The rebate riddle
Looking at the unexplained inconsistencies in tax refunds

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Breastfeeding is recommended for the first 6 months of life. Please seek advice before introducing solid foods.
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The Role of Sleep in Happy, Healthy Baby Development

Sleep has important cognitive, social, emotional and behavioural benefits

Sleep plays an important role in baby’s brain maturation, learning and memory,1 helping to retain existing memories and create new ones.2-4 Sleep also helps improve baby’s social skills, including the ability to form relationships and relate to others.5,6 Babies who sleep better have been shown to be more approachable and adaptable.7 Improving babies sleep has been shown to improve maternal mood.8,9

Sleep problems are universal

Sleep problems are common, especially in the first three years.10 Difficulty falling asleep and night wakings are the most common sleep problems during infancy.10,11 There are a number of strategies for bedtime behaviour problems and night wakings in children, including behavioural management techniques, parental education, and medication. Studies have shown that use of behavioural (non-pharmacological) therapies for sleep problems are highly effective during infancy and toddlerhood.12

Routines help babies learn

The developing brain thrives on routines. Studies show daily routines in general lead to predictable and less stressful environments for young children and are related to greater parenting sense of competence and improved daytime behaviours.13

Why experts recommend a consistent before bed routine

The sleep-wake cycle is regulated by light and dark and these rhythms take time to develop, resulting in the irregular sleep schedules of newborns. The rhythms begin to develop at about six weeks, and by three to six months most infants have a regular sleep-wake cycle.14

Before bed routines help make sleep times and wake times different and distinguishable, supporting the child’s ability to self-regulate their sleep states.15 A consistent bedtime routine gives baby the opportunity to fall asleep in a relaxed, calm and secure state and get better sleep overall. The more frequent the routine, the better the sleep outcomes.16

Simple strategies to help parents at bedtime

Recommended routines include a warm bath, a soothing massage, and quiet activities to wind down, such as a lullaby, or reading a book.17 In a clinical study, a 3-step bedtime routine was proven to help baby fall asleep faster and sleep longer.17

A routine that includes multisensory stimulation through a warm bath followed by massage and quiet time is a simple behavioural intervention for improved quality and quantity of sleep in babies.17 Better sleep outcomes are associated with a consistent before bed routine. The earlier the routine is started the better.16

Behind the headlines

Welcome to the August issue of Community Practitioner

Many of us are still reeling from the shock decision by 52 per cent of the British population to leave the European Union. Whatever the reasons behind the leave vote, which are still being fiercely debated on social media and beyond, we are left in a position of reluctant acceptance. And as if the headlines we woke up to on 24 June weren’t enough! I was recently struck by an article published by the Guardian documenting five stories that ‘slipped through the net’ in the wake of the news. It’s a tried and tested government tactic: burying statistics, policies and proposals, particularly those that are likely to be met unfavourably, by releasing them at the same time as a major political event.

Perhaps most disturbing is the fact that three of the five stories the article identifies involve children. The first is the announcement by the United Nations that the Tory party’s austerity policies breach the UK’s human rights obligations. Since they were introduced in 2010, the UN states, the measures have had “a disproportionate adverse impact” on the most vulnerable and disadvantaged people in our society: children, disabled people and low-income families.

The other stories make for equally grim, yet predictable reading. The fact that the number of children living in poverty has risen by 200,000 in a year, meaning 3.9 million children are now living below the breadline, was also buried under Brexit headlines, as was the news that up to four in five children with mental health problems are being denied access to treatment in some parts of England.

While being doom-mongers will get us nowhere, these figures speak for themselves and it is unacceptable not only that the situation of so many children has worsened to such a degree, but that the government hoped we would miss such critical news. Community practitioners can only do so much to support children and families in crisis: it is sadly down to those governing the country to enforce the drastic measures needed to turn this situation around – many of the same people who no doubt contributed, ironically, to the plight in the first place.

Meanwhile, here at Community Practitioner we are focusing on the excellent practice being carried out on the frontline as we open nominations for the CPHVA Awards 2017. Turn to page 18 to find out how you can put your colleagues and peers – those who deserve recognition at a time of challenge and austerity – forward for one of these prestigious awards and embrace the opportunity to celebrate.

I’d also like to highlight the fact that the CPHVA executive committee elections are now open, for which all members are encouraged to nominate. A chair and a deputy for each Unite region is sought, so to nominate for these influential and prestigious positions, please use the form on page 9 or access it online at tinyurl.com/cphvaexecelections2016. Good luck to all!
Four in five councils ‘failing’ children with life-shortening conditions

OVER 80 PER CENT OF LOCAL authorities are neglecting to plan and fund care for seriously ill children and young people, Freedom of Information (FoI) requests have revealed.

The UK children’s charity Together for Short Lives (TSL) sent local authorities and clinical commissioning groups (CCGs) a series of FoIs to establish how well these organisations were commissioning care for vulnerable children.

The findings showed that the majority of children in England with life-shortening conditions and their families are being “short-changed” or “ignored”.

According to the survey, four in five councils are failing to plan and fund palliative care for young people, and almost one in five CCGs are not currently commissioning children’s hospices.

Barbara Gelb, chief executive of TSL, said the approach to these vital services is “inconsistent” and “typified by ignorance”.

“We already know that children’s hospices in England receive on average only 10 per cent of their funding through CCGs; far less than the 30 per cent adult hospices receive.

“Yet children’s hospice services provide vital lifeline care that saves the NHS millions.

“I call on the government and NHS England to respond to this by writing to CCGs and local authorities to urge that they now commission care for these children and young people who frankly don’t have any time to wait,” she added.

TSL has also rated councils and CCGs by the different aspects of care needed by vulnerable children.

Almost half received a zero or one-star rating for palliative care, while just 10 received the maximum five stars.

According to the charity, there is an alarming “responsibility vacuum”, with a number of CCGs confused about what they should be doing to support vulnerable children at the end of their life.

There are 40,000 children and young people with life-shortening conditions in England, many of whom have conditions that are complex, unpredictable and need specialist children’s palliative care.

Mandated reviews placed under scrutiny

THE FIVE MANDATED UNIVERSAL health visitor reviews are under evaluation after the transfer of commissioning for children’s public health services to local authorities.

The review, commissioned to Public Health England (PHE) by the Department of Health (DH), will assess the sustainability of health visiting and the 0-5 years Healthy Child Programme, commissioning intentions and the impact of innovative service models.

This will include the contribution of health visitors to the six high-impact areas that link directly to measurable outcomes and the potential to support delivery against national priorities, such as the tobacco strategy and childhood obesity.

Currently the mandate of five health reviews is due to finish in March 2017 unless parliamentary action is taken.

Ministers will determine future arrangements of the mandate based on the results of this review and decide whether the regulations are allowed to expire, continue in force or be amended.

The survey can be accessed at: https://surveys.phe.org.uk/TakeSurvey.aspx?SurveyID=Mandationreview
**Mental health care for children ‘should begin in the womb’**

**TACKLING MENTAL HEALTH IN CHILDREN**

should begin before they are born, local authority representatives have said.

Expectant mothers suffering mental health problems can have a "devastating" impact on the unborn child, which could set their personal and emotional development back by years, the Local Government Association (LGA) said.

A new report unveiled at the LGA’s annual conference in Bournemouth claims early interventions, interactions and experiences directly affect how a child’s brain develops.

Councillor Izzi Seccombe, LGA portfolio holder for community wellbeing, said children’s mental health is a priority for councils.

“What is deeply concerning is that there are a substantial number of children and young people who are increasingly struggling with mental health problems, such as anxiety, depression and self-harm, in addition to a minority who face potentially life-threatening conditions such as eating disorders and psychosis,” she said.

To understand the scale of the problem, Councillor Seccombe said, you need to go back to before a child’s birth.

“This emphasises the need to intervene early, so we can help children and young people build and maintain good mental health which has lasting positive consequences throughout their lives, both inside and outside school," she added.

The report, *Best Start In Life*, cites research that shows that if a baby’s development falls behind during the first years of life, they are more at risk of falling behind later on in life.

Research also shows that one in 10 school children has a diagnosable mental health problem, and that those aged 11 to 25 with mental illness are twice as likely to leave or have left school without any qualifications.

Councils across the country are already coming up with innovative ways of providing support to children and families.

Knowsley Council, for example, has been piloting the ‘Building Bonds’ scheme to help mothers struggling with mental health problems, while Portsmouth's ‘Little Minds Matter’ programme supports parents with mental health problems and helps reduce the risk of it affecting their children.

In Luton, the ‘Flying Start’ strategy encourages positive communication and behaviour among two and three-year-olds.

**Associate nurse position “unlikely” to become major part of workforce**

**THE NEW NURSING ASSOCIATE ROLE IS unlikely to become an integral part of the broader health workforce before the middle of the next decade, according to new research.**

The Health Foundation, an independent charity and think tank, argues that there are some risks in the introduction of new roles in the health service, with role confusion, skills gaps and regulation being the most prominent.

In its report *Staffing matters, funding counts* the health think tank pointed out that NHS England (NHSE) has a “mixed” track record when it comes to introducing new roles, stressing that it is never an appropriate “quick fix”.

Plans for the support role were announced by the government in December 2015; it is intended to fit alongside care assistants and registered nurses to deliver hands-on care.

After a consultation period Health Education England (HEE) announced the new role would be introduced, with test sites recruiting as many as 1,000 students to start training in 2017.

Lisa Bayliss-Pratt, director of nursing for HEE, said these advanced roles are required because there is a need to give more holistic care to patients.

The Health Foundation argues that at a time when the NHS is trying to control the rapid increase in staffing costs, the economic space to support a “new” role isn’t clear.

Unless there will be a determined effort to scale up the role by earmarking funding for training capacity, it will be unlikely that the nursing associates will become a “salient” part of the workforce before the next decade, the report argues.

**Mary Seacole statue unveiled after 12-year campaign**

**A STATUE OF WAR NURSE AND pioneer Mary Seacole was erected outside St Thomas’ Hospital London on 30 June.**

The unveiling follows a 12-year campaign and £500,000 worth of fundraising.

The statue is intended as a symbol of recognition for the contribution made by black and ethnic minority people throughout British history, the campaign group said.

Sculptor Martin Jennings created the piece, which is the first named memorial statue of a black woman in the UK.

In 2004 Seacole was voted the greatest black Briton of all time by the public. She was recognised on coins and stamps and a rare portrait of Seacole was hung in the National Portrait Gallery.

But in 2012 then-education secretary Michael Gove tried to remove Seacole from the national curriculum but was stopped by a national campaign with more than 40,000 supporters.

Unite/CPHVA officer Obi Amadi, who attended the unveiling, said: “I was honoured to be asked to be an ambassador and so proud to be a part of this day.

"Mary epitomised many values of nursing today. She cared for the wounded soldiers and was known to visit the front line to attend to them. She exemplified courage and committed. And most importantly, she put her patients first and was determined in her efforts.”

**CPHVA supports PNDA week**

The CPHVA has signed up as a supporter of the first ever Pre- and Postnatal Depression Awareness week on 5 to 11 September. The inaugural #PNDAW16 aims to highlight perinatal mental illnesses, the symptoms and how people can get the help they need.

**August 2016 Community Practitioner 7**
Weight gain in children associated with low hormone levels

A MAYO CLINIC-LED study found that obese teenagers have lower levels of a hormone potentially tied to weight management than teens of normal weights.

The study, published in the Journal of Clinical Endocrinology & Metabolism, was the first to look at levels of spexin in the paediatric population.

Previous research found reduced levels of this hormone in adults with obesity.

"Overall, our findings suggest spexin may play a role in weight gain, beginning at an early age," said Seema Kumar MD, one of the study's authors.

The cross-sectional study analysed spexin levels in 51 obese and 18 normal weight teenagers between ages 12 and 18. The participants had blood samples taken between 2008 and 2010 as part of separate clinical trials.

Researchers tested the blood samples to measure spexin levels. Researchers divided the teenagers into four groups based on their spexin levels.

Among the participants with the lowest levels of spexin, the odds of having obesity were 5.25 times higher than in the group with the highest levels of the hormone.

"It is noteworthy that we see such clear differences in spexin levels between obese and normal weight adolescents," said Kumar.

At-risk families could benefit from tailored parent training

AT-RISK PARENT TRAINING can be improved by using technology, a Georgia State University study has found.

The study focused on a parent training programme that reduces child maltreatment and risk in high-risk families through structured behavioural skills training during weekly home visits with families with under-fives.

The parent-infant interaction module ‘SafeCare’ teaches mothers to engage with and stimulate their infants in developmentally appropriate ways.

Researchers explored the effect of using a digital picture frame on parenting outcomes across a spectrum of at-risk mothers.

“Our goal is to increase positive, affective expressions from parent to infant, as research has found this to be integral to optimal infant development,” said John Lutzker, co-author on the study.

“The incorporation of a technological enhancement to intervention is a potential way to improve mastery of skills and we hypothesised that a digital picture frame would support skills learned within parent-infant sessions.”

“We found that the use of didactic or picture-based materials increases the use of bonding skills, including touching, looking, talking and smiling,” Lutzker said.

Digital picture frames are a cost-effective means of improving parent-infant interactions to better address the risk of maltreatment and potentially reduce intervention costs, the study suggested.

Childhood-onset epilepsy has ‘long-term effects’ on health and social status

Children and adolescents with epilepsy experience significant long-term socioeconomic consequences and higher personal health care costs, according to a new research.

The findings come from a study that followed young epilepsy patients until 30 years of age.

The study, which included more than 11,000 Danish young people with epilepsy and more than 23,000 controls, found that people with epilepsy, even many years after diagnosis, are neither able to compensate nor catch up with their peers in relation to overall health, education, and social status.

"The findings indicate that greater efforts are needed to address the long-term needs of patients with epilepsy," said Dr. Poul Jemnun, lead author of the Epilepsy study.

Frequent moving ‘impedes’ children’s social and academic functioning

EACH ADDITIONAL residential move that children experience is associated with a corresponding decline in reading and maths scores, according to a new study.

Less positive social skills and higher emotional and behavioural problems were also linked to frequent moving.

The Boston College study analysed 19,162 children in the US from a nationally representative sample as they progressed between ages five and 13.

While moving was associated with small decreases in children’s functioning, these detriments could accumulate over multiple moves.

