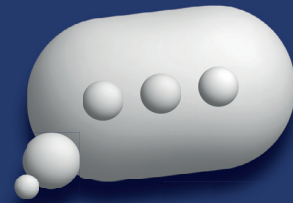
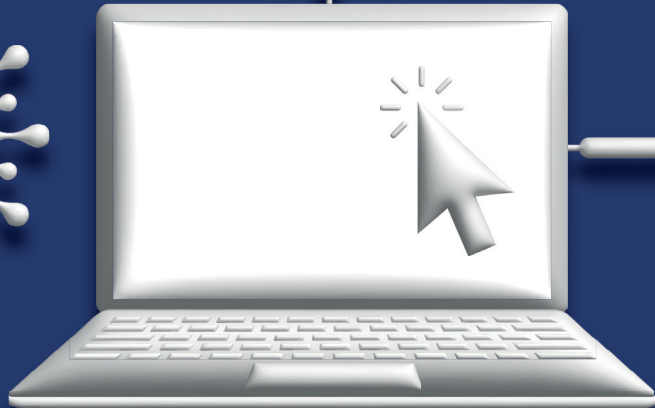


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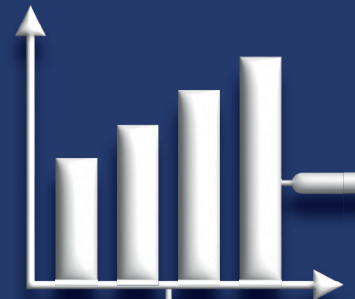
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MARCH / APRIL 2023



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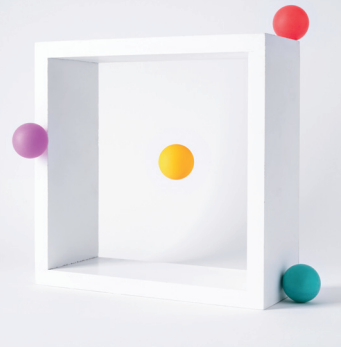


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WELCOME

from your editor, Aviva

At the time of writing this, Sadiq Khan had just announced his provision of emergency funding for one year of free school meals for primary school children in London. In the January/February journal, we explored how free school meals can benefit everyone, including the UK economy. Wouldn't it be amazing if the problems tackled in our current journal's Big story (page 8) – expensive childcare and an inflexible system – received some positive action in the coming months.

Meanwhile, our cover feature on page 20 looks at how school nurses (SNs) went above and beyond during the pandemic, creatively adapting the service to help young people. It features extensive research (which this journal was a part of) and asks what the service looks like now, plus what SNs need to make it work going forward.

The need for more resource and funding remains, as does the battle for improved NHS pay for all. On page 12, Unite national officer for health Colenzo Jarrett-Thorpe

offers an update and reveals how you can use your voice.

Turn to page 14 to hear from Scottish CNO Professor Alex McMahon about his work to help support CPs day-to-day.

Finally, thanks to all the members who have provided invaluable content this issue. See page 46 if you would like to contribute.



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twitter.com/CommPrac

COMMUNITY PRACTITIONER

Unite-CPHVA

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redactive

News in numbers

In a study of

286,732

people, the rates of those who have reported experiencing **abuse, assault or bullying in childhood** is **3 to 5 times higher** in the youngest generation of adults (**18-24**) compared with their parents and grandparents (**55+**).

The survey was taken across the internet-enabled population of **27 countries**, including the UK



A 6-year

study trialling **on-site pharmacies** in **49 care homes** across the UK has found it **safer** for residents, with a 'significant reduction in potential future harm from medicines'.

The study involved **25** specially trained **pharmacist independent prescribers** integrated into homes to improve management and safety

46%

of **nurses and healthcare workers** have faced **physical and verbal abuse** at work.

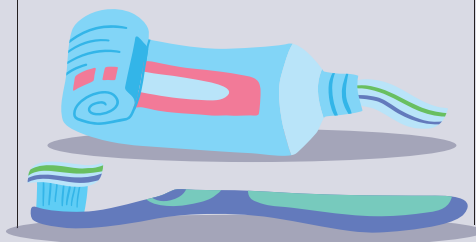
Of **463 qualified workers** within nursing, social care, elderly care, mental health and the NHS, **42%** had experienced **racist abuse**, and **7% sexist abuse**, according to a survey.

29% received verbal, physical or online abuse at work at least **once a week**, with **7%** suffering abuse as often as **once a day**

81%

of **young people** have **no access to regular toothpaste**, a survey of **260** UK state secondary school teachers found. This is leading to **1/3 of children** being **bullied**, and **40%** being **socially excluded** by their peers.

Only **44.8%** of young people saw their **dentist** last year, down **13.9%** year-on-year



CLICK HERE OR VIEW ONLINE FOR MORE NEWS IN NUMBERS




Find links to relevant reports and surveys highlighted in the news stories at bit.ly/CP_news_in_numbers

Public health

A look at recent programmes or campaigns launched, and reports published.

KEY

 Campaign
 Poll

 Report
 Website

 Video
 Health programme



England ROLL-OUT OF FAMILY HUBS BEGINS


Programme: The February government announcement set in motion the 2019 manifesto commitment to champion family hubs.

What are the main points?

- ▶ Family hubs will be rolled out in communities of most need: **75** areas with high deprivation will benefit from the **£300m** investment, with thousands of families offered help.
- ▶ The new hubs will act as a ‘one-stop shop’ to offer support right from conception through to age **19**, or up to **25** for children with special education needs and disabilities. Guidance and advice will be offered on issues such as infant feeding, mental health support and health visits.
- ▶ The government is also confirming the final five areas to receive investment to transition the services that used to operate under the Sure Start banner to family hubs. This will allow **12** more local authorities to open hubs by **March 2024**.

EXPERT THOUGHT

The government’s early years healthy development adviser **Dame Andrea Leadsom** said: ‘The best start for life is the most fundamental right of all. There is quite literally no better place to invest, either for human happiness or value for taxpayers’ money.’

 bit.ly/ENG_family_hub

Scotland RESPONDING TO THE DRUG DEATH EMERGENCY

Publication: *Drug deaths taskforce response: a cross-government approach*

More than **80** actions outlined in the report will be supported by **£68m**, with measures being taken across a broad range of areas to improve the lives of those affected by drugs.

What are the main actions?

- ▶ **£30m** ringfenced from the Enhanced Services Allocation to NHS territorial boards from April 2023 to support specific drug treatment services within primary care settings.
- ▶ **£18m** to develop stabilisation and crisis care services.
- ▶ **£4.3m** for a Stigma Action Plan, which includes an accreditation scheme to challenge stigma across public life.
- ▶ **£5.5m** for new programmes for children and families, including the expansion of the Routes youth work programme.
- ▶ **£3.4m** more to deliver a workforce action plan and expand the Addiction Workers Training Programme, and an additional **£3.3m** to expand trauma training.



bit.ly/SCT_drug_deaths



EXPERT THOUGHT ANGELA CONSTANCE

Drugs policy minister

‘Every drug death is a tragedy and unacceptable. This publication outlines our whole government commitment to addressing this challenge and ensuring that people with problem substance use can access the services they need.’



EXPERT THOUGHT

KEVIN STEWART

Mental wellbeing
minister

‘We want all mothers and their families to have access to good mental healthcare throughout pregnancy and during the postnatal period ... it is reassuring to see that from October 2020 to March 2023 over £2.5m has been distributed to successful charities via the fund.’

Scotland

SUPPORTING PERINATAL AND INFANT MENTAL HEALTH

Publication: Fund update: Perinatal and Infant Mental Health Fund

What are the main elements?

- ▶ Families across Scotland will benefit from a **£1m** investment in charities specialising in mental health and wellbeing support in pregnancy and early years.
- ▶ Provided by the Scottish Government's Perinatal and Infant Mental Health Fund, the support will go to **34** charities that help new families take their first steps in raising babies and young children.
- ▶ The fund enables organisations to provide one-to-one and group-based support and care that parents, carers and new babies need.
- ▶ More than **7000** parents, expectant parents and infants have been supported by the funded organisations.

- ▶ The extension of the existing fund was announced for another year from April 2023 to March 2024 at the current level of

funding, more than **£1m** across the **12 months**.



bit.ly/SCT_PIMH_fund



UK

A NEW PANDEMIC IN THE MAKING?

Publication: Mental health and the cost of living crisis report: another pandemic in the making?

Results of a survey by the Mental Health Foundation reveal that many people are not able to do what's needed for good mental health due to the cost of living crisis.

What are the main findings?

- ▶ Almost one in three (**30%**) adults are experiencing poorer quality sleep as a result of financial worries.
- ▶ Almost a quarter (**23%**) of people are meeting friends less often.
- ▶ One in six (**15%**) people are reporting engaging less with hobbies, while one in eight (**12%**) are exercising less frequently.

Mental Health Foundation, said: ‘This is not only a financial crisis – it is a public mental health emergency ... Concerns about finances are reducing people’s ability to do the basic things that we know support good mental health.

‘We need good-quality sleep. We need to be able to do things we enjoy. We need exercise. We need to be able to spend time with the people we love.

‘We need to do more than simply survive to have good mental health and wellbeing: we must thrive if we are to prevent mental health problems from developing.’

EXPERT THOUGHT

Mark Rowland, chief executive of the



bit.ly/UK_mental_health



BIG STORY

Patching Childcare

Expensive childcare and an inflexible system are having a tough impact on families, and government support must be unlocked, campaigners say. Journalist **Kaye McIntosh** reports.*

There is a crisis in childcare. Parents are struggling, particularly women. Campaigners, charities, economists and politicians agree costs are too high. Childcare is so expensive that six out of 10 women who had an abortion in the past five years cited cost as a factor in their decision, according to a survey by Pregnant Then Screwed (PTS, 2022a). Children's charity Coram (2022) says: '[Childcare] remains a deeply flawed patchwork system that makes it hard for families to get the support they need and forces some parents – particularly mothers – out of the workforce entirely.'

In October 2022, more than 12,000 parents took to the streets around the UK to demand change in the March of the Mummies. Lauren Fabianski,

head of campaigns at organisers PTS, says: 'A lot of women are unable to return to the workplace – who want to – because two-thirds of families are paying, according to our research, the same amount for childcare as their rent or their housing [PTS, 2022b]. So it's really making families struggle financially. We know it's making families turn to foodbanks. We know it's stopping families from having more children that want more children.'

She describes the survey finding on childcare influencing women's decision to end their pregnancy as 'a really shocking statistic'.

A survey of nearly 2000 childcare providers by the Early Years Alliance found 72% said government funding for two-year-olds did not cover costs, while 86% said funding for three- to four-year-olds was insufficient (Early Years Alliance, 2022).

WHY IS IT SO EXPENSIVE?

While 'international comparisons are hard' regarding childcare costs, says Christine Farquharson, senior economist at the Institute for Fiscal Studies, the UK is probably among the top three most expensive countries. 'It's clear that it's staggering,' she says.

So why are childcare costs so high? Campaigners blame the government. 'It is definitely an investment and a funding issue,' says Lauren. While three- and four-year-olds get 30 free hours a week, the state offers far less at other ages (see *Government help with childcare costs*, right).

And parents don't even know about, or claim, some funding. Christine says: 'Only 40% of parents with a pre-school-age child have even heard of tax-free childcare.'

Treasury figures in 2021 revealed a £2.4bn underspend on tax-free childcare since the scheme began five years ago (UK Parliament, 2021). Parents who start to claim Universal Credit have to wait weeks before childcare costs are refunded – a huge barrier for those who are struggling.

Christine says that as a result ‘take-up rates are very low, and a lot of families find it very difficult to access the support that they should be entitled to’.

WOMEN BEAR THE BRUNT

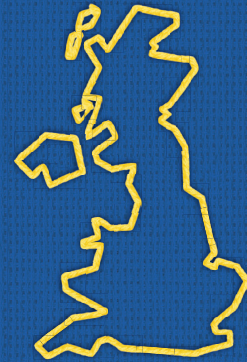
The impact of all this is particularly severe for women because they are typically the lower earners in any family. Lauren says the motherhood penalty – lower wages and slower career progression – starts when women take maternity leave, while men only qualify for two weeks statutory paternity leave. ‘Men are returning to work. The responsibility of childcare is put on women from that point onwards and it never really lifts, even if a woman does go back to work.’

Unite National Women’s Officer (seconded) Alison Spencer-Scragg adds: ‘Women are automatically still seen as the main care providers.’ The gender pay gap goes up after motherhood, she explains. The overall pay gap in April 2022 was 8.3%.

But for women in their 40s – who are much more likely to be mothers – the full-time gender pay gap is much higher, at over 10.9% (Office for National Statistics, 2022).

GOVERNMENT HELP WITH CHILDCARE COSTS*

There is a complex system of different schemes across the UK, depending on the child’s age and factors such as family income, disabilities and additional needs. Some of the main elements are:



ENGLAND

- ▶ All children aged three and four in England are eligible for 15 hours of early education a week.
- ▶ Working parents of three- and four-year-olds in England can claim 30 free hours a week for 38 weeks a year. They must earn at least minimum wage.

SCOTLAND

- ▶ Three- and four-year-olds can get up to 30 hours of early education a week in term time. Some two-year-olds are eligible.

NORTHERN IRELAND

- ▶ In the year before children start primary school, most places will be available at least two and a half hours per day, five days per week.

WALES

- ▶ Three- and four-year-olds can get up to 30 hours of early education a week, for up to 48 weeks of the year.

UK

- ▶ Tax-free childcare pays up to £2000 a year for each child aged under 11, for parents earning at least minimum wage for 16 hours a week.

WORSE-OFF CHILDREN LAG BEHIND

Childcare problems don’t just affect family income and women’s ability to work. Disadvantaged children reach fewer developmental milestones when they start school than better-off kids. There is an attainment gap of four and a half months in primary schools (Hutchinson et al, 2019).

Coram (2022) says: ‘Government-funded early education entitlements are a key tool in reducing this gap, and so it is essential that it is taken up by disadvantaged children who stand to benefit the most.’

MPs are increasingly concerned, and the Education Select Committee is launching an inquiry into the cost

of childcare. Chair Robin Walker says: ‘The childcare sector is intrinsically important because it has the potential to allow millions of parents to continue with their careers while giving young children a huge head start in their pre-school education.’

‘It’s vital that we identify solutions to the range of problems and challenges facing the childcare sector, understand why the costs have become too dear for many families, and see what the government could do to raise the esteem, affordability and quality of early years education.’

‘As many have pointed out, getting this right could be a huge boost for the UK’s productivity and the welfare of its future generations.’ He adds there is ‘cross-

SHUTTERSTOCK

*The March/April issue, including the Big story, was written and compiled before the Spring Budget 2023. For policy updates since the budget, see bit.ly/spring_budget_2023

party hunger to fix childcare' (UK Parliament, 2022).

SHAKE IT UP

Unite-CPVHA wants to see a huge shake-up of the system: nothing less than universal, free childcare. Alison says: 'We pay taxes. We've got a free healthcare system and free education, so we want free childcare.' That wouldn't mean state-run nurseries, but 'whatever childcare the parents choose'. One size doesn't fit all, she adds.

Until that is in prospect, there are still steps the government, and employers, could take, she says. Companies struggling to recruit need to look at subsidised workplace nurseries and flexible working.

Currently the law says you must be in your job for 26 weeks before you can even request flexible working, and you can only make one request in any 12-month period. Although some employers do better, there's no legal right to anything beyond this. Employers can also turn down requests for business reasons. Unite-CPVHA wants flexible working to be available from day one and spelled out in job advertisements so you know the score before you even apply.

In the meantime, the union is pulling together a database of employers to see what is happening on the ground. 'We are hoping to see employers that have actually made progress in terms of looking at more inventive ways that people can work and challenging where employers are just carte blanche saying no to any level of flexibility,' says Alison.

Often, women want to do condensed hours, she says, rather than go part-time. The cost of living crisis means they can't afford to work less; but working longer, fewer days would cut down on childcare costs.

The government made a manifesto commitment to supporting parents,

she points out. A consultation on proposals to update the system for early years funding in England for 2023-24 closed in December 2021. A Department for Education (DfE) spokesperson said: 'A response will be published in due course.'

