Stand out from the crowd

Celebrating excellence
At the CPHVA Awards 2016

Health visitor numbers
Do they add up?

Downbanding
We hear a CNN’s story
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May 2016 Community Practitioner 3
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Making lives better

Welcome to the May issue of Community Practitioner.

I’m writing this month’s editorial after attending my first CPHVA Awards on Friday 8 April. In spite of a very last-minute change of venue (huge recognition and thanks to the events team for handling this with aplomb!), the afternoon was a great success, returning once again to OXO2 on London’s South Bank.

Having attended other awards ceremonies within the healthcare sector, I am always struck by how humble and unassuming its members are. Despite the dedication and tirelessness of the nominees, a display of genuine shock and emotion never fails to ensue at the realisation that their hard work has been recognised by colleagues and peers. The CPHVA Awards were no exception: as we interviewed each of the winners immediately off stage from receiving their trophies we witnessed tears, speechlessness and gushing excitement as they attempted to put their feelings into words.

It’s as though, in this climate of uncertainty, those working in public health are genuinely staggered to receive recognition or reward of any kind. But deserve it they do, and every single nominee for this year’s Awards, whether a winner or not, is worthy of that recognition for their valuable contribution to our healthcare system. These are the people who make lives better and to whom we should be eternally grateful. A round-up of this fantastic afternoon celebrating the cream of community healthcare can be found from page 15 of this issue.

What also struck me while sitting at this celebratory lunch, surrounded by school nurses, health visitors and community nursery nurses is the stories I heard around the work you do, the exciting projects you’re engaged in and, inevitably, the challenges you face. A common thread among those England-based practitioners I spoke to was concerns around commissioning. The transfer of commissioning to local authorities has brought about significant changes for many of you, and those England-based practitioners I spoke to was concerns around commissioning. The transfer of commissioning to local authorities has brought about significant changes for many of you, and overwhelmingly, it seems, not for the good of the children and families with whom you work.

We’d like to hear more about the changes and challenges that face your area as a result of local authority commissioning. Whether the changes affect the integration of the 0 to 19 service now or in the future or staffing reductions within your service, we want to hear from you in order to get a better picture of the landscape across England. In this issue, for example, a community nursery nurse describes how the changes have affected her profession and the structure of the service (see page 22).

Of course, aside from commissioning we’re keen to hear more about the situation across the rest of the UK too, so please also get in touch if you’re a practitioner working in Wales, Scotland or Northern Ireland to share your experiences of public health nursing in these challenging times.
HOUSING CHARITIES HAVE SPOKEN
out about the rise of homelessness in Scotland after new figures revealed rise in families without permanent accommodation.

The latest quarterly statistics on homelessness from Scotland's chief statistician showed that on 31 December there were 10,467 individuals and families who were homeless and living in a temporary location – a rise of two per cent from December 2014.

The number of homeless children has risen by 13 per cent from 4,333 to 4,876 during the same period.

Families without homes are often moved around accommodations, which can include temporary council homes, hostels and B&Bs. This can have a detrimental effect on children's health and education.

Families with children made up 26 per cent of all those in temporary accommodation and homeless children spent almost one million days in these conditions last year.

Shelter Scotland has published data showing Scotland’s councils provided homeless households with an estimated 3.8 million days of temporary accommodation in 2014-15.

The charity has now raised concerns over whether the best use is being made of this expensive resource.

"For thousands of households every year this provision provides an important safety net in times of crisis. However, the average time spent in so-called temporary accommodation is 23 weeks, with one in 10 households spending over a year there," the report said.

“The impact of homelessness on children can be devastating to their health and life chances, with each homeless child losing on average 55 days of schooling a year,” it added.

“This rise in the number of homeless children will simply shock Scotland. For the figure to be 13 per cent higher than last year is simply unacceptable," Scottish Labour community spokesman, Ken Macintosh said.

“Some figures from Shelter Scotland make for grim reading. We shouldn’t have such widespread homelessness in Scotland in 2016, especially among children," he said.

A Scottish government spokesman said:

“We have legislated to enhance protections for families and continue to support local authorities in delivering on Scotland’s strong legal protections for homeless households.

“We are doing everything we can to make sure everyone has access to a warm and safe place to stay when homelessness occurs.”

Government injects £200m to social care programme

LOCAL AUTHORITIES AND CHARITIES will be given £200m to test innovative ideas for children’s social care over the next four years, it has been announced.

The Department for Education’s (DfE) Innovation Programme is providing the funds, with £100m set aside for projects in the first two years, which started from 2013.

The £200m funding for the period up to 2020 will be used to enable the most promising projects already supported under the scheme to continue their work.

New projects, focused particularly in the two areas of rethinking children's social care, and supporting the transition of adolescents through the social care system into adulthood, will also receive funding.

The announcement follows the prime minister's keynote speech on transforming life chances for the most vulnerable in which he described the government's children social care reforms as the “landmark reforms of the next five years”.

Education secretary Nicky Morgan said she wants charities and councils to come forward with bids for innovative and creative ideas to improve life chances for young people in their local area. Successful schemes will receive a portion of the £200m.

“We know children flourish when they are supported by leaders who have been given the freedom to translate their expertise, passion and drive into providing life-changing support,” she said.

Projects funded through the programme so far have transformed children’s social care, and help for vulnerable families across many UK boroughs.

Morgan also called on local authorities to use “devolution deals” so that they “have the freedom to deliver the kind of game-changing, innovative services that are right for vulnerable children and families in their area”.

The government said it now wants every devolution deal expanded to include children's services.
The Nursing and Midwifery Council (NMC) has appointed Dr Geraldine Walters as director of nursing and midwifery education, standards and policy.

Dr Walters, currently executive director of nursing, midwifery and infection control at King’s College Hospital NHS Foundation Trust, will take up the new role this summer. She is also a visiting professor at Buckinghamshire New University and at the Florence Nightingale School at King’s College London.

At the NMC she will be leading the work on transforming educational standards for nurses and midwives to meet future healthcare needs.

She also work to enhance career opportunities for nurses at all levels, and improved performance in infection prevention and control.

Dr Walters said: “I look forward to bringing my experience to my new role at the NMC, and working to ensure that our education standards are fit for the future.”

NMC chief executive and registrar Jackie Smith added: “We know that our education standards need to evolve in the future in order to meet the changing demands that the health and care environment will place on the nurses and midwives of tomorrow. I have no doubt that Geraldine is the best person for this job.”

The government must invest in physical education outside of term-time, exercise advocates say.

The Primary PE and Sport Premium will be doubled to £320m to spend from 2017 thanks to George Osborne’s ‘sugar tax’.

Executive director of ukactive Steven Ward said this is a chance to turn the tide on ‘generation inactive’.

Councillor Izzi Seccombe, the Local Government Association’s community wellbeing spokeswoman responded to a report calling for the sugar tax to be invested in school holiday sports.

“Sedentary lifestyles are a contributing factor to the child obesity crisis we are facing. Unless we act now, the number of obese adults in the country is forecast to soar by a staggering 73 per cent to 26 million people over the next 20 years,” she said.

“We back the calls of ukactive for funding raised from the proposed sugar levy to not just fund physical activity during the school term, but also in school holidays.”

The new levy on the soft drinks industry will be put in place in 2017 and is expected to raise £520m for school exercise programmes in the first year.

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Prestigious awards open for entries

Applications are now open for the Mary Seacole Awards 2016-17.

The awards are given to fund projects that aim to improve healthcare for black and minority ethnic (BME) communities.

Nurses, midwives and health visitors in England are invited to apply for the awards, which are funded by Health Education England (HEE).

The focus is on undertaking a specific healthcare project or other educational or development activity that benefits and improves the health outcomes of people from BME communities.

The work undertaken for an award is expected to contribute to raising the national profile of equality and diversity and health inequalities.

The two available leadership awards are worth up to £12,500 each and allow winners to strategically influence HEE and NHS England’s work around equality and diversity, and health inequalities.

The development awards are worth up to £6,250 each and four are available to nurses, midwives and health visitors who wish to make positive and lasting contributions to address health inequalities.

A pre-application workshop will take place at Unite’s headquarters in Holborn, London on 21 April at 2pm.

For more information on the awards and to download application forms, visit the NHS Employers website at: www.nhsemployers.org
Interface communities most linked to sectarian violence and deprivation

A NEW REPORT ASSESSES what types of risks affect young people and children who grow up in places of high religious segregation or interface communities.

The joint study was conducted by the University of Liverpool’s Institute of Irish Studies, Queen’s University Belfast and the University of Notre Dame, Indiana.

Interface communities within Belfast are the sites most commonly linked to sectarian violence and social deprivation in Northern Ireland.

The study looked at a series of risks faced by youth and children linked to that violence, both sectarian and non-sectarian, alcohol and illegal drug use and wider behavioural problems.

The report found that many young people’s lives are negatively affected by risks tied to violence within and between communities, exposure to drink and drugs, conflict within the home, transgenerational exclusion, behaviour problems in school and low aspirations.

The aim of the report was to gain a better understanding of the types of risk to help develop better personal and community development with regard to health, work, education, fear and prejudice and wider opportunities.

Breastfeeding reduces ear infections, study shows

BREASTFEEDING AND vaccinations help reduce ear infection rates in babies, a new study shows.

The University of Texas Medical Branch at Galveston found the rates of ear infections during a baby’s first year have declined.

The investigators suggested that higher rates of breastfeeding, use of vaccinations and lower rates of smoking may be the major contributors.

The rates of ear infection dropped from 18 to six per cent in three-month-olds, from 39 to 23 per cent in six-month-olds and from 62 to 46 per cent in one-year-olds.

Twenty-year survival expected for majority of liver transplant children

NEW RESEARCH SHOWS that 20-year survival after childhood liver transplantation can be expected for almost 80 per cent of patients.

The study, from the European Association for the Study of the Liver shared long-term outcome data from medical records of children who received liver transplants over a five-year period, with a mean follow-up of 22 years.

Paediatric patients currently account for approximately 12.5 per cent of liver transplant recipients.

“Until now there has been no good answer as to how long children could be expected to live after liver transplantation,” said Josefin Martinelli, lead author of the study.

“While each child receiving a transplant is unique, this study provides robust evidence on the average expected survival rates,” she added.

Research sheds light on type 2 diabetes origin

The presence of leptin, a hormone secreted by fat cells that is critical to maintaining energy balance in the body, inhibits the prenatal development of neuronal connections between the brain and pancreas, a new study has found.

The findings, from The Saban Research Institute of Children’s Hospital Los Angeles (CHLA), could help explain the origin of type 2 diabetes, particularly in children of obese mothers.

This study reveals an unanticipated regulatory role of leptin on the parasympathetic nervous system during embryonic development, which may have important implications for understanding the early mechanisms that contribute to diabetes.

“We showed that exposure of the embryonic mouse brain to leptin during a key developmental period resulted in permanent alternations in the growth of neurons from the brain stem to the pancreas, resulting in long-term disturbances to the balance of insulin levels in the adult mouse,” said Sebastien G. Bouret, researcher of developmental neuroscience at CHLA.
Five simple steps:
#CPHVAtt Twitter Tuesdays

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

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

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

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

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

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

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

And finally...

Don’t forget that everything on Twitter is public, so be mindful of this when sending tweets. The Nursing and Midwifery Council (NMC) and Unite/CPHVA both provide guidance on the responsible use of social media. Other than that, get stuck in and don’t be shy – everyone is helpful and friendly! Twitter Tuesday chats are fun, informative and can even count as self-directed continuing professional development (CPD).
Health visitor numbers appear to drop amid data collection confusion

As new figures show a drop in health visitors, Alice Harrold looks into the potential reasons and whether the data collection has been consistent.

THE NUMBER OF HEALTH VISITORS (HVs) in England is dropping since the HV Implementation Plan ended, according to new figures from the Health and Social Care Information Centre (HSCIC).

It also appears that the total number of HVs in England is no longer being monitored by the NHS.

Until October 2015 the number of all HVs was collected by the HSCIC in the Health Visitor Minimum Data Set (HV MDS), a subsection of the NHS Workforce Statistics.

NHS England commissioned HSCIC to record the numbers HVs from the Electronic Staff Record (ESR) as well as non-ESR service providers, such as local authorities and some social enterprises via area teams.

There were 518 non-ESR staff members recorded in the last published MDS from September 2015.

All providers of NHS-funded services are required to submit details of their staff to support workforce planning and the commissioning of education and training.

The HV MDS was set up to help support the government’s commitment to improve the health visiting service and recruit 4,200 more HVs by 2015.

From July 2013 the HSCIC also collected HV workforce numbers from area teams that include non-ESR organisations.

“The publication of these extra health visitor-focused numbers will exist as long as the specific collection exists,” HSCIC said last year.

“As the commissioning responsibility for the 0 to 5 Healthy Child Programme (including health visiting and family nurse partnership services) transferred to Local Authorities in October 2015, NHS England no longer collects or collates information from health visiting services about HV numbers,” a spokesperson for NHS England (NHSE) told Community Practitioner.

The latest figures show a drop in the community nursing workforce since September, when there were 11,895 FTE health visitors in England, according to the MDS.

The government’s plan to increase the number of health visitors to 12,292 full-time equivalent (FTE) by March 2015, from a baseline of 8,092 FTE in 2010, has been unsuccessful.

The National Audit Office, in its February report on clinical workforce numbers, found that the gap between the supply of and need for staff was greatest for nursing, midwifery and health visiting, with a shortfall of 7.2 per cent of the workforce in 2014.

The total number of NHS clinical staff increased by 1.4 per cent each year on average between 2004 and 2014, although the rate of growth varied between different staff groups.
Nursing, midwifery and health visiting staff are the largest component of the NHS, making up 38 per cent of total staff in 2014.

However, the number of nurses, midwives and health visitors – the largest staff group – has only increased by 0.9 per cent each year on average – the lowest level of growth per staff section.

Despite missing its goal, the HV implementation plan resulted in a staff increase of 47 per cent between May 2010 and September 2015.

The number came closest to the planned target in March last year.

MP Dan Poulter said at the time: “Investment by government has reversed the historic decline in the number of health visitors – we are rapidly closing in on our target of 4,200 extra health visitors and expect to have over 4,500 more than in 2010 by September 2015.”

