The Journal of the Community Practitioners' and Health Visitors' Association NOVEMBER 2017 VOLUME 90 / **NO. 11**

COMMUNITY PRACTITIONER

I FEEL SCARED AND UPSET WHEN MY PARENTS ARGUE

Exploring the effect of parental conflict on children

Call to action 2017
The highlights of this year's conference

Sepsis warning
Raising awareness and helping carers

Cutting violence
John Carnochan on early intervention

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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

CONFERENCE SPECIAL

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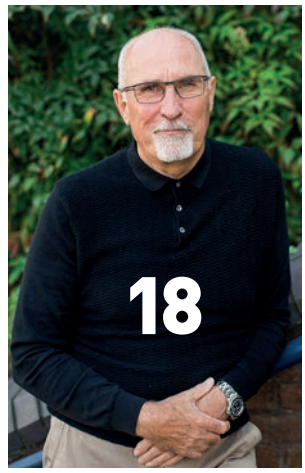

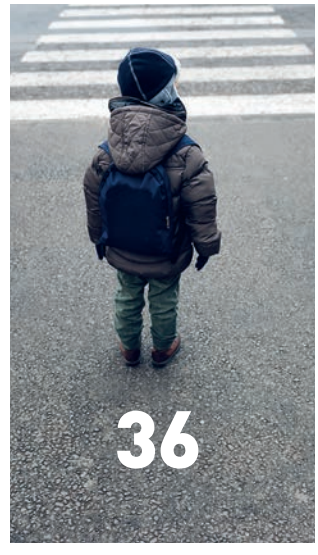

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*Formulated to minimise the risk of allergies

[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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COMMUNITY PRACTITIONER

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Thinking of the kids

Welcome to the November issue of *Community Practitioner*.

Rewarding, yes. Easy, no. We're referring to parenting, and while navigating parenthood can be hard enough, keeping the relationship healthy with your significant other can also be a challenge. No one's perfect, and it's normal to argue with your partner, but when it's consistent and remains visibly unresolved, parental conflict can have many negative consequences for children, emotionally and behaviourally. Any viewers of the recent BBC one hit drama *Dr Foster,* will know just how extreme it can get. On page 26, we explore the effect parental conflict can have on children, and how community practitioners are well placed to help families in these situations.

Someone who knows all about the value of early intervention is former detective chief superintendent at Strathclyde Police, John Carnochan. We caught up with John after his well-received presentation at the Unite-CPHVA Annual Professional Conference 2017. On page 18, he reveals the vital importance of focusing on human relationships to help all children have the happy lives they are entitled to.

On the subject of annual conference, more than 450 delegates from six different countries gathered to discuss the future of their professions at Cardiff Motorpoint Arena last month. During a lively two days, some 150 speakers shared their views and insight on the most pressing issues for community practitioners. See the highlights on page 20 onwards.

Health issues on the agenda are of course numerous, but one that is finally getting some much deserved (and life-saving) attention is sepsis. Unite-CPHVA have been involved in helping to produce a booklet for health visitors and school nurses on sepsis in children. And in Scotland, a campaign to raise awareness of sepsis was announced at the end of September. The clinical feature on page 32 takes a closer a look at sepsis, including how to spot and advise families on the life-threatening infection.

While ahead of World AIDS Day on 1 December, we ask on page 12 whether or not we're finally winning the fight against AIDS.

This time of year, getting out and about can be harder, and let's face it – less safe, with more journeys in the dark and British winter weather in full swing. On page 36, we assess the current road safety issues and the practitioner's role in advising all ages on how to stay safe. Despite the cold and the rain, ensuring children get sufficient outdoor playtime remains vital to their wellbeing, as we find out on page 44.

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. Whether you want to share your practice experiences, or you were inspired by a talk at conference, or simply saw an interesting news story – we want to hear from you. And if you have a research paper you're keen to submit, get in touch today. As always, we're really keen to hear your thoughts and learn 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

ENGLAND

MMR vaccination rate down for third year running

The number of children in England receiving their measles, mumps and rubella (MMR) vaccine by the age of two is down for the third year in a row.

MMR coverage among two-year-olds fell to 91.6%, compared with 91.9% in 2015-16, according to an NHS Digital report. And it has fallen year on year since 2013-14, when the coverage figure of 92.7% was the highest since the vaccine was introduced in 1988.

All regions except London achieved coverage above 90%, but none reached 95% – the target set by the WHO. Coverage was highest in the North East and lowest in London. Only 87.6% of children in England had received their first and second dose of MMR vaccine by their fifth birthday last year, down 0.6% from 2015-16.

However, the proportion of eligible children receiving a first dose of MMR by the age of five met the WHO's 95% target for the first time in England after rising consistently since 2006-7.

In the same report, NHS Digital reveals coverage of the DTaP/IPV/Hib – also known as the five-in-one vaccine – was down, with 93.4% of children having it before their first birthday in 2016-17, compared with 93.6% last year and 94.2% in 2014-15.

● **To read the NHS Digital report, go to bit.ly/ENG_vaccination**

WALES

Inactivity costs NHS Wales £35m a year

Sedentary lifestyles cost NHS Wales £35m in 2015, according to new analysis by Public Health Wales.

The huge cost of treating preventable diseases caused by physical inactivity is now being targeted with new visual guides produced for health boards to help them support staff and patients to be more active.

Robert Sage, principal health promotion practitioner at Public Health Wales, said: 'We all need to support those who are inactive to take those first steps towards making being active a normal part of their everyday lives. NHS staff are well placed to raise the issue and pass on simple tips and advice to the public.

'We're asking all NHS organisations and staff to work together to do all they can to increase activity levels in Wales.'

Health professionals can find out how to promote physical activity by visiting the Making Every Contact Count website at mecc.wales

● **Read more at bit.ly/WAL_inactivity**

SCOTLAND

Too few Scottish children eat enough fruit and veg

A new Scotland-wide survey that paints a picture of the nation's health found that just 13% of children are getting their five a day, and 29% are at risk of being overweight.

The Scottish Health Survey, which aims to measure the wellbeing of people living in Scotland, also found more boys were meeting physical activity guidelines – with 79% doing so – than girls, with 72% meeting the recommended amounts.

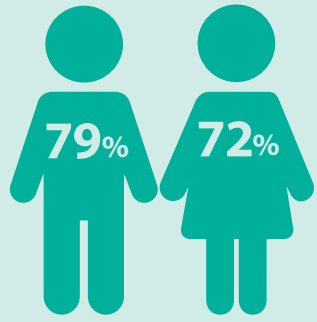
However, it found that 70% of two- to 15-year-olds were a healthy weight, and reported a significant decline in the prevalence of the risk of obesity in children, from 17% in 2014 to 14% last year – the lowest recorded since 1998.

A quarter of adults drink more than the recommended maximum of 14 units of alcohol a week, with men twice as likely to do so as women, and one in five smoke.

The survey also showed that the average adult managed just three portions of fruit and veg a day, down from 3.3 in 2015. The lowest consumption was recorded among 16- to 24-year-olds, who had just 2.5 portions a day; and 14% of men and almost one in 10 women reported eating no fruit or vegetables on the previous day.

- **Read the key findings of the survey at bit.ly/SCT_survey**

SCOTTISH HEALTH SURVEY FINDINGS



The number of boys and girls meeting physical activity recommendations

of two- to 15-year-olds were a healthy weight

1 in 10

women reported eating no fruit or vegetables

GETTY/ISTOCK/ALAMY

UK

NHS future 'precarious'

The health system is 'straining at the seams' and faces a 'precarious' future.

That is the judgement of the Care Quality Commission (CQC) in its annual report, which raises red flags about staff shortages, rising demand and the number of patients with preventable illnesses.

And while the quality of care has been maintained so far, the report warns that standards are likely to drop.

Among the concerns highlighted are vacancy rates in the NHS rising by 16% over the last two years, and bed shortages in hospitals, where occupancy levels have been consistently above recommended levels since April 2012.

CQC chief executive Sir David Behan said the NHS was 'struggling to cope with 21st century problems' such as obesity, type 2 diabetes and heart disease.

- **To access the report, go to bit.ly/UK_CQC**

WALES

Flu vaccination extends to year four pupils

Welsh schoolchildren in year four are being included in the free flu vaccination programme for the first time this term.

The annual campaign in Wales now covers children aged from two up to nine, pregnant women, over-65s and those with certain medical conditions.

Now children in nursery, reception and years one to four can all receive nasal spray vaccines at school.

Younger children and other eligible groups can have it at GP surgeries and some community pharmacies.

In August, the Welsh Government announced that all primary schoolchildren would be offered the flu vaccine within two years.

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

ENGLAND

Allow messy eating, says NICE

Children with slow weight gain should be allowed to 'be messy' with their food, new guidance from NICE says, urging parents to avoid 'coercive feeding' and 'punitive approaches'.

The new guidance is aimed at improving diagnosis, assessment and monitoring of children with faltering growth to help GPs and health visitors support parents.

Professor Gillian Leng, deputy chief executive and director of health and social care at NICE, said: 'Simple things such as encouraging relaxed and enjoyable feeding and mealtimes, eating together as a family or even allowing young children to be 'messy' with their food can help encourage them to eat.'

- **Read the NICE guidelines, entitled *Faltering growth* at bit.ly/ENG_feeding**

ENGLAND

Slump in number of NHS nurses

The number of NHS nurses has fallen for the first year since 2013, new research has revealed.

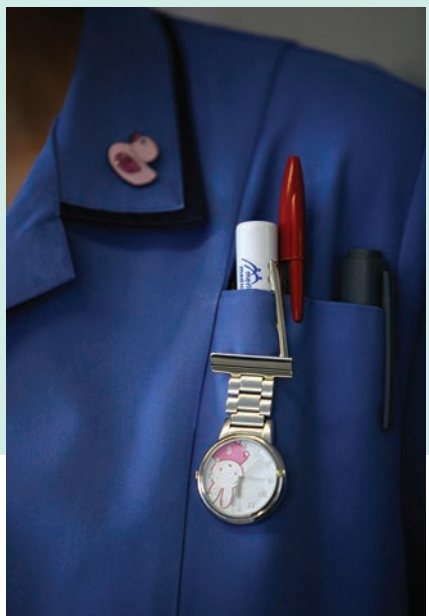
The analysis, by The King's Fund's director of policy Richard Murray, shows that fewer were in post in April this year compared with April 2016. And the trend continued in May and June, with 316,725 nurses in post in June 2017 – 703 less than a year ago, or a drop of 0.4%.

And that dip is even greater when looking at full-time equivalent numbers – with 1071 fewer full-time equivalent nurses in June 2017, compared with June the previous year.

The analysis finds that the decline is largely due to the decrease in EU nurses coming to the UK and to the high rate of burnout among existing registered nurses.

Writing in his blog for The King's Fund, Mr Murray says the analysis 'reveals a worrying picture… at a time when services are already overstretched and the demand for care is rising'.

- **To take a read of Richard's blog, go to bit.ly/ENG_slump**



WALES

Pilot scheme to offer early mental health support in schools

Pupils showing early signs of anxiety, depression or self-harm will receive specialist help at school under a pilot scheme being launched in Wales.

The £1.4m, two-year Welsh Government trial taking place across north-east and south-east Wales and Ceredigion will strengthen the support from specialist child and adolescent mental health services (CAMHS) to schools.

It will see dedicated CAMHS practitioners working with pilot schools to support and train teachers, and ensure children experiencing difficulties are identified early and given the right care.

Wales has led the way in the UK by being the only nation that requires local authorities to provide counselling services in their area for children and young people aged between 11 and 18, as well as pupils in year six of primary school. This initiative provides an additional layer of more specialist support in schools.

Health secretary Vaughan Gething said: 'We hope this initiative will improve accessibility to support services, better address school-related stress and ease pressures on specialist CAMHS by reducing inappropriate referrals. We also hope it will facilitate a wider culture which promotes and values positive mental health and wellbeing within our schools.'

- **For more information, visit bit.ly/WAL_CAMHS**

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UK

New advice on eggs

Infants, pregnant women and the very elderly can now enjoy runny eggs that carry the British Lion mark.

This is the latest advice from the Food Standards Agency (FSA), almost 30 years on from the UK's salmonella crisis.

The FSA has revised the advice relating to eggs produced under the British Lion Code, and those vulnerable to infection can now have raw or lightly cooked eggs without fear of exposure to salmonella bacteria.

It follows a report published by the Advisory Committee on the Microbiological Safety of Food in July last year, which said that the presence of salmonella in UK eggs had 'dramatically reduced' in recent years.

- **For the full advice, visit bit.ly/UK_eggs**

NORTHERN IRELAND

Steep rise in referred children

Almost 40,000 children in Northern Ireland were referred to social services in one year.

Figures from the Department of Health show 37,618 children were referred to social services in 2016-17 – an increase of more than 3000 from the previous year.

Police made the most referrals – 29% – and one in five came from social services, according to the *Children's social care statistics for Northern Ireland* report.

As of 31 March this year, 22,737 children were known to social services as being a 'child in need'.

- **Read the full report at bit.ly/NI_carestats**

NORTHERN IRELAND

Breastfeeding rates climb – but remain lowest in the UK

Breastfeeding rates in Northern Ireland are increasing, but are behind the rest of Ireland and are still the lowest in the UK.

The Institute of Public Health in Ireland (IPH) report, *Breastfeeding on the island of Ireland*, finds that, in 2015, 45% of infants were being breastfed at discharge from hospital – up 5% over the past decade, compared with a 9% rise in the Irish Republic in the same period.

But breastfeeding rates fall off quickly, with just 35% of babies in Northern Ireland receiving breastmilk at the first health visitor visit, 27% at six weeks, 21% at three months and 13% at six months.

IPH development officer Joanna Purdy said Northern Ireland society is 'slowly becoming more welcoming and appreciative of breastfeeding but still has a long way to go'.

- **Read the IPH report at bit.ly/NI_breastfeeding**

ITALY

Childhood infection linked to coeliac disease

Childhood respiratory infections have been linked with coeliac disease, research published in *Pediatrics* has found.

The study explored the relationship between early clinical events – including infections – and the development of coeliac disease in a prospective cohort of genetically predisposed infants.

Dr Renata Auricchio from the University of Naples Federico II led a team of researchers who followed 373 Italian newborns with at least one relative with coeliac disease for six years.

They found that respiratory infections predicted onset of coeliac disease. They also found that, compared with gastroenteritis, respiratory infections during the first two years of life conferred a two-fold increase in the risk of developing coeliac disease.

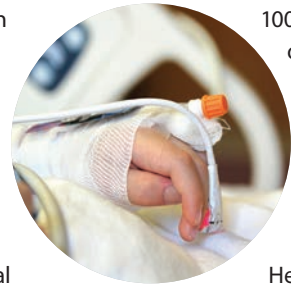
● **Read the full study at bit.ly/PED_coeliac**

SCOTLAND

Flu hospitalisation risk for children with older siblings

Children under two years are more likely to be admitted to hospital with influenza if they have an older sister or brother, a study has found.

Researchers studied data for 400,000 children born in Scotland between 2007 and 2015, and found that those with older siblings were more than twice as likely to be admitted to hospital with flu under six months than those who did not.



The work, published in the *European Respiratory Journal*, found that almost half of flu hospital admissions in babies under six months could be explained by older siblings; there was one extra hospital admission for every 1000 children for those with an older sibling compared with those without, and two extra hospital admissions for every 1000 children with two older siblings.

Dr Pia Hardelid, a lecturer in epidemiology at the UCL Great Ormond Street Institute of Child Health, who led the research, said: 'Flu can be a serious infection in very young children but at the moment there is no vaccine approved for babies under six months.'

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

THE NETHERLANDS

Children's learning regulated by unexpected part of brain

Learning during development is regulated by an unexpected brain region, according to research from the Netherlands.

Scientists from the Institute for Neuroscience in Amsterdam discovered that a structure deep in the brain – the thalamus – plays a crucial role in the regulation of the critical periods in which learning ability for specific skills and functions is strongly increased. It had previously been assumed that the start and end of these periods were regulated in the cortex.

The team found that plasticity of binocular vision also occurs in the thalamus.