'We continue to review all options to improve the cost, choice and availability of high-quality childcare for working parents, which remains a priority for this government.'

'We have spent more than £20bn over the past five years to support families with the cost of childcare, and the number of places available in England has remained stable since 2015, with thousands of parents benefiting from this support.'

It's clear that campaigners, economists, charities and parents think this is far from enough. Lauren says: 'It's very bleak. Households are being forced into poverty.' The current system is 'completely unsustainable', she adds. Something surely has to change – and action can't come soon enough for thousands of struggling parents across the country. 🇬🇧

RESOURCES

- ▶ Help advise parents and carers on how to get help paying for costs, wherever clients live in the UK [gov.uk/help-with-childcare-costs](https://www.gov.uk/help-with-childcare-costs)
- ▶ Pregnant Then Screwed is a charity dedicated to ending the motherhood penalty and campaigning for change [pregnanthenscrewed.com](https://www.pregnanthenscrewed.com)
- ▶ For providers, the Early Years Alliance guide to funding outlines what government support is available [eyalliance.org.uk/financial-planning-and-funding-sources](https://www.eyalliance.org.uk/financial-planning-and-funding-sources)

HOW CAN CPs HELP?

The childcare funding system is fiendishly complex. If you can point parents towards sources of advice, that could make a real difference. Find a guide outlining support for different circumstances (select specific UK country from drop-down menu) at childcarechoices.gov.uk

FIGURING IT OUT

43%

of working mothers have considered leaving their jobs

40%

were working fewer hours than they wanted to because childcare fees were unaffordable



The UK has the **third** most expensive childcare costs of 40 nations, including EU and North American states



For references, visit bit.ly/CP_news_big_story

SHUTTERSTOCK

Coram, 2022; Early Years Alliance, 2022; OECD, 2023; PTS, 2022.

Professional update

UK NEW COMMUNITY PRACTICE TEACHING STANDARDS

The Queen's Nursing Institute (QNI) has published new standards of education and practice for community practice teaching.

The standards include benchmarks and guidance outlining the transition from a practice supervisor and practice assessor role to that of a community practice teacher. It also includes the qualities required for community practice teaching, and the educational framework needed for learners undertaking specialist practice qualifications (SPQ) or specialist community public health nursing (SCPHN).

The new standards align with the four pillars of advanced practice of the Health Education England Advanced Practice Toolkit Framework. The pillars are as follows:

1. Clinical care
2. Leadership and management
3. Education and assessing learning
4. Evidence, research and development.

Higher education course leads, practitioners and commissioners from all four UK countries have contributed to the project through a Standards Advisory Group chaired by Professor John Unsworth OBE, QNI Chair of Council.

The project was led by Angie Hack QN, who said: 'These standards will ensure there is a robust basis for contemporary and future education and practice development in place for nurses undertaking an SPQ or SCPHN programme.'



bit.ly/UK_QNI_standards

UK FALL IN NURSING APPLICATIONS FOR 2023-24

There has been a decline in nursing applicants across all age groups and within each UK nation for **2023-24**, data published by UCAS reveals.

As of the January deadline, figures showed a **18.6% decrease** in the number of nursing applications compared with last year. However, the number of applications exceeds the number of acceptances seen in last year's cycle, showing there is still plenty of demand for places.

The number of UK mature applicants has also fallen compared to last year (**-14%**), mostly due to a decrease in nursing course demand.

Of the four UK countries, Scotland has seen the biggest decrease in the number of applicants compared to last year at **24%**. UCAS said that 5070 people had applied to study nursing in Scotland this year, compared with 6690 in 2022. Applications fell by **18%** in England, **17%** in Northern Ireland and **22%** in Wales.

While these declining figures reflect the situation for nursing courses, UCAS highlights that the number of UK 18-year-olds applying to an undergraduate course this year is the second highest on record.



bit.ly/UK_UCAS_nursing

SHUTTERSTOCK





NORTHERN IRELAND

SCOTLAND

ENGLAND

WALES

RIGHTS AT WORK

NHS PAY UPDATE SPECIAL

Colenzo Jarrett-Thorpe,
Unite national officer for health, reveals the ongoing situation with ballots, and how you can use your voice.

Unite-CPHVA is constantly campaigning for a better health service – and your pay, terms and conditions are key to delivering this. In England, Wales and Northern Ireland, Unite and other NHS trade unions are in dispute with their respective governments over their pay awards as recommended by the NHS Pay Review Body (NHS PRB) of £1400 backdated to April 2022.

ENGLAND

- ▶ In a consultative ballot of Unite members, 97% of Unite members who voted said that the pay award was not enough for all bands and was another real-terms pay cut. Subsequently Unite have run successful industrial action ballots in seven ambulance trusts and a number of other NHS trusts in England.
- ▶ Unite – with other trade unions in the ambulance service – has taken industrial action on several days in December, January, February and March.
- ▶ Unite and its sister unions have the simple demand for a pay rise for this financial year (2022/23) that is in excess of the inflation rate. This will help recruit staff to the NHS (there are over 130,000 vacancies in England) and address poor pay.
- ▶ The UK Government refuses to have meaningful discussions with trade unions regarding pay to address these issues and resolve the various crises that are currently engulfing our NHS.
- ▶ NHS trade unions have not submitted evidence to the NHS PRB for 2023/24 as they decided that they don't have confidence in the NHS PRB to deliver fair pay for health workers.
- ▶ In England, Unite will continue to ballot groups of workers who want to take industrial action to stand up for our NHS and decent treatment for NHS workers.

WALES

- ▶ Unite held a consultative ballot of Welsh NHS members, who voted comprehensively to declare the pay rise unfair and showed there was an appetite to proceed to industrial action. Anti-trade union laws for industrial action in Wales make succeeding in an industrial action ballot in the NHS a steep task, with 50% of the electorate needing to vote to validate a vote for industrial action.
- ▶ The Welsh Ambulance Service succeeded in clearing the necessary hurdles to take lawful industrial action in for two days across the nation in January 2023.
- ▶ Health trade unions engaged in talks with the Welsh Government at the beginning

of February in an attempt to avert further strike action. This resulted in an offer from the Welsh Government of an extra consolidated sum of 1.5% on top of £1400 from the PRB award from 2022/23 and an extra lump sum pay for each NHS Wales employee worth 1.5%.

- ▶ 90% of Unite ambulance workers have rejected this offer from the Welsh Government alongside the GMB.
- ▶ Unite ambulance workers will continue to take strike action in February and March, but are open to having further talks with the Welsh Government to discuss solutions to end the dispute.

NORTHERN IRELAND

- ▶ Because there is no government in Northern Ireland, health service pay has been progressing quite slowly and these health workers will only see the NHS PRB pay award of £1400 backdated to April 2022 in their March 2023 pay packets.
- ▶ This has not daunted health service workers in Northern Ireland, and with no anti-trade union laws to confront, this has enabled all our members across all the health employers in Northern Ireland to take industrial action in December, January and February following a successful industrial action ballot across all members where over 90% voted for strike action.
- ▶ Unite has attempted to bypass the political deadlock in Stormont by writing to the UK Government secretary of state for Northern Ireland, but the letter has not been met with a response at the time of writing.

SCOTLAND

- ▶ There are direct negotiations between the Scottish Government, employers and trade unions, and no reference is made to NHS PRB.
- ▶ Scottish trade unions twice balloted and rejected Scottish Government pay offers for 2022/23. Many unions in Scotland balloted successfully for industrial action including Unite. More pay discussions at the end of November brought a revised offer.

- ▶ Unite members who were on the cusp of taking lawful strike action balloted our members on the improved offer of an on-average 7.5% increase across NHS Scotland, with up to 11.24% for the bottom pay bands. It means Bands 1 to 4 will receive a flat rate payment of £2205, and Bands 5 to 7 will receive increases ranging from £2280 to £2660.
- ▶ Scottish Unite members accepted the offer, though three trade unions did not accept the offer implemented in January 2023.
- ▶ Pay discussions for 2023/24 have already started in Scotland and have yielded a fresh offer from the Scottish Government that proposes Agenda for Change pay rate increases of 6.5%. 🇪🇺

For further information, visit [unitedtheunion.org/nhs](https://www.unitedtheunion.org/nhs)

WHAT CAN YOU DO?

- ▶ Speak to your Unite-CPHVA locally accredited representative (LAR) regarding your membership details and ask for Unite promotional materials to display in your workplace and give to your colleagues.
- ▶ If you don't have a LAR in your workplace, why don't you become one or start a conversation about who might be one? Please contact CPHVA or your local Unite district or regional office to find out more what a LAR does.
- ▶ Please visit [myunite.org](https://www.myunite.org) to check your membership details are up to date so we can be ballot-ready.
- ▶ Take part in webinars, union stalls, branch meeting, rallies and days of action that your local Unite branch or sister union branch may be organising in your workplace to highlight our claims for decent pay for NHS workers.

ONE-TO-ONE INTERVIEW

SUPPORTING THE SUPPORT

Chief nursing officer for Scotland
Professor Alex McMahon talks about
his first year in post and important
developments that will affect CPs.

This year will see two significant professional milestones for Professor Alex McMahon. On one hand, he has just celebrated his first year as chief nursing officer (CNO) for Scotland, having officially assumed the post in January 2022. The second anniversary is more personal: it will be 40 years since he started as a student nurse.

Given the decades he has worked through, Alex's key observations are born from extensive experience. 'Every profession evolves over time, and what we deal with now are people who live longer but with much more complex health needs, and many of those are in a home setting rather than a hospital setting,' he says. 'But there are a lot of core elements to the job that have never changed – the compassion element of it, and the ability to communicate effectively.'

While the basics remain, the changing circumstances that Alex mentions, and their knock-on effects, are at the root of many of the specific challenges he has to face as CNO. 'One thing we need to think about as a profession is how we meet these demands,' explains Alex. 'Some of it is about capacity and having more people to do more caring but in different environments, such as in a community context, as well as in a hospital context. And we need different levels of skill, from healthcare support workers through to advanced nurse practitioners. That takes us to the issues of how we train and then retain staff, because we need more people with more skills.'

Alex continues: 'From my perspective, it's about trying to think of a longer-term model that will supply nurses and midwives who can work across all settings – not just in our big general hospitals, but across psychiatric services, community services and within district nursing and health

visiting. We're trying to ensure that we are creating good opportunities for people, but good retention opportunities as well.'

WISE COMMUNICATION

For many people, having such a packed and wide array of issues needing his attention could be overwhelming, but Alex's 40 years in a range of healthcare roles in different organisations mean that he is well prepared for the challenge.

Alex started his career as a mental health nurse, and then did his general nurse training before working up to clinical nurse manager level. A slight career change saw him join the Royal College of Nursing, where he became head of policy; then he worked in the private sector as head of government affairs for a global pharmaceutical company. Next he joined the Scottish Government's Centre for Change and Innovation, where he wrote *Delivering for mental health* (bit.ly/SCT_delivering_mental_health).



**'WE'RE TRYING TO ENSURE
THAT WE ARE CREATING
GOOD OPPORTUNITIES
FOR PEOPLE, BUT
GOOD RETENTION
OPPORTUNITIES AS WELL'**

Before taking on the role of CNO, a return to the NHS in a number of director roles eventually saw Alex as executive director of nursing, midwifery and allied health professionals for NHS Lothian.

'I think the training I had as a mental health nurse in the 1980s has stood me in good stead throughout my career,' reveals Alex. 'One of the things that you are trained in is communication and observation: knowing when to speak and when not to speak, knowing when to stay in the room and when to leave the room. As you go through your career, that emotional intelligence also helps you with relationship building. You get to know people, how to understand them and how to get the best out of them.'

And of the biggest challenges he's faced to date? 'When I was anticipating taking on the role of CNO, I think everyone thought that the worst was behind us with "the end" of the pandemic,' says Alex. 'But actually, since I've been in post, there have been so many challenges both in the UK and internationally, as well as still dealing with Covid-19 and then flu for the first time in a while. I'd say my first year has been challenging in many ways, but it's also been hugely rewarding.'

'When it comes to problems that people in Scotland face, I don't think they are any different to the rest of the UK. There are issues around geography, remoteness and access to rural areas, and there are issues about health inequalities and deprivation – those can all be found elsewhere in the UK as well. But our community nurses, particularly our health visitors, school nurses and district nurses, are picking those issues up as they interact with families every day, and they are helping those families find the support they need.'

UNIQUELY ALEX

Biggest lesson learned

'Knowing when it's important to step in and say something/support somebody, or when it's important to let others speak and just listen. You can teach people the theory of it all, but you need to practise it in different environments.'

Most surprising fact

'I had a real passion for graphic design – that's what I was best at in school and I thought I was going to go to art college to be a graphic designer,' reveals Alex.

Perhaps not what you'd expect from somebody with such a proud nursing career. But after a career guidance teacher at school said 'Alex, I think you'd make a really good nurse,' Alex applied for a nursing course.

'After two knockbacks from art colleges, I got an interview for nursing. Shortly after, I got a phone call asking if I could start three weeks on Friday.' And the rest, as they say, is Alex's own uniquely distinguished career history.

NEW WAYS AHEAD

Alex and the Scottish Government are working on two significant new schemes to ensure people get exactly the right support and care. The first is the emergence of a national care service highlighting the importance of individualised care. It is called GIRFE – 'Getting It Right For Everyone'.

'With GIRFE, we're trying to develop a model with the principle being that we put the person at the centre and work around them and their families to construct a community service,' says Alex. 'That way, it becomes almost unique to that local context, because areas like Glasgow or Aberdeen are quite different to Oban or the Western Isles.'

'There are challenges in how we provide that in a cooperative way between local communities and service providers.'

But nurses and community practitioners (CPs) working as part of a multi-disciplinary team will play a vital role in delivering those services.'

Finally, the second development is the Scottish Government's groundbreaking 'safe staffing' legislation – officially the Health and Care (Staffing) (Scotland) Act. It is the first of its kind in the UK, and sets out requirements for safe staffing across both health and care services. According to the Scottish Government, the bill's aim is to 'provide a statutory basis for the provision of appropriate staffing in health and care service settings, thereby enabling safe and high-quality care and improved outcomes for service users'.

'The safe staffing legislation is multidisciplinary, and it again builds on that principle of getting it right for patients and staff,' explains Alex. 'It's about safety for patients and for staff in every

care setting as well; not just in big hospitals but in community environments and care homes. With that, we need to look at how we support people to deliver the best care they can.'

'We have an implementation date of April 2024, but the process towards it has already begun and it will start to feel quite real to people in certain parts of the system.'

Alex hopes the two new schemes in Scotland will ultimately help support CPs in the great work they do, both during the current pressures faced and moving forward. 🎧



AUDIO EXCLUSIVE!
CLICK HERE OR VIEW ONLINE
Hear more from Alex in our exclusive audio interview, including his direct message and thank you to CPs.



PHILOSOPHY FOR WELLBEING

I had the pleasure of addressing Unite-CPHVA members in Bristol at their most recent conference about how philosophy can promote mental health and wellbeing. The concept is captured in the highly acclaimed and award-winning film *Young Plato*.

Community practitioners have a lot to do with philosophy, believe it or not. Especially when answering life questions such as: How do I handle an emotionally angry six-year-old? What is life's purpose? What happens when we die? These are real-life questions, and realism is the kind of critical thinking at the heart of *Young Plato*, as is the fearless approach to tackling all of the above questions with four- to 11-year-olds.

When the day of my conference session arrived, I put on the trailer of *Young Plato* (directed by Neasa Ní Chianáin and Declan McGrath, produced by David Rane) and began by setting the scene. The documentary film is set at our school in post-conflict Ardoyne, a working-class Catholic area of north Belfast. Having gained a reputation during the Troubles, it is now a marginalised community dealing with poverty, dissident activity, drugs and alcohol problems.

Philosophy (a word very difficult to define) is a shared experience and involves dialogue, questioning, reflecting on and re-evaluating philosophical themes. We at the school would side with Plato in saying 'it is thinking about thinking'! You will see

Headteacher **Kevin McAreevey*** reflects on teaching critical thinking to children in Belfast and his appearance at the Unite-CPHVA Annual Professional Conference.

many strategies and techniques used by our pupils in *Young Plato*, many from The Philosophy Foundation (TPF). The TPF trained all of our staff and we are known as a TPF school.