Between the end of the implementation plan and March 2016 the number of FTE HVs had dropped by 182, a 1.5 per cent decrease. This compares to a rise of 417 covering the same period in the previous year.

The report added: “Workforce policy in England is heavily centralised. The detailed pay, terms and conditions of 1.4 million staff are agreed in national negotiations under supervision from Whitehall.”

National Officer of Unite Health Sector, Barrie Brown, told Community Practitioner: “The whole report ignores the history and legacy of local negotiations in the NHS.”

“In the mid-1990s we had local pay negotiations and it was a total farce.

“The reality is that national agreements developed contracts that are common across the NHS so that health visitors across the country are rewarded in the same way.”

“If you dismantle national negotiations, you would lose what has been won from them already.”

He added: “And of course there are all these obstacles to local negotiations. It would cost time, money, and resources to localise contract negotiations. The way that they are done currently is the most economical.”

The NHS pay system, Agenda for Change (AfC), was developed at a national level in partnership with trade unions, based on the principle of ‘equal pay for equal value’.

The AfC was tested in 2009 by the Newcastle Employment Tribunal. It was ruled that AfC complies with anti-discrimination legislation and is consistent with the principles of equal pay.

Barrie Brown said that “leaving out” non-ESR staff from the HSCIC figures was “poor practice”.

“Although the commissioning process is taking place in many local authorities, the majority of health visitors are still employed by NHS Trusts,” he said.

“How can we track the changes that are taking place if NHS England have eliminated the MDS data?”

The number of HVs has now returned to being gathered from the NHS workforce census commissioned by the Department of Health.

The implementation plan target remains unmet and HV staff numbers once again appear to be dropping.
At Community Practitioner we are always striving to present the latest news and most relevant features to make your journal as valuable as possible. You – our readers – play a key part in this process by letting us know what matters to you.

We've created a short online survey to allow you to do just that. So, for the chance to share your views on your journal, please take a few minutes to answer our questions.

And there's more: by completing the survey you'll also be entered in a draw to win a £100 M&S voucher.

Complete the survey at: https://www.surveymonkey.co.uk/r/commprac

Thank you,
The Community Practitioner team
SAY WHAT?

We take a look at what you’ve been saying on Twitter this month during CPHVA’s Twitter Tuesdays (#CPHVAtt) and around important public health events.

@porkpielass
@clf0109 @RosGodson close working relations with the health visitors are valuable, base them together working in neighbourhoods #cphvatt

@RosGodson
@CommPrac to improve children & YP mental health I would do whole school health promotion on bullying and repeat EVERY YEAR! #cphvatt

@porkpielass
@RosGodson @CommPrac #cphvatt do we need to change our terminology from HV/SN to 0-19 HCP to work with LA commissioners?

@clf0109
@chelley1282 @RosGodson @Unite_CPHVA I’d like children to have breakfast at school & 30 mins exercise/pe clubs after school daily #cphvatt

@StudentHVA
@chelley1282 @clf0109 @davidamunday @CommPrac How would you rate a minor ailments clinic run by HVs good or bad idea? #cphvatt

@saffie
1 week till #cphvaawards16 excited to be there this year, celebrating practitioners and community practice #health visiting #schoolnurses

@leighannlittle1
Out in the dreary wet weather checking on patients. #nurse'sworkisneverdone. Love to all home health/visiting nurses out there.

@nmcnews
#Revalidation Historic change to improve standards for nurses & midwives comes into effect: https://goo.gl/7rRCm9

@LullabyTrust
Our new Safer sleep for babies animation – what you can do, what to avoid. #SaferSleepWeek bit.ly/1pp7MVC

@hayleyvernon3
@CommPrac journal arrived this morning with my reflections on my #adaywithdave with @davidamunday in London.

May 2016 Community Practitioner 13
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.

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


**Important Notice:** Breastfeeding is best for babies. Breastmilk provides babies with the best source of nourishment. Infant formula milks and follow on milks are intended to be used when babies cannot be breastfed. The decision to discontinue breastfeeding may be difficult to reverse and the introduction of partial bottle feeding may reduce breastmilk supply. **The financial benefits of breastfeeding should be considered before bottle feeding is initiated.** Failure to follow preparation instructions carefully may be harmful to a baby’s health. Infant formula and follow on milks should be used only on the advice of a healthcare professional.
The 2016 CPHVA Awards took place at London’s OXO2, with a spectacular view of the Thames, at a lunchtime ceremony on Friday 8 April.

The fourth annual awards day brought together school nurses, health visitors, nursery nurses, educators and community teams to recognise the exceptional work that CPHVA members do on a daily basis, in all corners of the UK.

Hosted by Community Practitioner managing editor Louise Naughton, this year’s event was the largest yet, featuring more categories to reflect evolving community healthcare practice and the diversity of roles that practitioners undertake.

The ceremony also incorporated the MacQueen Charitable Trust Awards, which were made possible through a bequest from Dr Ian MacQueen, former medical officer of health for Aberdeen and a passionate supporter of the work of health visitors and community practitioners.

Overlooking a bright day in London the 100 attendees, who had travelled from all parts of the UK, were served a three-course lunch before the widely anticipated awards presentation began. Turn the page for details of the 13 winners who were honoured at this year’s event, plus all the finalists who deserve equal recognition.

The prestigious ceremony was proudly sponsored by Kellogg’s, Vodafone, Johnson’s, Unite in Health, Community Practitioner, Zinc Media, Unite Insurance and the CPHVA Education and Development Trust.
Public Health Winner

Proudly sponsored by Unite in Health
Janet Taylor – Nurse manager, children’s services, South East Health and Social Care Trust, Belfast, Northern Ireland

Janet’s nominator said: “Janet cares about public health practice and inspires others to care as well. She advocates vociferously on behalf of marginalised groups to ensure their health needs are not overlooked. She promotes health visiting at every opportunity and continually stresses the importance of supporting parents to give every child the best start they deserve.”

Janet said: “Public health nursing is, I believe, the future. Our children and parents, and all the young people we work with depend on us so keep going!”

Finalists: Claire Clarke, Louise Hales and Niamh Hanlon

Universal Health Visitor of the Year

Proudly sponsored by Johnson’s
Fiona Semple – Health visitor/school nursing team leader, Campbeltown Hospital, Scotland

Fiona’s nominator said: “Fiona is an exceptionally dedicated health visitor who ensures the families she works with receive a ‘gold’ standard health visiting service.”

Fiona has contributed to the Early Years Collaborative and Getting it Right for Every Child programme in Kintyre and the NHS Highland quality improvement methodology.

Fiona said: “It’s such a privilege to be here. I never thought for a moment I’d win an award of this prestige. I’m honoured to represent the team that’s behind me. I love the job I do and it’s great to feel that we really are making a difference.”

Finalists: Helen Westwood, Asha Day and Audrey Martin

Student of the Year

Proudly sponsored by Unite in Health
Jenny Harmer – Student health visitor, Guy’s and St Thomas’ Trust, London

Jenny’s nominator said: “Jenny is a great inspiration both to her student colleagues and to the teachers who work with her. From the time that she applied for the programme Jenny has singled herself out by her commitment to getting the most out of her programme of study in order to make a significant contribution to child and family health, despite being a part time student. Jenny also encourages the same approach amongst her student colleagues. She has boundless energy and enthusiasm and has made a significant contribution to her student group over two years.”

Jenny said: “I’m not the strongest academically, so it’s really good to know that an award like this means you don’t have to be top of the class.”

Lecturer of the Year

Proudly sponsored by Zinc Media
Cath Coucill – Lecturer of family, community and public health, University of Central Lancashire

Cath’s nominator said: “As a lecturer Cath has successfully introduced training within health visitor and social work programmes in the Solihull Approach and is supporting the development of lecturer colleagues so that there is greater capacity to support workforce training. This achievement has been recognised widely and she has been invited on several occasions to speak at international conferences (recently speaking in Iceland) to support the training of practitioners in other countries.”

Cath said: “I see the award as being on behalf of all the other fantastic practitioners and my students who teach me. I learn from them every day.”

Finalists: Mary Malone, Lynn Sayer and Charlotte Smith
Community Nursery Nurse of the Year
Proudly sponsored by Unite in Health
Aleksandra Dackiewicz – Community nursery nurse, The Laurels Healthy Living Centre, London
Aleksandra’s nominator said: “Alex has been working in her team for over eight years. She is dedicated, committed, courageous and is always so full of life. She is always asking if there is more that she could do. She is always up for a challenge and also translates and works with most of the Polish families. She is the champion for ASQs in the team and will soon be involved in training some of the newly recruited nursery nurses. She deserves to be recognised.”
Aleksandra said: “Today is not about winning, it’s about being part of it. We’re all winners here so big credit to all the nursery nurses.”
Finalists: Sara Yardley, Deborah Morton and Amy Watkins

School Nurse of the Year
Proudly sponsored by Kellogg’s
Amanda Hulse – Specialist community public health practitioner in school nursing, Cumbria Partnership NHS Foundation Trust, Cumbria
Amanda’s nominator said: “Amanda’s passion, alongside hard work and determination, has helped to maintain a quality school nursing service within Cumbria, and to raise the morale of the school nurse and health visitor colleagues with whom she works. Comments from young people, alongside Amanda’s own evidence of exemplary practice, led to her being awarded the title of Queen’s Nurse in November 2014.”
Amanda said: “Keep doing what you like, test the boundaries, push yourself and just enjoy the job!”
Finalists: Angela McConvey

Leader of the Year
Proudly sponsored by Unite Insurance
Josephine Fee – Specialist safeguarding children’s nurse, Rusholme Health Centre, Manchester
Josephine’s nominator said: “Approaching retirement Jo has never slowed down. She is like a whirlwind and her energy and passion is contagious. During her career as an ambassador for supporting marginalised and vulnerable groups in society she has earned herself a reputation as an outstanding leader, which is reinforced by her dedication and commitment to safeguarding the most vulnerable in society. She really is an unsung hero.”
Josephine said: “I think the most important thing in leadership is kindness because staff are continuously going through changes and are evolving in their roles.”
Finalists: Fiona Semple, Sharon LePere and Claire Clarke

Specialist Health Visitor of the Year
Proudly sponsored by Unite in Health
Carroll Johnson-Chapman – Clinical team leader, health visiting teams for Spitfire and Boldmere, Stockland Green Primary Care Centre, Birmingham
Carroll’s nominator said: “Carroll deserves recognition because she has used her experience in an innovative way to support anxious parents to think clearly about their children’s health. She has worked on her project single-handedly raising funds and gaining support for her idea to become a reality. She has been inspirational in her leadership.”
Carroll said: “The award means a lot to me because I have worked really hard on the project. It was only a tiny idea on a beer mat in a pub and now here I am standing here today!”
Finalists: Mandy Hughes, Sharon LePere and Veera Samra
Practice Teacher of the Year

Proudly sponsored by Community Practitioner

Patricia Kelly – Associate practice teacher, Health Visiting Clinical Academic Hub, Sudbury Primary Care Centre, London

Patricia’s nominator said: “As an associate practice teacher supporting health visiting staff and students across three boroughs, Trish ensures that she keeps herself up-to-date with current research and leads and chairs regular development forums with health visiting practice teachers. She has made a substantial contribution to the development of health visiting PTs and students to meet the requirements of the national implementation plan.”

Patricia said: “I work with some amazing practice teachers in Brent and Harrow who all work incredibly hard and we have supported a large number of students over the last two years.”

Finalists: Penny Dougan, Rachel Dent and Jeffrey Ahmed

Team of the Year

Proudly sponsored by Unite in Health

Sue McCormick, Helen Golightly, Janine Newhouse, Julia Roose, Sandra Davies, Lisa Benn, and Jade Byatt – Children’s health inclusion team, Vauxhall Health Centre, Liverpool

Sue McCormick, who nominated her team, said: “The team really excels in showing compassion in a professional manner, and many families have moved on with renewed hope. Frequently the team sees families whose only possessions are the clothes they are standing in. This team is 100 per cent committed to this client group. They constantly strive to improve the care given by amending working practices. They really deserve recognition as this is a very challenging role. Every day they listen to traumatic histories from families and there can be a lot of tears. This is all in the context of an asylum system.”

The team said: “We all support each other because it’s a mentally and physically demanding role but we all love the job we do and that’s why we do it.”

Finalists: 0-19 homeless health team, First Community Health and Care; Seaside View Child Development Centre for Disabled Children; Community nursery nurses, First Community Health and Care; and Saffron Family, Young People and Children Centre

CPHVA Advocate of the Year

Proudly sponsored by Unite/CPHVA

Angela Lewis – Independent consultant for public health nursing, Yorkshire

Angela was selected as the Advocate of the Year by the CPHVA in recognition of her support for the association. Angela trained as a nurse in 1979 and as a midwife in 1981 prior to becoming a health visitor. She subsequently worked as a health visitor and practice teacher in Hull and the East Riding of Yorkshire. As professional lead for both health visiting and school nursing she was responsible for service improvement and for developing integrated working with the local authority. Angela is an active supporter of the #CPHVAtt Twitter chats every Tuesday and is passionate about promoting the work of the association.

Angela said: “I have been involved with the CPHVA since joining as a student, attending the annual conference and numerous other events. I have, and will continue to, contribute to roundtable events, I represent CPHVA at local, regional and national events. This advocacy role most recently extends to commenting and sharing posts on social media, raising the organisational profile and encouraging members to join in the discussions and become activists and advocates for themselves. There is strength in numbers. It’s important that we get a lot of support and guidance from being in the CPHVA.”
Elaine McInnes
The MacQueen Bursary of £12,500 for Excellence in Research was awarded to Elaine McInnes, policy advisor for Cambridge Community Trust, for her proposed project, What are the components of successful preceptorship programmes for newly qualified health visitors?

The judges said Elaine’s award followed “an excellent presentation in which she was able to justify her project fully and to clearly outline its significance for health visiting”.

Elaine said: “The quality of services that the health visiting profession delivers to families must remain first-class.”

