SEARCH AND RESCUE
The powerful health messages conveyed by superheroes

EQUAL RIGHTS
The case for gender-neutral HPV vaccination

LOST OPPORTUNITIES
What it means to be young and poor
Exploring Children’s Rights

A participative exercise to introduce the issues around children’s rights in England and Wales

Key features:
Extensively revised and updated second edition; written by an expert with experience of leading training sessions on children’s rights; handbook with heading cards and multi-coloured flashcards.

About the resource:
Exploring Children’s Rights introduces key ideas about children’s rights in England and Wales by means of a participative activity, or exercise, that can be used for groups or individuals. This has been created using the author’s own experience of leading training sessions on children’s rights. Exploring Children’s Rights equips a group facilitator to lead sessions in:
- types of children’s rights
- power issues in relation to children’s rights
- the historical development of children’s rights
- current and past law on children’s rights.

The training guide offers three versions of the exercise: a group discussion version (1 hour 20mins), a case histories version (1 hour 50mins) and an individual activity (1 hour).

The training will be of interest to anyone who wishes to introduce the complex issue of children’s rights in an informative and challenging way. It is particularly relevant to teachers and trainers in the fields of education, health and social work, but is designed for use by anyone who works with children and young people and who has a real concern for promoting their rights.

Format: A5 handbook (126pp) in polyprop presentation box with heading cards and multi-coloured flashcards and a CD-rom


Children’s Rights and Counselling

A training exercise exploring children’s rights to counselling, current law, types of children’s rights and power issues relating to them

Key features:
Companion resource; written by an expert with experience of leading training sessions on children’s rights and counselling; wirobound book with printable flashcards

About the resource:
Children’s Rights and Counselling introduces key ideas about the rights of children and young people to access counselling in a range of settings. It identifies key rights held by children and young people in England and Wales to confidentiality and to access therapy alongside court proceedings. It links these rights to crucial ethical values and principles held by therapists, such as respect for client welfare, participation and autonomy.

This training pack equips a group facilitator to lead sessions in:
- types of children’s rights to counselling
- power issues in relation to children’s rights to counselling
- the historical development of children’s rights to counselling
- current law on children’s rights to counselling.

The pack can be used as a stand-alone training resource, or can follow on with preparatory training for participants on children’s rights, delivered using Exploring Children’s Rights. The latter covers important developments such as the Children Act (1989), the United Nations Convention on the Rights of the Child (CRC) (1989) and the Human Rights Act (1998).

The training offers two versions of the exercise: a group activity version (runs for 1 hour 30mins) and an individual/pair activity (1 hour 30 mins).

Format: A4 Wirobound manual with CD-rom

Price: £35.00 Order code: E130 ISBN: 978-1-908993-40-3

Vital resources for: Trainers, counsellors and therapists, health care professionals, social care staff, teachers, all those working with children and young people.

OFFER: Get both Children’s Rights titles by Peter Jenkins for only £75.00 quote REF: CR20
Contents

4 WELCOME LETTER

6 NEWS AND VIEWS

8 RECRUITMENT
SAPRNA is looking for more members to join its Executive Board. Here are further details

9 LEADER
The lost generation
The Children’s Society’s Larissa Pople explains how school nurses can identify children living in poverty and how they can provide effective support

14 POLICY
All in the detail
ChiMat’s initial child health outcomes framework means there is a wealth of helpful material available for school nurses to analyse

16 YOUTH TALK
Making a difference
Frances Perrow explains how the GP Champions project can ensure that adolescents – the group with the smallest patient voice – can be heard

20 YOU SAID, WE DID
Lobbying for change
Sharon White offers an update on SAPHNA’s achievements

21 QNI
The past shapes the future
Matthew Bradby delves into the QNI archives to look at what today’s community nurses can learn from yesterday’s health professionals

24 CLINICAL
What about the boys?
The HPV-vaccination programme for girls is well established, but there is a case for gender-neutral vaccination, argues Peter Baker

27 JFHC LIVE
A thirst for knowledge
See what’s happening at JFHC Live in March. It is CPD-accredited and FREE to attend

28 PRACTICE
Diary of a SCPHN student
Paul Watson talks about finding inspiration when the going gets tough

30 PRACTICE
Every picture tells a story
See how superheroes and a puppet are helping to communicate effective health messages to children and young people. JSPHN’s Robert Mair and Penny Hosie explain more

34 DIARY DATES & NOTICEBOARD

Jan/Feb 2014 | School and Public Health Nurses Association | 3
I’d like to wish you all a very happy new year. Let’s hope the year ahead is fruitful for school nursing and, indeed, for the improved health and well-being of children and young people.