My fight for the Ardoyne area and the boys in our care is personal: I too was brought up in a working-class area of west Belfast (Lenadoon). My mother Rita and father Maxi were my rock and made sure that education stayed at the forefront of my mind - that was my salvation and escape from getting involved with any paramilitary activity.

We hope that *Young Plato* speaks to

communities everywhere whose young people have strife on their mind and mental health issues. And that you seek the best way forward for your children using the thinking and strategies as taught to children in the film and in my book *Think Think Respond*. The thinking behind both is to use philosophy to promote mental health and wellbeing, to be an antidote to fake news, and for children all over the world to adopt a critical attitude so that they become successful, wise and kind. This will help them uncover the most meaningful truths about what it is to live together, and to heal.

I am grateful to Unite-CPHVA and Janet Taylor for the unique opportunity to talk at the conference and to share my experiences with you here. 🙏

Kevin McAreevey is head teacher, Holy Cross Boys' Primary School, Belfast. Twitter @bigmactheking

- ▶ You can see the film via youngplato.com
- ▶ Kevin's book is available by contacting the school
- ▶ See page 20 for Kevin's comments on the new era of school nursing.

I began my health visiting career as a part of the Implementation Plan of 2011-15, entering practice in 2013. This year, I have left a job that I loved and families I had worked with for many years because I could no longer reconcile the service I was able to deliver with the service I believe the families deserve. A key contributing factor to the current recruitment and retention crisis is the loss of additional community children's services and the knock-on effect that this has had.

CENTRE CLOSURES

Community services have been reduced and removed at an ever-increasing rate. Government statistics show that by last June 1342 centres had closed over the past decade and 50 councils had seen children's centre numbers reduce by half. For example, Birmingham has seen a fall from 75 centres in 2010 to 35 centres in 2021 (UK Parliament, 2022). The closure of children's centres and removal of the Sure Start offer has had a massive impact on the service delivery of health visitors.

As children's centres close their doors or reduce their opening times, families are left without baby and toddler groups to attend, a safe place to go for support or access to family support workers. Despite knowing that group settings do not always attract the at-risk families, the offer in my practice area moved family support workers out of home-based support and into group provision. The loss of family support workers who could support families in their own home has a significant impact on the practical and emotional support available. This has left health visiting teams trying to fill this void.

Early intervention is one of the foundations of the health visiting profession and the loss or redeployment of support staff from children's centres has, in my experience, had a big impact on health visiting team caseloads, as well as family perceptions of and satisfaction with the service. Whereas previously families could be signposted to social groups or referred for family support with key skills including budgeting, parenting, literacy and emotional health, health visiting teams are now trying to offer a holistic, safe service to ever-increasing numbers. As safeguarding caseloads rise, the families who require support in the early stages of difficulty cannot be prioritised.

HIGH STAFF TURNOVER

Interprofessional working has become more strained as services reduce. Social care colleagues are under increasing pressure, with high staff turnover and caseloads, and can be difficult to contact. Information-sharing that is widely acknowledged to be crucial to avoid siloed working has become harder and harder, putting children and families at risk. The HV is often the only professional who has known the family for some time and can find themselves trying to manage ever-increasing risk alone. Relationships with social work colleagues are vital for protecting children from harm, yet the current working environment makes maintaining them very challenging. Interprofessional relationships are further strained by changes to referral processes so that services are increasingly failing to reach those who need them the most.

Self-referral services are often simply not appropriate for the most vulnerable families who lack the motivation, time or understanding to engage. Similarly, an 'opt-in' service provided by other community services only serves to increase HV workload; time spent completing re-referrals for services that HVs know a child or family needs to access continues to increase, along with additional time spent encouraging and checking in with families to engage. We cannot be an 'opt-in' service; we are universal and for all.

SAFEGUARDING THRESHOLD

Provision of support for the families most in need but who do not meet a safeguarding threshold has become highly challenging. Gone are the days of supporting families in accessing basic everyday needs such as cookers or carpets, and our availability to advocate for families in unsuitable housing or difficult conditions is ever-decreasing. Many HVs find it impossible to provide this service, which has long-lasting consequences. These include increasing childhood illness because of poor living conditions, poor diet owing to lack of cooking facilities or knowledge and

financial hardship due to not qualifying for support. Once again, the service aim of early intervention is becoming impossible, and the implications of this are far-reaching.

The HV is the one constant for these families – the person who tries to support and empower them while juggling many families in similar or worse situations. We need to be proud of what we have achieved and continue to achieve for the families we serve. However, we need to recognise that this is a wider issue with political roots caused by public spending cuts, which is not something that individual practitioners can resolve by themselves. We could work for 24 hours a day and it would

still not be enough. Instead, we need to think collectively, using our skills in advocacy to push for improvement, particularly in these times of ever-increasing austerity. Proposed strike action is an opportunity for those who wish to show their commitment to service improvement and raise awareness of the importance of health visiting teams. We need

'THE CLOSURE OF CHILDREN'S CENTRES AND REMOVAL OF SURE START HAS HAD A MASSIVE IMPACT ON SERVICE DELIVERY'

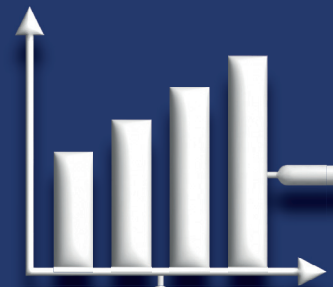
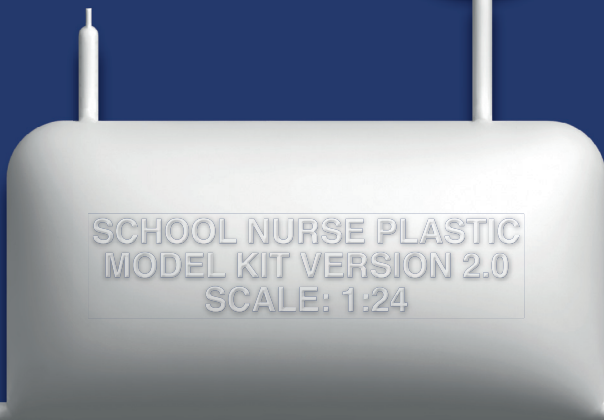
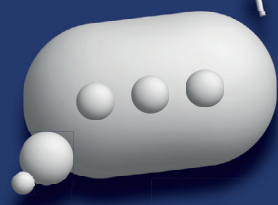
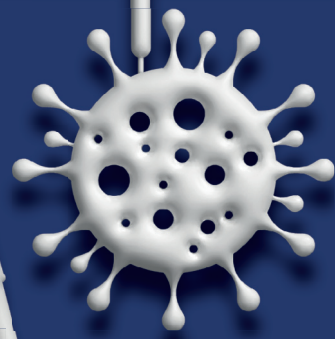
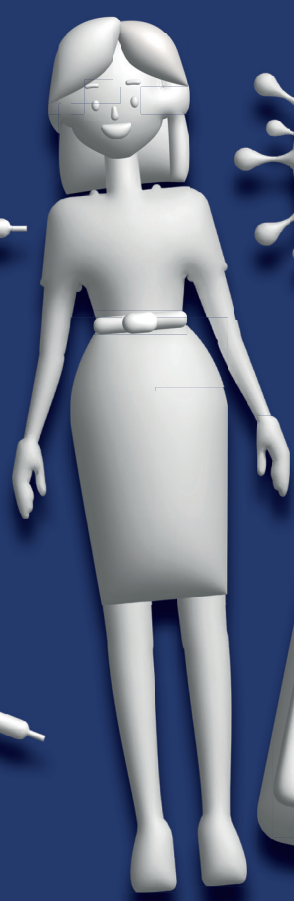
to put pressure on decision-makers to look at the very real consequences of the mass exodus of HVs and the links between professional attrition rates and funding for services.

Try not to work in the evenings or at weekends, although we know that 'work to rule' is easier said than done when there is risk involved. Advocate for yourselves. Engage with your unions and Unite-CPHVA – your voice is important and it deserves to be heard.

There is no simple solution to this issue, although there are common threads – financial and political investment. Community services and the lives of our children need investment. We know how important the First 1001 Days are, and we need help to provide the best support and service possible. We need adequate community support to improve outcomes for children and families while retaining a skilled, passionate and experienced workforce. 🙌

Joanna Day is lecturer in children and young people's nursing at Birmingham City University.

A NEW MODEL FOR SCHOOL NURSING?



During the pandemic, many school nurses brilliantly flexed their service to ensure they continued to support students. What practices have continued and how is the service looking now? Journalist **Anna Scott** reports.

It's well known that multiple lockdowns had an impact on the mental health and wellbeing of children and young people.

A number of longitudinal studies have highlighted the negative impact of the pandemic. For example, one study found that 44% of 11- to 12-year-olds reported an increase in the symptoms of depression, and 26% said they had greater post-traumatic stress disorder symptoms since the start of the pandemic (Wright et al, 2021).

School nursing practices also changed during this time. The pandemic restrictions combined with school nurses' remit to deliver 'new models of care to meet population health needs'. This meant creative and innovative practices were adopted by school nurses (Bekaert et al, 2022).

But what hasn't been clear until now is the effectiveness of such practices – for instance, online platforms for non-school premises to deliver health promotion and education, or formal health or safeguarding assessments that are part of school nurses' remit (Bekaert et al, 2022).

In December 2022, a scoping review of school nurse services during the pandemic was published that gives a clearer idea of how school nursing practices have changed (Cook et al, 2022). A corresponding survey, also published at the end of last year, gathered the views of a wide range of school nurses working across the UK in primary, secondary, mainstream and independent schools in a variety of ways (Sammut et al, 2022).

Furthermore, a learning report based on both the scoping review and survey, *Learning from school nursing practices and new ways of working in the Covid-19 pandemic* (Bekaert et al, 2022) reviewed evidence examining innovative school nurse practice with children, young people and partner agencies. All three pieces of work have helped build a better picture of what has changed and what has stayed the same, as well as overall challenges. In this article, the authors talk about that picture, while other voices from school nursing and teaching also share their experience.

The global scoping review highlights the range of responses of school nurses to Covid-19 restrictions. During lockdown, school nursing services in countries in the 'global north', including the UK, continued to offer casework to children, young people and families,

but used online and digital platforms for consultations and appointments (Cook et al, 2022).

The expanded school health offering due to Covid-19 included infection prevention and control with children, young people and families – including training others to use PPE – and dealing with negative responses from teachers and parents (Cook et al, 2022). School nurses were involved in team planning for school reopening, infection data collection and being on-call to the multidisciplinary teams and schools due to rapidly changing guidelines, among many other responsibilities (Cook et al, 2022).

SWIFT ADAPTATION

Despite the impact on their workloads, school nurses were also innovative in setting up systems to better manage Covid-19-related workloads and processes. This included developing a text support service, an online symptom-tracking system and a triage flowchart (Cook et al, 2022).

Nevertheless, school nurses surveyed across the UK reported a number of negative impacts, including an increased workload and decreased contact with children (Sammut et al, 2022 – see *Stats and facts: the evolving picture*, overleaf). This resulted in an increasingly reactive approach to school nursing and greater safeguarding, and virtual contacts were not satisfactory for all types of assessment (Cook et al, 2022).

On the whole, school nurses swiftly adapted their practices across the UK, and there were some benefits for multidisciplinary working, the learning report found (Bekaert et al, 2022). However, there were greater challenges in accessing, supporting and representing young children. And the changing nature of school nurses' work reduced the opportunity for preventative work, meaning more complex issues were identified later on (Cook et al, 2022).

It was also a challenge returning to face-to-face care after lockdowns, says Anne-Marie Gallogly, complex safeguarding nurse (within the Aspire Team, part of Stockport's school nursing service). Schools were reluctant to allow 'visitors' in, and there was pressure on schools to 'catch up', which sometimes presented as a reluctance to allow time for subjects such as personal, health, social and economic education.

'However, the relationships and visible presence already established with colleagues in education meant that school nurses were viewed as part of the solution rather than the problem,' says Anne-Marie.

DRAMATIC CHANGES

The landscape of school nursing changed 'dramatically', according to Dr Sarah Bekaert, senior lecturer in child health, Oxford Brookes University, and study lead of the learning report (Bekaert et al, 2022). 'School nursing teams flexed the service, drawing on a wide range of resources to best meet the needs of children, young people and their families, work closely with the wider professional network, and support colleagues.

'This has introduced or accelerated a range of modes and methods to facilitate school nursing practice that may be of use going forward post-pandemic,' she adds. So, the adaptations to practice made in response to the reduction in in-person contact led to creative ways of maintaining contact with children and young people. 'Walk and talks' (meeting a young person in an open space for therapeutic support) and home visiting jointly with social workers are two modes of practice that can facilitate care.

The most dramatic change has been the increase in the use of remote and virtual means of contact such as text (for example, healthcare messaging service ChatHealth) and video consultation. 'The increased use of teleconferencing was mirrored in multidisciplinary working,' Sarah adds. 'This in turn raised the visibility of the school nurse with professional partners and put school nursing on the map.'

Now there is increased accessibility to the school nurse for children, young people and families through a range of remote means, Sarah explains. There is also increased presence at multidisciplinary team meetings because they are online and easier to attend. This results in improved communication with the multidisciplinary team as a result of new and improved channels for contact. 'There is a better understanding of the school nurse role among the wider professional network – for instance, social workers or teaching staff.'

NEW CHALLENGES

However, while the use of remote and virtual modes enabled continued contact with children, young people and parents, school nurses were very clear that carrying out formal assessments and

interventions remotely was not comparable in quality to face-to-face contact.

'School nurses also have raised concerns about confidentiality and safeguarding when unable to assess the family dynamic or environment beyond what is visible on a screen, as well as "tech-poverty" being an issue for some families leading to inequality of access,' Sarah adds.

The use of technology and remote meetings can increase workload, with little consideration of staff wellbeing and mean lots of back-to-back meetings, according to Anne-Marie. 'Less face-to-face with colleagues means less informal supervision, and some staff feel isolated when they are home-based. It means less face-to-face contact with social care colleagues too.'

Redeployment has also proven to be a challenge. 'It fractured teams, with redeployed staff required to work in services that required a different skill-set, and those remaining carrying an increased workload through compromised numbers and escalating need and referrals,' Sarah says. 'School nurses, both on the ground and managerial, spoke of a range of supervision that had been put in place, as well as restorative work to respond to the trauma experienced by all staff.'

IMPACT ON CHILDREN AND YOUNG PEOPLE

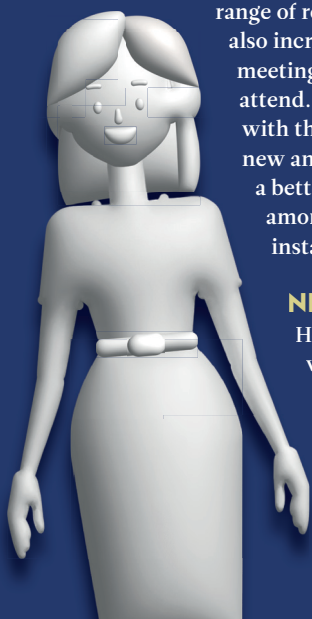
Embracing creative modes for service delivery has led to school nursing being delivered in a more flexible way, which has benefits for children, young people and parents' needs, according to Dr Georgia Cook, associate lecturer in the Department of Psychology, Health and Professional Development at Oxford Brookes University, study lead of the scoping review *School nursing: new ways of working with children and young people during the Covid-19 pandemic: a scoping review* (Cook et al, 2022) and co-author of the linked research.

'The range of tools to assist in service delivery enabled close and regular contact with children, young people and parents,' she says. 'These resources or means of contact facilitated a timely and effective response to increased demand.'

But there are some areas where young people and children are missing out. During the pandemic, the immediate infection control and disease management demands on school nursing services compromised the ability to carry out routine health promotion and education activity beyond that related to Covid-19.

'Delay in identifying concerns as a consequence of not seeing children and young people on a day-to-day basis, and compromised communication between service users and the school nurse, led to the emergence of more complex cases further down the line,' Georgia says.

