The Journal of the Community Practitioners' and Health Visitors' Association OCTOBER 2017 VOLUME 90 / **NO. 10**

COMMUNITY PRACTITIONER

CARE FOR MOTHERS?

Maternal mental health services are falling short

Meet the president
Carrie Grant has a passion for the CPHVA

Preterm hope
A better outlook for premature babies

Diabetes rising
How practitioners can help early on

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CPHVA

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Infant regurgitation affects **30% of babies** < 12 months of age[1]

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NICE* RECOMMENDS

a stepped-care approach

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3 TRIAL a thickened formula (for example, containing carob bean gum, rice starch or corn starch).

Cow & Gate anti-reflux is a specially designed **thickened formula**

- Shown to be effective for the dietary management of frequent infant reflux and regurgitation[2]
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REFERENCES: **1.** Vandenplas Y *et al.* J Pediatr Gastroenterol Nutr 2015;61(5):531–537. **2.** Wenzl TG *et al.* Pediatrics 2003;111:e355-9. **3.** Danone Research (data on file).

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

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Date of preparation June 2017

COMMUNITY PRACTITIONER

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COMMUNITY
PRACTITIONER

NEW WEANING CPD MODULE

AGE-APPROPRIATE WEANING FOODS

The CPD module will:

- Examine how age-appropriate weaning can contribute to child health
- Discuss official advice on weaning, also called complementary feeding
- Look at the steps involved in successful introduction of complementary feeding, including which foods and textures to introduce when
- Consider how to tackle problems arising during weaning, such as pressures around the timing of food introduction, avoidance of certain foods, fussy eating, or poor cooking skills
- Address common food myths which lead to confusion amongst families

Visit: **communitypractitioner.co.uk** for further information on the module.

COMMUNITY
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Looking after mum

Welcome to the October issue of *Community Practitioner*.

You don't need us to tell you that bringing a baby into the world is a life-changing experience, for all involved. This month however, we're shining a spotlight on a new reality emerging for mothers... in services for maternal mental illness. On page 24, we ask: while mum dotes on baby, who's looking after mum? Across almost half of the UK, pregnant women and new mothers have no access to specialist mental health services, and unsurprisingly, half of all cases of perinatal depression and anxiety go undetected. With one in five women developing a mental illness during pregnancy or in the 12 months following birth, clearly there's a gaping hole in services. This month's cover feature explores just how deep that hole is, how the situation might be improved, and how community practitioners can significantly help new mothers despite the challenges faced such as lack of resources.

The article on page 44 offers further advice to health visitors in this vital area: it outlines a literature review which aims to further understanding of how practitioners can help women with major mental illness and their children.

As health issues emerge and become national issues, it serves to highlight the essential role community practitioners play in protecting health. On page 12 we look at the worrying rise in type 2 diabetes, driven largely by the nation's expanding waistline. The steep increase can be viewed as an avoidable epidemic, so the feature looks at how community practitioners and health visitors are key in helping children develop healthy habits at a young age.

Talking of public health, we caught up with Public Health England's (PHE) chief nurse Viv Bennett. And on page 18, Viv reveals why PHE is adopting a healthy living approach, and how you can help spread the word. While on page 42, the issue of being overweight while offering healthy living advice is addressed – should it matter?

We also take great pleasure this month in introducing the new honorary president of the CPHVA – broadcaster, presenter and vocal coach, Carrie Grant. On page 20, you can read all about her passion for the NHS, her belief in the power of community practitioners, why she's an advocate for service users... and how she likes to unwind.

Finally, we're really keen to hear your thoughts and learn from you. If you have any feedback on the articles appearing this month, or you'd like to suggest ideas for the future then please get in touch. Perhaps you want to share your practice experiences, or maybe you were inspired by a talk at conference, or even a news story you read. Or perhaps you have a research paper you're keen to submit – whatever it is, we want to hear from you. Please send an outline of your proposed feature or paper to Aviva Attias at aviva@communitypractitioner.co.uk

Until next month...

The *Community Practitioner* editorial team

NEWS ROUND-UP

A look at the latest in public health

NORTHERN IRELAND

Outrage at health cut proposals

The five health trusts in Northern Ireland revealed £70m of 'cost-saving' proposals on 24 August, in five meetings across Northern Ireland.

A six-week consultation was opened on the same day.

Unite lead regional officer for health, Kevin McAdam slammed the label of 'savings plans', saying the proposals were Department of Health imposed cuts.

Unite the union are strongly opposed to these further cuts to healthcare.

'We were disappointed that the trusts chose to move ahead with the consultation in spite of representations from trade unions, community representatives and politicians to reject the proposals and go back... to seek more funding,' Kevin said.

In fact, Unite members and representatives in the health service across Northern Ireland attended.

Kevin later issued an open letter on behalf of Unite in Health, through the press. His comments included:

'These cuts will have a disproportionate and immediate effect on the old and vulnerable in society.'

He also wrote that the 'trusts' sums simply don't add up,' and that 'Unite will work with other trade unions and the community to oppose these cuts.'

- **Read the consultation document at bit.ly/NI_consultation**

NORTHERN IRELAND

Obesity warning over unhealthy snacking habits of families

Poor snacking habits could be fuelling the obesity crisis in Northern Ireland, experts have warned.

One in three parents admit they regularly give their children crisps alongside or between meals, and a quarter never choose low-fat, low-sugar foods, according to a survey commissioned by the National Charity Partnership, a collaboration between Diabetes UK, the British Heart Foundation and Tesco.

The survey found that half of all adults in Northern Ireland worry about the extra calories their families consume through unhealthy snacks, yet more than one in four never actively choose nibbles that are low in fat and sugar, and 34% of parents still regularly offer crisps to their children as snacks.

Katherine Hale, prevention programme manager for the partnership, said: 'Crisps and biscuits are still popular snacks for children because the food habits we learn at a young age can become ingrained and stay with us into adulthood.

'By developing unhealthy habits, you may be risking your family's health.'

- **Read more at bit.ly/NI_snacking**

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SCOTLAND

Record vacancies in nursing and midwifery

One in 20 nursing and midwifery posts are unfilled in Scotland – despite an increase in the number of qualified nurses and midwives.

The data, published by NHS Scotland's Information Services Division, shows the vacancy rate currently stands at a record 5.2%.

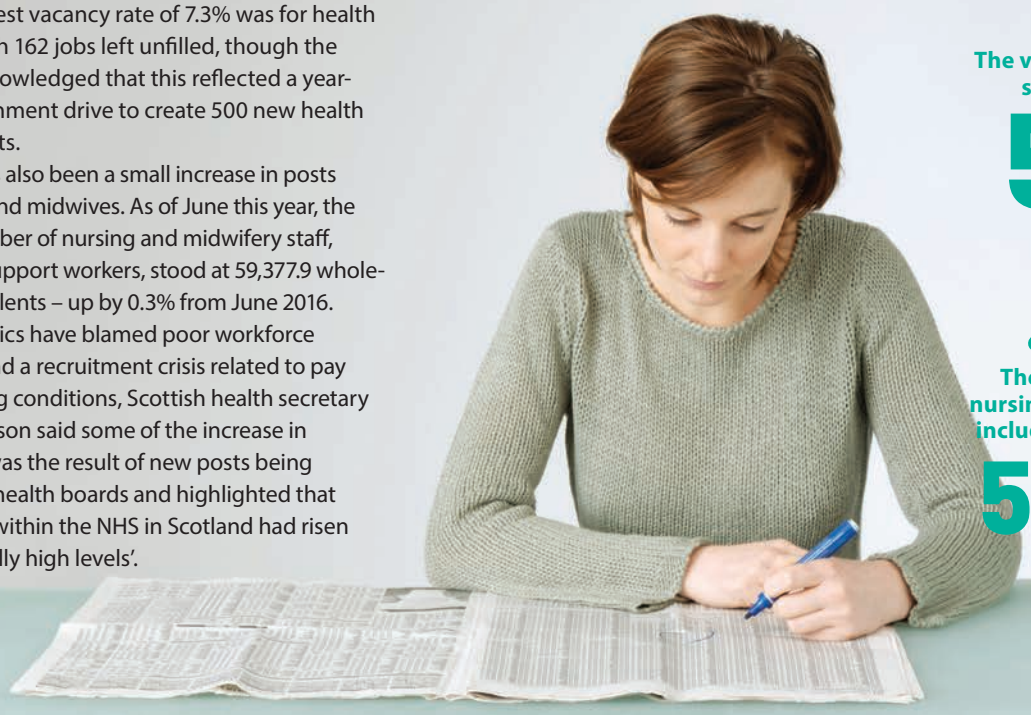
The highest vacancy rate of 7.3% was for health visitors, with 162 jobs left unfilled, though the report acknowledged that this reflected a year-long government drive to create 500 new health visiting posts.

There has also been a small increase in posts for nurses and midwives. As of June this year, the overall number of nursing and midwifery staff, including support workers, stood at 59,377.9 whole-time equivalents – up by 0.3% from June 2016.

While critics have blamed poor workforce planning and a recruitment crisis related to pay and working conditions, Scottish health secretary Shona Robison said some of the increase in vacancies was the result of new posts being created by health boards and highlighted that staff levels within the NHS in Scotland had risen to 'historically high levels'.

'We're committed to training and retaining our nursing staff, and earlier this year we confirmed a 4.7% increase in trainee nurses and midwives for 2017-18 – a fifth successive rise,' she said.

• Read the NHS report at bit.ly/SCT_vacancies



STAFFING RATES

1 in 20
nursing and midwifery positions are unfilled

The vacancy rate currently stands at a record

5.2%

The overall number of nursing and midwifery staff including support workers

59,377
in June 2016

SCOTLAND

A single day's training for Named Persons

Scotland's Named Persons will get just one day of training to prepare for the role, it has been revealed.

The Scottish Government has set aside £1.2m to train the health visitors, nurses and teachers, who will be Named Persons. The scheme will see them act as a single point of contact for every child in Scotland, safeguarding the children's wellbeing and connecting them with services.

The training will focus on sharing information about children – a contentious area following a legal challenge that argued the sharing provisions would breach human rights laws.

• For more on the scheme, go to bit.ly/SCT_NPs

WALES

Measles risk as children miss MMR jabs

More than 7400 children in north Wales are at risk of measles after not receiving two doses of the MMR vaccine.

An outbreak has affected Newport and Torfaen, and Public Health Wales said the disease could be seen anywhere while the 95% vaccination target is not reached. Parts of Europe have also seen outbreaks this summer.

Measles can cause permanent disabilities and can even be fatal in severe cases. Symptoms include a high temperature, cough, runny nose, red eyes and distinctive red rash.

• Find advice and information at bit.ly/WAL_MMR

ENGLAND

Vulnerable children 'falling through the cracks in the system'

Thousands of vulnerable children in England flagged to social services over neglect or abuse are not getting help from local authorities, a report warns.

The charity Action for Children said that 140,000 children were 'falling through the cracks in the system' because they do not meet the criteria for statutory support and only get help once they reach 'crisis point'.

By law, councils must provide services for children deemed 'in need' or at 'risk of harm', but other children can be referred to other services, such as parenting programmes.

The report was based on freedom of information requests to 152 councils. The charity found that 184,500 needs assessments were closed as 'no further action' in 2015-16 because they did not meet the statutory criteria for help. Of these, around one in four families received other help, such as referrals to children's centres, leaving around 140,000 children without assistance.

Action for Children said austerity measures have seen local authorities 'drastically shrink or abandon services'. The Local Government Association estimates that the funding gap to support vulnerable children will hit £2bn by 2020.

• Read the report at bit.ly/ENG_AFC

NORTHERN IRELAND

Nurse numbers climb – but turnover too

The number of nurses and midwives working in health and care services in Northern Ireland continues to climb, despite almost 1300 leaving during the past year.

The Northern Ireland health and social care workforce census shows that, as of March this year, more than 17,200 individual nurses and midwives were in jobs, equating to 15,134 whole-time equivalent (WTE) nurses and midwives at Band 5 or above, which is up 1.3% on the previous year, and up 7% since March 2013.

The figures also show an increase in nursing support staff, with just over 4267 WTEs in post, up 4.6% on the previous year.

Nursing and midwifery in Northern Ireland saw the largest number of people taking up jobs in the past year – a total of 1613. But a higher rate of nursing and midwifery staff also left their jobs than other health and care professionals – 1299, or 5.9%.

The figures also show 60% of nurses and midwives are aged 40 or over, with a significant proportion aged 50 or above, including 37% of health visitors.

• Read more at bit.ly/NI_census

WALES

A third of young children don't do enough physical activity

Almost one in three children under the age of five in Wales are not getting the recommended three hours of active play a day.

A survey by Public Health Wales found that 29% of under-fives fail to reach their daily quota. A lack of suitable outdoor space may be a key reason.

The research, involving 1503 telephone interviews with parents and carers, was carried out earlier this year as part of Every Child Wales, Public Health Wales' new programme to improve the health and wellbeing of under-fives.

Dr Julie Bishop, director of health improvement for Public Health Wales, said: 'Playing outdoors every day is a great way to help your child grow into a fit and healthy adult and will encourage them to stay active beyond their childhood.

'Time outside is a wonderful way to spend quality time with your child as well as being a great stress reliever from the busy life of a parent.'

• For more, visit everychildwales.co.uk

ALAMY/ISTOCK/GETTY

NORTHERN IRELAND

Number of children in care still rising

The number of children in care in Northern Ireland has risen 43% over the past decade.

More than 2200 young people have been looked after continuously for 12 months or longer, Department of Health figures show. That's 51 for every 10,000 under-18s.

The figures appeared in the *Children in care in Northern Ireland 2015-16* statistical bulletin, reporting the 2% rise year on year over the past 10 years.

Possible causes of the rise include an increased level of awareness of child protection issues, greater willingness to take action to protect children who are potentially at risk, and more adolescents becoming looked-after children because of family breakdowns.

The report also showed that children in care tend to perform less well than their peers at school, with only 54% of looked-after children achieving at least 5 A* to C GCSEs in Year 12 compared to 83% of the general school population.

Furthermore, one in four have a statement of special educational needs, compared to just 5% of the general school population.

- **To read the bulletin, go to bit.ly/NI_CIC**

WALES

Flu vaccine for all primary school children in Wales

All children at primary schools in Wales will be offered the flu vaccine within two years, it has been confirmed.

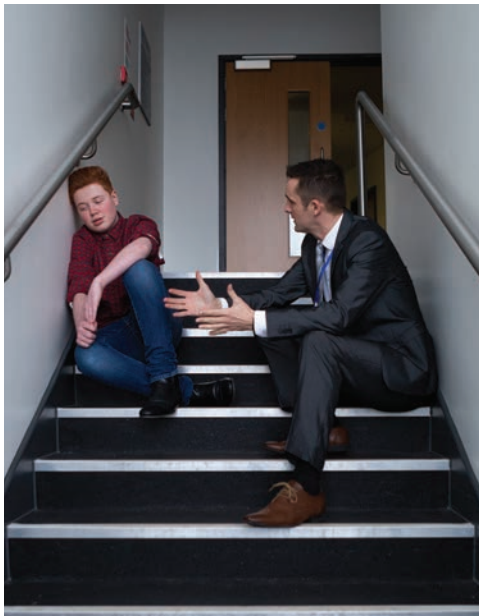
The move was announced by the Welsh Government as Public Health Wales published its annual report *Seasonal influenza in Wales* at the end of August.

At present, only primary school children in Reception to Year 3 are offered flu jabs, but from this term the vaccination programme will be extended to include all children in Year 4.

Almost a quarter of people in Wales received a flu vaccine in the past year, the report said.

Public Health Minister Rebecca Evans said evidence from vaccinating younger children elsewhere in the UK showed that it could have a 'significant impact' on preventing the spread of the flu virus.

- **Read the report at bit.ly/WAL_influenza**



SCOTLAND

Hundreds of thousands of children lack school counselling

More than 250,000 children in Scotland have no access to school-based counselling services, a BBC investigation has discovered.

Counselling services are guaranteed in every secondary school in Northern Ireland and Wales, but 14 Scottish local authorities have no formal school counsellors, and elsewhere provision was irregular.

Overall, only 40% of Scottish secondary schools were found to have onsite services – the equivalent of just 10% of all primary and secondary schools in the country.

The two councils of Orkney Islands and Dumfries and Galloway have yet to respond to the freedom of information request.

A government review into school counselling services is now underway.

- **Read the Scottish Government's mental health strategy in schools at bit.ly/SCT_counselling**

US

Pre-eclampsia associated with cardiovascular disease later in life

Pre-eclampsia may affect mothers long after the birth of their child, a new study suggests.

Researchers from the Mayo Clinic in the US have found that women with a history of pre-eclampsia are more likely to face atherosclerosis – hardening and narrowing of the arteries – decades after their pregnancy.

The research looked at 40 postmenopausal women with histories of pre-eclampsia and 40 with normal pregnancy histories. The artery wall thickness was significantly greater for women in the first group.

'Even without a history of cardiovascular events, women who've had pre-eclampsic pregnancies are facing a higher risk of atherosclerosis decades later,' said Dr Vesna Garovic of the Mayo Clinic Division of Nephrology and Hypertension.