Childhood abuse and domestic violence linked to later addictions

ADULTS WHO HAVE DRUG or alcohol dependency have experienced very high rates of early adversities, according to a new study published by University of Toronto researchers.

One in five drug-dependent Canadian adults and one in six alcohol-dependent adults were survivors of childhood sexual abuse. This compares to one in 19 in the general Canadian population.

More than half of substance abusers had been physically abused in childhood compared to a quarter of those who were not addicted.

After accounting for mental illness, poverty and social support, both sexual and physical abuse were associated with twice the likelihood of drug dependence.
## NOMINATION FORM

### Election notice

The CPHVA Executive elections are now live. We are looking to elect a chair and deputy for each Unite region. Please complete the below application form or access it online at: tinyurl.com/cphvaexcelections2016

Please return your nomination form by 23:59 on Monday 5 September 2016 to Irene Fynch, Unite in Health, Unite House, 128 Theobalds Rd, London, WC1X 8TN or fax to 020 7611 2555 or by email to cphva@unitetheunion.org

### Nomination proposed by:

Employer ..........................................................................................................................................................

Email address ....................................................................................................................................................

Phone number ..................................................................................................................................................

Unite membership number ..........................................................................................................................

Signature ..........................................................................................................................................................

### Nomination seconded by:

Name of seconder ............................................................................................................................................

Job title ............................................................................................................................................................

Employer ..........................................................................................................................................................

Email address ....................................................................................................................................................

Phone number ..................................................................................................................................................

Unite membership number ..........................................................................................................................

Signature ..........................................................................................................................................................

### Nominated candidate statement (no more than 500 words)

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A valid nomination will need to fulfil the following conditions:

- A CPHVA member without subscription arrears of more than 13 weeks.
- The nominee must be proposed and seconded by two CPHVA members without subscription arrears of more than 13 weeks from two different employers from a different branch of the constituency the nominee seeks to represent and a different employer to the nominee.
- The nominee should indicate which one of the twelve constituencies they seek to be elected to. The nominee must complete all sections of the nomination form including the personal statement which will have a maximum of 500 words. The statement should include details of activity that has supported the Association. The statement will be published in the October 2016 edition of Community Practitioner should it be necessary to hold an election.
Unravelling the rebate riddle

An exclusive Community Practitioner investigation has uncovered inconsistencies in the repayment of taxes and national insurance contributions overpaid during training, despite applicants sharing the same circumstances. Alice Harrold reports.

PUBLIC HEALTH NURSES WHO completed further training since 1999 may have been charged taxes in error and be entitled to a rebate of thousands of pounds, Community Practitioner has found.

In order to receive the money back, CPHVA members must apply through Her Majesty’s Revenue & Customs (HMRC). However, the procedure has been called “lengthy”, “inconsistent”, and “unfair”. Many applicants have been refused despite having the same circumstances as those who are successful.

“With each person’s response it’s like they are moving the goalposts,” one applicant said.

If the professional has moved Trusts since training, the process may be even more difficult, with some applicants waiting up to 18 months for a decision.

“We are working closely with NHS Trusts to ensure that all those who overpaid tax and NI receive refunds as soon as possible,” said HMRC.

A health visitor (HV) and CPHVA member, who asked to remain anonymous, told Community Practitioner that she has applied to have £4,000 worth of tax and NI contributions returned to her. So far she has had no success.

HMRC cited the £15,480 earnings threshold when they rejected her application for a rebate and said that the money she was paid during the course was employee income and exceeded this amount.

“On my letter it says: ‘Because you earned over the £15,480 per academic year of the course you are not entitled to any NI contribution refund’,” explained our anonymous source.

“But my colleagues who have been refunded earned the same amount or more than me during their WATS course.”

THE GUIDELINES

The Widening Access Training Scheme (WATS) is a pathway to professional development for many community nurses, including health visitors and specialist community public...
"It's a complete fluke that I even know about the rebates. I'm annoyed because HMRC or the NHS have not been forthcoming in saying that this is something that we are entitled to."

HMRC clarifies the tax rebate procedure

"The claimant must have been an existing NHS employee when starting the training scheme and have been working to widen their knowledge.

"They must also have been in full-time attendance at an educational establishment for at least one academic year, and must have attended the course for at least 20 weeks in that academic year.

"If the course was longer, the employee must have attended for at least 20 weeks on average in an academic year over the period of the course.

"If the individual is engaged under a contract of training, then any payment they receive is unlikely to be regarded as earnings for tax and NIC purposes so a PAYE tax and Class 1 NIC liability will not arise.

"A charge to tax may arise under the Miscellaneous income provisions in the Income Tax Trading and Other Income Act 2005 although generally any payment received under a contract of training is unlikely to attract a tax or NIC charge.

"Where the individual is engaged on a contract of service (employment) and has to undertake full time education, there are special rules about the tax and Class 1 NIC treatment to be applied - SP4/86 for tax and an NIC disregard provided by paragraph 12 in Part VII to Schedule 3 of the Social Security (Contributions) Regulations 2001 [SI 2001/1004].

"However, the NIC disregard will only apply to earnings up to £15,480 if all of the qualifying conditions are met.

"The special tax rules and NIC disregard are not limited to the NHS Widening Access Training Scheme (WATS). If the individual is engaged on a genuine training contract and does not undertake any service to the NHS Trust then it is probable that there will be no tax or NIC due.

"However, as is more likely, they will be engaged under a contract of service (employment) on the WATS scheme and the special tax rules and NIC disregard applies.

"However, if the employee is paid more than £15,480 in the academic year for attending the course then Class 1 NICs will be due on the full amount of any payments made for attending the course."

To contact HMRC about a claim, telephone 0300 200 3500.

To appeal your decision, write to the NIC&EO Complaints Team at: NIC&EO, HM Revenue & Customs, BX9 1AA.

"A complaints investigator will take a fresh look and give you a final response," HMRC said. For more information on the complaints process, you can download the complaints factsheet at http://bit.ly/29sYPHU.

"In all the other emails so far they have just said 'You're not eligible!' But the last email they said that this has been decided with the NHS. But who has decided it? And can you change policy and procedure like that?’” she asks.

"I signed my contract back in September 2014 so when did you make these decisions? 'I just feel like it's some big cover-up now’”

The health visitor’s claim has since been officially rejected.

NOT A MATTER OF OPINION

HMRC’s press office was asked about the discussions with the NHS. A spokesperson told...
Community Practitioner that ‘employment status is not a matter of opinion,’ but that they ‘could not speculate about what a colleague has said’.

“We did not receive annual leave or guaranteed employment after the course, and we all signed contracts of training,” our source confirmed. “And my successful colleagues also paid into the pension – we all did.”

The health visitor and her colleagues who were successful in receiving back their NI contributions sent their rebate decision letters and WATS contracts to HMRC to show the discrepancies in their treatment.

HMRC has declined to give information about other cases, even with the applicants’ consent and documentation. It will also not definitively explain its decision-making.

Unite advised the health visitor that the next step should be to contact the payroll department at her Trust, since the union itself is not in a position to offer advice relating to personal tax issues.

“My payroll said that at a recent managers’ meeting they were told to tell everybody that they are not entitled to it because they’re over the earnings threshold,” she added.

The health visitor complained that in the NHS Widening Access Training Scheme: Lines to Take document it states that if you’re on a contract of training your NI should be discounted. The payroll officer replied that they had been told to tell everyone they were employees during WATS.

“HMRC has been very non-responsive. It has not got back to my last two emails. You can’t get through on the telephone, that’s impossible.”

The single mother with three children added: “It would mean a great deal to me to receive my rebate. I took a £5,000 pay reduction to take the course in the first place. I took the financial loss to take the course, to better myself really.”

“I had to take out a student loan, which I’m just starting to pay back. I’ve got debts now that would be resolved by receiving the money back.

“The way I see it is if I owed tax then HMRC would take me to court and it would fine me. But all my colleagues and I are entitled to that money and it is holding that back and that’s not right.”

Looking for answers

Another health visitor told Community Practitioner: “It’s a complete fluke that I even know about the rebates. I’m annoyed because HMRC or the NHS have not been forthcoming in saying that this is something that we are entitled to.

“I will be even more annoyed if I go through the process, which seems quite long-winded, for them to tell me that I’m not entitled to it.

“We are obviously entitled to it but it’s unfair that they’re able to say no we aren’t and we are not able to do anything about it!”

An SCPHN nurse, who has so far been refused a rebate, told Community Practitioner: “HMRC states that the decision was made by the Trust; however, my Trust sent the same information for each applicant. Some have received the refund, others haven’t.

“During a phone call to HMRC, I was informed that I was not eligible for a refund as I trained September to September.”

HMRC classes the academic year as beginning in January.

“This was explained to me that as it covered two academic years, I exceed earnings of £15,480. However, I have colleagues who trained from September who have received a rebate so this is not the case.

“HMRC has not offered me any other explanation as to why I’ve earned in excess of £15,480 whereas the payments my colleagues received were ‘not employment income’ regardless of which month they started in.

“I would argue that all SCPHNS complete the same training, on a similar income, sponsored by their Trust.

“I am finding the process very inconsistent and I am unable to comprehend how some practitioners have received a refund whereas others have not, despite completing the course within the same parameters.

“I would love to discuss this with someone; however the phone number provided on the letter is permanently engaged,” the nurse added.
This month we rewind to the decade from 1956 to 1966, which saw the redefinition of health visiting and a milestone in the women’s liberation movement – the introduction of the pill.

1960

The contraceptive pill is introduced in the US and the following year in the UK, but for married women only. Take-up is fast: between 1962 and 1969 the number of users rose from around 50,000 to one million. Well into the 1970s UK and US women will pretend to be married in order to get a prescription, with reports that some passed around the same battered wedding ring around the doctor’s waiting room.

1962

The Women Public Health Officers’ Association becomes the Health Visitors’ Association (HVA) and on the 17-20 October there is a Health Visitors’ Centenary Conference in Brighton. The Health Visiting and Social Work (Training) Act sets up joint councils under a single chairman for health visitor and social work training, that for health visiting being the Council for the Training of Health Visitors (CTH-V), which allows health visiting to become an exclusive nursing specialty.

1963

When the function of the health visitor was being redefined for the purpose of redesigning the syllabus, knowledge of the relationship was almost, but not completely, incorporated into the function. The CTH-V’s leaflet, The Function of the Health Visitors, states: “the prevention of mental, physical and emotional ill-health is one of the five main aspects of the health visitor’s work.”

1965

The CTH-V develops a curriculum for a ‘new breed of health visitor’, which is a 51-week programme. By this point a nursing qualification is a statutory requirement for entry into health visitor training, along with either registration as a midwife or, at least part one of the midwife training. Although the minimum training period is six weeks, a number of courses extend the training to nine months.

1966

An editorial board is formed for the official journal of the HVA, Health Visitor.
Community champions

With a number of notable achievements being made by community practitioners in recent weeks, we’re bringing you a round-up to celebrate these champions of the sector

A TRUE HONOUR

CPHVA members Dr Cheryll Adams (below left) and Pauline Watts (below right) were given commendations from the Queen’s 90th birthday honours list.

Dr Adams from Emsworth, Hampshire, was awarded the Commander of the Most Excellent Order of the British Empire (CBE) for her service to public health.

She worked in the professional team at Unite/CPHVA for more than 10 years and has campaigned for reinvestment in a strong health visiting profession. Working closely with government, members and other organisations, Dr Adams was part of a team that helped to develop policy on behalf of community health services. This included Unite/CPHVA partnering with the Department of Health (DH) in its Action on Health Visiting programme in 2009.

Dr Adams sits on the NSPCC’s research ethics committee and is an adviser for UNICEF Europe.

Unite/CPHVA professional officer Dave Munday said: “It is a just honour for someone who has worked so tirelessly over the last 30 years to improve the health and wellbeing of the citizens of the UK and more recently across the world.”

Pauline Watts was awarded the Civil Order of the British Empire (OBE) for her services to nursing and health visiting. Hailing from Alcester, Warwickshire, Pauline lead nurse for quality, mental health, learning disability and dementia for Public Health England.

As a professional officer for the chief nursing officer’s professional leadership team in the DH, she advises the government on nursing and contributes to the development of health policy and strategy.

She told Community Practitioner: “I was so proud because it felt like I was being recognised for personal contribution but also I was proud to be part of the work that is going on, which is changing lives.”

“With a bit of luck it will help me to lead and inspire others to keep making a difference.”

After training as a learning disability nurse and a teacher, Pauline has worked in learning disability, mental health, district nursing and health visiting, Macmillan nursing and children’s services.

LAR OF THE YEAR AWARD 2016

Do you know a locally accredited rep who deserves special recognition?

CPHVA members are invited to nominate locally accredited representatives for LAR of the Year Award 2016.

Unite/CPHVA is calling for nominations for this year’s LAR of the Year Award, which is due to be presented at the Unite/CPHVA Annual Professional Conference 2016 in Telford on 15 and 16 November.

Members are encouraged to nominate suitable candidates for this important annual award, using the online nomination form at: www.unitetheunion.org/cphvalAR16

All nominations must be submitted by Friday 14 October 2016.
The Freedom of Belfast has been given to CPHVA members on behalf of Unite nurses in Northern Ireland who practised during the Troubles.

Janet Taylor, CPHVA executive vice chair and Northern Ireland chair, and retired CPHVA member Bernie McCrea accepted a scroll marking the honour.

Janet said it was an acknowledgement of all the work carried out for Belfast residents over the years.

“Throughout the Troubles in Northern Ireland nurses treated all of the community with care compassion respect and dignity.

“They dealt with all sorts of catastrophes including bombings and shootings as well as all of the normal work and care they gave on a routine basis.

“Nurses in Belfast worked within communities and travelled to ensure that clients had nursing care delivered. Health visitors were a big part of this.

She added: “Part of the job entailed dealing with families who may have been affected by the situation. There were often absent fathers in prison, or worse, dead or murdered.

“Families of security forces were also often separated. Belfast nurses treated families from both sides as well as innocent bystanders.”

Bernie McCrea, who also accepted the honour for CPHVA members, worked as a general nurse during the height of the troubles in Northern Ireland in the mid-1970s.

The CPHVA’s scroll was displayed in the Unite offices at Antrim Road, Belfast.

CPHVA member and health visitor Xena Dion has been named mayor of Poole.

Xena took office as mayor in May and promised to devote her time in the post to improving health and wellbeing.