The findings, published in *Nature Neuroscience*, have implications for understanding developmental problems ranging from a lazy eye to intellectual disability.

The scientists investigated the mechanisms by which critical periods are switched on and off in the hope of extending or reopening them for the treatment of developmental problems.

The study may provide hope for people with albinism, who can have limited binocular vision. It could mean that the vision of children with the condition could be improved through training.

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

US

Babies can learn persistence at 15 months

A new study has found that babies can learn to keep trying if they see an adult struggle to complete a task.

MIT researchers designed an experiment in which 15-month-old babies watched an adult perform two tasks. Half the babies saw the adult quickly succeed at the task three times within 30 seconds, while the other half saw them struggle for 30 seconds before succeeding.

Babies who had seen the adult struggle succeeded in their own task nearly twice as often as those who saw the adult easily succeed.

● **Read the full study at bit.ly/MIT_persistence**

US

Farsighted children at risk of falling behind at school

Farsighted children starting school find it harder to pay attention, a new US study suggests.

The research, published in the *American Journal of Ophthalmology*, saw researchers test preschool children aged four and five – with and without farsightedness – to evaluate their attention, visual perception and hand-eye coordination.

The children who were moderately farsighted were significantly more likely to have poorer scores on the attention-related tests. While some children were able to focus their eyes, others who struggled to see close-up had lower scores on tests of visual attention, visual perception and hand-eye coordination or copying skills.

The study included 244 children with moderate farsightedness and 248 children with normal vision.

'We knew from our previous work that preschool and kindergarten children with uncorrected farsightedness have decreased early literacy, and this new study shows that there are even more deficits in these children early on,' says Marjean Taylor Kulp, professor of optometry at Ohio State University.

- **For the full study, visit bit.ly/AJO_farsighted**

UK

Poor children most likely to enter child protection

Children in the most deprived areas are more likely than wealthier peers to become involved in the child protection system, a new research study has shown.

Academics from Queen's University Belfast and the universities of Coventry, Sheffield, Huddersfield, Cardiff, Edinburgh and Stirling found 'strong social gradients' in the rates of intervention across the four nations, with each step increase in neighbourhood deprivation bringing a significant rise in the proportion of children either 'looked after' in care, or on a child protection plan.

The study, funded by the Nuffield Foundation, looked at data on more than 35,000 children.

In England, the poorest children were 10 times more likely to be placed on child protection plans or looked after.

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

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UK

Bullying can leave mental health scars

A twin study has provided new evidence of the link between bullying and mental health issues in later life.

Once confounding factors were removed, bullying was shown to have an effect on anxiety, depression, hyperactivity, impulsivity, and inattention.

Two years later, there was still an impact on anxiety, but five years on, there was no longer an effect, although 16-year-olds who had been bullied at age 11 remained more likely to have paranoid thoughts or cognitive disorganisation.

- **Read the study at bit.ly/JAMA_bullying**

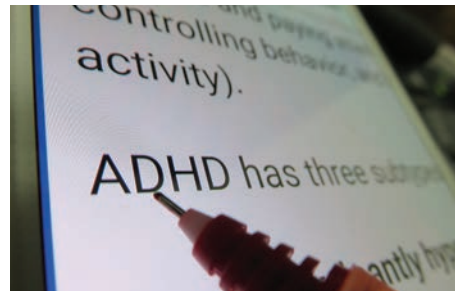
FINLAND

Youngest in class diagnosed with ADHD

Children who are young for their school year are more likely to be diagnosed with attention deficit hyperactivity disorder (ADHD) than their older peers, new research has shown.

The study, published in *The Lancet Psychiatry*, suggests parents and teachers may be mistaking relative immaturity for symptoms of the disorder, and calls for flexibility in school starting dates.

- **Read the study at bit.ly/TLP_ADHD**



AIDS

Are we finally winning the fight?

Ahead of World AIDS Day on 1 December, journalist **Juliette Astrup** takes a look at the fight against AIDS – from promising new developments and breakthrough treatments to some of the barriers undermining progress.

The battle against AIDS has come a long way since the disease first shook the world in the 1980s, and became a global epidemic within just a few years.

It still is – 36.7 million people are living with HIV globally (WHO, 2016) – but while stigma and discrimination remain, it is now a long-term condition rather than a death sentence. Patients receiving effective antiretroviral (ARV) treatment are living with HIV into old age, without the same level of fear of passing the infection on to others.

DECLINE IN NEW DIAGNOSES

Here in the UK there is much to feel positive about. New figures from Public Health England (PHE) show an 18% decrease in HIV diagnoses in the UK in 2016 – the largest ever (PHE, 2017). For gay and bisexual men, HIV diagnoses have dropped by 21% – a development hailed as 'one of the most significant advances in HIV prevention since the beginning of the epidemic' by the HIV/AIDS charity the Terrence Higgins Trust.

Combination prevention is working, says PHE. The decline in new diagnoses is driven by large increases in HIV tests among gay and bisexual men at sexual health clinics – 143,560 last year, up from 37,224 in 2007 (PHE, 2017).

Other factors include the uptake of ARV therapy following HIV diagnosis, sustained high condom use with casual partners and online purchasing of the pre-exposure prophylaxis (PrEP), which can protect those at risk of contracting the virus (PHE, 2017).

Further underlining this, in September NICE published a quality standard to encourage the uptake of HIV testing, advising that people living in areas with a high prevalence of the disease should routinely be offered HIV tests during healthcare appointments (NICE, 2017).

A 'CANCER-MODEL' TREATMENT

In addition to prevention and treatment, research is bringing about ever more effective drugs. Just weeks ago, a team of US scientists announced news of an engineered antibody that attacks 99% of HIV strains and can prevent infection in primates (Xu et al, 2017), hailed by the International AIDS Society as an 'exciting breakthrough'.

And Dr Sarah Fidler, a consultant physician and professor of HIV medicine at Imperial College London, is involved in clinical trials for new medicines that not only suppress the virus but also target the viral 'reservoirs' in cells where it lies dormant and can be reactivated if treatment stops. But she says only one man in the world has been cured of HIV, and an out-and-out 'cure' may not be feasible for everyone living with HIV.

'Rather than a cure, it might be more like a cancer model,' she adds. 'When treatment finishes, people understand that the cancer could come back – a similar model of treating HIV might be possible in the future. This is a very exciting and interesting area of research.'

HIGH NUMBER OF UNDIAGNOSED CASES

Even with such advances in medicine, the battle is far from won. While HIV treatment in the UK is excellent, the number of people diagnosed with the disease each year remains high. In 2015, an estimated 101,200

people were living with HIV in the UK, including 13,000 undiagnosed, and rates of late diagnosis remain high (PHE, 2016).

While the stigma around HIV remains a challenge globally, Dr Fidler says that in the UK there is a general awareness and understanding about HIV and its treatment and prevention. But it's important not to become complacent about it.

'We are all pretty bad at taking medication, but interrupting HIV treatment causes the virus to come back in four to six weeks, and it can lead to resistant strains of the virus, so there is quite a lot of anxiety around that "just one pill a day".'

HIGH-RISK GROUPS

Dr Fidler adds: 'In the UK, people get really good access to treatment – but what is still not good enough is the testing. A key thing is to keep having tests. For people in high-risk groups we recommend being tested every three months or after exposures. You can buy self-testing kits, or you can go to one of the many clinics. Without stigmatising them, we need to empower these communities to know their risk so they can do something about it.'

Sadly, efforts to support high-risk groups sometimes fall short. Scotland's busiest needle exchange service for drug addicts, which opened in Glasgow Central station in 2016 following a spike in HIV cases, has been closed by Network Rail, which owns the building.

There is also concern over access to PrEP, seen as a game-changing tool. While in Scotland PrEP is available on the NHS, and in Wales as part of a large-scale pilot, a similar programme in England is limited to 10,000 people and was delayed by months, only launching in the past few weeks.

And in England, services are facing continued funding cuts, and problems of fragmented and inconsistent commissioning as a result of the Health and Social Care Act.

'A growing body of evidence has recently demonstrated how changing models of NHS delivery have resulted in the fragmentation of HIV provision, with resulting harm – especially to HIV support services,' says Rosalie Hayes, policy and campaigns officer at the National AIDS Trust (NAT).

She adds: 'The success we have recently seen in reducing infections among gay and bisexual men is already at risk as investment in prevention is facing significant cuts. Prevention spending in high-prevalence areas has been cut by almost a third in the past two years' (NAT, 2017).

She also points to issues around public awareness and says: 'It's quite incredible that general understanding about HIV is so far behind. I think that is because treatment has developed so quickly – but also because there hasn't been a big public information campaign or any comprehensive education about it in schools.

'The knowledge that when the virus is suppressed a person can't pass it on is really significant in terms of reducing self-stigma, and it's important that everyone else knows that as well.' CP

HIV: ON THE WANE?

36.7 million

The number of people living with HIV globally

(Source: WHO, 2016)

101,200

people living with HIV in the UK

13,000

people living with HIV undiagnosed

↓18%

decrease in HIV diagnoses in 2016

(Sources: PHE, 2017; 2016)

USEFUL RESOURCES

- **National Aids Trust guide for care providers for those with HIV. Contains information on confidentiality and disclosure, an important factor for community healthcare workers – bit.ly/NAT_care_providers**
- **2016 PHE report on treatment and viral suppression – bit.ly/PHE_HIV**
- **NAT resources for schools – bit.ly/NAT_teachers**
- **The Children's HIV Association guidance for schools – bit.ly/CHIVA_schools**
- **NAT e-learning resource – bit.ly/NAT_elearning**

SHUTTERSTOCK

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Xu L, Pegu A, Rao E, Doria-Rose N et al. (2017) Trispecific broadly neutralizing HIV antibodies mediate potent SHIV protection in macaques. *Science* **358(6359)**: 85-90.

How can infants with feeding issues be supported in the community?

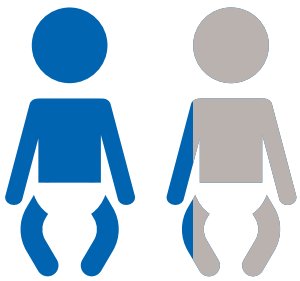
Infant feeding issues are very common, especially during the first few months of life.[1] Symptoms cause parental anxiety, driving parents to seek advice from primary care healthcare professionals.

Functional gastrointestinal disorders (FGIDs) include a number of symptoms that affect the gastrointestinal tract in otherwise healthy infants.[2] These symptoms are often frequent, age-dependent and related to the on-going physiological development of the gut that occurs naturally after birth. Although they usually resolve as the infant matures, they can cause considerable distress and anxiety for the parents as well as the infant.

As well as FGIDs, feeding issues also encompass lactose intolerance and cows' milk protein allergy (CMPA), both of which have a defined organic cause. The prevalence of lactose intolerance varies according to cause and ethnicity.[3] CMPA affects about 7% of formula or mixed-fed infants, with the highest prevalence during the first year of life.[4]

Research shows that FGIDs occur in up to 55% of all infants in the first 6 months of life.[1]

INFANTS WHO HAVE FEEDING ISSUES



OVER HALF

THE MOST COMMON FGIDs ARE:[3,5]

- **30%** REFLUX & REGURGITATION
- **25%** CONSTIPATION
- **20%** COLIC

Practical guidance on management of feeding issues

In the majority of infants, the most appropriate management of uncomplicated FGIDs should focus on:

- A review of feeding practices
- Parental reassurance
- Where necessary, offering infants adequate nutritional support[6,7]

Community based healthcare professionals are ideally placed to have a key role in the management of uncomplicated feeding issues:

- **Recognise** the symptoms early and conduct a thorough clinical history. In doing so, have a role in preventing hospital admissions and thereby associated costs, as well as reducing parental anxiety and emotional impact[8,9]
- **Refer** on to appropriate specialist services if required; such as an infant feeding specialist, paediatric dietetics, paediatric speech and language therapy
- **Reassure** and act as a key contact for the family, to help optimise communication, provide parental support and to coordinate care[9]

Feeding issues can cause considerable emotional impact on the family, and the community team can provide support with a clearly understandable and tailored management plan.

There are NICE guidelines to support the appropriate management of reflux, infantile colic and constipation,[10–12] as well as MAP guidelines on the management of CMPA.[5,13,14] These are key to reducing the impact on infant and family and the burden on the healthcare services.[15]

Find a summary of these guidelines to download from our website on www.smahcp.co.uk or www.smahcp.ie

Supporting you to support parents

You can also find more practical information on common feeding issues as well as unbranded helpsheets for parents in 7 languages on our website.

ADVERTORIAL FEATURE

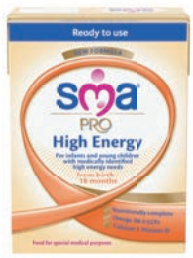
Mild digestive discomfort

Reflux and regurgitation

Cows' milk intolerance

Family history of allergy

Lactose intolerance



Faltering growth

IMPORTANT NOTICE: The World Health Organisation (WHO) has recommended that pregnant women and new mothers be informed on the benefits and superiority of breastfeeding – in particular the fact that it provides the best nutrition and protection from illness for babies. Mothers should be given guidance on the preparation for, and maintenance of, lactation, with special emphasis on the importance of a well-balanced diet both during pregnancy and after delivery. Unnecessary introduction of partial bottle-feeding or other foods and drinks should be discouraged since it will have a negative effect on breastfeeding. Similarly, mothers should be warned of the difficulty of reversing a decision not to breast-feed. Before advising a mother to use an infant formula, she should be advised of the social and financial implications of her decision: for example, if a baby is exclusively bottle-fed, more than one can (400 g) per week will be needed, so the family circumstances and costs should be kept in mind. Mothers should be reminded that breast milk is not only the best, but also the most economical food for babies. If a decision to use an infant formula is taken, it is important to give instructions on correct preparation methods, emphasising that unboiled water, unsterilised bottles or incorrect dilution can all lead to illness. • **SMA® Wysoy®** milk-free formula is intended to meet the nutritional needs of babies and children who are intolerant to cows' milk protein, lactose or sucrose. Soya infant formulae are not recommended for preterm babies or those with kidney problems, where medical guidance should always be sought. • **The following products must be used under medical supervision.** • **SMA® PRO Anti-Reflux** is a special formula intended for the dietary management of bottle-fed babies when significant reflux (regurgitation) is a problem. It is suitable as the sole source of nutrition up to 6 months of age, and in conjunction with solid food up to 12 months of age. If the baby's reflux does not improve within 2 weeks of starting SMA PRO Anti-Reflux, or if the baby fails to thrive, the family doctor should be consulted. • **SMA LF®** is a lactose-free milk based formula for the dietary management of babies and young children who are intolerant to lactose or sucrose, or who are experiencing symptoms such as diarrhoea, tummy ache or wind caused by temporary lactose intolerance. It is suitable as the sole source of nutrition up to 6 months of age, and in conjunction with solid food up to 18 months of age. SMA LF is not suitable for those who are allergic to cows' milk protein, or who suffer from galactosaemia or require a galactose free diet. • **SMA® PRO High Energy** is a milk based formula for the dietary management of babies and young children with medically determined high energy requirements as identified by a healthcare professional. It is suitable as the sole source of nutrition up to 6 months of age, and in conjunction with solid food up to 18 months of age. SMA® PRO High Energy is not intended for use with preterm babies, for whom fortified breast milk or a low birthweight formula such as SMA® PRO Gold Prem 1 is more appropriate.

SMA® Nutrition's Specialist formula range: the broadest, most comprehensive range available.

- ☑ Individually tailored to meet the challenges of specific feeding issues
- ☑ Based on latest advances in scientific and clinical research
- ☑ Wide availability in retail or to be ordered via pharmacy*

*SMA® PRO High Energy is available in pharmacies only.
NICE: National Institute for Health and Care Excellence
MAP: Milk Allergy in Primary Care

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ROI: 1800 931 832

sma® nutrition

Supporting you to support parents

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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.

93%

of health visitors said that the pay cap had caused a 'negative' or 'very negative' impact on morale

In a typical week

51%

of health visitors said that they 'always' worked more than their contracted hours

65%

of health visitors reported that their workload had 'increased a lot'

64%

of health visitors would 'probably not' or 'definitely not' recommend their own profession as a career in the NHS

Have a say in your pay

Make your feelings about morale and motivation known in the NHS Staff Survey, says **James Lazou**, research officer at Unite.

