshire used shared paperwork, enabling integration without needing to coordinate all stakeholders meeting together. Islington had trialled joint meetings and it was interesting to hear how they had implemented these and reported positive outcomes, although long-term effectiveness of the reviews and funding are still to be secured. Also, the original developmental review system continues to run in tandem for those using childcare outside of the borough or not accessing any childcare, with concerns that some of those most in need may be missing out.

Another typical element of #adaywithdave seemed to be a trip to Westminster. So, it was with great disappointment that I realised a few days before my trip that the Labour Conference clashed with my day, and so a trip to Parliament was unlikely. However, I was delighted when Dave suggested an extra half day to attend an All Party Parliamentary Group on the 1001 critical days Building Great Britons report, chaired by former Children’s Minister Tim Loughton MP.

Having watched Dave tweet his way through the NCB seminar, I made sure I had my phone to hand during the APPG meeting, especially as tweeting was encouraged (#1001CriticalDays). I had several tweets retweeted and it was great to pass on
information to other interested twitter users.

The first half was a presentation by the London Perinatal Mental Health Network regarding its establishment and the aim to build networks across the country offering consistent and joined-up care. We were given the first showing of a video funded by NHS England about its work. Questions and comments were then taken from the floor. The group was made up of a mix of interested parties and the questions reflected this. There was lots of discussion around how the work done by third sector organisations would be recognised and included within the networks, and on the importance of measuring outcomes as well as provision. It was brilliant to see so many passionate and knowledgeable people speak, and it left me with even more enthusiasm.

MINISTER VISION
The second part of the group was a speech by Alistair Burt MP, Minister of State for Community and Social Care. It was pleasing to hear him say that health visitors uphold the Healthy Child Programme and he was keen to emphasise how the past five years of growth in health visitor numbers had been the quickest rise of any profession within the NHS ever.

However, as Dave has blogged about (available on www.commprac.com), when asked to comment on our concerns about budget cuts now that services are commissioned from local authorities with evidence already available that Barnsley wants to slash its public health budget, Burt was unable or unwilling to give a clear answer. Feeling frustrated by this, and empowered by the moment, I stuck my hand up to add my own comment. However, persistence and my best Paddington Bear stare didn’t get the chair’s attention and I didn’t manage to comment during the meeting. But, with a little encouragement from Dave, I did approach the chair at the end, and explained my disappointment with Burt not backing up his enthusing of our profession. My concerns, I explained, were that with growing numbers, we have growing commitments and requirements, and while our workforce has grown, our most experienced health visitors may be looking to retire. This could leave us with a more junior team squashed between greater pressure to do more visits and our budget cuts so that the services we rely on to aid our work vanish. A worst case scenario could be that very able and skilled health visitors are squashed enough to take the route of least resistance and leave the profession altogether. While he had a concerned frown and nodded at the right points, I’m unsure how much of an impression I managed to make and whether my thoughts would go any further, but couldn’t leave without making my point.

With a ticket already bought for conference, and on the suggestion of Dave, an application was sent off to attend the CPHVA National Meeting. It was with a “see you later” rather than “goodbye” that Dave and I went our separate ways. I’ve been left feeling invigorated and with even more enthusiasm both for my work and CPHVA, and hope to become more involved with the organisation and pass my enthusiasm onto colleagues and friends.
A carer’s journey

CPHVA member and Community Practitioner editorial advisory board member Surrinder Bains explains how caring for her daughter has enhanced her professional role.

I WORK AS A HEALTH VISITOR/TRAINER

delivering the Solihull Approach to a variety of staff working with children and their families. I am also a carer for my daughter Nina, aged 20 years, who is on the autistic spectrum.

My values and beliefs influence my practice, and my learning from everyday life is helping me to improve my professional practice. My evolving self-awareness is an enriching, rewarding experience that enhances my own learning and my daughter’s learning.

The Solihull Approach is a psychotherapeutic and behavioural approach for working with children. This approach has helped me to view my learning as an ongoing process and removed my need to try to “fix” things for others.

The model built on my existing practice and provides a framework for my work. I have now extended it to all areas of my life, both professional and personal. The terminology used in the model helped me to describe what I am feeling and observing, not only in others but also in myself. For example, experiencing containment or a lack of it. I will provide examples of what it looks like in a person and how this may be impacting in their thought processes and behaviour.

The model recognises how important early relationships between caregivers and their children can help lay the foundations for future interaction. Health visitors have a key role in their work with families to improve early experiences for children leading to improved future mental health wellbeing. It is important as a practitioner that I recognise the power of my own relationships with others and how it can affect and influence them. It is not just technical skills that are important, it is my own development as a professional, which includes continually researching my professional practice to improve and contribute to the knowledge base for other health visitors.

DRAWING PARALLELS

There are parallels with the skills I use to support Nina towards independence and those I use in practice. I have learned so much from my carer role that I feel it has enhanced my professional role. For example, recognising the importance of using different forms of communication to share and reinforce information. How Nina hears and understands what is said to her will depend on her how she is feeling both physically and emotionally. A key part of my role is to be there to guide, advise, support, and encourage, but also provide enough space for her to make the right choice for herself. I have recognised that if I am to be there for her, I need to be present for myself first. I see being a carer as an extension of my role as a parent, which involves supporting Nina to become all she is capable of as a young person, and eventually independence.

THE SOLIHULL APPROACH

The Solihull Approach is based on three concepts: containment, reciprocity and behaviour management. The concept of containment is about allowing the other person to tell their story and therefore create enough space to view it more clearly. The person who is offering the containment hears the emotional communication from the other person but is not overwhelmed by it, and hands it back to them in a more manageable form. It can bring up feelings of helplessness, but I have found it more rewarding to sometimes do or say nothing. Clients can respond initially with anger and hostility as this can feel scary for them. However, if they can see that you are still available for them, it can help alleviate some of their anxiety.

I made a conscious decision to allow Nina to take risks and allow her to learn from taking actions. It may appear to be easier to make choices for her but in the long-term this will increase her dependence on others and affect her self-esteem/worth. Allowing her to learn from doing something is more enabling and confidence building. The hardest thing as a parent/carer/health visitor is to take a back seat and allow the other person some time and space to be heard.
There are occasions when I have had to step in and make subtle suggestions when Nina’s choice has presented a safety issue – such as wanting to go to London on the train and having an unrealistic set of aims to achieve while there. This is where having a creative and flexible approach has been invaluable.

Nina finds it hard to make choices for herself because she is scared of getting it wrong and then doesn’t want to feel bad. I have observed at such times that she looks sad and anxious, and is self-critical. I have found I have made choices for her that I thought she was in agreement with, but later she has been angry towards me when things have not worked out for her. I have learned that she needs to learn from her own mistakes in order to grow and mature.

READING CUES
A mother presented at clinic very distressed that her seven-month-old baby was not eating anything and was gagging when fed solid foods. A visit was arranged to observe a mealtime. That revealed mum was trying to feed the baby very quickly and not allowing enough time before offering the next spoonful. When the baby turned his head away or gagged on the food, she took it as a sign that he didn’t want it.

In this instance I was able to help mum recognise that she needed to read the baby’s cues and slow down the whole process and relax. Over time she has been able to see that she needs to take cues from her baby and hand over some control, such as allowing finger feeding. This is also an example of the dance of reciprocity whereby the parent is able to understand what the baby is trying to communicate and not be overwhelmed by emotions.

Change can cause significant anxiety for Nina. It has been a challenge for her to learn skills to manage her emotional state. At times she panics and this can affect her ability to regulate her emotions. She can be moody and have tantrums. At other times when she is frustrated and anxious she will become demanding and self-critical. This could result in her getting angry at those around her, going to her room or verbally saying what it is that is worrying her. I have found that if I give her the space to express her anxieties, she usually does get to a point where she can view things more clearly. She has started to come and apologise when she has calmed down. It is at this point I can help her and learn myself from what has happened. This could be to take preventative action or help to develop growing self-awareness.

I recognised that at times I have a need to take control and impose my values on others when it may not be right for them. Growing self-awareness throughout my life and professional career has assisted me with this understanding. Furthermore, it is not enabling or empowering the person if I tell them what to do, or do it for them.

I aspire to assist others to become all that they are capable of, and without falling into the emotional trap of wanting to rescue them. In the long-term this should help to achieve independence as well as my own health and wellbeing.

I am aware that everyone needs to find whatever coping strategies work for them. During this interaction it is an opportunity for us both to learn from one another and not feel under pressure to have all the answers. This also enables a more equal relationship and helps to reduce the power imbalance that can sometimes exist in professional-client relationships.

Nina needs to feel loved and accepted for who she is and what she can offer. She is slowly becoming aware that she is different and finds some things difficult to do, such as managing her anger. She feels anger when she is frustrated at what is happening around her, and not feel able to control it. For example, not being able to go out because it is raining. She needs to feel safe and secure in order to take risks and explore her own point of view. This will help her to learn and grow as a person with her own sense of self. It was when my needs were acknowledged that I had my greatest growth and development.

GIVING TIME AND SPACE
As a trainer I aim to create a safe, supportive space for the delegates to contribute. Identifying group rules can help towards achieving this space – be aware of the emotional temperature in the room and adjust the training accordingly. I use these same skills in my one-to-one work with families and as a carer. It is recognising that everyone brings something to a relationship which all interactions can lead to learning, and that each influences and is influenced by the other, which all interactions can lead to learning, and that each influences and is influenced by the other.

Moving away from the need to provide solutions for clients and their problems to a more facilitative approach is an option. It can also be more empowering for individuals and help with independence in the long term. This can be more rewarding for practitioners and help to prevent burn out.

In an NHS with limited resources, it is more important than ever for us to use creativity and imagination in finding solutions and to support families in continuing to develop their skills in facing change.
What is lactose intolerance and how can it be managed?

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

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

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

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

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

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

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

Available on prescription or to buy in supermarkets and other pharmacies

Supporting you to support mums

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

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

The only whey dominant LF formula available in the UK and Ireland³

Omega 3 and 6 LCPs

Fortified with iron to help support normal cognitive development⁷

Halal approved and suitable for vegetarians

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

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

Available on prescription or to buy in supermarkets and other pharmacies

Supporting you to support mums

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

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

The only whey dominant LF formula available in the UK and Ireland³

Omega 3 and 6 LCPs

Fortified with iron to help support normal cognitive development⁷

Halal approved and suitable for vegetarians

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

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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CPHVA collaborates on complex needs e-learning launch

THE CHILDREN’S EMOTIONAL AND ADDITIONAL Health Needs programme provides continuing professional development (CPD) content comprising six e-learning sessions, as both a resource pack for face-to-face training and as a learning resource, for health visitors and school nurses. It focuses on early and coordinated support for children with emotional health and wellbeing issues, and additional or complex health needs.

The sessions provide an overview of common issues for children with complex/additional health needs and emotional health and wellbeing concerns. This enhanced learning will equip teams with the essential skills to deliver high-quality services, and early help and support in these specialist areas. The e-learning materials have been developed by staff with a nursing qualification and expertise in either health visiting or school nursing. The sessions have been tested by a number of health visitors and school nurses, alongside a range of stakeholders and relevant networks, including Unite/CPHVA.

Safeguarding and Child Protection reference group

There have been many changes in workplaces and responsibilities recently, so we have decided to reconvene our Safeguarding and Child Protection reference group to assess what this means for practitioners and to develop guidance for Unite in Health members. If you are interested and have appropriate expertise, please contact Rosalind godson@unitetheunion.org for further information.

PO FOCUS

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Charity of the month

Unite/CPHVA members make a huge difference to the public that they serve. However, they don’t do this alone.

The CPHVA Charity of the Month (#CPHVAcharity) is our opportunity to celebrate the work that charities carry out that has an impact on the clients and families that CPHVA members serve and/or the knowledge of our members.

To nominate a #CPHVAcharity, visit www.unitetheunion.org/cphva/charity and complete the nomination form.

Nominations can be:
• For charities, big and small
• Based across the UK or in individual countries of the UK
• Must have an impact on the work that you do as a CPHVA member.

We are accepting nominations NOW and we’ll be celebrating charities from January 2016.

We will work with each #CPHVAcharity to inform our members across the UK about their vital work with briefings, online #CPblogs and #CPHVAtt
Unite/CPHVA and Community Practitioner journal were proud to launch the 2016 Awards at this year’s conference

It was amazing to receive so many nominations at conference

A true reflection of the outstanding work being carried out in community practice.
Thank you for sharing with us what the Awards mean to you

“Inspiring and encouraging excellence”

“Recognition for going beyond what you are required to do”

“Fantastic day and really motivated us to go back out there and continue with the work we do”

“It raised the profile of my role in my region”

“Ultimate reward for what we all do in practice”

“Sharing the celebrations with other well deserving colleagues for everything we do in practice”

We still need you to nominate so visit www.communitypractitioner.com/awards NOW!

Make sure you are part of one of the most prestigious events in the 2016 healthcare calendar
think the public want us to go back to levels of public expenditure not seen since the 1930s to get into surplus. That will mean the big inequalities that we are already seeing will only get worse.

Of course Scotland, Wales and Northern Ireland have their own issues, but at least there is national cohesion and you know who is in charge. We do not have that in England.

**INTEGRATION OF HEALTH AND SOCIAL SERVICES: WHERE DO COMMUNITY PRACTITIONERS FIT INTO HEALTHCARE?**

*Dr Raymond Jankowski, head of healthcare, Public Health England*

“The individual has to take responsibility for their health supported by the efforts of the community, underpinned by health and social care professionals messaging and the right legislation. All these layers have to work together, it is not sustainable if one isn’t working. Our work nationally is to work with our directors of public health locally. We will not let up in banging the drum for prevention. I would encourage you to speak with your director of public health because you can take part in a pincer movement to influence the thinking and understanding in councils and in CCGs.”

**THE CURRENT CHALLENGES FOR HEALTH AND SOCIAL CARE**

*RT Hon Philip Hunt OBE, Shadow Deputy Leader, House of Lords*

“Smoking, drinking and lack of exercise are seen as lifestyle choices but we have to look at them as an inequality issue. It is much wider than that. I worry that the impact of austerity measures is going to make this worse.

People don’t talk about mental health challenges as much as they should do. You don’t have to be a genius to work out there are going to be more carers in the future. These squeezed carers are going to face major health issues because we are relying on them to plug the gaps in our health and social care system. The more you squeeze mental health support, the more A&E admittance you would have. Those CCGs that disinvested in mental health services scored a massive own goal – what a stupid mistake they made.