• For the study, go to bit.ly/MCP_pre-eclampsia

UK

'Bad mum' stigma stops women seeking postnatal depression help

Fear of being seen as a 'bad mother' is a barrier for women seeking help for postnatal depression, a new study finds.

Researchers at City, University of London, and the RCGP found that this fear led to women not mentioning psychological distress after having a baby, despite regular contact with health services. The research analysed 24 studies on women seeking help during pregnancy or the first year after birth.

Co-author Professor Susan Ayers at City, University of London said: 'Women felt under pressure to be "good mothers" and that feeling they had "failed" impacted negatively on their likelihood to seek help. In addition, difficulty identifying they had a problem and bad experiences with healthcare led to women "self-silencing".'

The authors call for 'perinatal care services to look into ways to better inform women about the symptoms, and deliver better continuity of care'.

See our report on page 24.

• Read the full study at bit.ly/BJGP_depression

US

Living near a park eases asthma for kids

City kids with asthma who live near parks have fewer days with symptoms, says new research.

The study looked at inner-city children with persistent asthma and compared the number of symptomatic days over two weeks with the distance from their homes to the nearest park.

Researchers interviewed the parents of 196 children aged three to 12 in Baltimore who had either visited accident and emergency at least twice or been hospitalised for their asthma during the past year.

They found children had one extra day when they suffered with asthma symptoms for every 305 metres between their home and the park.

Public health nurse Kelli DePriest, who carried out the work with primary investigator Dr Arlene Butz and colleagues at Johns Hopkins University School of Nursing and the University of Maryland School of Medicine in Baltimore, said: 'The effect looks strongest for children aged six and older.

'These results provide further support for the benefits of city parks, and suggest that the right building policies can improve children's health.'

• Read the full study at bit.ly/JSN_asthma

SWEDEN

Joint custody lessens impact on children

Preschool children have better mental health when they live with both parents after a divorce, says a Swedish study.

Researchers looked at 3656 three- to five-year-olds – 3369 in families, 136 in joint custody, 79 mostly with one parent and 72 only with one parent. Those in joint custody had fewer psychological symptoms than those living with one parent.

• Read the study at bit.ly/AP_jointcustody

DENMARK

Mental health risk linked to medication during pregnancy

Babies born to mothers using antidepressants during pregnancy are more likely to develop a psychiatric disorder, says research from Denmark.

Researchers at the National Centre for Register-based Research at Aarhus BSS looked at 905,383 children born between 1998 and 2012, 32,400 of whom developed a psychiatric disorder later in life.

They compared children not exposed to antidepressants in the womb (group 1), those born to mothers who had been taking antidepressants up to pregnancy, but not during (group 2), those whose mothers used antidepressants before and during pregnancy (group 3), and children of mothers who only started taking the medication during pregnancy (group 4).

Almost twice as many children were diagnosed with a psychiatric disorder in group 4 (14.5%) than in group 1 (8%). In groups 2 and 3 respectively, 11.5% and 13.6% had a disorder at age 16.

'These women should not feel guilty about taking antidepressants. Our research shows that medication seems to increase the risk, but that heritability also plays a part,' says co-author Trine Munk-Olsen, who points out that it might be the mothers who suffer from the most severe forms of depression who need to take medication during their pregnancy.

● **For the full study, visit bit.ly/BMJ_antidepressants_pregnancy**

SWITZERLAND

Children of insomniac mothers sleep badly

Children's sleep can suffer if their mothers have insomnia, suggests research by the University of Warwick and University of Basel.

The researchers recorded the brain activity of nearly 200 seven to 12-year olds over one night with in-home electroencephalography (EEG), while parents reported their own insomnia symptoms and their children's sleep problems.

The EEG showed that children whose mothers have insomnia fall asleep later, get less sleep, and spend less time in deep sleep. No link was found between fathers' sleep problems and children's sleep.

Children might learn sleep habits from their parents, or family issues may affect their sleep.

● **Read the study at bit.ly/SJ_insomnia**

SHUTTERSTOCK/ISTOCK/GETTY

ROMANIA

Early signs of heart harm in obese toddlers

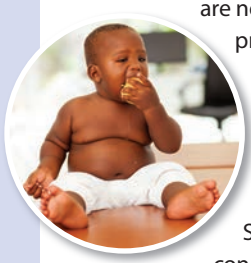
Changes in the structure of the heart have been found in obese infants – including babies under the age of one, a study shows.

The Romania-based study looked at 54 babies below the age of one and 125 toddlers. All had been bottle fed, which is linked to higher rates of obesity.

It found that obese children had 30% thicker heart muscle compared to those of a healthy weight. An abnormally enlarged heart is an early marker of heart disease.

Lead researcher Dr Delia Mercea, from Constantin Opris Hospital in Baia Mare says: 'It's a huge problem because it's possible that this [thickening] could lead to heart failure in time.'

Dr Mercea says drastic lifestyle changes are needed, and urged health professionals to intervene: 'We should encourage healthy food and physical exercise.'



The findings were presented at the European Society of Cardiology congress recently in Barcelona.

AUSTRALIA

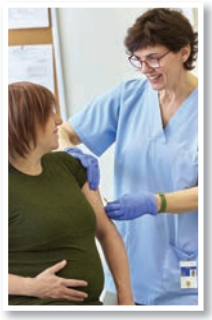
New mothers hesitate over vaccinations

First-time mums are more hesitant about vaccinations than those who already have children, say researchers at the Murdoch Children's Research Institute.

They surveyed 975 pregnant women at Australian public hospitals: 73% of new mums vaccinated while still pregnant, compared to nearly 90% of existing mums.

Dr Margie Danchin says first-time mums are more concerned about vaccine ingredients and the effect on children's immune systems.

● **Read the study at bit.ly/AFP_vaccinations**



Diabetes: the avoidable epidemic

Cases of type 2 diabetes are skyrocketing, taking a toll on the health of the nation and the overstretched NHS. Journalist **Juliette Astrup** looks at how you can help by encouraging children to get a healthy start in life.

We are witnessing a rise of epidemic proportions in diabetes. Since 1996, the number of people diagnosed with the condition in the UK has more than doubled, from 1.4 million to almost 3.5 million (Diabetes UK, 2017a). The vast majority – around 90% – have type 2 diabetes, which is largely preventable or manageable by lifestyle changes (NHS Choices, 2017).

Diabetes is a major cause of blindness, kidney failure, heart attacks, stroke and lower limb amputation. The National Diabetes Audit found that each year up to 24,000 people with diabetes in England die earlier from causes avoidable through better management of their condition (NHS Choices, 2011).

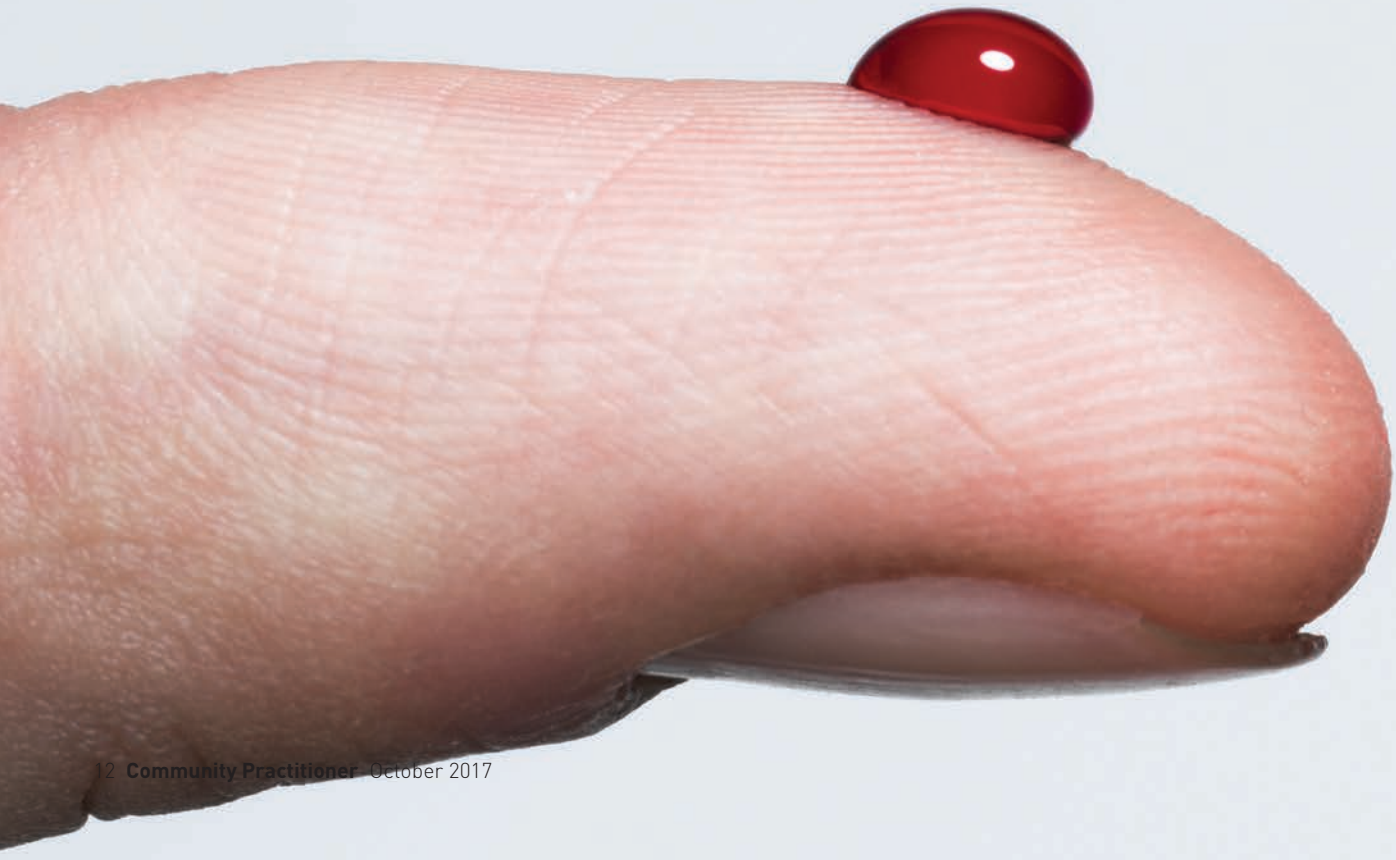
And while there is no cure for diabetes, three in five cases of type 2 diabetes can be prevented or delayed by healthy lifestyle choices, estimates Diabetes UK (2017b).

Tackling the disease is not only vital to the health of individuals, but it is essential to the sustainability of the health service. It is currently estimated that the NHS already spends about £10bn on diabetes every year – that's 10% of its budget (Hex et al, 2012).

This shocking increase in prevalence has seen NHS prescriptions related to diabetes rise by 80% in the past 10 years, reaching 52 million items in 2016-17 – accounting for around £1 in every £9 spent on prescription items across primary care, at a total cost of £983.7m (NHS Digital, 2017).

THE OBESITY RISK FACTOR

Underlying this diabetes epidemic is the nation's expanding waistline. Almost two in every three people in England are overweight or obese (Health and Social Care Information Centre, 2016) – and obesity is by far the most important risk factor for type 2 diabetes, accounting for 80% to 85% of the overall risk of developing the condition (Hauner, 2010).



The obesity issue is deep-rooted, and has an impact on ever-younger children. In Wales, 26.2% of reception year children were overweight or obese in 2015-16 (Public Health Wales, 2016). In England it was 22% (HSCIC, 2016); and in Scotland 22% of children in their first year at primary school were at risk of being overweight or obese (ISD Scotland, 2016). In Northern Ireland, one in four children aged between two and 15 is overweight or obese (Department of Health, 2016).

CHILDREN WITH TYPE 2 DIABETES

Unhealthy lifestyles in childhood mean type 2 diabetes is no longer a concern only in middle age. According to figures from the Royal College of Paediatrics and Child Health (2016), 621 children and young people under the age of 25 received care for type 2 diabetes from paediatric diabetes units in England and Wales, of which 78.5% were also obese. A total of 15 children with type 2 were aged between five and nine.

Libby Dowling, senior clinical adviser for Diabetes UK, calls the trend 'extremely worrying', adding: 'Type 2 diabetes seems to be even more aggressive in children, who develop high blood pressure and high cholesterol quicker.

'The government needs to take decisive action to make the healthy choice the easy choice, including stronger regulation on junk food marketing to children and supporting the reformulation of foods to reduce sugar and saturated fat. We need to make it as easy as possible for children and their families to lead healthy lives and reduce the risk of developing type 2 diabetes and its serious complications.'

THE ROLE OF PRACTITIONERS

Developing healthy habits at a young age is at the heart of the public health agenda across the UK – and community practitioners and health visitors are on the front line delivering these messages.

'For a school nurse it's part of every health assessment,' says Claire Elwell, CPHVA national executive north-eastern representative and chair of the school nursing expert reference group. 'We talk about eating a healthy diet from all the food groups, reducing snacks, and healthy food swaps.

GETTY

DIABETES IN NUMBERS

The estimated hourly cost of NHS spending on diabetes

The amount of hospital beds occupied by someone who has diabetes

The number of people estimated to have undiagnosed type 2 diabetes in the UK

(Source: Diabetes UK)

'I think from the frontline public health point of view we are all singing the right song – but the school nurse is a small cog michin a big wheel. I think as a country we should be targeting parents and try to engage them to make more conscious choices for the health of their children.'

Nursery nurse Barbara Evans agrees: 'At every contact we talk about things like baby-led routines, offering regular mealtimes and healthy options, removing anxiety around eating, ensuring children drink enough, as well as supporting breastfeeding.

'We need those public health messages, and we need more support for staff to have time to do that well, but we also need a cultural shift.'

The health promotion agenda is 'always running in the background' of what health visitors do, says Michelle Moseley, Wales chair, CPHVA executive committee, as part of 'making every contact count'.

'We have a lot of good practice going on. In Wales, it's particularly around the Flying Start programme, which is targeted at vulnerable families and children,' she adds. 'For example, we have weaning parties in some Flying Start areas in Wales. A dietician attends, and the health visitor and nursery nurses. Appropriate foods, weaning practices and handling food are discussed.'

She adds: 'It's about healthy food choices from birth, combined with health education and health promotion practice, in an attempt to prevent children becoming overweight and obese, with the potential to prevent type 2 diabetes and other non-communicable diseases.

'But with policy, it is imperative to underpin SCPHN practice and drive the public health and health promotion agenda forward.' **CP**

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I thought the poster presentations were inspirational and highlighted some great areas of practice."
Community Nurse, 2016 attendee

FIVE TOP TIPS

In preparation for conference, here are our top tips for getting the most out of your time away from work:

1. Create your own agenda. With so much on offer, view the full programme online and make a schedule of sessions you'd like to hear.

2. Pick your experts. Take a look at the speaker list to see who you'll hear from and when they'll be on stage.

3. Divide and conquer. If you're attending with friends why not make a schedule to attend different concurrent sessions and then collate your notes during the breaks?

4. Network, network, network. Make sure you allow yourself time to explore the exhibition and make those all-important connections.

5. Bring supplies. Don't forget to pack a notepad and pen so you can keep a record of all the information you gain.

For any final queries before the event please email events@cogora.com

No place to go?

Alone and frightened at a time when they are barely adults, a staggering 150,000 young people a year across the UK approach their council for help with housing. At least a third are turned away without meaningful support and, with broken family relationships often the cause of their homelessness, they are often left with no idea where to seek help. This is a time bomb for struggling public services. Research from homeless charity Centrepoint shows young people are left with impossible choices: sleep rough, risk staying with a stranger – or even hurt themselves for a hospital bed.

Whatever desperate measures they resort to, the impact on young people's physical and mental health can be devastating. But until February this year, there was no single source of help for homeless young people. That changed when the Duke of Cambridge launched the Centrepoint helpline. Our free phone and online service provides tailored housing advice to each young person and connects them with the support they need to repair the damage to their health and life chances. We're here to get young people to a safe place as soon as possible, but we can't do it alone. We need their health professionals – people they trust – to tell them about us. We're calling on community practitioners to help spread the word.

Paul Brocklehurst, Centrepoint helpline senior manager

- **It's free to call the Centrepoint Helpline on 0808 800 0661, Monday to Friday, 9am to 5pm, or visit centrepoint.org.uk/helpline**

JEFF MOORE

#AskAboutAsthma

The Children and Young People's Health Partnership (CYPHP) asthma team has pledged to improve the care it provides in Lambeth and Southwark, south London. Managers, researchers and the project team helped to raise awareness for the #AskAboutAsthma campaign run by Healthy London Partnership (HLP) and NHS England London:

- Nurse specialist Laura King pledged 'to support and empower young people and their families to confidently self-manage their asthma and navigate the healthcare system effectively.'
- The nursing team pledged 'to bridge the gaps between secondary and primary care so children, young people and their families with asthma can be happy, healthy and well.'
- **For more, go to bit.ly/HL_myasthmapledge**

#AskAboutAsthma wants children and young people with asthma to:

- Have an asthma management plan
- Use their inhalers effectively
- Have an annual asthma review.