The commitment is one of the three key themes for her mayoral year along with promoting Poole and focusing on business.

“Promoting business will help improve the economy and provide jobs, which we know as health visitors is important to supporting vulnerable people’s health,” Xena said.

She has worked for more than 12 years as a specialist public health practitioner in the Dorset Health Care University Foundation NHS Trust, including a few years as the locality lead.

She said: “I work in a very disadvantaged area and I know how important it is to create a sense of aspiration and ambition for young people, especially girls.

“I want to inspire them to make the most of their lives.

“My goal is to make this role work much better for local people by being more proactive in the community.”

Xena moved from a council backbencher to a leading cabinet member with focus on the environment, transportation, parks and open spaces, culture and leisure and economic development.

Earlier this year she stepped down from cabinet to take the civic position as mayor.

She was brought up in Poole and, since returning from practising as a midwife abroad, has worked there as a health visitor for 20 years.
The Unite/CPHVA Education & Development Trust is pleased to announce the following MacQueen bursaries:

MacQueen Bursary for Research or Practice Development (one award of £12,500)
This bursary is available to a Unite/CPHVA member to undertake a significant project leading to developments in the underpinning evidence base to community practice or to improvements in the nature and organisation of practice. The bursary is available to a team of practitioners although at least one member of the team must hold Unite/CPHVA membership.

MacQueen Bursary for Professional Development (two awards of £3,000)
This bursary is available to two Unite/CPHVA members who wish to complete post graduate study or participate in other professional development activities focused on enhancing their professional expertise.

Further details of the above bursaries and the application process is available from Denise Knight, chair of the professional advisory committee: d.knight@herts.ac.uk

Closing date for the receipt of applications for either of the above bursaries is 5pm on Monday 5 December 2016. Shortlisted applicants must attend an interview at Unite HQ on Friday 20 January 2017.

WHAT ARE THE BIGGEST DIFFERENCES IN 0 TO FIVE CARE IN SCOTLAND?
The regulations in Scotland now stipulate the minimum number of contacts in the first year of life is eight. I feel that having more visits is really important to the relationships with parents and to the information and support we are able to give them at that early stage for optimum outcomes in their infant’s development.

We’re also working with the Get It Right for Every Child framework, which the Scottish government has brought out in response to the Children and Young People Act 2014. Under the act we’ve been developing the ‘named person’ role. This means that the named person health visitors are the single point of contact for 0 to fives if there are any concerns raised by parents or anyone at all about a child.

It’s been quite controversial in the media. Some people are objecting and saying it’s almost like a corporate parenting role; that we’re taking responsibility away from parents, but I would refute that totally.

We put the children and family at the centre of everything we do and our work is very client-focused, with the health and wellbeing of the child being the key goal.

WHAT IMPACT HAS WINNING THE AWARD HAD?
It has influenced the team who are very proud of the achievement and equally the clients are proud too. I’m absolutely overwhelmed by the response we’ve had from people. I’ve had positive feedback from families saying that they are happy that the good work in their area is being recognised. It’s quite exciting.

I would like to thank the CPHVA because it has reenergised us as health visitors.

MacQueen Bursaries 2016-17

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Meet the winners

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HOW HAS THE INITIATIVE WORKED FOR FAMILIES?
I work in a rural area on the west coast of Scotland and it works very well here. In the Scottish Highlands we’re the pathfinder for this. Following success here it has been rolled out to other areas.

We have been using the named person role here since 2009. It’s well embedded in everything we do and has strengthened the relationships we have with parents.

HOW HAVE CUTS AFFECTED YOUR SERVICE?
The autonomous role of health visiting has been eroded somewhat in recent years so we are rebuilding that, but the need for greater prevention work is being recognised. It’s going to take years for us to get back to full capacity but the Scottish government has invested in increasing the training places for health visitors.

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This award enables attendance at the Unite/CPHVA Annual Professional Conference 2016 (to be held on 15 and 16 November in Telford). Applicants must be Unite/CPHVA members who have qualified within the past two years OR have never previously attended a Unite/CPHVA Conference.

The award will provide a full conference ticket and £50 towards travel/accommodation. Up to SIX awards are available. Further details about the award and the application process are available from Linda Llewellyn, member of the Professional Advisory Committee: Linda.llew@btinternet.com

Closing date for receipt of completed applications: 23 September 2016.
Friday 7 April 2017, London

TAKE ACTION AND NOMINATE

On the 1st of August nominations will open for the 2017 CPHVA Awards. The awards are to celebrate your colleagues in community practice who make a vital and critical difference to families’ lives every day.

Nominate a Unite CPHVA member TODAY and let them know their work has not gone unnoticed. To nominate, all you have to do is go to awards.communitypractitioner.com/enter and follow the submission process to put forward the name of those you want recognised. It really is that simple!

We want to recognise as many of our fantastic Unite CPHVA members as possible, from Health Visitors, School Nurses, Community Nursery Nurses and Community Practitioners. For a full list of categories and criteria visit our website awards.communitypractitioner.com

Avoid missing out on the event of the year and get your nominations in early to recognise the outstanding services your colleagues provide all day every day.

Nominations will close December 2016
The Unite/CPHVA Education & Development Trust is pleased to announce that applications are open for a one-off sum of £2,000 to cover travel connected with undertaking a public health project abroad. The award will allow the winner to:

- Share expertise with others
- Promote partnership working
- Enhance personal development by broadening knowledge of other cultures and developing the knowledge and practice of others.

Closing date for receipt of applications is Monday 5 December 2016.

To apply please contact Deborah Rountree (email: deborahrountree@live.co.uk).

Adventure of a lifetime

Carolyn Taylor, who was awarded the MacQueen travel bursary in 2015, describes one year on how the award has funded a valuable project in Uganda

MY PROJECT WAS A CONTINUATION of work that started 16 years ago and developed into a charity in 2007. Having formed the Mityana Community Development Foundation, originally supported by the Amicus Foundation, we have built a community centre providing a library, internet suite, credit union, adult literacy classes and a free study facility for thousands of students.

We have also delivered a PHSE programme modelled on a CPHVA school nurse resource to thousands of children who also receive a health pack containing toothbrush, soap and toothpaste with a health education booklet for the family.

The charity also supports a local primary school increasing, its classroom capacity by eight and extending to P7 students. All our P7 students in the last three years have attained grades to allow them to attend secondary education.

Another favourite activity is our annual sanitation award, which aims to improve health and hygiene standards across schools in the whole district.

STRENGTHENING TIES

This award also helped to widen the links of CPHVA/Unite worldwide as I was invited to the Ugandan Nurses and Midwives Union (UNMU) Scientific Conference, where I presented two papers. The UNMU is a relatively new union combining a professional association with a trade union with approximately 11,000 members. Through this work I’ve met some of the health visitors of Uganda who mainly work in the public health departments of the council but also do a level of home visiting.

These experiences and ongoing work would not have been possible without the bursary and support of South Tyneside Foundation NHS Trust. I am now planning my retirement and Uganda features heavily in my plans. I have been appointed as the international advisor for the UNMU and I am going back to the scientific conference this year, planning capacity building and professional training for the staff and members of the union.

IMPROVING EDUCATION

I am also hoping, with other UK colleagues, to open a nursing and midwifery school in Kapchorwa, an area where FGM is still practised. I hope that the curriculum will develop to educate young men and women about the dangers of FGM and thus influence their future practice.

Looking to all of those who are in nursing and health visitor education we would like, in the future, to provide alternative practice placements. Those who wish to learn more or become involved in this work please contact us through the Mityana Community Development Foundation Facebook page, or email me at: carolyn@taylor9299.freeserve.co.uk
HOW WOULD YOU LIKE TO INTRODUCE YOURSELF TO UNITE/CPHVA MEMBERS?
My name is Sarah Carpenter and I am the new national officer for Unite in Health. I have worked for the union now for 20 years. Prior to this I worked as a regional officer in the South East of England, where I’ve been for about 17 years so this is a really new and exciting role.

In the South East I primarily worked with our NHS members in Kent. I was the lead officer for health in the region. I’ve always been amazed by the variety of professional groups that we look after and I’ve worked particularly closely with our community nursing colleagues in the region.

WHAT WERE THE KEY ISSUES YOU WERE FOCUSED ON IN YOUR PREVIOUS ROLE?
Most of the problems I worked on in that capacity could be summed up as short-staffing and workforce pressures. Particularly within community nursing, there is never enough time to do everything that you are required to do.

I found that the health visitor role became a lot more about child protection issues. That is where everyone has been struggling most because they all know that the public health role is the absolutely critical bit.

Child protection is the sad end of the scale. The job that health visitors do is really positive work with families.

WILL YOU CARRY THOSE PRIORITIES IN YOUR WORK AT A NATIONAL LEVEL?
I absolutely hope so. What I really want to do on a national level is make sure that our members’ voices are heard at every available opportunity and at every possible level.

We have members in other parts of the health sector as well but an important message will be that there is more to the NHS than doctors and nurses. Don’t overlook the work that community professionals do. And of course don’t privatise them. The union will do absolutely everything it can to fight the privatisation agenda for all staff.
WHAT WILL BE DIFFERENT ABOUT UNITE IN HEALTH UNDER YOUR LEADERSHIP?
Something I’d like to focus on more is making sure that we really engage with our members on all levels and fight on the issues that matter to them.

I think we need to bring our members with us in lots of the campaigns that we do. So I’ll be making sure that our officers and our reps know what we are doing nationally and come with us on the journey.

It’s about being active and about being part of the dialogue. We want to hear people’s voices and their views, whether they are difficult and challenging for us or not. We want to make sure as an organisation that we truly represent our membership.

HOW WILL THIS BE ACHIEVED?
The first thing is making sure that our officers and reps get lots of information and communication. Looking at different forms of social media will be one way of doing that. We tend to stick around the traditional platforms such as Facebook but it’s been reflected back to me by my teenage daughter that “it’s for older people”. We need to look more into including Snapchat and Instagram and those other vehicles so that people can really tap into something.

The CPHVA professional officers do an excellent job of communicating with people via web chats. They are constantly finding new ways to engage busy people in conversation. We have to do more of that but nothing actually beats going out and speaking to people face-to-face. So as much dialogue as possible, and I want to be out meeting as many members as possible.

DECOMMISSIONING OF SERVICES IS ONE OF THE MOST CRITICAL ISSUES FACING COMMUNITY PRACTITIONERS RIGHT NOW. WHAT ARE YOUR PLANS TO SUPPORT THEM?
What we are facing there is change by stealth. That is a really difficult thing to fight against but I think what it goes back to is that we need to respond to the needs of our members and what tools they need to have those fights.

If they are up for the fight, either on behalf of themselves as employees – or, more often I think with community nurses on behalf of their client groups – then we are absolutely going to be there with them.

Another key element is putting people in touch with each other, sharing some of those ideas so that we are not looking at each case as a new situation but actually connecting those members with others who have been through the same thing.

DO WE NEED TO FOCUS ON THE ROLE OF WOMEN IN POLITICS OR HAVE WE MOVED ON FROM THAT ISSUE?
I don’t think we’ve ever got it resolved. All the time we still see violence against women, hostility against women and negative language against women. We haven’t won the battle. Maybe we never will but that doesn’t stop us trying.

I think we need to be out there and brave and very clearly saying that there are specific issues for women and they need to be dealt with.

There are a lot of excellent female leaders who are standing up and being counted and are also pulling other women up behind them, supporting other women to become leaders too.

That begins to change the profiles of organisations. We begin to see women taking leadership positions and standing up to say: “I want to be heard. You need to hear my voice.”

Let’s think of a way for everyone to get involved. We might need to think about things differently. A lot of women have 101 other things they need to be doing – taking care of families or elderly parents, for example. We need to make sure that how we function as a union means that people can get involved.

WHAT WILL THE NEXT YEAR OF UNITE IN HEALTH LOOK LIKE UNDER YOUR MANAGEMENT?
Hopefully it looks exciting, dynamic and busy. I also aim to deliver on some key objectives. For me one of the really key objectives is to engage student members in activity and bringing people who are just training into the union so that they have a voice. Another objective is seeing who we can bring on to our campaigns for terms and conditions, but also for improving client care.

WHAT IS YOUR INITIAL MESSAGE TO CPHVA MEMBERS?
I am so looking forward to working with you. This feels like coming home. It is really great to be back working with health visitors, school nurses, and in particular community nursery nurses.

As long as we can get together the voices will get louder. That results in activity, and that results in change. It’s an exciting time and I’m really looking forward to it.
#HVweek 2016 is running from 26 to 30 September 2016. It’s an opportunity to celebrate the amazing health visiting profession.

Over the coming weeks we’ll be regularly announcing updates to the programme for #HVweek. If you want to be the first to hear about the week and you want to be involved, please sign up as a supporter! All you have to do is visit www.unitetheunion.org/CPHVA/HVweek, click on the relevant link and register your support by email.

Here’s a taste of what the week has in store across the UK…*

Monday 26: Wales conference (Swalec Centre, Cardiff)
The Wales event will feature an opening address from chief nursing officer Jean White. Health minister for Wales Vaughan Gething is set to attend to launch the Healthy Child Wales programme, while health visitors from across the country will present areas of best practice.

Tuesday 27: Scotland conference (Unite Glasgow office)
The Scottish event will provide a focus for colleagues in Scotland to hear from the people behind the policy and strategic decisions that are impacting upon your practice. The issues to be considered on the day will include ‘The named person’, ‘More from less?’ and ‘What impact will austerity and impact have on the future?’

Wednesday 28: England conference (online)
A packed programme for Wednesday includes speakers Viv Bennett, chief nurse for Public Health England, executive director at PIP (UK) Clair Rees and chief executive of The Lullaby Trust Francine Bates.

Thursday 29: Northern Ireland conference (Unite Belfast office)
The Northern Ireland event will look at how recent political challenges have impacted on practice. Professional and political leaders will be in attendance sharing their views and answering your questions on issues that affect you. We will also have sessions on gender-based violence, your future as an employee, attachment theory and more.

Friday 30: Supporters’ day

*stay tuned for further updates at www.unitetheunion.org/CPHVA/HVweek
#whatisaHV

What is a health visitor? We've launched a survey to answer this very question. We're seeking responses from everyone involved in health visiting services, so we want people who have benefitted from a health visiting service, people who work with health visitors and health visitors themselves to answer a few quick and simple questions.

