

Safeguarding and protecting children: where is health visiting now?

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Abstract

This paper aims to reinforce the importance of a well funded health visiting service in safeguarding and protecting children. While the issues involved in safeguarding and child protection have not really changed in essence, in recent years the practice context, organisational climate and policy drivers have.

This paper briefly outlines health visitors' work with children and families, reiterating the profession's track record in safeguarding and protecting children work and discussing how important the health visitor role is and how eroded it has become. The small body of research evidence in this area is discussed, current policy drivers examined and obstacles to good safeguarding practice described. Health visitors' work in child protection is important, and part of a continuum of public health activity including universal preventative work, identifying and working with vulnerable children and their families, and protecting children from abuse and neglect.

Key words

Health visiting, safeguarding, child protection

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Introduction

This paper seeks to reinforce the importance of a well funded health visiting service in safeguarding and protecting children. It is 18 years since I first reviewed the role of the health visitor in relation to child protection (Appleton, 1994). In essence the issues have not really changed, but the practice context, organisational climate and policy drivers have. Safeguarding and child protection is now recognised across the UK and internationally as a key public health issue (Gilbert et al, 2009). In the UK, the magnitude of this public health issue is reflected in statistics on child deaths, the cases that have reached the threshold for serious case review (SCR) and the numbers of children on child protection plans and looked after by local authorities.

This paper will begin by briefly outlining health visitors' work with children and families. It will reiterate health visiting's track record in safeguarding and child protection work and discuss how important the health visitor role is in this area, but how eroded it has become. The small body of relevant research evidence will be discussed. The paper will then examine current policy drivers, while also describing some of the obstacles to good safeguarding practice. It concludes by stressing the importance of health visitors' work in the area of child protection, yet acknowledging that this should be part of a continuum of public health activity including universal preventative work, identifying and working with vulnerable children and their families, and protecting children from abuse and neglect.

Health visiting work

Despite variations in practice across the UK, for the majority of health visitors work with young children and their families continues to be a priority. This view is supported by evidence from the national survey of health visitor activities conducted by Cowley et al (2007), which found health visitors had most frequent contact with babies aged under one year, closely followed by pre-school children. This study also questioned the premise of

progressive universalism (HM Government, 2006), 'that all families receive a sufficient service for proactive health promotion, and for additional needs to be identified in a timely way' (Cowley, 2007: 878), as nearly half of the study's health visitor respondents found that it was impossible to deliver the planned core service. The authors describe a restricted and reactive service that was mainly focused on child protection and vulnerable families (Cowley et al, 2007). Indeed, the universal nature of the health visiting role is increasingly placed in jeopardy because of an increased focus on targeted services and crisis work.

Yet we must not forget that health visitors do have an established track record in safeguarding and child protection work (HVA, 1994; Rouse, 2002). Unfortunately, this role has become eroded over the last 20 years because of major staff shortages and cutbacks in resources. The substantial reduction in the numbers of health visitors means their ability to optimise their role in this key area of work has been considerably affected. Reports in the press highlight staff feeling demoralised, deprofessionalised and lacking expertise (eg Alston, 2009; Appleton, 2011), alongside doctors struggling to cope with the increase in child protection referrals (Higgs, 2011). Common sense tells us that with such service cutbacks, the ability to maintain a good quality service in this area will be compromised. There is also the problem that other agencies are not always fully aware of the current 'state' of health visiting. Hanafin (1998) has described the difficulty when other professionals construct the public health nurses' role in such a way that includes expectations beyond its remit (and resource capability). Peckover (2011: 9) also draws attention to the tensions facing health visitors, who on the one hand act as a supporter to families yet also have 'expand[ed] the scope of their gaze' to include 'surveillance and early intervention of a wider set of vulnerabilities facing children and young people'. However, if health visiting services are properly resourced these professionals are ideally placed through the Healthy Child programme (HCP) (DH, 2009) to identify

children who, with their families require advice, support and guidance, including children who are potentially vulnerable to abuse and neglect. The bottom line is that health visiting should be concerned with safeguarding and protecting children (DH, 2009).