Audrey Dillon
The MacQueen Travel Bursary of £2,000 was awarded to Audrey Dillon, health visitor practice teacher at South Eastern Health and Social Care Trust in Lisburn, Northern Ireland. Audrey’s project, located in Juba Teaching Hospital in South Sudan, was selected by the panel for “its sustainable approach to strengthen the education, skills and practice of the staff” and for “aiming to address the major causes of maternal and neonatal deaths and morbidity”.

Audrey said: “The project is very successful because it has been sustainable and when the people realise that you keep coming back, they engage with you more.”
WE WERE DELIGHTED WITH THE outcome of the CPHVA Awards. It was a chance to celebrate the fantastic work of community practitioners around the UK. Community practitioners work in some cases against all the odds and still provide fantastic services. We commend all those who were nominated and recognised at the awards ceremony.

Unite in Health is holding a roundtable meeting this month to discuss mental health. We will examine how we can stand up for people with mental health issues. We want to offer support to professionals with problems such as stress at work.

The meeting will discuss how we highlight and bring to attention mental health issues and improving the perception of mental health.

To include your views about mental health, contact your union rep or share your thoughts on Twitter using the hashtag #MHroundtable.

Social media is important for our members to use because it gives people the chance to share their views on a whole range of topics relevant to improving the health of the nation and the standing of healthcare professionals. Also it allows health professionals and anyone interested in health policy to contribute to the debate about the future of our NHS.

To mark World Health Day 2016 in April, Unite supported the first European Day of Action Against the Commercialisation of Healthcare. We did this by sending solidarity to our friends in Brussels through Facebook and Twitter. We’re asking our members to support this ongoing campaign by sharing the message online that our health is not for sale!

There will be a conference on 11 May, which Unite officers and members will be attending.

NHS England is responsible for a £65bn commissioning budget. If we want them to work effectively in delivering high-quality outcomes for patients, members need to get involved in the discussion.

The NHS England hierarchy needs to listen to healthcare professionals and recognise them as primary stakeholders.
The Social Partnership Forum has been established to tackle bullying and harassment in the workplace.

Unite has created a workforce issues group to challenge unfair behaviour and the culture of bullying which can be found in parts of the NHS.

Forums take place in each region of the country so that all health professionals’ concerns can be gathered nationally.

In order to increase involvement, we are asking members what they think are the three top principles that should be applied as the benchmark to workplace behaviour.

Share your thoughts on this with your colleagues, union officials, and on Facebook and Twitter using the hashtag #socialpartnershipforum.

It’s important that we get this right because there is a connection between harassment and bullying of professionals and patient experiences and outcomes.

The Home Office’s Migration Advisory Committee, a non-departmental public body, reviews the shortage of workers in various fields.

The committee of economists and migration experts put together a list of occupations and professions that have a shortage of people working in them.

This is used to advise the government on migration issues. It means that we can see when people from outside the EU are needed to address staff shortages.

Unite is fully involved in this process and is working to address the shortage of nurses and community practitioners.

We urge members to share their experiences of shortages. What is happening in your Trust? Are there constant recruitment drives? Why is there a lack of qualified people for roles?

Contact your union rep or tweet Unite and tell us if there is a shortage of staff in your workplace and how it affects your work and your patients.

Elections are one of the best opportunities that members have to have their needs recognised.

Unite urges its members to vote and to look at candidates’ manifestos in relation to health issues whether it is in Scotland, Wales, Northern Ireland, London, or Bristol – where they are having mayoral elections.

And in local elections, CPHVA members need to ask candidates about the commissioning of 0-19 services in their area. They should ask, for example, if the candidate would keep up the level of funding for these services when they go out to tender.

In London, members can ask mayoral candidates about the future of health visiting and community practitioner services.

Social media allows voters to ask the candidates personally if they care about these issues and what their opinions are. We need to put these issues on the agenda.

Of course the European Referendum will take place next month. Unite favours a common approach to dealing with the big issues like climate change, making sure there is a fair trade deal, and ensuring that there is equality and justice at work. We ask members to listen to the arguments carefully in the run up to the June vote.

Increasing union membership is always a top priority and the 100% Campaign aims to maximise membership in all workplaces across the union.

We have more power as a union if as many people as possible are members. We urge all members to ask others in their workplaces to join.

A high count membership is the strongest tool for a union as it gives those workers a say.

ColenzoJarrettThorpe@only1colenzojt
Happy #AntiRacismDay to all.
#StandUpToRacism big shout out to all that marched on Saturday. #equalityforall @ hopenothate
See: https://twitter.com/only1colenzojt/status/71197177678276609

PIP (UK)@EarlyPotential
PIP (UK) Retweeted Joseph Rowntree Fdn. #1001CriticalDays. Important issue for babies- emotional poverty has an enormous impact on developing mind.
See: https://twitter.com/EarlyPotential/status/710390591096561664

PHM@PHMglobal
European day of action against the commercialisation of health. 7 April. http://www.phmovement.org/en/node/10300
See: https://twitter.com/PHMglobal/status/710841851046187009

May 2016 Community Practitioner 21
Downbanding: in a CNN’s shoes

This month we hear from a community nursery nurse about how commissioning has affected their role and the changes that local authority commissioning is likely to bring

Interviews: Alice Harrold
THERE WAS AN ACKNOWLEDGEMENT

A number of years ago that there was a rapid decline in health visitor (HV) numbers. New HVs had not been trained in sufficient numbers in a long time and about 12,000 HVs had been diminished to 8,000.

During this period of time, there was not enough money to fund recruitment, so to combat the problem the NHS Trusts increased the number of community nursery nurses (CNNs) they employed instead.

Prior to this, CNNs were employed with HVs as part of the skill mix. This was where they took elements of a job that could be competently completed by somebody else with a different skill set and employed someone from another role to make up the skills missing from a certain team.

Alternatively, they brought others into the team with additional skills that the team did not have but which would be useful. CNNs fell into that latter category.

We are trained in child development and pretty much everything about children from 0 to eight years.

CNNs have some antenatal skills but predominantly their work is relevant once children are born. They undertake a two-year full-time or five-year part-time qualification Level 3 diploma.

CNNs started to become members of health visiting teams as long as 30 years ago, but it was in fairly small numbers – maybe one or two nursery nurses added to a patch.

They would be brought in to help with specific issues that arose, such as supporting parents with behaviour problems, potty training, eating problems, sleeping problems, teaching families how best to play with their children, and so on. So after HV numbers decreased, the number of CNNs increased.

Along with the skill mix, which is where they genuinely bring people in who are going to add something and bring something new to the team, there is also grade mix, which is where they bring people in that can do elements of the job but fundamentally what they’re after is somebody doing the job cheaper.

Grade mix is not about what’s right for the team and what’s right for the families – it’s about saving money.

On the whole the CNNs were employed under skill mix.

When the Call to Action came in most places managed to increase their HV numbers significantly; however, cuts were still needed to save money.

Nursery nurses became a really easy target, particularly because managers and commissioners suddenly thought: “We’ve got all these extra health visitors now so we don’t need all these nursery nurses anymore.”

Actually that was not the case at all, what we should have seen was the original number of HVs plus the nursery nurses.

Perhaps there may have been a little bit of overzealous recruiting of nursery nurses, but fundamentally they needed all the people to still do the job and complete the necessary work.

And the work has changed; it has increased. Safeguarding thresholds with social services have increased, for example, so there is a lot more caretaking of bubbling child protection issues for the HVs than there would have been previously.

Part of the Call to Action also laid out the expectation that HVs would take back all developmental assessments; a lot of which had become nursery nurse jobs.

Nursery nurses are very good in those roles because child development is what they are trained in.

Not realising that what CNNs did before they inherited the extra work from the lack of HVs still existed, many nursery nurses’ jobs have been scrapped or moved around since the HV implementation plan.

Most were not made redundant but the nursery nurse jobs have certainly gone in a lot of places, including Derbyshire.

When asked to comment, Derbyshire Council told Community Practitioner:

“The service has been commissioned to secure effective, professionally led provision across the county in line with need to achieve healthy child outcomes.

“The commissioning of the service has provided the opportunity and sufficient flexibility for the provider to develop a model of provision using appropriate skill mix to deliver the required outcomes.”

CNNs in many areas have been redeployed to new roles and locations,
not necessarily in the same band, for example, as healthcare assistants.

In the NHS suitable alternative employment is deemed to be ideally in the same band but equally it can be one band lower. In some areas last year CNNs received threats of redundancy and downgrading.

For example, if there were 10 CNNs in a team, the governing body could have decreed that they only needed five and those 10 staff members would have had to apply for the five jobs.

The five jobs would have been at Band 4 and the remaining five CNNs would have had to look for suitable alternative employment, most likely as healthcare assistants.

However, it is almost certain that those they had been downgraded would have been expected to do the same work they had been doing before.

It takes quite a strong person to say “no” to that because it is your job, it is your skill set, it is what you want to do. The process itself caused quite a significant number of nursery nurses to just leave – they’d had enough.

This process was fought very vigorously. Members of the public came out saying it was wrong and what the outcome would have been for them if it happened.

 HVs stood with us and said: “We can’t do this work without the nursery nurses – there’s not enough of us.”

The fight was won in as far as they didn’t do any of those things to the existing staff, so none of us were made redundant or downbanded.

However, they have created a new job with new criteria so that as we leave the workforce, they will review the post we’ve left and in all probability will employ a Band 3 family support worker instead of another CNN.

The new team members will probably have a nursery nurse qualification but will be recruited as support workers.

CNNs who remain as Band 4s have had to be very clear to try and differentiate what the Band 4 does over and above the Band 3.

However, there is only a matter of time before the Band 3s are being asked to do the same role and don’t know that they shouldn’t be.

Everyone was quite shocked when CNN jobs came under threat because the aim of the Call to Action had been focused on HVs. I don’t think anyone expected that outcome genuinely.

I think the results for the CNN role would have happened anyway but looking back, CNNs should have been mentioned specifically and repeatedly in the Call to Action, and perhaps the impact wouldn’t have been quite so bad.

There are lots and lots of positives from the Call to Action and the intent was very honourable.

Unfortunately, it is up in the air again now because that was only a guaranteed project until October 2015.

We are now in a situation where local authorities have taken over commissioning of HV services and they have a fraction of the budget that the Department of Health had.

With local authorities commissioning health visiting and school nursing services, CNNs are likely to come up against the same issues again.

For example, in children centres some of the staff roles are very similar to the CNNs. And unless it specifically says anywhere “you must employ a health visitor to deliver this particular area” I think both CNNs and HVs will be at risk. The local authorities are so cash-strapped that all the roles will go out to tender and they can use whoever they like.

The situation with school nurses (SNs) is very similar. Some teams are having to create almost seamless 0 to 19 services to make it much much harder for the commissioners to split their service up.

Many health visiting and school nurse services are going to other organisations, such as Virgin Healthcare. In Warwickshire, for example, school nursing has gone to a private company called Compass.

SNs have colossal caseloads. In some areas each SN has a high school and all the satellites schools that go with the high school, which often means that they have caseloads of around 3,000 children to one person. This is clearly impossible, so they end up with inactive caseloads and they can only activate the cases that they need to do something about.

This means that their work is based on what comes in rather than them going and seeking health needs which is what it’s meant to be about.

The gold standard for health visiting has long been to have caseloads of no more than 250 service users and to my knowledge that has never been achieved in most parts of the country. Most of the HVs that I work with have caseloads of 500.

In my area there is an absolute acknowledgement that the HVs won’t be seeing two-year-olds and that that will primarily be done by the nursery nurses.

There were also a significant number of Band 5 nurses who were employed to be part of health visiting teams and to my knowledge they were either encouraged to go and do the health visitor training or else their roles were scrapped and they found other jobs elsewhere. They very seldom make Band 5 nurses redundant because there was a shortage of nurses but this means for some people that they were put into a job they did not really want to be in anymore.
This month we look back to the period from 1926, when public health services became more accessible and the newly named WPHOA reached out to other countries.

**1926**

The WSIHVA’s newssheet enlarges and appears for the first time under the title of *Woman Health Officer*, which helps to inform people about the association and its work.

**1927**

Hundreds of gardens open to the general public for the first time after Elsie Wagg, a member of the Queen’s Nursing Institute’s fundraising committee, suggested opening private gardens to raise money for nurses. Members of the public pay a shilling a head to enter. The scheme is so successful it continues into September, by which time more than 600 gardens have opened and over £8,000 is raised. The funds are used to support retired nurses and towards training for nurses joining the profession.

**1929**

German public health and social workers travel to London for a visit organised by the association. This begins a regular series of international exchanges and educational tours between public health services across the world.

The Local Government Act sets out rules for the provision of a qualification and standard training.

**1930**

The WSIHVA changes its name once again to become the Women Public Health Officers’ Association (WPHOA) due to the inclusion of members working in other areas of public health. Specific training courses for health visitors are made compulsory so that each public health officer has appropriate training, for training.

**1931**

The WPHOA represents more than 1,000 members and the first of its regular series of annual conferences takes place.
Asthma is a long-term condition that can be well managed with regular medication. In some patients it is a very serious condition which, if not treated properly, can lead to asthma attacks that can be life threatening. However, with the right medicines taken at the right time according to a treatment plan, many patients are able to live a life without symptoms.

A new study from the University of Aberdeen – published in The Journal of Allergy and Clinical Immunology in January – claims that screening children with asthma for a common genetic change could help prevent attacks, but we are not quite there yet, Saša Jankovic discovers.
could help prevent asthma attacks and lead to more effective treatment.

The study of 4,000 children with asthma revealed that those with the gene change were 50 per cent more likely to suffer an attack than those without, when treated with a steroid inhaler and another treatment called a long acting beta agonist (LABA) – a medication that causes the muscles lining the breathing tubes to relax and widen the airway.

This is because around 60 per cent of people have a very common genetic change in the gene that makes the LABA work less well. The researchers found children with this change were 50 per cent more likely to have an asthma attack if treated with just a steroid inhaler and LABA. Children with the genetic change who were treated with other asthma medicines did not experience increased asthma attacks.