THE MOST DRAMATIC CHANGE TO SCHOOL NURSING HAS BEEN THE INCREASE IN THE USE OF REMOTE AND VIRTUAL MEANS OF CONTACT SUCH AS TEXT AND VIDEO CONSULTATION



STATS AND FACTS: THE EVOLVING PICTURE



60.3%
reveal a decrease in
contact with children,
young people
and families

74.4%
of school nurses across
the UK report an
increase in workload



CHANGES IN PRACTICE

- ▶ Increased appreciation for the school nurse role among colleagues because of increased interprofessional working
- ▶ Some key support services such as mental health became more coordinated because of new strategies
- ▶ A significant increase in telephone and online communication between professionals made contact easier
- ▶ But the changing nature of school nurses' work reduced the opportunity for preventative work, with the impact being felt now.

Cook et al, 2022

86.1%
talk of difficulty
in identifying
safeguarding needs



79.7%
say there is difficulty
in working with
known vulnerable
children

Sammut et al, 2022

UNITE-CPHVA VIEW...

Unite lead professional officer (health) Gavin Fergie says: 'The findings highlight the complexity of health needs that today's school nursing practitioners face on a daily basis.

'Numerous reports highlight the damage the pandemic has had on school-age children, and without appropriate strategies this damage is only becoming more entrenched.

'Yet sadly, school nursing practice and school nurses are still seemingly misunderstood by policy-makers. Unite-CPHVA has lobbied continually, alongside other organisations, for adequate funding to restore the required numbers of suitably qualified school nurses, not just for one financial year but on a recurring and fully funded basis.

'Unite-CPHVA hopes that policy-makers will redress the historic underfunding with a new package in the hope that at long last we can start to support the discipline of school nursing in the way young people and hard-pressed practitioners deserve.'

‘School nurses are also seeing the consequences of reduced socialisation and contact with support services during the lockdown periods, citing significant behavioural challenges, mental health concerns and a lack of relationship and sexual health knowledge in children and young people,’ she adds.

Tikki Harrold, a school health nurse and community practice teacher at Oxford Health NHS Foundation Trust, says she is seeing more disordered eating and anxiety and low mood. ‘Some children seem to be struggling more than before to manage educational expectations, as if their psychosocial development was stunted,’ she adds.

Also a co-author on the three pieces of linked research, Tikki says that the proliferation of some influencers during lockdown, when children were spending more time online, has impacted the views of young groups of boys in particular. She adds that some children ‘seem to swing to more extreme behaviours and reactions more quickly’.

IMPACT ON THE PROFESSION

Things haven’t gone back to normal for school nurses, according to Kevin McAreeve, principal of Holy Cross Boys’ Primary School in Ardoyne, Belfast, and a speaker at the 2022 Unite-CPHVA Annual Professional Conference. Prior to the pandemic, his school leadership team of the principal, the vice-principal, the special educational needs coordinator, social workers, the board of governors for child protection and the school nurse would meet termly to ensure individual children were getting the help they needed – that ‘no child gets left behind’ – and the nurse was ‘a vital part of the team’.

But when the pandemic hit, that stopped, and communications were weakened between school nurses and parents in particular. Now face-to-face meetings have resumed and communications are vastly improved. But, Kevin adds: ‘A lot of the work that we did pre-pandemic is being undermined by the high workloads of school nurses who are now working across numerous schools.’ Kevin is thankful for the good relationship the school has with their school nurse Angela Evans.

Many of the issues that the school nurse at Kevin’s school is dealing with are highly complex – difficulties that are the result of transgenerational trauma of the Northern Ireland Troubles, including addiction, gambling and domestic

‘IT IS VITAL THAT PROFESSIONAL BODIES MOBILISE TO ENSURE THAT THE VITAL PUBLIC HEALTH ROLE OF THE SCHOOL NURSE CONTINUES TO BE RECOGNISED’

violence – alongside helping children with care plans for conditions such as attention deficit hyperactivity disorder or allergies. But while there are challenges children face specific to where they live, many of the issues are similar across the UK, the research found, which means the challenges that school nurses face are similar too.

Nationally, it appears that

services such as sexual health and mental health can be hard to reach, according to Tikki. ‘Many of our schools have access to mental health teams in schools, but often schools do not identify the need until it is too great to meet the referral criteria,’ she adds.

‘CAMHS [child and adolescent mental health services] waiting times are long as they struggle to respond to the huge increase in demand. Walk-in sexual health clinic access for young people [in Oxfordshire] is extremely limited – currently after school in one venue once a week. Otherwise, young people have to have telephone triage and then travel to one of a handful of countywide clinics to collect any supplies. Fortunately, some aspects of sexual health care are available in school from us.’

NEW DYNAMICS AND DEMANDS

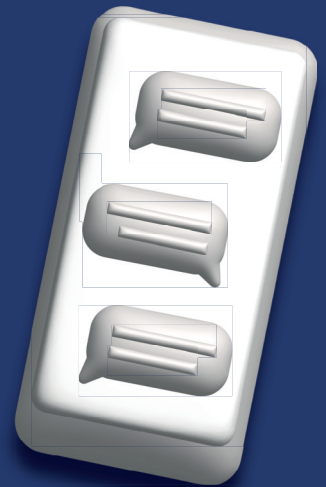
‘The current challenge is how to ensure informal and formal supervision is available to staff in order to maintain morale and facilitate staff retention,’ says Dana Sammut, research associate at the University of Birmingham, survey lead of *School nurse perspectives of working with children and young people in the United Kingdom during the Covid-19 pandemic: an online survey study* (Sammut et al, 2022) and co-author of the linked research. A further challenge is to maintain the highly visible profile that school nursing has had in the professional landscape since the pandemic, she explains.

‘School nurses voiced that they were noticing a return to pre-pandemic modes of interprofessional practice as we emerge from restrictions, and felt that they were being told to “get back in their box”. It is vital that professional bodies mobilise to ensure that the vital public health role of the school nurse continues to be recognised,’ she adds.

The researchers believe funding and clear policy guidance on school health service commissioning is key to providing a specialist public health workforce that can fulfil the remit of the Healthy Child Programme across the UK, in the context of the additional demands from the pandemic legacy.

‘Many health-related services or programmes are commissioned into schools, such as mental health workers or navigator services,’ Dana says. ‘These services often duplicate the work of the school nurse. There should be clear policy guidance for schools and commissioners regarding the school nurse remit. If health-related services are brought in in addition to the school health service, the school nurse, as named health professional for the school, should be involved in the commissioning discussions, and oversee the service once in place.’

The researchers of the recent linked-up work have deliberately avoided making recommendations for what nurses should do now, given their increased workload both



CASE STUDY

STOCKPORT NHS FOUNDATION TRUST'S SCHOOL NURSING SERVICE

THE POSITIVES

Stockport NHS Foundation Trust's school nursing service returned to face-to-face work in schools back in September 2020, with weekly drop-ins in all mainstream high schools in the Greater Manchester town and borough. In June 2021, the service launched ChatHealth, a confidential text messaging service, which has offered a different way of contacting the service.

'We saw a peak in contacts after the Covid-19 immunisation sessions in schools, with a lot of young people contacting us about their mental health,' says Anne-Marie Gallogly, complex safeguarding nurse within the Aspire Team, part of Stockport's school nursing service. 'Parent drop-ins have

returned, and attendance and demand have increased since Covid-19.'

A GROWING WORKLOAD AND LACK OF CAPACITY

But the rise in safeguarding concerns for young people that increases the demand for school nursing input into safeguarding processes means it's not possible for the service to offer twice-weekly drop-ins. 'There has been a significant increase in the number of referrals from school for young people with mental health concerns,' says Anne-Marie.

'The increase in safeguarding concerns has led to a significant increase in invitations to attend strategy meetings. The preparation before and actions after the

meeting has an impact on the capacity of the service,' Anne-Marie adds.

In addition, school nurses are now holding cases that would previously have been held by social care due to lack of capacity in social care, and cases that would previously have been stepped up to mental health services due to lack of capacity in CAMHS. 'We have an increasing number of referrals for children and young people needing continence support, especially around constipation.'

She concludes: 'In an ideal world, an increase in funding would allow us to have a more robust offer in terms of health promotion – such as sessions in schools promoting dental health, and puberty lessons.'

during and as a consequence of the pandemic 'because they have already gone above and beyond in their role,' Dana says. The researchers' next steps, however, are to produce an evidence-based accessible practitioner-facing toolkit from the focus groups and interviews with school nurses across the UK.

'This resource can be used by school nurses to inform their work, as well as lobby for the use of specific technology or modes of practice with managers and commissioners,' Dana adds.

MOVING FORWARD

It is fair to say the service is still helping young people on balance. As Kevin says: 'We have a great relationship with our school nurse and she provides support and improvement to mental health and wellbeing and advice on children's long-term health conditions. She has always been at the end of the phone, including for parents. There's a tripartite link between parents, the school and the trust, and things must be communicated in order to garner success.'

He concludes: 'I certainly do not believe nurses get paid for the job that they deliver. There's always more that can be done for nurses.'

RESOURCES

- ▶ Bekaert et al, 2022: *Learning from school nursing practices and new ways of working in the Covid-19 pandemic:* bit.ly/Bekaert_SN_learning
- ▶ Sammut et al, 2022: *School nurse perspectives of working with children and young people in the UK during the Covid-19 pandemic: an online survey study* bit.ly/Sammut_SN_survey
- ▶ Cook et al, 2022: *School nursing: new ways of working with children and young people during the Covid-19 pandemic: a scoping review* bit.ly/Cook_SN_scoping_research
- ▶ Harnessing digital and social media to connect teenagers with school nurses bit.ly/qhealth_socialmedia

For references, visit bit.ly/CP_features

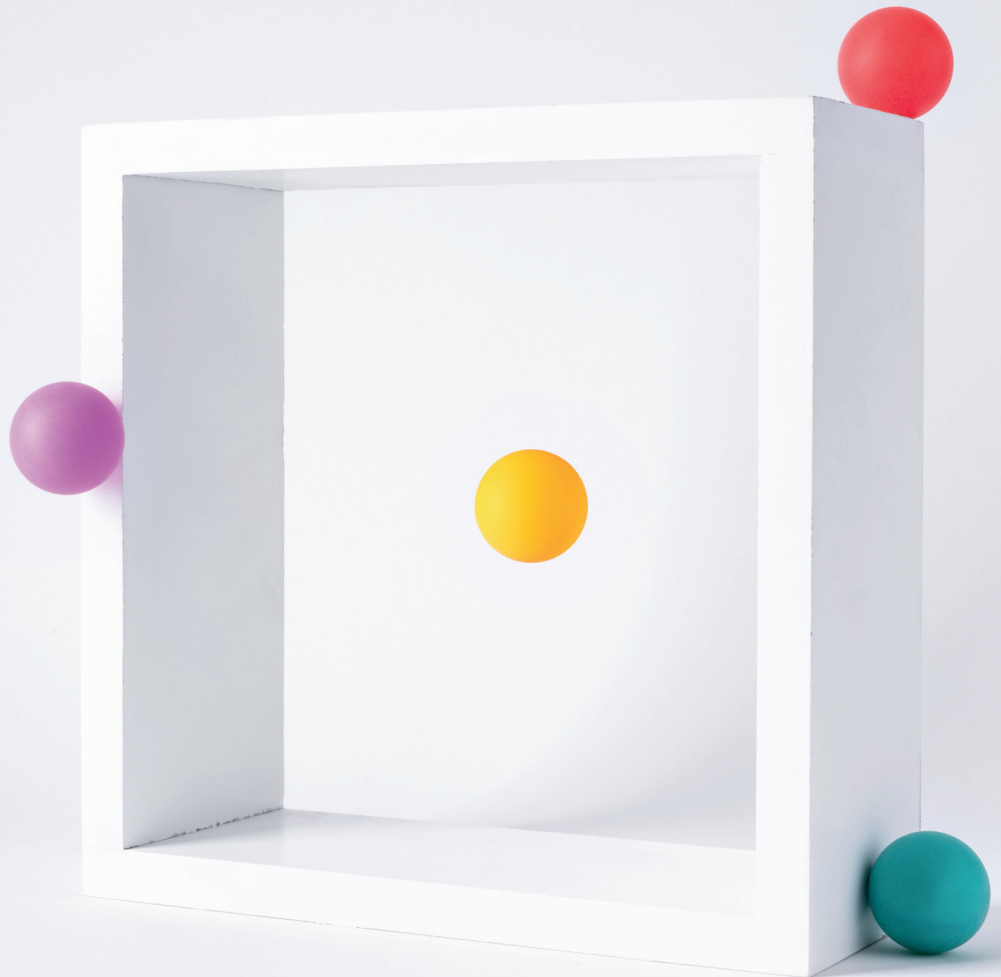




A framework to support healthcare support workers (HCSWs) to deliver school-aged childhood immunisations was developed in the school nursing service within the Rochdale Care Organisation, part of the Northern Care Alliance NHS Foundation Trust. This article aims to share the framework and the underpinning development work that led to this innovative change in practice, so that others may adapt and apply this to their own setting.

The HCSWs from the Rochdale school nursing service, who were redeployed to support the Covid-19 vaccination programme, thoroughly enjoyed the role they played in administering immunisations. After returning to the school nursing service, they expressed a desire to retain and further develop the knowledge and skills that they had gained during this experience.

The school nursing service is pivotal in the delivery of the school-aged childhood immunisation programme. Historically school-aged immunisations have been administered by school nurses (SNs) rather than HCSWs. School nursing is a profession where the professional demands have increased, but the numbers of practitioners within the profession have not.



Describing an innovative framework to support school-aged childhood immunisations.

INNOVATION IN IMMUNISATION

ISTOCK

Immunisation sessions depend on schools providing appropriate facilities and organising the flow of young people to the session. The sessions are reliant on the school timetable, therefore at times there can be a build-up and consequently a backlog of young people waiting for immunisation. It is imperative that young people are immunised as quickly as possible to prevent them from being out of class for longer than necessary and to ensure minimal disruption to the school day.

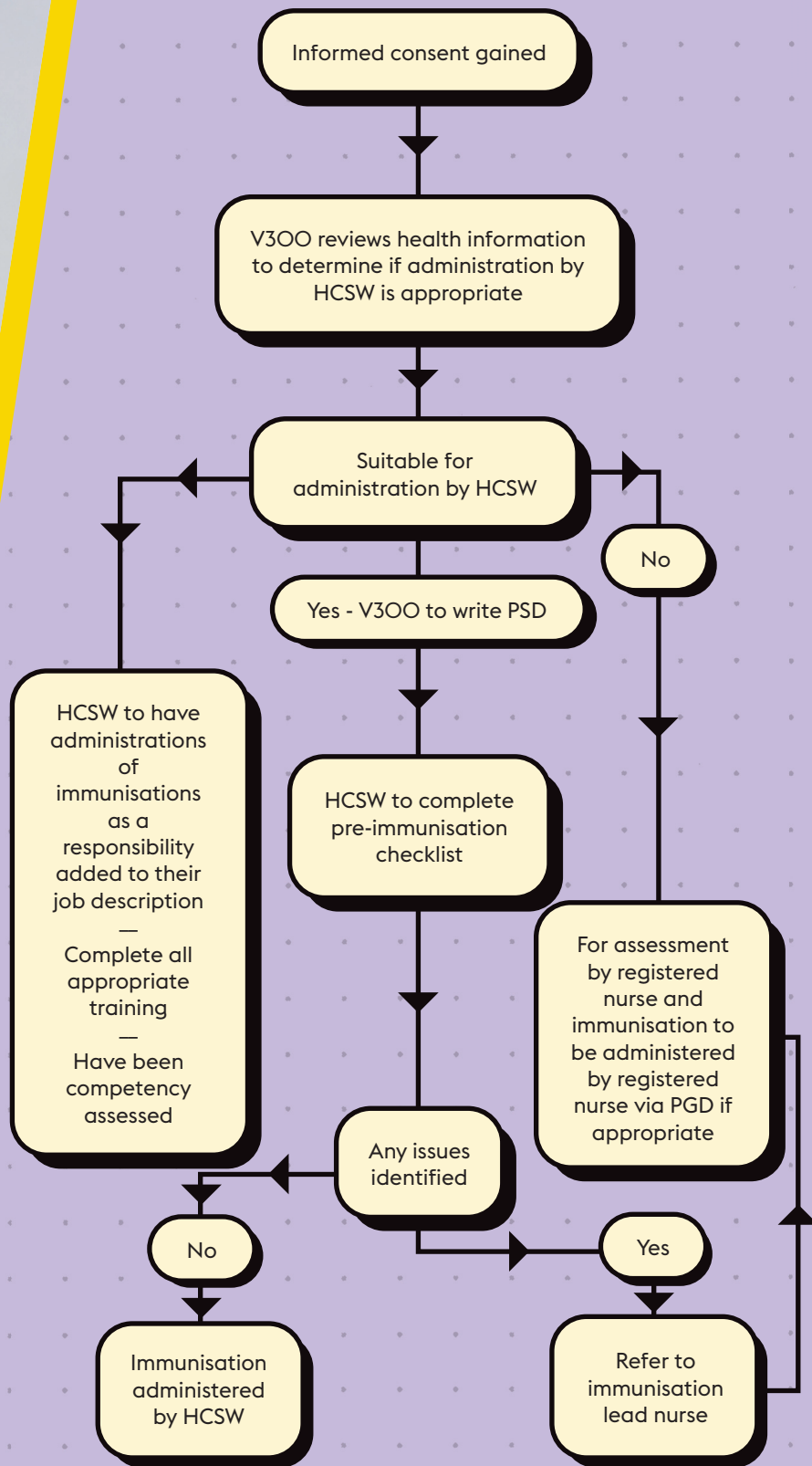
The project management team – which comprised the service manager for school nursing, the quality matron for children’s community services and the lead pharmacist for community services – explored the feasibility of enabling HCSWs to administer immunisations to young people. This was seen as a service development opportunity to enhance the HCSW role, making it more attractive, potentially improving retention and attracting new recruits to the service. Additionally, within a framework, extension of the HCSW role is a safe and pragmatic way of increasing the available workforce to administer immunisations as part of the school-aged childhood immunisation programme.