Definitions

The most recent statutory guidance *Working together to safeguard children* (HM Government, 2010) outlines the duties and responsibilities of all those working with children, young people and their families to safeguard and promote the welfare of children (while it applies to England, similar guidance applies across all UK countries). Safeguarding is defined as:

- 'Protecting children from maltreatment
- Preventing impairment of children's health or development
- Ensuring that they are growing up in circumstances consistent with the provision of safe and effective care
- Undertaking that role so as to enable those children to have optimum life chances and to enter adulthood successfully' (HM Government 2010: 34).

This definition of safeguarding covers not only protection and safety issues, but a broader and more positive focus on prevention and ensuring children and young people's wellbeing. It incorporates many activities that are included in the health visitor's domain such as protection from disease through immunisation, preventing impairment of children's health and development, reducing accidents and protecting children from child abuse and neglect (Appleton and Clemerson-Trew, 2008).

Child protection is defined in *Working together* as 'a part of safeguarding and promoting welfare. This refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm' (HM Government, 2010: 35). The document maintains that 'effective child protection is essential as part of wider work to safeguard and promote the welfare of children' (HM Government, 2010: 35). In practice, the terms 'safeguarding' and 'child protection' are often used interchangeably.

Evidence from research

An earlier review of the literature on the health visitor's role in identifying and working with vulnerable families in relation to child protection, concluded that although health visitors were often involved in this type of work there was little empirical research to describe their contribution (Appleton, 1994). There is still only a small body of research

work that has specifically examined health visitors' work in safeguarding and child protection. Crisp and Green Lister (2004), in their interviews with 99 nurses in Scotland of whom over a third (n=36) were health visitors, found a lack of agreement about their role in child protection. There was a lack of consensus about whether the nursing emphasis should be 'proactive' with an emphasis on prevention of abuse and neglect, or 'reactive' with 'an emphasis on detection and reporting' (Crisp and Green Lister, 2004: 661). Ling and Luker (2000) had previously described both elements in health visiting child protection work.

My study that followed the initial review of the literature found that health visitors had four key yet diverse roles to play with vulnerable families – identification of vulnerability, support agent, referral agent and reluctant monitor. Health visitors were often very concerned about those children who they identified as highly vulnerable, but where there was no involvement from children's social care (Appleton, 1996). The study also found that health visitors tended to use their own professional judgment rather than official guidelines or checklists in assessing vulnerability, indicating that such guidelines are inadequate in measuring families' needs (Appleton, 1995).

A preoccupation with such needs assessment tools continued in the 1990s, as NHS managers increasingly required health visitors to identify vulnerable children and families using such tools (Appleton and Cowley, 2004). Yet subsequent research evidence has cast doubt on their validity and underpinning evidence base, raising questions about their potential to constrain professional judgement (Appleton, 1997). The research evidence points to a number of difficulties associated with adherence to formal needs assessment guidelines, including increased stress and anxiety for vulnerable individuals (Cowley and Houston, 2003), the potential for client disempowerment (Mitcheson and Cowley, 2003), a negative impact on health visitor-family relationships (Cowley et al, 2004), insensitive questioning (Cowley and Houston, 2003), mechanistic practices (Mitcheson and Cowley, 2003) and the potential deskilling of health visitors (Barker, 1996). More recently, the Scottish Starting Well project has provided evidence that those vulnerable families needing most input were not consistently identified by health visitors as high risk in their baby's first four months of life using a health plan and family needs score (Wright et al, 2009). These researchers argue that,

certainly in deprived areas, a majority of families will require continued health visiting input 'if the most vulnerable families are to be reliably identified' (Wright et al, 2009: 23). This view is further supported by research by Wilson et al (2011: 6), who found that maternal depression scores measured at 13-month health visitor home visits 'acted as an additional powerful indicator of need'. These researchers conclude that a routine visit focusing on parenting difficulties at 13 months may be important in identifying families requiring additional support.