I don’t know anybody who thinks we are going to get anywhere near achieving the £22 billion worth of efficiency savings required by NHS England. Even if we procured as one organisation and cut the golden handshakes of chief executives, we aren’t going to get it. You can’t expect to get a high quality service if you don’t invest in it. I’m not sure the public are aware of the catastrophe that is around the corner. I don’t think the public want us to go back to levels of public expenditure not seen since the 1930s to get into surplus. That will mean the big inequalities that we are already seeing will only get worse. Of course Scotland, Wales and Northern Ireland have their own issues, but at least there is national cohesion and you know who is in charge. We do not have that in England.”

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*Louise Naughton and Anna D’Alessio*
Panel Discussion: How can we ensure quality in the care that is delivered?

Chair: Polly Toynbee, president, CPHVA
Sue McMillan, deputy chief inspector, Care Quality Commission
Dr Raymond Janowski, head of health, PHE
Andrew Webster, director, care and health improvement programme, Local Government Association

AW: In the last five years 400,000 people have dropped out of publicly-funded care. These people getting fewer support at home are the people that are going to go into hospitals.

SM: Society has mixed feelings about regulators – it can’t make up its mind whether it wants something that’s light touched, or absolutely on the front door. At the time where CQC was formed, people expected it to be ‘light touched’. We inspect for good, we’re checking if a good quality of service is provided. Ultimately, if a service is inadequate it can be closed.

PT: People are indignant about postcode lotteries, if they know someone across the border can get access to something that isn’t available locally.

AW: It needs to be a mature conversation. However, many of the existing postcode lotteries are quite invisible. It is better to have variation and accountability than be standardised and be invisible.

SM: We routinely inspect for safe effective care, particularly regarding safety, and need to apply national standards. If you know you have a large elderly population, then being able to assess that and flex your services without ignoring national standards is excellent practice. Where we’ve given excellent ratings is where the carers are really looking at what their community needs.

PT: But CQC standards don’t allow for a lot of variation.

SM: The reality is some very good services who have a good rating may fall down on one thing, and it’s very difficult to get everything right. It’s a very black and white situation. The hospital inspections hit the newspapers most, but if you look deeper you’ll find that we also say when they’ve got things right.

PT: At a time when everyone is talking about prevention, how do we get upstream? Can we get back to putting money where it’s better spent?

RJ: Prevention is better than cure and more cost-effective. It is very difficult to negotiate the boundaries between organisations. There’s something important about integration. If you can’t prevent the disease, tertiary prevention is very important. What’s measurable isn’t always what’s important and what’s important sometimes isn’t measurable. How do we measure the caring aspect?

PT: To what extent does CQC take into account the cuts?

SM: We often get asked ‘will you lower the standards’ and the answer is no. If we lower our standards it means it all becomes acceptable. It gives a notion that these cuts are affecting us, it is important for us to stand our ground.

PT: If the quality isn’t high, who will you blame? The person you’re inspecting?

SM: We are clear in our reports when finance has been an issue. We are a regulator, we have to be independent. We are a source of information about what’s out there.

AW: The tension between local and national will remain. The problem at the national level is what worked and didn’t work. These are the questions we need to get to the bottom of. We need pragmatic evaluation especially in time of great change.

President’s Address
Polly Toynbee, president, CPHVA

“These are very hard times for the NHS and everyone who works for it. Most NHS Trusts are now deep in debt, another £8 billion is promised but it needs to be front loaded. Now it needs another £4 billion each year for five years just to stand still. 90 per cent of NHS care happens in the community, but the media and government like to focus on hospitals. How do you prove what is being prevented? We must evaluate everything we do but not everything can be evaluated. Community nurses don’t get the screen time in shows like 24 hours in A&E but how often does their care keep people from ending up in A&E? We all know how much the acute sector relies on the bedrock of the community sector. Where there is a delay finding care packages at home, hospitals end up dealing with it. Health visiting is a universal service, not just for people diagnosed with acute conditions. They’re for you and me and our families. The six visits by health visitors to new mothers following birth, which are crucial to establishing good relationships, have now vanished according to senior members of CPHVA. Many health visitors are above 45 years of age – and while experience is important, retirement comes for all of us. And the numbers of school nurses are increasingly worrying – there are just 1,028 fully qualified school nurses for more than one million children. I look for stories about health visitors and school nurses on news outlets and there are very few. But the ones I find are full of criticism. Whatever school nurses and health visitors do or don’t do, it’s always wrong. I hope that wherever you go, whoever you talk to, make sure they know how deep the cuts are. You’re the invisible backbone of the NHS and I’m proud to represent you.”

INFORMATICS: WHAT IS THE ROLE OF THE COMMUNITY PRACTITIONER IN DRIVING EFFICIENT, PRACTICAL SOLUTIONS?
Jo Dickson, CNIO lead nurse, informatics, Leeds teaching hospitals NHS trust

“In the past we worked in silos and was very hard to communicate with other colleagues and have a conversation about the care we were providing. Now we are very much joined up what we do, but this is just the start and not an end point. We’ve had successes over the past year. It has improved the safety and quality of care. We want to make sure the record won’t become overwhelmed by the amount of information in it. We sometimes have too much information but we’re constantly working with software developers to review that.”

Maximising the Potential of Social Media as a Professional Networking Tool
Derek T Barron, associate nurse director, lead nurse, north Ayrshire health & social care partnership, NHS Ayrshire & Arran

“Thirty-one per cent of healthcare professionals use social media as a professional networking tool, and eighty-five per cent of people use the internet for prescription and medical advice. Tweeting as a nurse will seriously increase your nursing knowledge, give you more support, and the numbers of school nurses are increasingly worrying – there are just 1,028 fully qualified school nurses for more than one million children. I look for stories about health visitors and school nurses on news outlets and there are very few. But the ones I find are full of criticism. Whatever school nurses and health visitors do or don’t do, it’s always wrong. I hope that wherever you go, whoever you talk to, make sure they know how deep the cuts are. You’re the invisible backbone of the NHS and I’m proud to represent you.”

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December 2015 Community Practitioner
and connect you to passionate nurses.

Turn your knowledge into action, and you only get to do that by sharing your knowledge. Those who tweet are more likely to remember specific things about the conference. I’m not telling you it’s going to be easy, I’m telling you it’s going to be worth it.”

SAFE AND RESPONSIBLE USE OF TECHNOLOGY: EMPOWERING YOUNG PEOPLE IN THE DIGITAL WORLD

Will Gardner, chief executive officer, Childnet International

“A quarter of young people use six or more apps on a daily basis, and the majority of people think this technology is a positive thing. Thirty per cent of young people said they were cyber bullied while five per cent said people were mean to them ‘most of the time’ on the internet. Of those who experienced mean behaviour, just 27 per cent reported bullying online.

The age of first smartphone use is eight, and this number keeps declining – touch screens have made technology very approachable by young people.

Risks children face online can be summarised in 4 Cs - contact, content, conduct, commercialism.

Contact: with bullying or with adults that persuade them to meet in an offline setting.

Content: that isn’t age appropriate, it is important to remember that age ratings are there for a reason.

Conduct: as in oversharing information or pictures. The internet is free but children cannot tell the difference between what is an advertisement and what isn’t.”

ASSESSING HOW THE NEW NMC GUIDELINES ON REVALIDATION WILL AFFECT PRACTICE

Jackie Smith, chief executive and registrar, Nursing and Midwifery Council

“Revalidation is real, and there were a lot of people that thought the NMC is not going to deliver but we’re here and we’re doing it. We need to remember why we’re doing it, and it’s about the professional practice and professionalism. What’s involved? 450 practice hours, 35 hours of CPD, five pieces of practice relate feedback, five written reflective accounts, reflective discussion, health and character declaration and PII, and confirmation.

Revalidation is not about big hospitals, it’s about diversity of the registrar. The added value to revalidation is that the NMC will run checks, something it didn’t do with prep. It’s important that revalidation sets the bar higher.”

ENSURING RACE EQUALITY IN PRACTICE, IN PATIENTS AND IN THE WORKPLACE

Colenzo Jarrett-Thorpe, national officer health, Unite

“Nursing students from a BME background are 50 per cent less likely to secure a first job first time than white nurses. There is tangible evidence of inequalities in terms of race in the NHS. There is also evidence that shows if there is bullying and discrimination in the workplace, it will affect patients.

The Workforce Race Equality Standard (WRES) was launched in April 2015 and it requires all NHS providers to collect, monitor and act upon data collected from the workforce on race inequality. WRES would provide fairness and equality in the system, and improve patient satisfaction and safety. Addressing inequality could save £150,000 in agency and absenteeism.”

GENERAL SECRETARY’S ADDRESS

Len McCluskey, general secretary, Unite

“It will be all of our members that will determine what we do as a union. That’s why the theme of this year’s conference is Our voice, Our direction: Implementation, Integration and Inspiration.

We have never, and must never, let the government set the terms on public health. Public health should be the preventative arm of the NHS. If we’re going to invest into our future, every child and young person needs access to a school nurse. We need a strategic planning investing programme to protect key industries.

If you ask friends or family, ‘do you want less public services’, nobody would answer yes. Nobody wants less public services. We need more and better public services, and this is something your union has been fighting for. Now more than ever health professionals need a union, now more than ever health professionals need a union that fights for them. I want to thank you for all the work that you do, you should be proud of yourselves.”

MENTAL HEALTH: UNDERSTANDING SUICIDE RISK AND YOUR ROLE IN PREVENTION

Karen Lascelles, suicide prevention lead nurse, Oxford health NHS FT

“There have been 6,233 suicides in people aged 15 and over in the UK. On average, one person takes their life every two hours. Most people who take their lives are not in touch with mental health services, and health checks are something that we need to use to ask questions. We all have a responsibility to look for the signs. It’s not easy to ask about suicide, but there is no evidence that asking about suicide puts the idea in people’s mind. Five key risk groups are middle-aged men, people in the care of mental health services, people with a history of self-harm, people in contact with the criminal justice system, and specific occupational groups like doctors and nurses.

We need to be mindful about doing things such as changing appointments or looking at our watches waiting for the next patient because vulnerable patients tend to feel like they’re a burden. A little bit of human contact can save lives, human contact can relieve distress. It’s not about curing someone, it’s about making them feel normal. Therapy is important but it’s compassion that will get through. Suicide and self-harm are contagious, it is up to us to pick up and detect vulnerable individuals.”
How important is the integration of health and social care?

“I think it helps with the budget because when you see a need that is a social need, you don’t need to go to another commissioner to ask for it because you already got that permission. It enables you to commission to the needs of the child or the population in a much more effective way.”
Christine Nicholls – children’s nurse

“I’m a nurse consultant working with disabled children in Brighton and all the children and families I work for access both health and social care services to such a high level. The integration of those services is vital to those families. They can’t be telling their stories over and over again to different people. It’s a very important move forward.”
Tracey Young – nurse consultant

“It’s important because it enables you to streamline planning. So all the planning for all their needs is one streamlined pathway straight to the answer.”
Samantha Bouamar – children’s nurse

Will the appointment of a National Whistleblowing Champion make it easier for you to raise concerns about standards of care?

“Yes, I think that would really help and change the whole culture in the NHS. I just think it would make us feel a lot more easy about saying something that we don’t agree with. We’ll feel like we have got someone to go to. People will be more willing to talk about things that they don’t agree with.”
Natalee Lee – midwife

“It’s about focusing on the client, and that’s why it is essential. It’s about what the client needs and delivering that care at the client’s point of need and at the right time. I think unfortunately what happens is it becomes a battle over who’s going to pay for it. I think that’s a real shame because it is about the client being at the centre of it.”
Kathy Walters – trustee of McQueen Awards and health visitor

Do you support the introduction of a digital ‘red book’?

“Yes. I think going paperless would work really well.”
Louise Sowerby – health visitor

“I think it everything is going digital now, so as long as it’s safe and secure and information is not going to go missing then yes. And as long that the parents are happy with it I don’t see why not. People might look at it more, whereas at the moment a lot of parents don’t look at the red book and don’t really use it.”
Suzanne Betts – health visitor and practice teacher

Do you feel confident about your role in reporting and supporting victims of FGM?

“The NSPCC has a specialist helpline that provides advice to professionals and also to members of the public if they’ve got concerns about FGM. We’re surprised at the number of people contacting this helpline as it’s many more than we expected. The more awareness and publicity around FGM that is given to the issue, the more people will contact the helpline. Tackling FGM is a priority for governments and health professionals are responding to that. I think among the professional community in general, there is a need for more understanding of FGM.”
Chris Cloke – NSPCC head of safeguarding and vice president of CPHVA

“As a health visitor I feel confident now. Initially when it came out that we had to ask it, I struggled with finding the right way. But now, it’s just a normal part of my initial assessment. I’ll ask it openly – just like I would domestic violence.”
Jennifer Griffith-Beech – health visitor

“I think it’s very important. I’ve already experienced it when I worked in a pilot project scheme in Barnsley called ‘Strong Families’ connecting and supporting families around domestic abuse. I worked with social care and it was fantastic. I picked up quite a lot of good skills and knowledge from social care.”
Tracey Richardson – health visitor
FMc mandatory reporting duty

Regulated health and social care professionals and teachers are now required to report to the police cases of FGM identified in the course of their professional work in girls under-18

Are you concerned that a child may have had FGM or be at risk of FGM?

- The child/young person has told you that they have had FGM
- You have observed a physical sign appearing to show your patient has had FGM
- Her parent/guardian informs you that she has had FGM
- You consider the girl to be at-risk of FGM. To consider what action to take, refer to the DH FGM safeguarding and risk assessment guidance (see link overleaf)

Mandatory reporting duty applies.

Professional who initially received the information: You need to make a report:

- Remember: Record all decisions/actions
- Do not delay, report to police officer to call you back
- Best practice is to report before COP
- Do not make any information available at this stage

You will have to provide:
- Girl’s name, DoB and address
- Your contact details
- Contact details of your safeguarding lead
- Your assessment of presence/absence of additional safeguarding concerns, and documented action accordingly

Immediate response required

- National GIRFEC guidance (see link overleaf)

Police and social care take immediate action as appropriate

ASSESSMENT OF CASE: Multi-agency safeguarding meeting convened in line with local safeguarding arrangements, including police, social care and health as a minimum.

Health professional (with relevant paediatric competencies) leads on the assessment of the health needs of the child:
- The assessment (with consent) may consider the need for:
  - General health assessment (physical and mental health)
  - Treatment and/or referral for any health needs identified (whether related to the FGM or not)
  - Use of FGM Protection orders
  - Referral for genital examination using colposcope to the designated local service in your area
- Social care and police develop an appropriate pathway
  - This is likely to consider:
    - Use of FGM Protection orders
    - Whether a care plan or other safeguarding response is required
    - Referral for safeguarding inquiry required for siblings, family members/ others identified through the contact
    - Referral to community third sector
    - If there is a need for criminal investigation

A CURRICULUM FOR LIFE

Report on the case for statutory PSHE launched

The case for statutory PSHE education brings together compelling evidence of the benefits of PSHE education

The PSHE Association is urging ministers to heed new calls from parents and pupils to make PSHE education statutory. Ministers have committed to a decision by the end of this year on whether to make PSHE education statutory, as recommended by the Education Select Committee.