The study concluded that the presence of this genetic change made the LABA treatment less effective, with the implication that routine testing for this common gene may let clinicians know which asthma treatment works best in children with asthma and spare them an unsuccessful ‘trial by treatment’. However, with clinical trials still needed, this is not going to happen overnight, according to Richard Iles, consultant in respiratory paediatrics and clinical lead for the National Paediatric Asthma Collaboration.

“Our study shows that those with the gene change are more likely to suffer an attack because they are being treated with LABA, which is ineffective for them,” he explains.

In the meantime, he says, the question is: “How do we match the right children to the right treatment?” adding: “This is research work in progress – very encouraging – but it may be several years before it is fully interpreted and available as a clinical tool.”

SCREENING NOW

How and where can parents and carers of children with asthma access screening? At the moment, according to Asthma UK, there isn’t a screening process for asthma, and instead children are “usually trialled with an inhaler” if they are suspected to have asthma.

Because the causes of asthma vary from person to person, diagnosis involves asking about symptoms and when they’re worse, whether anyone else in the family has asthma or allergies, and whether the child was born early or had breathing problems as a baby. The GP or nurse may also listen to the child’s chest for any wheezy sounds, or test their lungs with a peak flow meter if they are old enough.

Since asthma symptoms can come and go, they will also ask if the child has been wheezing, coughing at night or in the morning, has difficulty breathing or has a tight, sore feeling in their chest.

A diagnosis of asthma is likely if the child experiences symptoms frequently and they keep coming back, even when they don’t have a cold or virus, or come in between colds; if symptoms are more obvious at night, in the early morning or after exercise, if they develop when the child is around pets, cold or damp air, or other asthma triggers, and if their symptoms get better after a ‘trial of treatment’, where they are given one or more asthma medicines to see if they help.

If the child responds to the trial of treatment, Asthma UK says it’s a very good indication that they have asthma and the treatment is likely to be continued at the lowest possible dose to manage their symptoms. If severe asthma is suspected, the child will be referred to a specialist doctor, who will be able to explain more about their diagnosis and treatment and how to manage their asthma. If a diagnosis is unclear or they don’t respond to the trial of treatment then further tests may be carried out.

AFTER DIAGNOSIS

According to Asthma UK, a number of measures can reduce a child’s risk of having an asthma attack. Practitioners, parents and carers should make sure the child has an up-to-date written asthma action plan that lists the medicines they need to take every day to stay well, as well as what to do if their asthma gets worse, and what to do in an asthma attack. The child should also attend an asthma review at least every six months, and take their asthma medicines regularly as prescribed.

WHO SHOULD BE SCREENED?

In relation to the Aberdeen study test, Iles says the gene frequency “is not yet determined accurately enough to be specific – so much more work is required to work this out”, and Dr Charles Godden, consultant paediatrician and honorary medical adviser for the British Lung Foundation, agrees. He says: “In my opinion, no child should be screened for asthma at the moment as there is not enough proven clinical benefit for the cost associated with it.”

According to Godden, the problem of diagnosis is that “the goalposts move”. ‘It depends what you mean by ‘asthma’, as that definition changes all the time. For example, I see hundreds of parents every year who want to know if their child has asthma, and I explain that what matters more is whether they are on the right treatment for now, because in time it will become obvious,” he adds.

Another factor to bear in mind is that 50 per cent of children under five cough and wheeze, according to Godden, but “we don’t want to go and diagnose 50 per cent of our children as having asthma”.

“In the pre-school child sometimes asthma is a secure diagnosis because of family history and/or if the child is allergic and responds to treatment, but sometimes it’s uncertain because what they have are episodes of wheeze that may not continue – so we need to be cautious of labeling them as asthmatic [because] this wheezing can either be ‘viral induced wheeze’ [which comes with colds], or ‘multi-trigger wheeze’ [which is in between colds and tends to respond better to steroids],” he explains.

WHAT COULD CHANGE?

Iles says that, in theory, this new method of screening could “allow more targeted treatment”, but still “would not necessarily prevent all asthma attacks”. For now, he says asthma should continue to be treated in accordance with BTS/Sign guidance, with review of the patient to determine if a medication improves, maintains or worsens a patient’s control.

He says this review is “very important and is very effective when undertaken, but unfortunately these simple steps and principles are often missed even in basic care. This is a very important message to stress because if we did the basics well we would see a significant improvement in care.”

FURTHER PREVENTION

What else can be done for children living with asthma to prevent attacks? Godden
95% of Paediatricians† reported an improvement in common infant feeding problems with a formula like Cow & Gate Comfort¹

Evidence shows these partially-hydrolysed formula milks containing oligosaccharides (GOS/FOS) improve the symptoms of colic in bottle-fed babies.¹,² So if a bottle-fed baby’s colic is more than mum can manage with practical tips alone, put digestive care first with Cow & Gate Comfort.

Learn more about the evidence-based management of colic at in-practice.co.uk

*Important Notice: Breastfeeding is best for babies. Breastmilk 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 bottlefeeding may reduce breastmilk supply. The financial benefits of breastfeeding should be considered before bottlefeeding 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.

CLINICAL FEATURE

Asthma in numbers

- 5.4 million people in the UK are currently receiving treatment for asthma: 1.1 million children (1 in 11) and 4.3 million adults (1 in 12)
- Asthma prevalence is thought to have plateaued since the late 1990s, although the UK still has some of the highest rates in Europe and on average three people a day die from asthma
- In 2014 (the most recent data available), 1216 people died from asthma
- The NHS spends around £1 billion a year treating and caring for people with asthma
- On average, there are three children with asthma in every classroom in the UK
- The UK has among the highest prevalence rates of asthma symptoms in children worldwide
- Asthma attacks hospitalise someone every eight minutes; 185 people are admitted to hospital because of asthma attacks every day in the UK
- A child is admitted to hospital every 20 minutes because of an asthma attack.

Source: https://www.asthma.org.uk/about/media/facts-and-statistics/

More information:
British Lung Foundation
https://www.blf.org.uk/Page/asthma#Diagnosis

Asthma UK’s My Asthma resources for parents and children aged 6-11 years
https://www.asthma.org.uk/advice/resources/#one

remains quite a gap between clinical research and practical use on the shop floor, and there is still some way to go before we can use this helpfully. Iles agrees that there is a way to go before asthma screening is a viable option. He says: “[Aberdeen’s] work is exciting, but not relevant to the majority of asthma patients in primary care at the moment, but maybe in a few years.” For now, he advises, practitioners should stay up-to-date with current guidance. “If we cannot get the basics correct we will not be able to determine the utility of exciting new work.”

Iles agrees that there is a way to go before asthma screening is a viable option. He says: “[Aberdeen’s] work is exciting, but not relevant to the majority of asthma patients in primary care at the moment, but maybe in a few years.” For now, he advises, practitioners should stay up-to-date with current guidance. “If we cannot get the basics correct we will not be able to determine the utility of exciting new work.”
In the UK around one in 10 children and young people have a bowel or bladder condition (NICE, 2010), or a combination of conditions. These include daytime wetting, nighttime wetting and constipation and soiling. Bedwetting is the most common ailment affecting about half a million youngsters. Continence problems are more prevalent among young children, with studies suggesting up to 29 per cent of four-and-a-half-year-olds suffer from constipation and 15.5 per cent of seven-year-olds wet at night (Butler and Heron, 2008). Teenagers are affected to a much lesser degree with one to two per cent of teenagers wetting the bed (Verhulst et al, 1985). Continence problems can have a serious impact on the emotional wellbeing of children and families, particularly as children get older. Both sufferers and their families report feeling ashamed, embarrassed, isolated and scared of being ’found out’.

Common misconceptions about bladder and bowel conditions and how they should be treated, coupled with a general societal reluctance to talk about “wee and poo” mean many children’s conditions go undiagnosed, misdiagnosed and/or improperly treated for years. Many parents who call the helpline operated by ERIC, the children’s bowel and bladder charity, have had to visit multiple doctors before getting an accurate diagnosis for their child, during which time the child’s condition has deteriorated and the impact on the child and family’s wellbeing has worsened. There are simple things that can be done to help children and families get an accurate early diagnosis and the right treatment.

As Unite/CPHVA signs a letter from the Paediatric Continence Forum to NHS England requesting more investment in community-based services for children with continence problems, it seems that this particular area of child health could become neglected amid local authority cuts. Rhia Favero from ERIC, the children’s bowel and bladder charity, explains how public health nurses can help bring it back into focus.

An urgent need

In the UK around one in 10 children and young people have a bowel or bladder condition (NICE, 2010), or a combination of conditions. These include daytime wetting, nighttime wetting and constipation and soiling. Bedwetting is the most common ailment affecting about half a million youngsters. Continence problems are more prevalent among young children, with studies suggesting up to 29 per cent of four-and-a-half-year-olds suffer from constipation and 15.5 per cent of seven-year-olds wet at night (Butler and Heron, 2008). Teenagers are affected to a much lesser degree with one to two per cent of teenagers wetting the bed (Verhulst et al, 1985). Continence problems can have a serious impact on the emotional wellbeing of children and families, particularly as children get older. Both sufferers and their families report feeling ashamed, embarrassed, isolated and scared of being ‘found out’.

Common misconceptions about bladder and bowel conditions and how they should be treated, coupled with a general societal reluctance to talk about “wee and poo” mean many children’s conditions go undiagnosed, misdiagnosed and/or improperly treated for years. Many parents who call the helpline operated by ERIC, the children’s bowel and bladder charity, have had to visit multiple doctors before getting an accurate diagnosis for their child, during which time the child’s condition has deteriorated and the impact on the child and family’s wellbeing has worsened. There are simple things that can be done to help children and families get an accurate early diagnosis and the right treatment.
WHAT CAN YOU DO?
Families don’t always seek help for a child’s bladder or bowel problem. This tends to be because they either do not know where to go for help or that help exists or because of the associated stigma which stops them reaching out for help.

Parents might fear that their child will be bullied in school if their secret is discovered, or they might think that what is happening to their child is the result of bad parenting or behaviour, or that their parenting style will be thought of as oversensitive. Public health nurses can ease these fears by enhancing their own knowledge of bladder and bowel health and passing it on to families in easy-to-understand ways and by signposting further information and support.

It’s important to make it clear to parents, carers and children that continence problems are very common. This will help children and their families break free from the thought that they’re the only ones suffering and that they have to deal with their problem alone.

It’s also important to explain that continence problems develop outside of the child’s control and that neither the child nor the parents are to blame. In the vast majority of cases they are not a sign that a child has behavioural problems, nor are they a sign of bad parenting.

Put parents at ease by explaining that in most cases continence problems can be overcome, and by talking through the treatments available for their child. Information about treatment for different continence problems can be found on the ERIC website – www.eric.org.uk.

Community practitioners can also signpost parents and children towards ERIC’s guides to children’s bladder and bowel problems. There are four guides covering potty training, daytime wetting, nighttime wetting and bowel problems which can be downloaded from the ERIC website or ordered in bulk free of charge (see box for details). A selection of guides could be placed in a nursery or children’s centre and individual guides could be given out at clinics or home visits.

You could direct parents and carers towards places of support such as ERIC’s message boards for parents, children and teenagers and the ERIC helpline (see box) and recommend tools parents can use to manage wetting and soiling while they help their child to get clean and dry, such as bedding protection, absorbent underwear, specially designed swimwear and sleeping bag liners.

IMPROVE YOUR KNOWLEDGE
Public health nurses looking to enhance their knowledge of child and adolescent bladder and bowel health and earn CPD credits are invited to attend the Paediatric Continence Care Conference hosted by ERIC on Tuesday 12 October in Birmingham – see www.eric.org.uk/conference for details.

On Tuesday 24 May World Bedwetting Day will highlight how common the condition is and to encourage more people to seek help to stop wetting the bed.

In most cases bedwetting is caused by over-production of urine at night, reduced capacity of the bladder to hold urine, or inability to wake to the bladder’s signal that it’s full.

Bedwetting is nobody’s fault, and families and health professionals should be able to discuss the condition without embarrassment or guilt. However, the impact of bedwetting can be underestimated and trivialised and parents are often told to wait until their child ‘grows out of it’ instead of being offered a solution.

In the UK children aged five and over can receive treatment for bedwetting, so no one should have to endure years of waking up in wet sheets.

Head to www.eric.org.uk to find out how you can spread the word about World Bedwetting Day or search for #WBD16 on Twitter.
Recognition and management of learning disabilities in early childhood by community practitioners

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INTRODUCTION
Learning disability is defined by three criteria: lower intellectual ability, onset in childhood, and significant impairment of social functioning or adaptation (NICE, 2015). Internationally, the term ‘intellectual disability’ is becoming more acceptable but the term ‘learning disability’ is still widely used and accepted in the UK. In 2013 an estimated 1,068,000 people (adults and children) were living with learning disabilities in England. A significant proportion (n=224,930) were children aged 0 to 17 years (Public Health England, 2014). These figures incorporate population predictions and data regarding the number of people using health and education services. They also take into account those who are estimated to have undetected learning disabilities, especially in early childhood – it is often only severe learning disabilities that become apparent.

Each child will have a different combination of issues in areas such as communication, reading, writing and learning new things, and hence requires individualised support and resources. A number of children will be unable to perform basic daily activities and will require support throughout their lives – as they grow into adults they are at higher risk of adverse health, social and economic outcomes (Emerson et al, 2009).

CURRENT SITUATION IN THE UK
The Healthy Child Programme (Department of Health, 2009) and the Special Education Needs and Disability Code of Practice (Department of Health, 2015) have both highlighted the need for early identification of children with learning disabilities in the UK. This term is broadly used to denote children (aged 0 to five years) who show signs of significant delay in development in two or more of four key areas: gross motor skills; fine motor skills and vision; speech, hearing and language; and social, behavioural and emotional development (Bellman et al, 2013). Currently the NHS is facing a number of challenges in providing adequate provision of individualised care to support these vulnerable children. This is partially due to the current financial constraints in the NHS, lack of trained therapists and the model of care packages being split and hence delivered by different authorities (eg primary, secondary and private service providers) alongside education and social care providers. This paper addresses some of these issues, highlights those children at risk of developmental delay, outlines how this may present and suggests a management strategy for community healthcare professionals.