Evidence from SCRs

The need for universal provision of health visiting services is further reinforced in the common themes emerging from recent reviews of SCRs. SCRs in England and Wales (case management reviews in Northern Ireland and significant case reviews in Scotland) seek to examine the involvement of agencies and professionals in child maltreatment cases that are at the severe end of the scale, ie those concerning serious and fatal child abuse and neglect, to establish whether lessons can be learned from the case. A number of reports have analysed common themes from across SCRs, and these draw attention to the fact that many cases concern babies under one year of age (Brandon et al, 2008, 2009, 2010). For example, the 2009 biennial review pointed out that 'almost half of 189 children were under one year of age and a third were very young babies under three months' (Brandon et al, 2009: 50).

Furthermore, in the 2010 report, two-thirds of the cases concerned children under five years of age and nearly half of all SCR cases were in relation to babies under one year of age. Brandon et al (2010: i) stress that this finding underlines 'the importance of effective universal services provision for young children, for example health visitors and early years services such as Sure Start children's centres'. These researchers draw attention to the fact that 'many of the very young children do not come to the attention of children's social care, so the role of GPs, midwives and health visitors, and other early years provision like Sure Start children's centres, is crucial for this highly vulnerable group' (Brandon et al, 2010: 52). These findings again point to the need for health visitors to be providing a universal service to identify and work with vulnerable children across all levels of need.

Policy directives

Many recent policy directives across the UK have continued to reinforce that health

visitors have an important role in relation to child protection. The statutory guidance on safeguarding and child protection for all four countries of the UK provides a key framework outlining how individuals and organisations should work together to safeguard and promote the welfare of children.

Since the tragic death of Peter Connelly ('Baby P') in Haringey, London in August 2007 and the review of child protection arrangements in England that followed, there has been an increased focus directed toward the health visitor's child protection role. Lord Laming's (2009: 57) progress report was very clear in outlining the health visitor's role in protecting children: 'Health visitors play a key role in child protection, particularly for very young children who are unable to raise the alarm when suffering from abuse or neglect... the role of health visitors as a universal service seeing all children in their home environment with the potential to develop strong relationships with families is crucially important. A robust health visiting service delivered by highly trained skilled professionals who are alert to potentially vulnerable children can save lives.'

In addition, this Laming (2009) report was also influential in highlighting some of the difficulties facing frontline children's safeguarding services, including the climate of excessive bureaucracy, under-resourcing of health visitors and social workers, and need for improvements in leadership, training and support for professionals working with children and families. Many of these issues were also reinforced by the Care Quality Commission (2009) in its survey of NHS trusts and their arrangements for safeguarding children.

The subsequent Action on Health Visiting programme in 2009 highlighted the importance of the health visiting contribution to safeguarding children. Two of five key areas of work described in the document *Getting it right for children and families: maximizing the contribution of the health visiting team* (DH and Unite/CPHVA, 2009) were:

- Supporting vulnerable families and those needing extra support
- Using specialist skills to protect children.

This document reiterated the health visitor as a team leader, making explicit that they should consider team members' competence in safeguarding and child protection, ensuring they are aware of relevant policies and statutory guidance and understand their own safeguarding roles and responsibilities (DH and Unite/CPHVA, 2009).

In the revised English *Working together* guidance (HM Government, 2010: 42-3), the

specialist skills of the health visitor are outlined. The guidance notes that health visitors are 'crucially important in protecting children', contributing to all stages of the child protection process and supporting the work of the local safeguarding children board. It states: 'health visitors are trained to recognise risk factors, triggers of concern and signs of abuse and neglect. Through their preventative work, they are frequently the first to recognise children who are being or are likely to be abused or neglected and therefore when safeguarding procedures need to be initiated. Knowledge of the family and their circumstances, as well as the child, probably gathered during home visits, enables the health visitor to recognise signs and symptoms of a worsening environment, lack of progress to improve the child's circumstances, or actual harm being suffered by the child' (HM Government, 2010: 42-3).