According to new YouGov polling, 90 per cent of parents agree PSHE education should be taught in all schools. Young people agree on the need for such lessons to negotiate life’s challenges and opportunities.

Chief executive of the PSHE Association Joe Hayman said: “We should have high expectations of every element of our children’s education, and yet for years we have tolerated standards of provision in PSHE that are simply not good enough in many schools. As those schools which teach the subject to a high standard demonstrate, PSHE education can meet the calls from pupils and parents for ‘a curriculum for life’, but only statutory status will bring the rigour we need in all schools. We’ve reached a tipping point that ministers can no longer ignore. It is time to listen to parents and pupils and make the subject compulsory.”

Source: Department of Health

Book Review

Uncut Cords - caring for our sons and daughters with learning disabilities
Published by Caring Expressions ISBN978-0-9932857-0-7

Parenting and caring for children is hard work, but caring for children who have learning disabilities brings many additional challenges. ‘Uncut Cords’ shares many stories and experiences of raising children with a wide range of learning disabilities, including autism, developmental delay and behavioural difficulties.

The book describes in detail many of the challenges they have faced, and continue to face, together with the joys. It gives a genuine insight into what the families’ lives are like, and documents how their unconditional love for their children is tested, and the stresses of having to continually fight for their rights – welfare support, education or housing, for example.

I found the writers’ commitment to their children humbling. Their courage is evident throughout, as they strive to get the best for their children in the most difficult circumstances. The complexity of the bureaucracy and government systems is a recurring source of difficulty and frustration. There is also constant anxiety about medical appointments, benefits, the impact of austerity measures and the uncertainties of the future.

For me, the key message is about listening and communicating more effectively in order to be able to offer the most appropriate care for each individual.

Kitty Lamb

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

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 hydrolyising the proteins to form smaller peptides makes the formula easier to digest.

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. 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.

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

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.

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.

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.

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Supporting children and families through key transition stages

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INTRODUCTION
In 2012, the Newcastle-upon-Tyne health visiting and school nursing services were invited to participate in a five-day Rapid Improvement Event (RIE) to respond to the new working models for health visiting and school nursing (DH, 2012).

The RIE involved all grades of staff, including senior management and administrative staff, and was facilitated by the transformation team. RIE are part of the lean toolkit, providing a mechanism to make radical changes to current processes within short timescales (NHS, 2012). Protected time away from caseloads allowed all staff to analyse policy, documentation and current practice, and initiate improvements in service delivery over a short period of time.

The idea for Hello/Goodbye pre-school events evolved from the RIE in response to the national call to action (DH, 2012). The concept was to allow parents to say “Goodbye” to their health visitor and “Hello” to their new school nurse. The GP hosted the session and provided catch up preschool immunisations on the day. Posters raising awareness were put up in key locations to advertise the event. The Oral Health Promotion department and Sure Start were invited to attend to provide advice and support. A community dietician was also invited to provide advice and early intervention where needed. All children that attended had the opportunity to have up-to-date height, weight and BMI measurements recorded. Early intervention and engagement in health is only likely to be successful if started early in life (Wanless, 2002). Staff prepared and provided a goody bag for children who attended.

The day of the event dawned and the staff event and were given the opportunity to say “Goodbye” to their health visitor and “Hello” to their new school nurse. The GP hosted the session and provided catch up preschool immunisations on the day. Parents arriving early at the GP practice to discuss their child’s health, and a continuous stream of parents with persistent heavy rain. We were, however, completely surprised by the response and barely had time to draw breath as we found

Aims and objectives
Our aims were to respond to public health priorities. Well-planned and coordinated interventions can reduce problems throughout childhood and adolescence and promote self-care resilience in communities (RCN, 2012).

We wanted to improve transition from health visiting to school nursing services and offer a universal face-to-face health assessment prior to school entry (DH, 2012). In addition our aim was to:

• Increase vaccination cover in line with national standards.
• Carry out height, weight and BMI measurement prior to starting school. It is well documented that weight-related problems are estimated to cost in the region of £50 billion by 2050 (Forsight, 2007). Children in Newcastle-upon-Tyne have worse than average levels of obesity: 11.6 per cent of children aged between four and five years, and 23.2 per cent of children aged 10-11 years, are classified as obese (Public Health England, 2015).
• Promote oral health with the aim of preventing tooth decay in five-year-olds. The city has levels of decay that are lower than the average for England. However, there is variation across the city, with high proportions of children (Public Health England, 2014) living in deprived wards being affected with decay experience.
• Reduce hospital admissions for unintentional injuries. Accidental injury is one of the biggest killers of children in the UK second only to cancer, and costs the NHS more than £275 million a year (Child Accident Prevention Trust, 2015).
• Improved transition for vulnerable families in a universal event, which is fun and accessible to their needs.
• Building community capacity.

Parents said they would like our service to “do this again with other children” and we invited all parents that attended to complete an anonymous evaluation form and had a 100 per cent response. The evaluation of the event was overwhelmingly positive. The response to the Hello/Goodbye events was fed back to all staff, leadership teams and commissioners.

Parents said they would like our service to “do this again with other children” and we have subsequently rolled out the events citywide since 2013 – they are now annual events held in June each year.

The events are held in various locations
across the city including sports centres, GP practices, Sure Start Centres and libraries.

**COLLABORATIVE WORKING**
One of the benefits of these sessions is that there is an opportunity for other partner agencies to meet parents and provide health promoting activities linked to public health priorities.

The Oral Health Promotion service is a vital part of our events and has supported us by attending sessions and dressing up in toothpaste outfits, which the children love. Health promotion messages and resources are used to engage families and children, with information on new dental registrations and how children should look after their teeth, with the aim of improving dental health in five-year-olds. A mini dentist room, with scene setters, an inflatable dentist chair and dress-up outfits for children dispels fears and encourages attendance at the dentist.

Student dentists from the university have been involved with the events as part of their community health promotion practice and feedback from parents has been very positive.

Local Change 4 Life organisations and child weight management services have attended targeted events to support parents with advice, information and early referrals into programmes. 0-19 years staff are able to give advice and support around nutrition and early intervention.

The child health information service is also crucial in collecting and analysing data and providing lists of outstanding immunisations. Reducing hospital admissions for unintentional injuries is a clear objective (DH, 2012) and a pilot session was held in conjunction with a community safety event in national child safety week. These events are to be extended to one per locality in future sessions.

Local supermarkets are contacted and asked if they will donate fruit for the children. This year, a community development worker from a local supermarket attended one of our larger events with health promoting messages.

Stop smoking champions have also attended targeted events for parents with advice and support.

Last, but definitely not least, our fantastic administrative team are crucial to the planning and administration involved in processing parent and child invitations in a timely manner, coordinating events, and meeting and greeting parents when they attend.

A Hello/Goodbye working group meets monthly to plan future sessions and to analyse and respond to evaluations and feedback from parents. Staff have great support and encouragement from management, which is essential to continually review and improve the events.

The response from parents has been very positive. Parent comments have included:

- “Loved it. Wished my older child had the same sort of thing”
- “This has been a very welcome session, really accessible with lots of great information in a really relaxed environment. Brilliant.”

**WHERE ARE WE NOW?**
In 2014, we were extremely pleased to win the Trust’s annual Nursing and Midwifery award, which provided us with a prize fund to use for the events to source equipment and resources for the goody bags, including a water bottle, a high visibility jacket, toothpaste and toothbrush and tooth brushing timers.

In response to comments from parents in previous years, we have held late sessions until 6 or 7 o’clock in some cases to allow working families the opportunity to attend.

This year, a late 5-9pm pilot session was held on a Friday in a local supermarket community room and, as with the pilot session, we were overwhelmed by the response from parents. 118 children plus parents and siblings attended from 33 of the 36 GP practices in the city. More late evening and Saturday sessions are planned next year to respond to the needs of parents.

**MEASURED IMPROVEMENTS**
Families that have attended the events have had a face-to-face health assessment, which was not previously done. Early intervention or brief advice can be implemented on a number of health concerns prior to starting school, for example behaviour management, sleep concerns, toileting issues and medical conditions, providing reassurance for parents on school entry.

We are now reaching national targets for immunisation cover compared with five years ago. Rates for preschool booster and second MMR have risen from 86 per cent to 95 per cent.

Children attending the event now have their BMI measured prior to school entry and parents are made aware of raised BMI earlier and given support around this.

Safeguarding families receive a smoother transition from health visitor to school nurse in an universal event.

We would advise other teams to embrace the concept to innovate and bring about change. Partnership working allows families to benefit from an integrated approach to public health and see services as a whole rather than as individuals, with the purpose of improving children’s lives.

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**References**
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We barely had time to draw breath as we found parents arriving early at the GP practice to discuss their child’s health and a continuous stream of parents with children arriving throughout the day.
Oh the times they are a-changing! Never a truer word was sung. This year I celebrated 40 years since qualifying as a health visitor and I have lost count of the changes during that time.

We thought the Health Visitor Implementation Plan in England was going to be a panacea to all our problems but immediately after completion the commissioning arrangements were changed, after reducing all the budgets for both health and local authorities.

I have always worked in the North East of England where, despite the deprivation, we have delivered a patient-focused quality service where the protection of children, young people and their families has always come first.

Not any more with hospital management delivering most of the community-facing services – it is all about supply and demand, and acute services come first, where the minority of clients are cared for.

Cynical? Why me? So what are we going to do about it? Next year will see the 120th anniversary of the Health Visitor Association and I know that my colleagues and I are going to be fighting tooth and nail to protect the services that our clients deserve and that this country is respected for around the world.

So join us and make your predecessors – those that made us the first female trade union to be affiliated to the Trade Union Council – proud.

I am nearing retirement but I will certainly be around to lead your excellent Executive with support from Unite’s Professional and Industrial Officers next year. We are also looking for deputies in all regions and in school nurse and community nursery nurse professional groups, so watch for the application process.

Join us, find your branch and support your representatives, who day-after-day put their neck on the line on behalf of you and the clients we serve.

Next year there will be a number of new initiatives all reported in your journal: CPHVA Awards, Charity of the Month, Health Visitor week, plus birthday celebrations so dust off the banners and the chains, CPHVA is on the march again for a better future for all our clients.

My best wishes to you all. Please don’t hesitate to contact me with any issues, ideas or just because you want to be more involved – there is plenty of fight left in this health visitor yet!

If you think this has been a year of drama for people working in the NHS, this was just the overture, the starter. What’s to come is more change, much of it below the political radar, with no new law or parliamentary debate.

But over the next couple of years those working in the community are more likely to find themselves shifted from one provider to another, with CCGs merged and the new vanguard experiments rolled out to bring all health and social care under one local accountable body. Is it a good idea? It makes good sense to pull services together – but change always means turmoil for those on the ground, far from where abstract decisions are made in Whitehall offices. Never-ending change has just become the new normal and NHS staff get on with it.

How much change, though, can the NHS take while it endures its toughest finances and deepest debts since it was formed in 1948? There are plenty of reasons for health visitors, community practitioners and school nurses to worry at being transferred to local authorities. No sooner did that begin, than the chancellor reached in and took £200 million out of the public health budget. That makes belonging to local authorities seem less secure than before.

What always impresses me, wherever I go in the NHS, is just how well practitioners do in keeping services running in these hardest times. With support shrinking, overwhelming caseloads, down banding and fewer recruits, it’s not surprising many plan to retire early, losing invaluable experience to the service.

I hope you will get in touch, and let me and CPHVA know what’s happening in your neck of the woods. You are the eyes and ears to tell us where you see good innovations that should be spread to everyone else – and where you see the gravest pressure points in the next hard years ahead.
It seems difficult to believe that I was appointed as a vice president of Unite/CPHVA as long ago as 2011. It remains a great honour and a privilege, and I always remember those happy years working as a school nurse assistant, then later on as a health visitor. During this past year I have had several opportunities to meet members and hear about their various achievements, as well as the many issues they face. The opportunity to sit on some of the executive meetings has been something of an eye-opener. It has really brought home to me the various challenges faced by so many members. These include maintaining health visiting numbers now that the service in England is under local authority commissioning. It is also very sad and outrageous to hear about cuts in school nursing and community nursery nursing services.

On a more upbeat note, I never tire of seeing the surprised reaction of those called up to receive a well-deserved award at the annual Awards ceremony. My wish for 2016 is that it brings greater resources for members so that they can deliver a high quality of service to families. Another wish, as vice chair of the Mary Seacole Memorial Statue Appeal, is that we will at last see the memorial installed in the gardens of St Thomas’ Hospital, London. Thanks to everybody who kindly gave a donation to the charity at the Unite/CPHVA AGM and at the conference in Manchester, and it was an opportunity to literally bump into so many members at the wonderful ceilidh.

As a vice president of the Community Practitioners’ and Health Visitors’ Association, I am pleased to have been invited to contribute a few words to the CPHVA Annual Report. You may be asking what does a Veep for the CPHVA do, and I have to admit some tinges of guilt that I do not do more. I’d like to take this opportunity to say that I am more than willing to become more involved at any level. All invitations are gratefully received – just ping me over an email.

During the past year, I have seen many examples of the positive, practical side of CPHVA’s work. I was pleased to take part in the judging of the Annual Awards. There are a number of categories for the awards that honour both individuals and teams. What has impressed me is the wealth of good practice and strong commitment that is demonstrated, and the fact that some nominees have been working in the sector for such a long time. The awards are a celebration and they recognise the great service of often unsung heroines and heroes. I would encourage more names to be put forward. I also attend the annual CPHVA conference, last year held in Birmingham. Wearing my NSPCC hat, I gave a keynote address on child protection and my colleague Helen Westerman, one of our local campaign managers, ran a workshop on the NSPCC Underwear Rule campaign. We also had a stand in the exhibition that attracted a lot of visitors and lively discussion. The NSPCC values our relationship with the CPHVA. I’ve been going to conference for a number of years and I’m always impressed by the standard of debate. I would, however, like to see a greater input from the politicians.