IMPORTANT OF EARLY DETECTION
Early detection and referral means that these infants and young children are given the maximum support in terms of specialist services, prompt intervention and education. This can improve their prognosis by limiting disability, and also improve the wellbeing of the child and family as a whole (Pratt and Patel, 2007). In addition, the multidisciplinary teams involved can target prevention of future sequelae and management of any secondary disability that may gradually manifest.

The parents or carers should also be involved in care as early as possible, with reassurance that, although a diagnosis of learning disability exists, appropriate management strategies will be initiated and their concerns will be addressed. Parents can then be given appropriate information and be empowered about what to expect in terms of the long-term prognosis (Shevell et al, 2003). Since some parents may blame themselves, it can be comforting to be told it is not their fault. Determining the aetiology of the developmental delay allows the families to undergo genetic counselling before they plan to conceive again, providing them with the knowledge that their child may have inherited a learning disability and there could similar risk in future offspring. It may also mean that certain risk factors can be altered before subsequent pregnancies, for example, giving high-dose folic acid to mothers of children with congenital spinal defects (Reisch and Flynn, 2002).

Early detection of learning disabilities also prevents victimisation of the child, both at home and in society as a diagnosis will provide better understanding of the difficulties the child is facing or likely to face in the future, and hence necessary adaptations can be made, such as a wheelchair ramp leading to a classroom. Finally, it also means that parents can access different support networks such as disability living allowance, care and mobility aids as soon as possible in order to support them and their child.

NORMAL DEVELOPMENT AND IDENTIFYING CHILDREN AT RISK
Development is generally assessed according to developmental milestones, defined by the four areas of development, which most children should be able to reach by specified ages. Premature babies should be corrected for gestational age until their second birthday.
while assessing development, as they will be delayed for their chronological age (D'Agostino, 2010). Community practitioners should monitor children's progress according to the developmental bands in the Early Years Foundation Stage (EYFS) (Early Education, 2012). If a child has a problem in one area or more, and especially if there are risk factors present (see Box 1), then a developmental delay may not be apparent at a young age, the developmental milestones become more advanced.

**Challenges in Recognition**

It is difficult to screen for learning disability because of the wide spectrum of normal development in young children. A national hearing screening programme (Public Health England, 2013) and pre-school screen for visual problems are in place – the pre-school vision screen is usually carried out between four and five years of age by a school nurse or orthoptist, depending on local policy (UK National Screening Committee, 2013). The Healthy Child Programme recommends assessing development in a number of areas at the six- to eight-week review, before the child's first birthday and at around two-and-a-half years of age; however, the National Screening Committee does not recommend screening for learning disability or developmental delay (National Screening Committee, 2005). This is because, although it fulfils the criteria of being an important health problem, there are no screening tests that show good predictive validity, ie they are not very effective at predicting who will have problems in the future. Furthermore, there is weak evidence that both screening and interventions are effective: although severe deviations from normal ranges of development can be detected easily. The screening committee does, however, recommend health promotion surrounding primary prevention and what is normal and abnormal in children, suggesting it should be delivered by health visitors. It also suggests the importance of "responsive child development and disability services able to assess children referred by parents".

In other developed countries, such as the US, formal developmental surveillance is part of every health visit – of which there may be up to 14 (Wood and Blair, 2014) – and specific developmental screening is recommended at nine, 18 and 30 months (American Academy of Pediatrics, 2006). In Sweden a nurse-led child healthcare programme exists, which includes surveillance, immunisations, individual support and group support for parents, where concerns such as developmental issues can be discussed and parents can be given reliable information and reassurance about their child's health (LeFèvre et al, 2014). Despite these and many other developed countries offering more reviews for developmental assessment than the UK programme, there is little evidence that regular reviews improve outcomes (Wood and Blair, 2014). Although most parents are 'experts' on their own children and are usually right in expressing concern (Hall and Elliman, 2006), this may pose difficulty in certain circumstances. Often children at risk come from a background where parents may be unable to recognise problems

**Box 1: Risk factors for developmental delay (Department of Health 2009; Emerson et al 2009; National Joint Committee on Learning Disabilities, 2007)**

**Perinatal factors**
- Prematurity
- Low Apgar scores at birth
- Low birth weight
- Hospitalisation > 24 hours in NICU
- Difficulty with swallowing, suckling etc.

**Environmental factors**
- Parents with learning disabilities or mental health problems
- Poor social background
- Poor living conditions
- Domestic violence
- Single parenthood
- Drug and alcohol abuse
- Victims of child abuse

**Genetic factors**
- e.g. Down's, William's, Turner's, Fragile X Syndrome, parental learning disabilities

**Chronic medical conditions** which lead to recurrent hospital attendances and admission may hamper learning due to lack/minimal stimulation, missed school days, ill health in conditions such as problems relating to prematurity, cystic fibrosis, chronic heart conditions, metabolic conditions, etc.

**Box 2: 'Red flag' signs (Bellman et al 2013; Horridge 2011)**

By first two years of life:
- Unable to sit unsupported by nine months
- Unable to transfer objects from hand to hand or show hand dominance by one year
- Abnormal pincer grasp beyond 15 months
- Unable to walk alone by 18 months
- Failure to speak recognisable words by two years

By pre-school:
- Unable to perform self-care tasks, eg hand washing, simple dressing, daytime toileting
- Lack of socialisation
- Unable to participate in play with other children
- Unable to follow commands during an examination.
early, due to their own learning disabilities, or indeed neglect the issues of learning disabilities in children due to their own health issues (eg substance abuse, mental health problems). Many parents may also be reluctant to admit to both others and themselves that their child may have problems as they may be apprehensive of the negative impact, its consequences and associated stigma. Others may have the misconception that the child will ‘grow out’ of his/her problems – though some children may do so – and therefore might delay seeking help.

MANIFESTATIONS

Learning disabilities can present in children in a variety of ways, in several different contexts and settings. These include the following.

- Sometimes parents may seek an opinion after noticing a delay or being concerned about behaviour and social skills. They will compare their child to others, for example to siblings or cousins, although first-time parents may be less aware of what is expected to be normal. Grandparents or other relatives or friends may also notice delay and highlight this to parents.
- Children may show developmental delay at scheduled contact with community health professionals or when under surveillance due to previously identified risk factors (eg prematurity, meningitis in early life, looked after children).
- When the child goes to pre-school or day care, professionals or other adults (with previous experience of child development) might recognise a deviation from the norm and discuss concern with parents, prompting referral. Later on at school, the child may have behavioural difficulties or be falling behind compared to their peers.
- Healthcare professionals such as a practice nurse or GP may recognise developmental problems when seeing the child for an unrelated illness or another health contact, eg for immunisation.

MANAGEMENT

History

It is important to gather a detailed history of the pregnancy and birth and review the Personal Child Health Record (PCHR), commonly referred to as the ‘red book’, as previous concerns from other health professionals may have been recorded there. This history should include: prenatal, perinatal, and postnatal events; mode of delivery; gestational age at birth; birth weight and head circumference; Apgar scores, newborn infant physical examination (NIFE), newborn blood spot and newborn hearing screening results. The child’s developmental history should be elicited, including at which age the child reached relevant developmental milestones, how they communicate and behave with adults and children, and how they interact socially and play. After this, one should sensitively enquire about social history, history of drug and alcohol abuse, domestic violence and other environmental factors. It is important to find out about family history of learning disabilities and consanguinity (parents being close relatives), which may point to a metabolic or autosomal recessive condition.

The questions suggested in Box 3 may be used when discussing concerns about development and a standard questionnaire, such as the Parental Evaluation of Developmental Status (PEDS), Denver Scale, Ages and Stages Questionnaire (ASQ) or Schedule of Growing Skills, could be used to validate concerns or demonstrate problems to a parent. (Department of Health, 2009b; Hall and Elliman, 2006).

Examination

To accurately assess development, the child should be examined appropriately by a trained health professional comparing the findings to the expected developmental milestones for their age. The initial developmental examination should be pitched at a slightly lower level than the child’s chronological age to allow for the variation in normal abilities and it is important not to frustrate the child or parents. The child can be shy and unwilling to speak, in which case it is sometimes necessary to rely on parental reports of their child’s abilities.

The child’s weight, height and head circumference should be assessed and plotted on an appropriate growth chart. This should be followed by a general examination for any skin abnormalities or signs of dysmorphism, ascertaining whether the child looks like their parents and siblings or has any unusual features. Any signs of neglect should also be noted and addressed appropriately. The child should be allowed to play while the history is taken from the parents, in order to observe their skills unimpeded. Their fine motor skills can be assessed, for example, by asking the child to pick an object up or draw a circle. Their movements should be assessed for any unsteadiness, lack of tone, spasticity, or weakness, and whether they can hold themselves upright and stand up, depending on age. Interaction between the child and their parents or the examiner should also be noted, including their speech and communication. Finally their vision and hearing should be assessed by an audiologist and orthoptist.

The authors suggest the following scheme for developmental assessment:

1. Examine the child yourself – this will allow independent objective assessment of the child’s abilities.
2. Involve the parents – this should be tried next, as the (reluctant) child will then feel more protected in a comfortable environment that is more conducive to exhibiting their skills.
3. Ask questions – this should be tried last, as there is risk for subjective reporting.

Box 3: Suggested questions to ask parents (Bellman et al 2013)

Community practitioners can ask the parents a series of questions to elicit any worries about development.

- Do you have any concerns about the way your child is behaving, learning, or developing?
- Do you have any concerns about the way he or she moves or uses his or her arms or legs?
- Do you have any concerns about your child’s speech and understanding of what you say?
- How does your child play? Do they enjoy playing?
- Has your child stopped doing something they could previously do? (i.e. developmental regression)
- How does your child interact with others?
- How does your child learn things?
- Has your child got any ongoing health problems?
- Was your child born early?
Referral to a specialist
Any child with speech problems should be referred for a formal audiology assessment and to the speech and language team. A child with fine or gross motor delay should have their vision assessed and be referred for physiotherapy and occupational therapy input. The under-fives may be referred to Portage, which often offers a combination of these as one support package at home (Russell, 2007).

If there is a concern in more than one area, taking into account risk factors, the child should be referred to a medical professional for assessment. The initial medical assessment will be undertaken by a specialist paediatrician and will involve determining the diagnosis of a learning disability and any identification of underlying genetic conditions or other co-morbidities. If there is any suggestion that an underlying medical condition may be responsible, investigations may be requested. These could include blood tests for haematological, biochemical abnormalities, metabolic problems and genetic associations. In selected cases neuroimaging, such as an MRI scan for structural intracranial abnormalities or an electroencephalography (EEG), may be indicated. Most cases of developmental delay are not severe enough to require extensive investigation and in the majority of cases no specific cause is found.

Assessment by multidisciplinary team
The child will then be referred for a multidisciplinary assessment, involving a number of health professionals, such as a community paediatrician, a physiotherapist, a speech and language therapist (SALT), a psychologist or an occupational therapist. Detailed tools and scales will be used to assess the child’s development and abilities in specific areas. Specialised tests may be undertaken for autistic spectrum disorders. They will formulate an individualised plan of intervention over the next few weeks.

ROLE OF COMMUNITY PRACTITIONERS
In the current scenario, with serious constraints on health services, it is important that health professionals work as a team to provide a complete care package to children with learning disabilities. Though there are many challenges in recognition and referral, this will ultimately improve the wellbeing of the many vulnerable children with learning disabilities in the UK. The authors suggest a few practice points that community health professionals may find useful, drawn up from the available literature (American Academy of Pediatrics, 2006; Bellman et al, 2013; Department of Health 2009; Horridge, 2011) and their experience in managing such children:
• Identify children with developmental delay early. Identification of risk factors and consequent manifestations of delay should trigger referral to specialist professionals.
• Support the health needs of children and families at risk, such as immigrant children, children from a low socioeconomic background, and children who are victims of abuse.
• Ensure that children are immunised as recommended to prevent further illnesses, especially as parents may forget to take their child for vaccinations among other complex aspects of their child’s care, or may consider development delay being a contraindication to immunisation. This is particularly of importance in immigrant children and children from travelling families.
• Community health professionals should work closely with GPs to monitor and reassess the changing needs of children with learning disabilities in order to consequently refer to a specialist, which may encompass physical, social or psychological issues.
• Ensure that all appropriate services can be accessed, including Disability Living Allowance.

CONCLUSION
Learning disabilities are common in children, but often remain undiagnosed or unrecognised. Initial presentation can often be subtle, leading to a delay in diagnosis. It is important that community health professionals remain aware of the risk factors and red flags for developmental delay while assessing a child. Community health professionals play a vital role in early recognition, referral and supporting families in the community before and after diagnosis.
It’s usually a mild condition which can easily be treated, but understandably may be a worry to parents. The key feature of nappy rash is a pink or red rash around the nappy area.

There are a number of ‘trigger’ times when infants are particularly prone to nappy rash. A survey identified seven ‘trigger’ times when parents believed their child was more prone to nappy rash:

- Teething
- Diarrhoea
- A cold
- First sleeping through the night
- Weaning onto solid foods
- Antibiotic use
- A change in diet like switching to a different type of milk

Being aware of these ‘trigger’ times means that parents can take steps to help prevent nappy rash occurring.

SKINCARE ADVICE

Good skincare advice has a key role in both treating and preventing nappy rash. Recommending these simple steps will help:

- Lie your baby on a towel and leave your baby’s nappy off when you can
- Change wet or soiled nappies as soon as possible
- Clean the nappy area using plain water or alcohol / fragrance free wipes
- Gently pat rather than rub your baby’s bottom dry
- Use a suitable barrier ointment at each nappy change

Most mild cases of nappy rash can be easily treated with a combination of good skin care and the use of an appropriate barrier ointment.