The statutory guidance points out that 'health visitors must have time to maintain effective contact with the child and family, to establish and develop a successful working relationship so they can consider the situation objectively' (HM Government, 2010: 42-3). This reinforces earlier research on the importance of relationship building in health visiting and the time needed to develop meaningful relationships and to undertake a thorough professional assessment (de la Cuesta, 1994; Bidmead and Cowley, 2005). Additional key themes in safeguarding children work highlighted in the statutory guidance include information sharing and the need for professionals and agencies to work together to meet the child's needs.

Importantly, in 2010 cuts in the health visiting workforce were highlighted by the Audit Commission (2010) report *Giving children a healthy start*. This reported that health visitor numbers had declined by 13% from 2004 to 2008, and 'that safeguarding is a high priority for health visitors and that, in some cases, it was considered that limited capacity made it difficult for them to discharge their wider health responsibilities' (Audit Commission, 2010: 24-5).

In June 2010, the new coalition government appointed Professor Eileen Munro to conduct an independent review of child protection, in recognition that the system of child protection was not working as well as it should (Gove, 2010). Munro's initial report (2010: 9) described how professionals are 'constrained from keeping a focus on the child' by bureaucracy of inspection, regulation and managerial targets. She also highlighted that previous reviews had paid insufficient attention to the skills required by

professionals to engage with families, as well as the expertise to bring enduring changes in parenting behaviour (Munro, 2010: 7). Alongside the Munro Review, the English government announced its commitment to increase the number of health visitors by 4200 by 2015 in recognition of how depleted the service had become.

When the interim Munro (2011a) report was published, there was again an emphasis on early identification and the provision of help and support to families as being vitally important in promoting children's wellbeing. However when the final Munro Report (2011b) report was published, it came under some criticism for paying little attention to the health visitor's child protection role. While there are only six references to health visit(or/ing) in the final report, several of its recommendations are highly relevant to health visitors, for example:

- Plans to revise the statutory framework to reduce the amount of regulation and prioritise direct work with children, young people and their families
- Acknowledgment of the importance of professional judgment
- That 'preventative services can do more to reduce abuse and neglect than reactive services'
- That the local authority and its partners should be co-ordinating sufficient early help for children and families when problems arise and needs do not meet the criteria for children's social care services
- Recognition that it is not always 'easy to identify abuse and neglect'
- The need for those working with children and families to have 'easy access to social work expertise to discuss concerns and decide whether a referral to children's social care is needed' (Munro, 2011b: 7).

While the government response to the Munro Review, published in July 2011, was supportive of the majority of its recommendations and reinforced the 'expanded health visitor workforce' (DfE, 2011: 6), with continued budget cuts it is hard to see how these recommendations will be fully implemented. Furthermore, the House of Commons Education Select Committee launched its own inquiry on 14 July 2011 into the child protection system in England, which raises questions about the standing of the Munro (2011b) review.

Health visiting's distinctive contribution

So if health visiting services are properly resourced, what is the unique contribution of health visitors to safeguarding and protecting children? Arguably, this will reflect a range of

family-based interventions that will depend on an infant, child and family's individual needs. Rouse (2002) has previously described the health visiting role in child protection in terms of primary, secondary and tertiary prevention. Unite/CPHVA (2007), in its examination of the *Distinctive contribution of health visiting*, unpacked in detail the prevention and early detection of child maltreatment to safeguard children by health visitors using the principles of health visiting. My argument has always been that if health visiting services are adequately resourced these professionals are in an ideal position through the HCP (DH, 2009) to identify children who, with their families require advice, support and guidance, including children who are potentially vulnerable and at risk of abuse and neglect.

With proper funding, health visitors should provide a universal service to all families and this should not be confined to a one-off new birth review. Health visitors are ideally placed to provide education about normal child development patterns and provide parenting support. As leaders of the Healthy Child programme (DH, 2009) for families with children under five years of age, health visitors should have the opportunity to use their skills to assess children's and their parent's health needs, and work with colleagues in the health visiting team and children's centres to provide preventative packages of care (DH, 2009). The use of highly developed and sensitive listening and observation skills are key. For example, a mother or father might seek guidance or reassurance from a health visitor that would constitute the beginning of preventative work. This might lead to a health visitor suggesting ways of understanding an infant's emotional needs, perhaps supporting a change in parenting pattern through the provision of evidence-based advice, or in some cases referring for specialist assessment and support. The importance of such early intervention work with children and families is extremely important in promoting children's wellbeing and has been outlined in Frank Field's (2010) report on childhood poverty and life chances and Graham Allen's (2011) review of early intervention.