The English NHS Staff Survey* is out again, and Unite is calling on all NHS staff to ensure that employers and government are fully aware of how you feel about the state of the NHS. If you haven't received the survey yet, your employer will soon be asking you to fill it out.

We should be under no illusions – the results of the survey have an impact on your pay. Since 2012, ministers have used the survey to justify interfering in the normal pay-setting process for NHS staff and capping pay rises at 1%. The politicians argue that the NHS Staff Survey shows that the pay cap is not affecting staff morale and services.

We all know that this is simply not true. In August 2017, Unite carried out a survey of its health sector membership for our NHS Pay Review Body submission. Just looking at the health visitors' results illustrates the kind of pressure our members are under.

BLOWS TO MORALE

Nearly 93% of health visitors said that the public sector pay cap had caused a 'negative' or 'very negative' impact on morale, with 54% saying it had negatively impacted on services for patients; and 78% said that an above-inflation pay rise would improve job satisfaction.

Health visitors also complain of increased workloads. Compared with the same time last year, 65% of health visitors reported that their workload had 'increased a lot' while 22% reported that it had 'increased a little'. As many as 82% of health visitors and 76% of nurses reported 'frequent' staff shortages in their departments over the previous 12 months.

GOVERNMENT IN DENIAL

In a typical week, 51% of health visitors said that they 'always' worked more than their contracted hours. A further 33% also reported this happening 'frequently'; 65% of health visitors reported that these additional hours were 'all unpaid'.

When asked about their 'morale and motivation' over the previous year, 88% of health visitors reported that it was worse or a lot worse in their workplace. When asking why morale had generally worsened, the most frequent answer given was 'increased workplace stress' at around 90%. Pay was the second most frequent, and third was 'dissatisfaction with the quality of care you feel able to provide'.

Taking the above into consideration, it is perhaps unsurprising that 64% of health visitors would 'probably not' or 'definitely not' recommend their own profession as a career in the NHS and 45% had 'very seriously' considered leaving the NHS during the past year.

Sadly, the government continues to be in denial, either through incompetence or design. Unite is campaigning for this unfair policy to end and NHS staff to receive a truly decent pay rise. We can deliver this but we need your help to keep up the pressure. **CP**

WHAT WE ARE ASKING FOR

Fourteen NHS trade unions have come together to ask the government to give you a meaningful pay increase in April to help keep up with the cost of living and begin to make up for the years of lost pay. This will help secure the future of the NHS by making it a more attractive place to work. We are asking for:

- **A pay increase in line with inflation**
- **An £800 consolidated lump sum for all staff**
- **Meaningful discussions with government about how we make the NHS pay system better, fairer and more sustainable.**

*All countries have their own processes

The source of ignition

Former detective **John Carnochan OBE** reveals where his belief in early intervention began, its importance now, and the progress made in shifting the agenda.

After his well-received presentation at the Unite-CPHVA Annual Professional Conference 2017, *Community Practitioner* caught up with John Carnochan, a former detective chief superintendent at Strathclyde Police and now senior fellow at the WAVE (Worldwide Alternatives to ViolencE) Trust.

John has a way of speaking that cuts through the noise and makes you sit up and listen.

As the detective leading Scotland's fight against violent crime, he famously said that he would rather have 1000 more health visitors than 1000 more police officers.

A decade has passed since then, but he is no less emphatic in his belief in early years intervention: 'We're getting 500 new health visitors [in Scotland], but it ought to be 1000. That applies even more now – just look around you at what's happening with mental health.'

He adds: 'What a health visitor does is establish relationships with the people doing the most important job in our community and society – particularly mums, but dads as well.

'Every politician talks about how childhood is so important, about how we can protect children – but we can't help children unless we help parents, so what health visitors do is absolutely critical. It's that influence on mums and dads, that relationship. It's someone there at the right time saying "I'll help you through this".'

Is John concerned to hear that health visitor numbers are falling in England? 'The most important question is always why we want to do it. If the answer is to save money, then that's the wrong reason. If you want to set up the UK's future, it's by investing in something for 10, 20 years down the line.'

THE PREVENTION MOVE

During 40 years in the police force, John dedicated his working life, and since then his 'retirement', to tackling violence – though it's been from two very different perspectives.

In fact it was only after three decades working in Glasgow, then branded the violence capital of western Europe, that John shifted his focus from fighting fires to searching for the source of ignition. He hasn't looked back since.

John was tasked by then chief constable at Strathclyde Police, Sir Willie Rae, to come up with a homicide reduction strategy. John and his colleague, Karyn McCluskey, concluded that 'the homicide is happenstance. It was about the violence – we need to do something about that.'

In 2005, John and Karyn set up the Violence Reduction Unit (VRU), and began casting their net wide to pull in knowledge and expertise from a range of disciplines.

'We started working with public health people, educationalists, economists – people who I would never bump into in my job,' explains John. 'We started to look at doing things differently.

'We didn't have a plan or a strategy, we didn't have a goal except we knew we didn't want to be where we were, with that level of violence – we wanted to change that.'

Coming across the work of Vincent Felitti, a pioneer in research into the impact of adverse childhood experiences (ACEs) on adult outcomes, was a lightbulb moment.

'It just made sense,' says John. 'It's not about the language of "hard on crime" or "soft on crime" – that punitive response. We needed to start thinking about prevention in the same way health thinks about prevention; what would that look like?'

Over the past 12 years, the VRU has answered that question. In April 2006 it assumed a Scotland-wide role, bringing in a range of initiatives that helped cut levels of violent crime year after year.

With its fundamental tenet that 'violence is preventable – not inevitable', it changed the agenda, addressing the root causes of violence and treating it as much as a public health problem as a justice problem.

John was awarded the Queen's Police Medal in 2007 for distinguished police service, and in 2010 was made a fellow through distinction of the Faculty of Public Health. An OBE followed in 2013.

Even after his retirement from the police in 2014, he has continued to work in this area as an independent consultant and adviser on violence prevention.

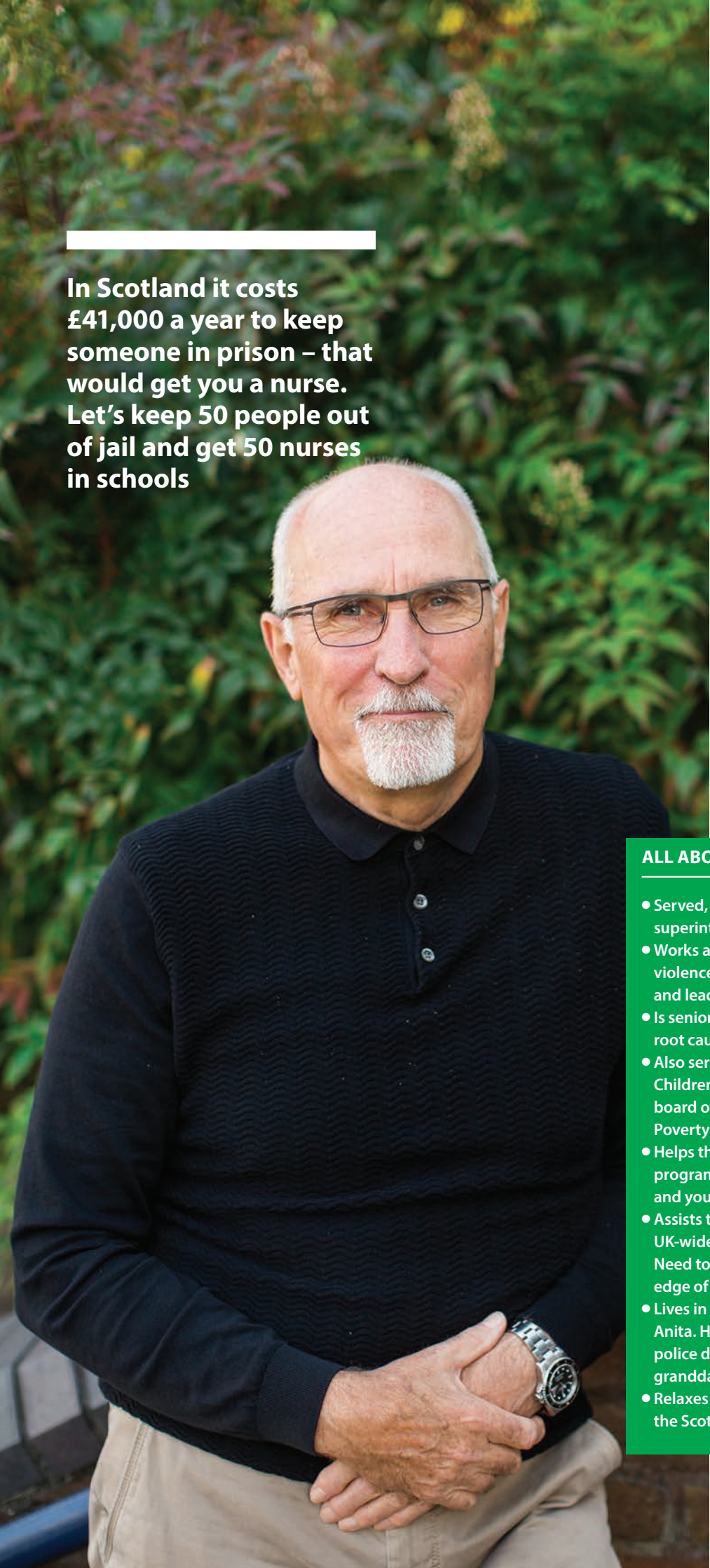
'IT'S RELATIONSHIPS, STUPID'

Now, more than ever, John believes getting it right for children is paramount – and the key to that is human relationships.

'There's that phrase from Bill Clinton's campaign, "it's the economy, stupid",' says John. 'But it ain't. We're humans first, so it's relationships, stupid. Health visitors are already doing that – it's their bread and butter. In establishing relationships with parents, they are supporting change, and in doing that they are helping to change other relationships – between mums and babies, fathers and children, and a mother's relationship with herself.'

Is he frustrated that after so long beating the drum for early intervention, it isn't higher up the public agenda?

'It takes a long time,' John says. 'It's fine to have strategies and diagrams and policies, but at the end of the day it's attitudes. As the saying goes, "culture eats strategy for breakfast". Unless you change the culture, you can have as many strategies as you like, but it won't work.'



In Scotland it costs £41,000 a year to keep someone in prison – that would get you a nurse. Let's keep 50 people out of jail and get 50 nurses in schools

WHERE ARE WE NOW?

'Wales is leading the way in terms of policy around ACEs,' says John. 'They have an ACE hub, and we have one set up in Scotland now – there are really good things happening.'

The risk if we don't get it right is hard to overstate, says John: 'It will get worse: more people going to prison, more crime, antisocial behaviour, alcohol, drugs. If we don't take the opportunity to invest, then we are just going to make it more expensive down the road.

'In Scotland it costs £41,000 a year to keep someone in prison – that would get you a nurse. Let's keep 50 people out of jail and get 50 nurses in schools, or 100 people out of jail and get 50 health visitors as well.

'When I said that I'd rather have 1000 more health visitors than police officers I made a joke as well. I said if you have 1000 extra police officers you'd need more prisons, more criminal justice social workers, more lawyers – and if you have more lawyers you'd need more BMW dealerships.

'It's about where you want to put your money – as simple as that.' CP

ALL ABOUT JOHN

- Served, until February 2013, as detective chief superintendent with Strathclyde Police.
- Works as an independent consultant and adviser on violence prevention, effective partnership working and leadership.
- Is senior fellow at the WAVE Trust, which tackles the root causes of damaging family cycles.
- Also serves as a trustee on the board of the Children's Parliament, a member of the executive board of Alcohol Focus Scotland and a friend of the Poverty Truth Commission.
- Helps the Tapestry Partnership develop its programme to improve the life chances of children and young people.
- Assists the Hunter Foundation in developing a UK-wide project in partnership with BBC Children in Need to improve the outcomes for children on the edge of care.
- Lives in Carluke in the Clyde Valley with his wife Anita. He has two daughters, one of whom is a police detective inspector, and a five-month-old granddaughter.
- Relaxes by playing golf and walking, especially in the Scottish Highlands and the Cotswolds.

CALL TO ACTION

More than 450 delegates from six different countries gathered to discuss the future of the profession at the annual professional conference at Cardiff Motorpoint Arena last month. During a lively two days, some 150 speakers shared their views and insight on the most pressing issues for community practitioners.

The event saw members from practice, academia, stakeholder organisations and government put forward their ideas on how best to tackle the areas of priority, one of which was identified as child abuse and neglect. Read on for a summary of the key insights.

What happened at this year's annual professional conference? We bring you the highlights.

We will rebuild public health, says shadow minister

Shadow secretary of state for health **Jonathan Ashworth MP** told members of his plans for a 'radical upgrade in prevention and public health', with health visitors and school nurses at the heart of that strategy.

'When I meet NHS staff they are working longer hours, with fewer colleagues, with bigger caseloads and more patients. It's not safe and it's not sustainable,' he told delegates.

'You have our gratitude, our support and our commitment that a Labour government will tackle vacancies, will bring back the training bursary and will scrap the pay cap.'

Highlighting the falling numbers of health visitors and school nurses in England, and the drop-off in enrolments, he promised to increase health visitor numbers and 'improve the uptake of specialist training, and improve recruitment and retention as well'.

'We want to make sure we have enough staff and services to enable this country to keep children safe,' he added.

Among his proposals was redirecting £250m spent on management consultancy in the NHS, requiring all government departments to develop a child health strategy, and a new child health index to measure progress against international standards.

He concluded: 'We will make it our target to rebuild the public health service, to rebuild health visiting in all our communities, to rebuild school nursing in all our schools.'

Transformational plans and public health – where are we heading?

Dr Nicola Jay explored the place of sustainability and transformation partnerships (STPs) on the children's public health agenda, in a presentation to delegates.

These 44 'place-based systems', in which councils and the NHS come together to deliver care, were introduced just a year ago and 'things have been very, very rushed,' said Dr Jay, a member of the Paediatrics in Medical Management Committee at the Royal College of Paediatrics and Child Health (RCPCH).

She highlighted the RCPCH analysis which found that just four STPs had any mention of early years provision, adding: 'That is extremely disappointing – and that's a very polite way of putting it.'

She also pointed to their lack of reference to other systems that feed into child health, such as schools, the youth justice system and adoption services, and shortfalls in chronic disability issues: 'STPs really aren't working. We all have a lot to do in terms of going back to our areas and finding out what's happening for children and young people's health.'

She also shared what the 'next step' for STPs might look like: the aim at her hospital, Sheffield Children's NHS Foundation Trust, was to move away from hierarchical structures towards collective responsibility.

What will you take away from this conference?

'I do feel reinvigorated by hearing the speakers, and I will be going back with a renewed focus and sharing with my colleagues. It's also about the networking, meeting other nursery nurses and finding out what's going on in other parts of the country – not just in your own little area'

Sally Robinson, *community nursery nurse from Ashford*

'There's quite a lot on the programme. It keeps you up to date and there is a lot of networking going on. There's a lot for us to bring back to the team'

Emma Burstow,
health visitor from Tunbridge Wells

Transitions in care

In a talk covering transitions in care, the importance of preparing disabled children and young people early and empowering them came through loud and clear.

Hannah Warwick, principal officer for social care at the Council for Disabled Children, shared some of the guidelines around transitions in care for children with disabilities and special educational needs.

Among those insights was the need to include young people and their carers in the service design, and to take a 'person-centred' approach – supporting the young person to direct their own care over time.

And she told of the risks when people fall through the gaps – of decreased support, not engaging with services and a lack of leadership and accountability.

'Transition is not the same as transfer,' said Hannah. 'It's about empowering young people.'

She shared the powerful testimony of Katy, a young woman with cerebral palsy, who was left feeling like a 'broken object', and went through her transition in care largely unsupported, alone and uncertain how her condition would affect her adult life.

Hannah urged practitioners to be ambitious: 'Outcomes for young people are all different – but the support from professionals should not be.'