The risks and benefits associated with enabling HCSWs to administer elements of the school-aged immunisation programme was carefully considered. In principle the project management team believed that with a robust framework in place HCSWs could be enabled to administer school-aged immunisations. This development was supported by both the director of nursing and the director of pharmacy; NHS England has expressed its backing for this unique initiative during immunisation development meetings.

The framework that was developed to support the project includes the following:

- ▶ Independent prescribers, otherwise known as V300 non-medical prescribers (NMPs), with expertise of the childhood immunisation programme, assess the young person’s suitability to be immunised by a HCSW based on responses to health questions included as part of the informed vaccination consent form.
- ▶ NMPs write a patient-specific direction (PSD) on an individual basis for the young person deemed suitable to be immunised by a HCSW.

FLOWCHART 1: THE FRAMEWORK



WHAT IS A PSD?

A patient-specific direction (PSD) is the traditional written instruction, signed by a prescriber for medicines to be supplied and/or administered to a named individual after the prescriber has assessed that individual on a one-to-one basis (Specialist Pharmacy Service, 2023).

- ▶ A pre-immunisation checklist (see *Pre-immunisation checklist* below) was designed for the HCSW to complete with the young person prior to administering the immunisation.
- ▶ Pre-immunisation checklist completed by the HCSW with young person prior to administering the immunisation
- ▶ If requirements are not met, the HCSW refers the young person to the immunisation lead nurse responsible for the coordination of the immunisation session.

TRAINING AND COMPETENCY DEVELOPMENT

The V300 prescribers involved in the initiative were provided with bespoke training on the writing of a PSD for the school-aged childhood immunisations. This was delivered by the lead pharmacist for community services, who also delivered training to the HCSWs on interpretation and utilisation of a PSD.

The Northern Care Alliance clinical skills team developed and delivered training on injection technique for the HCSWs. Additionally, the framework outlines the necessity for HCSWs to remain compliant with basic life support (BLS), paediatric basic life support (PBLs) and anaphylaxis mandatory training. It should be noted that HCSWs are expected to receive anaphylaxis training to enable them to identify signs and symptoms so that they are able to alert the registered staff and provide basic first aid. HCSWs are not permitted to administer adrenaline.

A competency assessment framework was developed to ensure

that the HCSWs were competent and confident to administer school-based immunisations. Furthermore, the function of administering immunisations was added to the HCSW job description to ensure coverage under the Clinical Negligence Scheme for Trusts (CNST).

ADDITIONAL OPPORTUNITIES AND RESOURCES

Some of the HCSWs are based in Healthy Child Programme (HCP) teams rather than the immunisation team. The HCP teams are linked to schools. The service development included allocating the HCSWs to the immunisation sessions being delivered in the schools to which they are linked – not only developing their clinical skills, but also widening networking opportunities.

This service development required an increase in the number of V300 non-medical prescribers within the school nursing service. It has therefore created an opportunity for the school nurses to access the V300 course. Overall, an additional four

SNs have been trained, with a further two scheduled to complete the course by April 2023.

As an interim measure, to initially support the service development, V300 prescribers from the health visiting service assisted in completion of the PSDs, widening their scope of practice and further harnessing opportunities for collaborative working across the 0 to 19 years service.

All five Band 3 HCSWs working within the school nursing service have received the essential training, been assessed as competent and are administering school-aged immunisations.

LEARNING

The service development has been operational since November 2021. There were a few initial teething problems that needed to be addressed – the most significant being the wording of the pre-immunisation checklist, which was limiting the number of children that the HCSWs could immunise. Initially the pre-immunisation checklist asked:

- ▶ Do you have any allergies?
- ▶ Do you see any health professional regularly for any health problems?
- ▶ Do you take any regular tablets or medicines?

The HCSWs interpreted this to mean that if the young people answered yes to any of these questions, they could not administer the immunisation, even though anything disclosed on the consent form had already been reviewed by the V300. The question was changed to the following statement:

- ▶ Have no allergies, medical conditions or taking medication other than that disclosed on the consent form.

This resolved the presenting issue.

EVALUATION

Initial feedback from the school nursing team leader indicated that the HCSWs embraced the

PRE-IMMUNISATION CHECKLIST

- ▶ Consent in place
- ▶ PSD in place
- ▶ Child feels well
- ▶ No allergies, medical conditions or medication other than that already disclosed
- ▶ No injections in the last month
- ▶ Not pregnant

TABLE 1: AREAS DISCUSSED WITHIN THE FOCUS GROUPS

The impact on the job satisfaction of HCSWs and SNs
The impact on the relationship between HCSWs and schools/pupils
The impact on the teamworking between HCSWs and SNs
The hopes and aspirations for the initiative moving forward
Impact on the schools and young people

role extension and worked conscientiously through their competency framework. In doing this, they provided observations and feedback to the registered nurses, who reflected on their own practice. This allowed the service to critically reflect on immunisation session delivery.

A formal evaluation has taken place in the form of two focus groups, facilitated by a lead nurse independent of the service. Areas discussed within the focus groups are outlined in Table 1, right.

Participants of the first focus group included two HCSWs (trained to immunise); the second included a school nurse from the immunisation team and a school nurse from the HCP team. The focus groups took place face to face and were recorded and transcribed using the Microsoft Teams record/transcription function. Unfortunately, the transcriptions from the Microsoft Teams recordings were inaccurate due to the overlap of voices during the focus group. Transcription was therefore undertaken manually, and subsequently transcriptions were reviewed and coded in line with thematic analysis. Analysis was undertaken by the main author RB and subsequently checked again by co-author NS.

Themes emerging from the data included:

1. Increased variety of role and job satisfaction

Participants described how the development of the skill to immunise has been a great opportunity that has brought variety to their role; they also report that it has greatly increased their job satisfaction and confidence. HCSW A said: 'Oh, I love it. I really, really do enjoy doing it. It's the variety I suppose.

'You know, I've worked in the NHS 31 years, so I've done it a long time and you get in a bit of a rut ... this has been a nice change, learning a new skill.'

2. Robust training and competency development

The conversations outline that while some HCSWs may have had an element of apprehension about their involvement in administering immunisations to young people, they felt that the training they received was robust and they were not rushed to develop the competencies that equipped them for the role. In fact, the HCSWs highlighted that they felt that the competency development was a little slow and could have been completed more quickly, although they do recognise that the management team was trying to protect them by preventing them from feeling rushed.

3. Positive impact on teamworking

Focus group participants believed that the service development has had

a positive impact on team-working. The HCSWs feel that they are better able to support the nurses in the immunisation sessions and the nurses think that the HCSWs being able to immunise makes a huge difference to the running of the immunisation sessions. There is clear evidence of a mutual respect of each other's roles within the transcriptions. HCSW B said: 'This development has been really big – it's helped me feel like part of more teams.'

4. Increased efficiency of the service

The service development has enabled the service to increase immunisation capacity and direct appropriate resource, resulting in the sessions running more smoothly. The more efficiently run sessions have been shorter or have reduced the need for the school nursing team to return to a school to deliver a further immunisation session. However, both groups do highlight the original issue with the wording of the pre-immunisation checklist, which impacted on the flow of young people through the session at the beginning of the project.

The positive impact of the quick and efficient flow of children through an immunisation session is highlighted in the focus groups, especially for those children who

WHAT IS V300 TRAINING?

Independent prescribers (IP) are nurses who have successfully completed an NMC independent nurse prescribing course (also known as a V200 or V300 course) and are registered with the NMC as an IP. They are able to prescribe any medicine provided it is in their competency to do so (Royal College of Nursing, 2022).

The V300 course is designed to develop knowledge of the legal, ethical, professional, pharmacological and therapeutic aspects of prescribing. This is a recordable qualification.

Access to the course is available to the service via continuing professional development funding, therefore there is no cost implication for the service, other than releasing staff to attend.

may be feeling stressed or emotional at the thought of having the immunisation. The faster flow of young people means that they are not as anxious because their waiting time is reduced. Additionally, the school staff are happier that the sessions are streamlined, and the young people are spending less time out of the classroom. SN A said: 'I felt like the sessions that I've been to ... ran really well, like that it made a difference having the healthcare support workers there.'

The feedback from the focus groups has highlighted a further learning point to the project management team. Covid-19 has created a backlog of outstanding school-aged immunisations that necessitated deployment of HCSWs to immunisation sessions other than those delivered in schools that they are linked to. This has resulted in some of the HCSWs feeling that they may have missed updates in their HCP team. This will be considered moving forward.

All staff involved in the focus groups expressed a strong desire for the initiative to continue.

SUMMARY AND NEXT STEPS

The initiative has achieved the original aim of optimising the job satisfaction of HCSWs and improving the flow of young people through immunisation sessions, with all the consequential impacts described in the paper. There has been learning throughout the journey and indeed there may be more to come as the service development becomes embedded into practice.

The framework was a safe and effective means of implementing a change to service provision. This

'I FELT LIKE THE SESSIONS THAT I'VE BEEN TO RAN REALLY WELL, LIKE IT MADE A DIFFERENCE HAVING THE HEALTHCARE SUPPORT WORKERS THERE'

has led to several improvements, including improved flow and an ability to increase the number of young people vaccinated in any given session. Additionally, both HCSWs and SNs involved in the initiative report feeling more valued and having increased job satisfaction, underpinned by increased knowledge and experience related to delivery of the immunisation program.

It is understood that enabling HCSWs to administer school-aged immunisations is a novel

approach and we are not aware of this innovation being implemented elsewhere. The framework that has been put in place in Rochdale is completely replicable, albeit with potential adaptations to meet local contextual factors. ☺

Richelle Buckley is quality matron, Rochdale Community Service; Nicola Sharp is service manager school nursing; Robert Hallworth is lead pharmacist, community services, all at Northern Care Alliance NHS Foundation Trust.

ACKNOWLEDGEMENTS:

Charlotte Towell, lead nurse community assessment accreditation, Northern Care Alliance NHS Foundation Trust; and Heather Iles-Smith, professor of nursing, University of Salford.



For references, visit bit.ly/CP_P_features



Between one in five and one in seven adolescents in England self-harm (Uher et al, 2021). But there is no governmental health campaign focusing on the prevention and treatment of self-harm in adolescents; this is alarming, considering that in 15- to 17-year-olds, for example, for every male suicide, 120 males present to hospital with self-harm, whereas for every female suicide, 919 females present to hospital for self-harm (Geulayov et al, 2018). This article will examine the influences behind self-harm in adolescents and its increasing rate, the opportunities and challenges that are associated with self-harm and the realistic solutions and health promotion resources that can be implemented to prevent and manage self-harm within the community.

In an average size class of 22.6 students (Department for Education, 2022a), there are potentially four students who self-harm. Nationally, this further suggests that out of three million secondary school students, there could be approximately 900,000 students who are, at present, self-harming, which can lead to long-term consequences: those who continue to engage in self-harm during adolescence are reported to have a significant increase in anxiety, depression and negative health outcomes as adults (Daukantaitė et al, 2020).

Emmie Hopkinson and Zoe Clark discuss how a self-harm educational website for teachers can positively impact children and young people.

In addition, there is a correlation between using self-harm to cope with emotional behaviours and an increased risk of suicide (McManus et al, 2019). Therefore, the evidence suggests that early intervention in adolescence is imperative to prevent increased negative mental and physical health outcomes and the risk of suicide.