Following a health and development review as part of the HCP (DH, 2009), a health visitor may identify one or more health needs that may need short-term targeted intervention with children and families. An illustration of this could be management of a child's sleep problems. In some situations where health needs are identified, the health visitor may enable parents to join peer support groups in local children's centres to support

their parenting needs. Without a universal service, those families highlighted in the health visitor implementation plan (DH, 2011: 10) as requiring additional services 'some of the time' or 'vulnerable families requiring on-going additional support' are unlikely to be spotted and helped.

Health visitors must have the skills to identify families with high levels of risk factors and lower levels of protective factors (DH, 2009), and this may include families where multiple adverse issues are present such as severe financial difficulties, domestic violence, mental health issues and substance misuse. This may lead to the offer of 'additional support, building on parents' strengths' (DH and Unite/CPHVA, 2009: 17), evidence-based intensive programmes, access to support groups or community resources to reduce isolation, programmes promoting the development of parenting skills through children's centres or referral to specialists. However, it is generally recognised that establishing positive working relationships with vulnerable families does require considerable skill, time and determination.

Where short-term work does not result in an improved situation or where a family consistently avoids or is unable to achieve an improved situation for a child, there will be a need to discuss the child's situation with children's social care (Appleton and Clemerson, 1999). All health visitors 'should know when it is appropriate to refer a child to children's social care for help as a "child in need" and know how to act on concerns that a child may be suffering, or likely to suffer, significant harm through abuse or neglect' (HM Government, 2010: 61). Practitioners should be fully conversant with the guide *What to do if you're worried a child is being abused* (DH, 2003) and *When to suspect child maltreatment* (NICE, 2009). The latter provides very practical and helpful guidance dividing the alerting features of child maltreatment into when to 'consider' or when to 'suspect' child abuse and neglect.

Where a child protection conference is called and there are pre-school children in the family, health visitors should be part of the decision-making process in considering if a child is at continuing risk of significant harm and whether a formal child protection plan is implemented. Health visitors must be trained in writing child protection conference reports, delivering their professional assessments in a multi-agency context, and have the training and confidence if required to attend court. The statutory guidance also stresses health visitors' on-going contact with a child and family where there are formal

child protection procedures in place to deliver preventative health interventions (HM Government, 2010).

Obstacles facing health visiting

The need to substantially increase the numbers of frontline health visitors has been accepted by the UK government (DH, 2011), however it remains to be seen how this will be realised. The Information Centre for Health and Social Care (ICHSC) reports that at September 2010 'there were 8125 FTE health visitors, a decrease of 394 (4.6%) since 2009 and a decrease of 1922 (19.1%) since 2000 (an average annual decrease of 2.1%)' (ICHSC, 2011: 24). Despite the national roll-out of the health visitor implementation plan, realistically it will take a number of years to rebuild the health visiting workforce, which has been so depleted over the last 20 years. It takes time, nurturing and experience to build new staff's skills and expertise and improve the morale of the existing workforce. Health visitor education should include a theoretical, empirical and practice examination of the cause and consequences of child maltreatment as well as training in recognising risk and the signs of abuse and neglect, how to respond to maltreatment, and strategies for the prevention of child abuse and neglect. Furthermore, when health visitor caseloads often exceed 450, health visitor interventions with children and families can only be targeted and short term, and if home visiting does not take place vulnerable children will continue to be missed. In the current fiscal environment, anecdotal evidence suggests that targets relating to new births and other planned contacts that have a contractual basis take priority, and there is huge pressure to attain them to the detriment of work with vulnerable clients that has no target attached.