The campaign ran from 11 to 24 September to coincide with the new school year and to raise awareness of 'week 38' in mid-September, which shows the biggest spike in hospital admissions for asthma each year. Hundreds of pledges were made. London mayor Sadiq Khan got involved via a video on the HLP website: bit.ly/2ysmwrF

ALAMY/ISTOCK

WORKING TOGETHER to improve NHS pay

Living costs are spiralling and wages are in the doldrums, but NHS pay is now a hot topic in politics and the media. It is essential to keep up the pressure on government to win a fair deal, says Unite's head of health **Sarah Carpenter**.

Public sector pay has been a huge issue in politics and the media this summer, and shows no sign of changing as we head into the autumn.

Alongside the other NHS unions, including the Royal College of Nursing, Unison and the GMB, Unite-CPHVA is calling for an end to the public sector pay cap. This is the government policy that dictates that pay rises in the NHS, for example, can be no higher than 1%, and this 'remit' is passed on to the pay review bodies to work within. This has meant that while inflation and the cost of living have risen year on year by more than 1%, your pay is capped, and so your income drops significantly in real terms.

Recent news has shown that the government is prepared to change that approach for some public sector groups, and we are continuing to keep the pressure up to ensure that this change comes to the NHS too.

CALL FOR CLARITY

By the autumn, NHS unions are usually beginning to gather evidence for the independent NHS Pay Review Body (NHSPRB). And usually we do this in the knowledge that Jeremy Hunt, the secretary of state for health, has already written to the NHSPRB to let them know their remit. But so far Hunt has written no letter, and so there is confusion about the process.

In September, not wanting to sit and wait to be told what to do, 14 NHS trade unions united to launch their campaign for a meaningful NHS pay increase from April 2018 with a letter written directly to the chancellor, Philip Hammond. The pay claim is for an increase to keep up with the cost of living and to start to make up for the years of lost pay – that means an increase in line with inflation, plus an £800 lump sum for all staff, and for this to be fully funded. We also want to speak about pay beyond 2018, through engaging with the government about how we make the NHS pay system better, fairer and more sustainable.

We are under no illusions that this will be easy to achieve, but we need all our members to start talking about pay, and how important it is that public services staff are valued and paid what they are worth.

When we asked Unite members before the summer, 63% said they would be prepared to take action short of a strike as part of a campaign against the pay cut, and we know that members have got angrier about the government's position as the months have passed. There will be chance at the CPHVA conference to have your say, and local meetings will also be taking place.

What is important is that all unions are standing up and speaking out with one voice on pay. Together we will make a difference. CP

The contents of the letter from 14 NHS unions to chancellor Philip Hammond included the following:

3.9% - the current rate of RPI inflation - and the pay rise called for by unions

£800 - additional payment to staff to restore lost pay over the past seven years

15% - the average real-terms pay cut for NHS staff since 2010

CHANGING DIRECTION

Viv Bennett CBE explains why Public Health England is adopting a healthy living approach, and how you can play a key role in spreading the word.

When *Community Practitioner* caught up with Public Health England's (PHE) chief nurse Viv Bennett, it was the final day of the month-long #WeActiveChallenge – an interactive social media campaign that saw healthcare professionals competing with each other to be more active.

Viv has been working out in the gym, jogging and walking miles, and completing the 747 Fitbit challenge – climbing the equivalent of the height of a 747 jet in flight, or 4000 floors. Now, she jokes, she 'needs a good rest'.

While it's all about fun and friendly rivalry, the activity challenge addressed a serious issue – and a key priority for PHE to tackle over the next five to 10 years.

Physical inactivity is responsible for one in six UK deaths – the same as smoking – and up to 40% of many long-term conditions, ranging from type 2 diabetes to coronary heart disease and cancer (PHE, 2017).

Yet we are facing an inactivity epidemic – with the UK population around 20% less active than in 1961 and forecast to be 35% less active by 2030 if the trend continues (Ng and Popkin, 2012).

A NEW FOCUS

'We've always known how important [physical activity] was, but now we are articulating it far more,' Viv says.

This new emphasis is part of an ongoing journey that has seen the focus of public health extend from 'communicable disease to include lifestyle-related non-communicable disease', explains Viv.

It is also about understanding the 'wider determinants of health and health inequalities. Rather than thinking about care just as risk to the individual person, we work more with people and communities to help them get the best health.'

'We are trying to look at the world in a different way – much more of a healthy living approach.' This approach is now setting the agenda for PHE.

'There are ever more problems with diet and physical activity fuelling the obesity epidemic,' says Viv. 'We still have big problems with alcohol and other substance abuse, and we are much more aware of mental health and wellbeing.'

LET'S GET PHYSICAL

PHE's latest tool to tackle physical inactivity is an app called Active 10, designed to encourage at least 10 minutes' brisk walking a day, as part of the ongoing One You campaign.

'Evidence shows that the pace of walking matters,' says Viv. 'The message is that a brisk walk once a day, or even better three times a day, can really help you improve your health.

Viv suggests that health visitors can use the Active 10 app to help new mums with their physical and mental health. 'While school nurses can link it to the mile-a-day school programme (thedailymile.co.uk),' she says.

Community practitioners, says Viv, have a 'huge role to play' in the new healthy living approach. 'We really value the role of frontline professionals in working with us to support these big campaigns.

'Health visitors and school nurses are really familiar with the family and child health agenda – but might not be so familiar with the latest physical activity evidence as mentioned, and the new Tobacco Control Plan.

'A particular focus of the latter is reducing smoking rates during pregnancy. Some women give up but start again with the pressures of the transition to motherhood. Health visitors can really engage with people and help keep them smoke free.'

But, with the transfer of public health budgets to local authorities reshaping services across the country, will the role of frontline professionals continue to be so important?

'PHE has been very clear that we absolutely value health visitors and school nurses as leaders in the field force in children's public health,' says Viv.

'What is changing is the increase in focus on outcomes. I think, alongside that, there is a lot of interest in health economics. That's somewhere public health is really seeking to up its game. We know some of the answers, but we have less evidence about whether who does what makes a difference to the outcomes.

'We are also trying to develop really robust case studies describing the transformed approach to care and demonstrating the impact that it has had. Health visitors and school nurses are trained in public health and individual health so are a very strong bridge between public health and primary care, and between children's services and health services.'

She urges practitioners to 'continue, as they have done, to embrace the changes', and adds: 'We are seeing some great examples of commissioners working with providers and professionals to think about how we transform services locally, to get the best integration and the best transition.

'We live in a time of devolution to local authority areas – this is the political context within which we work. Those decisions have to be local.

'At PHE we can continue to provide the evidence, the robust case studies, and keep the profile of the frontline public health field force high.

'They themselves and their leaders can continue to showcase what they do so well.' **CP**

ALL ABOUT VIV

- **Qualified in 1979 and began her career as a nurse on a children's ward in Oxford.**
- **Trained and worked as a health visitor while studying for a BA, then a master's degree in health and social policy.**
- **Joined the Department of Health as deputy chief nursing officer in 2007, and was appointed director of nursing and the government's principal adviser on public health nursing in 2012.**
- **Is a visiting professor at King's College London, and was honoured with a CBE for services to nursing in January 2016.**
- **Her grandson turned one last month, when Viv also celebrated her 60th birthday.**
- **She upped her step count during her month-long #WeActiveChallenge by being 'really inefficient' with the laundry – taking one item to the line at a time.**

10.8%

The proportion of women in England that smoke during pregnancy. Health visitors can engage with people and help keep them smoke free

(Source: NHS Digital, 2017)

SHUTTERSTOCK/ISTOCK/PA

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Meet the talented NEW PRESIDENT

Broadcaster, presenter and vocal coach to the stars **Carrie Grant** is the new honorary president of the CPHVA. She tells us about her passion for the NHS, her vision for patient-led healthcare, and the power of community practitioners to effect change.

It's about how I can serve the CPHVA for however long I'm here – I want to make a difference

ALAMY

It's almost impossible to sum up Carrie Grant. While best known for her television appearances, including as a judge on *Pop Idol* and a reporter on the BBC's *The One Show*, she is also a MOBO-award-winning gospel singer, an author, a business and leadership coach, a tireless campaigner and a mum of four.

She is certainly no stranger to the health service, having lived with Crohn's disease since the age of 18, and as a mother of four children with special educational needs. Her eldest daughter Olivia, 22, has ADHD and dyspraxia; Talia, 15, has Asperger's syndrome; Imogen, 11, is autistic; and her seven-year-old adopted son Nathan has attachment difficulties and ADHD.

Her experiences have led her to become an active campaigner for change in healthcare systems and an advocate for service users. She is the patient lead for the College of Medicine and an ambassador for three charities: Crohn's & Colitis UK, the National Autistic Society and the Diana

Award. She sits on the largest transforming care panel in the UK for mental health and learning disabilities and, with her husband David, runs four community support groups from her home.

'HUMBLED AND HONOURED'

It is this background that makes her a good fit for her latest role as honorary president of the CPHVA, an appointment she is 'humbled and honoured' by.

'I have spent years gathering families, children and young people; I wanted to take another position in the team around the child, to try to understand and add value to the professional's perspective,' explains Carrie, 52.

'When I was offered the presidency I had to think about whether I can be effective. Raising four children, I don't have time to waste. It's about how I can serve the CPHVA for however long I'm here – I want to make a difference.

'I believe we have some amazing community practitioners and health visitors out there who just need the encouragement to believe they can make a big difference. They need permission to fully be the leaders they have the potential to be.'

Carrie has spoken many times about the need for patients to lead in their own care. She believes that bringing people together in communities, be that in charities or parents' groups, is fundamental to making this work.

'I absolutely love the NHS and I will support it all the way,' she says. 'I have seen massive changes, and the question now is how to make sure the NHS is sustainable. When you've got a couple of million people working in the NHS and 65 million using it, you can do the maths. How can we get patients and clients to share the load?

'I think the health visitors and community practitioners have an amazing opportunity to assist communities to empower individuals. The pressure is shared out.'

Only a few weeks into her presidency, Carrie has already attended the CPHVA executive committee meeting.

'I love that the CPHVA sits on a rich heritage of "can do" women,' she says. 'They are the frontline professionals, the first base to connect and share. No matter how many boxes need to be ticked in a meeting, this is the most vital work – the connection between one another, helping others to believe they "can do" as well.

'These early connections make a way for parents, children and young people to open up and speak, be empowered and move forward. Now that is a privileged work to be a part of.'

A NEW PERSPECTIVE

Carrie has already tuned in to pressing concerns around workloads, down-banding and retention issues, especially among those brought in during the government's 'call to action', which sought to train 4200 new health visitors by 2015.

She says: 'I am looking forward to going into meetings with policy-makers and arguing the case from the patient perspective – I'm on the receiving end of this. They need to listen to what's happening on the ground.'

She is also committed to raising the profile of the CPHVA and the members it represents: 'I don't think people truly value or understand the work they do, unless they've had a really good personal experience with a health visitor or school nurse.'

Carrie herself credits an 'amazing health visitor' with spotting the signs of autism in her daughter when she was still a toddler: 'I thought she might be deaf or have problems with her hearing as she was covering her ears. My health visitor was a complete life-saver – she set me on the right road.'

And she is full of praise for school nurses who did everything they could to meet the needs of her daughter with Asperger's during her recent immunisations.

'Some school nurses have caseloads of thousands. As parents you think you're the only one – and that's how I was made to feel, which is incredible.'

Passion and ideas flow from Carrie as we speak – but underpinning it all is the desire to learn and understand.

'I really want to listen. I want people to get in touch – on Twitter, on email – to hear their stories, so I can advocate effectively for them.

'There's a lot out there that's not going right and needs to be challenged but, in spite of that, they are still able to do one of the most amazing jobs in the country.' CP

ALL ABOUT CARRIE GRANT

Carrie is married to singer, television presenter and vocal coach David.

HOW DO YOU RELAX?
'I take long baths, read, sew, chat to friends and have a date night with David.'

WHAT ABOUT YOU SURPRISES PEOPLE?
'My TV career is only a small part of my life – I have a rich and broad hinterland.'

DO YOU HAVE ANY AMBITIONS YET TO FULFIL?
'As I get older I feel more passionately about making sure people are empowered whatever situation they find themselves in.'

WHAT DOES A TYPICAL DAY CONSIST OF (IF SUCH A DAY EXISTS)?
'You are right, there isn't one! I get up really early to make sure the structure is in place to access services for my children. I normally have at least one meeting for one of them every weekday.

'My working hours are odd, so I may drive to Manchester for the evening and arrive home at 2am. *The One Show* can call the night before and ask me to fly to Glasgow the next morning.

'Weekends are sacrosanct. We run support groups at our home, so sometimes the house is full of people. It's a place of sharing and supporting one another.'

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Who's supporting mothers?

Services for maternal mental illness are emerging as the UK's secret shame. How can the situation be improved for new mothers, and what role can community practitioners play, despite the challenges faced? Journalist **Phil Harris** takes a look.

'One evening I asked my mum to babysit my eight-week-old son, went straight to my bedroom and took as many pills as I could, washed down with vodka.

'It felt blissful to be free of worry and in control for once. For a long time, absolutely nothing had felt positive. I had hit rock bottom. But suddenly I felt calm.

'Fortunately it didn't work.'

For Xanathia Woods, then just 20, having her son Jackson was not the time of overwhelming love and happiness she had expected, and her attempted suicide was the consequence of many months of undiagnosed and untreated perinatal mental illness.

'I developed anxiety when I was pregnant but didn't tell anyone, and no one really asked,' Xanathia recalls. 'Then I had a traumatic birth, and felt like I couldn't hold my son. I didn't bond with him. I told everyone I was fine, and I did what I was supposed to do, but it felt robotic.

'There was a constant battleground in my head. I told myself I was useless and that my son would be better off without me, and that I should die.'

Sadly, Xanathia's story is not unique, and perinatal mental health is an area where the numbers paint a revealing – and troubling – picture.

HEART OF THE MATTER

One in five women will develop a mental illness during pregnancy or in the 12 months following birth. This equates to around 160,000 women across the UK each year (National Records of Scotland, 2017; Northern Ireland Statistics and Research Agency, 2017; Office for National Statistics, 2017).

Some mental health problems are particularly common or linked to pregnancy and childbirth. This includes depression, anxiety, obsessive compulsive disorder, postpartum psychosis and postpartum post-traumatic stress disorder (PTSD). Depression is the most common maternal mental illness. Some women also develop eating disorders (Mind, 2017).

And the consequences can be grave. In December 2016, the third confidential enquiry into maternal deaths found maternal suicides to be the top cause of deaths occurring in pregnancy or up to a year after birth, with figures showing 111 women had taken their own lives between 2009 and 2014 (MBRRACE, 2016).

Despite all this, half of all cases of perinatal depression and anxiety go undetected, a report by the London School of Economics (LSE) and the Centre for Mental Health found (Bauer et al, 2014). Many of those that are detected fail to receive evidence-based forms of treatment. The report also said that specialist perinatal

mental health services are needed for women with complex or severe conditions.

In fact, across almost half the UK, pregnant women and new mothers have no access to specialist mental health services, and less than 15% of localities provide specialist services at the full level recommended in national guidance (RCOG, 2016).

'Sadly, health services are falling short when it comes to perinatal mental health, and it remains an unmet need,' says Unite in health lead professional officer Gavin Fergie.

COUNTING THE COST

As well as the human impact, perinatal mental health problems are costing the UK around £8.1bn each year – equivalent to £10,000 per birth – according to figures from the LSE report (Bauer et al, 2014). Nearly three-quarters (72%) of this cost relates to adverse impacts on the child rather than the mother.

The LSE report called on the government to spend an extra £337m a year to bring perinatal mental health care in the NHS up to the recommended levels.

Meanwhile, in 2016, Health Education England issued guidance for healthcare commissioners that called for the creation of new specialist health visitor posts in perinatal care, as part of efforts to end the 'postcode lottery of care'.

There at least appear to be signs the problem is being recognised. Last year, the prime minister pledged a £290m investment in the years to 2020, with the aim of helping at least 30,000 more women each year to have access to specialist mental health services (HM Government, 2016).

The incidence of reporting of perinatal illness doesn't even scratch the surface or the reality of the situation

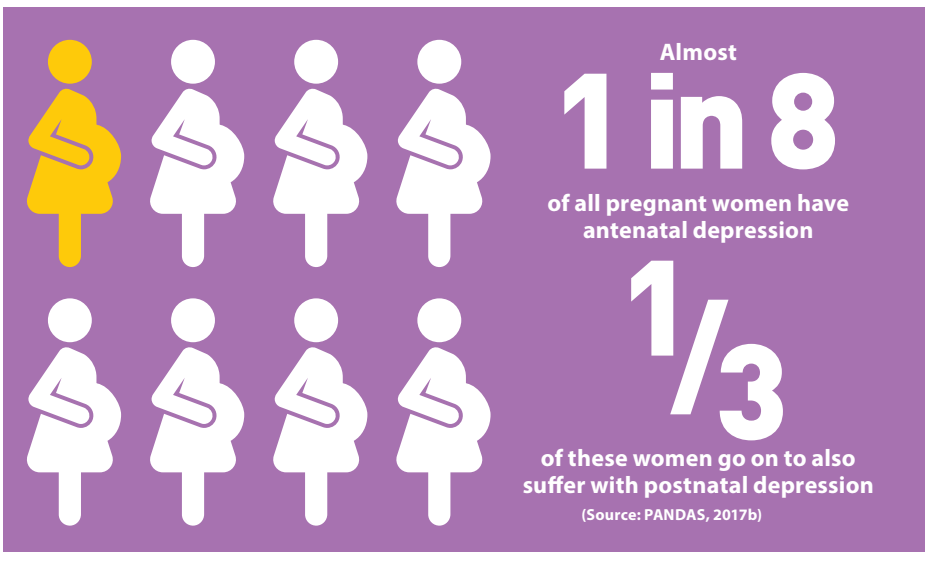
And in November 2016, NHS England chief executive Simon Stevens said that £40m is to be allocated to 20 areas of the country to fund new specialist community perinatal mental health services. Last month he announced four new dedicated mother and baby units for England, set to open in 2018 (NHS England, 2016).