The NSPCC benefits from the knowledge and experience of CPHVA’s members and this helps inform our work. One way in which we learn about the practice of health visitors and community practitioners is through the NSPCC Health Liaison Committee, which comprises representatives from the main health groups and royal colleges, including CPHVA. We value your insights. The new public health agenda, ably championed by CPHVA, is supported by the NSPCC. We see this as integral to preventing child abuse and neglect. Health visitors, school nurses, and other community practitioners have a critical role to play and we hope there will be many opportunities for future collaboration.

Sit on the Executive as the representative on the Community Nursery Nurse Organising Professional Committee. The committee has met three times since last year’s conference. Despite a depleted membership, I am pleased to say we have managed to complete the work plan that was set for us at conference.

This year has continued to be a challenging one for CNNs and as we look across the UK we see fewer in post each year. This has motivated us as a group to ensure we have a presence at a strategic level and continue to make our issues known and heard. The first item that was completed was a fact sheet that highlights the role of the CNN within the Universal/Universal Partnership Plus programme. The second item was a national job profile to make recommendations of what needs to go into a job description issued by employers wishing to employ a CNN. The third item of the work plan was to look at the commissioning of the health visitor service by local authorities, and promote the value of the CNN within the health visitor team. The commissioning document was produced as part of the health visitor work plan.

The CNN OPC has vacancies at present for Scotland, Wales, North West, Northern Ireland and East Midlands. Any CNNs interested in representing one of the vacant areas please contact me, the chair, Stella Mann.

Brooke Wilson who represented the North East has resigned so we would like to thank her for her contribution during her time on the OPC. We have filled the North East vacancy, as Maria Rodgers has taken on the role, and we would also like to welcome back Sujata Mahendran as London and Eastern rep after her secondment with the local authority, and look forward to sharing her knowledge, information and experiences.
This year the West Midlands regional CPHVA has not met due to issues around rooms, access and funding. However, the members have attended CPHVA question time events, revalidation workshops and CPHVA CPD events in high numbers. This has indicated the membership wants professional support from CPHVA and the plan for 2016 is to resolve some issues and add to these training events. Members who contributed to enquiries said they would like meetings to rotate around the region, to be held in the early evening, and be accessible.

I am informed the Unite in Health branches in the West Midlands are now formed. This is a change from last year and I hope this has made a difference to our members.

Many school nursing members were subject to recruitment and retention of staff, and aspiring to deliver the Healthy Child Programme under increasing financial pressures. This year we have had a well attended regional event held by the CPHVA and hope to have more sessions on revalidation to support staff with the process or other subjects that are relevant to your professional needs.

Attendance at meetings is always a challenge due to work demands and I am planning activities like a recruitment drive to get more members joining and attending. Actions this year include revalidation, promoting the CPHVA within our region and attracting new membership, especially within school nurses in our area.

Please do get in touch and let me know what is good or bad in your region. If there is a professional issue that you want raised please do get in touch.

As a CPHVA executive member, I attend meetings in London four times a year. I have also attended a meeting with Ten Alps (who publish the Community Practitioner journal and run the CPHVA Awards) to discuss the CPHVA executive role in the CPHA awards, which take place in April 2016. The executive has a work plan for the year, which has been identified by the members at the annual meeting and each member works on a different work stream. I, along with the representative from Northern Ireland, have been the executive link regarding revalidation, and was invited to sit on the South of England Revalidation Board, whose remit was to assess the readiness and preparedness of organisations within our region. I attended several of these meetings, but NHS England withdrew its support and the meetings were subsequently cancelled.

As the South East is a large geographical region, we need to embrace using technology for the possibility of virtual meetings, or alternative times and venues. The aim for the future is to increase the engagement of professionals at a regional level, and to re-engage members from Trusts and branches who have not recently been represented. I welcome contact from members in the South East region who would like more information.

I am also the representative for the South East Region Organising Professional Committee (OPC), which meets four times a year. Unfortunately, this year has seen reduced members attending, since we had to change the venue for our meetings from Esher to Slough. Other factors were increased workload demands, and members being unable to be released from work.

The regional OPC provides a supportive network for members across the region to come together to share professional best practice and raise concerns. These concerns can then be raised at the National OPC. As the regional chair, I have also attended the National OPC meetings and the CPHVA executive committee meetings.

Some Unite branches appear to be functioning well, while others appear not to be supported following the change from CPHA centres into the Unite branches. The concerns that members continue to raise are possibly mirrored across the country. Service redesign, increased workloads, mobile working, community staff nurse redundancies and retirement are all leading to low staff morale. If there is a professional issue that you want raised please do get in touch.

I have recently joined the CPHA Executive Committee, and I represent the North West region. Since taking up the post, I am learning about the policies and issues that are important to members and I want to be informed and involved as much as possible so that I can actively contribute and influence the issues affecting you in our region. I am working as a community practice teacher and health visitor in North Cumbria and am a local accredited rep for Unite, having had a varied career in the NHS and other public health arenas.

Challenges in our region continue to be rurality, recruitment and retention of staff, and aspiring to deliver the Healthy Child Programme under increasing financial pressures. This year we have had a well attended regional
I have recently become the Welsh representative on the CPHVA Executive Committee. My background is children’s nursing and I qualified as a health visitor in 1999. I am currently a lecturer in primary care and public health nursing on the SCPHN and pre-registration nursing programmes at the School of Healthcare Sciences at Cardiff University. I work closely with practitioners, particularly the practice teachers who are our partners in educating health visitor students.

We are extremely lucky in Wales in that we do not face the challenges posed by the move by commissioning of services to local authorities, and there does not appear to be any plans for this. In addition, the Welsh government has invested heavily in Flying Start programmes to support children and families in the most deprived areas of the country and these are really making a difference. However, the implementation of the Healthy Child Wales Programme has been delayed, with a definite date still to be agreed.

Wales has a robust means of liaison and communication via the All Wales Health Visiting and School Nurse Forum, and I would like to forge links between the CPHVA and this group to ensure that issues throughout the region are raised at a national level. I would also like to strengthen links between the CPHVA and Welsh members by increasing the level of activity in the area, and I plan to use the 2015 conference as an opportunity to network with my Welsh practice colleagues and discuss a way forward. It has been suggested to me that a column in this journal for each of the smaller countries of the UK might be a way of highlighting specific issues, while also celebrating what the four countries of the UK have in common.

I look forward to representing Welsh community practitioners in the year ahead. You are all very welcome to contact me to discuss professional issues and offer support.

Another year has gone, and over the past 12 months we have seen the end of the Call to Action for health visiting and services up and down the country transferred to local authority commissioning.

The latter may mean major changes for some health visitors. I am based in the London region, working for North East London Foundation Trust. Our health visitors in NELFT have already been told of planned changes that will have huge implications for our services – something that will be familiar to many of you across England.

I am pleased to see so many newly qualified health visitors. I know you have a lot to offer health visiting and hope you will enjoy your time in the profession, as I have done during the past 29 years working for the same borough. While the school nursing numbers are still low, I hope more nurses and midwives will see this as a future career.

During this year I have been involved in a number of committees within Unite, including the CPHVA Executive. My involvement with the CPHVA Executive has included working on the safeguarding work stream. This has seen major changes with FGM (female genital mutilation) now refreshed in law, meaning professionals have a legal duty to report confirmed cases of children who have had, or are at risk of, FGM to the police.

The past year has been very challenging and I have not achieved many of the things I hoped to do regarding the professional agenda. However, I will be organising meetings so that we can come together and discuss our common issues and identify our priorities for action.

I hope that I can continue to support the health visitors in the London region and I am hoping to have regular meeting in the London area where we can hear what your challenges and concerns are, and facilitate support in rectifying them.

The health agenda is devolved in Scotland and so I, the professional officers, and members, have been engaged in strategic working groups. The programme to deliver the 500 promised extra health visitors in Scotland has now started to be realised. NHS Education Scotland (NES) has directly invested into the universities that offer the SCPHN health visitor programme to fund all places. The courses are at Masters Level 11, apart from one institution where it remains at Honours 10. Health Boards are fully funding students on a mix of Band 5 and Band 6. Professionally it would now prove helpful to agree one process across Scotland.

School nursing is lagging behind in this process, and discussion on the future school nursing role and workforce continues nationally.

We have supported the investment in practice teachers, and both the professional and industrial discussions regarding the grading of the practice teacher role. It is hoped that by 2016 all qualified practice teachers will be working to a band 7 job description. Underpinning the expansion in the health visitor workforce is the Children and Young People Act, Scotland, and the full implementation of the National Practice Model and Named Person Service. The Act becomes law in August 2016 and we are actively involved in agreeing the final guidance. The Universal Pathway in Scotland was launched in October 2015. This introduces 12 named person (health visitor) contacts and well being assessments in the child’s first five years. This includes two antenatal contacts and a now standardisation of the two-and-a-half-year contact to utilise the Ages and Stages Questionnaire. The two-and-a-half-year review has been a challenge. We are pleased it is in the new programme but it is a postcode lottery on how or what tool will be used. They outcomes and what to do regarding referrals remains an issue.

There is local activity from professional colleagues, members and reps in most areas but it has proved difficult for us to all come together, largely due to the geography and workloads in Scotland.

During 2016 we hope to explore the option of hosting more online professional forums to gain and maintain members’ professional interests across the country.
As you have read our president, vice presidents and the executive committee have all been busy on your behalf. Whether it was detection, analysis or formation of policy your interests were first and foremost. The Executive Committee has been representing you both at their regional/country level as well as coming together nationally to give the strategic steer and determine professional priorities.

The professional team has also been very busy, at the time of writing this we are heavily engaged in presenting our revalidation workshops that are helping all NMC registrant members prepare for the introduction of revalidation in April 2016. We hope you are addressing this early. Remember attending CPHVA annual conference is a perfect way to boost your CPD hours, make sure it is in your diary next year – we hope to see you there.

Their message to you all is genuine; they want you to be active, involved and plan to create more opportunities for you to meet together.

We are aware of the many challenges out there for you in practice and we have now come to accept that changes to the work environment are constant, however, what we don’t accept are the organisational changes that limit or diminish the services we provide to children and families. We need you all to raise these issues with us and ensure our voices are heard as a profession that is ‘Radical, Professional, Caring’.

The CPHVA Education Reference Group has a remit to discuss and review national policy and identify impact of policy on the community workforce. We make use of a wider reference group for consultation and additional expertise may also be invited into the group on an ad hoc basis for particular work. The group has maintained links to the United Kingdom Standing Council for Specialist Community Public Health Nurse Educators (UKSC) and relate to other national organisations such as the School and Public Health Nurses Association (SAPNHA) and Institute for Health Visiting (iHV).

Based on the CPHVA Executive workplan, the CPHVA Education Reference Group has national membership and includes a variety of health professionals to represent the needs of the CPHVA membership.

Our workplan will be developed in conjunction with the CPHVA Executive. We will do a scoping exercise on the notion of ‘no touch’ infant examination, which was raised at our last meeting and required greater clarity to establish the parameters, evidence and source.

We will also run a survey to scope child protection and children in need thresholds across all four countries and investigate leadership and clinical supervision provision, and consider the English 4, 5, 6 model rolled out in response to local needs.

We want to look at workforce stress issues based on the results of the OPC survey as well as vacant caseloads and higher sickness reporting with some job freezes.

With the move to commissioning by local authorities and public health cuts in England, health visitor and school nurse workforces will change. In some areas this may mean lack of capacity to provide the core offer for 0-19 year olds because of the increase in numbers of children requiring safeguarding. What impact it will have on capacity to deliver core offer? Reduction in training may impact on capacity to support, recruit and retain SCPHN students and the change in role of CPT could devalue this activity.

This year has been one with all too familiar challenges. All services have had to work more efficiently to try to provide services with less resource, yet with higher client expectations.

As chair of Northern Ireland (NI) and vice chair of the Executive Committee, I have been working to support members in both roles. We have been active in NI representing members’ interests at various meetings and boards. We have been encouraging members to keep up-to-date by offering different learning opportunities. I organised for lead professional officer Obi Amadi to come and present on FGM at a professional meeting.

As vice chair of the Executive, I have supported the chair and the committee to represent our members. Within our workplan we have addressed various professional issues such as commissioning, safeguarding, community nursery nurses’ role and revalidation. I hope you have taken up the professional team’s offer to speak to you and your colleagues about revalidation. It will put the requirements in perspective and help you to make sense of what you will need to do.

I want to thank the other members of the committee and say that I believe we are ready for 2016 and all that comes with another policy year where health services and welfare will be reduced and child health and child poverty is likely to get worse without the dedicated healthcare staff that you are.

I look forward to meeting and working with you in 2016.

We are ready for 2016 and all that comes with another policy year where health services and welfare will be reduced.
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 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.

For more information visit egginfo.co.uk

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, as well as the box.

References:
2. EAT (Enquiring About Tolerance) and LEAP (Learning Early About Peanut Allergy).
Female Genital Mutilation: A practical guide for health visitors and school nurses

BETSY ALLEN MSc, Dip HV, RGN, on behalf of the School and Public Health Nurses Association (SAPHNA)

RUTH OSHIKANLU FFHV, MSc, PDip, PGDip, Dip Trop Nursing, BSc (Hons), Dip HEd on behalf of the Community Practitioners and Health Visitors Association (CPHVA)

Public health nurses (health visitors and school nurses) have a pivotal role in the prevention of female genital mutilation (FGM). As they work closely with families, children and young people in a variety of settings, they are ideally placed to raise awareness about FGM, to help prevent its occurrence and to identify and address its consequences.

The practice of FGM interferes with the natural function of girls’ and women’s bodies and involves procedures that include the partial or total removal of the external female genital organs for cultural, non-medical reasons. Four main types have been described:

- Type 1: Removal of all or part of the clitoris and clitoral hood.
- Type 2: Removal of the clitoris and inner labia.
- Type 3: Removal of all or part of the inner and outer labia, and closure of the vagina, also known as infibulation.
- Type 4: All other harmful procedures to the female genital organs for non-medical purposes, for example piercing, pricking, incising, scraping, stretching or cauterising the labia.

Girls and women may not know what type of FGM they have experienced, or indeed whether they have actually had it. They may not associate their health problems with the practice. There is no therapeutic justification for the practice and it carries the risk of significant health problems. FGM has been illegal in this country since 1985 and is always a child protection issue.

In order to address and prevent FGM, the issue should be raised both routinely and opportunistically with sensitivity, for example during health visiting ante-natal visits, at school entry, and with those women who are choosing to have cosmetic surgery on their genitalia.

PREVALENCE
It is estimated that, across the world, there are around 130 million women and girls living with FGM, mainly in 29 African countries, the Middle East and Asia. There are a variety of names for FGM in different countries.

Different communities practice different types of FGM for various reasons and at different ages. Currently in England and Wales, it is estimated there are at least 20,000 girls aged between five and 15 at risk. Around half of these will have experienced the most damaging form of FGM, type 3.