The vision set out in the health visitor implementation plan (DH, 2011: 10) is about 'making sure the appropriate health visiting services form part of the high intensity multi agency services for families where there are safeguarding and child protection concerns'. While this a laudable aim, the on-going reorganisation of the NHS is contributing to considerable service complexity and lack of clarity about where the responsibility for child safeguarding will be located. In particular, how far 'health and wellbeing boards' will contribute to the assimilation of NHS and local authority children's services remains to be seen. Additionally, local authorities are facing major cuts in resources, with particular demands on early intervention services (Featherstone et al, 2011).

An important element of this is for all health visitors to 'have access to regular proactive child protection supervision to ensure good practice' (HM Government, 2010: 43). Statutory guidance acknowledges the importance of effective supervision to promote good standards of practice and that it is essential that practitioners have access to good advice and support (Hall, 2007). Yet anecdotal evidence from some areas of the country suggest that with service cutbacks in specialist safeguarding teams, supervision time for health visiting staff is being halved or reduced. Equally problematic are systems where line managers act as child protection supervisors and the line between supervision and management becomes blurred.

Conclusion

This paper has examined the role of the health visitor in safeguarding and protecting children. It has reviewed relevant policy and research evidence. The paper has outlined the distinctive contribution that a properly resourced health visiting service should be making in safeguarding and child protection work. It has made the argument that if services are adequately resourced, health visitors are ideally placed to identify children who, with their families require additional support and guidance, including those children who are potentially vulnerable and those at risk of abuse and neglect.

However, despite recent policy continually reinforcing the importance of the health visitor's role in relation to safeguarding and protecting children work, this paper highlights a number of obstacles to that function, including a depleted workforce, large caseloads, low morale among health visitors, on-going financial constraints, little evidence of a universal service, cuts in child protection clinical supervision and a lack of recognition by other agencies of the complexity of health visitors' work with vulnerable families. These issues have to be addressed by central government if the vision for health visitors' work as part of a continuum of public health activity including preventative work, and the full range of safeguarding duties through to the protection of children from abuse and neglect is to be realised.

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KEY POINTS

- Although the issues involved in safeguarding and protecting children have not changed in essence over the last 18 years, the practice context, organisational climate and policy drivers have
- Safeguarding and child protection is recognised as a key public health issue and health visiting has been identified as being vital in addressing this
- Health visiting has an established track record in safeguarding and protecting children, but the health visitor role has been increasingly eroded in recent years
- Health visitors' work in child protection is of key importance, while being part of a broader continuum of their public health activity

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Children's earaches: What advice should community practitioners give?



Earache is a common problem in babies and young children. It is usually due to a bacterial or viral infection in the middle ear called acute otitis media or AOM. The pain, which results from a build-up of pressure and fluid behind the eardrum, and inflammation in the middle ear, can be severe and distressing. Incidence peaks between 6 and 15 months of age, and therefore anxious parents may often seek guidance during this time¹. But do you really know how AOM affects children and what, if any, treatment you should advise parents use to relieve their child's symptoms?

Diagnosis

Older children may be able to tell you if they have earache, but young children usually cannot, and the symptoms can be difficult to spot. They usually pull or rub at one or both ears, have a fever (> 38°C), and may show general signs, such as irritability, crying, poor feeding or restlessness. Coughing and nasal discharge (or a preceding history of these) is also common. The eardrum will look red, yellow or cloudy. AOM is more certain if the eardrum bulges or there is fluid behind it, or if the eardrum is perforated and there is discharge. In young babies though, the eardrum is often not visible and symptoms are likely to be non-specific.

Treatment

Children younger than 3 months with a temperature $\geq 38^{\circ}\text{C}$, or under 6 months with a temperature $\geq 39^{\circ}\text{C}$, and those with suspected complications, such as meningitis, mastoiditis, or facial paralysis, require urgent medical assessment¹. For other children, you can reassure the parent that in most cases, AOM will resolve without any treatment within 2 to 3 days¹. Since antibiotics make little difference to symptoms and may cause adverse effects, they are only given if the child is:

- systemically very unwell
- at risk of serious complications due to chronic disease, immunosuppression, cystic fibrosis or premature birth.