WHAT'S GOING ON?

The current reality is that many women simply do not get help when they need it, for many reasons, according to Gavin.

'Of course all health services are under huge stress and financial pressures,' he says. 'Midwives and health visitors are stretched to the limit, and a five-minute GP appointment is unlikely to give enough time for a proper consultation.'

In fact, CPHVA research from 2015 found that 41% of health visitors thought their service did not adequately respond to postnatal depression. And now there are even fewer health visitors in the workforce (Unite-CPHVA, 2016).



Training to prepare professionals – or rather the lack of it – is another significant factor.

A 2017 survey by PANDAS and the CPHVA produced some stark truths on training and the consequences for practice. Nearly three-quarters of the health visitors and midwives who responded, both qualified and in training, reported they did not feel their current level of training on perinatal mental illnesses was sufficient (PANDAS, 2017a).

And in June this year a National Childbirth Trust (NCT) survey showed that nearly half (42%) of new mothers' mental health problems did not get picked up by a health professional, with over a fifth (22%) of women saying they were not asked about their emotional wellbeing (NCT, 2017).

Gavin says: 'The double whammy of austerity and lack of equity for mental health has really hit the service professionals can provide. In turn this impairs educational and training opportunities for community practitioners to enhance their skills.'

STIGMA STRIKES AGAIN

The reasons new mothers aren't getting the help when it's needed also go beyond lack of funds, resources and training.

'There is still lots of societal pressure about mental health, and it remains a strong reason why women might not want to seek help,' highlights Gavin.

'Society has also become more fragmented,' he continues. 'When there was less mobility, mothers probably had close family members to talk to and share their burdens. Now, work or financial pressures move people from these traditional ties.'

Stigma is a particularly acute problem for new mothers, according to Donna Collins, managing director of PANDAS.

Donna believes this means problems are significantly under-reported, with many women simply going without help or treatment, and desperately trying to cope with the illness alone and in secret.

She says: 'The incidence of reporting of perinatal illness doesn't even scratch the surface or the reality of the situation. Although much work has gone into breaking the stigma, unfortunately there is still an element of this, which is a barrier to people reaching out for help.

'There is also a common misconception that by speaking out, people will judge your

ability to parent, and therefore they may wish to take the child/children away from the family unit – and that simply is not the case.'

It's a view Xanathia recognises, however. 'For a long time I didn't want anyone to know I was struggling because I was very concerned about social services getting involved.'

Donna is reassuring: 'Social services and all the other elements that are supporting families do not want to break families up. They exist to find ways to keep the family together, and to support all of the individuals within that family.'

HANDS TIED

So how can community practitioners improve the situation for new mothers? Lack of resources means there is no easy answer, according to Su Lowe, a health visitor and West Midlands health-visiting representative for Unite-CPHVA.

'Health visiting thrives on early intervention and screening' says Su. 'Building relationships enables practitioners with high-level specialist knowledge to spot signs of deteriorating mental health or circumstances at the earliest opportunity.

'By nurturing and supporting mothers we are adept at ensuring that they have an awareness of their mental wellbeing and they know when and who to go to for support. But there are less of us now, and so services are struggling.'

Su also believes that health-visiting service cutbacks to the minimum five mandated contacts have erased quality contact, relationships and support. 'There is so much more to a universal perinatal mental health assessment than a list of questions from a stranger at a half-hour contact,' she says.

Likewise, after their survey in June, the NCT called for more funding for GP checks so that new mothers get a GP appointment to address their health, not just the baby's.

'While not all mothers seek help, if they do, services need to be available, appropriate and accessible,' says Su. 'This is not always the case when our mental health teams are triaging and booking therapeutic interventions weeks later as they struggle to fund their services. Mothers are feeling let down.'

Su points out that many services have also lost the postnatal groups and breastfeeding support in communities, where often signs and symptoms could be spotted or even prevented by local peer support.

'People learn from each other and in a supported environment, a disclosure to friends by a mum that she may have survived postnatal depression and no one removed her baby or questioned her parenting ability can go a long way to removing stigma.'

SPOTTING RED FLAGS

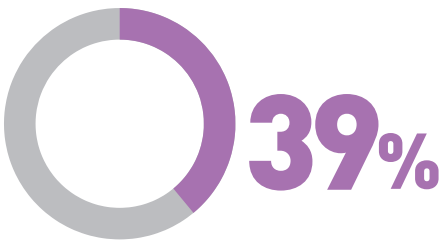
There are some 'red flag' signs for severe mental illnesses. If you encounter any of the following then urgent psychiatric assessment should be arranged:

- Recent significant change in mental state or emergence of new symptoms
- New thoughts or acts of violent self-harm
- New and persistent expressions of incompetency as a mother or estrangement from the infant.

(Source: MBRRACE-UK, 2016)

MORE TRAINING, PLEASE

of health visitors and midwives said they had received no more than one to three hours of formal education about perinatal mental illnesses during initial training



don't feel they have the appropriate skills and knowledge from diagnosis to referral for treatment and follow-up appointments

do not feel confident talking to women about mental illness

(Source: PANDAS, 2017a)

POSITIVE STEPS

Su thinks there are steps practitioners can take, such as learning about and using as many local resources as possible.

Michelle Ostrowski, a health visitor working in Shropshire, agrees. While Michelle has been 'quite fortunate in that our area has invested heavily with supporting mothers with PND and giving us training', she offers the following advice.

'Seek out any study days you are able to attend, even if that means self-funding (within reason), as this will give you skills and more confidence supporting mothers' mental health.

'You can join Twitter to find a wealth of professionals and support groups at your fingertips. You can also find out what support groups are available locally for mothers and how to access them.

'It's also important to seek supervision for yourself. If you are doing listening visits without good headspace, how much support are you able to give?'

Su also advises challenging trusts and commissioners to change practice to ensure health needs are met.

Su says: 'We have evidenced that a comprehensive quality health-visiting service supports women and prevents mental ill health from affecting mother and child adversely. With the right intervention

at the right time by the right service we are in a unique position to observe parent-child interactions and intervene and support appropriately.

'Perinatal mental health affects the next generation, not just the mother suffering here and now. By reducing services we are risking the mental health and wellbeing of our grandchildren.'

MAKING A DIFFERENCE

After her suicide attempt, Xanathia decided she needed to seek help. This came in the shape of Cheryl Hale from East Coast Community Healthcare's family nurse partnership (ecch.org).

Xanathia says: 'Cheryl was lovely and warm right from the start, and keen to help however she could, but I put up a front. Thankfully Cheryl persisted and eventually the walls broke down.

'She was quick to pick up on what was going on and never stopped contacting me. She took me to the doctor and helped me to express how I was feeling, and made me challenge the way I had been thinking.

'Cheryl also organised so much. She helped to arrange cognitive behavioural therapy and got a mental health youth worker to help me. She also helped sort funding for Jackson to go to nursery to give me time and space to recover.'

Xanathia was diagnosed with postnatal depression, anxiety and PTSD, and started on the road to recovery. She has since gone on to have a daughter, and although she was worried about developing depression again, she feels she had the tools to cope and knew the warning signs to look out for.

She came off medication almost two years ago and is enjoying life with her young family. She is fully aware of the value of the professional support she received.

'Cheryl saved my life, without a doubt. She helped me through it and taught me how to see things in a different light, to talk about how I feel and that it was ok. She was the positive among all the negative.'

And that kind of impact on mothers' lives shows just what is possible. CP

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MATERNAL MENTAL HEALTH SERVICES ACROSS THE UK

According to Gavin Fergie, Unite in health lead professional officer, the situation and prospects in Scotland are slightly better for maternal mental health care than in many parts of England and Northern Ireland, as both of these administrations have been more affected by cuts and austerity than the rest of the UK.

He says: 'It could be argued that as Wales and Scotland move towards their increased contact points with mothers that they can develop their knowledge of and relationship with the mothers on their caseload.

'With increased contact, hopefully a therapeutic relationship can develop where the mother feels more at ease to raise their feelings with a trusted professional rather than with someone who visits once.'

However, the provision of specialist services is very limited in some areas. Wales and Northern Ireland do not have any specialist mother and baby units, meaning that mothers have to travel long distances for treatment where they can stay with their child.

RESOURCES

There are lots of online resources on maternal mental health, both for health professionals and to offer to women, including:

Health Education England: Produced a perinatal mental health care skills competency framework to support professionals **bit.ly/HHE_professional**

The Maternal Mental Health Network: A network for health professionals, with resources and a secure discussion forum **maternalmentalhealth.org.uk**

Mind: Details on perinatal mental health issues, including treatment, support and advice **bit.ly/Mind_perimental_health**

PANDAS: Information and support for women with perinatal mental health problems, including peer support groups **pandasfoundation.org.uk**

PND & Me: Online network for women with postnatal depression **pndandme.co.uk**

Getting to the bottom of nappy rash

Most babies get nappy rash at some time and around a third of nappy wearing infants are likely to have nappy rash at any one time[1].

It's usually a mild condition which can easily be treated, but understandably may be a worry to parents. The key feature of nappy rash is a pink or red rash around the nappy area.

There are a number of 'trigger' times when infants are particularly prone to nappy rash. A survey identified seven 'trigger' times when parents believed their child was more prone to nappy rash[1].

NAPPY RASH TRIGGER TIMES

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

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

SKINCARE ADVICE

Good skincare advice has a key role in both treating and preventing nappy rash. Recommending these simple steps will help[1]:

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

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

THE METANIUM RANGE – HERE TO HELP

Metanium Everyday Easy Spray Barrier Lotion is the latest addition to the Metanium family. In a handy, easy-to-use spray, Metanium Everyday Easy Spray forms a barrier to protect delicate skin from irritants like urine and faeces that can cause nappy rash. Two sprays should be enough to protect the skin to form a thin protective layer. Pat around the area to maximise coverage. No need to rub in. Easy Spray has a unique, water-free formulation to create an effective barrier against irritants. Both urine and faeces contain water, so any water-based formulation is unlikely to offer sufficient protection from nappy rash.

Metanium Everyday Barrier Ointment has both a protective and moisturising formula to provide daily protection from nappy rash and is gentle enough to use every day and at each nappy change. If nappy rash does strike, then Metanium Nappy Rash Ointment is licensed specifically to treat nappy rash. Metanium Nappy Rash Ointment is a medicine and is listed on the Nurse Prescribers' Formulary for Community Practitioners.

Most cases of nappy rash only cause mild symptoms and the community practitioner has a valuable role to play in advising parents about skincare routines, as well as prescribing or recommending an appropriate barrier ointment.

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A new type of CARE

More premature babies are surviving, but with complex health needs. Community practitioners play a vital role in giving support, says journalist **Anna Scott**.

The positive facts: two large-scale pieces of research in recent months have said that the outlook for premature babies is improving.

A US study (Younge et al, 2017) found that survival rates for extremely premature babies born between 22 and 24 weeks of pregnancy are showing small but measurable improvements compared to those born a decade earlier. Not only did 36% of infants born between 2008 and 2011 survive compared to 30% of those born between 2000 and 2003, but the proportion of babies living without moderate or severe neurological impairments also improved over the 12-year study from 16% to 20%.

A French study (Pierrat et al, 2017) looking at similar data found that 80.5% of babies born between 22 and 34 weeks in 2011 survived without severe motor or sensory impairments compared to 74.5% born in 1997, and that survival rates had increased most for those born earliest.

DEVELOPMENTAL ISSUES

More premature babies may be surviving and living longer – especially those born extremely preterm – but they are also presenting with particular needs, ones that health visitors and community nursery nurses need to be aware of.

Premature babies often have a difficult time in intensive care and may face challenges when they go home

'Developmental delays are common among children who were born before 28 weeks of gestation,' says Noelle Younge, assistant professor of pediatrics at the Division of Neonatology, Duke University Medical Center, North Carolina, and co-author of the US study.

'Some of these extremely premature infants have mild developmental delays in early childhood and will catch up to their peers by school age, while others have persistent developmental problems, including cognitive delays, problems with motor development including cerebral palsy, and vision impairment. Each of these neurological or developmental problems can range from mild to severe.'

Extremely premature babies also often have a difficult time during their stay in intensive care, so even those born without significant developmental delay may face a range of challenges when they go home, adds Andrei Morgan, post-doctoral fellow at EPOPé at CRESS, Paris, and co-author of the French study.

'Feeding is a common issue, and children born before 32 weeks are often smaller than they might have been otherwise,' says Andrei. 'Similarly, they may be more prone to infection due to less-developed immune systems when they were born. As the children get older, more subtle problems may become apparent. For example, there is a higher rate of hyperactivity and attention deficit among those born preterm. Some of these risks and challenges may be mitigated if there is sufficient support available to the child,' he says.

LATER LIFE ISSUES

Children's charity Action Medical Research is funding a variety of research projects into the issues premature children face as they grow up, including anxiety. Dr Tracy Swinfield, the charity's director of research, explains: 'Many children who were born very prematurely, before 32 weeks of pregnancy, have learning difficulties, and babies who are born this early are also thought to be nearly twice as likely to have problems with anxiety during adolescence. They're also more susceptible to some health problems during adulthood, such as high blood pressure and diabetes.'

These kind of lifelong issues faced by the 9522 babies born in the UK each year before 32 weeks of pregnancy will become apparent to community healthcare professionals caring for premature babies and their families (Public Health Intelligence Unit, 2016; Office for National Statistics, 2016; ISD Scotland, 2015). The 49,453 babies born moderate to late preterm – between 32 and 37 weeks – also potentially face a range of health issues, but any complications typically decrease the longer the gestation period (Public Health Intelligence Unit, 2016; Office for National Statistics, 2016; ISD Scotland, 2015). They and their families often still require emotional and practical support from community healthcare professionals.

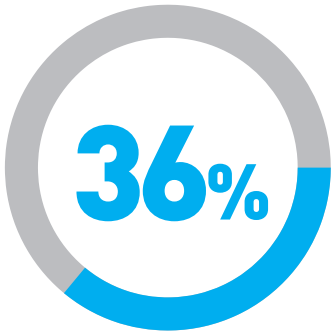
EMOTIONAL SUPPORT

'Following discharge from the neonatal unit, the preterm baby's health and development needs to be closely monitored,' says Zoe Chivers, head of services at the premature and sick baby

PREMATURE BABIES

58,975

The number of babies born prematurely each year in the UK



The rate of severely premature infants born in the US in 2008-2011 who survived – compared to 30% of those born in 2000-2003

(Sources: ISD Scotland, 2015; Office for National Statistics, 2016; Public Health Intelligence Unit, 2016; Younge et al, 2017)

SHUTTERSTOCK/ISTOCK

charity Bliss. 'It's important for health visitors to empathise with the parents of premature babies by keeping in mind that they have just been through the emotional rollercoaster of having a child in hospital.'

In practice this means supporting the family through any emotional or mental health concerns they may have, providing continued support to them and validating their parenting skills. Zoe says that while offering support to families might feel tricky when 'the parents are experts in the medical conditions of their baby', health visitors 'can play a major role.'

The team lead for children's disability nursing at NHS Greater Glasgow & Clyde, who also has a health visiting background, agrees that community practitioners need to be very involved in providing early support to parents and developing trusting relationships through which they can recognise and respond to concerns.

'The emotional impact of surviving a premature experience is huge and parents experience anxiety when coming home from a supportive hospital environment where staff have provided direct care to parents who now have sole responsibility for that care,' she says. 'They will have to learn new skills, some of which may be quite complex and technical, in order to care for their child.'

Health visitors are ideally placed and can play a major role in providing emotional support to parents, 'and help to reduce their anxieties and manage their range of emotions, which may include shock, fear, grief, love, joy, blame and guilt', says Lindsay Bevan, health visitor practice teacher from the Preston Central Team, Children and Young People's Wellbeing Network, Lancashire Care NHS Foundation Trust.

PRACTICAL SUPPORT

Health visitors can also help parents with premature babies still in hospital. 'Parents may experience financial difficulty and need time off work,' says Lindsay. 'They may also have issues travelling to and from the hospital, especially if the baby has been transferred to another hospital which is a significant distance from the family home. Parents who have other children will often express feelings of guilt that they are away from their other children for long periods and may experience problems in finding childcare when visiting the hospital.