References: 1. Morris H, Getting to the bottom of nappy rash, Community Practitioner, November 2012, Volume 85, Number 11
1. Which of the following describes the criteria for learning disability?
   a) Lower intellectual ability
   b) Onset in childhood
   c) Significant impairment of social functioning or adaptation
   d) All of the above

2. Which of the following is not a key area of development?
   a) Gross and fine motor skills
   b) Speech, hearing and language
   c) Height and weight
   d) Social, behavioural and emotional development

3. Which of the following is not a benefit of early detection?
   a) Improved prognosis and monitoring of secondary disabilities
   b) Reassurance and education of parents
   c) Improved access to support networks
   d) All of the above are beneficial

4. At what age approximately does universal developmental surveillance occur in the UK?
   a) Six weeks
   b) Six weeks and nine months
   c) Six weeks, nine months and 12 months
   d) Six weeks, nine months, 12 months and 18 months

5. Which of the following is not a risk factor for developmental delay?
   a) Poor socioeconomic background
   b) Prematurity
   c) High birthweight
   d) Victim of child abuse

6. Which is the correct definition of a developmental milestone?
   a) Something the majority of children will be able to do by a certain age
   b) Something 50 per cent of children will be able to do by a certain age
   c) The minority of children will be able to do by a certain age
   d) None of the above

7. Which of the following is not a red flag for developmental delay?
   a) Unable to sit unsupported by nine months
   b) Abnormal pincer grasp by 15 months
   c) There is a concern in three areas of development
   d) None of the above

8. Which of the following does not indicate a risk for developmental delay?
   a) Parents with learning disabilities
   b) Parental smoking
   c) Something 50 per cent of children will be able to do by a certain age
   d) Failure to speak recognisable words by two years

9. Community health professionals should refer to a specialist if:
   a) There is a concern in one area of development
   b) There is a concern in two areas of development
   c) There is a concern in three areas of development
   d) All of the above, taking into account risk factors

10. Which professionals should be involved in assessing and supporting the child and their family?
    a) Healthcare professionals
    b) Healthcare professionals, physiotherapists and psychologists
    c) Healthcare professionals, physiotherapists, SALT
    d) Healthcare professionals, physiotherapists, SALT, psychologists and occupational therapists
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Attachment icebergs: Maternal and child health nurses’ evaluation of infant-caregiver attachment

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ABSTRACT
Secure attachment of infants to their caregiver is important when promoting the emotional wellbeing and mental health of infants. Maternal and child health (MCH) nurses are well positioned to observe the quality of interactions between infants and caregivers and to assess and intervene. However, as yet there are no approved methods to assess the emotional and mental health of infants in community settings. A qualitative descriptive study of 12 MCH nurses in Victoria, Australia, using semi-structured interviews, was thematically analysed. The data revealed that nurses used many skills to identify and manage attachment difficulties. Key among these were observations of interactions, collaboration with caregivers and reflective practice. Assessments and interventions are also influenced by nurses’ emotions, attitudes and workplace factors. An unexpected finding was that attachment markers can be likened to an ‘iceberg’: warning indicators at the tip can be easily observed by the nurse, while the less obvious underlying factors need to be explored in order to support attachment and improve infant mental health outcomes. Education for nurses should include concepts of attachment and link behaviours with emotional wellbeing.

KEYWORDS
Attachment, infant mental health, assessment, maternal child health nurse, universal service

INTRODUCTION
Assessment and support to improve infant-career attachment is an important consideration for health professionals working with children (Lieberman et al, 2015). Unrecognised attachment issues and their underlying causes can adversely affect the health of infants and their families.

Attachment is described as the connection between an infant, a child under four years of age (Mares et al, 2011), and caregiver (Bowlby, 1982). When secure, the infant will seek protection and reassurance from the caregiver, especially in situations of need and stress (Ainsworth, 1985). Secure attachment of an infant to their caregiver positively influences social, physical, behavioural and emotional development (Barlow et al, 2015).

Infant mental health is facilitated by secure attachment and enables an infant to experience and control emotions within a secure relationship, empowering effective environmental exploration and learning (Zero to Three, 2005). While infant development, resilience and socialisation is strengthened through secure attachment (Barlow et al, 2015), insecure attachments weaken psychological health and may lead to psychopathology and potentially, intergenerational transmission of psychopathology (Lieberman et al, 2011).

Attachment is a reflection of the infant’s perception (Ainsworth, 1985) and is influenced by the infant and caregiver interactive behaviours and internal representations (Vreeswijk et al, 2012). Healthy internal representations drive positive interactive behaviour and support the development of secure attachment. Caregivers’ negative internal representations, such as those resulting from abusive childhood experiences, can be replayed through maltreatment and rejection of their infants (Lieberman et al, 2011).

BACKGROUND
Early assessment of attachment quality is important as timely intervention leads to improved child, and ultimately societal health outcomes (Lieberman et al, 2011). In order to identify all infants at risk, policymakers aim to improve the screening of emotional development in children. This screening focuses on families with high-risk factors and results in the application of interventions aimed at building secure and restoring insecure attachments. Families at high risk of insecure attachment often experience mental illness, substance abuse, family violence, psychosocial or economic adversity, or social isolation (Barlow et al, 2015). In these circumstances, the infant is more likely to demonstrate avoidant, ambivalent or disorganised insecure attachment, with disorganised having the poorest outcomes (Madigan et al, 2013).

There is a generally understood need for more structured professional assessment of infant-parent attachment (Lieberman et al, 2011) to ensure that vulnerability from an insecure attachment does not remain undetected. Yet, assessment of attachment is complex and requires highly skilled practice (Bailey, 2009). Attachment assessment includes the observation and evaluation of the quality of the infant-caregiver relationship (Vreeswijk et al, 2012), the determining of social, environmental, psychological and biological risk factors (NICE 2012; Nelson and Mann, 2011) and an approach ensuring the empowering of the caregiver, supporting principles of health promotion (Lawless et al, 2014). Structured assessment might involve using a validated assessment tool enabling early screening of attachment quality (Appleton et al, 2012) or using a framework that assists practitioners to assess infant-carer interactions and behaviours (Cousins, 2013). The Infant Mental Health and Carer
Responsiveness Framework uses infant behaviours as indicators of infant emotional wellbeing and highlights potential indicators of infant mental health and indicators of concern regarding carers to identify infants at risk (Cousins, 2013).

As providers of a community-based, well-child health service and holders of qualifications in nursing, midwifery and child and family health nursing (Department of Education and Early Childhood Development (DEECD), 2009), MCH nurses are well positioned to observe interactions between infants and caregivers. The universal service, available from birth to six years, addresses individual, family and community needs (DEECD 2009). It is widely used, with almost all families receiving the service in the early weeks following discharge from maternity services (DEECD, 2014). The enhanced service offers home visiting for families needing further support.

AIM

The aim of this research was to gain insight into MCH nurses’ practice of facilitating an infant’s attachment to their caregiver and subsequently supporting improved attachment assessment. As there is limited use of assessment tools in health visiting to support a structured attachment assessment (Appleton et al, 2012), the authors decided to use Cousins’ (2013) Infant Mental Health and Carer Responsiveness Framework to guide the design of interviews.

METHOD

A qualitative, descriptive research design was selected in order to facilitate the collection of rich narrative data (Creswell, 2014). MCH nurses’ thoughts, perceptions and skills related to attachment of the infant to the caregiver were explored.

Victorian MCH nurses working in the universal service were purposively recruited via service providers and professional associations. Snowballing techniques, allowing participants’ colleagues to contact the researcher were also used (Schneider et al, 2013). Pilot interviews (Merrian, 2014) and one-hour, semi-structured interviews informed by current literature (Cousins, 2013; Merrian, 2014; NICE, 2012; Schneider et al, 2013) were conducted with nurses.

The interviews were audio-recorded and confidentially transcribed verbatim with member checking as needed. Contextual note taking was carried out post-interviews (Liamputtong, 2009). Coding and team-thematic analysis was carried out (Liamputtong, 2009) while NVivo data analysis software (version 10, QSR International) was used to organise and manage data and assist with analysis (Liamputtong 2010). Ethics approval was obtained from La Trobe University and supported by the Victorian Government Department of Education and Training (DET, formerly DEECD).

RESULTS

Participants: Interviews were conducted in 2015 with 12 female MCH nurses who had one to 15 years’ experience. Participants ranged in age from 43 to 59 years and were predominately employed on a part-time basis (one casual, one full time). All were employed in the universal MCH service and four had experience in the enhanced MCH service. Seven had undertaken additional professional development in infant mental health.

Themes: Thematic analysis identified five key themes to describe factors influencing nurses’ evaluation of attachment between infant and caregiver: personal, workplace, knowledge, intervention and skills. Subthemes described the MCH nurses’ perceptions in more detail (see Figure 1).

Theme one: Personal

Personal describes the personal qualities of the MCH nurses that influenced the assessment and management of attachment-related infant and caregiver interactions. Within this were two subthemes: emotions and attitudes.

The emotional context of the MCH nurse was seen to influence their practice. Positive emotions such as passion, enjoyment and hope appeared to be associated with a strong motivation to contribute to health change.

“It makes me feel motivated, because there are opportunities to make a difference.” (P6)

Negative emotions included a sense of burden, worry and sadness. Emotional mastery in managing complex emotional contexts was essential, for example in the need to manage conflict of interest scenarios. One participant (P9) verbalised a conflict of concern for the emotional wellbeing of the infant while supporting the needs of the caregiver who was impacting infant wellbeing.

MCH nurses’ attitudes of courage, healthy curiosity, honesty and open and non-judgemental communication positively influenced successful engagement when relating to caregivers.

“We need to be brave enough to ask her what it is, when you see it, not act like you haven’t seen it” (P2)

Theme two: Workplace

Workplace describes organisational factors influencing practice under the subthemes opportunities and challenges. Opportunities in the workplace highlighted positive aspects of employment which supported assessment and intervention. Continuity of care, enabling more trusting relationships, when combined with collegial support and clinical supervision, provided optimal assessment and intervention conditions.

Workplace challenges for MCH nurses reflected time and capacity pressures which could hinder assessment and intervention. These included: impacts of reduced funding, changing eligibility criteria and poor orientation of new nurses who were sometimes unaware of the available resources in the locality.

Theme three: Knowledge

Knowledge identifies aspects of MCH nurse knowledge that are important when assessing attachment. The two subthemes were: meaning of attachment and professional development.

The MCH nurses’ understanding of the meaning and impact of attachment was a strong motivational driver. Through their descriptions of infant and caregiver behaviours, all MCH nurses demonstrated their understanding of attachment and had a clear view of the criticality of attachment, yet an explicit description of attachment seemed challenging for some.

Professional development included MCH education, practice experience and further infant mental health training. Advanced knowledge attainment appeared linked to an individual interest in infant mental health. Some expressed concern that there was inconsistency of attachment understanding across the profession.
Theme four: Skills
For this study, the term ‘skills’ describes various abilities of MCH nurses that enabled them to achieve their goals of assessment and intervention. The subthemes were: observational, collaborative and reflective skills. The concept of attachment ‘icebergs’ appeared within these subthemes.
Assessment of attachment was likened to an iceberg: some aspects are clearly visible while other, often more significant, aspects are well hidden below the surface and only become clear when examined more deeply (Figure 2).

In addition to known risk factors, observation of the infant development, infant-carer interactions, behaviours and words were the focus of the assessment. Observed behaviours and words acted like signals pointing to underlying issues affecting the quality of the attachment and wellbeing of infants. These signals equated to the ‘tip of the iceberg’ (Figure 2).

Some participants identified that behaviours provided insight into the needs of the infant and the mental state of an infant and/or caregiver.

“It’s not just reacting to the behaviour, it’s looking at what’s actually happening underneath and what’s this child really asking” (P1)

Most nurses identified a link between observed behaviours and the infant’s emotional wellbeing and many noticed a connection between caregiver’s parenting skills and their own childhood experiences.

“So she’s going to give baby everything she’s got in her little cupboard. In terms of skills and love… and some of them don’t have many things in their cupboard” (P4)

MCH nurses needed to employ varied engagement tactics, such as collaboration, in navigating the complexities of building trusting relationships with the caregivers.

“Just sort of gently probing, building relationships so that the mother or the father feel safe to disclose.” (P6)

As the therapeutic relationship strengthened through being focused on addressing caregiver and infant needs, interactions between the infant and the caregiver could be addressed and underlying issues could be explored.

“Part of my job is to try and get it out there so she can have a look at it, and so we can explore what might be happening here.” (P3)

Collaboration allowed nurses to identify and address the dangerous ‘iceberg’ below the surface, the hidden underlying issues impacting on attachment. The nurses noted various psychosocial, economic and biological triggers affecting attachment (Figure 2). Some discovered ‘ghosts in the nursery’, the impacts of the past that influence parenting capacity (Barlow et al, 2015). Using this collaborative approach, some MCH nurses discovered vulnerability in seemingly low-risk families.

“With some probing I’ve uncovered family violence, uncovered history of sexual abuse with parents; some of those deep dark secrets that start to… be woven into parenting… in a seemingly very well-functioning parent and family, with no history of any sort of violence or anything that’s amiss.” (P6)

The combination of observation and collaboration enabled nurses to explore the complete attachment ‘iceberg’ through identification of concerning caregiver behaviours and infant behaviours and then collaboration with the caregiver to address the underlying issues in their life.

MCH nurses used reflective skills to improve practice through increased awareness of their own limitations and hindering emotional responses.

Theme five: Intervention
Intervention represents the management strategies of the nurse. The three subthemes identified were: promotion of attachment, strategies and services.

All nurses were eager to promote the attachment relationship. Many made this a priority using various approaches and strategies. MCH nurses expressed a great need to discuss the concept with the caregivers.

The strategies used by nurses aimed at addressing the caregiver’s and infant’s needs with the purpose of strengthening the responsiveness of the parents. Many focussed on highlighting the infant’s perspective and recognised the importance of making the needs of infants relevant to the caregiver. Caregivers and infants were referred to various programs or specialist services, depending on their particular needs. Those nurses with enhanced service experience had increased knowledge of available resources.

DISCUSSION
This research has revealed factors influencing the MCH nurse’s efficacy in assessing attachment quality and implementing appropriate interventions: personal, workplace, knowledge, intervention and skills (Figure 1). The efficacy of assessment and intervention supports the identification of vulnerabilities in families and subsequent pathways to strengthen the emotional wellbeing of infants and children (Cousins, 2013).