• Turn to page 48 for Hannah's take on young people and transition.

CONFERENCE COUNTING

457 delegates from six different countries

39 exhibitors

Speakers, including poster presentations 150+

4560 cups of tea drunk

The horrors of 'honour-based' abuse

Eyes were opened to the realities of honour-based abuse and forced marriage during the Nick Robin Memorial Lecture, which closed the first day of conference.

Jasvinder Sanghera, the founder of Karma Nirvana, a charity and helpline for victims of such abuse, shared her account of being disowned by her family at 15 when she ran away to escape a forced marriage to a man she'd never met.

She described how the harrowing fate of her sister Robina, who died after setting herself on fire to escape her own forced marriage, was the catalyst for founding the charity, which now takes 850 calls a month – including many from professionals seeking advice.

Jasvinder said: 'Families will use culture, tradition, religion [as an excuse]. We have to frame this as a safeguarding issue, as a child-protection issue.'

Other insights included that of honour-based abuses always have multiple perpetrators, often including female relatives – even the victim's own mother.

● **See page 48 in the August 2017 issue for Jasvinder's *Last word*.**

'We are humans first'

Almost 10 years on from the last time he spoke at a CPHVA conference, **John Carnochan** was back, and beating the drum for early intervention all the harder.

The former detective chief superintendent, who once caused headlines when he said he'd rather have 1000 more health visitors than 1000 more police officers, touched hearts and minds with his compelling presentation that reminded delegates of the power of connection and the human qualities that made a difference in their work.

'Why don't we recruit people because they care – because they have compassion?' he asked. 'We are humans first; we can't help ourselves but be connected.'

He told how by working in the Violence Reduction Unit at Strathclyde Police he'd come to understand the impact of adverse childhood experiences (ACEs) and how vital early interventions are in reducing violence.

Rather than chipping away at the top of the iceberg, he said: 'If we want to reduce violence we have to think about how to raise the temperature of the water.'

And, as Frederick Douglass once noted, he said: 'It is easier to build strong children than to repair broken men.'

● **Read more about John and early intervention on page 18.**

Our focus is on our children, says chief nurse

Chief nursing officer for Wales and nurse director of NHS Wales **Jean White** welcomed delegates to Cardiff in her video address on the morning of the second day of conference.

She shared a little of the work going on in the nation, telling delegates: 'For us here in Wales, we have a particular focus on early years and making sure all our children have the best start in life.'

Areas of focus include 'tackling adverse childhood experiences, which sadly so many young people experience' and 'trying to move care closer to home'.

And she said the role of 'primary care-based nurses is vital to the way we deliver services for our population in Wales'.

51
posters

1
The number of choirs created as a result of the leadership session with new honorary president Carrie Grant

45,861
steps taken over two days

Poster prizes

BEST PRACTICE DEVELOPMENT POSTER
Winner: An integrated targeted intervention to prevent obesity in infants born into a diverse community
Julie Greenway, *health visitor team leader, Black Country Partnership Foundation Trust*

BEST RESEARCH POSTER
Winner: The Health Visitor Observation and Assessment of the Infant (HOAI)
Amanda Holland, *lecturer – public health, Cardiff University*

THE PEOPLE'S CHOICE AWARD
Winner: Evaluation of a 0-19 public health advice line
Lena Abdu, *health visitor/ clinical team leader, First Community Health and Care;* Athina Doyle, *health visitor, First Community Health and Care;* Chris Jones, *health visitor, First Community Health and Care*

LOCAL ACCREDITED REP OF THE YEAR 2017
Winner: Liz Brumwell

NSPCC urges parents to 'take 5'

The NSPCC has launched a new campaign in Wales promoting 'positive parenting' designed to help tackle child abuse.

The Take 5 campaign, presented to delegates at the CPHVA conference a day after its launch, encourages parents to pause when they feel 'at the end of their tether' in order to react calmly to their children.

Take 5 incorporates a poster campaign, developed with the help of parents, which features common 'trigger moments', such as when children throw a tantrum in the supermarket or refuse to get dressed in the morning – and the tagline 'Stop. Breathe. React calmly.'

Among those presenting the campaign to conference was **Christopher Cloke**, head of safeguarding in communities, NSPCC, and honorary vice-president, Unite-CPHVA.

He said health visitors and school nurses and other community practitioners 'really have a role in supporting positive parenting and alternatives to smacking'.

He also said it was time for law and policy to catch up with public opinion: 'Physical punishment has no place in 21st century parenting.'

Refer early and often to save babies' lives, health visitors told

Parity of esteem between mental and physical health is key – this was the message impressed upon delegates by **David Foreman**, from the Royal College of Psychiatrists and King's College London.

Drawing on a wealth of evidence, he sought to demonstrate not just the need for practitioners to assess mental health issues in children and mothers, but also the dramatic difference their interventions can make.

Professor Foreman's message was that the arrival of a new baby is a time when health visitors are in a position to reach even the families that are most difficult to get hold of.

He added: 'Refer early, refer often, work as a team. Paying attention to mums' mental health saves the lives of babies.'

While he referred to studies which showed even lay-based interventions could have an impact on postnatal depression scores in new mothers, he added: 'One critical thing is getting trained. It's the most effective way of improving detection rates – and a little goes a long way at the treatment level.

'We have seen that no treatment, just advice, has a significant effect – you can double that effect if you get training as well.'

CPHVA EDUCATIONAL AND DEVELOPMENT TRUST – MACQUEEN BURSARY WINNERS 2017 ***Alis Rasul, Telisha Jenkinson, Maura Hubbard, Judith Nembhard and Sue Fitzell***

Childhood trauma causes health to deteriorate '10 to 15 years faster'

Traumatic events in childhood, such as neglect and child abuse, lead to poorer physical and mental health, said **Mark Bellis**.

Professor Bellis, a policy director at Public Health Wales and the chair of the WHO Centre for Violence Prevention, was describing the effects of ACEs.

In England and Wales, almost half of all children have one ACE, and one in 10 suffer four or more.

Victims are more likely to suffer a host of ill effects including diseases such as diabetes, cancer and heart disease, and are more likely to develop drinking problems, take drugs, have underage sex, and end up in prison.

Professor Bellis said ultimately their health was deteriorating '10 to 15 years faster than those who didn't have any ACEs'.

But Professor Bellis said that children can still thrive in later years. He said: 'A trusted adult can make all the difference.'

● **See page 44 in the July 2017 issue for Mark's *Last word*.**

From childhood abuse to damehood: Elizabeth Anionwu shares her journey

Professor Dame Elizabeth Anionwu closed this year's conference with a moving account of her journey through the profession – and through her life.

She told delegates of her years in care, and the cruelty she experienced, including the physical abuse from her stepfather after she went to live with her mother.

But woven into her account was a narrative of hope – the kindness from others, her own determination, and a series of 'rescues' which led her to get to know her father and reconnect with her Nigerian heritage, to study nursing, and become aware of sickle cell disease in her work as a health visitor.

From there her stellar career includes her appointment as the first ever UK sickle cell/thalassaemia nurse counsellor, more than a decade as head of a sickle cell information and screening centre, and setting up the Mary Seacole Centre for Nursing Practice at University of West London.

She was awarded a Damehood earlier this year.

Insight into the dangers of chronic stress

People regularly working more than 11 hours a day have a likelihood of depression 250% higher than those working fewer hours.

This was the shocking statistic with which **Ivan Robertson** began his talk on resilience to a packed auditorium.

Evidence for the physical damage wreaked by poor levels of psychological wellbeing was 'absolutely clear in three areas', he said – cardiovascular health, weight and diabetes, and the immune system.

He added: 'If you stay chronically under pressure, the cortisol keeps coming, and the whole system starts to break down.'

The antidote, he said, is resilience, which helps protect psychological health, but he rejected the 'simple sticking plaster solution of building resilience in individual employees', adding that 'senior leadership need to engage… making the workplace a fit and proper place to work.'

Factors that can improve resilience include overcoming tough challenges, although he cautioned that 'respite from the challenge is really critical'.

Crucially, Professor Robertson concluded that 'physical activity is the closest thing we have to a magic bullet to improve psychological health and wellbeing'.

What will you take away from this conference?

'We have just moved under the local authority, and what I will be taking back today is that we really need to evidence our outcomes for children and young people. In early years they are very good at doing that and we need to be better at it'

Catherine Churchill, *pathway lead, stakeholder engagement, at Lincolnshire Community Health Services*

'I enjoyed the talk on ACEs. It was quite visual and showed how we can make changes and put prevention in place'

Rebecca King, *nursery nurse from Tunbridge Wells*

Carrie Grant @CarrieGrant1
The @Unite_CPHVA union are totally dedicated to their members – this really came across yesterday, so many ideas on how the union can help.

su L0we @saffie
I don't normally sing until Xmas! 3 days #CPHVA17 conference and I've laughed and sung and cried.

Zarida Riaz @zaridariaz
#CPHVA17 "It's easier to build strong men" @JohnCarnochan you are #inspiration

Unite_CPHVA @Unite_CPHVA
Have you heard of 'parity of esteem'? #CPHVA17 audience not sure about this campaign to diagnose & treat mental & physical health equally.

Holly Claire @hollyastley
To ensure the future of the NHS, then prevention must be at the heart of any change #CPHVA17 @Unite_CPHVA @JonAshworth

#hellomynameis Jenny @loftyjen
Cultural differences shouldn't stop effective safeguarding @Jas_Sanghera_KN #CPHVA17

DON'T MISS OUT ON NEXT YEAR'S CONFERENCE!

It's by the sea in Bournemouth on 17 to 18 October 2018. Register your interest at **cphvaconference.com**

Welsh rhythms

The Unite-CPHVA party is legendary, and this year's event was no exception...

I FEEL SCARED AND UPSET WHEN MY PARENTS ARGUE

SUFFER THE CHILDREN

Children can be the silent victims when their parents' relationship goes sour, reports journalist **Phil Harris**. But with the right awareness, it doesn't have to be that way…

Sophie* from London will never forget the night her husband Rob* admitted he was having an affair.

'I thought it was a joke at first. Then came a massive wave of shock, disbelief, rage and despair. I felt it was the ultimate betrayal – not just of me, but our whole "team" – our 12-year-old son, twin girls aged five, and our 12-month-old baby.'

The next six months were a rollercoaster ride as the couple tried to make things work. But every discussion soon descended into shouting and resentment, with most of it played out in front of the children, she says. 'The kids would plead with us to stop, or just run and hide.' Eventually Rob moved out.

'I think it hit my son the hardest,' Sophie continues. 'And in ways I didn't expect. He started being very hard on my girls, like getting angry with them for wasting food and acting like he was their father. He became very bitter about Rob and wouldn't even be in the same room. I didn't do much to discourage that, if I'm being honest.'

The impact on children when relationships break down has been in the spotlight of late, courtesy of the hit TV drama series *Dr Foster*, in which a couple's once-happy marriage slowly unravels, and their angry and confused son becomes violent, behaves inappropriately towards girls, gets excluded from school and eventually runs away from home.

And like all good dramas, it hits home because there's more than a kernel of truth to the story.

COUNTING THE COST

Clearly it's impossible to know how many children are affected by parental discord, but some insights can be gained from divorce levels, and in 2015 there were 101,055 in England and Wales, with around 100,000 children involved every year (Office for National Statistics, 2017).

There are also around 10,000 divorces each year in Scotland (National Records of Scotland, 2017) and more than 2000 in Northern Ireland (Northern Ireland Statistics and Research Agency, 2017). Plus there are also many unmarried couples with children who separate, so the real number of families and children affected by parental relationship breakdown across the UK will be significantly higher.

Of course divorce isn't the only time when children can feel adverse effects of their parents' relationship. According to the NSPCC, in 2015-16 there were more than 39,000 sessions provided by Childline counsellors

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for children across the UK in relation to family relationships and problems in the home. Nearly one in five (18%) of these took place during the school summer holidays when families spend more time at home together.

The NSPCC says callers commonly report feeling depressed, lonely and isolated. Worryingly, some young people felt their family life was so unhappy they were considering running away from home or even harming themselves.

One of the older children callers said: 'I feel scared and upset when I see my parents argue. Sometimes they swear and scream at each other and other times they hit each other. It triggers my depression and I start to self-harm to cope.'

Family problems, including parental conflict or separation, are second only to low self-esteem and unhappiness as the main reason children call Childline.

THE TRUE IMPACT

Parental conflict can have many negative consequences for children, and this often means emotional or behavioural difficulties. There is a considerable body of research on the subject, going back almost 90 years.

There is a strong evidence base to show that children's social relationships suffer, as they become more likely to develop poor interpersonal skills (Harold et al, 2007) which can cause difficulties for the child in getting on with other children, their parents and grandparents, their siblings, and teachers.

In later life this can mean they are less likely to be able to form successful relationships with romantic partners. It is also linked to anxiety, depression, aggression, hostility, antisocial behaviour and criminality (Harold et al, 2007).

School life can be affected, with children of warring parents being less able to settle and more likely to struggle to make friends. They are also less likely to achieve academically due to the impact on their cognitive abilities (Tavistock Relationships, 2016).

The effects can be physical, too. Research shows that children of conflicted parents have a higher risk of health problems including digestive illnesses, fatigue, reduced physical growth, headaches and abdominal pains. They may also have problems sleeping (Tavistock Relationships, 2016).

Dr Sarah Helps, a consultant clinical psychologist at the Tavistock and Portman NHS Foundation Trust and the Association for Family Therapy, says she has seen these issues constantly during the 25 years she has spent working with families.

'Obviously it's a very common experience that parents don't always get on, and sometimes relationships break down.'

'[But] if parents are saying nasty things to each other in front of the children, or saying negative things to the children about each other, then that puts the child in a very difficult and stressful position, and causes considerable anxiety.'

Children may then mirror what they have experienced at home in other environments, such as being confrontational with other children or teachers, refusing to co-operate or being disaffected. They may be jumpy, watchful or on edge, ready for something bad to happen.

She adds that often children worry about their parents' relationship but feel helpless or even to blame for what is going on at home.

'Sometimes it can be better for the kids in the long run if the family breaks up.'

There is also a body of evidence that parental discord, particular at the more extreme end of the spectrum, can affect the architecture and chemistry of the developing brain, leading to difficulties in how affected children deal with relationships in future (van Goosen et al, 2008).

CALLS TO CHILDLINE

39,000

The number of sessions provided by Childline counsellors for children across the UK in relation to family relationships and problems in the home in 2015-16

1 in 5

of these took place during the school summer holidays when families spend more time at home together

(Source: NSPCC, 2016)

DOMESTIC ABUSE – THE IMPACT ON CHILDREN

This article focuses on the impact of non-violent parental discord such as repeated arguing and verbal hostility, silence and emotional withdrawal. Domestic abuse is of course a different matter altogether, with immediate safety considerations for adults and children alike.

Statistics suggest that 6.5 million adults in England and Wales have experienced domestic abuse (ONS, 2016), and 20% of children have been exposed to it (Radford et al, 2011). Many children cope with and survive abuse, displaying extraordinary resilience. But the physical, psychological and emotional effects can be severe and long-lasting. Experts say domestic abuse is one of the most serious risks to children in our society (Refuge, 2017).

Consequently calls are growing for more action. In September this year, Ofsted called for more focus on children in cases of domestic abuse and a greater awareness of how it affects their wellbeing. And in October NICE issued guidance on child abuse and neglect, including advice on how to identify 'soft' signs.

RESOURCES

Department of Health. (2017) *Guidance for practitioners*: bit.ly/DH_guidance
National domestic violence freephone helpline (24 hour): 0808 2000 247

WHEN MY PARENTS ARGUE IT TRIGGERS MY DEPRESSION AND I FEEL THE NEED TO SELF-HARM

AN ALTERNATIVE PATH

Thankfully, relationship issues don't automatically mean there will be a negative effect on children. 'The impact on a child primarily depends on how the adults are able to resolve their arguments between themselves and how they are able to model the skills to do this,' says Dr Helps. 'What children need is a story, an account that makes sense to them.'

And it's the unresolved conflict in particular that is damaging. Dr Helps explains: 'All parents argue at some point and most kids turn out ok. But there can be negative and damaging consequences if the conflicts are not being resolved.'