'The health visitor can also provide information on preparing the home environment for the baby, and advise around issues such as room temperature and appropriate clothing.'

Premature babies will often require closer monitoring of their weight, so health visitors should be available to provide support regarding a variety of issues such as feeding (particularly for mothers who are expressing milk), promoting development (including infant brain development), immunisation, safer sleeping guidelines, car seat safety and reducing the risk of infection. 'Practitioners are also vital in signposting parents to organisations where they can access help, advice and support,' adds Lindsay.

Health visitors are ideally placed and can play a major role in providing emotional support to parents

COMPLEX CASELOADS

All this of course means an increase in workload for community practitioners. 'And when we consider babies who have complex or exceptionally complex health needs as a result of their prematurity, these children and their families will require a high level of support throughout their lives,' says Lindsay.

So health visitors and community nursery nurses need to be aware of the risk factors associated with prematurity, while also recognising that parents are the experts in their child's care. However, community practitioners will be expected to be as involved in particular family situations as much as they feel is necessary, depending on the needs of the baby and the family. 'Many families will receive support from hospital outreach teams when their baby is first discharged home, and they will take the lead on the baby's care,' says Lindsay.

ISTOCK

NEED TO KNOW

Premature babies may be discharged from hospital with a range of health issues and conditions that are documented on their discharge letters, including:

Bronchopulmonary dysplasia (BPD) A long-term lung condition caused by scarring to the lungs, with symptoms of rapid, shallow, breathing and shortness of breath.

Hypoxic-ischemic encephalopathy (HIE) Lack of oxygen and/or blood flow to the baby from the placenta during birth that can damage the brain and hypoxia can also affect the lungs, liver, heart, and kidneys. Symptoms include being hyper-alert, irritable, eye-rolling and abnormal movements.

Intrauterine growth restrictions (IUGR) A condition in which the baby's growth slows or stops in utero, often caused by placental failure. Usually diagnosed during antenatal appointments.

Necrotising enterocolitis (NEC) The wall of the intestine is invaded by bacteria, which cause local infection and inflammation that can ultimately destroy the wall of the bowel (intestine). Such bowel wall destruction can lead to perforation of the intestine and spillage of stool into the infant's abdomen.

Neonatal respiratory distress syndrome (NRDS) Other names include hyaline, membrane disease and surfactant deficiency lung disease. NRDS occurs when babies don't have enough respiratory surfactant (proteins and fats) to keep the lungs inflated. Symptoms include blue-coloured lips, fingers and toes, rapid, shallow breathing, flaring nostrils and a grunting sound when breathing.

Retinopathy of prematurity (ROP) Associated with excessive oxygen during the early weeks of a premature baby's life causing retinal blood vessels to grow too quickly.

Respiratory syncytial virus (RSV) A virus causing cold-like symptoms which can cause breathing difficulties if lungs are affected.

Small for gestational age (SGA) Birthweight that is lower than 90% of babies of the same gestational age.

(Sources: Bliss, 2017; Children's Hospital Los Angeles, 2017; NHS Choices, 2017; Tommy's, 2017)

'They will provide advice around many clinical issues such as giving medications, monitoring baby, resuscitation and tube feeding. Health visitors provide more family-centred care to ensure that the families' social and emotional needs are considered, and will continue to provide support where required when the baby has been discharged from outreach care.'

What is particularly important is that parents are informed, involved and supported in all aspects of their babies' care and decision-making.

As neonatal research continues to examine improvements to long-term outcomes and to the care provided to premature babies during and after their tay in hospitals, community practitioners play an essential role in ensuring they understand how they can best care for children and their families. CP

• For more on the subject, read the *Community health professionals' information guide* at bit.ly/Bliss_CP

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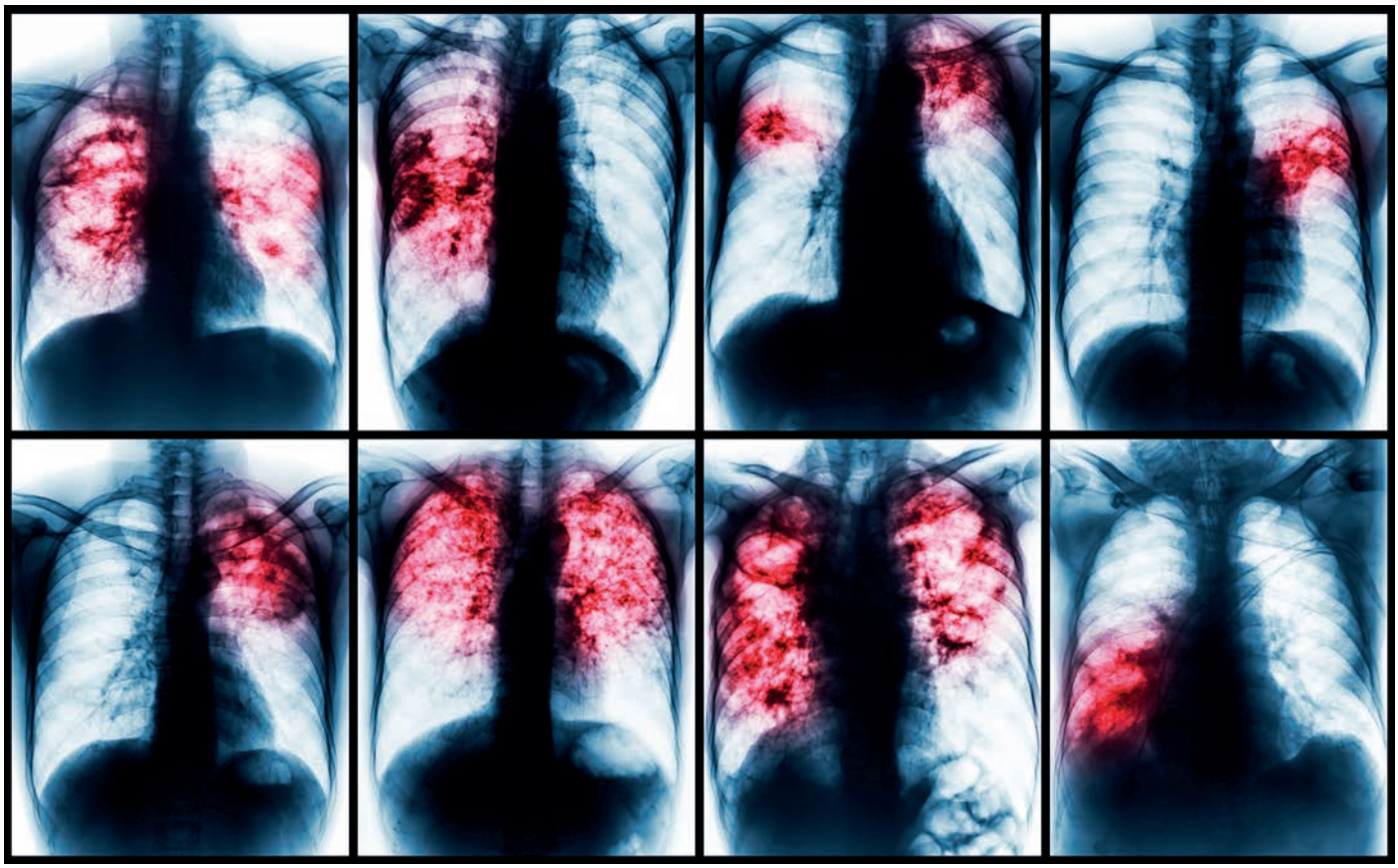
A GHOST FROM THE PAST

Tuberculosis is still rife in some parts of the community. But even where it remains rare, community practitioners need to be alert to its seriousness.



Tuberculosis (TB) is perceived as a disease of the past – an illness harking back to Victorian Britain associated with images of gaunt patients dying in impoverished surroundings. It was an insatiable killer then and is still potentially fatal.

In the UK, cases of TB became much less common in the mid-1980s but saw a resurgence in the following two decades (TB Alert, 2017). And while the past four years have seen a decline in rates – in England, there were 5758 cases in 2015 compared with 8280 in 2011, according to Public Health England (PHE) (2016) – the UK still has one of the highest levels of incidence in Western Europe.

'A lot of people, healthcare professionals included, are unaware of the real picture of TB in this country,' says Gini Williams, nurse consultant for the charity TB Alert and a former health visitor.

'Many believe it to have been eradicated, but it never has been. And it is a serious and painful bacterial disease. The fear of it is still rife.'

URBAN RISKS

The reason that awareness of the disease can be patchy is because it is less common in some parts of the UK than in others. It tends to be concentrated in large urban areas, says Gini. A staggering 40% of TB

cases in England are found in London, one of the highest rates in a capital city in Western Europe (PHE, 2016). This is possibly connected to higher levels of homelessness, drug and alcohol use in cities.

Around the UK, many areas have dedicated TB services and in Scotland and England, coordinated national strategies are in place to reduce TB incidence. The *Collaborative tuberculosis strategy for England 2015 to 2020*, developed by PHE and NHS England, improves access to services – ensuring early diagnosis – and screening. It also set up seven TB control boards.

'It's an important and much-needed national response,' says Gini.

However, what shouldn't be overlooked is the role of community practitioners in helping to curb TB cases and expedite treatment.

A KEY ROLE IN IDENTIFICATION

'Health visitors, community nurses and school nurses are those well placed to spot the signs early, which is key to timely treatment and preventing onward transmission. So practitioners need to have a good knowledge and awareness of TB,' she advises (see box on page 36). Even in areas where there may be just a handful of sufferers, practitioners need to stay alert to the problem, she warns.

Those at greatest risk of TB include people who come from or have spent time in places with high levels of TB such as Africa, South-east Asia, China, Russia and Eastern Europe (NHS Choices, 2016). In England, the rate of TB in the population not born in the UK is 15 times higher than in the UK-born population, and 73% of all TB cases notified in 2015 were born abroad (PHE, 2016).

'Globalisation means people are travelling or moving from high-incidence countries to different parts of the UK. So TB can develop anywhere, not just in the big cities,' says Gini.

Plus TB bacteria can actually lie dormant (see panel, right) in the body without causing any symptoms and reactivate at any time. 'That could happen in weeks or years – there is no way of knowing when it might develop into illness.'

Community practitioners' first responsibility is to investigate levels of TB in their area, Gini advises, and then find out about local

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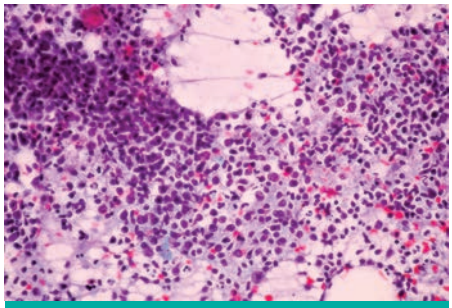


TB – THE LOWDOWN

What is TB?
TB develops when *Mycobacterium tuberculosis* bacteria are inhaled into the lungs, causing infection. TB can spread within the lungs (pulmonary TB) or to other parts of the body (extrapulmonary TB). The infection can be controlled by the body's immune system. However, the inactive bacteria can remain latent for months, even years, before developing into illness.

Is it infectious?
It spreads between people in close contact spending prolonged periods together. The risk of infection is very low where contact is brief.

Symptoms
Common symptoms are a cough for three weeks or longer – which may be bloody – weight loss, loss of appetite, high temperature or fever and lack of energy. Extrapulmonary symptoms include swollen throat, aches and pains in joints and severe headache.

Diagnosis
Tests for TB include chest x-rays, sputum tests and scans. The Mantoux (or tuberculin skin) test is also used.

Treatment
Usually, a combination of antibiotics is taken for at least six months. The emergence of TB strains resistant to drugs is an increasing problem worldwide.

Prevention
The BCG vaccine doesn't stop someone being infected but it stops the illness progressing. It should be offered to key eligibility groups.

(Sources: NHS Choices, 2016; The Truth About TB, 2017; WHO, 2017a)

TB can be associated with being poor or dirty, so people can feel reluctant to admit they are suffering symptoms. Health visitors can help dispel those myths

TB services. So how might a health visitor support a family with possible TB symptoms? Being able to spot the signs is essential.

SIGNS AND SYMPTOMS

'A health visitor needs to be aware of the general health of all the people living in that household, not just a child's. So it's about being vigilant, noticing when a person may be coughing persistently or if a family member hasn't been well for a while, then sensitively asking questions such as whether they have seen a GP and what treatment they have been given,' says Gini.

'It's worth also bearing in mind social risk factors such as a history of drug misuse, alcohol misuse, poor diet, homelessness or imprisonment – although TB can affect anyone.'

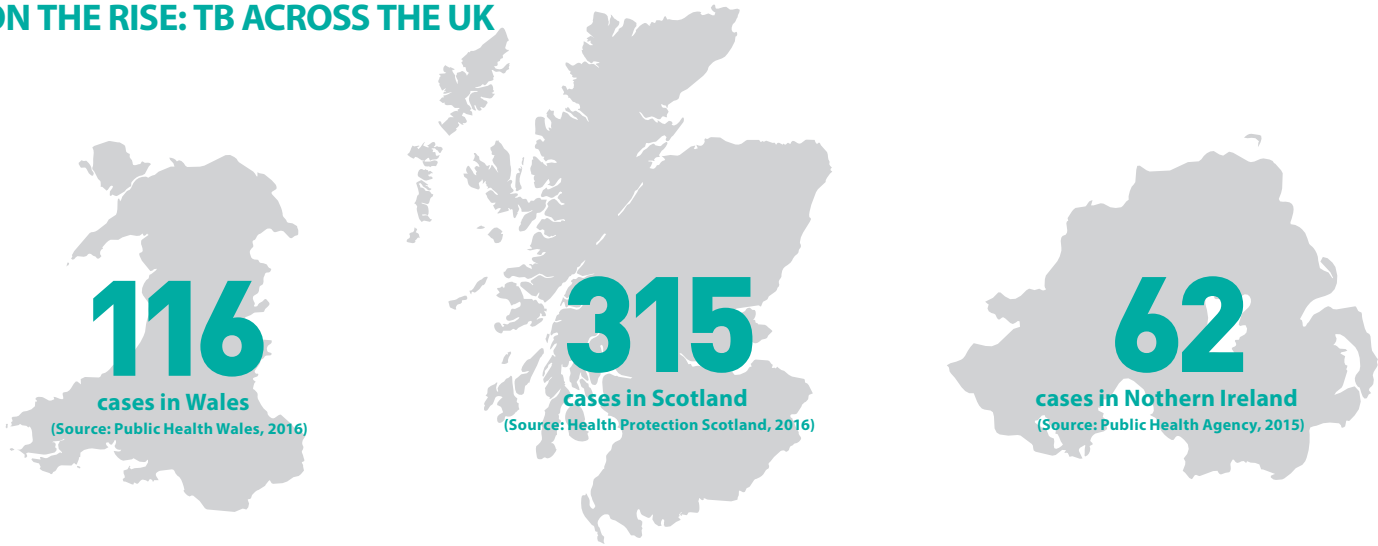
Typical symptoms to look out for include an unresolved cough, or coughing up blood, fever, night sweats, loss of appetite and rapid weight loss for no apparent reason, advises Gini.

School nurses and nursery nurses should similarly be aware of symptoms and not overlook possible signs from teachers or staff, she adds. Wherever a case of TB is suspected, the next step will be to contact either the GP or the local TB service.

TREATMENT AND CARE

Catherine Mullarkey is senior TB health visitor with Leeds Community Healthcare NHS Trust. She works as part of the local TB nursing service that comprises both specialist nurses and health visitors. She explains that treatment for TB requires a combination of drugs – commonly, isoniazid, rifampicin, ethambutol and pyrazinamide. Since the course lasts six months, this can take its toll on patients.

ON THE RISE: TB ACROSS THE UK



'Specialist health visitors and nurses are vital at this time to ensure patients are completing their treatment. By visiting them we can see first-hand some of the barriers they may face in taking their medication, such as a chaotic lifestyle, and can help deal with some of the problems.

'Some people feel quite unwell and need support. Or they may need help with side effects such as nausea, for which we can make sure they are prescribed an antiemetic.'

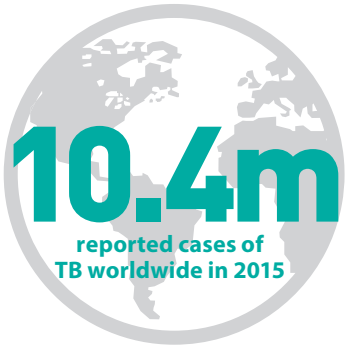
SOCIAL STIGMA

'There is still a big social stigma around TB,' Catherine says. 'It can be associated with being poor or dirty, so people can feel reluctant to admit they are suffering symptoms. Health visitors can help dispel those myths and encourage people to come forward by promoting the message that anyone can get TB.'

Community practitioners should also be aware of who is eligible for the BCG vaccination and TB screening – for example, new entrants to the UK from high-incidence countries. 'Cases may be reducing,' Catherine says, 'but we need to work hard at eradicating it. That's the aim, anyway.'

Scientists at Oxford and Birmingham made a breakthrough towards this goal earlier this year, when they succeeded in isolating different strains of the disease using genome sequencing. This quick diagnosis means that patients can begin their recovery straight away. This prompted health secretary Jeremy Hunt to say: 'We can move closer to what we all want, which is to eradicate TB from the shores of the country.'