LEGISLATION, SAFEGUARDING AND MANDATORY REPORTING

Legislative framework
It is illegal to perform FGM in the UK, or to assist in carrying out FGM abroad, on a girl or woman who is a UK national or permanent resident, under the Female Genital Mutilation Act 2003 in England, Wales and Northern Ireland, and in Scotland under The Prohibition of Female Genital Mutilation (Scotland) Act 2005.

Safeguarding
“FGM is a form of child abuse and violence against women and girls, and therefore should be dealt with as part of existing child protection structures.”


There are safeguarding assessment guidance sheets (Annex 1, pages 19-24 of the above document) to aid clinical decision-making:

- for pregnant women,
- non-pregnant women and adult women,
- children and adults under 16.

In summary, public health nurses should:

- Discuss any cases of potential or actual FGM with their local child protection/safeguarding lead
- Consider other girls and women in the family who may be at-risk
- Refer these to social care or the multi-agency safeguarding hub (MASH), following discussion with a designated safeguarding lead
- Be part of a multi-agency response
- Undertake mandatory reporting
- Continue to support the girl/family as appropriate
- Be aware that if there is a Section 47 investigation by social care, there will be a strategy meeting within four or five days that the public health nurse is likely to be involved with.

INTER-AGENCY WORKING

Working across and between agencies is essential with all safeguarding work, and this is particularly so in the complex area of FGM. Information about girls and women at-risk, or who may have suffered FGM, and details of discussions held with families and community groups should be shared between agencies so that safeguarding plans are up-to-date, lack

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It is illegal to perform FGM in the UK, or to assist in carrying out FGM abroad, on a girl or woman who is a UK national or permanent resident, under the Female Genital Mutilation Act 2003 in England, Wales and Northern Ireland, and in Scotland under The Prohibition of Female Genital Mutilation (Scotland) Act 2005

MANDATORY REPORTING
There is a mandatory duty to report cases of potential or actual FGM in girls under 18. This:
• Requires reports to be made to the police within one month of the original disclosure/identification.
• Applies to all regulated healthcare and social care practitioners and education practitioners.

Currently, mandatory reporting will also include women choosing to have cosmetic surgery on their genitalia.

REASONS WHY FAMILIES CHOOSE FOR THEIR DAUGHTERS TO HAVE FGM
The reasons families choose FGM for their daughters are complex, and deeply rooted in tradition. Parents may not articulate their reasons, but believe it to be an important aspect of their culture, and that their family and daughters will be dishonoured without it. Although FGM is both a legal and a child protection issue, it may be carried out by loving families who believe they are doing the best for their children.

ASSESSMENT AND REFERRAL
Points to consider when discussing FGM or completing a health assessment with a girl or young woman
No assessment undertaken by a public health nurse should be simply a tick-box exercise, and with suspected or actual FGM the usual skills are required – establishing a rapport with the girl/woman/family, asking questions in a straightforward, open way that develops understanding and trust, and being empathic and non-judgmental. All contacts should, of course, be documented according to Nursing and Midwifery and local guidelines. However, there are further points particularly to be considered:

1. The assessment process is underpinned by the understanding that FGM is illegal and always a child protection issue if the girl is under 18.
2. It is usually the role of the specialist safeguarding nurse, social worker or police to make specific, detailed enquiries. The public health nurse should generally be wary about tackling the issue of FGM directly, but should make an assessment about general health and refer appropriately if concerned.
3. The public health nurse should be informed about FGM and should not show shock or disgust if it is disclosed.
4. If the girl/woman has experienced FGM, take time to listen to the narrative of her experience. This may well shed light on the family/community influences and attitudes that led to it occurring, and give information about other family members who may be at-risk.
5. Ensure that a female professional is available if the child/woman would prefer this.
6. Consider using an interpreter if English is not their first language. Female interpreters should not be used as interpreters.
7. Be sensitive to the individual and their culture. Girls will often feel extremely loyal to their parents, so to disclose about FGM could be extremely difficult for them. Girls and women may be embarrassed to talk about their genital area.
8. Use simple questions and straightforward language. Be aware that information may be available if the child/woman would prefer this.

Referral processes for public health nurses

1. A girl or young woman under 18 where there are concerns of actual or potential FGM:
   • Contact your designated or named child protection/safeguarding lead.
   • A referral to social care must be made.

2. A woman over 18:
   • Consider referral to FGM services for assessment and support.
   • If she is pregnant, risk assess and consider referral to social care.
   • Document in health record.
   • If you are unsure, contact your named safeguarding lead.
   • Consider any girl children in the family.
   • If there are any children at risk of FGM: contact your designated or named child protection/safeguarding lead.

NB: FGM is considered to be illegal in all women born after 1969.

3. After discussion with your designated safeguarding lead, consider referral to specialist community workers or groups.

Reasons given for practicing FGM*

<table>
<thead>
<tr>
<th>Reasons given for practicing FGM*</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is the convention (social norm) in certain countries, and there is strong pressure to maintain the practice</td>
</tr>
<tr>
<td>It honours the girl and her family and brings them added status, and a sense of belonging to their community</td>
</tr>
<tr>
<td>It cleanses and purifies the girl</td>
</tr>
<tr>
<td>It preserves virginity and chastity</td>
</tr>
<tr>
<td>It fulfils a religious requirement</td>
</tr>
<tr>
<td>There is a social obligation, and the family may experience rejection, marginalisation and ostracism</td>
</tr>
<tr>
<td>It makes childbirth easier</td>
</tr>
<tr>
<td>It accords with the culture’s ideals of femininity and modesty and is cosmetically desirable</td>
</tr>
<tr>
<td>It reduces women’s libido and discourages illicit sex</td>
</tr>
</tbody>
</table>

*note that reasons given are not necessarily objectively true
Potential physical consequences of FGM

Immediate
- Severe pain
- Infection, including septicaemia
- Haemorrhage
- Urinary retention
- Damage to adjacent organs
- Wound infections, including tetanus
- Fractures
- Death

Long-term
- Failure to heal. This can lead to infibulation cysts (dermoid or inclusion), neuromas and keloid scar formation
- Difficulties in voiding (both urine and faeces), chronic UTIs and incontinence
- Pelvic infections and urinary tract infections (three times more likely)
- Complications in pregnancy for the mother
- Complications in pregnancy for the baby
- Painful sexual intercourse, and reduced sexual sensitivity and psychosexual complications
- Increased risk of blood-borne infections, for example HIV or Hep B
- Menstrual problems, for example the menstrual flow can take much longer than normal
- Infertility
- Recurrent abscesses formation/fistulae

Emotional and mental health consequences of FGM

Immediate
- Confusion at reconciling the ordeal of FGM with its initiation by a loved family. This can lead to a sense of betrayal and loss of trust and confidence
- Psychological shock
- Long-term
- Post-traumatic stress disorder
- Anxiety
- Psychosexual problems including low libido, pain during sex and lack of pleasurable sensation
- Problems with body image and self esteem
- Affective mood disorders
- A sense of incompleteness
- Regret
- Negative impact on education/learning/ friendships at school
- Social factors – relating to family and community

NB. The need for counselling and other psychological support services should be considered.

Case study: Health visiting

You have been notified by the midwife that Amina, a woman who is 28-weeks pregnant, has had Type 2 FGM. What actions will you take?

- Determine what the midwifery service and/or the Family Nurse Partnership has done:
- Has the relevant department been notified as part of the mandatory reporting process?
- Has the woman been referred to relevant services? If applicable, what services has the woman been referred to?
- Has any reversal of FGM been undertaken? If so, when and where was this done?
- Make contact with Amina to arrange either a home visit or an appointment in clinic to undertake an antenatal health assessment as per the Healthy Child Programme (HCP). At the telephone contact, enquire if she speaks and understands English or requires an interpreter.

At the contact:

- Advise her that you have been notified by the midwife that she has had FGM and ascertain her understanding about what the midwife has done.
- Undertake a comprehensive health assessment, taking the opportunity to make every contact count, but avoiding duplication of what may have been done by the midwife. Enquire about Amina’s country of origin and the age at which she had FGM. Ask her to relay the experience if she remembers it.
- Assess for any complications of FGM, physical and psychological.
- Explore her views and feelings regarding having had FGM performed. Is there evidence of unresolved trauma – refer for counselling and/or specialist services with Amina’s consent?
- Using a genogram, explore who/if anyone else has had FGM in her family (aim to get history of three generations – Amina’s mother and aunties, siblings and daughters).
- If Amina has any daughters and/or is expecting a female infant, ascertain any risk to her daughters having FGM performed by exploring Amina’s partner and family’s views on FGM.
- Explain your role as a health visitor in promoting health and wellbeing of all members of the family and safeguarding children. Discuss with Amina about FGM, the consequences to a girl/woman’s physical and psychological health. Inform her about UK law in relation to FGM; it is illegal and so is a criminal offence that is likely to result in prosecution even if a girl is taken outside of the UK to have FGM performed.
- Advise her that professionals have a duty to share information to safeguard children at risk.
- Endeavour to engage her partner and other influential members of the family [eg mother in-law] where appropriate.
- Check Amina’s (and her partner’s) understanding of what has been discussed. Answer any questions that they may have. Jointly agree a plan of action and advise her (them) about the next steps.
- Provide Amina with your contact details for her to be able to contact you if she requires further support.
- If you feel a girl is at-risk of having FGM, follow local policies and seek support of the children’s safeguarding team and refer to children’s social care.
- If there are older girls in the household that are of school age, ensure that the school nurses have been advised.
- Ensure that mandatory reporting of Amina’s FGM has been undertaken by the midwife.
- Maintain detailed records of the contact, advice received from the children’s safeguarding team and referral to children’s social care.
- If no other support is required, liaise regularly with the midwife and follow up at the new birth visit.
You have recently been involved in jointly running some awareness raising sessions about FGM with teaching staff and a specialist FGM community worker in the secondary school that you are attached to. At the end of one of the sessions, two 14-year-old girls, Shani and Aluna ask if they can talk with you.

You let them know your drop-in clinic times, and encourage them to attend. This they do, and you learn that the girls are both from Kenya. One of the girls, Shani, now believes that she had FGM as a child and is extremely concerned about her younger sister, aged six, as there is a long family holiday planned back to Kenya during the next summer holidays. Aluna, also from Kenya, is clear that her family do not believe it right to practice FGM, and it is not something she’s experienced.

How will you continue to work with Shani and her family? What actions will you take?

1. Thank the girls for coming and for their openness. Let them know clearly about confidentiality, and that although you will be there to support Shani you will need to share it with someone who can help her and keep her younger sister safe.
2. In this instance, an interpreter is not necessary, but this should be considered.
3. Consider whether the friend should continue to stay. Generally, it would be better if you could have a conversation with Shani on her own, as it may be difficult for the friend to keep the situation confidential.
4. You will need to refer this case to your designated safeguarding lead as soon as possible. A referral will then be made to the multi-agency safeguarding hub or to social care.
5. At this stage, it is best not to make a full assessment, but to continue to build a rapport with the girl, to give reassurance that she has done the right thing by sharing her situation with you, and to answer any queries she may have. She is likely to be having problems as a result of the FGM she has experienced, for example painful, long periods and/or mental health issues, and it may be an opportunity to discuss these. Let her know that you will be there to continue to support her.
6. Consider competence using Gillick competency guidelines as the girl is under 16. As this is a child protection issue, it is appropriate to discuss this without parental consent in this instance.
7. Do not inform the parents, as Shani and her younger sibling may be at-risk. Initial contact with the family will be from social care or the police.
8. Document as per NMC/local guidelines.
9. Seek supervision from line manager or safeguarding lead as appropriate.
10. Continue to work with the family/child support, begin interaction with the family as appropriate, and Shani in particular, within a multiagency framework to raise awareness with the family about the legal and safeguarding consequences of FGM, and to do all that is necessary to safeguard the children’s welfare. This will probably include attending a multiagency strategy meeting within four to five days of any investigation.

HEALTH CONSEQUENCES OF FGM

The health consequences of FGM can be considerable and serious, depending on the age at which it is done and the type that has been carried out. It is important for public health nurses to be aware of these significant health problems in order to identify potential or actual FGM as early as possible.

The mental health consequences are not diminished by the practice being culturally embedded.

References
- http://www.primarycarerecruitment.co.uk/images/PDFs/revised-nmc-code.pdf
- http://www.orchidproject.org/category/about-fgc/what-is-fgc/

December 2015 Community Practitioner 33
Instant messaging: The way to improve access for young people to their school nurse

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ABSTRACT
Children and young people require ease of access to their school nurse. Alongside this, school nurses are charged with the need to work smarter, being cost-effective and timely in response. School nursing teams across the country provide access through text messaging, however, there is presently no access provided to young people to have a consultation as a web-based chat facility. Using digital media, Doncaster school nurses have worked closely with young people to redesign and launch a totally interactive web-based clinic facility. This allows for improved access, reduction in travel costs and consultations to take place outside of the traditional times for accessing school nurses. This paper discusses a pilot project around the establishment of an e-clinic connecting young people and school nurses. It outlines the journey towards providing this innovative service in an attempt to provide cost-effective, timely services while reducing the barriers for service users.

KEYWORDS
Access, School nursing, Digital media, Innovation, Consultation

INTRODUCTION
The Department of Health (DH, 2012) states that young people should have access to services that are visible, accessible and confidential, that deliver universal public health and ensure there is early help and extra support available at the time of need. School nurses, working to provide the Healthy Child Programme (5-19) (DH, 2009), work in a progressive manner to provide services with escalating need. In order to give young people universal access to their school nurse, school nurses are required to work smarter providing services via a variety of media (Wanless, 2002).

Health IT has the potential to enable a dramatic transformation in the delivery of healthcare, making it safer, more effective, and more efficient (DH, 2013). The new NHS information strategy urges health and social care services to make full use of online technologies – putting patients in control of their health and improving access to services.

Locally, the Improved Access to Psychological Therapies (IAPT) services are providing client-based consultations through the web-based platform Talking Sense e-clinics, an interactive two-way confidential, secure service. This service enables clients to access therapies wherever they feel at ease, improving accessibility and reducing the anxiety of face-to-face consultations. Additionally, practitioners may provide a service to a wider service area giving benefits to organisations including reduced travel costs and reduce impact of non-attendance. This service raised thoughts of how young people could use a web-based interactive system accessing early intervention from school nurses. This article describes the journey towards developing an interactive e-clinic app instant messaging service for young people to access help and support.

METHOD
School nurses in the Doncaster area wishing to work proactively with young people and provide a ‘user friendly’ service change – as advised by the British Youth Council (BYC, 2012) – attempted to understand the needs of young people. Qualitative and quantitative methods were employed as part of a service redesign.