To complete the survey and to pass it to others, visit: [https://response.questback.com/uniteheunion/whatisahv](https://response.questback.com/uniteheunion/whatisahv)

And if you're a Twitter user, please tweet or retweet this link as often as you can to help us get a wide range of responses.

Thank you!

#HVweek supporter organisations
Working together: Peer support and occupational health

Amid challenging times and with the introduction of revalidation, nursing practice, and in particular occupational health nursing, can benefit greatly from peer support, as Catherine Kelsey* explains

ONE OF NURSING’S MANY CHALLENGES

is the development of an adaptable, confident, skilled workforce able to work in increasingly diverse environments (Davies and Allan, 2014). Nowhere is this more evident than within post-registration nursing practice, particularly in occupational health, where the changing landscape of both education and professional practice is dominant.

Nursing has already witnessed the move to an all-graduate profession and pre-registration nurses (on completion of training) moving directly onto post-registration courses. Within occupational health we have observed the specialist community public health nurse (SCPHN) course move to postgraduate-only in some universities and we have merged the role of the occupational health technician into everyday professional practice. More recently all nurses have experienced the launch of revalidation (NMC, 2015).

All of these changes, albeit welcomed by many, have created significant challenges. For those registered on part three of the nursing register, there is also increasing apprehension surrounding the government’s response to a law commission report expressing uncertainty about its continuation (DH, 2015).

A number of occupational health nursing groups, including the Development Group of the Faculty of Occupational Health Nursing (FOHN) and Association of Occupational Health Nurse Practitioners (AOHNP) are currently striving to ensure the voices of occupational health nurses are heard, the aim of which is to help influence future decisions surrounding education and professional practice. Despite the potential changes that lie ahead, however, it is important to ensure a sense of calm and ‘business as usual approach’ at least in the short term, for revalidation is currently taking centre stage.

DIGESTING REVALIDATION

Revalidation was a significant milestone in nursing history when it was first introduced in October 2015 and all nurses must now focus on meeting the requirements. This could possibly present more of a challenge for some nurses than others.

All nurses are required to provide five written reflective accounts using the Code (NMC, 2015a) to demonstrate learning from CPD activities, professional feedback or a practice-related event in the three years prior to revalidation (NMC, 2015). A further requirement is for all nurses to undertake a reflective discussion with another NMC registrant, which covers the written reflections and how they apply to the Code (NMC, 2015).

For most occupational health nurses this reflective discussion will be one of the greatest challenges faced, particularly if they are independent practitioners or the only person in the team who is a nurse. Arguably, this discussion should not simply take place once every three years to meet the needs of revalidation but should be a regular feature of nursing practice that supports collaboration and reduces the sense of isolation. This can be achieved through gaining appropriate and effective peer support, which it is maintained can help enhance communication skills and support the development of assertiveness and leadership capacity (Davies and Allan, 2014). Experienced peers are in a unique position to act as information providers, role models and facilitators (Davies and Allan, 2014). Peers are defined as those who have had similar experiences, are able to better relate to others and are consequently able to offer authentic empathy and validation (Mead and MacNeil, 2006).

SUPPORTING EACH OTHER

Peer support, it is claimed, is a significant component of professional practice and can be defined as “a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful” (Mead, 2003: 1) and purports Beatty (1997) enables the professional to learn more than simply reflecting alone on their practice.

The partnership between participating

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Plews et al’s (2005) taxonomy of support

| Emotional support allowing the person to feel cared for |
| Social integration or being part of a network |
| Bolsters self-esteem |
| Offers advice |
| Provides information as part of a network of reciprocal help |
| Instrumental aid |
colleagues needs to be established so that peers can share their understanding and perceptions within a confidential forum (Purnell and Monk, 2012). As Schuck et al (2008: 6) note, the characteristics of successful professional learning conversations are based on ‘mutual respect; risk-taking; a determination to improve and professional, progressive discourse’.

Peer support can be achieved in a number of ways, including the joining of professional groups, which focus on providing diverse learning opportunities and a sense of cohesiveness and belonging. One such group is that of the West Yorkshire Occupational Health Nurses Group, which runs monthly meetings and this year aims to provide learning experiences as diverse as neurolinguistic programming or NLP, writing for publication and developing presentation skills. Such meetings have the potential to support the development of new knowledge, which in turn can be applied to professional practice and thus help to meet the needs of revalidation.

EMBRACING REVALIDATION

Revalidation replaces post-registration education and practice (PREP). The process aims to promote good practice across the whole population of nurses and midwives and to encourage lifelong learning; the fundamental principle of which is to ensure the protection of the public (NMC, 2015). This approach to learning requires all learners (in this case the nurse) to draw upon an assortment of educational opportunities and learning experiences, all of which are designed to support professional development and personal fulfilment (Alsop, 2013).

The significant failings identified in the Francis Report (2013) and the recommendations made have been a driving force in making revalidation happen, the challenge to the profession is whether we have the capacity and the commitment to invest the significant time required to building strong relationships and networks to ensure we meet these requirements (Brackenbury, 2014). Although these requirements must be met in order to renew professional registration, it is perhaps how we embrace these requirements that is fundamental to providing high-quality patient care.

The effect of receiving quality support as outlined in Plews et al’s (2005) ‘taxonomy of support’, (see box) can create an environment for effective learning in which nurses can learn from each other and demonstrate mutual respect. Crucial to any successful interaction and effective peer support is the ability and willingness to learn from others, enabling the development of a structured approach to learning (Kelsey and Hayes, 2015). This approach known as ‘scaffolding’, first defined by Vygotsky (1930, cited in Spouse, 1998) encourages an approach in which nurses can learn from and build upon their experiences, perhaps discovering new and innovative ways in which they can develop their professional practice.

WORKING TOGETHER

One of the challenges for all nurses, particularly those who work independently, for example those working in occupational health, is that the profession must meet the standards as laid down by the NMC, while at the same time fulfil the requirements of employers. In recent times, these requirements, as discussed by O’Reilly (2015) have led to conflict within the occupational health profession.

Considerable time and investment therefore is required to seek out and undertake regular peer support, rather than simply be a ‘nice to have’ or an ‘add on’ to professional practice it could be considered an essential requirement. For it is argued that professional involvement can be significantly influential in achieving success (Wood, 2015). Working with employers to enable this to happen could be a significant challenge, but is one worth adopting. If few occupational health practitioners engage with peer support, there is a risk for example that employees will not be made aware of services that may facilitate an early return to work, or that changes to the service may not be made. This potential trade-off between time spent receiving peer support and keeping up to date with new innovations could be possible if presented in the right way.

Revalidation, it could be argued, advocates a change in the way in which we support each other in the occupational health profession. It is essential that we remain open to change for it is evident that change is occurring right now.

We must stay abreast of these changes and seek out opportunities for networking, whether this is by attending conferences, occupational health nursing groups or simply getting in touch with other professionals. If there is one absolute, it is that change will happen with or without us, we must be part of those changes and to do this we must be willing to work together, not in silos.

*Catherine Kelsey MSc, specialist community public health nurse – occupational health, NMC teacher, sign-off practice teacher

References


Do parents and carers know how to use car safety seats correctly? On observing a lack of safety measures, health visitor Anne Horder* devised a project that aims to improve car seat safety using a partnership approach.

RETURNING TO PRACTICE IN THE context of the government’s Implementation Plan coincided with a drive to raise the skills of health visitors in building community capacity. While on placement I identified a public health issue related to the incorrect use of child safety seats. This was of particular concern to the local community; one ranked by the Census (ONS, 2011) as being in the bottom one per cent for income deprivation.

Observations of car safety seats in well baby clinics showed several did not have the harnesses adjusted as the baby had grown, resulting in shoulder straps being used around the tummy. Some seats were old and battered and, on enquiry, had been handed down from family and friends or purchased second-hand, often without fitting instructions.

On identifying a project to build community capacity I decided to incorporate my previous experience of working in the community using trained volunteers. The two principles of working in partnership and using trained volunteers are pertinent to the Five year forward view (NHS England, 2014).

The model used in this project is a close fit to the community-centred approach described by South (2015). It also aligns with the recently updated NICE guidelines on community engagement (NICE, 2016).

LOOKING AT THE LITERATURE
The NICE guidelines (2010) state that “most injuries and their precipitating events are predictable and preventable.” Yet CHIMAT (2013) data identified that in Birmingham 77 children were killed or seriously injured in road traffic accidents between 2009 and 2011. This was significantly higher than the national average.

Birmingham City Council staff held car seat checking events in 2010 and 2011, which showed 70 to 80 per cent of the car safety seats checked were not correctly fitted (unpublished data). A correctly fitted car seat can reduce the risk of death by 70 per cent for infants and by around 50 per cent for those aged one to four years (Zaza et al, 2005).

Research identifies that in the UK, America (Zaza et al, 2005) and Australia (Bilston et al, 2011) there is typically a high number of parents using car seat safety restraints incorrectly, with many parents believing they were using the seats correctly. Muller et al (2014) note that lack of...
knowledge is often cited as “a barrier against the use of child restraints”.

In considering methods to raise parents’ awareness of the correct use of car safety seats studies identified from the Cochrane central register of controlled trials (2011) identified that the rate of incorrect use of car restraints could be reduced with hands-on intervention at restraint fitting stations (Brown et al., 2011), with nationally certified child passenger safety technicians at well child care (Quinlan et al., 2007) and with education and incentives (Tessier, 2010).

Practical demonstrations, while effective, are time-consuming and labour-intensive. Stores such as Mothercare and Halfords offer a fitting service at the time of purchase; however, most parents approached for this project had inherited the car seat from family or friends, bought it second-hand or from a supermarket that did not offer a fitting service.

The most successful car seat checking events held in Birmingham in 2010 and 2011 were held in supermarket car parks where typically 25 checks could be carried out in two to three hours by accredited car seat checkers.

Considering an asset-based approach (Friedli, 2012) to the strengths available within the local community I was impressed by the work being done by organisations like the Neighbourhood Forum, the local community project and the local faith-based organisations, albeit independently from each other.

Linking with Skinner’s (2006) concept of building community capacity I sought to address the issue of incorrectly fitting car safety seats using more than one agency from the community, with each agency involving a number of their own volunteers.

A one-day training course in car seat checks was identified as being suitable for both staff and volunteers to attend. Once funding was confirmed representatives of six interested organisations met monthly for the duration of the formal project.

PROJECT AIMS

A key aim was for more parents to use car seats effectively, as well as increasing awareness of other agencies and community groups both in how they work, what they offer and the opportunities there may be for collaborative working. This was linked in part to the NICE guidance (2008), which identified that approaches used to ‘inform’ communities may have a marginal impact on health, while approaches that help communities to work as equal partners may lead to more positive health outcomes.

It was also hoped that using volunteers would both increase capacity and be of benefit to those volunteering.

Funding was obtained to provide a one-day training course in checking car seats. Over four days a total of 36 people were trained. They were a mix of staff and volunteers from six different agencies, who were required to have a clear CRB (now DBS). Childcare costs for the volunteers were covered during the training period.

CHECK AND ADVISE EVENTS

Those trained were then equipped to help at ‘check and advise’ events. These offered a free service to parents who had parked in the parent and child spaces at supermarket car parks and at children’s centres.

The events were risk-assessed, had received permission from the supermarkets and were covered by public liability insurance. At the end of each check the parent was to be the last person to fit the seat.

Several events were held over the six-month period of the project, with further events held later outside local schools and children’s centres.

POSITIVE OUTCOMES

An initial baseline measurement in January 2013 identified that 76 per cent of the car seats checked were being used incorrectly. Common errors included using a rear-facing seat in a forward-facing position and twisted seat belts.

After several months the lowest rate of incorrectly fitting seats at a ‘check and advise’ event was 63 per cent.

Through working in partnership and using volunteers we doubled the number of checks at each event. However, the process of engaging parents and checking the fitting of car seats was time-consuming, lasting around 15 minutes for every car seat checked.

Evaluation of training days showed that most people enjoyed the day, found it informative and were more aware of car seat safety issues. Two volunteers referred to it as “increasing their confidence”.

Fewer training places were taken by volunteers than originally planned since most organisations had fewer volunteers than they had envisaged.

<table>
<thead>
<tr>
<th>Child’s weight</th>
<th>Car seat</th>
</tr>
</thead>
<tbody>
<tr>
<td>0kg to 9kg</td>
<td>Lie-flat or ‘lateral’ baby carrier, rear-facing baby carrier, or rear-facing baby seat using a harness</td>
</tr>
<tr>
<td>0kg to 13kg</td>
<td>Rear-facing baby carrier or rear-facing baby seat using a harness</td>
</tr>
<tr>
<td>9kg to 18kg</td>
<td>Rear- or forward-facing baby seat using a harness or safety shield</td>
</tr>
<tr>
<td>15kg to 36kg</td>
<td>Rear- or forward-facing child seat (high-backed booster seat or booster cushion) using a seat belt, harness or safety shield</td>
</tr>
</tbody>
</table>
BREASTFEEDING IS BEST FOR BABIES 
FOR HEALTHCARE PROFESSIONALS ONLY

Which First Infant Milk is most in line with expert opinion on growth?

The Department of Health recommends exclusive breastfeeding for the first six months of life.¹

Protein and the importance of slower growth rates

Because the protein in breast milk is adapted to a baby’s needs,² a breastfed baby tends to grow more slowly than a formula fed baby.³ This slower growth rate has shown to have significant long-term health benefits, including a lower risk of obesity, cardiovascular disease and diabetes.⁴

We’ve responded to expert opinion about proteins in SMA® PRO First Infant Milk

“Protein intakes of infants are generally well above the requirements, so protein content of Infant Formula and Follow-on Formula could be reduced”
European Food Safety Authority 2014⁵

“Protein intakes of infants are generally well above the requirements, so protein content of Infant Formula and Follow-on Formula could be reduced”
European Food Safety Authority 2014⁵

“Protein intakes of infants are generally well above the requirements, so protein content of Infant Formula and Follow-on Formula could be reduced”
European Food Safety Authority 2014⁵

SMA PRO First Infant Milk has lower levels of insulinogenic amino acids compared with other first infant milks⁸

Of the essential amino acids, four have been shown, when supplied in excess, to be associated with increased release of insulin. This may trigger a cascade of reactions in the body which may result in faster growth.⁶
European Childhood Obesity Trial Study Group 2015⁹

Getting the right quantity and quality of protein in infant and toddler diets has lifelong health benefits.