The discovery is all the more welcome after experts have warned that a rise in drug-resistant strains of TB is endangering the ultimate goal of eliminating the disease. CP



with

1.8m

dying from the disease

(Source: WHO, 2017b)

RESOURCES

- **thetruthabouttb.org**
  A resource to direct patients to, plus a dedicated professional section
- **bit.ly/health_matters_TB**
  PHE's professional resource on the actions that can be taken to reduce TB
- **bit.ly/HPS_TB**
  TB facts from Health Protection Scotland
- **bit.ly/HSC_TB**
  TB information from Public Health Agency Northern Ireland
- **bit.ly/PHW_TB**
  Facts on TB from Public Health Wales

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Using the NICE guidelines to manage frequent infant regurgitation with marked distress

BASED ON NICE GUIDELINE [NG1], JANUARY 2015[1]

FOR HEALTHCARE PROFESSIONAL (HCP) USE ONLY

IN BREAST-FED INFANTS WITH FREQUENT REGURGITATION AND MARKED DISTRESS NATIONAL GUIDELINES RECOMMEND:[1]

Trained professional carry out a breastfeeding assessment and provide advice

With persistent regurgitation, consider trialling alginate therapy for 1-2 weeks

IN FORMULA-FED INFANTS WITH FREQUENT REGURGITATION AND MARKED DISTRESS NATIONAL GUIDELINES RECOMMEND:[1]

a **ASSESS**
Assess feeding history and reduce feed volume if excessive for infant's weight

S **SMALLER, MORE FREQUENT FEEDS**
Trial smaller, more frequent feeds (while maintaining an appropriate total volume of daily feed)

T **THICKENED FORMULA**
Trial a thickened formula (e.g. containing rice starch, cornstarch, locust bean gum or carob bean gum)

Thickened formulas have different preparation and teat requirements to regular formula

A **ALGINATE THERAPY**
If the stepped-care approach is unsuccessful, stop the thickened formula and trial alginates for 1-2 weeks

R **RE-ASSESS**
If alginates are successful, continue use but stop at intervals to assess recovery

DIAGNOSIS CRITERIA FOR INFANT REGURGITATION:[2]

2+ TIMES PER DAY **FOR** 

3+ WEEKS without the presence of symptoms*

Infant regurgitation is frequently confused with Gastro-Oesophageal Reflux Disease (GORD), which is less prevalent, more serious and may require specialist referral[1,3]

Look out for **'red flag'** symptoms, which may suggest disorders other than FGIDs:[2]

- Projectile vomiting
- Appearing unwell
- Retching
- Hematemesis
- Aspiration
- Apnea
- Failure to thrive
- Feeding or swallowing difficulties
- Abnormal posturing

For further information, downloadable resources and e-learning visit **www.eln.nutricia.co.uk/reflux-regurgitation** or contact our HCP helpline on **0800 996 1234**.

NUTRICIA
Early Life Nutrition

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*As defined by the Rome IV diagnostic criteria for functional gastrointestinal disorders

The path to positive learning

Good-quality placements enhance student nurses' understanding of illness in the community. **Amy Noakes** highlights how all parties can build beneficial learning opportunities.

Community placements provide valuable learning experiences by enabling students to gain an insight into the background to health status. The government is also currently emphasising – in *Transforming primary care* (Department of Health, 2014) and *Five year forward view* (NHS England, 2014) – the transfer of patient care away from the acute setting and closer to home, aiming for hospitals to be more available in providing specialised and acute care. This denotes a need for student nurses to be further prepared in caring for patients out of the hospital setting.

The Willis Commission (2012) identified the difficulties in obtaining good-quality community placements for student nurses, yet pre-registration nursing commissioning numbers have expanded. This makes clear the need to ensure the drive for greater capacity of community placements is balanced with adequate support for student nurses' learning needs. This article aims to provide consideration of preparation and support for students and mentors within the community setting, enhancing this valuable student learning experience.

WHAT CONSTITUTES A COMMUNITY PLACEMENT?

The NMC (2010) considers a community placement to constitute time spent learning and experiencing care provided outside the acute hospital setting. Temple (2013) has highlighted the difficulties of defining what constitutes a community nursing practice setting. This is due to rapid changes in community nursing, as well as the need to expand student placements to a greater variety of settings due to capacity issues. Temple therefore indicates that the only aspect that categorised a placement as 'community' was a setting that does not encompass a prolonged inpatient hospital stay. This highlights that the community setting is moving away from the traditional image of solely community nurses such as health visitors or district nurses, and transferring to an out-of-hospital experience. A community placement could therefore encompass the following environments:

- Hospice care
- Specialist services such as neonatal or Macmillan nurses
- Respite centres
- Care homes
- General practice
- Health visiting
- Community children's nursing teams
- Children's centres
- School nursing
- Outpatient services
- Pre-assessment services
- Continuing care services
- Virtual hospital services
- Day surgery settings
- Community hospitals
- Walk-in centres
- Minor injury units.

ISTOCK

Mentors should endeavour to facilitate learning by explaining aspects clearly, and encouraging reflection and questioning

With such a variety of placements being provided within the community, it is important students are able to adapt to these environments, while also being fully equipped for the experience.

WHY ARE GOOD-QUALITY COMMUNITY EXPERIENCES IMPORTANT FOR STUDENTS?

The NMC (2010) standards for pre-registration nursing education identify the need for practice placements to provide diverse learning opportunities within a multitude of health and social care environments, including the community. This was supported by the Willis Commission's *Raising the bar* review (2015), where the need for community placements to occur throughout nurse training was emphasised.

Health Education England, higher education institutions and the NMC have been collaboratively trying to meet the recommendations of the Willis review to improve pre-registration nursing education and encourage positive practical learning environments. This includes a proposal regaling changes to the structure of nursing education programmes and mentorship. It is therefore recognised that innovative methods of mentoring students in the community must be employed to provide good learning opportunities and support students in completing their nurse training (Perrin and Scott, 2016).

Technological enhancements have enabled patients to live longer; however, this has meant more patients are living with co-morbidities, requiring complex care interventions (RCN, 2014). Students need to have greater awareness of this as nurses possess a fundamental role in coordinating care pathways post-discharge and implementing the reform to encourage care at home. Community placements also provide valuable student learning opportunities because of the ability to gain understanding of services available outside of the acute setting, in addition to recognising how policy and guidelines are implemented within this environment. Students are also able to gain a multitude of transferable skills, including communication, teamwork and some comprehension of the concept of health promotion and lifespan development.

It is hoped that by providing more community placements, the stereotypical image of nurses working within the hospital-based setting could be changed. It is also envisaged that this will increase the workforce within this environment, particularly as an NHS census showed a 10.7% (29,689) increase (to 307,692) in the qualified nursing workforce within the community between 2003 and 2013 (Health and Social Care Information Centre, 2014). A survey by the RCN (2012) showed that nurses in the community felt reduced capacity and increased caseloads applied additional pressure on nursing teams. This survey revealed that 86% of the 2219 participants thought patients were discharged from hospital more quickly than before, and 92% considered that staff were dealing with more complex health needs. Encouraging good-quality student placements could help reduce this deficit and fully equip students to work within a transformational environment, enhancing confidence to apply for community positions post-qualifications.

WHAT ARE THE SUPPORT REQUIREMENTS WITHIN COMMUNITY PLACEMENTS?

When stress and anxiety are reduced for both the mentor and student, practice environments become more beneficial to learning (Miller, 2014). It is therefore necessary to ensure that support needs within placement are considered. Factors affecting student enjoyment of placement are multifaceted in respect of the placement environment, the student, the mentor and link lecturer (university representative who acts as a connection between the university and placement). Suggestions of ways to

provide support and enhance student enjoyment are presented below.

Placement environment

The breadth of experience available within the practice learning environment has been recognised as a possible impact to student learning (Emanuel and Pryce-Miller, 2013). This can be aided by a thorough initial interview, with a discussion between the student and mentor regarding their aims for the placement setting, appropriate objectives and identifying how these will be reached.

Student inclusion within the placement area can impact their enjoyment and ability to learn; for example, a space to sit within the office environment and access to computers can enhance students' feelings of purpose (Papp et al, 2003). An environment that is unstructured and not inclusive can lead to students feeling unsupported, which impacts on their learning.

There is a need for community health providers to support both the mentor and student as it has been shown that mentors who feel their workload is excessive experience greater difficulty in supporting students (Kenyon and Peckover, 2007). This can potentially impact on the quality of their placement. Therefore, adequate time should be made available to ensure the mentoring role can be undertaken thoroughly.

The mentor

The mentor's knowledge and how this is imparted can greatly affect students' learning: those who possess a positive attitude towards students are considered to provide better placements (RCN, 2009). This is particularly important within the community because students could be working solely with the same individual for the majority of their placement. There is a need for mentors to be supportive via encouraging teaching and involvement within the placement.

Mentors should endeavour to facilitate learning by explaining aspects clearly, encouraging reflection and questioning, and organising a variety of experiences related to the placement (Foster, 2015). Students have reported that they enjoy a participatory role as much as possible, rather than an observational role (Tattam, 1991). However, there may be difficulties for practice areas in which the nurse's role chiefly revolves around communicating with patients/clients, rather than practical skills, and so post-visit reflections should be encouraged.

Willis (2015) identifies student feedback as key to ensuring a positive and high-quality learning environment. It is therefore crucial that mentors review the feedback provided to them via students, and an action plan for improvement is constructed, as necessary, to ensure continual improvements.

The student

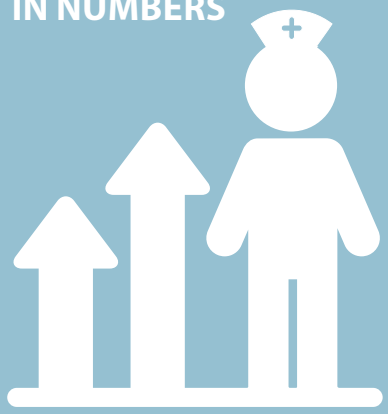
The students' approach to the placement can influence their enjoyment and ability to learn. The placement needs to be perceived as relevant to the student to enhance their learning. Student preparation for practice sessions within university can assist not only in respect of placement expectations, but also in relating the relevance of the placements to themselves. Thus it is encouraged that students should arrive at the placement with a positive attitude, ready to learn and gain a greater view of the context of health. Wilson (2015) points out that, to make the most out of a placement, it is important to recognise that every patient experience is valuable; due to the speciality of a community placement, this could be the sole opportunity to work with this client group, and therefore motivation and ability to reflect are paramount.

A professional attitude to placement, according to the NMC guidance on conduct for students (2012), should be maintained throughout. Students should treat others with dignity and honesty, and collaborate to promote the wellbeing of clients/patients, in addition to providing a high standard of care within their limitations. Students' personal preparation for practice, by reviewing current literature in respect of the placement, can also emphasise the placement relevance to individual nursing knowledge.

The university

Students and mentors consider the link lecturer role a key communication conduit between practice and university. The role is harder to deliver within the community because of the dispersed locality of placements. It is therefore necessary that the link lecturer is easily contactable by and readily available to provide support

COMMUNITY NURSING IN NUMBERS

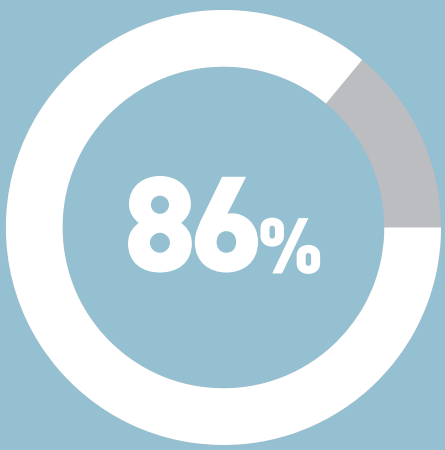


10.7%

The increase (of 29,689) in the qualified nursing workforce within the community between 2003 and 2013 (to 307,692)

(Source: Health and Social Care Information Centre, 2014)

Thanks to community placements,

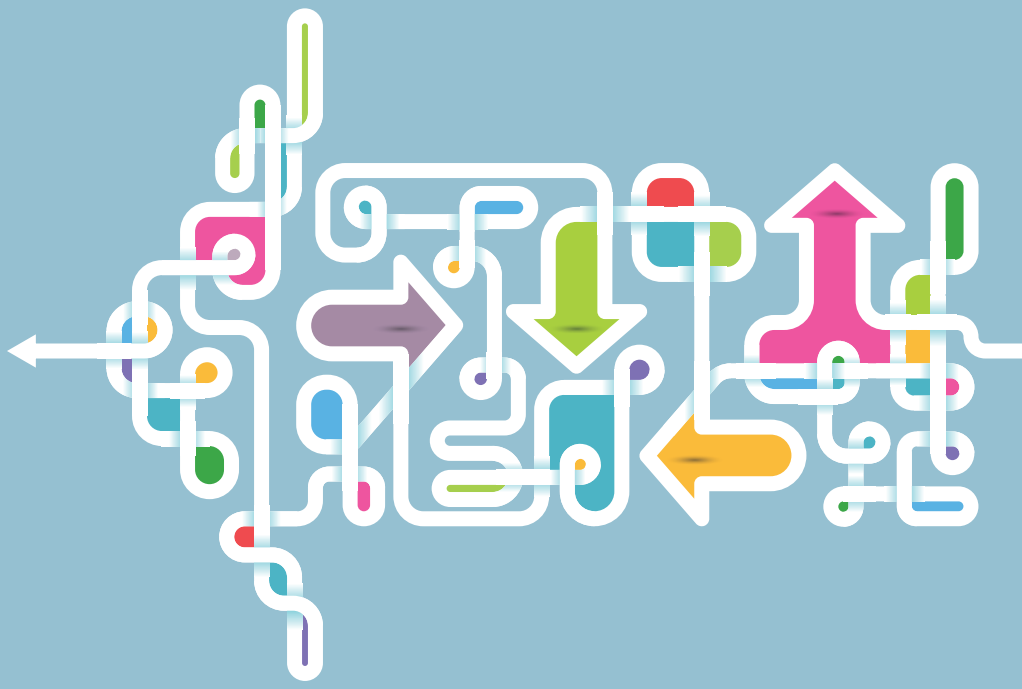


of the 2219 survey participants thought patients were discharged from hospital more quickly than before, and

92%

considered that staff were dealing with more complex health needs

(Source: RCN, 2012)



(Foster et al, 2015). Also, regular visits to practice learning environments enable visualisation of support for both students and mentors. Sessions for students to reflect on their experience at the placement midpoint enable the learning undertaken to be related to theory, in addition to providing the ability to detect early any issues within placement.

Support to mentors by providing yearly updates within practice areas and timely educational audits aims to ensure the quality of practice learning environments. It also enables good links with the practice areas, so any organisational changes that could impact student learning could be identified and resolved.

CONCLUSIONS

A collaborative approach is required to ensure good-quality community placements. When this is provided, students can gain a good overview and learning experience regarding community services, with an aim of encouraging students' enthusiasm to want to work within this environment. However, not all students can have a desire to work within the community post-registration. It is hoped that these students will still gain good understanding of services available out of the acute setting to enable a smooth transition for patients when discharged from hospital.

The community placement is a valuable experience in which students can acquire a breadth of knowledge. Continued consideration of the supportive needs for students is required by all professionals working within the community and the university to enable a positive learning experience. CP

• What is your experience of the evolving multi-option approach to what 'community' – and therefore community nursing – means? What are the advantages of the new approach, and of the previous divide between acute hospital-based nursing and community nursing? Let us know at aviva@communitypractitioner.co.uk

• Amy Noakes is senior lecturer in the Department of Children's Nursing, School of Health and Social Care, at London South Bank University

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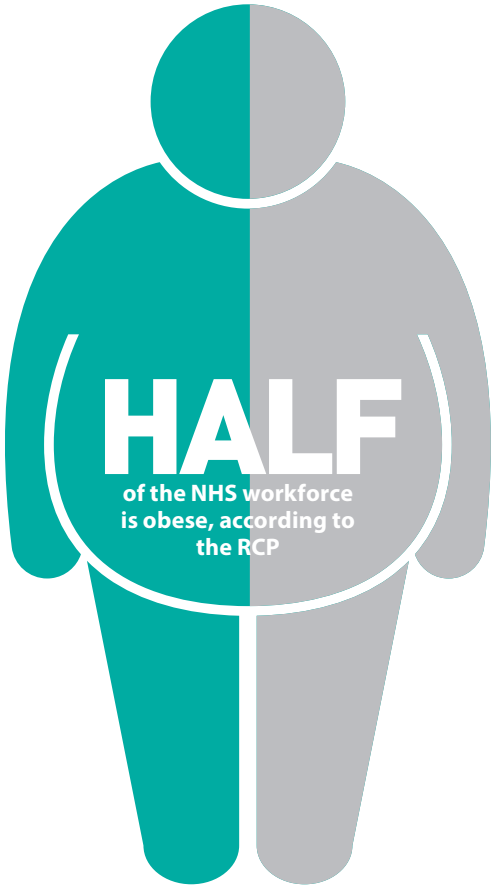
KEY POINTS

- **The community placement has transitioned from the traditional view of occurring solely with a health visitor or district nurse. It now encompasses learning within a variety of out-of-hospital environments.**
- **A community placement provides a valuable learning experience for pre-registration nurses to gain understanding of patients' needs in the community in addition to lifespan development.**
- **There is a need for trusts, mentors, universities and students to work collaboratively to ensure a positive and supportive learning experience during a community placement.**

ISTOCK

PRACTISE what you PREACH?