An initial qualitative consultation was undertaken with young people to gather young people’s thoughts. The basic concept was explained to the young people, who ranged from year 7 (11-12 years) to year 12 (16 – 17 years), by school nurses during school based sessions randomly assigned by staff in school. In total, 50 young people provided a written response to the following question posed by the school nurses.

“What do you think about using virtual clinics to access the school nurse?”

A wide range of positive responses were gained. Young people highlighted the ease of access, the reduced embarrassment and a perceived increase in confidentiality. One young person pointed out that they would not want to use the service in case parents became aware. Additionally, it became apparent that young people were less enthusiastic with the use of webcams, with one saying: “a webcam may not be a good idea, may be inappropriate possibly”, it was also described by one young person as “a bit pervy.” Young people explained they would feel most at ease using an instant messaging facility, with no face-to-face contact via webcam this resulted in a change to the planned service.
How can you influence lifelong health by choices in the first 1000 days?

The first 1000 days of a baby’s life (from conception to the age of 2) are crucial in terms of their long-term health.1-3 Making the right nutritional decisions now can deliver lifelong benefits. The endocrine, immune systems, and even appetite are believed to be programmed for life by what happens in the first 1000 days.4

Breastfeeding is recommended

The Department of Health recommends exclusive breastfeeding for the first six months of life. This is because breast milk supplies all the nutrients needed in all the right amounts — and breastfeeding has been shown to have many health benefits for both mother and baby.5

Protein and the importance of slower growth rates

Because the protein in breast milk is adapted to a baby’s needs,6 a breastfed baby tends to grow more slowly than a formula fed baby.7

This slower growth rate has shown to have significant long-term health benefits, including a lower risk of obesity, cardiovascular disease and diabetes.8

The European Food Safety Authority (EFSA) recognised that protein intake in infants is in excess of requirements, and recommends a reduction of protein quantity in infant formula and follow-on formula.9

“Protein intakes of infants are generally well above the requirements, so protein content of infant formula & follow-on formula could be reduced”10

Improving the amino acid profile of infant formula is key

The key to lowering protein levels in infant formula is improving the amino acid profile.

According to the WHO/FAO/UNU expert opinion,

“the breast milk content of amino acids is the best estimate for infant amino acid requirements”

Getting closer to this profile allows the overall quantity in infant formula to be reduced.

New infant formula with low protein content can achieve comparable growth rates to breastfed babies

Studies have shown that newer infant formulas which have both a lower total quantity and a higher quality amino acid profile achieve a growth rate comparable to a breastfed baby.10 As parents start to introduce complementary foods into their babies’ diet, protein intake continues to be important. National dietary surveys show that older infants and toddlers have more protein than they need compared with recommended amounts.11 This potentially increases their risk of later overweight and obesity.12–14

Protein levels in follow-on milks and toddler milks should therefore be as low as possible and within the regulations where applicable.

IMPORTANT NOTICE: Breast milk is best for babies and breastfeeding should continue for as long as possible. Good maternal nutrition is important for the preparation and maintenance of breastfeeding. Introducing partial bottle-feeding may have a negative effect on breastfeeding and reversing a decision not to breastfeed is difficult. You should always seek the advice of a doctor, midwife, health visitor, public health nurse, dietitian or pharmacist on the need for and proper method of use of infant formulae and on all matters of infant feeding. Social and financial implications should be considered when selecting a method of infant feeding. Infant formulae should always be prepared and used as directed. Inappropriate foods or feeding methods, or improper use of infant formula, may present a health hazard.

8 Registered Trademark

Further to gathering qualitative information, 68 young people responded to a short closed-ended questionnaire distributed to three classes (88 pupils in total) during health promotion sessions, which gave figures of possible uptake and use of internet (fig 1). This showed that of the 68 respondents, just eight did not have access to the internet, highlighting the possible potential coverage of the service.

<table>
<thead>
<tr>
<th>YES</th>
<th>60</th>
</tr>
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<tbody>
<tr>
<td>NO</td>
<td>8</td>
</tr>
</tbody>
</table>

Fig 1 Do you have access to the internet?

Of those, 39 young people commented on where they access the internet (Fig 2).

It was acknowledged that young people who do not have internet access have a further raised vulnerability. This raises the question of how to offer school health services to those without access to the internet more effectively. This has not yet been resolved. The plan is to work closely with schools to give young people access to the internet through school-based systems. A further consultation took place across two secondary schools where a total of 80 young people answered a randomly-assigned, short questionnaire following a further information giving session (see Fig 3).

**MAKING IT HAPPEN**

The initial phase of making the e-clinic a reality was a stressful one involving collaborative working with various departments within the organisation including IT, print and design, and web page design. Each had a differing set of working criteria and business models, and these did not always marry up.

Persistence, however, paid dividends. Following a meeting with the assistant director of children, young people and families, a report was requested and written outlining the need for the service change. The evidence collated the value to both service users and providers. This report was forwarded to the Business Intelligence Group who gave outline permission to move forward with the project. Additionally, one full-time member of staff was assigned to take on the lead role of moving the Talking Sense eClinic platform forward, particularly to meet the needs of young people aged 11 – 19 years. This role was to undertake a scoping exercise around the use and future development of digital media services and the e-clinics as well as undertake a pilot offering e-clinic online appointments in one secondary school for the provision of instant messaging between young people and a school nurse.

A school nurse e-clinic board was established with membership from IT, print and design, communications, school nurses, e-clinic lead and an area clinical manager. The preliminary meeting was established and fortnightly meetings were planned. Most excitingly, timescales were agreed and a launch date was set as a target. The project planning document outlined aims, scope, objectives, stakeholders, budget, timescales and changes. This document was used as the basis for all meetings, alongside all supporting project documents employed.

Supporting project documents

- Project management document. This included the following project information, benefits, work log, activities, risks and issues, and change requests.
- Standard operating procedure
- Talking Sense e-clinics Policy
- Benefits map to ensure all measurable benefits could be audited, and improvements and benefits shared with the Trust board.
A pilot was agreed to start on 20 January 2014 to run in two secondary schools with around 1,600 pupils where the initial consultation had been undertaken. Within the initial planning phase it was agreed the service should be extended to those young people in the area who were known to be not in mainstream education or educated at home. This was achieved by working with colleagues in the education welfare service.

MARKETING THE SERVICE
Consultation with young people around the publicity of the service was undertaken to enable enhanced access (DH, 2011). Young people were clear in their responses. They needed information within marketing materials around confidentiality, where, how and when they could access the clinics and that they associated the NHS logo with a service they could trust. Marketing materials, posters (Fig 5), credit cards, stickers and web design were thought to require bright colours and young people-friendly language. Prototypes for all were made, shared with focus groups of young people within the pilot project schools, and changes were made to incorporate their thoughts and wishes. This led to the finished product.

THE LAUNCH
The launch date for e-clinic pilot was 20 January 2014. The instant messaging online service was staffed with two school nurses working on alternate days between 5pm and 7pm offering 15 minute consultations with times dictated by the initial consultation. The times were to be extended if the pilot was successful, however, it was suspended on 13 January 2015 due to very limited access by young people. Initial response was encouraging, with one young person logging in on the launch day. Fig 6 shows the statistics that were logged for a single month from 20 January 2014 to 21 February 2014. This was encouraging but the incompatibility issues outweighed any benefits, leading to the suspension.

Feedback from one young person contacting us by email following use of the system has been positive, stating that:

“I find the website easy to understand. I, myself, have found it embarrassing in the past to see the school nurse in school. So I would

like to thank you for creating this brilliant way of communicating with you.”

There have been issues and problems encountered, and these were noted throughout the pilot with the formal evaluation being undertaken following the instigation of the app. Many of the problems have been easily resolved, aided by the partnership working between informatics and school nurses. Our greatest challenge to-date is the lack of compatibility between the software package and some devices young people use. This is prioritised as an immediate need and ultimately led to the cancellation of the service.

The pilot became a learning experience, highlighting the gaps and incompatibilities with hardware that young people use, such as tablets and smart phones. Ultimately, the vision is to provide a one-stop-shop for young people accessing a whole range of children’s health services via the internet. This pilot provided a starting point, a springboard enabling school nurses within Doncaster to lead the way providing innovative practices. We are now about to embark on the next part of the journey using applications (apps). In partnership with a local web design company, we are producing an app enabling the connection.
issues previously encountered to be resolved providing an instant messaging service for young people to contact their school nurse.

CONCLUSION
Young people have responded positively to e-clinics, which is evidenced by the number of visitors to the webpage and registered user accounts. There has been positive feedback from young people around the idea of instant messaging a school nurse and from those who have used the service. There is an on-going need for further development of the e-clinic platform and production of the app is almost completed.

Key points
- The need for greater access to school nurses is evident from work carried out by the British Youth Council. This is clear with the results of the small focus groups carried out.
- Young people require a voice to provide a high quality service meeting their need to access support outside the traditional boundaries.
- E-clinics is a virtual platform for young people to book appointments with their school nursing service. The early work completed with Young People is described; providing a platform for future development.
- Continued development of services is required to constantly review and update service provision. The initial cycle is described. Further cycles will follow as the provision of this service is improved.

Fig 6 Number of visitors to site

<table>
<thead>
<tr>
<th></th>
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<tr>
<td><strong>Website</strong></td>
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<td>Visits</td>
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<tr>
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<td>Page views</td>
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</table>

This is in line with feedback from users who have been unable to connect to the service and will enable access to e-clinics using android and iPhone technology.

Additionally, the application is considered to provide potential for wider usage than just the initial use in school nursing services.

A number of allied agencies within health working with young people, including our local child adolescent mental health services, are interested in the use of e-clinics to offer easy access to services for young people.

References

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

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Talking about domestic abuse: Crucial conversations for health visitors

INTRODUCTION
Domestic abuse (known also as domestic violence or intimate partner violence) is described by the World Health Organization (WHO, 2013) as the infliction of physical, sexual or mental harm, including coercion or arbitrary deprivation of liberty. The UK Home Office (2012) defines domestic violence as: any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 and over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to, psychological, physical, sexual, financial or emotional. Both of these descriptions reflect the varying forms of abuse and the different relationship configurations in which it occurs.

The prevalence of domestic abuse is hard to assess because it is under-reported and tends to be a hidden issue. The World Health Organization has suggested that up to 71 per cent of women may experience physical or sexual violence perpetrated by a husband or partner (WHO, 2009) across their lifetime. It is not just women that experience domestic abuse and in the UK, the National Institute for Health and Care Excellence (NICE, 2014) has reported more than 1.2 million women and 750,000 men in England and Wales experience domestic abuse. There is a correlation between domestic abuse and mortality – apart from risk of domestic homicide – domestic abuse is associated with increased rates of suicide (Devries et al, 2011).

The effects of domestic abuse are not confined to those who experience it directly. It infiltrates family and social networks, and children who live with domestic abuse are affected in multiple ways. While some children may learn to positively negotiate stress and conflict, they are far more likely than other children to experience a range of detrimental impacts to their health, including post-traumatic stress, depression and behavioural difficulties (Smith et al, 2014). Importantly, they are at elevated risk of being abused themselves (Coordinated Action Against Domestic Abuse, 2014). Historically, domestic abuse has been considered something that happens behind closed doors – a private issue, but this has changed. It is now known that the health burden of domestic abuse is greater than more commonly-accepted public health priorities (such as smoking) and it now ranks as a top public health concern (Public Health England, 2013; Bacchus et al, 2012).

Nurses are ideally placed to recognise and respond to domestic abuse, and although most are competent and confident to do so, some lack confidence in dealing with the issue (Taylor et al, 2013). It is well-known that people who experience abuse rarely discuss it unless asked, so when nurses are prepared to raise the issue with people in their care, a dynamic of silence exists (Bradbury-Jones et al, 2014). Silencing of the issue of domestic abuse is evident in other areas of nursing too. Bradbury-Jones and Broadhurst (2015) investigated student nurses’ and student midwives’ experiences of learning about domestic abuse. The student midwives had learned something about the issue, but the student nurses had not been taught about domestic abuse in university and many had not had the opportunity to learn about it in clinical placement either. They perceived...
reluctance among some mentors to discuss the issue of domestic abuse with them.

The purpose of this article is to present the findings from two studies, and along with broader literature, explore health visitors’ role in dealing with domestic abuse, particularly the need for them to open up discussions about the issue with students, families and colleagues. The Institute of Health Visiting has referred to “difficult conversations” (McInnes and Nettleton, 2015). Similarly, Patterson and colleagues (2012) refer to “crucial conversations” as those that may contain 1) opposing opinions 2) strong emotions and/or 3) high stakes. This article arises from recognition that domestic abuse is a difficult issue to discuss. It emphasises how important health visitors are in having crucial conversations about this emotive subject. It is based on the premise that domestic abuse is regarded as a ‘high stakes’ issue and one in which health visitors are catalysts for the safety of families with whom they work.

HEALTH VISITORS AND DOMESTIC ABUSE

Disclosure is a well-recognised concern for people who experience domestic abuse (Spangaro, Zwi and Poulos, 2011; Salmon, Baird and White, 2013). Peckover (2003) reported many women conceal their abuse from health visitors. Reasons include concerns about confidentiality (Feder et al, 2009); risks of further abuse (Robinson and Spilsbury, 2008) and fear of removal of children (Montalvo-Liendo et al, 2009). But although women are disinclined to disclose, they do want domestic abuse to be discussed, and there is evidence that most find it acceptable to be asked about it (Koziol-McLain et al, 2008; Feder et al, 2009).

Research indicates that health professionals are reluctant to address the issue of domestic abuse, including midwives (Lazenbatt and Thompson-Cree, 2009) and district nurses (Sundborg et al, 2015). Bacchus and colleagues (2012) have suggested that some health professionals regard the issue of domestic abuse as a burden. In order to understand this issue, in 2011 a study (study one) was undertaken in Scotland to investigate primary healthcare professionals’ beliefs about domestic abuse (see Box 1).

Many of the primary healthcare professionals who took part in the study were confident in dealing with domestic abuse. However, there was disinclination among some to address the issue with patients and clients. The reasons for this included fear of causing offence (Bradbury-Jones et al, 2014) and concerns about “opening a can of worms” (Taylor et al, 2013). The study highlighted a potential dynamic of silence between health professionals and abused people in their care. As indicated in Box 1, the participants were from different healthcare disciplines, but the majority (sixteen) were health visitors. The study findings hold direct relevance for health visiting practice.