CHALLENGES AND OPPORTUNITIES

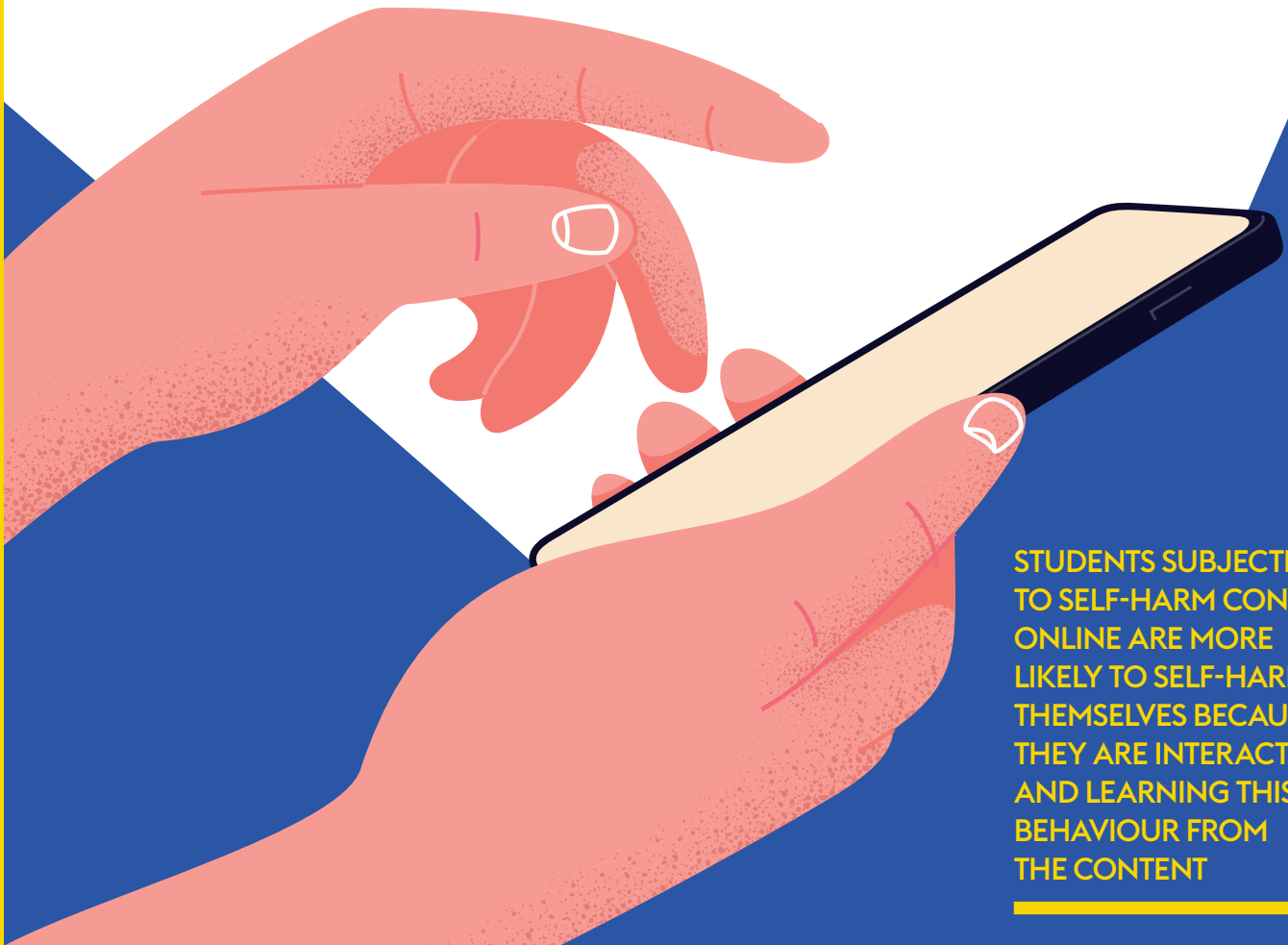
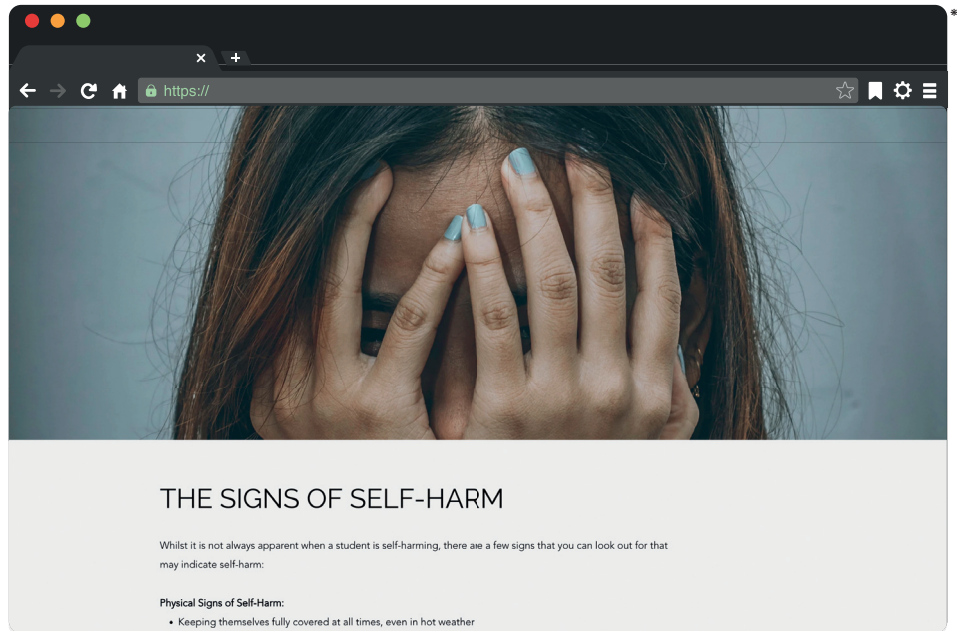
An apparent challenge in addressing self-harm is the lack of standardised framework in the personal, social, health and economic (PSHE) national curriculum (Department for Education, 2021). One study (Davies and Matley, 2019) concluded that teachers felt they received insufficient access to training in PSHE, and the confidence

SAFE FROM SELF-HARM



to teach the topic of mental health was lower than for other topics. A potential solution to this challenge could be for teachers to receive PSHE education from school nurses. This is because school nurses are more knowledgeable in PSHE topics such as mental health and have access to clear, evidence-based information. The school nurse can then implement this information into training programmes for teachers, giving them the information they need to teach their students effectively and confidently (Price, 2020).

Another challenge is the lack of appropriate self-harm education for nurses. In their study of emergency department nurses, Rayner et al (2018) identified limited empathy towards patients who self-harmed



STUDENTS SUBJECTED TO SELF-HARM CONTENT ONLINE ARE MORE LIKELY TO SELF-HARM THEMSELVES BECAUSE THEY ARE INTERACTING AND LEARNING THIS BEHAVIOUR FROM THE CONTENT

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and recommended education and knowledge for emergency department nurses around this issue. Creating an e-learning module on self-harm that educates nurses on this topic would provide an opportunity for nurses to have a more developed understanding of self-harming patients (Rouleau et al, 2019).

SAFEGUARDING

In accordance with the 'Keeping Children Safe in Education' policy (Department for Education, 2022b), school staff are required to receive safeguarding training at their induction and receive further updated training regularly. It can be inferred that, due to lack of clarity around the word 'regularly', schools will only update their safeguarding training according to their perception of the word 'regular', which could mean every few weeks, months or years.

Moreover, this policy recommends that emails and e-bulletins are used to convey updated information. While this can be effective, it is important to have regular face-to-face sessions so that teachers continue to develop theoretical and practical knowledge within their teaching practice (Torok et al, 2019). An excellent safeguarding against self-harm resource is the sample self-harm policy

created by Norfolk County Council and the NHS (2020). This policy demonstrates the importance of teachers being knowledgeable and non-judgemental in their approach to identifying students who self-harm, and it advises the teacher on steps they should take to best intervene and support the student.

For example, there is clear structure on how the teacher should respond when a young person is self-harming, some conversation phrases that can aid the teacher when discussing self-harm with the young person, and guidance on how the school can prevent self-harm by taking steps such as blocking websites that promote self-harm.

HEALTH PROMOTION

One health promotion model that can be utilised in relation to self-harm is social cognitive theory (Bandura, 1986). This posits that behavioural learning occurs within the social context of the individual's interactions, behaviours and environment. For example, students subjected to self-harm content online are more likely to self-harm themselves because they are interacting and learning this behaviour from the content they are viewing and from the internet users that they are interacting with (Marchant et al,

2017). However, Bandura's theory used within a health promotion resource can be positively influential in intervening and preventing adolescents from self-harming. For example, by creating a website aimed specifically at educating teachers on self-harm, these teachers then have the confidence and the knowledge to have open discussions with their students on self-harm (interaction), implement positive coping mechanisms (behaviour) that the students can use and potentially intervene in self-harm behaviours earlier by creating a safe space (environment) in which students can discuss their feelings (Dowling and Doyle, 2017).

Montagni et al (2016) found that the internet was a useful tool for finding specific health information. This demonstrates that a website could potentially be a practical and accessible form of health promotion resource for teachers to obtain, use and distribute to other school staff.

CONCLUSION

In conclusion, self-harm in adolescence is a growing public health issue that needs to be addressed. A website is an easy-to-use, accessible and evidence-based resource that can assist teachers in understanding self-harm and encouraging them to become more knowledgeable and confident in discussing self-harm openly with their students, which can lead to prevention and intervention in self-harm behaviour.

Likewise, an accessible website would also be beneficial to increase awareness and knowledge for school nurses, as well as be a relevant tool for children and young people themselves to utilise for educational and informational purposes. 🗣️

Emmie Hopkinson is a third-year student nurse at Kingston University; Zoe Clark is associate professor for quality at Kingston University.



For references, visit bit.ly/CP_P_features

HOW YOU CAN HELP

Realistic Solutions

Advice on encountering a student who is self-harming.

STREP A IN THE SPOTLIGHT

Journalist **Claire Moulds** looks at why strep A infections made headline news in winter and how you can help support and reassure parents.





Streptococcus A has found itself in the media spotlight over the last few months, thanks to

an unseasonal rise in cases and, as of January 2023, 39 tragic child deaths (30 in England, five in Wales, three in Scotland and one in Northern Ireland).

Alarmist reporting on the situation, a population that's understandably nervous three years into a pandemic and misinformation on social media – including false rumours that the nasal flu vaccine given to school children causes strep A – left families confused and worried.

Crucially, in its early February update, the UK Health Security Agency (UKHSA) noted a fall in the number of weekly notifications of scarlet fever and invasive group A strep (iGAS) in children, but also cautioned that it's not unusual to see a drop in the number of cases before the spring and that infections could rise again in the coming months (UKHSA, 2023). So what do you need to know about Strep A?

WHAT IS STREP A?

'Humans are a great culture medium for bacteria as we provide lots of warm, dark, moist locations for them to thrive, such as in our nose and throat,' says Dr Steve Turner, consultant paediatrician in general and respiratory paediatrics at Royal Aberdeen Children's Hospital. 'For every single human cell, there are 10 bacteria, and strep A is one that we are used to living alongside.'

'The likely level of carriage is around 2% in the UK but, during an outbreak, you might find it in 25% to 40% of children in a classroom,' says Shiranee Sriskandan, clinical professor of infectious diseases at Imperial College London. 'Almost all will have no symptoms, a handful might report a sore throat and an even smaller number might have scarlet fever [caused by the same type of bacteria], despite the fact they've all been exposed to a similar level of strep A.'

'We think this is a result of having different levels of immunity due to prior exposure, although genetics might also have a part to play.'

In rare cases, it can also lead to serious and potentially fatal infections when it gets into areas of the body where it is not normally found, such as the lungs or bloodstream. This is known as iGAS, which can present as:

- ▶ Toxic shock syndrome
- ▶ Pneumonia
- ▶ Sepsis
- ▶ Necrotising fasciitis
- ▶ Meningitis.

'The majority of people with iGAS who become critically ill will have developed sepsis,' says Dr Ron Daniels, chief executive and founder of the UK Sepsis Trust. 'It's therefore vital that community practitioners are aware, and make parents aware, of the different sepsis symptoms a child might display so they can act quickly' (see *Resources*).

'It's exceptionally rare to get an invasive infection but, if it does happen, it can progress rapidly with devastating consequences,' says Shiranee. 'It's important to note that children are much less likely to die from an invasive strep infection than adults.'

WHAT'S BEHIND THE RECENT RISE IN CASES?

'We'd normally see the peak of infections between March and May, but in 2022 the increase in numbers just kept climbing well into July, accompanied by an increase in invasive infections in children,' says Shiranee. 'After a brief lull in August, due to the school holidays, we saw rates pick up again, reaching what we hope was a peak just before Christmas.'

The UK isn't alone in seeing a significant increase in cases of scarlet fever and iGAS, with a similar pattern reported in France, Ireland, the Netherlands and Sweden (WHO, 2022).

'Nobody can say for definite why this has happened,' says Steve. 'We've had group A strep spikes for generations, and this was just one example of a particularly bad winter. What we do know is that, unlike Covid, which was a completely new illness for our bodies to deal with, children have evolved over those same generations to cope with strep A and to cope very well.'

There is no evidence of a new strain of strep A in the community, and a rise in cases is most likely due to high amounts of circulating bacteria, increased social mixing compared to the previous years and an increase in respiratory viruses (UKHSA, 2022).

Shiranee says: 'I believe the Covid lockdowns have led to a build-up of children who didn't get exposed to the usual strep A outbreaks in their first school year, so we now have two or three year cohorts of children all being exposed for the first time, which is driving the numbers up.'

WHY IS IT HARD TO DIAGNOSE EARLY?

'There are three key problems with early diagnosis,' says Steve. 'Firstly, a child might have strep A but no symptoms. Secondly, they might have lots of symptoms but, until a swab is taken, you won't know if these are the result of a strep A infection.'

Thirdly, other common viral conditions, such as a cold, can produce similar symptoms.'

'Another difficulty is that while strep A throat and scarlet fever can, on very rare occasions,

progress to become iGAS infections, the vast majority of iGAS develop in people who haven't suffered from either,' says Shiranee. 'This is because the bacteria are easily transmitted from

'WE'D NORMALLY SEE THE PEAK OF INFECTIONS BETWEEN MARCH AND MAY, BUT IN 2022 THE INCREASE IN NUMBERS JUST KEPT CLIMBING WELL INTO JULY'



▲ Symptoms of strep A include scabs and sores around the mouth and a rough rash, while a red and swollen tongue (strawberry tongue) could be a sign of scarlet fever

those who have such throat infections to others via tiny droplets that can spread in the air, on hands and on objects. We therefore often see an increase in the frequency of iGAS infection in the community when we see high levels of strep throat.'

RISK FACTORS AND LATEST ADVICE

'Roughly half the people who develop iGAS will have some sort of skin or mucosal break that allows the bacteria to penetrate into the deeper tissues,' explains Shiranee. 'Common examples in children would be eczema or

chickenpox sores, which is why there can be problems if the latter and strep A circulate at the same time in the community.'

High rates of viral respiratory viruses also put children at risk of co-infection with strep A, leaving them more susceptible to severe illness.

'Flu A or flu B are a good example of this where, together with strep A,

they can provoke pneumonia. So one way of protecting the population is through vaccination against flu and chickenpox,' says Shiranee. 'While we have a vaccine to combat *Strep pneumoniae*, we don't have one for strep A. We're therefore

currently seeing strep A as a leading cause of some types of invasive lung infections in children, such as empyema.'

A weakened immune system can also leave children at greater risk of a strep A infection.

Across the UK the

advice remains for parents to contact NHS 111 or their GP surgery if they suspect their child has strep throat or scarlet fever (see *Strep A symptoms*, right) to ensure prompt treatment. Not only does this reduce the chances of a child developing iGAS, but it also reduces the risk of the infection spreading to others.

HIGH RATES OF VIRAL RESPIRATORY VIRUSES ALSO PUT CHILDREN AT RISK OF CO-INFECTION WITH STREP A, LEAVING THEM MORE SUSCEPTIBLE TO SEVERE ILLNESS

HOW IT'S TREATED

Caught early, strep A can easily be treated and most children will be given oral antibiotics to take at home.

'We have a range of excellent antibiotics to treat strep A and it remains very sensitive to these, especially penicillin, which is great news,' says Shiranee.

Given the unusually high level of cases, the UKHSA issued guidance in December advising GPs to have a low threshold for the prescription of antibiotics to children presenting with features of a strep A infection and for prompt referral to secondary care of any children presenting with persistent or worsening symptoms.

'GPs have previously been encouraged not to treat sore throats unless essential or to defer treatment in case things get better on their own,' says Shiranee. 'However, this delay in treatment can mean an infectious child attends school, which is why the threshold for considering treatment this winter was lowered.'

'Swab results take 48 hours, so clinicians will start antibiotics straight away if there's a reasonable index of suspicion of strep A,' says Steve. 'If the swab then comes back negative they can be stopped – or, if

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there is some uncertainty, they will give the patient a prescription but ask them not to take it to the pharmacy until a positive result is confirmed.’

‘Children should be kept off nursery or school for at least 24 hours after starting treatment to reduce the risk of infecting others,’ adds Shiranee.

It’s also important for parents to monitor any changes, both during and after treatment, in case there’s no improvement or a sudden deterioration in a child’s condition.

REDUCING RISK

‘Simple, basic hygiene and common sense are the most effective ways to reduce the risk of transmission,’ says Steve. Community practitioners (CPs) can emphasise to families the importance of:

- ▶ Regular, thorough handwashing with soap and hot water

- ▶ Using tissues when you cough or sneeze and putting these in the bin afterwards
- ▶ Not sharing cutlery or glasses when eating or drinking
- ▶ Making sure cuts and wounds are cleaned and covered, as these can be entry points for strep A
- ▶ Regular cleaning, especially of hand touch surfaces such as door handles, toilet flushes, taps and items such as phones, tablets and remote controls
- ▶ Washing sheets and towels at a high temperature
- ▶ Avoiding contact with someone you know is infected
- ▶ Keeping homes well ventilated.

HOW CAN YOU REASSURE PARENTS?

It’s important to ensure parents have correct information. ‘Parents should not be

worried but should be alert for the increased incidence of strep A and aware of the key symptoms,’ says Shiranee.

‘There are a lot of seasonal viruses going around, so many children with a sore throat or fever won’t have a strep A infection,’ says Steve. ‘If parents have a child with symptoms, suggest that, in the first instance, they try paracetamol and a sugary drink, milk or orange juice and wait 30 minutes – often this is transformational.’

You can also help parents feel confident in trusting their instincts and seeking medical attention when required.

Steve says: ‘Parents know their child best and when something doesn’t feel right, either because the symptoms are different to their “normal” coughs and colds, they seem more unwell than usual, or they can see a deterioration, it’s time to take action. Parental instinct is particularly important with very young children who can’t tell you how they’re feeling.’