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


ZTC1238a/07/16
The results of this indicated that:
- There was an increased awareness of the challenge being faced by each of the partner agencies.
- There was increased trust between organisations.
- The community was strengthened.
- They were able to participate in open and respectful dialogue at partnership meetings.

**BENEFITS TO HEALTH VISITING**

Increased awareness of the scale of the problem of incorrectly fitted car seats led to a positive change in health visitors’ practice. Feedback from team meetings informed me that this is no longer the single question: “Have you got a car seat?” At new birth visits there is now a far more detailed discussion based on the evidence of the need both for public health issues (ROSPA). In areas where communities share a concern of this public health issue, this could be an effective area to invest in a community-centred approach using trained and supported volunteers to continue to disseminate this important message.

*Anne Horder, BSc (Hons) RGN RHV, health visitor with Birmingham Community Healthcare Trust at the time of this project*
Clinical update: Fever and rash in children

VICTORIA JOY BLACK, Trainee Physician Associate, Peninsula College of Medicine and Dentistry, Plymouth University

RUBY PAUL, Foundation Year 1 Doctor, Derriford Hospital, Plymouth

SIBA PROSAD PAUL, Consultant Paediatrician, Torbay Hospital, Torquay

INTRODUCTION
Children presenting with fever and rash is a common reason for parents requesting consultation with a health professional. Assessment of a febrile child presenting with rash can be challenging because of the wide range of the differential diagnoses associated with this presentation. It may be caused by a minor condition (e.g. viral illnesses) to rarely life-threatening conditions (e.g. invasive meningococcal disease) (McKinnon and Howard, 2000; Shivaraman et al, 1993). It is important that community practitioners therefore remain aware of the common conditions that febrile children with rash usually present with and be able to identify the sick child with a potential serious condition and refer them urgently to secondary care services. However, most of these rashes in a febrile child in the post-vaccination era in the UK are likely to be caused by common childhood illnesses and community practitioners should be able to provide appropriate reassurance to parents as well as guidance regarding fluid and fever management (Barnetson et al, 2016).

EPIDEMIOLOGY
Children presenting to the emergency department with a rash and fever is very common. In a retrospective paediatric study of 1381 visits, 31 per cent of the cases primarily involved the skin and most cases were classified as contusions, lacerations, and burns; non-traumatic causes included viral exanthems, bacterial infections, and contact dermatitis (Shivaraman et al, 1993). In a study undertaken by Wells et al (2001) before the introduction of the meningococcal C vaccine in the UK, 2.5 per cent of all children (n=233) initially presented with a non-blanching rash to an emergency department over a 12-month period. However, only 11 per cent of those with a non-blanching rash were finally diagnosed with Invasive Meningococcal Disease (IMD). Following the introduction of the meningococcal C vaccine in the UK, an outcome audit with 99 children admitted with non-blanching rashes, Hicks et al (2014) demonstrated that only two per cent were diagnosed with IMD.

IMPORATANCE OF DESCRIBING THE RASH
Rashes can be classified depending on their characteristic morphology, distribution, and accompanying symptoms. This is important as certain rashes are associated with particular pathologies whereas few conditions may have a combination of them simultaneously e.g. chicken pox. Rashes are further described as systemic or localised, depending on their distribution and symmetry (Kang, 2015) (see Table 1).

COMMON CAUSES OF FEVER AND RASH IN A CHILD
A large number of conditions can present with fever and rash in a child although some of the conditions are incredibly rare in the UK or even worldwide. This is due to successful immunisation programmes that have led to either eradication (e.g. small pox) or a reduction in caseloads. The mnemonic “Very Sick Person Must Take Double Egg” describes causes and timing of rashes after onset of fever in children: Very – Varicella (day one) Sick – Scarlet fever (day two) Person – Pox [small pox (day three) (eradicated completely by 1980)] Must – Measles (day four) Take – Typhus (day five) Double – Dengue (day six) Egg – Enteric fever [typhoid] (day seven) While small pox was eradicated more than three decades ago, other conditions such as typhus and enteric fever are uncommonly seen in the UK practice except in immigrant population or native travelers who have stayed in the endemic regions for a length of time. Common causes of fever and rash in children including those that are likely to be seen in the UK are highlighted in Table 2.

Conditions in children presenting with rash and fever are diagnosed clinically based on a focused history, including recent travel, contact with animals, medications, and exposure to other natural environments (Kang, 2015). It is also important that healthcare professional obtains a history regarding time of onset of symptoms and the characteristics of the rash (morphology, location, distribution) in order to narrow

<p>| Table 1: Morphological characteristics of rashes (adapted from Kang, 2015) |
|--------------------------|-------------------------------------------------|
| Macule                   | Circumscribed area of change in normal colour, with no skin elevation or depression; may be any size |
| Papule                   | Solid, raised lesion up to 0.5cm in greatest diameter |
| Nodule                   | Similar to papule but located deeper in the dermis or subcutaneous tissue |
| Plaque                   | Elevation of skin occupying a relatively large area in relation to height |
| Pustule                  | Circumscribed elevation of skin containing purulent fluid of variant characteristic |
| Vesicle                  | Circumscribed, elevated, fluid containing lesion &lt;0.5cm in diameter |
| Bulla                    | Same as vesicle, except that lesion is &gt;0.5cm in greatest diameter |</p>
<table>
<thead>
<tr>
<th>Disease and causative organism</th>
<th>Age group affected</th>
<th>Signs and symptoms</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chicken pox</strong>&lt;br&gt;(Causative organism: Varicella zoster virus)&lt;br&gt;[NICE, 2015]</td>
<td>Usually &lt; five years old</td>
<td>• Presence of characteristic rash (initial red papules that evolve into vesicles containing fluid) and that different stages of lesions are present simultaneously&lt;br&gt;• Rash has a centripetal distribution – mostly on the face and trunk and sparsely on the limbs&lt;br&gt;• Pyrexia&lt;br&gt;• Myalgia&lt;br&gt;• Headache</td>
<td>• Mainly supportive&lt;br&gt;• Antipyretics&lt;br&gt;• Antihistamines&lt;br&gt;• Keep well hydrated&lt;br&gt;• Suspect bacterial super infection - manifest as sudden high grade fever; erythema and tenderness surrounding the original chickenpox lesions, refer to medical professional&lt;br&gt;• Children with complications (e.g. encephalitis, meningitis, necrotizing fasciitis) will need hospitalisation&lt;br&gt;• Do not give aspirin</td>
</tr>
<tr>
<td><strong>Scarlet fever</strong>&lt;br&gt;(Causative organism: Group A Streptococcus)&lt;br&gt;[NICE, 2015]</td>
<td>Five to 15 years old</td>
<td>• Sandpaper rash&lt;br&gt;• Sore throat&lt;br&gt;• Strawberry tongue&lt;br&gt;• Lymphadenopathy&lt;br&gt;• May have skin peeling in extremities</td>
<td>• 10-day course of phenoxymethylpenicillin&lt;br&gt;• Analgesics&lt;br&gt;• Keep hydrated&lt;br&gt;• Isolation is recommended to avoid spread&lt;br&gt;• Children with heart disease or immunocompromised, or where complications are suspected should be referred to a medical professional</td>
</tr>
<tr>
<td><strong>Measles</strong>&lt;br&gt;(Causative organism: single-stranded RNA Morbillivirus)&lt;br&gt;[NICE, 2013]</td>
<td>Any age, children under five years are at risk of serious morbidity and mortality</td>
<td>• Maculopapular rash appears first behind the ears and then spreads over trunk and limbs over three to four days&lt;br&gt;• Fever with at least one of the following: cough, coryza, conjunctivitis&lt;br&gt;• Prodromal symptoms – last two to four days with cough, fever, mild conjunctivitis&lt;br&gt;• Koplik spots on buccal mucosa (opposite lower 1st and 2nd molar teeth)</td>
<td>• Mainly symptomatic relief&lt;br&gt;• Analgesia and antipyretics&lt;br&gt;• Keep hydrated&lt;br&gt;• Isolation is recommended to avoid spread&lt;br&gt;• Young infants or those with complications may need hospitalisation</td>
</tr>
<tr>
<td><strong>Typhus</strong>&lt;br&gt;(Causative organism: Rickettsia)&lt;br&gt;[Saffar et al, 2013]</td>
<td>Any age group</td>
<td>• Child will start to feel unwell 10 to 14 days after being infected&lt;br&gt;• Sudden, severe headache&lt;br&gt;• A pink/ red rash starting on the chest and spreading to arms, hands, legs and feet (not face, palms or soles)&lt;br&gt;• Nausea and vomiting&lt;br&gt;• Abdominal pain and diarrhoea&lt;br&gt;• Myalgia&lt;br&gt;• Cough</td>
<td>• Prompt treatment with either doxycycline or tetracycline&lt;br&gt;• Most patients improve dramatically within 48 hours of treatment</td>
</tr>
<tr>
<td><strong>Dengue fever</strong>&lt;br&gt;(Causative organism: Flavivirus)&lt;br&gt;[Saffar et al, 2013]</td>
<td>&lt;15 years old Common in immigrant population but known to occur in native travellers to endemic regions</td>
<td>• High fever with frontal/ retro-orbital headache&lt;br&gt;• Generalised macular and blanching rash&lt;br&gt;• Myalgia&lt;br&gt;• Arthralgia&lt;br&gt;• Nausea and vomiting&lt;br&gt;• Central nervous system involvement</td>
<td>• Symptomatic management&lt;br&gt;• Analgesia and antipyretics&lt;br&gt;• Hospitalisation if unwell&lt;br&gt;• Intravenous fluid resuscitation might be needed&lt;br&gt;• Haemorrhage and shock may require FFP and platelets&lt;br&gt;• Intensive care support might be required</td>
</tr>
</tbody>
</table>
“Give me peace, how long will this irritation last?”

Spread Calm

Soothing, calming and protecting, Diprobase has been helping people with eczema to hydrate their skin, relieve symptoms and live more peaceful lives for over 30 years.

Diprobase Prescribing Information

Uses: Diprobase Cream and Ointment are emollients, with moisturising and protective properties, indicated for follow-up treatment with topical steroids or in spacing such treatments. They may also be used as emollients for topical steroids. Diprobase products are recommended for the symptomatic relief of red, inflamed, damaged, dry or shaped skin, the protection of raw skin areas and as a pre-treatment emollient for hydrocortisone-based skin to alleviate drying effects. Dosage: The cream or ointment should be thinly applied to cover the affected area completely, massaging gently and thoroughly into the skin. Frequency of application should be established by the physician. Generically Diprobase Cream and Ointment can be used as often as required.

Contra-indications: Hypersensitivity to any of the ingredients. Side-effects: Skin reactions including pruritus, rash, erythema, skin exfoliation, burning sensation, hyperkeratosis, dry, dehydrated and balsamic dermatitis have been reported with product use. Package Quantities: Cream: 50g tubes, 500g pump dispensers; Ointment: 50g tubes, 500g tubes. Basic NHS Costs: Cream: 50g tube = £1.28, 500g pump = £6.32; Ointment: 50g tube = £1.26, 500g tub = £5.99.

Legal Category: GSL.

Marketing Authorisation Numbers: Cream: PL 00010/0658; Ointment: PL 00010/0659.

Marketing Authorisation Holder: Bayer plc, Consumer Care Division, Bayer House, Strawberry Hill, Newbury, Berkshire, RG14 1LA, U.K.

Date of Revision of Text: December 2014

Diprobase Lotion

Essential Information: Diprobase Lotion

Uses: Diprobase Lotion is an emollient with moisturising and protective properties, recommended for the management of eczema and other dry skin conditions. Relieves and soothes dry or eczematous skin. Side-effects: No skin reactions have been reported with product use. Contra-indications: Hypersensitivity to any of the ingredients. Dosage: Apply to affected area as often as required. Package Quantities: 300ml pump pack, 50ml tubes. NHS Price: 300ml £3.49, 50ml £1.28; Recommended Retail Price: 300ml £7.99, 50ml £3.99. Date of preparation: December 2014. For further information contact Bayer plc, Consumer Care Division, Bayer House, Strawberry Hill, Newbury, Berkshire, RG14 1LA, U.K.

Diproseaseindicate
**Enteric fever**  
(Causative organism: *Salmonella enterica*)  
(Saffar et al, 2013)  
Endemic in many developing countries and more common in immigrant population  
- Rose spots on chest and abdomen  
- Pyrexia  
- Dry cough  
- Relative bradycardia  
- Headache  
- Weight loss  
- Hepatomegaly  
- Confusion  
- Abdominal pain and diarrhoea  
- Referral to medical professional  
  - Antibiotics  
  - Supportive: rest, rehydration and correction of electrolytes imbalance

**Meningococcal disease**  
(Causative organism: *Neisseria meningitidis*)  
(Hicks et al, 2014)  
Occurs in all ages, but infants, young children are more vulnerable  
- Widespread, non-blanching rash  
- Fever  
- Headache  
- Neck stiffness  
- Photophobia  
- Irritability  
- Poor feeding  
- Confusion  
- Immediate referral to hospital if suspected  
  - Intramuscular benzylpenicillin may be administered by GP  
  - Antibiotics and other supportive management including intensive care support

**Kawasaki disease**  
(Paul et al, 2013; Paul et al 2016)  
Children < 5 years. Higher susceptibility in children of Asian origin  
- Widespread non-vesicular rash  
- Fever lasting ≥5 days  
- Peripheral oedema  
- Chapping of lips  
- Strawberry tongue  
- Bilateral non-purulent conjunctivitis  
- Cervical lymphadenopathy >1.5cm in size  
- Marked irritability in the child  
- Peeling of skin in hands and feet  
- Refer for medical opinion and hospitalisation  
  - Use of aspirin and intravenous immunoglobulin (within 10 days)  
  - Supportive management

**Erythema infectiosum** (fifth disease; also called slapped cheek syndrome)  
(Causative organism: *Parvovirus B19*)  
(Saffar et al, 2013)  
Children three to 12 years of age  
- Fever  
- Anorexia  
- Sore throat  
- Abdominal pain.  
- Once the fever resolves, the classic bright-red facial rash (‘slapped cheek’) appears.  
- Within several days, the exanthem progresses to diffuse, reticular rash that may remain for six to eight weeks  
- Self-limiting – mainly symptomatic relief  
  - Analgesia and antipyretics  
  - Keep hydrated  
  - Exposure in pregnant women has been associated with fetal hydrops and subsequent fetal death  
  - Need to update midwifery/obstetric team if pregnant women are exposed

**Henoch-Schönlein purpura**  
(Exact cause unknown; vasculitic etiology)  
(Barnetson et al, 2016)  
Children three to 10 years of age  
- Rash (may have fever)  
- Arthralgia  
- Abdominal pain  
- Proteinuria, haematuria  
- Intussusception  
- Testicular torsion  
- Glomerulonephritis  
- Joint swelling  
- Refer to medical professional  
  - Analgesia  
  - BP monitoring  
  - Urine dipstick

SPECIAL CIRCUMSTANCES WHERE POST-EXPOSURE IMMUNOGLOBULIN THERAPY IS INDICATED

Although chicken pox and measles are considered to be self-limiting conditions, administration of post-exposure immunoglobulin are necessary in some patients. Community practitioners will be able to guide them to medical professionals for arranging this.