She says that children exposed to arguments do not necessarily suffer as long as their parents are showing that they can resolve them, such as through compromise or agreement.

Nicole Hobson, a Family Nurse Partnership supervisor in Suffolk, agrees that while conflict is normal in all relationships, the amount and nature of that exposure is important in determining how children are affected.

'If this becomes a regular normal experience, children will internalise this as normal, and think that conflict is dealt with in that way. Parents are models of behaviour, and children mirror what they observe and are exposed to. If it becomes internalised, this becomes the child's internal working model.'

Nicole adds that having a baby has a dramatic impact on all parents, and this can be a key time when relationship difficulties arise.

HOW PROFESSIONALS CAN HELP

Health professionals such as health visitors and school nurses are well placed to help families suffering from conflict.

They need to be mindful of and look out for obvious signs, such as poor communication between parents and a lack of togetherness or joint parenting, and not being afraid to ask about any such difficulties.

This can give parents an opportunity to talk about how conflict may be affecting them and their children. This in itself can often be of enormous benefit and relief to people who may have been struggling with such issues for a long time.

'It is important to raise awareness with parents [of how their conflict may affect their children] and talk about challenges at each contact, and to be curious,' says Nicole.

'When it comes to having a baby, professionals need to be open in discussing how this is affecting the relationship, both positively and negatively. They can play a vital role in devising strategies to help and support.'

School nurse Claire Elwell, in Tyne and Wear, says the role of school nurses is crucial in this area, as they are a trusted authority figure children can approach, and are well placed to intervene.

'Children will often try to protect their parents and become secretive. But kids [still] hear everything. They learn from adult behaviour and the sad fact is that negative behaviour can then play out throughout these children's lives, with the process repeated.

'In some cases I have to point out the impact to parents as they haven't acknowledged it. In other cases the child comes to me for advice on how to handle situations. Sometimes they might have been brought in for behaviour or health, and during assessment parental relationship problems are brought up.

'We can offer early help directly and promptly, and we can discover and identify issues. This is all about careful and tactful communications, being child focused and keeping their needs central.'

Claire says that school nurses can be instrumental in arranging early referral to mental health specialists where necessary, but the day-to-day intervention is also vital.

'The main thrust should be talking to kids, age appropriately and helping them understand what's happening. It's important to make sure they don't think it's their fault, and that they are loved. All professionals should have this insight.'

PEARLS OF WISDOM

Not all conflict is the same in its severity, and so it is perhaps understandable that some practitioners may feel reluctant to open up the issues relating to couple distress for fear of not knowing what they can offer.

Social embarrassment or concern about social services getting involved can also mean that parents may try to keep their discord secret from outsiders, but Dr

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SOMETIMES THEY SWEAR AND SCREAM AT EACH OTHER AND SOMETIMES THEY HIT EACH OTHER

Helps says there are many telltale signs professionals can watch out for.

'Some signs in children are obvious, such as changes in behaviour – becoming more aggressive or tearful when they are not usually like that. Younger children can become much more clingy, or even much less so because they don't feel they trust the adult to love them back.'

She adds that bedwetting is common, even in children who have previously been dry for some time.

'The effects on children can be subtle but they are there to see if you look out for them. For example, when one parent is slagging off the other one, the child can pick this up and start using language that doesn't sound like it belongs to them.'

There are other signs of neglect, such as changes in who is taking children to school or nursery, and of course changes in appearance such as dirty clothes. Any signs of potential neglect, abuse or domestic violence should be cause for significant concern (see *domestic abuse* box, page 28).

Practitioners can also help to signpost families to the many sources of support, online and across the UK (see *resources*) and reassure them they will not be judged.

For Sophie, the growing impact on the children was a 'cold shower' that prompted her and Rob to try to improve the situation. 'My health visitor came round one day and it all came pouring out of me, all the things I was seeing in the kids. I realised that being bitter wasn't helping any of us, so I talked to Rob and we agreed that we needed to stay calm and be respectful to each other, and show the kids we were in control and things could be stable.

'She helped me to explain it to them in a way that made sense – that although we had stopped loving each other, it didn't mean we had stopped loving them, and that it was fine for all of us to feel sad and angry about it, but we were still their parents. They needed a story that made sense to them.

'In the end we split up, but things have definitely improved. My son now meets up with Rob and his girlfriend, and the girls seem happier.

'It's not always easy, but we're still a family – just a bit different to what we used to be.' **CP**

RESOURCES

ASSOCIATION FOR FAMILY THERAPY AND SYSTEMIC PRACTICE: Offers advice and training on relationships and counselling **www.aft.org.uk**

EARLY INTERVENTION FOUNDATION: Carries out research and provides resources **eif.org.uk**

ONE PLUS ONE: A charity dedicated to research and training on family relationships. Provides courses for professionals **oneplusone.space**

SOLIHULL APPROACH: training and resources for practitioners **solihullapproachparenting.com**

These can also be highlighted to parents:

Family Lives (familylives.org.uk) in England and Wales, Children 1st Scotland (children1st.org.uk) and Parenting Northern Ireland (parentingni.org)

NSPCC: Resources on safeguarding **nspcc.org.uk**. Children can call Childline (**0800 1111**) or visit **childline.org.uk**

RELATE: UK-wide counselling **relate.org.uk**

TAVISTOCK RELATIONSHIPS: parenting groups for couples and training courses for professionals **tavistockrelationships.org**

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*Names have been changed

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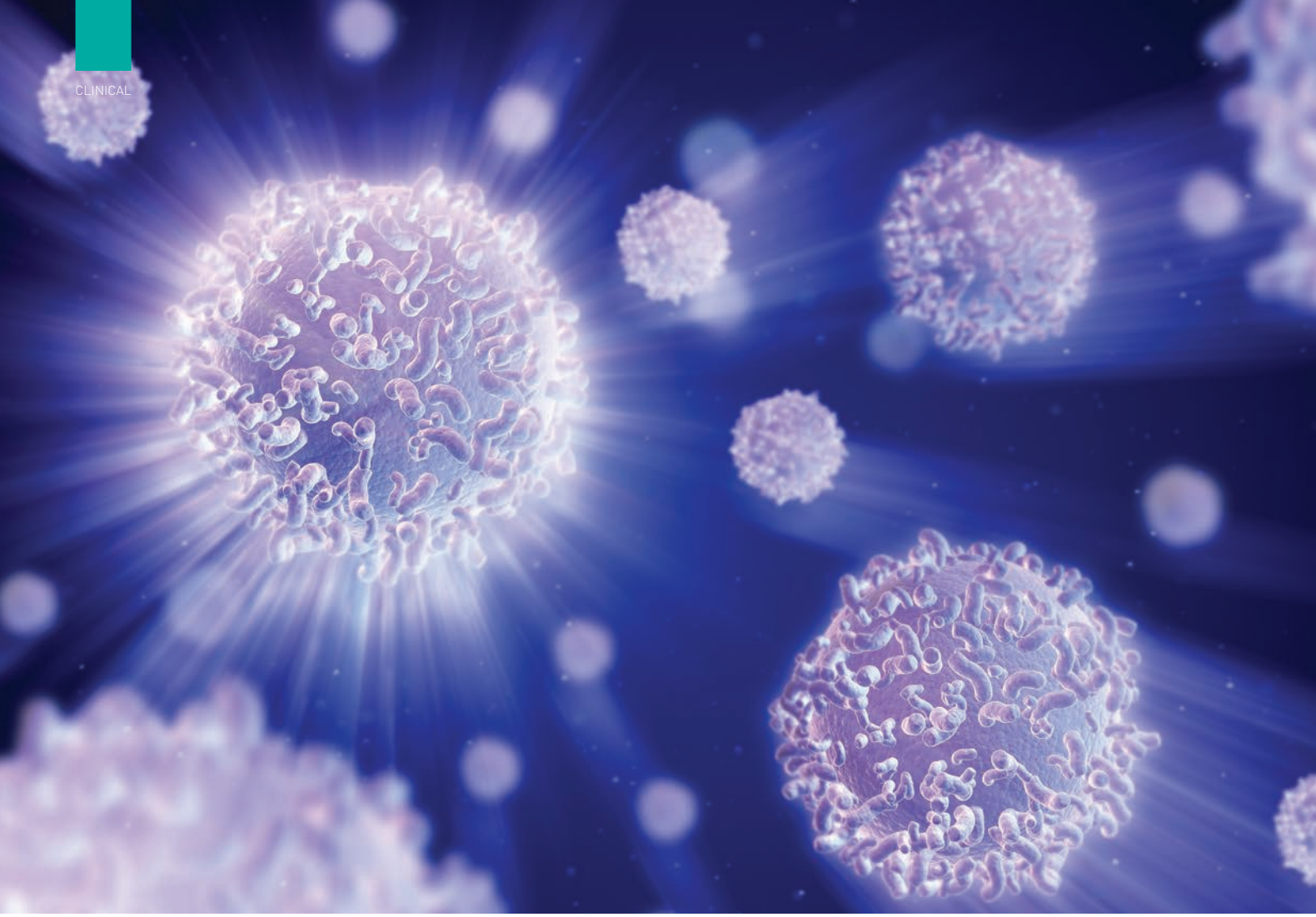
Dippy eggs now safe for all!

The Food Standards Agency has confirmed that it's safe for infants, children, pregnant women and elderly people to eat their eggs runny, enjoying all the goodness they contain – as long as they have the British Lion stamp on.

British
Lion Quality

British Lion eggs are approved by the Food Standards Agency to be served runny, or even raw, to pregnant women, young children and elderly people

To find out more about British Lion eggs visit egginfo.co.uk



Sepsis in the COMMUNITY

Health campaigns are finally raising awareness of the life-threatening infection, sepsis. Independent nurse and health visitor **Dorothy Karikari-Boateng** takes a closer look, including how to spot and advise families on the infection.

Where is the place for sepsis as a discussion topic or technical subject in community health? Someone dies from sepsis globally every 3.5 seconds (UK Sepsis Trust, 2017) and it accounts for the majority of pregnancy-related deaths in the UK (Acosta et al, 2013). The WHO estimates that six million lives are lost to sepsis annually. Around 44,000 of these are in the UK (UK Sepsis Trust, 2017).

It's hard to overemphasise the importance of awareness of sepsis, its symptoms, and the steps to take in the event of a suspected case of sepsis in any health setting, in this case community health. Yet many people have either never heard of sepsis, or only in passing, until its devastating effects come knocking at their doors.

England and Wales had recent public health campaigns, and Northern Ireland is working with the UK Sepsis Trust to get a plan in place. Meanwhile, a campaign to raise awareness of sepsis in Scotland was announced at the end of September, albeit three weeks after the Scottish Government said it didn't think such a campaign was 'necessary at this time' (BBC, 2017).

These campaigns come after a number of medical and health organisations have been working for years to raise awareness and reduce mortality, with WHO making sepsis a global health priority in May this year (Reinhart et al, 2017).

In this article we take a closer look at sepsis, its definition, causes, symptoms and treatments, and what a community practitioner can do when confronted with a suspected case of sepsis in the community, as well as resources for support.

WHAT IS SEPSIS, EXACTLY?

Sepsis is a life-threatening infection in the body that overwhelms the immune system so that the immune response

SIGNS AND SYMPTOMS

Children under five

If this age group show any sign of sepsis, immediate attention must be given. Symptoms in this age group include:

- **Altered mental state – drowsiness or lethargy**
- **Behavioural changes – refusal to feed, frequent/incessant crying, clinginess**
- **Skin changes – mottled or ashen appearance, cyanosis of skin/mucous membranes, non-blanching rashes**
- **Physiological changes – fewer wet nappies, infrequent passing of or lack of urine for 12 hours**
- **Noisy breathing**
- **Muscle pain and refusal to move (not their usual active self)**
- **Extremely cold to the touch**
- **Has a fit or convulsion.**

Older children and adults

- **A change in mental state – such as confusion or disorientation**
- **Nausea and vomiting**
- **Slurred speech**
- **Severe muscle pain**
- **Severe breathlessness**
- **Reduced urine production compared to normal**
- **Cold, clammy and pale or mottled skin**
- **Loss of consciousness**
- **Localised symptoms such as redness, swelling, heat and pain in an area of suspected infection.**

For all ages

Using age-appropriate criteria, a community practitioner should stratify the severity of risk of sepsis based on:

- **Temperature – above 38°C or below 36°C**
- **Breathing rate, as well as assessing breath sounds**
- **Heart rate.**

(Sources: NHS Choices, 2017; PHE, 2017; The UK Sepsis Trust, 2017)

It's hard to overemphasise the importance of awareness of sepsis, its symptoms, and the steps to take in the event of a suspected case

causes damage to tissues and organs. It is often referred to as septicaemia or blood-poisoning, but these terms refer to the infection's invasion of the bloodstream (the sequential step before sepsis, which may or may not occur) rather than the tissues and organs. It is also mistaken for septic shock, which is sepsis that causes dangerously low blood pressure (shock) – as a result, internal organs typically receive too little blood, causing them to fail. Septic shock is a possibility if sepsis goes untreated (NHS Choices, 2017; Singer et al, 2016).

Although bacterial infections are by far the most common cause of sepsis, viral and fungal infections can also be implicated. Sepsis can be triggered by an infection anywhere in the body, from something as small as a scratch on the skin right through to abdominal infections, lung infections, urinary tract infections, and post surgery. Sometimes the source of infection or site of origin are never found, so it's important not to get bogged down in trying to locate the source.

WHO IS AT RISK?

Anyone can develop sepsis after an injury or minor infection, although some people are more susceptible. The groups at higher risk of sepsis (NICE, 2017; 2016) are:

- The very young (under one year) and very old (over 75 years) or very frail older persons
- Those who have just had surgery or an invasive procedure in the past six weeks
- Those with a weakened immune system, either because of a medical condition (such as diabetes or sickle cell disease) or ongoing drug treatment (cancer patients, steroid users)
- People with any skin breach (such as cuts, burns, blisters or skin infections)

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- People with in-dwelling lines, such as long-term catheters or feeding tubes
- Women who are pregnant, postpartum or have had a termination or miscarriage within the past six weeks
- People who are genetically prone to infections – for example, cystic fibrosis and lung infections
- Anybody on a long inpatient stay with a serious condition, and anybody who has recently returned home from a long hospital stay.

WHAT TO LOOK OUT FOR

Sepsis is difficult to identify with certainty even in the presence of a history of infection. The signs and symptoms at the early stages are often non-specific, resulting in missed diagnosis. Community practitioners must be tuned in and adopt a 'could this be sepsis?' attitude, especially when dealing with an unwell patient with an infection, and particularly in the higher risk groups. This way, you can help to reduce avoidable deaths.

Having adopted this way of thinking, you need to make a face-to-face assessment of the person suspected of having sepsis, followed by stratifying the risks and putting into place a plan of action.

Early symptoms of sepsis often resemble a viral illness. This makes sepsis difficult to diagnose (Journal of Family Health Care, 2016). However, if a child develops any of the 'red flag' symptoms (mottled, blue or pale skin; lethargic or difficult to wake; feels cold; fast breathing; non-blanching rash; fit or convulsion – see 'Signs and symptoms' on the previous page for an expanded list) then parents, carers and community practitioners must take immediate action.

WHAT'S NEXT? YOUR ROLE

Services provided by community practitioners are not intended to be a treatment or diagnostic service for the acutely unwell. However, when attending somebody who is unwell, the practitioner must have the knowledge to help parents and carers make a decision about the most appropriate course of action, and direct them to the most appropriate help, based on the presenting symptoms.

If you suspect sepsis, acting quickly is important. With consent, report your concerns to a GP as soon as possible. If a GP is not accessible, call NHS 111 (in Wales, NHS Direct 0845 46 47; In NI, GP out of hours). and tell them you suspect sepsis. Using the national early warning score* is a great aid to help with decision-making. NICE sepsis guidance algorithms can also be a great help.

If the patient has recently had an infection or injury, get urgent medical advice from a GP or NHS 111. This will help to stratify it into either medium or high risk. Severe sepsis and septic shock are medical emergencies.