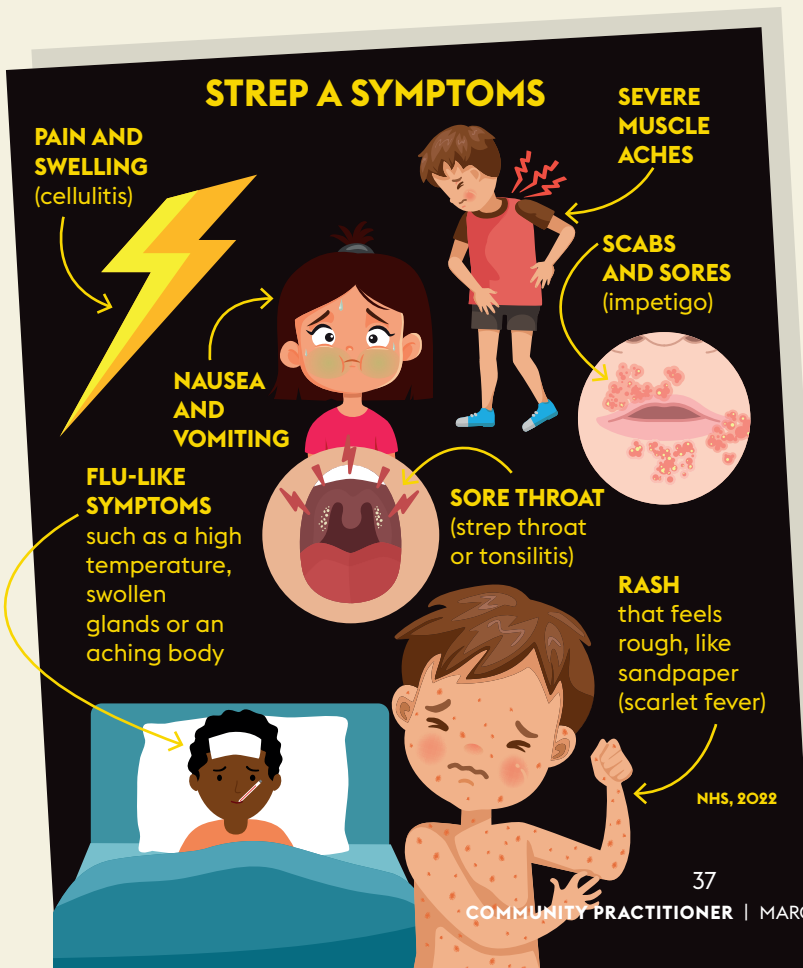
Shiranee is reassuring on any future cases. ‘I would hope, by Easter, that the current strep A spike will have settled down and we will see a return to a normal pattern of cases.’



For references, visit bit.ly/CP_P_features

RESOURCES

- ▶ NHS information on strep A bit.ly/NHS_strepA and scarlet fever bit.ly/NHS_scarlet
- ▶ A guide to spotting sepsis in children for parents from the UK Sepsis Trust bit.ly/Sepsis_Trust_children
- ▶ Sepsis screening tools for different age groups from the UK Sepsis Trust:
 - Age five and under bit.ly/sepsis_screening_under_5
 - Age five to 11 bit.ly/sepsis_screening_5
 - Age 12+ bit.ly/sepsis_screening_12



Research digest

A round-up of research news from around the globe.

US MISGUIDED 'INFLUENCER' CONTRACEPTIVE TIPS

Taking contraceptive advice from social media influencers could lead to unplanned pregnancies in young people, research suggests.

Experts searched YouTube for videos in which influencers with at least 20,000 followers talked about their experiences of contraception. Between December 2019 and December 2021, 50 videos posted by influencers with up to 2.2 million followers were identified and analysed.

The videos were examined to determine the influencers' attitudes to hormonal and non-hormonal birth control.

It was revealed that most of the influencers talked about stopping hormonal birth control, with 92% saying

they were using it or had used it and 74% saying they had discontinued or planned to discontinue it. Around 40% of the influencers said they were using, or had used, non-hormonal birth control, with fertility trackers being the most popular. The lead study author said this was 'concerning' as these may not be as effective at preventing pregnancy as hormonal birth control.

The authors conclude that while social media can be a valuable source of information, young people should treat influencers' advice about contraception with caution.

Health Communication

 bit.ly/HC_contraceptive_advice

GLOBAL MEN, BOYS AND FAMILY PLANNING

A wide range of family planning interventions aimed at men and boys in low- and middle-income countries have shown efficacy in increasing contraceptive use, a systematic review has found.

A third of the studies were conducted on programmes that made a special effort to engage males. The review found that the most effective types of interventions include

community-based educational programmes offered in schools, homes or community facilities, targeting males as well as females of all ages, and programmes delivered by professionals, trained facilitators or peers.

Engaging men and boys in enhancing gender equality for women and girls as part of family planning programming was highlighted as a key strategy, but researchers say this remains under-used.

Campbell Systematic Reviews

 bit.ly/CSR_family_planning

UK HRT AND ALZHEIMER'S PREVENTION


New research suggests that hormone replacement therapy (HRT) could help ward off Alzheimer's among women at risk of developing the disease.

The study reveals that HRT use is associated with better memory, cognition and larger brain volumes in later life among women carrying the strongest risk factor gene for Alzheimer's disease – the APOE4 gene. HRT was found to be most effective when introduced early in the menopause journey.

The research team used data from 1178 women participating in the European Prevention of Alzheimer's Disease initiative – which was set up to study participants' brain health over time. The project spanned 10 countries and tracked participants' brains from 'healthy' to a diagnosis of dementia in some.

One of the authors pointed out that while their research looked at associations with cognition and brain volumes using MRI scans, they did not look at dementia cases, but cognitive performance and lower brain volumes are predictive of future dementia risk.

Alzheimer's Research and Therapy

 bit.ly/ART_Alzheimers_HRT



GERMANY
EMOTIONAL MALTREATMENT
IN CHILDHOOD

Of all forms of maltreatment, emotional maltreatment had the strongest effects on the psyche of children and adolescents, even in comparison with physical abuse, a study revealed.

Researchers carried out an elaborate study on the psychological effects that abuse, neglect and emotional maltreatment have on young people. Examples of emotional abuse considered include when parents subject their children to extreme humiliation, threaten to put them in a home, or blame them for their own psychological distress or suicidal thoughts.

Extensive interviews were used to collect family data, and files from youth welfare offices were analysed. The study of 778 children found that 80% of the children and adolescents who reported having been maltreated had also experienced emotional maltreatment.

In younger children between the ages of three and eight, emotional maltreatment led primarily to behavioural problems, while in older children it was more likely to lead to depression and anxiety disorders.

The findings suggest that the risk of developing psychiatric disorders after maltreatment is already increased in early and middle childhood, which underlines the need for early intervention, the researchers say.

Child Maltreatment
 bit.ly/CM_emotional_maltreatment

UK
TREATING HIGH
BLOOD PRESSURE

Research using a new type of CT scan has enabled doctors to detect and cure the most common cause of high blood pressure.

The 10-minute scan lights up tiny nodules in a hormone gland and their removal can cure high blood pressure. The nodules are discovered in one in 20 people with the condition.

For the study, 128 people used the new scan after doctors found that their high blood pressure was caused by a steroid hormone, aldosterone. The scan found that in two-thirds of patients

with elevated aldosterone secretion, the hormone was coming from a benign nodule in just one of the adrenal glands, which could be safely removed.

The scan uses a radioactive dye that sticks only to the aldosterone-producing nodule. The scan was as accurate as the old catheter test, but quick, painless and technically successful in every patient. Until now, the catheter test was unable to predict which patients would be completely cured of hypertension by surgical removal of the gland.

Nature Medicine
 bit.ly/NM_high_blood_pressure


US
TEENS' EMOTIONAL WELLBEING

A sense of purpose may have a significant impact on adolescents' emotional wellbeing, a study suggests.

Two hundred participants aged 14 to 19 were asked each day for 70 days to rate how purposeful they felt, and the levels of positive and negative emotions they were feeling.

Teens who scored high on purposefulness were more satisfied with their lives and experienced more positive emotions and fewer negative emotions. The researchers also found that on the days when these adolescents felt more purposeful than usual, they also tended to experience greater wellbeing. One of the study authors said the findings show that no matter where teens are in comparison with their peers, when they feel more purposeful than usual, they have better outcomes.

'Our 70-day study is one of the most consistent examinations of youths' purposefulness to date and helps cement the beneficial influence it has on their wellbeing,' said study lead professor Kaylin Ratner. 'Interventions that promote purposefulness may be viable routes to enhancing the wellbeing of many young people.'

Journal of Happiness Studies
 bit.ly/JHS_teens_wellbeing



RESEARCH: ABRIDGED VERSION

FEMALE GENITAL MUTILATION: IS SAFEGUARDING TRAINING SUFFICIENT?

Robyn Byrne conducts an integrative literature review on global FGM training and its application to community practitioners.

RESEARCH SUMMARY

- ▶ The aim of this integrative literature review is to investigate whether training on female genital mutilation (FGM) for healthcare practitioners across countries in Europe, Africa, Oceania and the Americas has an impact on the safeguarding of women and girls from FGM.
- ▶ The subject and study of FGM has wide-reaching implications for women and women's health. Gender inequality and the representation of women within health research continue to be a cause for concern.
- ▶ Despite legal duties being in place, concerns remain that healthcare professionals' knowledge of FGM and how to safeguard against it remains poor.
- ▶ Overall, the studies which included specific data about FGM training noted few participants having received education on FGM, either during their initial training or at a postgraduate level.
- ▶ A review of FGM training internationally may be beneficial in understanding the strengths and weaknesses of existing training programmes, and guidance produced for governments and safeguarding partnerships on improving quality and compliance with FGM training.
- ▶ Community practitioners should ensure that they are up to date with recommended FGM training, that they have a good understanding of risk indicators and their legal responsibilities to report risk of FGM in children/young people, and knowledge of support services available.

The practice of female genital mutilation (FGM) has been performed in many countries across Africa, Asia and the Middle East for centuries, becoming a deeply rooted cultural ritual (Kaplan et al, 2013). It is important to establish that FGM has no grounding in religion (Abolfotouh et al, 2015) and is not referenced in religious texts such as the Bible, the Quran or Hadith. FGM is defined as any procedure in which the female genitalia are 'deliberately cut, injured or changed' when there is no medical justification for doing so (NHS, 2019).

Despite the work of governments and other non-governmental organisations to eradicate FGM, it is estimated that there continue to be more than three million girls at risk globally (Weny et al, 2020). While much is known about prevalence in areas in which FGM continues to be a common practice, accurate data on prevalence in places such as Europe remains limited (De Schrijver et al, 2020). Many countries worldwide have implemented regulations for professionals, such as those in the public sector, which mandates them to report cases of FGM and to protect girls deemed at risk of undergoing FGM (Johansen et al, 2018).

Consequently, it is essential for professionals to receive training on the identification, culturally competent management and legal implications of FGM (Holmes et al, 2017). Despite legal duties being in place, concerns remain that healthcare professionals' knowledge of FGM and how to safeguard against it remains poor (Njue et al, 2019). While it could be considered the responsibility of the practitioner to be aware of their legal duties, Gonzalez-Timoneda et al (2018) note a greater need for healthcare organisations to communicate effectively with employees regarding their legal duties. This is supported by Choudhary et al (2019), who highlight the need for healthcare providers to provide education and information to professionals about their duties relating to FGM.

The aim of this integrative literature review is to investigate whether training on FGM for healthcare practitioners across countries in Europe, Africa, Oceania and the Americas has an impact on the safeguarding of women and girls from FGM.

DATA ANALYSIS

Twenty papers met the inclusion criteria and were deemed to be of acceptable quality following appraisal; these were then reviewed to identify themes. These papers were a mix of quantitative, qualitative and mixed-methods research. To ensure depth of analysis three key themes emerged: knowledge, training and identification; understanding of response to FGM and the law; and attitudes, opinions and culturally sensitive care. For the purpose of this paper, only the theme of training will be further discussed, and not all 20 papers will be referenced (see Table 1 overleaf).

DISCUSSION

Engagement with ongoing education and training is an important aspect of healthcare practice to ensure compliance with changes to policy and procedure (Pool et al, 2013). In the UK, it is mandatory for healthcare staff to complete safeguarding training and for NHS trusts to ensure compliance with this training (Fleming, 2015). In many NHS trusts, this mandatory safeguarding training includes advice and guidance about FGM, while in others FGM training is obtained separately through the local safeguarding partnerships. WHO has highlighted the need for improvements to FGM training for healthcare practitioners (WHO, 2001). All of the studies included in this literature review were conducted after the recommendation by the WHO for improvements to FGM training for healthcare professionals.

Overall, the studies that included specific data about FGM training noted few participants having received education on FGM, either during their initial training or at a postgraduate level. The lowest level of training was observed by Relph et al (2013), where no participating medical students had received training on FGM; the paper does not detail levels of training received by other professional groups surveyed.

Similarly, a further six studies also specifically noted poor levels of training received by healthcare practitioners: between 5% and 29% of participants reported that they had received training (Molina-Gallego et al, 2021; Young et al, 2020; Calvert et al, 2019; Castle et al, 2018; Gonzalez-Timoneda et al, 2018; Jackson, 2017; Sureshkumar et al, 2016).

Two further studies noted that the majority of their participants had not received formal training in FGM: 68.8% in the study undertaken by Cappon et al (2015) and 66% in the study by Akinsulure-Smith et al (2021). Similar results were noted by Deane et al (2022), who found that 90% of

respondents felt more training was required to support them in delivery of care to women and girls with FGM.

Donnenwirth et al (2021) surveyed whether schools of nursing in the US included FGM as part of their curriculum; only 37% of the responding schools of nursing did. It is important to note that none of the studies included within this review found a majority of participants stating that they had received training about FGM.

These studies provided a perspective of practitioners across the health economy, including doctors, nurses, midwives and mental health practitioners from the Americas, Europe, Africa and Australia. It could therefore be interpreted that the findings provide a global picture of limited or poor-quality FGM training delivered to healthcare practitioners. Similar data was noted in an earlier literature review by Zurynski et al (2015), which found low levels of training across participants in the studies reviewed. As it pertains to safeguarding, limited training received by healthcare practitioners is likely to impact upon the practitioner's ability to recognise FGM, and those at risk of undergoing FGM, and to respond effectively when safeguarding protocols need to be initiated. This is

supported by Simpson et al (2012) and Rose (2019), who highlight the importance of training for healthcare practitioners to ensure that women and girls are safeguarded from FGM. It could be concluded from the data presented within the included studies that a review of FGM training internationally may be beneficial in understanding the strengths and weaknesses of existing training programmes, and guidance produced for governments and safeguarding partnerships on improving quality and

compliance with FGM training.

CONCLUSION

This review aimed to establish whether levels of FGM training are impacting on the safeguarding of women and girls from FGM across the whole spectrum of risk, from identification before it occurs to response when it has already occurred. The studies included identified that overall level of training was poor across all geographical regions and healthcare professions included in this study. This review suggests that there may be a systemically low level of training on FGM internationally, which could be impacting upon practitioners' ability to safeguard effectively.