Varicella-zoster immunoglobulin is recommended by NICE (2015) following exposure to chicken pox in:
- Immunocompromised individuals (e.g. oncology patient, individuals on immunosuppressant medicines) where varicella antibody status is negative
- Pregnant women with negative varicella antibody status after confirmation of laboratory results

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Babies whose mother have a negative varicella antibody status and was exposed to chickenpox seven days before delivery or mother developed clinical manifestations of chickenpox within seven days of delivery (NICE, 2015).

NHS England (2016) has published guidance on the indications for the use of human normal immunoglobulin in cases where certain susceptible population groups have been exposed to measles:

- Immunocompromised contacts
- Pregnant women with negative antibody status
- Infants under one year of age.

**IMPORTANCE AND CHALLENGES IN IMMUNISATION**

In the UK, the combined measles-mumps-rubella (MMR) vaccine has been used since 1988. In the early 1990s, the number of confirmed cases of measles fell significantly from 80,000 (in 1988) to around 100 cases (in 2000) (Pegorie et al, 2014). Unfounded fears about a potential link between MMR vaccine and autism in the late 1990s damaged public confidence in the MMR vaccine, leading to reduced uptake, and increased the risk of sustained transmission leading to the number of confirmed cases of measles in England and Wales increasing to above 1,000 in 2008 and remaining above 1,000 since then (Pegorie et al, 2014). These figures highlight the importance of continued uptake of vaccines in the community to maintain ‘herd immunity’. Individuals where vaccination may be contraindicated such as young infants, pregnant women, or immunocompromised individuals will get some protection because the spread of contagious diseases are contained through herd immunity (Lloyd et al, 2015).

The Men C vaccine introduced in the UK in 1999 has played a significant role in minimising new cases of IMD caused by the bacterium. With the introduction of meningococcal B and meningococcal ACWY vaccine in the UK in 2015, it is expected to render further protection and significantly decrease the number of cases of IMD in the UK (Lloyd et al, 2015).

**ONGOING OUTBREAK OF MEASLES AND MUMPS IN THE UK**

Measles is a highly contagious vaccine-preventable condition that has caused large outbreaks in England in areas which failed to achieve herd protection levels consistently (Ghebrehewet et al, 2016). Uptake rates for the combined MMR vaccine have been below the required 95 per cent in the UK since the time of MMR and autism controversy in late 1990s. A semi-structured telephone interview amongst parents or carers of 47 unvaccinated measles cases in children aged between 13 months and nine years, during a large measles outbreak in Merseyside showed that concerns over the specific links with autism remain an important cause of refusal to vaccinate children, with over half of respondents stating this as a reason (McHale et al, 2016). Reduced vaccination rates mean that vaccine-preventable infections are likely to occur more often thereby placing increased burden on the NHS and its resources. The Merseyside outbreak in 2012-13 with 2458 reported cases had an estimated increased cost of £4.4m. A further 11,793 MMR vaccinations would have been needed to achieve herd protection in the previous five years in Cheshire and Merseyside at an estimated cost of £182,909, a mere four per cent of the total cost spent on the measles outbreak (Ghebrehewet et al, 2016).

Outbreaks of mumps have also been reported recently. A study by Aasheim et al (2014) reported 28 cases of mumps being identified in a school setting in 2013. Vaccination status among this cohort included 84 per cent of children having a documented history of two doses of MMR while eight per cent had a history of one dose and the remaining eight per cent had not been vaccinated with MMR. An outbreak control team recommended that MMR vaccine should be offered to all pupils whose parents consented to it, regardless of their previous vaccination status. A third dose of MMR is not part of the routine immunisation schedule in England, but has been given as a public health response on several occasions in the US (Ogbuanu et al 2012).

**MANAGEMENT IN THE COMMUNITY**

Community practitioners can play an important role in supporting febrile children with a rash in their home environment. A few helpful strategies have been suggested which we hope will help to improve care for these children in the community (Paul et al, 2016; NICE, 2013; Barnetson et al, 2016; Public Health England, 2016):

- Early identification and referral of children presenting with a rash and fever where serious pathologies are suspected
- Encouraging uptake of vaccines for children and providing correct information on effectiveness of vaccination and the potential consequences of vaccine refusal
- Provide guidance on supportive management with fluids and antipyretics in febrile children
- Suggest isolation for infectious conditions e.g. chicken pox, measles, etc. (NICE, 2013; NICE, 2015)
- Parents should be given safety net advice on signs of deterioration and information on when to seek further help
- Remove myths regarding fever and immunisation amongst parents
- Encourage catch-up immunisation in children who have developed an infectious condition e.g. measles after they are back to normal health.

**CONCLUSION**

While a rash in a febrile child is common, most children presenting to health professionals
will have a self-limiting viral illness that needs appropriate advice and reassurance. Identification or suspicion of a serious condition should lead to an immediate referral to a medical professional. It is important to actively look for red flag manifestations as that may help community practitioners determine the seriousness of the illness. Improved uptake of vaccines will keep outbreaks of vaccine preventable conditions to a minimum and ultimately reduce the strain on NHS resources.

References


Infant regurgitation is frequently confused with gastro-oesophageal reflux disease (GORD) which is less prevalent, more serious and may require specialist referral. Symptons of GORD include:

- Projectile vomiting
- Haematemesis
- Fever
- Feeding or swallowing difficulties

The distressing levels of crying and disrupted feeding can cause serious anxiety for parents. Despite evidence to support first line nutritional management in bottle fed babies, use of infant alginate therapies remains high.

Infant regurgitation places a significant burden on families, the NHS and the economy alike:

The NHS spent £5.2m in 2015 on infant alginate prescriptions and this figure is increasing by 10% year on year.

For breastfed babies:

National guidelines recommend:

- Assess feeding history and reduce feed volume if excessive for infant’s weight
- Smaller, more frequent feeds
- Thicken formula
- Alginate therapy
- Re-assess if alginate are successful, continue with regular intervals to assess recovery

For formula fed infants:

a STAR approach to treating infant regurgitation:

Assess
Smaller, more frequent feeds
Thicken formula
Alginate therapy
Re-assess

To assist healthcare professionals with correct evidence-based management of frequent reflux and regurgitation in formula-fed infants the acronym a STAR can help to convey the NICE-recommended, stepped-care approach.

References:


FUNCTIONAL GASTROINTESTINAL DISORDERS (FGIDs) ARE AN UNDER-RECOGNISED AND POORLY MANAGED GROUP OF DIGESTIVE SYMPTOMS AND FEEDING PROBLEMS.
Born to move: The importance of early physical activity and interaction

INTRODUCTION
The project was based on the Active Movement initiative in New Zealand (Fraser Mustard, 2006), that acknowledged a growing body of neuro-scientific research, which demonstrates that when a child is born their brain is still very underdeveloped (Goddard-Blythe, 2012). The immature brain of a baby requires stimulation to connect neurones (nerve cells) together to form the essential neurone pathways that lead to successful development. Stimulation of nerve pathways in the skin, eyes, muscles and vestibular system all help to mature these pathways, which in turn support all aspects of early child development.

The opportunity for movement from birth provides this stimulation and therefore the project advocates physical activity for every child from the age of 0 to five, in order to enhance emotional, intellectual, social and physical growth, to help achieve their potential.

Movement is an essential part of life for a human being, particularly in the first thousand-and-one critical days where development is at its most rapid. Exposure to movement and play enhances a positive self-image and offers opportunities for social interaction. It also enables the brain to develop intelligence, logic, memory, higher levels of thinking and movement patterns.

Anecdotal evidence from local primary schools indicated a worrying trend of school-age children with coordination disorders and speech delay starting school. There is a relationship between immature motor skills and educational underachievement (NEELB, 2005). Both of these issues can be addressed by stimulation of the child’s brain and opportunities for active play during critical periods in the first three years of life. “There is increasing evidence to suggest that under-developed postural reflexes can, at a later stage in life, have an effect on advanced learning and social adaptability” (Goddard-Blythe, 2004: 65).

To gather further local evidence of a need for a new approach, funding was obtained from the local early years advisory board in 2010 for a paediatric physiotherapist and a foundation stage teacher to review children at a local state primary school at school entry (four to five years old), using an assessment tool based on the Active Movement programme (Mustard and Connell, 2006). They found that a surprising number of children were unable to stand on one leg, had balance problems, and poor spatial awareness. In addition to this lack of awareness of their body’s capabilities there was also a lack of confidence to tackle new tasks. For example, when asked to step over a ruler balanced between two low children’s chairs, almost half the children refused to attempt the task for fear of ‘getting it wrong’ or ‘knocking it down’. Only 17 per cent had the expected level of gross motor skill, previously expected at school entry.

It was also noted that 30 per cent of children had tracking problems with their eyes, so were not developmentally ready to start to learn to read as they could not keep their eyes steady to track words across a page. In particular it was noted that some of the children with eye tracking problems had previously been reported by parents to be ‘experts’ on computer games, which may have impacted on development of peripheral vision and tracking skills.

Approximately 40 per cent of the local children aged four to five years had not achieved a pincer grip (ideally developed by six months of age), and as a result they were not able to hold a pencil without concentrating solely on that task, which would delay their readiness for managing zips, buttons, scissors, cutlery and learning to write. It was also noted that some children who spoke English as a first language had fewer words in their vocabulary than children of a similar age who spoke English as their second language, which restricted...
their communication skills.

“Poor neuro-motor development in key motor milestones such as sitting unaided and crawling infers that delay in gross and fine motor development at nine months is linked to the likelihood of lack of school-readiness.” (Goddard-Blythe, 2012: 5). This local intelligence stimulated a passion among health visitors to take a more proactive role in delivery of the Healthy Child Programme (DH, 2009) to improve outcomes in the first year of life.

RATIONALE

Anecdotal evidence from health visitors indicated that there had been a shift in behaviour with babies spending much longer sitting in baby carriers and lying supine since the introduction of the successful ‘Back to Sleep’ campaign by the Foundation Study of Infant Deaths (FSID) in 1996, which aimed to reduce sudden infant death.

It appeared that mothers had lost confidence in putting their babies on their tummies for play. A study by Bounty for the FSID found that the number of mothers who gave babies regular awake tummy time had fallen by 52 per cent in eight years. Only 18 per cent of mothers were offering their babies any ‘awake tummy time’ at all; and one of the trends noted following these changes was a delay in the acquisition of early gross motor milestones such as crawling. This study revealed that infants who have even 15 minutes or more of ‘awake tummy time’ per day would reach their motor milestones earlier. The study recommended that prone playtime should be stressed in all pre- and postnatal contacts, along with supine sleeping (FSID, 2006). This ‘light bulb’ moment led to a literature search. The Born to Move project was designed to educate parents and carers about the important link between giving young babies movement opportunities from birth to encourage on-going healthy development.

The health visitor-led project promotes three key messages to encourage interaction at each universal contact: ‘Active play’ on the importance of daily awake tummy time in preparation for crawling; ‘Chatter matters’ to educate about the importance of developing vocabulary; and ‘Eyes need to move too’, highlighting that screen time should be minimised for under-threes to support eye muscle development for tracking and reading skills later on.

WHY IS ‘AWAKE TUMMY TIME’ IMPORTANT?

Awake tummy time refers to an awake infant being placed lying prone while supervised, to encourage neck and upper body muscle development from birth. This increases core strength before the baby has doubled in size (usually between four and six months), to prepare the infant for independent movement and to increase the likelihood of crawling. Sedentary children restricted to the confines of a baby seat for long periods lack the opportunity to move to develop core strength and maturation of baby reflexes. A child must interact with both its environment and caregivers to form the main pathways for many later learning skills. Awake tummy time is also thought to encourage the infants to open their hands to inhibit the palmar reflex. Children who retain this reflex are observed to be more likely to go on to develop speech and articulation difficulties, because the Babkin response in the brain will continue to prevent the development of independent muscle control at the front of the mouth, which will then affect articulation and speech development (Goddard-Blythe, 2004). It also helps to develop the vestibular system; children with poorly developed vestibular systems are likely to have poor attention spans and be fidgety and easily distracted, possibly affecting achievement at school. Adequate opportunity for movement from birth correlates with maturation of baby reflexes supporting normal development. Links have been found between neuro-motor readiness for learning and that immature vestibular functioning is frequently found in children who have specific learning difficulties such as dyslexia;
dyspraxia and problems with attention. “In children with autism, aggression and phobias, the reflexes may not have integrated with the higher functions, and thus the child is reactive, reflexive, hyper-vigilant and often labelled with attention deficit hyperactivity disorder.” (Hannaford, 2005: 111).

Perhaps the most obvious of all the advantages of awake tummy time is the development of a stronger bond between the baby and parent/carer: the NSPCC states that supporting attachment is the single greatest opportunity to safeguard and to promote infant emotional wellbeing. (Cuthbert, Rayns and Stanley, 2011).

The importance of touch along the back, arms, hands, feet and face of the baby stimulates the senses involved in movement and stress responses, and improves the bond between baby and parent/carer. If there is inadequate stimulation for the development of the reticular activating system it can “lead to impaired muscular movements, curtailed sensory intake, overreaction to stress, and a variety of emotional disturbances and learning defects” (Hannaford, 2005: 45).