An important phase of the study was the interviews with fourteen women who had experienced domestic abuse. They had clear messages about the issue, and in line with findings from earlier research, they wanted the issue of domestic abuse to be discussed. The women were angry that health professionals found it so difficult to discuss the issue. They acknowledged that domestic abuse is a difficult subject, but likened it to other issues that nurses deal with daily, such as cancer. One woman questioned why health professionals find it so difficult to broach the subject of abuse, asking “what is their problem?”

It is incumbent upon health visitors to demonstrate safe practice in safeguarding and to intervene effectively in families where there are concerns about domestic abuse (Public Health England, 2013). Early intervention is crucial to responding effectively to domestic violence and abuse (Allen, 2011; Department of Health, 2011). The health visitors in the study valued this aspect of their role and most were able to describe exemplary practice in this respect (as evidenced in Taylor et al, 2013). Nevertheless, many described the same degree of hesitancy as their colleagues from other disciplines in addressing the issue with families. McInnes and Nettleton (2015) suggest a pressing need to build the capacity of health visitors to have “difficult conversations” with families about sensitive issues such as living with domestic abuse. A key message for health visitors arising from study 1 and earlier research, is that domestic abuse is a difficult subject to broach. However, most people - whether they have experienced abuse or not – are not offended when asked about the issue. Importantly, when people are experiencing abuse, most want to be asked. They may deny that it is happening, but discussing it shows willingness to engage with the issue and

Box 1: Study 1

Primary healthcare professionals and domestic abuse

This qualitative, two-phase study was conducted in Scotland during 2011. The aim was to explore primary healthcare professionals’ beliefs about domestic abuse and the influences of these beliefs on responses to disclosure. In the first phase, twenty-nine primary healthcare professionals (health visitors n =16; community midwives n =11; general practitioners n =2) took part in semi-structured, individual interviews. Three focus groups were also conducted with a total of 14 women who had experienced domestic abuse. In the study, many health professionals (including health visitors) told us that they lacked confidence in addressing the issue of domestic abuse. They were worried about causing upset or offence when talking about the issue with patients and clients and causing damage to their relationship with families. The study highlighted the risk of a ‘dynamic of silence’ between health professionals and those who experience abuse.


Box 2: Study 2

Nursing students and domestic abuse

This qualitative study was conducted in England in 2014. The aim was to investigate student nurses’ and student midwives’ knowledge, confidence and educational needs regarding domestic abuse. A total of 55 students (student midwives N=32; student nurses n=23) took part in eight focus groups. Students in the study viewed the issue of domestic abuse as important and they possessed good knowledge theoretically. However, most nursing students felt insufficiently prepared to deal with domestic abuse. They reported that they had not learned about the issue in university and sometimes it was not addressed while they were on clinical placements. Some students reported that their mentors seemed hesitant to talk about the issue with them. Importantly, it was their placements with health visitors that provided the greatest opportunities for learning about domestic abuse. The study highlighted the crucial role of health visitors in supporting nursing students to learn about domestic abuse.

For full details of the study see:

STUDENT NURSES AND DOMESTIC ABUSE

There is very little research about student nurses and domestic abuse. Of the available studies there is indication that it is not included in most undergraduate nursing curricula (Davila, 2005), but when it is included, it is associated with higher perceived preparation and knowledge among students compared to those who have no training (Connor et al, 2013). In light of the limited research on the subject, in 2014 a study (study 2) was undertaken to investigate student nurses’ and student midwives’ knowledge, confidence and educational needs regarding domestic abuse (see Box 2).

Of the 55 students who took part, 23 were student nurses. None of the students had learned about domestic abuse as part of the curriculum in university. Regarding clinical placements, the situation varied. Some students, particularly those on the child and mental health fields, had come across people with domestic abuse experiences on placement. These students had a relatively strong sense of perceived knowledge and confidence in recognising and responding to the issue. This was only relative, however, in comparison to most students on the adult field who lacked confidence on issues relating to domestic abuse. Adult field students reported that some mentors do not optimise opportunities for them to learn about domestic abuse in placement. Many were removed from situations where domestic abuse was an issue. Additionally, the students described a perceived reluctance among some mentors to discuss the issue with them and attributed this to mentors themselves being anxious and uncertain about domestic abuse (Bradbury-Jones and Broadhurst, 2015).

Study 2 was concerned with nursing and midwifery students, but the findings have relevance for health visitor mentors. Generally, students in the study reported that they were unable to learn experientially about domestic abuse, but there were exceptions. A number of students reported that placements with health visitors provided the greatest opportunities for learning about domestic abuse, for example one student reported: “when I was with health visitors I always went to the safeguarding and domestic violence things”. Health visitors are therefore crucial in supporting nursing students to learn about domestic abuse and counter the lack of exposure characterised by some other clinical placements.

Connor and colleagues (2013) reported that preparing student nurses to deal with domestic abuse is necessary if they are to enter the nursing profession with the ability to impact positively on the care of people with domestic abuse experiences. Similarly, the Nursing and Midwifery Council (NMC) states that on entry to the register, nurses must be able to recognise when a person is at risk of abuse and take steps to protect them (NMC, 2010). The UK Public Health Outcomes Framework involves safeguarding children and families at risk of domestic abuse (Public Health England, 2013). Study 2 has highlighted how students value the support of health visitors in achieving this. It reinforces the importance of health visitor mentors engaging with crucial conversations about domestic abuse with the next generation of registered nurses.

IMPLICATIONS FOR HEALTH VISITING PRACTICE

The studies used as the basis for discussion in this article were not explicitly concerned with health visiting, but health visitors were included as participants (study 1) or were discussed by those who took part (both studies). Combined, the studies have highlighted some key messages for health visiting practice that hinge on the importance of talking about the issue of domestic abuse. Discussing the issue with families opens up opportunity for disclosure and subsequent safety planning. Exploring the issue with students and allowing them to be safely exposed to the issue are important. Given the prevalence of domestic abuse, many nurses and students have been exposed to domestic abuse themselves either personally or in someone they know. For this reason, an important implication for health visiting practice is one of safety and support. Clinical supervision and support of each other are necessary. Education and training have been identified as vital in promoting health professionals’ confidence in addressing and responding to domestic abuse (Feder et al, 2011; Bacchus et al, 2012; Beynon et al, 2012). In terms of being enabled to have the type of critical discussions advocated in this paper, health visitors need to access domestic abuse related education and training on a regular basis.
**CONCLUSION**

Health visitors work closely with children and families to meet a range of public health outcomes (Allen, 2011; Department of Health, 2011). As a public health issue, domestic abuse is, or at least should be, one of these. With reference to Patterson et al’s (2012) notion of ‘crucial conversations’, domestic abuse is certainly a high stake issue. Ignoring it and failing to discuss it risks safety and lives. The responsibility does not fall solely on health visitors, but their close relationships with families means that they are particularly well placed to address the issue with families (Taylor et al, 2013).

Lord Willis, the independent chair of the recent review of nurse education, called for a high-quality learning environment in undergraduate nurse education (Health Education England, 2015). In comparison to many other placement environments, health visitor placements have potential to provide a rich learning environment regarding domestic abuse. Overall, responding to the public health imperative to safeguard children and families from the burden of domestic abuse related harms is vital. In this, health visitors play a pivotal role in turning difficult conversations about domestic abuse into crucial conversations about domestic abuse.

**Key points**

- Domestic abuse is a serious public health issue
- Nurses play an important role in recognising and responding to domestic abuse
- Many nurses are relatively knowledgeable about domestic abuse but lack confidence in raising the issue with patients, clients and students/colleagues
- Health visitors play an important role in opening up crucial conversations about domestic abuse and may utilise their influencing relational skills to improve public health outcomes for suffering children and families.

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Improving health visitor emollient prescribing using a CQUIN-based approach

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ABSTRACT
Prescribing is an essential element of health visiting practice. This initiative used the payment framework of Commissioning for Quality and Innovation (CQUIN) to develop health visiting practice across a large health visiting workforce in the East Midlands. A focus on emollient prescribing practice was agreed and a guidance booklet regarding preferred emollient products was produced, based on the local formulary. Each health visitor benefitted from receiving additional training and was given a guidance booklet to inform their practice. Targets were set for each quarter to demonstrate an improved prescribing adherence to the preferred product list. The targets were achieved for each quarter. Prescribing rates and confidence improved across the service. Therefore, it was demonstrated that specific guidance and ongoing support can improve prescribing practice within the health visiting service.

KEY WORDS
Non-medical prescribing, Health visitors, Emollients, Eczema, NICE guidelines, CQUIN

BACKGROUND AND CONTEXT
Health visiting practice and health visitors’ confidence regarding non-medical prescribing was discussed and reviewed in previous work (Brooks, 2013). In this previous work, Brooks (2013) identified that health visitor prescribing rates could be improved by offering continued professional development and guidance. Brooks (2013) had also made the recommendation that following the Call to Action (DH, 2011), newly qualified health visitors would require a robust support system to ensure that prescribing was inherent to their daily practice. This paper describes an initiative to develop health visitor prescribing practice and confidence, and more specifically, emollient prescribing.

Non-medical prescribing (NMP), and specifically the Community Practitioner Nurse Prescriber (V100) qualification, has been an inherent element of the health visitor training course since 1999. NMP was first proposed in the Crown Report (DH, 1989) and there are now more than 54,000 nurse prescribers in the United Kingdom (RCN, 2012). The number of Community Practitioner Nurse Prescribers has increased since 2011 due to the Health Visiting Implementation Plan: A call to action (DH, 2011). An additional 6,000 health visitors have been trained across the UK due to the Call to Action and the majority of these newly qualified health visitors will have had the Community Practitioner Nurse Prescriber (V100) training incorporated into the Specialist Community Public Health Nurse (SCPHN) course, although it is accepted that this is not a mandatory element of all the SCPHN courses on offer. It was identified by Brooks (2013), Hall et al (2006) and Thurtle (2007) that health visiting prescribing practice is low. Less than 50 per cent of health visitors regularly prescribe, and a strong theme identified by Brooks (2013) was that continued professional development can support an increase in prescribing practice.

A limitation of Brooks’ previous work was that it had only been carried out in one small inner city locality and therefore this project would be widened to include all health visitors in the organisation. The project was carried out in a large NHS Community Trust in the East Midlands area. The Trust covers an inner city area as well as large rural county districts. There is a vast diversity within the region and the Trust services more than a million people.

Due to the Call to Action targets, the health visiting workforce has increased threefold between 2011 and 2015 in this locality. The health visiting workforce in this organisation stands at more than 250 whole time equivalent health visitors in 2015. This translates to more than 300 individual health visitors and therefore it can be seen that it was essential to engage this large workforce and ensure that their skills were effectively utilised. Young et al (2009) and Davies (2005) have conducted qualitative research with health visitors regarding their prescribing practice, and the themes that emerge focused on good quality patient care and a seamless service for patients. Non-medical prescribing has been evaluated very positively by patients, nurses and organisations (Courtenay 2010).

The initiative was to develop a prescribing decision making tool that all health visitors could use in their daily practice. The rationale for this was that it had been identified by Brooks (2013) that health visitors required Continued Professional Development to support their practice. It was also important to recognise that a high number of the health visiting workforce would be newly qualified within the organisation and the development of a tool would enhance their prescribing practice. A recommendation made by Brooks (2013)
was that a Commissioning for Quality and Innovation (CQUIN) could be developed to further improve health visitor prescribing practice. A CQUIN supports excellence in practice by linking a proportion of the commissioned budget towards achieving the agreed aims and objectives. Emollients made up two-thirds of all health visitor prescribing in the local area. These figures were retrieved using ePact, which is the national prescribing data tool. However, the ePact data also demonstrated that there was no standardised practice regarding the choice of emollients prescribed by the health visitors. Formulary products are carefully selected to ensure safety, efficacy and value for money, formulary adherence is therefore important where possible. Every regional area in the country has a database that recommends first choice products that medical and non-medical prescribers should advocate. There are sections for all treatable diseases and ailments, including a condition most relevant to this project, eczema.

The prescribing lead for health visiting and the lead pharmacist met and agreed that the focus moving forward would be on emollient prescribing. It was decided they would apply for support via the CQUIN payment framework as this would allow a financial incentive to be linked to the demonstrable improved practice.

**PROJECT**

The aims of the CQUIN were multi-faceted and focused on prescribing practice, improved knowledge of the local formulary, improved knowledge of the NICE guidelines for Managing Atopic Eczema (NICE, 2007) and standardising record keeping practice. The aims and objectives were:

1. To establish a baseline formulary adherence for emollient prescribing by health visitors.
2. To achieve the targeted formulary adherence for emollient prescribing by health visitors.
3. To raise awareness of emollients in the local formulary.
4. To raise awareness of the management of eczema based on the NICE guidelines Managing atopic eczema in children under 12 yrs (NICE, 2007).
5. To increase confidence of staff in this area of practice and possibly other areas of prescribing as a consequence.
6. To establish robust record keeping of prescribing practice that is auditable.

The prescribing lead for health visiting and the lead pharmacist for children’s services led and agreed a timetable to manage the project. The CQUIN proposal included the above aims and objectives, and was duly submitted to the joint commissioning panel. The CQUIN was accepted and the targets for each quarter were agreed. The commissioners linked £249,000 to this CQUIN, which therefore meant it became increasingly important to deliver on the targets set. The CQUIN targets agreed with the commissioners were as follows:

- **Quarter 1 (April –June)**: To establish a baseline of current health visiting practice regarding emollient prescribing. Demonstrate the current adherence to the formulary first choice products.
- **Quarter 2 (July- September)**: To raise the profile of the CQUIN across the health visiting service. To produce a formulary and guideline document for each health visitor.
- **Quarter 3 (October – December)**: To achieve a standardised prescribing practice of 60 per cent adherence to the first choice formulary emollient products.
- **Quarter 4 (January to March)**: To achieve a standardised prescribing practice of 70 per cent adherence to the first choice formulary emollient products.

The aim for quarter one was to establish a baseline figure of all emollient prescribing and cross reference this to the local formulary. We would then have a baseline figure to measure any progress against. The baseline formulary adherence was 29 per cent, which meant 29 per cent of all emollients prescribed by health visitors in the organisation were listed in the local formulary as the desired first choice products to prescribe. Or in other words, 61 per cent of emollients that had been prescribed were not the first choice products. The ePact database was used to run this report and develop this baseline figure. This percentage was low but was unsurprising as the health visitors were generally unaware that there was a local formulary that advocated first choice products to prescribe. Over the previous year the author had been leading on the delivery of essential training updates on non-medical prescribing, and from these training sessions there was anecdotal evidence that most health visitors were unaware of the local formulary. The locally-agreed formulary gives medical and non-medical prescriber’s guidance on the first choice products to prescribe on all medical complaints, within this there is guidance on emollient prescribing (Leicestershire Health Community, 2015), so therefore the baseline report was run against these particular products.