RECOMMENDATIONS FOR FUTURE RESEARCH

This review has identified areas in which future research may be beneficial in supporting better overall knowledge of FGM as well as clinical practice. Further research to understand the types and quality of FGM training provided across the globe may be beneficial in identifying good practice, as well as

A REVIEW OF FGM TRAINING MAY BE BENEFICIAL IN UNDERSTANDING THE STRENGTHS AND WEAKNESSES OF EXISTING PROGRAMMES

TABLE 1: FGM PAPERS REVIEWED

Article author(s)	Publication year and country	Article title	Methodology used
Castle et al	2018 Ethiopia	<i>Female genital mutilation/cutting in Jimma, Ethiopia: a study of knowledge, attitude, and practice among healthcare practitioners</i>	Cross-sectional descriptive study using questionnaires
Cappon et al	2015 Belgium	<i>Female genital mutilation: Knowledge, attitude and practices of Flemish midwives</i>	Quantitative methodology using semi-structured questionnaire
Molina-Gallego et al	2021 Spain	<i>Female genital mutilation: knowledge and skills of health professionals</i>	Cross-sectional descriptive study
Calvert et al	2020 US	<i>National survey of US plastic surgeon experience with female genital mutilation</i>	Quantitative survey methodology
Deane et al	2022 Canada	<i>Are healthcare professionals prepared to provide care for patients who have experienced female genital cutting? A cross-sectional survey</i>	Cross-sectional survey
Gonzalez-Timoneda et al	2018 Spain	<i>Knowledge, attitude and practices of primary healthcare professionals to female genital mutilation in Valencia, Spain: are we ready for this challenge?</i>	Cross-sectional descriptive study
Akisulure-Smith et al	2021 US	<i>Addressing female genital cutting among service providers in New York</i>	Qualitative interviews
Jackson C	2017 UK	<i>Counselling professionals' awareness and understanding of female genital mutilation/cutting: training needs for working therapeutically with survivors</i>	Mixed-methods survey
Sureshkumar et al	2016 Australia	<i>Female genital mutilation: survey of paediatricians' knowledge, attitudes and practice</i>	Quantitative survey
Relph et al	2013 UK	<i>Female genital mutilation/cutting: knowledge, attitude and training of health professionals in inner city London</i>	Quantitative survey
Young et al	2020 US	<i>Female genital mutilation/cutting – pediatric physician knowledge, training and general practice approach</i>	Quantitative survey
Donnenwirth et al	2021 US	<i>Searching for content on female genital cutting/mutilation in curriculums of US nursing schools</i>	Quantitative survey

identifying gaps in training that need improvement. This may also support development of training programmes to enable better healthcare practitioner knowledge of FGM.

RECOMMENDATIONS FOR FUTURE PRACTICE

Globally, there appear to be low levels of training on FGM received by healthcare practitioners. The overall recommendation for practice following this review would be for considering development and implementation of comprehensive and robust training packages for staff. These packages should include the following: detailed information on identification of FGM, including classification and possible variations; risk indicators for practitioners to identify those at risk of FGM; and detailed descriptions of local FGM laws and the expected responses from practitioners where FGM risk is identified. In the UK, this training should be delivered to all healthcare practitioners who work clinically with patients, such as specialist community public health nurses, GPs, midwives and those who may encounter at-risk women and girls in non-clinical roles such as specialist safeguarding teams. It could be considered that enhancing the quality and

quantity of FGM training delivery may be the most effective way to enhance practitioner knowledge and make the safeguarding of women and girls at risk of FGM more effective.

IMPLICATIONS FOR COMMUNITY PRACTITIONERS

Community practitioners (CPs) such as community nurses and specialist community public health nurses may be well placed to identify risk factors for those at risk of FGM or who may have undergone FGM previously. These CPs may often be the first health practitioner someone may come into contact with when they have a health issue or concern, and as such may be the first practitioner to identify these concerns. It could therefore be considered pertinent that CPs ensure that they are up to date with recommended FGM training, that they have a good understanding of risk indicators and their legal responsibilities to report risk of FGM in children/young people, and knowledge of support services available. 🔄

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REFERENCES

- Abolfotouh SM, Ebrahaim AZ, Abolfotouh MA. (2015) Awareness and predictors of female genital mutilation/cutting among young health advocates. *International Journal of Women's Health* **7**: 259-69.
- Akinsulure-Smith AM, Wong T, Min M. (2021) Addressing female genital cutting among service providers in New York. *Professional Psychology: Research and Practice* **52**(3): 202-12.
- Castle A, Mersema A, Marsa S et al. (2018) Female genital mutilation/cutting in Jimma, Ethiopia: a study of the knowledge, attitude and practice among healthcare practitioners. *Ethiopian Medical Journal* **56**(1): 67-73.
- Calvert C, Nathan S, Sakers A et al. (2020) National survey of US plastic surgeon experience with female genital mutilation. *Plastic and Reconstructive Surgery Global Open* **8**(3): e2624.
- Cappon S, L'Ecluse C, Clays E et al. (2015) Female genital mutilation: knowledge, attitudes and practices of Flemish midwives. *Midwifery* **31**(3): 29-35.
- Choudhary I, Mishori R, Kim S. (2019) Words matter: charting the landscape of US and international health profession organizations' public statements about FGM/C. *Journal of Minority Health* **21**: 892-904.
- De Schrijver L, Van Baelen L, Van Eekert N et al. (2020) Towards a better estimation of prevalence of female genital mutilation in the European Union: a situation analysis. *Reproductive Health* **17**(1): 105.
- Deane A, Mattatall F, Brown A. (2022) Are health care professionals prepared to provide care for patients who have experience female genital cutting? A cross-sectional survey of Canadian health care providers. *Journal of Obstetrics and Gynaecology Canada* **44**(4): 403-6.
- Donnenwirth JA, Hess RF, Wyss L. (2021) Searching for content on female genital cutting/mutilation in curriculums of US nursing schools. *Journal of Professional Nursing* **37**(1): 80-5.
- Fleming J. (2015) Training to raise staff awareness about safeguarding children. *Nursing Children and Young People* **27**(3): 22-7.
- Gonzalez-Timoneda A, Ros VR, Gonzalez-Timoneda M et al. (2018) Knowledge, attitudes and practices of primary healthcare professionals to female genital mutilation in Valencia, Spain: are we ready for this challenge? *BMC Health Services Research* **18**(1): 579.
- Holmes V, Farrington R, Mulongo P. (2017) Educating about female genital mutilation. *Education for Primary Care* **28**(1): 3-6.
- Jackson C. (2017) Counselling professionals' awareness and understanding of female genital mutilation/cutting: training needs for working therapeutically with survivors. *Counselling and Psychotherapy Research* **17**(4): 309-19.
- Johansen REB, Ziyada MM, Shell-Duncan B et al. (2018) Health sector involvement in the management of female genital mutilation/cutting in 30 countries. *BMC Health Services Research* **18**(1): 240.
- Kaplan A, Cham B, Njie LA et al. (2013) Female genital mutilation: the secret world of women as seen by men. *Obstetrics and Gynecology International* (online only) See: bit.ly/3Xrt5oJ (accessed 14 February 2023).
- Molina-Gallego B, Mordillo-Mateos L, Corral GMD et al. (2021) Female genital mutilation: knowledge and skills of health professionals. *Healthcare (Basel, Switzerland)* **9**(8): 974-84.
- NHS. (2019) *Female genital mutilation (FGM)*. See: nhs.uk/conditions/female-genital-mutilation-fgm (accessed 13 February 2023).
- Njue C, Karumbi J, Esho T et al. (2019) Preventing female genital mutilation in high income countries: a systematic review of the evidence. *Reproductive Health* **16**(1): 113.
- Pool I, Poell R, Gate OT. (2013) Nurses' and managers' perceptions of continuing professional development for older and younger nurses: a focus group study. *International Journal of Nursing Studies* **50**(1): 34-43.
- Rose B. (2019) Female genital mutilation in the UK: considerations for best nursing practice. *British Journal of Nursing* **28**(12): 788-91.
- Relph S, Inamdar R, Singh H et al. (2013) Female genital mutilation/cutting: knowledge, attitudes and training of health professionals in inner city London. *European Journal of Obstetrics & Gynaecology and Reproductive Biology* **168**(2): 195-8.
- Simpson J, Robinson K, Creighton SM et al. (2012) Female genital mutilation: the role of health professionals in prevention, assessment and management. *BMJ* **344**: e1361.
- Sureshkumar P, Zurynski Y, Moloney S et al. (2016) Female genital mutilation: Survey of paediatricians' knowledge, attitudes and practice. *Child Abuse & Neglect* **55**: 1-9.
- Weny K, Silva R, Snow R et al. (2020) Towards the elimination of FGM by 2030: a statistical assessment. *PLOS One* **15**(10): e0238789.
- WHO. (2001) *Management of pregnancy, childbirth and the postpartum period in the presence of female genital mutilation*. See: bit.ly/3Xq61zX (accessed 13 February 2023).
- Young J, Rodrigues KK, Imam B et al. (2020) Female genital mutilation/cutting – pediatric physician knowledge, training, and general practice approach. *Journal of Immigrant and Minority Health* **22**(4): 668-74.
- Zurynski Y, Sureshkumar P, Phu A et al. (2015) Female genital mutilation and cutting: a systematic literature review of health professionals knowledge, attitudes and clinical practice. *BMC International Health and Human Rights* **15**: 32.



To view the full paper, *Are levels of training on female genital mutilation for healthcare practitioners making effective safeguarding more challenging? An integrative literature review*, visit bit.ly/Byrne_FGM_training

THE PERIL OF POISONS



t's vital for parents, carers and community practitioners (CPs) to be aware of the

potential hazards for children when it comes to wrongly consumed objects: choking on small objects, accidental poisoning from hazardous substances and internal injuries from ingesting magnets or button batteries. Ultimately, ingestions can cause death. In fact, children under five are among those most at risk from an accident in the home. Yet the prevention measures for many types of ingestion injury are often the same.

BEWARE BUTTON BATTERIES

The Safe and Secure campaign from the Royal Society for the Prevention of Accidents (RoSPA) aims to reduce the number of incidents involving the ingestion of button batteries by children. It was launched in conjunction with the Nil by Mouth safety campaign from the Office for Product Safety and Standards (OPSS) in March 2022.

Button batteries – also known as button cell batteries or coin batteries – are small, flat circular batteries that are used to power many objects, such as watches, electronic toys, LED lights, key fobs and remote controls. They come in various sizes, but most are 1cm to 2cm in diameter. This means that they are of a similar size and shape to some sweets and can easily be swallowed.

These batteries have the potential to seriously harm or prove fatal if swallowed. When combined with

Ashley Martin at RoSPA outlines some of the key risks to children from ingestion and poisoning – with an essential reminder on preventing risk.



saliva, the electrical current from the battery produces caustic soda that can burn through the throat or stomach and can cause damage to other internal organs.

The main symptom to look out for is vomiting fresh, bright red blood (Great Ormond Street Hospital NHS Foundation Trust, 2018). This requires immediate medical help. Other signs can include children suddenly developing a cough, gag or drooling a lot; appearing to have a stomach upset or a virus; being sick; pointing to their throat or stomach; having a pain in their tummy, chest or throat; being lethargic, quieter or more clingy than usual or otherwise



‘not themselves’; and not wanting/being unable to eat solid food.

If it is suspected that a child has swallowed a button battery, they should be taken to the nearest A&E department immediately.

So how can the risk be reduced? CPs should advise parents and carers to look around them for items containing button batteries. Although toys are legally required to have lockable compartments, checks should be made to ensure that they are secure. Other products are not legally required to have lockable compartments, so these items should be moved out of reach and sight of young children. Toys and other equipment should only be bought from reliable sources as they are more likely to have passed safety regulations.

Care should be taken when changing batteries to make sure the compartment is secured afterwards and the old battery is kept out of reach of children until it can be disposed of safely. New batteries should be kept in their original blister packaging, preferably out of reach or in a locked cupboard.

STAY ALERT TO MAGNETS

The NHS issued a patient safety alert in 2021 after revealing that at least

SHUTTERSTOCK

65 children had been admitted to hospital for urgent surgery in the previous three years after swallowing magnets (NHS, 2021). Product safety alerts have also been issued by the OPSS (2021).

High-strength magnets can be found in toys, puzzles and some craft and fashion items, and can cause horrific damage to the body if swallowed.

During 2022 RoSPA partnered with the OPSS to launch #SafeFashion, a campaign that aims to raise awareness of the dangers of magnets when used as fake tongue or face piercings and jewellery.

Instances where the magnets have detached and been swallowed have led to the need for surgery and can cause serious infections, lifelong digestive disorders or even death. When two or more of the small ball magnets are swallowed, they can stick together, causing damage to the digestive system. A magnet in one loop of the bowel will be attracted to another in a different loop and pull the two together. This traps parts of the digestive system, cutting off blood flow and rapidly killing intestinal tissue.

The biggest problem is that people just don't know how dangerous magnets are, so it's crucial that the safety message reaches parents, carers, CPs and young people themselves.

The symptoms of someone swallowing magnets are similar to those with button batteries: stomach pain, nausea or vomiting, and the person may not be able to keep down fluids. If you suspect that someone may have swallowed magnets, take them straight to A&E or call an ambulance.

All products containing high-strength magnets should be kept out of reach of young children, and older children should be made aware of the dangers.

SUPERVISION KEY TO PREVENT POISONING

Hospital admissions data reveals that, on average, 10 children under five are admitted to hospital each day because of suspected poisoning in England alone (Office for Health Improvement and Disparities, 2023).

As ever, supervision is one of the best ways to prevent this kind of accident. However, the following steps can also help to keep children safe:

- All household chemicals – including liquid laundry capsules – should be kept out of the sight and reach of children, preferably high up in a locked cupboard
- Cupboard latches should be used to keep small children away from potentially dangerous products
- Household cleaning chemicals should be kept in their original containers

- Lids should be replaced, and all products put away immediately after use
- Unwanted household cleaning products should be disposed of safely
- All medication should be stored in a lockable cupboard out of reach of children
- If it is believed that a child has accidentally ingested medication or household chemicals then medical treatment should be sought immediately.

Through its Take Action Today, Put Them Away campaign launched back in 2013, RoSPA has worked with the cleaning products industry and local practitioners to highlight how children can be kept safe from the dangers of household cleaning products. The programme has been delivered across 80 local authority areas of the UK, and CPs working with their local communities to share the key safety messages with families have been a vital part of its success. 📢

Ashley Martin is public health adviser and policy lead for home and product safety for RoSPA.

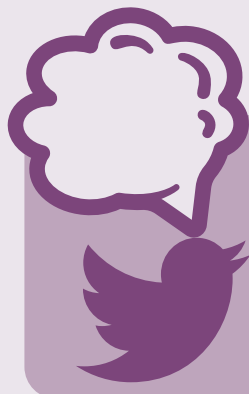
'THE BIGGEST PROBLEM IS THAT PEOPLE JUST DON'T KNOW HOW DANGEROUS MAGNETS ARE'

RESOURCES

- ▶ RoSPA's Safe and Secure campaign rospa.com/safe-and-secure
- ▶ The #SafeFashion campaign rospa.com/safe-fashion
- ▶ RoSPA's child safety resource hub, with advice on keeping children safe in all areas, both at home and out and about rospa.com/keeping-kids-safe
- ▶ Take Action Today, Put Them Away rospa.com/home-safety/advice/household-cleaning-products



For references, visit bit.ly/CP_features



TIME TO REFLECT

How can you help ensure parents and carers are up to date on the latest home safety advice and greatest areas of risk so you can continue to help inform them? Join the conversation on Twitter via [#CommPrac #homesafety](https://twitter.com/CommPrac)

Share your work



Would you like to inform readers of your work projects, specific clinical issues or new innovations? Or perhaps you have a research paper that you would like to be considered for publication. Simply email your article, paper or synopsis to editor **Aviva Attias** at aviva@communitypractitioner.co.uk and see communitypractitioner.co.uk/author-guidelines



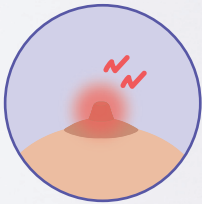
CLINICAL RESEARCH

HPA® Lanolin* and its ability to protect the nipple when breastfeeding: evidence from a novel clinical model for breastfeeding.

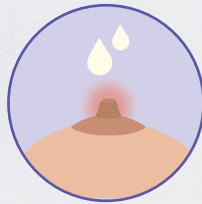
Latest research by Lansinoh Laboratories UK Ltd demonstrated that HPA® Lanolin replenished the essential lipids of the skin, repairing the skin’s natural barrier function, whilst simultaneously moisturising, protecting and conditioning the skin.

Whilst positioning and attachment are paramount to enable, pain-free effective breastfeeding, mothers may find it helpful to use HPA® Lanolin to prepare and protect their nipples, immediately prior to, or during breastfeeding.

How it works:



Mother may experience sore, cracked nipples due to friction and repeated suction



Keeping sore, cracked nipples moisturised can soothe and protect the skin



Mothers can continue to feed while the cause of soreness is addressed



*Lansinoh HPA® Lanolin Research poster presented at: **RCOG World Congress 2022**
Scan to download the report.



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