If symptoms are severe, antibiotics may be considered for children younger than 3 months, children younger than 2 years with bilateral AOM, and children with perforation or discharge¹. However, for most children, it is usual to follow a 'wait and see' approach, and control the pain using a suitable analgesic. Antibiotics are not given unless the child becomes acutely unwell or if the symptoms last more than 4 days.

Symptomatic relief

Until the child's earache symptoms do settle, provided there are no contraindications, you can advise the parent uses a paediatric ibuprofen suspension, such as Nurofen for Children, to alleviate their child's pain and fever. Ibuprofen is an anti-inflammatory drug. It provides effective relief of pain associated with earache, and reduces a fever more effectively than paracetamol.

Nurofen for Children (contains ibuprofen; always read the label) is an ibuprofen suspension specially formulated for babies and young children as young as 3 months and weighing over 5kg (11lbs). It brings fast and effective relief from pain and fever, and comes with an easy-dosing syringe for accurate and mess-free dosing.

- Relieves the pain of earache
- Starts to work in just 15 minutes to relieve fever
- Relieves fever for up to 8 hours – which is up to 2 hours longer than paracetamol
- Easy-dosing syringe for accurate and mess-free dosing

ESSENTIAL INFORMATION: NUROFEN FOR CHILDREN ORANGE 3 MONTHS TO 12 YEARS: Suspension of ibuprofen 100mg/5ml. **Indications:** Reduction of fever, and relief of mild to moderate pain. **Dosage:** 20–30mg/kg bodyweight in divided doses (see pack for details). Not suitable for children under 3 months of age unless advised by a doctor. For oral administration. For short-term use only. **Contraindications:** Hypersensitivity to constituents. History of, or existing peptic ulceration. History of asthma, rhinitis or urticaria associated with aspirin or other NSAIDs. **Precautions and Warnings:** Consult doctor if symptoms persist for more than 3 days (for a child aged over 6 months); for children under 6 months, seek medical advice after 24 hours use (3 doses). Do not exceed the stated dose. Caution in patients with renal, cardiac or hepatic impairment. Asthma sufferers, anyone allergic to aspirin, receiving any other regular treatment, and pregnant women should consult a doctor before use. Nurofen for Children is not suitable for patients with stomach ulcer or other stomach disorder. **Side Effects:** Hypersensitivity reactions including (a) non-specific allergic reaction and anaphylaxis, (b) respiratory tract reactivity comprising of asthma, aggravated asthma, bronchospasm or dyspnoea, or (c) assorted skin disorders, including rashes of various types, pruritus, urticaria, purpura, angioedema and, more rarely, bullous dermatoses (including epidermal necrolysis and erythema multiforme). Side effects may include abdominal pain, nausea, dyspepsia, gastrointestinal bleeding and peptic ulceration. Also, very rarely, thrombocytopenia. Bronchospasm may occur in patients with a history of aspirin sensitive asthma. **Product Licence Holder:** Crookes Healthcare Ltd, NG2 3AA. **Product Licence Number:** PL 00327/0085. **Legal Category:** P. **MRRP:** 200ml £5.13 **Date of preparation:** July 2010.

¹ CKS (2009) *Otitis media – acute*. Clinical Knowledge Summaries. Available at: www.cks.nhs.uk/otitis_media_acute [Accessed 15 February 2011].

² NICE (2007) *Feverish illness in children – Assessment and initial management in children younger than 5 years*. Clinical Guideline. London, RCOG Press. Available at: www.nice.org.uk [Accessed 15 February 2011].

³ BERTIN L et al (1996) A randomised, double-blind, multi-centre controlled trial of ibuprofen versus acetaminophen and placebo for symptoms of acute otitis media in children. *Fundam Clin Pharmacol* 10(4):387-392.

⁴ KELLEY MT et al (1992) Pharmacokinetics and pharmacodynamics of ibuprofen isomers and acetaminophen in febrile children. *Clin Pharmacol Ther* 52(2):181-189.