In fact, community practitioners should have direct access to their aligned GP surgery or local A&E department and should be able to get a doctor to see the patient within 30 minutes if possible (for red flag symptoms or all cases involving under ones and over 75s).

Be alert if the patient has any additional factors that put them at higher risk. So for instance, if they are under one year old, over 75, have impaired immunity, just had a baby, or are not acting themselves (NICE, 2013).

SEPSIS BY NUMBERS

Someone dies from sepsis globally every

3.5 secs

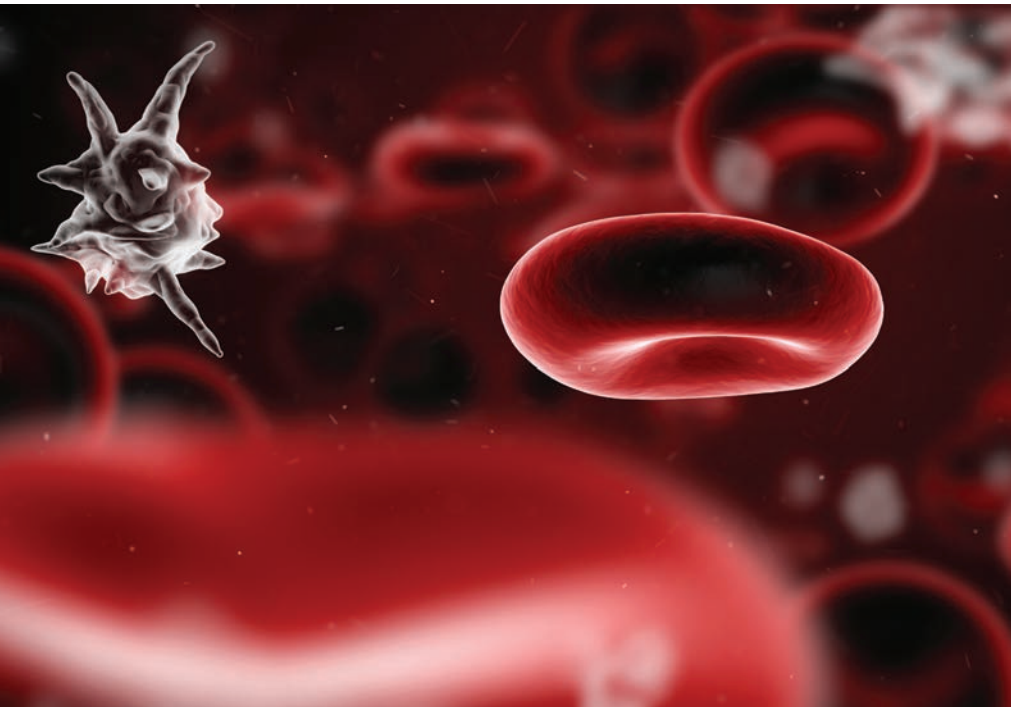
6 million

the lives lost to sepsis every year globally

44,000

the lives lost to sepsis every year in the UK

(Source: UK Sepsis Trust, 2017)



***A COMPOSITE SCORE OF SIX VITAL PARAMETERS – heart rate, blood pressure, oxygen saturation, body temperature, respiratory rate and mental state.**

Computer templates such as Sick Patient EMIS, Sepsis SystemOne, which aids in recording and prompting, can help see what is abnormal for the age of your patient/client.

ADVISING PARENTS AND CARERS

Make parents and carers aware of the signs and symptoms of sepsis, and when they should seek immediate medical attention. Give them information on local healthcare services, including the GP's contact details, when to call 999 or attend the nearest A&E (for red flag symptoms), and when to call NHS 111 (Public Health England (PHE), 2017).

Parents and carers need to know that prevention is the best course of action to avoid the development of sepsis. For example, good hand hygiene can help, especially when handling food and caring for wounds. Children should be fully vaccinated according to the national immunisation schedule, against preventable infections. At-risk adults should have their pneumococcal vaccination and flu vaccines when advised. This will help to protect them from developing respiratory infections, which can lead to sepsis.

About one in 10 sepsis cases follows a skin infection (Novosad et al, 2016). Wounds should be washed with soap and water, cleaning out any dirt or debris, and then covered. Good foot-care practices are vital for people with diabetes, since wounds can often develop dangerous infections.

A quarter of all sepsis cases are estimated to be a result of urinary tract infections (National Confidential Enquiry into Patient Outcome and Death, 2015), so these infections should be treated promptly.

Also, patients should check with their GPs immediately about any infection that is not improving or seems to be getting worse with symptoms such as redness, swelling, discomfort and pain, localised heat in the affected area, or fever and chills.

As well as these alerts, reassurance is important. Many people, especially children, recover from sepsis completely and their lives return to normal (PHE, 2017).

In conclusion, the majority of sepsis cases are caused by community-acquired bacterial infections (rather than those that start in hospital) that are sensitive to antibiotic treatment. Less than 20% relate to healthcare-associated infections (Friedman, 2012). To put this in context, sepsis has the same frequency of occurrence as heart attacks, and a death rate close to that of lung cancer (NHS England, 2015). So awareness of sepsis and its symptoms as well as prompt management is imperative in community practice (McCarthy, 2016). CP

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PROFESSIONAL RESOURCES

Sepsis in children: information for health visitors and school nurses (PHE, 2017) gov.uk/government/publications/sepsis-in-children-advice-for-health-visitors-and-school-nurses
Sepsis: recognition, diagnosis and early management: NICE guidelines QS161 (2017) nice.org.uk/guidance/qs161/history
Sepsis: recognition, diagnosis and early management: NICE guidelines NG51 (2016) nice.org.uk/guidance/ng51/chapter/Recommendations
Clinical tools (The UK Sepsis Trust in collaboration with NICE, NHS England and other experts) sepsistrust.org/education/clinical-tools/
Care of deteriorating patients. Consensus recommendations.
SIGN 139 (Scottish Intercollegiate Guidelines Network, 2014) sign.ac.uk/assets/sign139.pdf
Sepsis toolKit (RCGP) rcgp.org.uk/clinical-and-research/toolkits/sepsis-toolkit.aspx

These can be highlighted to parents:
NHS Choices. Sepsis nhs.uk/Conditions/Blood-poisoning/Pages/Introduction.aspx
The UK Sepsis Trust. Spotting sepsis in children sepsistrust.org/wpcontent/uploads/2015/08/UST602_DL_6pp_SpottingSepsis_Leaflet_070716.pdf
The UK Sepsis Trust. What every parent needs to know about sepsis sepsistrust.org/wp-content/uploads/2015/07/Sepsissymptoms-leaflet.pdf

Parents and carers need to know that prevention is the best course of action to avoid the development of sepsis. For example, good hand hygiene can help

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With more cars on the road, and at higher speeds, there is an increase in fatal accidents. Journalist Caroline Roberts explores how we can keep each other safe.

TREADING CAREFULLY

Last year saw the highest number of deaths on Britain's roads since 2011, with an average of five fatalities and 66 serious injuries every day (Department for Transport, 2016).

Children are among the most vulnerable of road users, with under-16s accounting for 26% of last year's pedestrian casualties (injuries and deaths). Overall, the number of children killed on the road (69) were up 28% on the previous year (Department for Transport, 2016).

WHAT'S GOING ON?

It's hard to pinpoint the exact reason for these statistics, and the report urges some caution in interpretation between years due to changes in reporting systems. But the fact is that tragic casualties are still happening, and there are factors that clearly don't help road safety.

For instance, the Department's figures show that traffic volume has increased by 2.2% since 2015. If the trend continues, it seems reasonable to assume that road safety will become more of an issue. And traffic-calming measures, such as traffic-responsive speed signs, along with road safety officers and school crossing patrols all cost councils money.

Driver distraction is also a factor. The 2016 RAC motoring report shows that one in five motorists check social media while waiting in traffic, despite this being illegal, and 6% of drivers admit to using their mobile phone 'all or most of the time' while they're behind the wheel.

And of course, pedestrians of all ages can be distracted by their phones when crossing the road. The AXA RoadSafe Schools report (2013) revealed the average age at which children first own a mobile is 11 years old, with further AXA research showing children are distracted by their phones on school runs (AXA, 2014).

Then there are road speeds. The campaign for Road Safety Week this year (20-26 November) is 'Speed Down Save Lives'. It makes the point that up to 20mph is the only safe speed in built-up areas that have many pedestrians and cyclists. 'Up to around the age of 14, children struggle to gauge the speed of cars that are moving faster than 20mph, so this limit is key,' explains Dave Nichols, community engagement manager with Brake, the charity behind Road Safety Week.

SLOWING DOWN OUR TOWNS

Recent research has found that average stopping distances at 30mph are almost double those at 20mph, and that the Highway Code actually underestimates these by around a third (Cuerden, 2017).

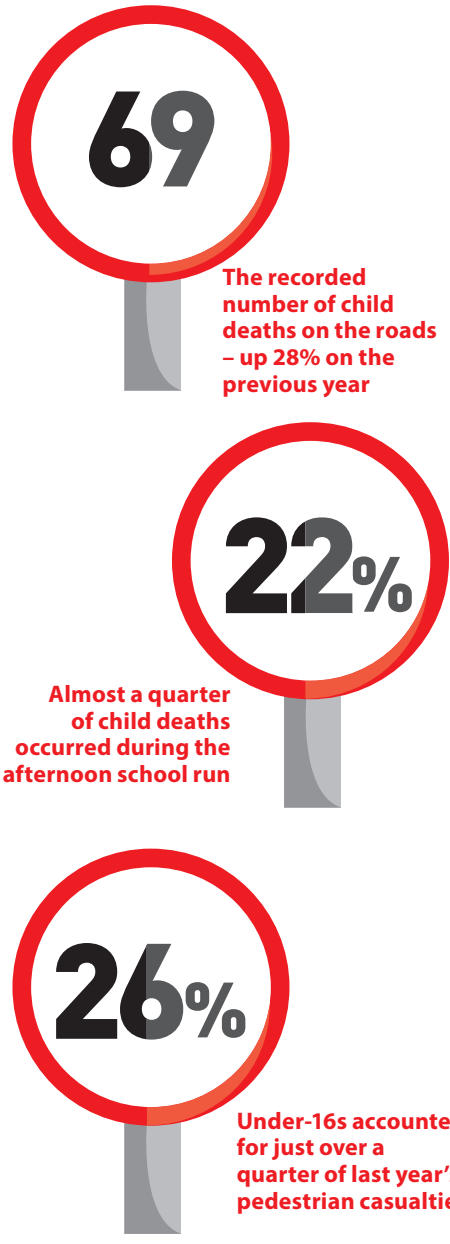
'One of the things deterring children and their parents from walking and cycling is that they feel the roads around them are too fast, reveals Dave. 'Making them safer will encourage active travel involving walking and cycling, which in turn reduces the number of cars on our roads, and even results in less pollution.'

Encouragingly, Brake says that around a quarter of Britain's urban environments have now adopted 20mph speed limits. While this is a move in the right direction, Brake would like to see this set as a default speed limit for all built-up areas, with councils needing to opt out for roads where faster speeds are appropriate. 'It will save money on repeater signs and other infrastructure and make it clearer for everyone. People shouldn't be subject to a postcode lottery.'

More progress is being made towards this in Scotland than in other parts of the UK, where Green Party MSP Mark Ruskell has put forward a bill to make 20mph the default speed in urban areas across the country. In Edinburgh, a blanket 20mph limit is currently being rolled out for residential roads, shopping streets and the city centre, and this is due to be completed in 2018.

Alex Quayle, senior policy officer for active travel charity Sustrans Scotland, which is supporting the moves, says: 'On average, a one mph decrease in speeds leads to a decrease in collisions of between 4% to 6%, which underlines how much safer our streets can be at slower speeds. Sustrans hopes the Scottish Government will see the enormous benefits of the bill currently under consideration.'

CHILD CASUALTIES



(Source: Department for Transport, 2016)

HELPING YOUNG FAMILIES

As trusted professionals working closely with families and schools, community practitioners are well placed to make a difference on road safety. Tips on paying attention and not being distracted by mobile technology, for example, could go a long way. There are also resources, such as roadsafetygb.org.uk/regions, that list local campaigns and other interventions that professionals could engage with and help to promote in their communities.

And for practitioners working with disadvantaged communities, it's important to note that there are clear links between social deprivation and child road casualties (RoSPA, 2012).

It's important that practitioners promote active travel among families to give young

WINTER ROAD SAFETY TIPS

Dark mornings and evenings, and poor weather conditions, make roads more dangerous at this time of year, so pass on this key advice:

- **Wear light-coloured clothing and attach reflective tape to clothing and children's school rucksacks.**
- **Check car and bike lights, and the tread on tyres, weekly.**
- **When driving, remember that braking distances can be doubled in wet and slippery conditions, so allow extra space between you and the car in front. Pedestrians should make sure cars have come to a complete stop before stepping onto crossings.**
- **Keep windscreens clean so it's easier to see in the dark and when the sun is low.**
- **Hoods and scarves can obscure vision and muffle sound so pedestrians should take extra care when crossing the road wearing these.**

children controlled exposure to roads, says Nick Lloyd, road safety manager with RoSPA. 'When parents walk or cycle their children to school or nursery, rather than bundling them into the car, they're teaching them valuable road safety skills and preparing them for independence.'

These road safety skills include modelling good practice, such as always using a crossing where available and waiting for the green man, even if the road is clear; involving children by asking them to 'stop, look and listen'; and explaining the dangers of crossing between parked cars.

Pedestrian and cycling fatality rates are 20x higher among children from the most deprived backgrounds, compared to those from the least deprived (RoSPA, 2012).

For older children who are starting to cycle, it's suggested that parents look into the Bikeability scheme (bikeability.org.uk), which provides cycle safety training.

Parents with babies as well as other young children may need help to develop strategies for ensuring the family's safety, such as the use of reins and teaching young children to hold on to the buggy.

The purchase of a suitable car seat is also an important consideration for the parents of babies and young children, so it's important that practitioners are well informed on this. Development checks are a good opportunity to remind parents of the need to change the way they transport their baby as it grows. Some parents may also need advice on bike seats and RoSPA has a useful child bike seat fact sheet.

WHAT ABOUT ELDERLY ROAD USERS?

Practitioners working with elderly people, or with families in which grandparents look after children, can help promote road safety in this age group.

DVLA figures show that there are more than 4.5 million drivers aged over 70 in the UK (HM Government, 2017). Many people take fewer risks as they grow older and accident figures for elderly drivers are consistently lower than those for some other age groups, such as young men (Musselwhite, 2016).

However, reaction times and hearing often deteriorate with age, and certain health conditions can affect the driving standards of the older driver.

While drivers over 70 are able to continue driving provided they renew their licence every three years and meet the minimum eyesight requirement (HM Government, 2017), health professionals can offer guidance and may find it easier than family members to raise the issue of when it's time to stop driving. Elderly drivers can be signposted to information sources and assessments such as the Institute of Advanced Motorists' Mature Driver Review, featured in the recent ITV series *100-year-old driving school*.

Mobility problems, slower reactions and less acute vision and hearing also mean that older pedestrians are more vulnerable, so it's worth reiterating key road safety messages, particularly for those with cognitive decline. Advice could include remembering to use designated crossings and checking carefully before crossing the road. Some people may also need help to map safer routes to places they visit regularly, such as local shops.

As well as raising road safety awareness in their day-to-day work, Brake hopes that practitioners will get on board with campaigning, particularly for the 20mph limits that can make such a difference, says Dave. 'Road Safety Week [20-26 November] is a fantastic opportunity for health professionals to work with community groups and road safety officers, and write to MPs, to show there's a real desire for this in their area.' **CP**

RESOURCES

- **Register for a free action pack containing advice, activity ideas and resources, and information on campaigns roadsafetyweek.org.uk**
- **For guidance in teaching road safety; support for victims brake.org.uk**
- **Find advice at rospa.com/road-safety/ plus links to related sites, such as childcarseats.org.uk and olderdrivers.org.uk**
- **RoSPA fact sheet on child bike seats rospa.com/rospaweb/docs/advice-services/road-safety/cyclists/child-bike-seats.pdf**
- **Contact your local government road safety team at roadsafetygb.org.uk/regions to see if there are any projects in your area**

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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

SET THE record straight

Clear and accurate record-keeping is vital to support the effective delivery of care and defend against litigation, writes journalist Anna Scott. Is it being given the priority it deserves ?