Personal factors (Figure 1), including positive and negative emotions and attitudes, have a potential impact on the MCH nurse’s receptivity and commitment to facilitate the infant attachment to the caregiver. Pettit (2008) reflected on the impact of negative emotions and recommended the implementation of specialist attachment services in local areas to ensure adequate support for nurses. Theodosis (2008) identified that there is personal gain from offering support to clients and that investment in the ‘emotional labour’ that nurses bring is important for establishing therapeutic relationships. Efforts to strengthen therapeutic relationships in...
order to positively influence the effectiveness of attachment assessment and intervention was uncovered by the research. Workplace factors (Figure 1) have an impact on the effectiveness of assessment and intervention. Continuity of care is commonly identified as a critical assessment success factor (McAtamney, 2011) and the participants identified continuity of care as an important strategy to aid the assessment process through stronger therapeutic relationships. Pettit (2008) recommends regular support for professionals through clinical supervision. Although not explored in detail, when supervision was provided nurses felt it was beneficial. Time pressures were experienced by MCH nurses in this study. This finding reinforces the resource implications of MCH nurses working with child behaviour problems identified by Sarkadi et al (2014). Resource capacity in the workplace needs to be addressed (Nelson and Mann, 2011).

The personal knowledge of the MCH nurse (Figure 1) significantly influences assessment and intervention. A clear understanding of concepts of attachment is important (Pettit, 2008). This study revealed knowledge of attachment was usually gained through additional education in infant mental health. Despite training, some participants had difficulty in describing the concept of attachment. Pettit (2008) found an uncertainty of definition and urged clarification to promote successful collaboration with intervention agencies. The MCH nurses’ skills (Figure 1) most directly impacted on the effectiveness of assessment and intervention. In the absence of obvious risk, it is the observational skill of detecting concerning behaviours and words that enables nurses to identify the ‘tip of the attachment iceberg’ (Figure 2) – the warning signals that point to underlying concerns. Puckering (2011) confirms the criticality of observational skills when a lack of eye contact, no name calling and an indifference of the mother towards an infant triggers awareness of underlying issues. Cousins (2013) links observation skills to the identification of signs of infant emotional and mental wellbeing.

**Figure 2: The ‘attachment iceberg’ illustration**

- **Infant signs**
  - Unusually quiet, clingy
  - Anxiousness, insecurity
  - Screaming, tantrums, anger
    - Poor feeding
    - Developmental delays

- **Caregiver signs**
  - Misinterpreting behaviours of infant
  - Intolerance, impatience, defensiveness
  - Argumentative family
  - Rough interaction or overprotectiveness
  - Not responsive to infant needs

- **Caregiver signs**
  - Controlling relationships, family violence
  - Relationship problems
  - Childhood issues
  - Difficulties with adjustment to parenthood
  - Caregiver mental illness
  - Large families or single caregivers
  - Intellectually disabled caregiver
  - Congenital abnormality in infant
    - Financial stress
    - Sexual abuse

**Beneath the surface: Sample of underlying root causes associated with attachment issues, often discovered through collaboration skills**

- Controlling relationships, family violence
- Relationship problems
- Childhood issues
- Difficulties with adjustment to parenthood
- Caregiver mental illness
- Large families or single caregivers
- Intellectually disabled caregiver
- Congenital abnormality in infant
  - Financial stress
  - Sexual abuse
and suggests health professionals need to understand the link between infant and caregiver behaviours and emotional wellbeing to be able to assess skilfully. Appleton et al (2013) confirm improved assessment skills when health professionals refer to the behaviours of infants.

Skilful collaboration with caregivers enhanced the therapeutic relationship, enabling a more detailed assessment and identification of hidden elements of the attachment ‘iceberg’ (Figure 2). The freedom to explore behaviours, mental states and economic, biological and psychosocial circumstances enables ongoing assessment, intervention and strengthening of attachment enhancing behaviours. While Rossetter et al (2011) highlight the importance of collaborative skills and using a partnership approach with vulnerable families based on health promotion principles, the findings from this study indicate the need for MCH nurses to also collaborate with apparently low-risk families. Puckering’s (2011) identification of ‘ghosts in the nursery’ in a seemingly low-risk family emphasises the need for adequate assessment and intervention in all families.

Collaboration with caregivers is supported by reflection, enabling nurses to incorporate past experience, knowledge gained from training and their own emotional responses to improve their capacity (Beam et al, 2010) to identify families in need of greater support. Through this, they are more likely to get to the substance of the ‘iceberg’ and discover the underlying causes for attachment concerns.

Nurses use interventions (Figure 1) such as referral to influence therapeutic outcomes (Barlow et al, 2015) and promote attachment. Universal services are encouraged to promote infant-caregiver attachment and offer various approaches of intervention (Barlow, 2009). Infant mental health strategies need to be evidence based (Nelson and Mann, 2011) and recommendations to guide practice should be developed.

LIMITATIONS

The research would benefit from including an observational component and repeating research with a larger group of MCH nurses who have no additional professional development in infant mental health training or experience in enhanced MCH service.

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Key points

- Promotion of secure attachment between infant and caregiver matters
- Assessment of infant-caregiver attachment and timely intervention is required in high- and low-risk families
- The observational skill of health professionals is vital to assess the emotional wellbeing of infants
- Observational and collaborative skills enable detection of attachment ‘icebergs’

RECOMMENDATIONS

Structured assessment of attachment quality in the universal service is recommended. Further education of MCH nurses should include concepts of attachment and link behaviours with emotional wellbeing. Resource implications need to be considered.

CONCLUSION

Attachment is a prevalent issue in both high- and low-risk families and secure attachment needs to be promoted. Detecting the tip of the ‘attachment iceberg’ requires skilful observation by health professionals to support the early identification of attachment issues. Skilful collaboration between MCH nurses and caregivers enables a more meaningful exploration of the underlying risk factors of attachment issues, potentially improving attachment assessment and management.

References


Health visitors have much to offer pre-registration child branch student nurses

INTRODUCTION
Recruitment into health visiting was placed in the spotlight by the Health Visitor Implementation Plan (DH, 2011). The primary care workforce has subsequently become the focus of several reports, which have highlighted the preparation and upskilling of nurses for a move to acute care in the community and primary care. Health visitors, such as those in local communities (DH; QNI, 2013), the Five Year Forward View (NHS England, 2014) and The future of primary care: Creating teams for tomorrow (HEE, 2015), Raising the bar: the Shape of Caring review (Lord Willis, 2015) recommends that the current workforce is upskilled to deliver the advanced skills and knowledge needed by future graduate nurses.

COMMUNITY PLACEMENTS
One of the key findings by Lord Willis in the Shape of Caring review (2015) is that it places far greater emphasis on the community for placements throughout nurse training. Health visitors and other primary care nurses can anticipate that they will be called upon to mentor and support pre-registration students in far greater numbers than they have before. Health visitors are in a key position to review and develop their nursing students’ placement experiences in line with theme five, Assuring a high-quality learning environment (Lord Willis, 2015:63).

Higher education institutes (HEIs) are currently working with Health Education England (HEE) and the Nursing and Midwifery Council (NMC) to address a number of recommendations in the Shape of Caring review (Lord Willis, 2015) for improving pre-registration nurse training and education. This includes a review of mentorship programmes, developing flexible models of training and to explore the introduction of additional fields of practice, such as community nursing (Lord Willis, 2015).

Attrition from nursing programmes is a concern (Wright and Wray, 2012) and along with recruitment of newly qualified nurses, it needs further consideration. Brown (2013) suggested that third-year learning opportunities in the community can make a difference to students feeling confident to apply for a community nursing post on qualifying. Studies have identified a link between adult branch students who spend their final placement in the community and their subsequent recruitment to community and district nursing posts on qualification (Shelton and Harrison, 2011; Brooks and Rojahn, 2011). This practice supports the current drive towards more nurses being prepared and feeling ready to start their career in the community.

There has been very little research to date that explores the learning opportunities or the value of the health visiting placement to the pre-registration student nurse. Research is therefore required to explore the potential of the health visiting placement in order to identify the impact that health visitors may have on pre-registration students’ learning. Further insight may also promote future discussion in terms of the health visitor offering a final sign-off management placement to pre-registration student nurses. The complexities of this have been tentatively broached by Brown (2012), such as the student achieving acute illness competencies before they reach their final 12 weeks of practice and meeting the NMC (2015) requirement of ‘due regard’ and sign-off status as a mentor, but these issues remain unexplored in practice.

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ABSTRACT
The primary care workforce has recently become the focus of several reports, which highlight the preparation and upskilling of nurses for a move to acute care in the community and primary care workforce, such as those in local communities (DH; QNI, 2013), the Five Year Forward View (NHS England, 2014) and The future of primary care: Creating teams for tomorrow (HEE, 2015). Raising the bar: the Shape of Caring review (Lord Willis, 2015) recommends that the current workforce is upskilled to deliver the advanced skills and knowledge needed by future graduate registered nurses.

KEYWORDS
Community placements, health visitors, learning opportunities, child branch, pre-registration
It is pertinent to consider the competing demands being placed on health visitors’ time while considering the benefits of the community placement. Health visiting has undergone a period of rapid growth and change (DH, 2013) as a result of the Health Visitor Implementation Plan (DH, 2011). A study by Kenyon and Peckover (2008) identified that students placed increased demands on practitioners’ time; for example, health visitors described reorganising their work to select appropriate learning experiences and reducing their administrative duties in order to accommodate the students’ learning needs. This led to tension among health visitors arising from the competing needs of students and clients and the subsequent pressure from ‘juggling’ several different roles. Kenyon et al (2008) identified an urgent need to ensure health visitors are supported in their role as mentors. The climate of upskilling nurses to work in the community setting can be viewed as an ideal time for health visitors to consider new ways of accommodating students and how to make learning opportunities explicit in the community placement.

LINKS TO CHILDREN’S NURSING

Health visitors can play an important role in training children’s nurses to become competent and committed to working with children and their families and working to the professional standards of practice and behaviour set out in The Code (NMC, 2015). Health visitors are well placed to provide an extensive learning experience, drawing on their broad knowledge of community services, multi-agency working and public health issues. They can draw on their extensive networks to explore learning opportunities in various multi-agency settings. One study demonstrated the benefits to be gained from students learning in a children’s centre, such as developing skills of collaborative working, learning about professional identities and each other’s roles, thus making the children’s centre an ideal opportunity for inter-professional learning (McCombe et al, 2008). The concept of interprofessional learning reflects the current shift towards working together to develop new networks and models of care in Raising the Bar (Lord Willis, 2015). Students need to consider new models of flexible working and innovative ways of working together as registered nurses are being called on to take responsibility for leading and managing interprofessional teams in Raising the Bar (Lord Willis, 2015) and to take a more prominent role in the management of a wide range of child health problems (HEE, 2014).

The supportive and nurturing nature of the one-to-one relationship offers an opportunity for the health visitor to role model and assess the student according to the six Cs as set out in Compassion in Practice (DH, 2012) following the Francis Report (Francis, 2013). Students value the opportunity to work one-to-one with a skilled practitioner (Greenglass, 2003; Murphy et al, 2012; Coyne and Needham, 2012) and this provides more opportunity for supported discussions, allowing students time to critically consider clinical situations (Brammer, 2008; Brooks et al, 2011). Shelton and Harrison (2011) identified that when there is positive shift in culture, and staff view students in practice as a resource to be valued by the team, the placement is more highly evaluated. There is also evidence that students who are encouraged to take on a more active role in practice can feel safe and more able to develop their independence and competencies (Brooks et al, 2011).

Box 1: The student’s experience

In my first year I was allocated to a team of health visitors for my placement. My initial thoughts were to be envious of the other half of my nursing cohort venturing out to the children’s ward. I didn’t yet understand the significance of health visiting to children’s nursing: I heard that the HV’s role was checking up on babies and weighing them. So when I contacted my mentor for the first time I was surprised and excited to hear what the role entailed and felt reassured that this was a great start to the point to my training. I was instantly welcomed by the team and taken under the wing of my mentor, whose enthusiasm made such a difference to my placement.

My health visiting placement gave me the opportunity to recognise developmental milestones in babies and children, and the ability to recognise any deviations in this. I found this beneficial later on while working in the hospital with clinically unwell children as I had gained an understanding of what to expect from a healthy child. Together we identified alternative learning opportunities to broaden my experience. I observed the community midwife and the specialist homeless health visitor. I also spent several days working with a practice nurse, which was an amazing experience. I gained insight and hands-on experience of clinical skills, which I would be using over the next three years.

I was able to observe the Universal Partnership Plus model of care through attending interprofessional learning opportunities, including: a professional panel to assess children and families referred through the common assessment framework (CAF), a core group, a mother and baby group in a children’s centre and a community planning meeting to set up a food bank. The health visitor encouraged me to develop my understanding of the local population through compiling a local community profile. I was able to visit and appraise the local facilities and services available for children and families while building a profile of my learning experiences to reflect on and discuss with the health visitor.

Regular home visits exposed me to safeguarding issues, which helped me to develop my observational skills; for example, learning how to observe the child’s and parents’ behaviour and their environment as part of a risk assessment. These skills greatly benefitted me in later acute placements. On my first home visit I observed a new baby review. It became evident that there were safeguarding issues and these could affect the health of the newborn baby. I learned about building relationships and developing a rapport to encourage families to engage with services. The benefit of the long placement allowed continuity as I was able to observe my mentor through the next three months of visits, meetings and liaison.

My mentor took me to visit a child in the special care baby unit who had complications as a result of being born extremely prematurely. We visited the child and his mother at a later date in his own home and I was able to observe the care package put in place by the paediatric community nurse, GP, health visitor and health visitor assistant. This helped me to think about needs in a holistic way and to consider, from the mother’s perspective, the reality of looking after a baby at home with complex health needs.