**WHY IS CRAWLING IMPORTANT?**

Crawling is recognised as an important and possibly underestimated early motor milestone, which contributes to many other areas of development. Crawling is the first opportunity for movement that crosses the midline, meaning that both sides of the brain are used together in a co-ordinated manner. This strengthens the corpus callosum (nerve fibres that link the specific areas of the right and left sides of the brain), with the corresponding area in the other side. The stronger the corpus callosum, the more able the child is to cope with stress and problem solving later in life, since the brain can utilise the logical right side with the creative left side of the brain to tackle new tasks. “Crawling has now been accepted as vitally important for the wiring of the brain, in particular to develop the cross pattern movements of arms and legs.” (Stevens, 2013: 38). Crawling uses almost all the major muscle groups to develop co-ordination of movements and balance.

Further studies have shown that children who do not crawl show lower scores on tests for motor skills at pre-school age (McEwan et al, 1991). The Millennium cohort study suggested a delay in gross and fine motor skills in the first year was significantly associated with delayed cognitive development at the age of five years and readiness for formal learning across the social spectrum (Goddard-Blythe, 2012).

It was found that parental involvement in the form of at-home good parenting has a significant positive effect on children’s achievement and adjustment, even after all other factors shaping attainment have been taken out of the equation (Flett, 2007).

**EYES NEED TO MOVE TOO**

The second key message encouraged by health visiting teams and children centre teams has been in recognition of the research on the impact of increasing amounts of screen time on the emotional development of infants. “The need to replace screen time with more developmentally nurturing activities calls for parental education on the issue” (Napier, 2014: 25).

Screen time can impact negatively on parent-child interactions. Local intelligence indicates that the average pre-school child has an average of six hours of screen time per day, which encourages ‘ocular lock’ which is where eyes focus on screens directly in front of them, impairing the chance of development of other eye muscles and peripheral vision. Professionals raised awareness that ‘eyes need to move too’, to encourage parents to understand the importance of allowing children to develop the ability to track moving objects by watching, in readiness for being able to track words across a page. This also encourages the development of eye muscles for close and distance vision so that they will be able to adjust focus from the white board to close-up work at school later. In addition the increased exposure to screen time is making children increasingly sedentary and might impact on development (Vandewater, 2005).

**CHATTER MATTERS**

The third message concentrated on development of communication skills as the Millennium Cohort Study (2007) found that children who demonstrated comprehension and used facial expression and gesticulation to communicate by the age of one, were less likely to go on to have speech and language delay. Communication was encouraged to address the feedback that some children were starting school with a 19-month delay in speech and language development. Economic and social factors, such as unemployment, ill-health, homelessness and illiteracy affect the wellbeing of families. “Immersing a child in language even before s/he can speak may help their brain develop connections for hearing, language, comprehension, and acquisition and interaction with the world around them” (Oldershaw, 2002: 46).

The project highlighted the need to encourage involvement of children in conversations and to raise awareness that communication skills are learned best through experiences. Children learn best when they ‘see it, hear it and do it,’ face-to-face from birth. This enables children to make the links between the words and the feelings, objects and actions. “Health and early year’s professionals should encourage parents to read to their children as an effective and straightforward way of strengthening early attachment and language development.” (Leadson, 2014: 9).

**THE PROJECT**

The aim was to utilise the unique position of health visitors to lead early intervention. By developing creative approaches for delivery of the Healthy Child Programme (DH, 2009), through early intervention, health visiting teams could reduce later costs to society by promoting positive parenting.

The evidence shows that high-quality early years interventions provide lasting and significant long-term effects on young children’s development. (Department for Education, 2011: 4)

Born to Move focuses on supporting more children reaching their expected developmental milestones, when seen at universal contacts, in addition to collating the number seen.

The plan was to utilise qualitative data from the one-year review, in addition to quantitative data, to gather baseline statistics on local crawling rates at the one-year review. In the initial feasibility study of 100 babies on our caseload, the number of babies crawling by their one-year review was 30 per cent (30). After the first year of input of key messages, the number of babies who
had crawled had risen to 94 per cent (94). This provided enough evidence of improved outcomes for the early years district advisory board to agree to fund my project lead role for five hours a week the following year to roll the project out across the whole district of 1,500 new babies annually.

This pilot demonstrated that health visitors working in partnership with children centre teams can positively influence the developmental outcomes of children. The results were replicated and again showed 93 per cent crawling rates at the one-year review by the end of that year.

Following a report to commissioners explaining that the project was improving outcomes through existing contacts, it was decided that it should be rolled out right across the county.

**METHOD**

The challenge of rolling out the project across all 12 districts was achieved using a train the trainer model, empowering local teams made up of two health visitors and two children’s centre staff from each district. These district teams then cascaded the practical workshops to all front line staff (see Figure 1). This enabled multi-agency delivery of the workshops covering healthy development from birth to one and toddler to pre-school through active learning. Workshops were delivered to the health visiting teams and children centre staff, home start volunteers and nursery staff attached to children centres to achieve a consistent approach for children. This has been sustained for two years. Quality of delivery has been assured by monitoring the evaluation forms used following each workshop.

Supporting the newly qualified workforce has been achieved through conference style workshop days at the university for student health visitors and school nurses for the last three years and also the paediatric student nurses who come on community placement in our teams. This pilot demonstrated that health visitors working in partnership with children centre teams can positively influence the developmental outcomes of children. The results were replicated and again showed 93 per cent crawling rates at the one-year review by the end of that year.

**CONCLUSION**

It could be argued that parenting is the single most powerful influence on emotional and behavioural development, and health visitors are uniquely positioned to be able to encourage and educate parents and carers in how best to support their child’s healthy development. “All the available evidence on child development suggests that supporting intellectual, emotional and psychosocial development in the early years of life contributes to improved educational performance and to better adult economic opportunities and life chances. Improved physical and emotional care in early childhood contributes significantly to better long-term health and improved psychological and emotional wellbeing and sociability in adolescence and adulthood” (McClenaghan, 2012: 25).

The health visiting teams involved in the project have reported great interest from the majority of parents about the links between early play activities and their child’s development and readiness for school with reignited passion for reinstating the preventative public health role in helping ensure children reach their developmental potential. Early years staff have also reported improved job satisfaction. They also felt empowered after having received the evidence base to be able to explain how these activities are the early building blocks to support skills to enable children to grow into happy, healthy confident learners, rather than assuming healthy development will just happen. This should reduce the number of children requiring specialist intervention, when developmental delay is identified later, as a result of lack of opportunity.

The philosophy of the project supports early infant brain development and has much wider implications for children’s long-term future in terms of educational attainment, positive mental health and physical wellbeing.

Although the full outcomes will not be evident until the children are older, the early evidence is very promising and the project has enormous potential for improving the lives of children at minimal cost, through existing staff at existing contacts. ‘Born to Move’ has enabled health visitors to influence policy with a cost effective, innovative approach, achieving measurable outcomes, which enables us to maximise our unique opportunity to improve outcomes for all children in the first 1001 critical days of life and beyond.

**References**


• Educating parents and carers about the benefits of movement and interaction for infants can have a significant benefit on the later development of their children.

• Awake tummy time in infants is related to an increased likelihood of reaching developmental milestones in the critical periods.

• Early interventions by health visitors can improve a child’s school-readiness and can help them reach their full potential.

• Health visitors can effectively take the lead to educate both early years teams and parents.

• The project is low-cost; optimising the impact of existing staff and contacts, and monitoring measurable outcomes is achievable through audit.

Key points


Innovation from the inside: Collaborating for school readiness

JO TURNER PRDN (Child), BSc SCPHN, PGDHE, School Nurse Practice Educator for Sussex Community NHS Foundation Trust

ABSTRACT
This paper will critically reflect on a service evaluation project that was undertaken within Sussex Community NHS Foundation Trust in 2014/15. The project sought to provide a new way of working that supported health visitors (HVs) and school nurses (SNs) in developing effective collaborative and partnership working practices in order to meet the health needs and improve the health outcomes of children aged four to five years in preparation and readiness for school. HVs and SNs are well placed to work with families and provide the early interventions and health support required to support school readiness, e.g. behaviour, sleep, eating and continence advice. Historically, within Sussex Community NHS Foundation Trust, this public health approach has been taken on by the SN service. However, problems were identified locally with this model due to several factors including reduced staffing and confusion regarding transition of care from HVs to SNs. In response, a new way of working was considered locally to ensure the best possible service for families.

KEYWORDS
Health visitors, school nurses, school readiness, collaboration, clinical leadership

INTRODUCTION
Increasingly in policy and practice, the concept of whether a child is ready for school is being debated. In recent years we have seen an increase in public opinion on when children should start school resulting in the government announcing in September 2015 an intention to allow summer-born children the right to start in reception at the age of five (Department for Education, 2015). To understand the impact and challenge for some children in starting school, imagine for a moment George. George is three years old and will turn four on 5 August 2016. George will start school in September. He is 6.4 percentage points less likely to achieve five GCSEs grade A*-C than his peers who will turn five years old in September nearly a year ahead of him. He is unlikely to be as well socially or emotionally developed and he is likely to have less confidence in his ability (Crawford et al, 2013). George is also likely to engage in more risky behaviours such as underage smoking (Crawford et al, 2013), while the difference relative to those born in September is largest for August born children, even a one-month difference in age has an effect. For example, those born in January are 2.8 percentage points likely to achieve 5 A*-C whereas those born in May, the difference is 4.4 percentage points, (Crawford et al, 2013).

The ongoing debate is not a surprise for those working within children's services; in 2013-14 four out of 10 of all children (equating to over quarter of a million) were judged by teachers to have not achieved a good level of development by the end of their reception year (National Children’s Bureau, 2015). Locally the rate is below the national average with only 58.8 per cent reaching this milestone by the end of the foundation stage (Public Health England, 2015).

CONTEXT
A child’s physical, emotional, cognitive and social development in the early years is fundamental in determining their success in educational attainment and their health and employment prospects as an adult (The Marmot Review, 2010). While many interventions supporting school readiness may be undertaken by early year’s education settings, the wider determinants and environmental factors that may influence a child’s development cannot be ignored and public health contribution at this early stage is important (National Children’s Bureau, 2015). HVs and SNs are in a unique position to work with families and share expertise to ensure a consistent message to parents about their role in their children's development. The Healthy Child Programme (HCP), a service delivery model for HVs and SNs, has a strong focus on prevention in the first years of life (DH, 2009) and effective implementation of this should lead to school readiness and improved learning. Key recommendations regarding school readiness and professional practice are available in the CPHVA briefing 'School readiness: the role of health visitors, community nursery nurses and school nurses in supporting children into school' (CPHVA, 2016).

Historically, within Sussex Community NHS Foundation Trust, this public health approach has been taken on by the SN service who in line with the guidance provided by the Department of Health (DH, 2012), liaise with parents once the child has started school, to make an assessment of a child’s health needs and school readiness through use of a School Health Questionnaire. Problems were identified with this model; provision was not provided early enough. The questionnaires were given out in the September that a child started school and once they had all been returned, reviewed and contact made, it was often Christmas before families were receiving support. Delaying the support of children and their families by a whole term could decrease the chance of them achieving success in their Reception year.
and thus educational equity and learning outcomes (United Nations Children’s Fund, 2012). Questions arose about sharing finite staffing resources equitably and who was the most appropriate practitioner to manage this transition programme. The majority of work involves liaising with parents rather than children and it was suggested, may, best meet the skills of HV practitioners. Discussions took place as to whether a qualified HV/SN had to take on this work or whether this could be effectively managed by a nursery nurse or assistant practitioner.

The HV Implementation Plan (DH, 2011) set out a framework to expand and strengthen HV services based on the HCP and was the precursor to the SN Implementation Plan (SNIP) (DH, 2012a). However, there was no similar financial imperative to increase the numbers of SNs. A new way of working was considered locally to ensure the best possible service for families by integrating HV and SN teams, who were at the time working separately, to work collaboratively on the school readiness agenda and share workload. This resource deployment provided opportunity for greater success in implementation of the SNIP (DH, 2012a) where the focus is predominantly on adolescence. Additionally, investment in preparing parents/carers for school entry may reduce referrals to the SN service while improving individuals’ ability to learn once in the school setting (DH, 2012b).

**PROCESS REDESIGN**

Having identified a health need locally and nationally (CPHVA, 2016) in preparing children in readiness for school and an awareness of the potential for improvement in local service delivery, an opportunity for process redesign occurred. Process redesign is the method of reviewing the procedures and practices which are undertaken in healthcare and looking for improvements that seek to improve the quality and experience of patients (Institute for Innovation and Improvement, 2015).

Remembering George, to begin with a ‘wishlist’ was developed to consider what we hoped could be achieved:

- Effective resource deployment
- Upstream, preventative approach

**Figure 1: Project process**

The SN team prepare the packs to be delivered to schools. These include the school health questionnaire, a school health leaflet and accompanying letter.

The school health assistants (SHA) deliver these packs to schools during the summer term.

Schools will then either put them out at their ‘new parents evening’ for collection by parents, or in September when children have started school, they are in a named envelope and given out via their classes.

The SHA will collect the completed questionnaires from schools at various points during the summer and autumn term.

The SHA will review all of the school health questionnaires and will send dental letters and wetting advice and also note any issues with regard to hearing/vision or growth. The SHA will sign and date the top of the questionnaire.

<table>
<thead>
<tr>
<th>Yes</th>
<th>Does the child attend one of the following schools?</th>
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<tr>
<td>No</td>
<td>The SHA will pass all other school health questionnaires that require support with health issues to the relevant SN.</td>
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</table>

If there are any other health issues that require support, the SHA should pass these on to their SN as with other schools.

The HV team will contact the parent and provide the support required whether this be a telephone call or more intensive support over six to eight sessions.

The SN team will contact the parent and provide the support required whether this be a telephone call or more intensive support over six to eight sessions.

The HV team will complete the work required and either discharge the child and family or refer back to the SN service.

In either case, the original school health questionnaire should be returned to the relevant SHA ready for screening and a copy should be kept in the HV records.

SN service continues to manage child’s health needs as per commissioned service.
prevailence of health needs where support or intervention is required. In order for the aims of the project to be successful, as many health questionnaires as possible needed to be handed over to HV teams. The ‘study’ part of the cycle determined evaluation methods. Evaluation took place through two separate cohorts; the first cohort ascertained how many questionnaires were given out to all of the seven schools and were returned prior to the start of the summer holidays. The second allowed us to consider what could have been achieved had the questionnaires been returned earlier. The service evaluation was completed in February 2015 and in line with the ‘acting’ part of the cycle, five key recommendations (Figure 3) were made and implemented as of April 2015 across the Trust and continue to be audited.