In order to raise the health visitors’ awareness of the formulary, and the NICE guidance on Managing Atopic Eczema (NICE, 2007) and to increase confidence regarding prescribing practice, an emollient prescribing booklet was produced and every health visitor received a copy. The booklet was four pages and was produced in A5 size so that it could be carried in the practitioner’s diary. It was simply held together with a keyring so that if the local formulary changed in the future a new PDF document could easily be produced, laminated and added to the booklet.

The booklet gave guidance within a number of areas. Firstly, it detailed general prescribing guidance, which was taken from the NMC standards of proficiency for nurse and midwife...
prescribers (NMC, 2006). This reinforced the standards that the health visitors had to follow regarding their prescribing practice, particularly regarding repeat prescribing. There was also guidance taken from the NICE guidelines for Managing Atopic Eczema in Children Under 12 Years (2007). The inclusion of the NICE guidance gave the practitioners more support and direction regarding management of eczema and dry skin conditions (Fig 1 and 2).

A further aim was to improve record keeping and ensure that a robust system for audit was in place. The reason for this aim was that an audit of SystmOne would be undertaken to demonstrate the emollient adherence over quarters three and four. Therefore, a section was included within the guide on how to record prescriptions on the electronic record keeping system, SystmOne (Fig 2). During the planning stage of the project, the prescribing lead and the lead pharmacist considered the most appropriate and accurate way of undertaking the audit required for quarters three and four. The choices available were either the ePact system or SystmOne. It was decided that SystmOne should be used for a few reasons. Firstly, it was important to ensure health visitors knew how and where to record their prescriptions accurately as part of their normal record keeping practice and secondly, SystmOne is a live and up-to-date system where as there is a three-month delay in achieving accurate results via the ePact system. There is a time lag between the prescription being written and it being registered onto the ePact system. Also, ePact cannot identify patient information and so it would be impossible to ascertain why a non-formulary product was used.

SystmOne had been in use within the health visiting service since 2010 as a fully integrated paper-free record keeping system. However, recording and auditing of prescribing had not been addressed within the health visiting service prior to this project. It was therefore agreed that SystmOne would be used as this gives immediate month-by-month data. By teaching the staff how to record their prescription accurately, the data could be easily extracted by the information technology staff within the Trust. It was essential that this data was readily available as the targets set by the commissioners required there to be an improvement in the prescribing practice and formulary adherence.

The guide included the essential information regarding the first choice products that the health visitors were now encouraged to prescribe. This was presented in a table format as per Fig 3. The first choice emollient products were listed in the 1,2,3 approach that the NICE (2007) guidelines advocate. The 1,2,3 approach is a complete emollient therapy for the client. Practitioners were advised that it was best practice to prescribe an emollient, a soap substitute and a bath additive. Within the emollient section of the guide the products were listed from light to greasy in consistency so that the practitioner could give advice to the client about the products and how they feel and work.

Within this section of the booklet there was also information about other emollients and products that were acceptable to prescribe, however, practitioners were advised that these products should only be prescribed if it was the patient’s choice to have one of these products or if treatment with the first choice product had failed.

The formulary is reviewed every few years to ensure that the products remain the most efficient and cost effective. The project lead was very careful to give the message that the best emollient is the one that the patient will use. Therefore, it was acceptable to prescribe any other product from the Nurse Prescribers Formulary if the patient preferred that product. However, if the patient was presenting with a new skin problem then the health visitor should prescribe one of the first choice products initially.

Finally, advice regarding management of eczema was also included in the guide. This final sheet could be photocopied and given to the patient or the parent if required (Fig 4).

Two launch events were held, during which the staff were given the booklets and a presentation was delivered. The presentation addressed the aims of the CQUIN, which were to raise awareness of managing atopic eczema, prescribing emollients and record keeping. The prescribing lead also visited every health visiting team as a ‘mop up’ exercise to reach practitioners that had not attended the launch events.

Once the staff had been given their booklets and had attended the presentation, the outstanding aims of the CQUIN were to monitor prescribing practice and identify if there were any health visiting geographical teams who were not meeting the targets. The contingency plan was that the prescribing lead would revisit any health visiting team to discuss any problems that the staff were experiencing.

RESULTS

One of the main aims of the CQUIN was to increase prescribing adherence to the local formulary and hence standardise prescribing practice regarding emollient prescribing. The adherence results were recorded throughout the year-long project by running audit reports from SystmOne. As discussed previously, the baseline for formulary adherence at the start of the project was 29 per cent. The target agreed with the commissioners was to increase the formulary in quarter three to 60 per cent and quarter four to achieve 70 per cent adherence.

Table 1 demonstrates the monthly increases in formulary adherence and the average quarterly percentages.

The overall data per quarter was 69 per cent adherence in quarter three and 72 per cent in quarter four, therefore, the CQUIN targets of 60 per cent and 70 per cent adherence to the emollient formulary were achieved. A secondary result was that overall prescribing practice increased from 20 per cent to more than 60 per cent of all health visitors prescribing as part of...
their regular practice. Further audits have been undertaken since the project ended and this demonstrates that the formulary adherence remains stable as it remains above the targeted level of 70 per cent.

Qualitative feedback from practitioners has also been very positive. Evaluation forms were completed at the launch events and at additional training updates. Comments such as: "This is fantastic – just what I needed" "I now feel more confident and ready to prescribe as part of my normal practice." "Thank you."

An audit undertaken at the end of March 2015, a year after the project was completed, demonstrated that a high percentage of the newly qualified health visitors, who completed their training in 2013-14, were now regular prescribers. It is the authors’ view that this project was delivered at a significant time during the Call to Action (DH, 2011) and the culture of anxiety regarding prescribing is changing within the local health visitor service.

CONCLUSION
This project was driven by an aim to improve health visitor prescribing and was developed following work undertaken by Brooks (2013). This project used the basis of a CQUIN to demonstrate that an innovative approach to improve the quality of care can change practice. Prescribing among health visitors is generally low as discussed by Brooks (2013), however, by changing the culture this project has demonstrated that more health visitors value this skill as essential to their role and the seamless care that they can offer patients. The findings demonstrate that by giving health visitors training and guidance, their prescribing practice can be improved and standardised. Over the course of the project, health visitor prescribing increased in other areas of care, for example management of oral thrush in newborns, as well as emollient prescribing. It was very positive to note that a high percentage of newly qualified health visitors have embraced prescribing. The booklet is now part of each health visitor’s essential toolkit along with their NPF and their prescribing pads. The ongoing plan for the work is to ensure the momentum and focus on prescribing continues. Staff have the opportunity to attend essential updates every two to three years. The management of eczema remains a high priority for the health visiting service. It is also an aim to ensure that the culture regarding prescribing remains positive in the health visiting service by targeting newly qualified health visitors and health visiting students.

This work was presented in poster format at the CPHVA conference in 2014 and at the Institute of Health Visiting’s conference in 2015. The poster won the best poster competition at both of these conferences, and the author would like to thank the McQueen Institute and the iHV for their support at these conferences.

Table 1. Formulary adherence results by month and quarter

<table>
<thead>
<tr>
<th>Month</th>
<th>% Formulary adherence</th>
<th>% Quarterly results</th>
</tr>
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<tbody>
<tr>
<td>April 2013</td>
<td>25%</td>
<td>Quarter 1 (baseline) 29.6%</td>
</tr>
<tr>
<td>May 2013</td>
<td>33%</td>
<td>Quarter 2 61%</td>
</tr>
<tr>
<td>June 2013</td>
<td>31%</td>
<td>Quarter 3 69%</td>
</tr>
<tr>
<td>July 2013</td>
<td>43%</td>
<td>Quarter 4 72%</td>
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<tr>
<td>August 2013</td>
<td>68%</td>
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<tr>
<td>September 2013</td>
<td>72%</td>
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<td>October 2013</td>
<td>70%</td>
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<td>November 2013</td>
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<tr>
<td>December 2013</td>
<td>81%</td>
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<tr>
<td>January 2014</td>
<td>83%</td>
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<tr>
<td>February 2014</td>
<td>71%</td>
<td></td>
</tr>
<tr>
<td>March 2014</td>
<td>64%</td>
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</tr>
</tbody>
</table>

Key points

- Less than 50 per cent of health visitors regularly prescribe as part of normal practice.
- Emollients were the main item that health visitors prescribed.
- Health visitors were not up-to-date with the NICE guidance: Managing Atopic Eczema in under 12 year olds [NICE 2007].
- There was a demonstrated change in emollient prescribing practice within the health visiting service, which is now in line with the local formulary.
- Health visitors positively engaged with the guidance booklet regarding emollient prescribing, therefore prescribing practice can become standardised and prescribing episodes increase when guidance is offered.
- A large majority of the newly qualified health visitors, who had been trained during the Call to Action period, have embraced prescribing within their practice.


REFERENCES

As we come to the end of 2015, Community Practitioner sits down with the Unite/CPHVA professional officer team to chart their highs and lows from the past 12 months

**HIGHS**

1. The biennial School Nurse International Conference was held at Greenwich University this year (27 to 31 July). Delegates from the US, Japan and the Far East, Australia and Europe gathered together to see how the public health of school age children is articulated around the globe.

2. I was part of the pilot for the newly revamped NMC revalidation. This was a bit daunting, as I had to collect three years’ worth of information in a couple of months. However, it proved manageable and rather cathartic being able to concentrate on my own professional experiences for once.

3. The Scientific Advisory Committee on Nutrition (SACN) came out with its report on the dangers of too much sugar in the diet, and Public Health England supported the findings. I won’t hold my breath, but it would be nice to see something done about the incredible amounts of sugar that we all consume.

4. The students I’ve worked with as part of #adaywithdave during lectures at university and when Karen Heggs, one of my #adaywithdave students, won CPHVA Student of the Year 2015 at the CPHVA Awards.

5. The success of CPHVA Twitter Tuesday (#CPHVAtt), a hobby that Ros Godson and I have developed (with expert help from Louise Naughton, Amy Brewerton, Jane Beach and Angela Lewis), which has seen more than 850 participants getting involved and over 25,000 tweets in 2015.

**LOWS**

1. The Conservative Party came into government in May’s general election. This has sealed the end of the NHS as they are ideologically opposed to socialised medicine, and want an insurance-based system that gives healthcare according to what you pay, not on health need.

2. Austerity measures have led to great cuts in public health budgets, which will build up enormous health and social problems for the future.

3. The (English) government has ignored the House of Commons Education Select Committee’s recommendations that PSHE education should be made a statutory subject, despite intensive lobbying from statutory, voluntary and young people’s organisations.

4. The Trade Union Bill, which will undermine basic human rights and criminalise normal behaviour as well as making it extraordinarily difficult for trade unions to operate and thus allow poor managers to treat their workers badly, is going through Parliament without many people being aware of the consequences.
Obi Amadi, Lead professional officer

**HIGHS**

1. Female genital mutilation (FGM) being placed firmly on the professional agenda in the UK and internationally, hearing ministers say that the intercollegiate report Unite/CPHVA produced was a key driver.

2. The introduction of the workforce race equality standard.

3. I have been able to contribute to the development of the new e-learning programme for children’s emotional and additional health needs. This will be a really useful resource for practitioners.

4. The change to the immigration bill so that nurses from overseas do not have to return to their country of origin if they earn less than £35,000.

5. The release and development of the QNI/ONS voluntary standards for district nursing. This will shape the future for the profession in terms of education and service development.

**LOWS**

1. Hearing reports of professional staff being down banded, as we know that also means service delivery is likely to suffer.

2. Planned cuts to vulnerable families’ income, for example, tax credits. This makes it harder for professionals to provide services.

3. Still no progress being made on resolving our issues on the SCPHN part of the NMC register. We know it needs to be reviewed and strengthened, but as the Law Commission’s review recommendation did not make it into this year’s Queen’s Speech, we cannot move on.

Jane Beach, Professional officer, lead on regulation

**HIGHS**

1. Participating in the NMC revalidation pilot was an excellent opportunity to influence the model and to keep our members up-to-date with developments.

2. Delivering the #PORevalidation roadshows to members and non-members in their work settings. Take-up and attendance has been excellent, with participants reporting feeling much more reassured about what to expect.

3. Being part of the CNO/Wales conference planning group and reviewing the abstracts for the event.

4. Being part of a steering group tasked with aligning the Spiritual Care Standards with the revised Health and Care Standards in Wales.

5. CPHVA Conference!

**LOWS**

1. Waking up on May 8 to another five years of austerity.

2. Attending a talk on TTIP and understanding the adverse effects it will have on the health service.

3. My local hospital maternity and neonatal services being transferred to another site as the Trust says it cannot safely staff them.

4. Tendering of school and health visiting services, leading to uncertainty for our members and the children and families they care for.

5. The Trade Union Bill.

Gavin Fergie, Professional officer, lead for Scotland and Northern Ireland

**HIGHS**


2. The direct contact with members.

3. The Unite/CPHVA conference.

4. The Unite/CPHVA Awards.

5. Working with colleagues who are as passionate as I am in pursuing a quality outcome, not just those in the professional officer team, but at publishers, Ten Alps, our conference agents, Cogora, and more.

6. Being fortunate to be employed in a job that’s rewarding and offers such diversity.

**LOWS**

1. Not being able to make the advances for school nursing in Scotland and Northern Ireland that the discipline requires.

2. The governance issues from Stormont that directly and indirectly impact upon our members’ practice.

3. That those who are vulnerable are still vulnerable, with the ranks swelling with those who can no longer cling on.

4. That the ongoing challenge of the too few being asked to do too much is still the reality for members.

Ethel Rodrigues, Professional officer, lead on education

**HIGHS**

1. Revalidation: The chief nursing officer has finally announced the implementation of revalidation in England, launching in April 2016.

2. For the second year running, regional events have been held all over the UK.

3. Primary care conference in Birmingham: Our relationship with the Primary care conference has ben improving and we are now playing a wider role in this event.

4. Beyond Snowy White Peaks: Unite launched an initiative to end race inequality in the NHS.

5. City of London Career Fair: Unite in Health was among the panel on career opportunities for postgraduate students.

**LOWS**

1. Health visiting comes under the control of local authorities.

2. Important NMC rule change implemented in November 2015.

3. The government’s decision to cut £200 million from public health funds could see reductions in health visiting services, and possibly numbers.

4. The Trade Union Bill and the effects on a worker’s right to strike.

5. Ongoing NHS restructuring of services resulting in downbanding of senior practitioners.

December 2015 Community Practitioner 49
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