I look back over my time with the health visitors and remember how much I learned and what an excellent start it was to my nursing career. I was lucky to have such an amazing and supportive mentor. If you have a mentor who is enthusiastic and willing to teach you, you can make the most out of any placement you are allocated.
LEARNING OPPORTUNITIES

Students need to feel valued (Wright et al, 2012) and the health visitor can play an important role in supporting the student through their community experience. Health visitors can help the student to identify transferable skills and develop their observational, assessment, negotiation and feedback skills through discussions in practice. Such discussions will support students to make crucial links to theory and reflect over practice. This is supported by an account from Greenglass (2003) who identified while undergoing her second year of pre-registration nursing studies that the community children’s nurse encapsulated everything she believed nursing to be. She described the community as instrumental in her understanding of the nurse’s role in demonstrating empathy, compassion, facilitation, listening and being with families. The concepts of holistic care, family-centred care and working in partnership were not felt to be as transparent to the student in the acute setting as they were in the community setting (Greenglass, 2003).

Key learning opportunities for students lie within the Healthy Child Programme (DH, 2009; DH, 2010a) and the vision offered in the Five Year Forward View (NHS England, 2014). The health visitor can provide a valuable insight for students into improving public health outcomes set out in the Healthy Child Programme (DH, 2009) and Healthy Lives, Healthy People (DH, 2010b) and a focus on the health of local populations and integrated person-centred care (DH, 2014; NHS England, 2014). Placements and learning opportunities can be planned with the six high-impact areas in mind: transition to parenthood and the early weeks; maternal mental health; breastfeeding; healthy weight, healthy nutrition; managing minor illness and reducing accidents; health, wellbeing and development of the child age two – two-year-old review and support to be ‘ready for school’ (DH, 2010a). In addition to the high-impact areas, Table 1 identifies additional learning opportunities that can be used as a springboard for student discussion and reflection over practice during the community placement.

The community placement can provide a learning environment in which students can begin to understand how experiences and environmental factors could influence a child’s physical and emotional development. A study by Wainwright and Parry (2014) highlighted how students may only begin to realise the value of the community experience once they return to the hospital, for example, being able to identify the significance of the illness or condition on a child’s development and the impact of this on the child’s development (Wainwright et al, 2014). Students can learn about early intervention and preventative public health policy and practice. The health visitor can translate their practice through reflection to help the student understand how parents can attune to their child’s needs and provide the child with the responsive reciprocal relationship needed for healthy emotional development. Students can also be encouraged to review and reflect over the various services and opportunities available to children and their families (Cummins et al, 2010).

Health visitors can also guide students to navigate and make sense of the assessment, planning and evaluation of care through the service model: Universal, Universal Plus, Universal Partnership Plus and Community. This offers...
providing a high-quality and supportive aim of helping other health visitors who nursing and a strong grounding for future. It soon became clear that the placement working as a health visitor the author was a community placement in their first year. While also experienced in giving information and promoting positive lifestyle choices families with strength-based approaches an experienced practitioner. Health visitors to discuss complex and sensitive issues with who are at risk of poor outcomes. Learning is reinforced through the valuable opportunity insight into the identification of families that are in need of additional support and children who are at risk of poor outcomes. Learning is reinforced through the valuable opportunity to discuss complex and sensitive issues with an experienced practitioner. Health visitors can demonstrate their role in working with families with strength-based approaches and promoting positive lifestyle choices through positive parenting practices. They are also experienced in giving information and involving clients in their care as recommended in The Future of Primary Care (HEE, 2015). Child branch students from Anglia Ruskin University (ARU) currently undertake a 12-week community placement in their first year. While working as a health visitor the author was a mentor to a child branch student nurse for the duration of her first clinical placement. It soon became clear that the placement offered a valuable introduction to children’s nursing and a strong grounding for future nursing practice. This has prompted the authors to share their experience, with the aim of helping other health visitors who may perhaps feel daunted with the task of providing a high-quality and supportive placement for child branch students (Box 1).

CONCLUSION

Health visitors have much to offer pre-registration child branch student nurses in the community placement. There is a valuable opportunity for health visitors to promote a positive learning environment through a one-to-one nurturing and supportive relationship with students. The health visitor is an autonomous, experienced and valuable role model who is able to assess a student’s ability to demonstrate the six Cs. It is clear that the community placement offers numerous learning opportunities, which can serve to equip student nurses with many key nursing and interprofessional skills, such as leadership, management, assessment, communication and negotiation. In a supportive environment, students can begin to identify their strengths and weaknesses, and flourish as caring and compassionate nurses. It is evident that further research is required into the health visiting placement and learning opportunities for pre-registration students in the community. There is also a need to explore the possibility of the health visitor as a sign-off mentor in order to reflect the current climate of upskilling and widening the community workforce and the transfer of acute care into the community. Health visitors will need to strive to find a balance between caseload management and raising the bar for pre-registration student nurses’ community placements. The student featured in this paper provides an example of how a positive experience in the community can enhance a student learning. She has since secured employment as a children’s nurse on qualifying and says she would consider a move into health visiting in the future.

Key points

- Health visitor need to strive to find a balance between caseload management and raising the bar of pre-registration student nurses’ community placements
- There is a need to explore the community placement further in order to reflect the current climate of up-skilling and widening the community workforce, and the move of acute care into the community
- Health visitors can offer a positive learning environment through a one-to-one nurturing and supportive relationship with students
- There are numerous opportunities for student nurses to develop key nursing and interprofessional skills, such as leadership, management, assessment, communication and negotiation
- The community placement can be a valuable opportunity for students to identify their strengths and weaknesses, while mentors support them to flourish as caring and compassionate nurses.

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started the If U Care Share Foundation (IUCSF) after losing my eldest son Daniel to suicide in March 2005. Eleven years on and the charity, which I set up in Dan’s memory, has supported more than 600 people bereaved by suicide and worked with more than 15,000 young people in schools and football clubs up and down the country.

After the loss of Daniel, aged 19, his two younger brothers Matthew and Ben, along with their cousin Sarah (then aged 10, 5 and 13 respectively), hoped to do something positive to try and prevent another family suffering a similar experience. They felt his death could have been prevented and that if you care about someone then you should share how you are feeling. From this simple idea the three young family members created a wristband to be sold at football matches and other events in the North East to promote the ‘If U Care Share’ message.

After starting in 2009, IUCSF gained registered charity status two years later. Now the charity works throughout the North East providing one-on-one practical and emotional support to people bereaved by suicide. I work alongside other support workers who have their own personal stories of being affected by suicide. Matthew, Daniel’s younger brother, coordinates the TEAMH Project, which seeks to tackle emotional and mental health with young people. A large part of his time is taken up delivering talks to young people and sharing his story about the importance of talking about how you’re feeling.

In September 2014 IUCSF launched a national campaign, Inside Out, to raise awareness of suicide prevention. An annual Inside Out event is held on 10 September each year, which coincides with Worldwide Suicide Prevention Day. Many people who take their own lives display no prior signs and have no contact with mental health services. The results are devastating and life-changing for their families, friends and the communities they belong to. Quite literally, suicide turns people’s lives inside out.

IUCSF’s relationship with CPHVA began following support the charity has given to some Unite members who had been affected by suicide. Our charity would welcome the support of the CPHVA members whether through volunteering at events, fundraising or raising awareness around the issues surrounding suicide and promoting our Inside Out campaign. Any help given is greatly appreciated, no matter how great or small, as it all contributes to our work in prevention, intervention and support for those bereaved by suicide.

IUCSF believes that talking can make a difference, that suicide is preventable and that, in some cases, talking about your feelings can save lives. The campaign is simple: we ask people all over the country, from all walks of life, to wear at least one item of clothing ‘inside out’ on the 10 September, along with our ‘Ask me why?’ sticker. This is to prompt a conversation around the issues of suicide and to help reduce the stigma surrounding this subject, but most importantly to encourage people to open up and ask for help, when needed.

Last year’s campaign saw thousands of stickers distributed and hundreds of people from all over the UK joined us in bringing what’s Inside Out. We believe this campaign could make a real difference and start a lifesaving, culture-changing conversation.

For further information, visit our website at www.ifucareshare.co.uk

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Articles are considered for publication on the understanding that they are not being offered to any other journal and have not been published or accepted elsewhere. Manuscripts should be submitted with full author contact details to the editor via email to: helen.bird@zincmedia.com and authors should keep a copy of the material they submit.

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

- Where either ‘s’ or ‘z’ can be used, use ‘s’ (e.g. organisation)
- One to nine should be in words, 10 and over in figures
- Percent should be written as %
- Full stops should not be used to indicate abbreviations: CPHVA, eg. ie, NHS
- Some abbreviations do not need to be explained – eg CPHVA, NHS, NMC – but most should be spelled out in full when first used followed by the abbreviation in brackets (if in doubt, spell it out on its initial use)
- Capitals should not be used for role titles or professions, such as ‘health visitor’ or ‘nursing’.

**ARTICLE CONTENT AND LENGTH**
Articles should be written with our readers in mind – health visitors, school nurses and community nursery nurses, and others working in primary care and community settings. We welcome the inclusion of relevant figures, tables and images, though original work on paper is submitted at the owner’s risk. Electronic images should be at least 300dpi resolution and in tif, jpg or eps format.

**TYPES OF ARTICLE**

- **Professional and research**
Papers should be between 2000 and 3500 words in length (including references), and are subject to double-blind peer review following submission. Papers should begin with an unstructured abstract of 150 to 200 words, and up to five key words or terms that reflect the article’s subject and focus accurately. Research articles should be arranged in the usual order of introduction, background, study aim/purpose, method including confirmation of ethical approval, results, discussion, implications and recommendations, conclusion, acknowledgments and references.

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

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

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

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


Normally, references should not exceed 25 in number, and should usually be far fewer.

**POTENTIAL COMPETING INTERESTS**
Authors of professional, research and clinical papers are asked to declare:

- Any support from any organisation for the submitted work other than a funding grant
- Any financial relationships with any organisations that might have an interest in the submitted work during the previous three years
- Any other relationships or activities that could appear to have influenced the submitted work. We are not looking to exclude authors with competing interests, but do want to improve transparency for our readers.

**EDITING AND PUBLICATION**
The editor reserves the customary right to style and shorten material accepted for publication. The editor also reserves the customary right to determine priority and time of publication, though every effort is made to publish without delay.

If you have any queries, please do not hesitate to contact the editors of the journal:

- **Helen Bird**, editor
  Tel: 020 7074 7768 or email: helen.bird@zincmedia.com
- **Jane Appleton**, professional editor
  Tel: 01865 482606 or email: jvappleton@brookes.ac.uk
Touch-Learn International’s Baby Massage Teacher Training

Venues across the UK, plus in-house option. A five-day, comprehensive baby massage teacher course for health professionals and parenting practitioners provided by Touch-Learn International, the exemplary training company. This highly acclaimed programme is accredited by The Royal College of Midwives and the University of Wolverhampton.

This quality training programme includes simple massage techniques, coupled with an in-depth knowledge to practise safely, ethically and professionally so practitioners feel confident to teach parents in a variety of settings. Trainers are all experienced practitioners with professional/HE teaching qualifications.

Included within the course:
- Strategies to empower parents
- All mechanisms identified in current research to support parent-infant relationships
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- Relevant anatomy and physiology
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For further details of in-house training and UK dates please ring or visit www.touchlearn.co.uk

Touch-Learn International Ltd
Tel: 01889 566222 info@touchlearn.co.uk
www.touchlearn.co.uk

Learn Baby Massage with the International Association of Infant Massage

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

Our highly acclaimed comprehensive training comprises:
- A four-day training course including supervised practical teaching of a parent/baby massage class
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- By training with our highly respected organisation you will join a worldwide network of instructors offering a supportive environment to teach life-long parenting and relaxation skills.

Membership of the IAIM UK Chapter includes:
- A local, national and international support network
- Continued professional development including study days with expert speakers, trainer-led massage stroke refresher sessions and a biannual international conference
- Access to relevant articles, information and the latest research on our website
- A regular newsletter

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

Find us on Facebook - IAIM UK Chapter
For further details please visit www.iaim.org.uk. In-house trainings are available on request.

IAIM (UK) Chapter
0208 989 9597
info@iaim.org.uk
www.iaim.org.uk

Conference - Effective Work with Troubled Families and Families in Trouble: How to Build Best Outcomes for Children

Friday 10 June 2016

Time: 9.00am - 4.15pm
Chair: Honor Rhodes, OBE
Speakers: Carwy Oppenheim, Chief Executive, The Early Intervention Foundation
Susan Clayton, Head of Service: Early Help & Family Engagement, Rotherham Central, Strategies: Lead Family Support, with more speakers to be announced shortly.

Fee: £140

Prize includes various published materials – CPD Certified as 6 hours of study.

The pressures on families living with troubled relationships, and the challenges for the professionals working with them, is greater than ever. Research evidence is clear that fragile, strained and broken parental couple relationships are at the heart of family trouble. It is the quality of this particular relationship that adversely affects children and their parents, leading to poorer physical and mental health, lower academic attainment and disadvantaged life chances.

This conference looks at the research and policy arena that underpins the Life Chances Strategy, announced by the Prime Minister. It offers frontline staff from children and adult services the opportunity to explore current research and to test skills and techniques that help strengthen adult couple relationships to put it practice in their own work.

For more information and to book: www.tccr.ac.uk or training@tccr.ac.uk
Dying for a Tan

SunSense™ Tackles Melanoma with a New Tour
Supported by Melanoma UK

With the number of malignant melanomas continuing to rise, SunSense is on a mission to tackle the problem head-on. The SunSense Dying for a Tan Tour will return to the UK this year, educating the public on the dangers of UV rays and promoting a healthy attitude to sun protection.

Using an ultraviolet camera, SunSense will show people their hidden skin damage, caused by exposure to the sun and other UV sources.

Our message is ‘a tan is not a sign of good health’ and there is no better way to communicate this than seeing it for yourself.

Last year, 70% of the 2,000 people photographed said that they would make a positive change to their tanning habits, which is why we’re back and taking the tour to an even bigger audience during 2016.

Why don’t you or your patients visit us on our tour to have a UV picture taken – plus you will receive a 25% discount off the SunSense range.

Dying for a Tan
Tour Dates 2016

Healthcare Professional Events
18–19 May: Primary Care, Birmingham NEC.
5–7 July: BAD, Birmingham ICC.
19–20 October: Best Practice in Nursing, Birmingham NEC.
For general public event dates, please visit www.sunsense.co.uk

References:
4. NHS BSA prescription services, prescription cost analysis England 2014 data.