In September the NMC's Fitness to Practise Committee suspended a health visitor for six months following charges of misconduct and a lack of competence.

Among the facts proven at the hearing were that the health visitor, who was employed by NHS Greater Glasgow and Clyde, wrote a note on a specialist children's services assessment document about an incident of child sexual abuse and filed it with the wrong family's record card.

The health visitor also did not include significant clinical information on a baby's scan in a care plan, did not adequately document the results of a hearing test, and scored out progress notes were without explanation.

The committee decided that the health visitor had, 'through poor practice, put patients at risk of harm, brought the profession into disrepute, and breached fundamental tenets of the nursing profession' (NMC, 2017).

According to Jane Beach, lead professional officer for regulation at Unite, at least 25% of fitness-to-practise cases involve poor record-keeping as the primary referral or a secondary charge.

The NMC's code states that nurses across the UK are expected to keep clear and accurate records that are relevant to their practice (NMC, 2015) (see panel opposite). An NMC spokesperson says: 'Record-keeping is a vital part of the delivery of safe and effective care for every nurse and midwife, whatever their scope of practice. The code clearly outlines that, to practise effectively, all nurses and midwives must keep clear and accurate records relevant to their scope practice, and that they must take immediate and appropriate action if they become aware that someone has not kept to these requirements.'

The current picture

So what are the reason's behind poor record-keeping? Pen and paper can pose particular challenges. 'When we need records from another base we have to fill in a piece of paper and send it through internal post,' says school nurse Laura*, part of a team split across several bases, which all tend to keep paper records. 'It can take days to get the records back,' says Laura. 'Often the records are misfiled and our admin team hands the request back to us, thinking we already have them, slowing things down further.'

It's tricky to get a clear and accurate understanding of how many health visitors, school nurses and community nursery nurses are using pen and paper to keep records of their clients and how many are using technology – desktop, laptop, smartphone or tablet – because the way records are kept is usually set by trusts individually (NMC, 2012).

Anecdotally, paper and pen appears to be the norm. 'I've worked with paperless records, and prefer them, but my current trust is entirely paper,' says Laura.

Time pressures

These aren't the only record-keeping problems that Laura faces. 'If I send records back to file and then something else needs recording, I have to re-request

*Name has been changed

The code

To achieve clear and accurate records, practitioners must:

- **Complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event**
- **Identify any risks or problems that have arisen and the steps taken to deal with them, so colleagues using the records have all the information they need**
- **Complete records accurately and without any falsification, taking immediate and appropriate action if community practitioners become aware that someone has not kept to these requirements**
- **Attribute entries in any paper or electronic records to the community practitioner, ensuring they are clearly written, dated and timed, without and unnecessary abbreviations, jargon or speculation**
- **Take all steps to ensure records are kept securely**
- **Ensure all data and research findings are collected, treated and stored appropriately.**

(Source: NMC, 2015a)

records, which takes time. Or if they are misfiled I won't receive them at all, because admin doesn't check for them beyond the first slot that they looked in.'

Time is a big factor. 'The system encourages me to see fewer children,' says Laura. 'We're not allowed to use "progress notes" yet. From experience, this helps when you see a big family because you can copy and paste into siblings' records.'

Jane Beach – who is often asked to run training on record-keeping for school nurse and health visiting teams – says that time is the most commonly reported difficulty in keeping records.

'It is clear that when time for contacts and visits is determined, time to complete the records is not always included as an essential part of the care contact and not an "add-on",' she says. 'The focus always seems to be on recording the key performance indicators!'

It's not just about time, however, says Jane: 'It's interesting that when asked who taught the participants [on my training courses] about record-keeping it is always other practitioners, so of course the quality will depend on the skills of the teacher. As a result, poor practice can be perpetuated.'

The rise of technology

Difficulties and inconsistencies in relation to record-keeping have an impact on community practitioners' day-to-day practice. 'I feel like I am wading through treacle in order to perform basic nursing tasks,' Laura says. 'It affects my motivation and my timekeeping.'

> I feel like I am wading through treacle in order to perform basic nursing tasks

She says the situation could be improved if paper records were moved to school nurses to manage or more administrators were in place, or the trust moved to paperless records. 'We keep being promised "paper-lite" working,' she adds.

Laura's trust recently implemented the patients' record system and software EMIS, but it is primarily designed for GPs, so 'doesn't really fit my team's requirements'.

'We can't even see which team has the biggest caseload because most referrals are inactive,' Laura says.

Another issue is duplication – many trusts have both paper and electronic systems, so they have to input the same information in a number of places. 'My experience is that most services either don't have electronic systems yet or are in the process of switching and still have both,' says Jane.

'I did some training with 25 school nurses in the Midlands who had been electronic for 10 years,' she adds. 'But they still reported that there were times when they couldn't connect to the system or had a problem with their laptop, which means they have to go back to paper. There is some inconsistency in whether this then gets transferred to the electronic systems or scanned once the issue is resolved.'

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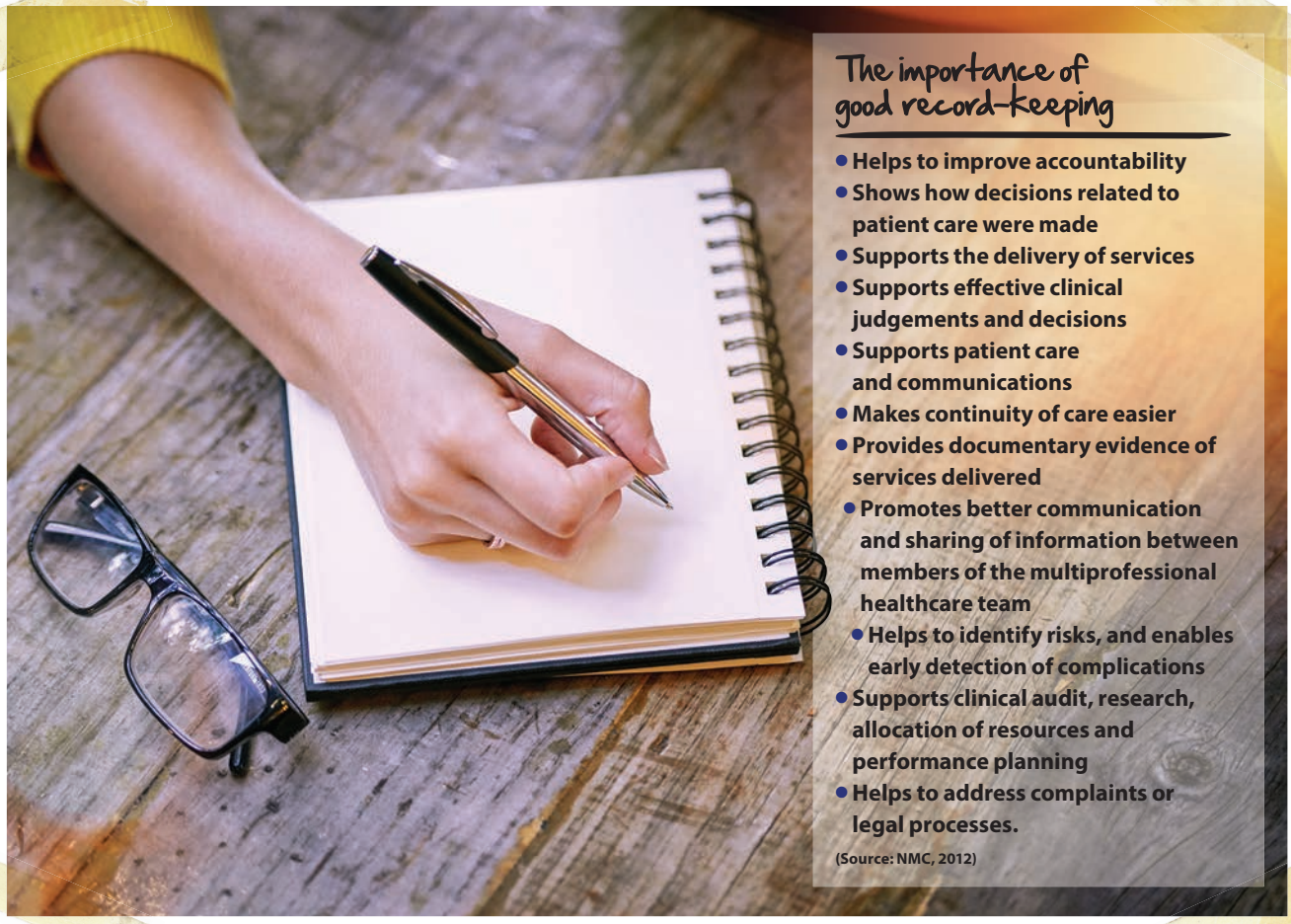

The importance of good record-keeping

- Helps to improve accountability
- Shows how decisions related to patient care were made
- Supports the delivery of services
- Supports effective clinical judgements and decisions
- Supports patient care and communications
- Makes continuity of care easier
- Provides documentary evidence of services delivered
- Promotes better communication and sharing of information between members of the multiprofessional healthcare team
- Helps to identify risks, and enables early detection of complications
- Supports clinical audit, research, allocation of resources and performance planning
- Helps to address complaints or legal processes.

(Source: NMC, 2012)

Inconsistency in process is another problem, Jane says, and there is a need for consistent policy and training on what community practitioners should do in these kinds of circumstances.

Fast followers

One issue is that investment in technology – what to buy or when to buy it – and policy on record-keeping is a matter for individual trusts, not central government agencies, and is dealt with differently across the devolved nations.

For example, NHS Digital does not get involved in making any procurement-based decisions on record-keeping technology – they differ from organisation to organisation, a spokesman says.

NHS England has the Global Digital Exemplars programme, which is funding seven mental health and 16 acute health trusts that are delivering exceptional care efficiently to help them 'move forward digitally', according to a spokesman for the organisation. These trusts will receive funding and international partnership opportunities over the next two to three and a half years (NHS England, 2016a).

Poor record-keeping comes out time and again in serious case reviews, so should have more focus than it does

The idea is that exemplars will share their learning and experiences with digital technology through partnerships with 'fast followers' – trusts that will support the spread of best practice and innovation and receive NHS England funding – to enable other trusts to 'follow in their footsteps as quickly and effectively as possibly' (NHS England, 2016a).

This may mean sharing software or a common IT team, or adopting standard methodologies and processes (NHS England, 2016a). This programme is part of the NHS Driving Digital Maturity programme, which has the goal of ensuring the NHS is paper-free at the point of care (NHS England, 2016b).

For how the other home nations are treating record-keeping, see panel, *Digital record-keeping plans across the UK*.

Best practice

But there will 'always be a need to have a contingency for when the IT systems fail,' Jane says. 'Due to funding, organisations are not always able to invest in the best IT solutions, and my

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experience is that they do not always involve the practitioners that will be using them in the design – so there are complaints that systems are not suitable. This happens particularly when acute systems are transferred to community settings, which of course are very different. There is also huge variation in the systems used.'

So what's the advice for practitioners? It's very important to keep refreshing yourself on the fundamentals and to raise concerns when you feel managers are not allowing time to complete records. Jane recommends self-auditing records or auditing them as a team – reading each other's records and discussing what action was taken and what the plan is. 'The person who wrote them can then assess whether this is what actually happened/was planned.'

Jane also says that the fundamental principles of record-keeping should be taught during university courses – the scope of practice and what to write, how much and what content. She adds: 'Poor record-keeping comes out time and again in serious case reviews, so should really have more focus than it does. It is important to remember that it is a part of the contact and not an add-on.' **CP**

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Digital record-keeping plans across the UK

Scotland

The new Digital Health and Social Care Strategy 2017-2020 will be published at the end of this year, encompassing a new eHealth strategy for the whole of the NHS – patients and workforce – across the country (Scottish Parliament, 2017).

Northern Ireland

The eHealth and Care Strategy, published in 2016, sets out a range of measures for the increased use of digital technologies to support the delivery of health and care services up to 2020, and includes plans to 'explore the potential for a fully integrated digital health and care record system', according to the Department of Health (2016).

Wales

Welsh health secretary Vaughan Gething announced in September a central government investment of more than £5.5m for digital priorities in the NHS in Wales. The money will be spent on projects including the Welsh Community Care Information System (WCCIS), which allows staff working in health and social care to use a single system and a shared electronic record of care (Welsh Government, 2017).

'Roll-out of WCCIS will provide significant benefits to the work of frontline practitioners, particularly in reducing travelling time, improving the standard of document keeping, improved care planning compliance, reduced duplication in record-keeping and ultimately information being available to all practitioners involved, together with releasing time to care,' a Welsh Government spokesman says.

More than a GAME

Young children aren't getting enough playtime outside, but why is that a problem, and how can you help to change the situation? Journalist **John Windell** reports.

The latest figures on the amount of time children spend playing outdoors make for worrying reading.

A global survey last year of around 12,000 concerned parents found that in the UK almost a third of children aged five to 12 play outside for just 30 minutes a day (Persil/Edelman Berland, 2016). One in five don't play outside at all. In fact, children were found to spend twice as much time on screens as they did playing outside.

Another poll found that children's freedom to explore nature and wildlife has shrunk (The Wildlife Trusts, 2015). Again, parents are worried: 91% of 1000 parents with children under 18 thought access to nature and wildlife important, but 78% worry children don't spend enough time outdoors.

Most recently, a Welsh survey found that 97% of parents think children should play outdoors every day (Public Health Wales (PHW), 2017). Yet almost a third of under-fives (29%) are not getting that time. PHW recommends that children under five should have at least three hours of active play every day.

THE BARRIERS

Why aren't children playing outdoors as much as they should? Marianne Mannello, assistant director at Play Wales says a number of factors prevent them. 'Children say it's the speed and volume of traffic. Parents say it's safety and stranger danger.'

Helen Bilton, professor of outdoor learning at the University of Reading, points to the 'electronic babysitter'. She says: 'In the past, children would go out and stay out until teatime, now they're given an iPad. It's addictive, and they need an adult to say it's enough.'

Then there's perception of weather. 'We're the ones who stand around and get cold,' highlights Sarah Chapman, who works with young children in a forest school. 'The children just sweat their way through all the activity!' Sarah believes colder weather is more a problem for the adults.

GOLDEN GAINS

Numerous studies have found health and wellbeing benefits of being active outside, or simply getting outdoors. To give just one example, children who get more 'green' exercise are likely to be more healthy as adults

NO PLAY TODAY

1 in 5

UK children don't play outside at all

(Source: Persil/Edelman Berland, 2016)

(Pretty et al, 2009).

For Marianne, the health benefits of playing outdoors are 'all about being active and fit'.

Outdoor play is vital to children's physical development. 'If you want young bones and muscles to develop, they need to be used,' says Helen. 'Sitting in a chair isn't going to do it. By the age of seven, children should have all the basic motor skills in place, but increasingly, that is not happening.'

BEYOND THE PHYSICAL

Outdoor play also offers social, personal and educational benefits for children (Burdette and Whittaker, 2005, for instance).

'They get to know their communities,' says Marianne, 'they socialise, and their independence grows. It also supports their creativity and imagination, with opportunities for them to challenge themselves, solve problems, and cope with uncertainty.'

For Helen, the outdoors offers a vital sense of freedom. 'Children see that parents control the home, teachers control the classroom, but nobody controls outside. So if they try something, they won't be judged. From an emotional point of view, they feel free and able to explore the environment and their own abilities.'

Sarah gets to see the many benefits first-hand. 'You watch them learn to balance, climb and swing. But you also see them become more confident. If you give them some freedom to explore and be themselves, they take it. They even begin to understand how things work in a basic scientific way.'

That's a lot to potentially miss out on, if children aren't playing outside.

ENCOURAGE OUTDOOR FUN

So how can community practitioners help promote more outdoor play? One way is through providing information to parents, encouraging them to give their children more opportunities for it.