One part of the evaluation that was undertaken for this project was to ask parents who received a service from the HV team to evaluate this care by completing a questionnaire that consisted of nine questions in total and was given out to parents by the HV team. The questionnaire was in two parts – pre- and post-intervention. The term intervention refers to any supportive advice provided to parents on an individual basis via face-to-face or telephone contact regarding one of the identified health issues of toileting, behaviour, sleep or eating as per the parameters of the project. Parents were asked about the health concerns that they had regarding their child starting school and the timeliness of the intervention provided. They were also asked to score on a scale of 1-10 how confident they felt about their child starting school pre and post intervention. Ten parents responded out of a possible 64; all but one parent reported an increase in their confidence in their child starting school. One, who did not report an increase, remained the same. This is a small sample, yet it demonstrates a positive trend and illustrates that a small, local project can achieve positive outcomes for patients. It is likely that the small number of respondents to the questionnaire (6.4 per cent) was a result of them not always being given out to parents by the HV team, particularly if the intervention carried out was over the phone rather than face to face.

Figure 2: The PDSA cycle

- Appropriate practitioners working with children and their families
- Deliver excellence
- Allow SNs greater opportunity for implementing SNIP where the focus is predominantly on adolescence
- Investment in preparing children and their parents for school may reduce referrals to the SN service while improving the child’s ability to learn once in a school setting.

To support the implementation of the school readiness service evaluation project and achieve the aims identified within the ‘wishlist’ the PDSA (plan, do, study, act) cycle was utilised (NHS Institute for Innovation and Improvement, 2015) (Figure 2).

In terms of ‘planning’, a convenience sample of seven schools was identified and the wards in which the schools were in had index of multiple deprivation scores that rank within the 20 per cent of most deprived nationally providing a varied cohort. The ‘doing’ part of the cycle was determined within the methodology of the project; any questionnaires that highlighted the four health issues of toileting, behaviour, sleep or eating were handed over to HV teams. Any other identified health concerns were handed over to the SN as usual. The four health issues above were identified, as previous local audits had found them to be the highest

![Figure 2: The PDSA cycle](image-url)
There is a general consensus that clinical leadership is fundamental in bringing about the changes required to provide better service delivery within the NHS (Mulla et al, 2014) and this cannot be ignored when reflecting on the success of this project within practice. The project was not led from the top down; the project was small, unsupported financially and was about the service recognising that it needed to change for the children and families that it serves. Collins (2015:2) suggests that champions for quality healthcare seek transformation and that this plight for improvement is “an intense and never-ending focus on meeting the needs and expectations of ‘customers’ – the people the organisation serves”. This did not come easily and the project was not without its challenges. Storey and Holti (2013) argue that provision of clinical leadership is problematic due to differences in context and levels of legitimacy. I was fortunate to be supported by my line manager and Trust in leading this project, yet this is not always the case within all teams. Mulla et al (2014) acknowledge that enacting change in practice can be very challenging; I was enabled by my line manager to take the time to work on the project and was supported by her in engaging other staff members in the project. I continued to have a clinical caseload throughout the project and as such time management was difficult; determination and support from my manager at difficult times aided continuation of the project. There were also some issues regarding who constitutes a ‘clinical leader’, while completing the project the question arose regarding who can legitimately take on this role (Storey and Holti, 2013). A leader does not have to be someone at band eight and above. Anyone within a team, can take on a leadership role and make changes within that team and this is supported by Ham (2014:3) who argues that “transforming the NHS depends much less on bold strokes and big gestures by politicians than on engaging doctors, nurses and other staff in improvement programmes”. This is only achievable if the clinical leader is empowered by a senior manager and should be attempted by all staff seeking to make improvements in their practice.

Figure 3: Recommendations

<table>
<thead>
<tr>
<th>Recommendation 1</th>
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<tbody>
<tr>
<td>All school health questionnaires involving the following health issues are handed over to the HV service:</td>
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<tr>
<td>• Continenence (wetting/soiling)</td>
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<td>• Behaviour</td>
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<td>• Sleep</td>
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<tr>
<td>• Eating</td>
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<td>• Immunisations</td>
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<td>• Social/family issues</td>
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It is appropriate for the SN service to continue to manage health issues related to medical conditions in school as they have relationships with school staff to support this and may need to offer further training to the school in relation to this.

<table>
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<th>Recommendation 2</th>
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<tr>
<td>In order to ensure that support is provided much earlier for children and families:</td>
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<tr>
<td>• SNs to liaise with headteachers about the importance of schools handing out the school health questionnaires as soon as possible to parents and promoting prompt return of these.</td>
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<tr>
<td>• SNs to attend prospective parents days/evenings at all Infant schools to promote the SN/HV service and iterate the importance to parents of returning their school health questionnaire as soon as possible or by contacting the SN service direct via telephone.</td>
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<tr>
<td>• SHAs to aim to collect 100 per cent of all the school health questionnaires that have been completed prior to the Summer Holidays and pass these on to the either the HV team lead or named SN.</td>
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<tr>
<td>• The HV/SN service to ensure that 100 per cent of those children and families that require are contacted within the six-week period before they start school if not before.</td>
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<tr>
<td>• HV teams to be aware of what is available locally and to liaise with the leaders of these groups so that they are able to refer/signpost parents to the HV service is required.</td>
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<th>Recommendation 3</th>
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<tr>
<td>NNs and assistant practitioners (APs) are well placed to deliver on the health outcomes related to the school readiness agenda. This should continue and NNs and APs should be supported to continue to deliver this role.</td>
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<th>Recommendation 4</th>
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<tr>
<td>Up to six contacts with the parent/child where concerns were identified is an appropriate amount of time to allow a HV intervention to be completed and for the majority of children/families to be discharged. This time frame should continue as per the commissioned service.</td>
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<th>Recommendation 5</th>
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<tr>
<td>There is a large volume of work generated through BCG contacts yet very few referrals are made. This would indicate that parents are unsure whether their child requires a BCG vaccination or not. The school health questionnaire requires review in an attempt to resolve this issue.</td>
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</table>

**COLLABORATIVE WORKING**

While the project was predominantly a success, when reflecting on the challenges the issue of cross-boundary and collaborative working kept arising. Partnership working between health visitors and school nurses has always been evident, as shown in the recent Department of Health (DH) (2014) leaflet: Getting to know your health visiting and school nursing service. In view of this, when implementing the school readiness project in practice there was an expectation that HVS and SNs would consistently work together seamlessly, reduce duplication and reduce gaps in care (Masterson, 2002). HVS and SNs have a shared concern for those children and families who face inequity due to a lack of readiness for school and it is this vision that despite difficulties, promoted the directive to seek ways to work together more effectively.

In West Sussex, at the time of the service evaluation project, HV and SN services were
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Date of preparation: June 2016
working in separate teams. While both HVs and SNs are adept at working within multi-agency teams for the purpose of safeguarding, for universal and universal-plus work, the picture locally was that, despite many excellent examples of collaboration, more could be done to increase integration. Masterson (2002) suggests that high quality healthcare depends on health professionals working well together. While the majority of SCPHN do achieve this, there are many complicating factors that, despite the rhetoric, can make this difficult in practice. For example, the HV and SN team in West Sussex, were at the time, using different patient records, had their own professional culture and educational forums. The importance of breaking down these barriers is instrumental in supporting staff to work more collaboratively (Masterson, 2002).

While the Healthy Child Programme (DH, 2009) highlighted the significant role of the school nurse as well as the health visitor, the increased emphasis of the Health Visitor Implementation Plan and the impact on health visitor recruitment has in some ways, differentiated the two groups. HVs that I spoke to were supportive of the project but expressed some frustrations that they were being given more work to do in the belief that they were better staffed following the HVIP, which they reported was not the case. Feedback was also provided that HVs felt they were being asked to support health needs that previously would have been identified by the three-year health assessment and part of the HV service specification. On top of this, the project identified a lack of role understanding (Valios, 2009). Both HVs and SNs have such a vast role that it is sometimes difficult for them to clarify and articulate what it is that they provide. Machin and Pearson (2013) suggest that there are often inconsistencies within the public health practice of HVs and go on to suggest that this is due to the large breadth of practice legitimised within the role. The same can be said of SNs, while there is value in holding vast knowledge, particularly of various local services, this can also potentially undermine the specialist part of the role and cause role confusion within interprofessional teams.

While it is very clear that HVs and SNs are public health specialists, narrowing the specialist status further to HV and SN specific pathways can potentially lead to something of a reductionist division of public health work which does not view families as a whole. HVs and SNs are both specialist community public health nurses trained to work at individual, family and community level. The project highlighted the value for both families and staff of effective collaboration to provide holistic care (Trodd and Chivers, 2011); therefore, in order to improve inter-professional working, our focus should lie on what we share within our professional roles rather than on what is different.

There is some discussion in the literature regarding the role of HVs and SNs collaborating for the purpose of safeguarding practice (Obadina, 2013) but little else on joint working between the two disciplines.

Key points

- HVs and SNs are well placed to support the holistic health needs of children and families and facilitate school readiness
- HVs and SNs need to reconsider their professional boundaries and think more creatively about effective integrated working with each other but also with educational colleagues
- Further research is required to more closely examine the ways in which HVs and SNs integrate and suggestions made as to how this can more effectively be achieved.
otherwise. The NHS Five Year Forward view (NHS England, 2014) sets out a shared view on how services need to change. It suggests that barriers in how healthcare is provided should be broken down and that models of care should be much more integrated than they are now. In order for this to be achieved, research is required to determine the extent to which HVs and SNs work collaboratively and suggestions provided as to how this can be improved.

Reflection is also required on the issue of effective collaboration and partnership working with education colleagues; any model of public health to support school readiness would not be successful if delivered in siloes. SNs traditionally have good working relationships with schools and this was evident within the project. However, there were still examples of Head teachers not giving out the school health questionnaires until the last week of term and as such, recommendations were made from the project to increase collaboration and relationship building between SNs and Head teachers and all SNs locally now attend new parent talks in schools. In 2015, 96 per cent of three- and four-year-old children benefitted from some funded early education (Ofsted, 2015). It was surprising that early year’s settings were not identifying gaps in school readiness and reporting this to HVs so that interventions could be commenced at a much earlier stage. Locally, following discussions with HVs, it was apparent that there was little collaborative working between them and early years settings and they continue to receive very few referrals from this route. Trodd and Chivers (2011) suggest that early years is the obvious starting point for this can more effectively be achieved.

Conclusions

In conclusion, HVs and SNs are well placed to support the holistic health needs of children and families which can aid and facilitate school readiness. This in turn will reduce health inequalities and support healthier futures. However, effective service delivery and processes need to be considered to ensure that this public health approach is delivered in the most effective way.

Clinical leadership is fundamental within the NHS to make effective service delivery changes that supports excellent patient care. This can be achieved through a bottom-up process redesign, even in times of austerity. However, for this to be achieved it needs to be supported by effective management structures and education and supervision of junior staff to enable and empower them to make changes.

The contemporary focus on school readiness is challenging HVs and SNs to reconsider their professional boundaries and to think more creatively about partnership working both with each other but also with educational colleagues to consider effective service re-design. Research is required to more closely examine the ways in which HVs and SNs integrate and suggestions made as to how this can more effectively be achieved.

References


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i-HOP is England’s national, one-stop information hub, which supports all professionals to work with the children and families of offenders. It provides free access to practical resources, key information, targeted services and much more.

I have been working on the i-HOP service from the outset. When it was first funded by the Department for Education in 2013, i-HOP was set up by national children’s charity Barnardo’s in partnership with POPS (Partners of Prisoners Support Group) based in the North West. The service was commissioned in response to growing recognition of the negative experiences that children and families face when a loved one is involved in the criminal justice system (CJS): financial and housing disruption, isolation, stigma and poorer physical and mental health.

Further to the growing body of research into the impact of parental offending on children, there has been increasing interest from UK policy-makers in the benefits of maintaining family ties on reducing reoffending. Despite this recognition of the children of offenders there is still no robust identification process in England as to who they are. This means there is both a lack of awareness of their needs and no consistent statutory response to meet them.

i-HOP brings together an information directory to support all professionals to work with children affected by familial offending. The website hosts information about specialist prison and community-based services for these children, practice examples, tools and resources for families as well as professionals, training opportunities, events, relevant research and local and national policy. We share our website updates and important information about work with children of prisoners across England via Twitter, and with our 2000+ members via the i-HOP e-newsletter. You can sign up for these free monthly updates at www.i-hop.org.uk.

Through our contact with various health professionals it became clear that there was a need for guidance around working with these children and their families. This culminated in the comprehensive i-HOP Guide for Community Health Practitioners, endorsed by Wendy Nicholson, lead nurse for children, young people and families. The guide was launched in February 2016 at a Public Health England event in London and featured in the June issue of Community Practitioner.

i-HOP’s other resources include the practical quality statements and toolkit, developed in partnership with Research in Practice, which enable services to self-assess their work with offenders’ children. All i-HOP resources are available to download for free from the website.

As of 2016, i-HOP is run solely by Barnardo’s. We are working to embed our resources within university courses and we’re delivering guest lectures to community health courses, as well as developing new training in how to use the quality statements and toolkit. We’ll also continue to update the website to ensure its usefulness and relevance to those developing work with offenders’ children.

If you have a case study or practice example of working with a child or family with a loved one involved in the CJS, please get in touch; we would love to share your work with professionals across the country. i-hop@barnardos.org.uk
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1. The importance of Emotional Intelligence and a Loving Touch, Bonding and Attachment - birth to eight weeks (can also be taught antenatal)
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   - Introducing overall good reciprocity to facilitate mother-infant relaxation and bonding
   - Relive intra-uterine and difficult birth experience
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2. Developmental Baby Massage – 8 weeks to Standing
   - Baby-led sessions
   - Quality time for parents to get to know their baby through a loving touch, learning about baby’s cues and communication.
   - Benefits of safe tummy time
   - Baby observation for a foundation of secure attachment
   - Infant development, relevant anatomy and physiology
   - Improving circulation, respiration, back strength, joint flexibility and overall muscle tone
   - Relief of common infant ailments.
   - Consideration of babies with additional needs and developmental delay.
   - Includes contra-indications, safety, correct baby massage oils and usage.

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

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1 Contains 1.89g/100kcal of protein, including alpha-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.

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