Research suggests that patients are less likely to accept weight-loss advice from an overweight or obese health practitioner. So should we be taking more of our own advice as a profession, or is it more complex than that?

In the spring of 2013, alarming reports appeared in the press of a health crisis in the NHS. 'Half of the NHS workforce is obese,' claimed the Royal College of Physicians (RCP, 2013). Soul-searching opinion pieces followed on the state of our health service and the nation's health.

Dig a little deeper and the picture is not so simple. The RCP was quoting from a Department of Health report which concluded that of 1.2 million NHS workers, about 300,000 were likely to be obese and a further 400,000 overweight, meaning about 58% of the workforce are either overweight or obese (Cross-Government Obesity Unit, 2009). Unsurprisingly, this reflects the weight of the UK population: in England, nearly 62% of adults are overweight or obese, in Scotland 65%, 59% in Wales and 60% in Northern Ireland (Department of Health, 2016; NHS Digital, 2015; Scottish Government, 2015; Welsh Government, 2015).

So all we've learned is that the healthcare workforce reflects the general population. And that working in healthcare settings isn't always conducive to a healthy lifestyle. As Tam Fry, chairman and spokesperson for the National Obesity Forum, says: 'Healthcare professionals are often required to work ridiculous hours. They snack and they are unconscious of the number of calories they're eating. That doesn't absolve them, but it's a fact of life for them.'

DIFFICULT DYNAMIC

From a public health perspective, however, this gives rise to a potentially tricky dynamic between health workers and patients, notably when overweight and obese health workers try to help patients struggling with weight issues. 'Patients might assume, rightly or wrongly, that health professionals would know enough about the problems to keep themselves in check,' Tam says.

Fiona McQueen, Scotland's chief nursing officer, agrees: '[People think] "How can a nurse who's very overweight advise me to lose weight?"'

This is the crux of the issue. Are patients less likely to heed the advice of an overweight health professional? There's evidence to suggest that they are.

In 2014, a Royal Society for Public Health (RSPH) survey of 2100 people found that 41% would be reluctant to take advice on diet and exercise from an overweight or obese healthcare professional, compared

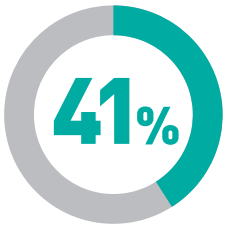
ON THE FRONT LINE

A member of a Nottinghamshire health visiting team gives her view:

'I have a colleague in the school health team who presents as obese. She is also the lead on the healthy eating project. One parent said she had left the session because she felt patronised by a larger person telling her how to manage her daughter's weight when "she clearly can't manage her own".

'I could do with losing a stone or two! I generally use the excuse of being the wrong side of 40 and having two children under the age of five. I'm often exhausted by the time I get home so reach for convenience over healthy food. Working in the community, lunch breaks often get missed, and long hours mean grabbing food when you can. Long periods are spent typing up records, and there is always a tin of biscuits or a box of chocolates at work, which doesn't help.

'I think the overall appearance of health professionals is important – not just weight but hair, clothing and cleanliness. It's important to look like you have made an effort yourself, before you help people to change their own approach to life.'



of the 2100 people surveyed were reluctant to take advice on diet and exercise from an overweight healthcare professional
(Source: RSPH, 2014)

HEALTHCARE PROFESSIONALS ARE OFTEN REQUIRED TO WORK RIDICULOUS HOURS. THEY SNACK AND ARE UNCONSCIOUS OF THE CALORIES THEY ARE EATING

80%

of 103 health professionals surveyed believe practising what you preach is important for the public to trust you in maintaining a healthy weight
(Source: RSPH, 2014)

with 17% who would.

In another study, former mental health nurse and psychology student Helen McDowall found that people are less likely to believe or act on healthy lifestyle advice from an overweight health professional (Stephenson, 2017).

Research suggests that healthcare professionals are aware of the issue. The RSPH also surveyed 103 people working in public health: more than 80% said they believe that practising what you preach is particularly important for the public to trust you on maintaining a healthy weight.

A US study showed that doctors felt overweight or obese patients were less likely to trust weight-loss advice from overweight or obese GPs. Overweight or obese doctors were also less likely to engage their patient in weight loss discussion in the first place (Bleich et al, 2012).

So how does this affect health workers' interactions with patients? Fiona Sim, a GP who has designed training for healthcare professionals on talking about healthy weight to patients at Imperial College London, says: 'It's not in anybody's interest to start stigmatising people. The most important thing is to ensure health professionals are trained and comfortable raising the subject of healthy weight.'

She adds: 'Obviously there's the issue of "What gives an overweight or obese health professional the right to preach to me?" But the other side of the coin is that health workers who find the subject of weight difficult can very often empathise with people who are also struggling.'

CHANGING LIVES

Fiona reports that, anecdotally, training in raising weight issues with patients has a positive impact on health workers' own lifestyle. 'A lot of people that have gone through our training say it's made a difference to their own eating and lifestyle, and to that of their families,' she says.

Others believe that employers should make it easier for practitioners to stay healthy. The RCP, for example, said in its *Action on obesity* report (2013): 'Workplace health and wellbeing should be placed high on the agendas of NHS trusts' and 'Staff wellbeing and health should become embedded within the culture of the NHS'.

There are various healthy weight initiatives to help people working in the NHS. For instance, clinical commissioning groups in England are empowered to commission staff health and wellbeing services under the Commissioning for Quality and Innovation payments framework. NHS Wales has a charter outlining the expectation that all its employers will plan services and staffing to take account of staff's health and wellbeing. NHS Scotland's Safe and Well at Work framework sets out how health boards should approach occupational health and safety. And in Northern Ireland, each of the six health trusts has its own policy for staff health and wellbeing.

These initiatives and frameworks are no doubt changing the lives of individual NHS workers across the country. How effective in the long term these initiatives will be while the UK's obesity epidemic worsens, however, has yet to be seen. Healthcare professionals are themselves part of the country's health landscape – they are human, after all. **CP**

RESOURCES

- **The NHS's Active 10 app: helps you fit 10 minutes of activity into each day**
  nhs.uk/OneYou/Active10
- **Nursing You: an interactive online tool to help nursing staff manage their weight**
  bit.ly/RCN_healthy_weight
- **Training for healthcare professionals on talking about healthy weight to patients**
  bit.ly/CPD_healthy_living

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SHORT VERSION

Mothering with a major mental illness

How can health visitors support new mums who have major mental health problems? Flying Start health visitor, **Diana Skibniewski-Woods**, explores what the research says.

An estimated 50% to 66% of parents have a severe and enduring mental illness, including schizophrenia and personality disorders, and have one or more children under 18 living at home. This amounts to about 17,000 children in the UK (Mental Health Foundation, 2015).

Childbirth is associated with an increased risk to women's mental health, with a rise in depressive illness and greater risk of recurrence of affective disorders and deterioration of existing severe mental illness (Joint Commissioning Panel for Mental Health, 2012). This is significant for health visitors as NICE (2014) finds that the relationship between the mother and infant in the first year after birth are significant for maternal mental health and can influence infant cognitive and emotional development.

A literature review was carried out to help further understanding of how health visitors can help women with major mental illness and their children. So what themes emerged?

SHAME, GUILT AND SOCIAL ISOLATION

Hill (2015: 184) differentiates shame from guilt. Shame is 'intensely visceral and painful, all-encompassing and disorganising', whereas guilt is more to do with reflective processes and moves us towards reparation with another person. Mothers reported feeling guilty that they were letting their children down and that they were not fulfilling the role of the imagined mother that they had wanted to be (Dolman et al, 2013). These thoughts are essentially reflective in nature.

Practitioners working with families where parents have mental ill health need to be sensitive to feelings of shame and guilt. For practitioners, understanding that our relational abilities are an adaptation to our previous environments can help generate self-compassion and reduce shame among parents; this can begin with making the implicit explicit and encouraging reflective functioning as a healing process (Hill, 2015).

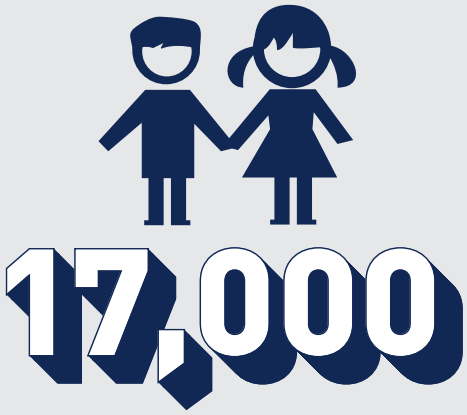
TRAUMA

Trauma is considered to account for one of the major burdens of disease associated with mental disorders (van der Kolk et al, 2007). Van der Kolk explains that traumatised patients experience current stress with the emotional intensity of past experiences, leading to repeated hyperarousal and or emotional numbing. The methods used to regain control are frequently self-destructive and include substance misuse and self-harm. Trauma was categorised into physical neglect, emotional abuse, emotional neglect and sexual abuse.

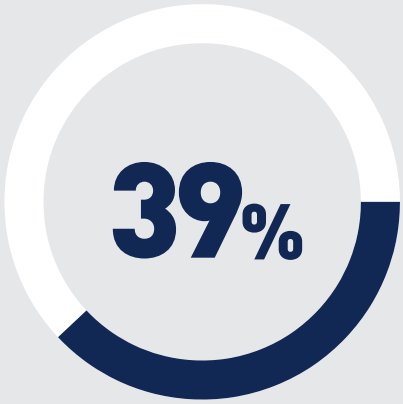
The effect of trauma can be corrosive especially when it occurs in childhood, as this is when our ability to form collaborative relationships with others is formed. Trauma that is perceived to be life threatening may bypass the rational part of the brain in the neo-cortex and go straight to the fight or flight mechanism in the amygdala. This is thought to lay down behavioural pathways that influence later coping abilities (Schore, 2003).

KEY POINTS

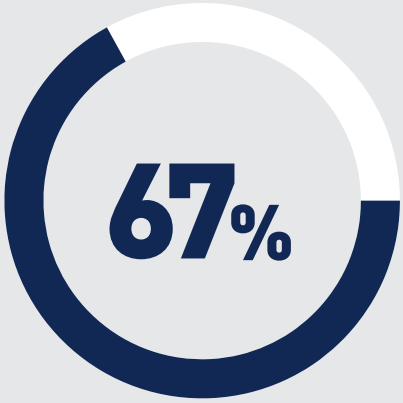
- **Acknowledge the value of the mothering role as a motivating factor.**
- **Acknowledge the client's own concerns for their children.**
- **Acknowledge parental fear of child protection services.**
- **Always ask about maternal mental health functioning.**
- **Consider the importance of maternal reflective functioning when making assessments of maternal functioning.**
- **Consider recovery-orientated approaches that can build a life beyond illness.**



The number of children in the UK whose parents suffer from mental illness



of the 295 carers surveyed reported mental health problems of their own



of these young carers hadn't told anybody that they were carers

An overactive stress response system in the brain is felt to underlie many disorders, including depression, anxiety, phobias and obsessions (Sunderland, 2007). Sleeping and eating can be affected, concentration and attention can be difficult. The focus on threat affects people's ability to make relationships and their judgment of others' intentions (Cairns, 2014).

Childhood trauma is found to affect reflective capacity in mothers who are struggling to identify infant relational cues and interpret the emotional needs of their infants (Elliot et al, 2014).

THE EFFECT ON CHILDREN

Several studies identified parental concern for their children's wellbeing and the burden of responsibility being placed on them (Herbert et al, 2013; Wilson and Crowe, 2008; Razzino et al, 2004).

Research showed there was a connection between lack of parental support and externalised behaviour, such as aggression (van Loon et al, 2014). Children were also felt to be more likely to experience negative emotions, which could lead to internalised behaviour, such as depression and anxiety (van Loon et al, 2014).

A survey and report by Young Carers International (Sempik and Becker, 2013) found that 38% of young carers reported mental health problems of their own. It recommends that young carers should have regular assessments of their needs, and that social and healthcare practitioners should develop a greater awareness of the impact of parental ill health on children. However, 67% of the 295 young carers surveyed hadn't told anybody that they were carers. The reasons they gave included a fear of negative reactions, embarrassment and not knowing who to tell. When children did receive appropriate support, benefits included greater confidence, having more friends and doing better at school.

Practitioners can help parents to understand the experiences of their children by helping them to understand the potential for children to increase problematic attachment-seeking behaviour because of concerns and worry about family members or themselves (Pynoos et al, 2007). Practitioners also need to recognise parents' need for affirmation (Dolman et al, 2013).

The cascade effect of giving praise is a recognised approach in many parenting programmes, including The Incredible Years Programme (Webster-Stratton, 2006).

FEARING THE REMOVAL OF CHILDREN

Parental concern around child protection and losing custody of their children was identified in several papers (Dolman et al, 2013; Montgomery et al, 2011; Khalifeh et al, 2009; Davies and Allen, 2005).

This may be a legitimate concern for some parents given that parental mental ill health is identified within the 'trilogy of risk' for child protection agencies – the other parts are substance and alcohol misuse, and domestic abuse (Ofsted, 2013).

Understanding how people with mental illness organise their parental behaviour is important if practitioners are to decide what preventative and supportive interventions are appropriate (Crittenden, 2012). The availability of services is seen as an issue – Clark (2011) details the UK government initiative to improve access to psychological therapies.

Parents often choose not to seek help with children during mental health crisis because they fear losing custody (Khalifeh et al, 2009). This fear is also a major impediment to establishing collaborative relationships with health practitioners (Dolman et al, 2013). This is a difficulty for health visitors. Khalifeh et al (2009) suggest that simple interventions, such as access to childcare, can be effective in reducing parental distress and improving outcomes for children – and may be a better alternative to implementing child protection legislation.

INFANT EXPERIENCE

A challenge for practitioners working with mothers who have severe mental illness is the knowledge that these women are very ill they may not be psychologically available to their infants (Pawlby and Fernyhough, 2009). The mother's internal world influences the way she is able to interact with her baby, and, as the infant brain is developing as a result of early interaction, the internal working model the child is building will contain a sense of self that is potentially life long (Barlow and Svanberg, 2009).

Attachment theory suggests that securely attached infants seek comfort when distressed. They recover from an aroused and disorganised state to a calm and organised state when comforted (Barlow and Svanberg, 2009). If mothers are withdrawn, and find it difficult to talk and smile to their babies, or are intrusive and

over-stimulating, the babies may become passive and avoidant, or reactive with excessive crying (Pawlby and Fernyhough, 2009).

In avoidant type A attachments, insecurely attached infants learn to down-regulate to inhibit expression of effect or distress. In ambivalent type C attachments they learn to up-regulate, becoming highly vigilant in order to guard against abandonment or separation (Geddes, 2012; Barlow and Svanberg, 2009; Sunderland, 2007).

Svanberg and Barlow (2009) say that the development of infant-centred services are inevitable given the progress in the understanding of infant mental health, but this challenges practitioners to develop the required skills.

IDENTITY

Several studies recognised the importance for people of having an identity outside of mental illness (Dolman et al, 2013; Wilson and Crowe, 2008; Duffy, 1985). Women who live with severe mental illness may find motherhood a normalising experience, which creates meaning and a role outside of illness (Nicholson et al, 1998).

People may interpret and experience severe mental illness as stigmatising, hopeless and damaging to self-esteem. Yanos et al (2010) suggest that internalised stigma creates disempowering narratives, which can lead to a vicious cycle of symptom severity. Becoming a mother may provide a healthy life focus, which creates an alternative self-image. Mothers report 'pride' in being a mother (Dolman et al, 2013). Children are able to provide meaning and focus outside of mental illness. They also provide a sense of normality, giving a purpose for living and opportunity for meaningful loving relationships (Dolman et al, 2013).

The role of practitioners is a mediating one between the 'mother' identity and the 'mental illness' identity (Davies and Allen, 2005). This allows the integration of the person in an effective way, supporting parental capacity while recognising the importance of addressing mental health needs.

In conclusion, Montgomery et al (2011) encourage practitioners to use the value that mothers place on the maternal role to motivate these women to develop resilience for themselves and their children.

Conversely, practitioners need to understand parents' fear of child protection services (Dolman et al, 2013; Montgomery et al, 2011; Khalifeh et al, 2009; Davies and Allen, 2005) and to be aware that this is a barrier that they may encounter.

To work with this group of mothers, health visitors are likely to require extra training in active listening skills and cognitive support measures (Joint Commissioning Panel for Mental Health, 2012).