Marianne says creative thinking is sometimes required. 'Many parents say children have nowhere to play, so it can help to encourage parents to see things differently. There may be some open space, a lane with puddles, or even the pavement. It's not all about equipment where children can slide, climb and swing, wonderful as they are.'

Helen says that parents' mindset is vital. 'They need to know their children are playing in a safe place, and that it will benefit their health. In the long run, if you give children the repeated opportunity to go outside, they will be much better able to judge what they can or can't achieve. They will be safer and healthier as children and adults.'

Sarah agrees. 'Let parents know that bruises are not to be feared! A bruise or two is a sign that a child is exploring and learning how to use their body.'

With winter looming, it's about getting the clothing right, rather than shying away. 'A waterproof coat and trousers, and a pair of wellies can make all the difference,' says Helen. 'Children's feet, head and back of the neck need to be warm.'

As well as helping parents, practitioners can also promote the benefits of outdoor play in local public health campaigns and help to create links between play services and communities.

The scope of outdoor play is clearly more than a game. CP

● **Discover more: playwales.org.uk; playscotland.org; niatplay.com; playengland.org.uk**

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ADVICE TO OFFER PARENTS…

Play Wales has lots of tips for overcoming key barriers to outdoor play, including:

THERE'S NOWHERE TO PLAY

Most children will play anywhere given time, space and other children to play with. Local authority websites normally list local play areas such as parks, playgrounds and suitable spaces.

IT'S RAINING

Children worry less about bad weather than adults. It usually comes down to common sense, and ensuring children are dressed appropriately.

MONEY IS TIGHT

Communities often have free outdoor play areas or facilities. But a little imagination can turn an outdoor space at home into a play area – empty cardboard boxes can become cars or castles!

IT'S NOT SAFE

Children need support to play outdoors with confidence. Help them to get to know the basic layout and key routes in their community, and how to keep safe around roads (see our feature on page 36). Mostly, the benefits of play outweigh the risks.

THEY WANT TO WATCH TV

Strike a balance, so there's time for TV/computers and play. Set an example – if parents and carers restrict their time on electronic devices, children will do the same.

ISTOCK

Thank you, Ros!

Ros Godson, lead professional officer at Unite, retires at the end of 2017 after a 40-year career in nursing. Her colleagues share their thoughts…

Sarah Carpenter, *head of health*
'Ros has been a huge part of the professional officer team, adding the school nursing dimension to our work. We will miss her, but she leaves a legacy we can build on.'

Colenzo Jarett-Thorpe, *national officer for health*
'Ros has been an illuminating presence in our professional team, providing wisdom and passion, a keen wit and sense of fun. Our office won't be the same without her. I wish her a happy retirement, filled with mischief!'

Lead professional officer team:
Obi Amadi
'School nursing is Ros' passion and she has never been afraid to speak up on behalf of the profession. She has persistently lobbied on their behalf. We've lost a team member but I have no doubt her activity will continue after she's left as a member of Unite.'

Jane Beach
'Ros was always on hand to answer my questions about how Unite worked and willing to give her expertise. She was a whizz with briefings and factsheets and integral to the process. I will miss her input.'

Gavin Fergie
'Ros is unique: her passion, her advocacy and her style. School nurses and nursing will be sad to see her go, and those who she challenged will be sighing with relief! I'll miss her infectious enthusiasm and cheery smile – always a tonic when the going got tough.'

Dave Munday
'Ros has been a staunch supporter of public health. Just talking to her for a few moments, you understand that this goes through to her bones. She brings even more passion to her promotion, defence and celebration of school nursing. She truly cares about young people and their journeys through life, and she believes that much can be made better by a great school nurse. I hope she'll take the credit for the many millions of lives she has influenced in her campaigning to get this message and many others heard. Ros has been an amazing colleague and friend.'

ROS IN HER OWN WORDS

Where did your career begin?
St Thomas', 1974. Never looked back.

Why did you stay in school nursing?
Three weeks into my first job in a school, I had to look up the records of a boy who'd been arrested for murder. They showed we'd failed him from day one. I wanted to change this.

What impact can school nurses have?
We care. It's hard to persuade children that they matter to you personally, but any difference you can make could stop them going off the rails.

Your hopes for the membership?
To persuade the government that preventative public health and school nursing can change health outcomes for the better. And to keep persuading colleagues that investing in children can make a difference.

What are your plans?
A gap year, work with STPs, work politically, sort out the garden, 40th wedding anniversary celebrations.

Three words to sum you up?
Full of bright ideas. That's four!

One guest for dinner?
Someone I could argue with, such as Ann Widdecombe.

Ethel Rodrigues
'I would like to wish Ros a very happy retirement.'

Other team members
Ros is caring, compassionate, courageous, committed, competent, and a great communicator. Beyond the six Cs, they added, kind, irreplaceable, unique, funny.

Leona Sanders
'I've supported Ros for more than 10 years with her administration and she has been a pleasure to work with, often surprising my colleagues and me with supplies of fresh fruit and encouraging us to adopt healthy lifestyles, particularly by climbing the stairs, all seven floors!' **CP**

Apply TODAY for a MacQueen Bursary 2017-18

The CPHVA Education and Development Trust is pleased to announce the MacQueen Bursaries for 2017-18 are open. There are two categories of bursary available to Unite-CPHVA members.

MACQUEEN BURSARIES IN PRACTICE DEVELOPMENT, RESEARCH OR STUDY

A total of **£20,000** is available and applications should be focused on any of the following activities:

- A project undertaken in practice to facilitate the health and wellbeing of individuals, groups or communities

- A research project focused on the enhancement of practice in community settings

- Engagement in professional or academic study activities to enhance the applicant's practice.

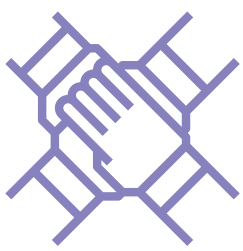
Project applications may involve a multiprofessional team providing at least one individual has current membership of Unite-CPHVA.

Applicants will need to state the total amount they are seeking and should include a detailed costing for the project or study activity. Priority will be given to the shortlisted applications that demonstrate the greatest potential to enhance practice.

MACQUEEN TRAVEL BURSARY FOR PUBLIC HEALTH

This bursary provides **£2000** to cover some of the costs associated with an overseas public health project. It will enable the winner to either engage in a public health project or to explore an initiative to determine its relevance to UK practice. It provides the opportunity to:

Share expertise with others



Promote partnership working

Enhance personal development by broadening knowledge of other cultures and developing the knowledge and practice of others

- **Further details of the MacQueen travel bursary and application process are available from Linda Llewellyn, member of the Professional Advisory Committee: lindallewellyn@nhs.net**
- **For the other MacQueen bursaries, contact Denise Knight, chair of the Professional Advisory Committee: d.knight@herts.ac.uk**
- **Closing date for the receipt of applications is 5pm on 18 December 2017**
- **Shortlisted applicants for bursaries of over £3000 must be available to attend for interview at Unite HQ on 16 January 2018**

GROWING PAINS

Hannah Warwick

looks at supporting disabled young people through the transition from children's to adult services.

In 2011, I led a study tour of special educators to the original Project SEARCH site at Cincinnati Children's Hospital in the US. Project SEARCH is a year-long supported internship programme for students who are disabled or have special educational needs. It was one of the first examples I had seen of effective transition planning and support for disabled young people. It was exciting for me and, crucially, for the group of teachers from the UK preparing their students for a life beyond school. It helped them realise that things could be done differently – and effectively.

My experience as a social worker in a deprived London borough had magnified for me many of the barriers that children and young people face in preparing for and progressing to adulthood. I am now involved in developing and delivering support to professionals on transition through the Council for Disabled Children's (CDC) Transition Information Network. This specialist network leads on policy issues, responds to government consultations and works with leading organisations to develop and promote good practice in transition.

THE TRANSITION EXPERIENCE

Transition describes the period of time when a disabled young person is preparing to move from children's services to adult services and, more broadly speaking, from childhood to adulthood. Transition is a long-term process that covers the period before, during and after the time when a young person moves from children's to adult services. Good transition is linked to our ideas about what a good adulthood means: choice, training and education opportunities, living independently, and having positive friendships and relationships. But getting it right is not always a simple process.

For non-disabled young people, transition to adulthood can be a daunting prospect, but it also connotes freedom from parents, as well as new and exciting experiences and opportunities. In contrast, many disabled young people and their families refer to the fear of 'falling off the cliff'.

For Lucy Watts MBE, a young woman with Ehlers-Danlos syndrome, moving from a paediatric ward to an adult ward was a bewildering experience. Her new co-patients were elderly dementia patients, and she found that she was now expected to make decisions alone, having previously been supported by her mother (Together for Short Lives, 2015).

Lucy isn't alone: transitioning to adult healthcare can be a very anxious time. Research from the STEPP project (a national study on healthcare transitions for young adults with significant and potentially life-limiting conditions) shows that many young people experienced social anxieties about meeting the adult team and fears over the quality of their care altering (Transition Partnership, 2013).

PRACTICE RECOMMENDATIONS

Policy changes over recent years have created opportunities to look at new ways

MOVING ON UP: THE PATH TO ADULT SERVICES

- **Working in partnership with young people and their families, start planning for the transition from year nine (age 13 or 14) at the latest.**
- **Help the young person choose one practitioner (a named worker) from those who support them to take on a coordinating role. The worker should act as a link to other professionals and provide advice and information.**
- **Review and update these plans at least annually. This meeting should include the young person, their family and all those who support them.**
- **The named worker should consider each of the following outcomes when helping the young person to plan and set goals:**
  - **-- Education and employment**
  - **-- Health and wellbeing, including emotional health**
  - **-- Community inclusion**
  - **-- Independent living and housing options.**

(Source: NICE, 2016)

of working to support young people as they transition to adulthood. New legal duties in the Children and Families Act 2014 and the Care Act 2014 overlap for young people moving into adulthood during the ages of 18 to 25. Some of the requirements in the legislation endeavour to overcome the 'cliff edge' or 'black hole' that families refer to (Broach et al, 2015). In particular, education, health and care (EHC) plans can continue up to the age of 25, and transition assessments as part of the Care Act are intended to reduce the number of young people experiencing a gap in provision while they await the outcome of adult needs assessments. Through EHC plans, there is also now a legal imperative to focus on preparing for transition when a child is 14, which ties in to the year nine review.

Despite efforts to embed transition planning in legislation, for too many young people and their families, the information available is patchy, with parents finding that the best source of information comes from other parents (Care Quality Commission, 2014). Information about, and communication with, relevant services and professionals is critical.

The NICE (2016) transition guidelines aim to help young people and their carers have a better experience of transition by improving the way it is planned and carried out. At a strategic level, NICE is clear that collaboration is key to successful service delivery. At an individual level, it recognises that transition planning should be person-centred.

For practitioners, this might mean being the single named worker for a young person. NICE advocates this practice, where one professional takes responsibility for coordinating services and for supporting a young person in navigating them.

But transition isn't a single professional's responsibility. All practitioners and professionals working with young people in transition up to the age of 25 need to understand the principles of person-centred care, the young person's development and communication needs, the legal context, and how to involve families in a supportive, professional way. A culture change is needed so all professionals 'think transition' at each stage of the process and form a genuine part of person-centred planning.

To achieve this, practitioners should be ambitious about outcomes for young people. These will be different for all young people, but the motivation of professionals to support young people in their transitions to adult services and, ultimately, to adulthood should not be. CP

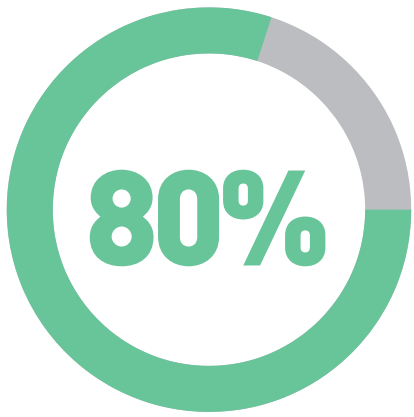
- **Hannah Warwick is principal officer for social care at the Council for Disabled Children. She discussed the key issues for transition based on the latest legislation, research and guidance at the CPHVA conference, drawing on CDC's experience and sharing key action points for practitioners** **(see page 21)****.**

LOST IN TRANSITION

55,721

young adults (aged 18 to 40) living with life-limiting conditions in England in 2009-10

(Source: Fraser et al, 2013)



of 14- to 18-year-olds with complex physical needs did not have a transition plan that included their health plan

(Source: CQC, 2014, out of 103 case records)

GETTY

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Diversity matters

We look at the winners of this year's **Mary Seacole Awards**, together with the vital issues raised at the ceremony.

The Mary Seacole Awards have a dual purpose. They directly provide funding for healthcare projects and activities that will benefit and improve the health of people from black and minority ethnic (BME) communities. Additionally, they provide an opportunity for individuals to be recognised for their outstanding work in the BME community, with awardees benefiting from a career development programme.

EQUALITY YET TO BE REACHED

Work is still needed to ensure that people from different backgrounds have the same opportunities while employed in the NHS. The claim comes from the Mary Seacole Awards ceremony, which was held in London in October.

The event was hosted by Unite, and Obi Amadi, lead professional officer for strategy, policy and equalities, gave the opening remarks. Obi said: 'From January this year, we will have had a total of 35 development awards and 27 leadership awards. This represents an inspiring body of work, and we will showcase that legacy.'

Deborah Isaac, senior lecturer for mental health nursing at the University of Greenwich, presented her research at the event, having received a leadership award last year. Her project seeks to 'highlight the visibility, yet invisibility' of people from BME backgrounds in the NHS.

'One in five people working in the NHS is from a BME background; however, BME staff remain invisible in senior and managerial roles,' she said.

'Those from a BME background are three times less likely to be Band 8 and 9 – I really can't understand why we are still talking about this.'

Following focus groups, her research recommends transparency in job advertisements, identifying career enhancement and potentially having equal opportunities consultants to work with the NHS.

The keynote speech at the event was given by Kathy Sienko, who was a Mary Seacole Leadership Scholar in 2000 and has since gone on to receive various awards, including an OBE for services to healthcare in the UK. She addressed the winners of the Mary Seacole Awards for 2017-18, who had just been announced. The awardees this year are Dorcas Gwata and Bertha Ochieng, who received leadership awards. Saeideh Saeidi, Faye Bruce and Liza Mitchell received development awards. (See panel, right, for their winning projects).

Kathy said: 'The snowy peaks of the NHS are starting to change colour and you are part of that challenge.'

The awards are funded by Health Education England and are awarded in association with Unite, the RCM, the RCN and Unison, with support from NHS Employers. CP

THE WINNERS (2017-18)

LEADERSHIP AWARDEES

Dorcas Gwata is clinical lead at the Integrated Gangs Unit for Westminster CAMHS at the Central and North West London NHS Foundation Trust. **Project:** Improving leadership in mental health interventions for adolescents from African and Middle Eastern backgrounds who are affected by gang culture and are vulnerable, violent and exploited in Westminster.

Bertha Ochieng is associate professor for nursing and midwifery at De Montfort University in Leicester. **Project:** Meeting the nutritional needs of BME children aged 0 to 5, developing an evidence-based training tool for weight management.

DEVELOPMENT AWARDEES

Saeideh Saeidi is service evaluation manager for Leeds and York Partnership NHS Foundation Trust. **Project:** Ethnicity matters: cultural competence in mental healthcare.

Faye Bruce is senior lecturer and programme leader in nursing at Manchester Metropolitan University. **Project:** Developing health literacy among Caribbean and African faith leaders and champions to influence health decision-making at strategic levels.

Liza Mitchell is skin cancer research nurse at Barts School of Medicine and Dentistry, Queen Mary University of London and lecturer at the School of Health and Social Care at London South Bank University. **Project:** Raising knowledge and awareness of skin conditions and skin cancer in the BME patient population associated with organ transplantation and other immunosuppressive conditions.

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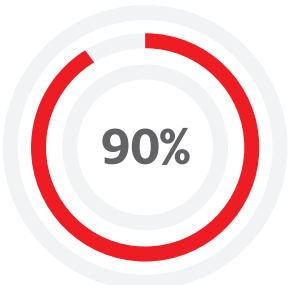

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