The Royal College of Psychiatrists (RCP) suggests a recovery-orientated approach for people, which is socially inclusive and places value on developing a sense of personal control that involves self-management and self-determination. It is less about clinical recovery and more about engendering hope and the prospect of 'building a life beyond illness' (RCP, 2009: 11). **CP**

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Flying Start health visitor, Hywel Dda University Health Board

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To view the full version of this research paper, entitled *Mothering with a major mental illness: examining emerging themes from literature*, go to **bit.ly/CP_research_skibniewski-woods**

YOUR JOURNAL NEEDS YOU

Why not help shape the direction of the journal by contributing to the content or suggesting some ideas?

The heart of *Community Practitioner* is all about you – reflecting your life and work as healthcare professionals. We're always striving to produce the best journal for you – and here's where you can help make it even better. We would love to receive your feature ideas, written stories and research papers for future publication.

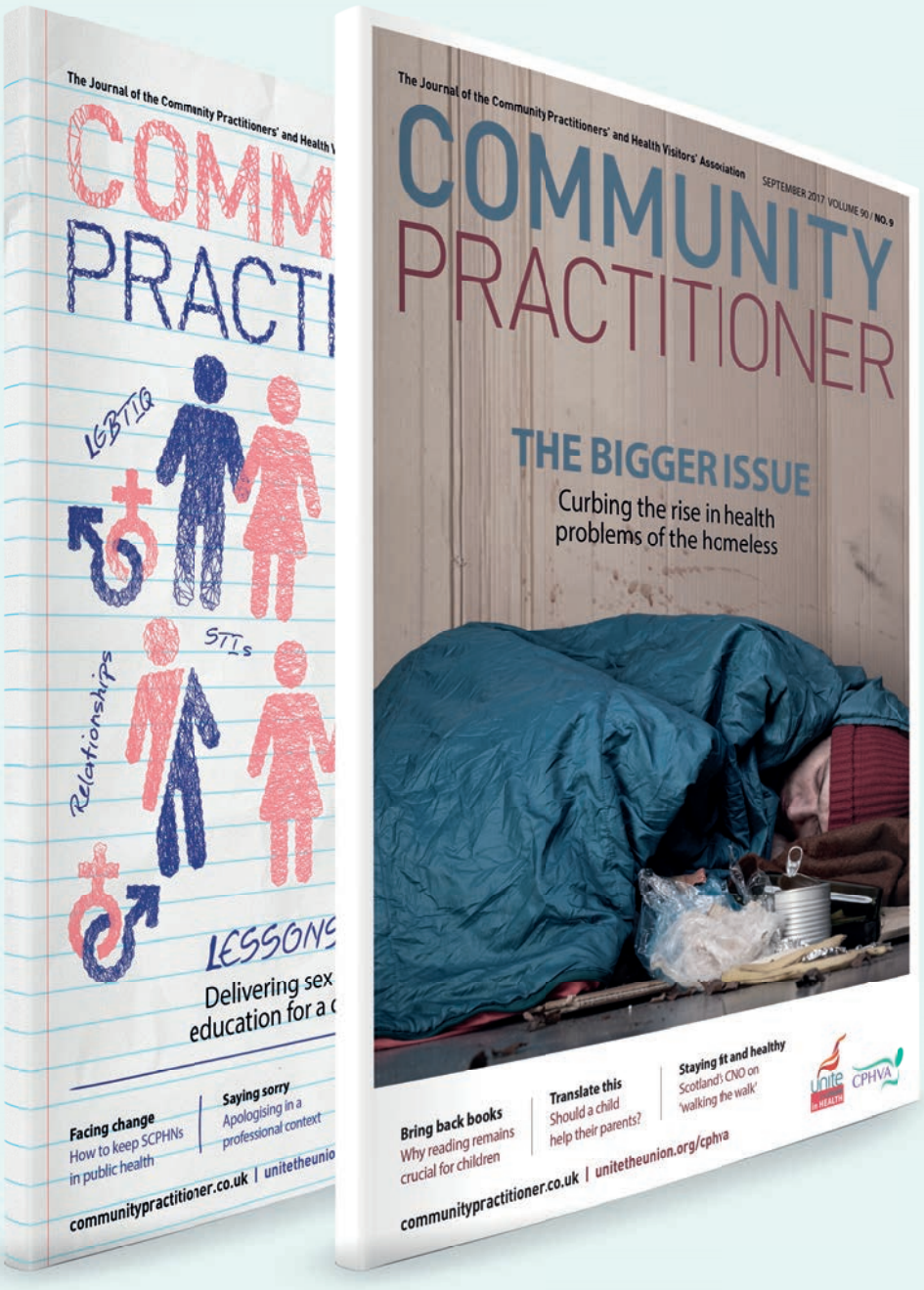
Perhaps you've been working on a research paper you'd love to see published? Or you're passionate about a subject you'd like to write about? And if you've had an experience or insight you feel would make an informative read and you don't want to write about it yourself – you could simply tell us about it.

In short, *Community Practitioner* needs your input! We're always on the look-out for interesting, incisive and relevant material. Examples of what we're looking for include:

- Research papers – recent topics published in the journal include the increase in childhood obesity, and health visiting in honour-based communities
- Standalone features or ideas – stories published recently include how to make the transition from student health visitor to practitioner; improving breastfeeding rates; health professionals and the digital revolution
- Feedback – items on professional events and insider information.

If any of these are appealing to you, please don't hesitate to get in touch.

Send your research papers, features and ideas to the deputy editor, **Aviva Attias**, at **aviva@communitypractitioner.co.uk** and you could see your work and/or ideas in the pages of the journal.



EATING DISORDERS

Let's carry on IMPROVING CARE

Mandy Scott, mental health nurse, discusses the challenges faced in helping people with eating disorders – lack of funding, transitions from child to adult care and ensuring full understanding of the illness.

Eating disorders (EDs) have the highest mortality rate of any psychiatric illness through either medical complications or suicide (Smink et al, 2012). And yet we still struggle to understand what really causes them.

There can in fact be many contributing factors or triggers of an eating disorder: stress vulnerability, family history of ED, trauma or abuse, a history of dieting, social and media pressures, chemical imbalances in the brain, and physical illness such as flu. While not everyone experiencing these triggers goes on to develop an ED, it is estimated that more than 725,000 people in the UK are affected by an ED (BEAT, 2015).

CHILD TO ADULT CARE

My experience as a registered mental health nurse has highlighted many of the challenges we face when trying to treat eating disorders. As an in-patient nurse working with young people in a specialist unit, helping the patient realise the seriousness of their ED, restore weight (when they are terrified) and helping reintegrate them back into home life are key challenges.

As a child and adolescent mental health services (CAMHS) outreach nurse in the community, engaging the patient, when denial is a key feature of ED, can prove difficult. However, it is very rewarding when you build up a trusting, therapeutic relationship and see quality of life improve.

Maintaining change can be difficult psychologically once the person restores weight, and this is where a robust support package is key. Juggling resources when thresholds are different for children and adults is a real challenge, especially as the transition age approaches and the patient is used to 'the CAMHS way'.

A suggestion would be to develop standardised protocols relevant throughout the transition period and dependent on risk. For example, a patient who came to my charity explaining she had been under CAMHS was advised to stay out of sixth form and study at home. When she transitioned to the adult team, she was told she should be in school and that it would help her recovery. While both sides have merits, the conflicting views can be very confusing for the patient and family.

Mandy will be running a masterclass on the new guidance on managing EDs at the Unite-CPHVA Annual Professional Conference on **17-18 October**

As a CAMHS and adult ED case manager for NHS England, I had the aim of keeping people as close to home as possible when needing hospital admission, facilitating repatriation where patients had gone out of the area and working with the local clinical commissioning groups (CCGs) to improve care pathways. This proved particularly difficult when the CCGs no longer had the budget for in-patient admissions.

The most obvious suggestion would be for more collaboration between NHS England and local CCGs, with an incentive for CCGs to

invest more into their community services. For example, they show that their services are reducing hospital admissions or length of stays, and NHS England gives a percentage of the hospital budget back for them to further invest in local services, including early intervention services and training.

HELPING GPs AND BEYOND

I set up my charity Personalised Eating Disorder Support (PEDS) to focus on helping people earlier and providing training to schools, GPs and other key organisations such as swimming clubs, ballet schools and so on. We support school nurses and teachers, who are the eyes and ears in detecting EDs before they become life-threatening.

Our work includes establishing links with nurses and teachers across our area and rolling out training to raise awareness and support the management of EDs in school. Some excellent charities are working around the clock to support people with EDs; however, a huge challenge we all face is funding. Government funding for the third sector has become almost non-existent, yet this is where we could be saving lives and money for the NHS.

With GPs, our charity's focus is on sharing best practice and helping to manage risk (see resources box, right). The nature of an ED makes it difficult to get help, so if your issues are not taken seriously by a GP, you are less likely to go back. For instance, a mum spent weeks trying to get her daughter, who was reluctant and in denial, to the doctor. Eventually, she saw the GP on the basis that her periods had stopped. The doctor told her that her BMI was fine and she was a healthy weight. What was overlooked was that she had undergone extreme, rapid weight loss of four stone, which was affecting her physical and mental health.

This highlights the importance of getting to know your patient and looking beyond weight/BMI. With children it is advisable to look at child percentile graphs, while remaining aware that weight may not be the whole picture (it is common for people to water-load or hide weights). With bulimia, acknowledge that many individuals present as a healthy weight but can be very unwell.

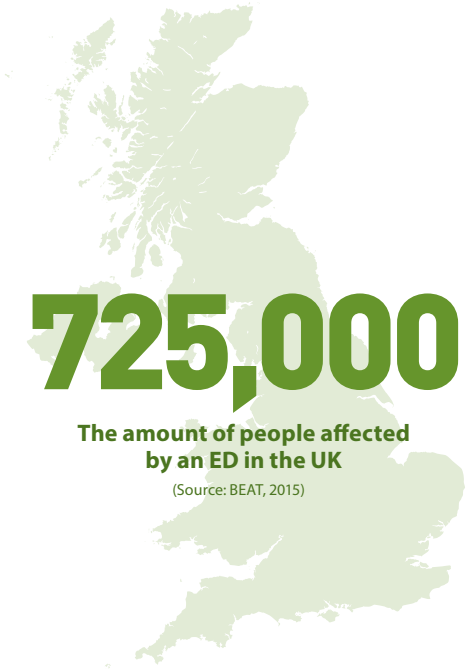
My own experience as a service user involved two lengthy hospital admissions as a teenager and very little input from the community. Things have moved on in that we now have dedicated CAMHS ED teams being set up throughout England, in line with the new access and waiting times standard for children and young people.

We still face issues with GPs. For instance, I would receive praise for any gain in weight (despite it being a fabricated weight). This praise encouraged me to lose more weight as I felt I was failing the anorexia and the desire to please it was overwhelmingly strong.

Over the next three years, I hope to see standardised access and waiting times, closer working relationships within the third sector, and for all community teams to be funded appropriately. With the right support packages in place, we can reduce the number and length of hospital admissions and as a result require less beds, reinvesting this money into better care in the community. CP

• **Mandy Scott** is a registered mental health nurse, co-founder of PEDS, an expert adviser to NICE and guideline committee member

A GROWING PROBLEM



725,000

The amount of people affected by an ED in the UK

(Source: BEAT, 2015)

£80m-100m

The annual healthcare cost of treating EDs in England

(Source: JCPMH, 2017)

The percent rise of EDs in men from 480 in 2010-11 to 818 in 2015-16

(Source: Marsh, 2017)

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EATING DISORDER RESOURCES

- **Personalised Eating Disorder Support (PEDS) pedsupport.co.uk**
- **Junior and adult management of really sick patients with anorexia nervosa (MARSIPAN) reports bit.ly/marsipan**
- **NICE guidelines for EDs, updated May 2017 bit.ly/ED_NICE**
- ***Access and waiting time standard for children and young people with an ED: commissioning guide* bit.ly/waiting_time_ED**
- **Children's weight for height graphs bit.ly/childrens_weight_graph**

Dates for your diary

Upcoming courses, training and events relevant to practice.

BLACK HISTORY MONTH

October

This month celebrates, recognises and values the inspirational individuals and events from within the BME communities. Important figures from the past, as well as those who contribute to and help society today, are remembered and celebrated.

W: bit.ly/Black_history_17

STOPTOBER

October

The 28-day stop smoking campaign is back, starting from 1 October. Stoptober has driven over one million quit attempts to date. It is based on research that shows that if you can stop smoking for 28 days, you are five times more likely to stay smoke-free for good. This year, for the first time, the campaign embraces e-cigarettes.

W: bit.ly/stoptober_17

WORLD MENTAL HEALTH DAY

10 October

Hosted by the World Federation for Mental Health and recognised by WHO, this year's theme is mental health in the workplace.

W: bit.ly/WMHD_17

CPHVA ANNUAL GENERAL MEETING

16 October

As a member, why not attend your AGM? You can apply for a supported place, too.

Location: Motorpoint Arena, Cardiff

W: bit.ly/CPHVA_AGM_2017

UNITE-CPHVA ANNUAL PROFESSIONAL CONFERENCE 2017

17-18 October

Join colleagues and peers in community practice to network, share best practice and discuss ideas.

Location: Motorpoint Arena, Cardiff

W: bit.ly/conference_17

NATIONAL BUG BUSTING DAY

31 October

Community Hygiene Concern is a non profit-making organisation that helps schools, community health services and parents cope successfully with head lice. Many schools take part either on this date, 31 January or 15 June each year.

W: bit.ly/bugbust_17

WORLD ANTIBIOTIC AWARENESS WEEK

13-19 November

With antibiotic resistance a growing threat to health, this worldwide event will encourage best practice among the public and health workers.

W: bit.ly/w_antibiotics_17

ALCOHOL AWARENESS WEEK

13-19 November

This year, charity Alcohol Concern is partnering with charity Adfam (families, drugs and alcohol) to look at the effects of harmful alcohol use on the family.

W: bit.ly/alcohol_aware_17

#AAW2017

SCT TRAINING UPDATE, PLUS FREE KCL COURSE

15 November

In collaboration with King's, the Sickle Cell and Thalassaemia (SCT) Screening Programme are providing free one-day courses for health visitors, non-specialist nurses, and midwives so that they can gain a basic knowledge of SCT, and the screening programme in England.

Location: London

W: bit.ly/SCT_training_17

COMMUNITY PRACTITIONER
communitypractitioner.co.uk | unitetheunion.org/cphva

Learn Baby Massage with the International Association of Infant Massage

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

Our highly acclaimed comprehensive training comprises:

- A four-day training course including supervised practical teaching of a parent/baby massage class
- A take home written assignment
- Further practical teaching and reading.

By training with our highly respected organisation you will join a worldwide network of instructors offering a supportive environment to teach life-long parenting and relaxation skills.

Membership of the IAIM UK Chapter includes:

- A local, national and international support network
- Continued professional development including study days with expert speakers, trainer-led massage stroke refresher sessions and a biennial international conference
- Access to relevant articles, information and the latest research on our website
- A regular newsletter.

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

Find us on Facebook - IAIM UK Chapter

For further details please visit www.iaim.org.uk. In-house trainings are available on request.

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

Touch-Learn International's Baby Massage Teacher Training

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

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

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- Massage for Babies with Special Needs
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For further details of in-house training and UK dates please ring or visit www.touchlearn.co.uk

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www.touchlearn.co.uk

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FOR FLYING START and CHILDREN'S CENTRE STAFF and all FAMILY HEALTH PROFESSIONALS

Two Day Teacher Training in Developmental Baby Massage with Peter Walker

Courses Accreditors:
Federation of Prenatal Education and
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Peter Walker a physical therapist yoga teacher and author gives this unique course with over forty years' experience in teaching teachers and working directly with mothers and babies. Techniques based upon the stages of the baby's physical and emotional development. Supported by neuroscientific research this forms the basis of a high quality inexpensive teacher training program.

Peter is credited with the free teaching of baby massage in NHS centers throughout the UK. Peter personally teaches all his teachers and his teacher training programs remain unfranchised. Certificate accepted in childcare centres and high quality health studios.

Childhood lasts a lifetime and starting from confinement the first two years is known to be the most significant in all aspects of a child's development. (1001 Critical Days)

Full set of illustrated course notes 'step by step' from birth to standing supplied.

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Can be shown to expectant mothers during late pregnancy and/or during the early days and weeks following childbirth.
A program of gentle massage and movement to relieve any trauma resulting from fetal distress during confinement, birth and /or early days. To assist in the release of physiological flexion and thereby encourage a deeper breathing rhythm, more relaxed tummy and a much happier baby.

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Assess and remedy. Using massage and movement to ensure the flexibility of the body's major joints before the child strengthens. To maintain suppleness and coordination. Encourage well balanced postures - sitting, standing and walking. Continue good reciprocity between mother and baby.

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The JOHNSON'S® brand is committed to developing safe, mild and effective baby products that contribute to healthy skin development.

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We welcome any feedback, please email us at jbhcpcontact@its.jnj.com

*Formulated to minimise the risk of allergies

[1] Lavender T, Bedwell C, Roberts SA, et al. Randomised, controlled trial evaluating a baby wash product on skin barrier function in healthy, term neonates. Journal of Obstetric, Gynecologic & Neonatal Nursing. 2013; 42, 203-214.

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