So much is happening on the school nursing front it’s hard to know where to begin! The School Nurse Development Programme (SNDP) races onward and, as part of that, we see the first ever national award for school nurses launched. This has been long awaited and I can think of many worthy nominees. The overall winner will be announced in May. Alongside this we have been working arduously with others and the Department of Health (DH) to produce a national school nursing service specification, this will be welcomed by many and will give much needed clarity on our roles, responsibilities, core and additional service offers.

In this edition we have a number of features which further help to inform the services we provide. The recent children and young people’s outcomes data toolkit produced by ChiMat is of great assistance in informing school nursing services and our partners, where they need to target their public health approaches (p14). It will also, in time, identify where these are making a difference. There is a sobering reminder in the article from the Children’s Society on the impact that poverty is having on society and how this too must influence and shape the school nursing services that need to be delivered (p20). The GP Champions project (p16) involves young people themselves changing and challenging for best practice, which, in turn, can help improved partnership working with school nursing; essential for co-ordinated and seamless care. As well as the profiling of populations to inform school nurses’ work, our student journey article also reflects on other key partners and the ‘team around the child’ approach, ‘making every contact count’ (p28). Finally, our article on superhero comic books and toys prove there are many inspiring – and fun! – ways to get health messages across to children and young people (p30).

SAPHNA also have many exciting developments afoot too! In order to respond to an increased demand for our services we are recruiting to our Executive Committee. For more information see page 8 on how to apply. I already know lots of you are interested and will be a great asset to us and our work. We look forward to receiving your applications! Alongside this we are delighted to announce we will continue our work regarding young carers with the Queen’s Nursing Institute. We are also working with the Department of Health and Health Education England, developing e-learning modules to support the ongoing professional development of the school nursing workforce. Updates on these and our other current projects will be brought to you in our next issue.

We seem to have hit the ground running again. However, I firmly believe that this year holds many positive opportunities for us all! Have a good month and hope you enjoy the issue.

sharon@saphna-professionals.org Twitter: @SaphnaSharon

PS You can purchase extra copies of the journal for £15 each (£90 p.a.) by calling 01273 434943.

Executive board members

Helen Ross  Chairperson  Lead for school nursing and the National Child Measurement Programme for Central Essex Community Services

Sharon White  UK professional officer for the School and Public Health Nurses Association (SAPHNA)  Formerly consultant nurse for looked after children, Leeds Community Healthcare

Jill Beswick  Health visitor and early years workforce development lead  Greater Manchester Public Service Reform Team

Babs Young  Health visitor, Kent

Sally Norfolk  Treasurer  Retired school nursing manager

Betsy Allen  Professional lead for school nursing and nurse for children  Integrated children’s services, Virgin Healthcare, Devon

Penny Greenwood  Nurse consultant public health  Barnsley Metropolitan Borough Council

Elaine Davies  Public health school nurse  Northumbria Healthcare NHS Foundation Trust, North Shields team

Veronica Hetherington  Secretary  Lead public health school nurse  North Tyneside, Northumbria Healthcare NHS Trust

Jane Walton  Immunisation and screening co-ordinator  Public Health England

All of these people come from a variety of nursing backgrounds and currently work across a broad spectrum of public health nursing roles and are committed to the success of the association.

Further information

Please contact Sharon White, Babs Young or any other board member if you require any further information about the association or wish to become active in SAPHNA activities. Email SAPHNA at info@saphna-professionals.org
Help parents Beat the Itch with our FREE app

With over half of children reluctant to have cream applied, many parents worry that they’re not treating their child’s eczema well enough. In fact, in a recent survey of over 500 parents, 79% told us that they use distraction methods to encourage them to comply.

That’s why we developed ‘Beat the Itch with QV’, a game for children with dry and sensitive skin conditions such as eczema. The app, available on iPhone and iPod Touch, features our loveable bear, Qool Vince, in a race against time to apply his QV emollients before he gets too itchy.

It’s a fun, interactive way to distract children during the often challenging task of applying emollient and can help improve compliance.

Tell parents to download their FREE ‘Beat the Itch with QV’ app now from the App Store, or visit www.qvskincare.co.uk for more information.

Scan the code to download ‘Beat the Itch with QV’ now!

www.qvskincare.co.uk
New rules to make residential care safer will come into force this month.

Children and Families Minister Edward Timpson announced the new rules, which will put an end to unnecessary out-of-area placements for vulnerable children. The changes form part of the government’s response to the consultation on residential care reform and will result in much stricter scrutiny of councils’ decisions about where children are placed.

Announcing the changes, Edward Timpson said: “It’s totally unacceptable for local authorities to routinely place children miles away from their homes for no good reason. Far too often an ‘out of sight, out of mind’ culture prevails, and I’m determined to tackle it.

“In future, only senior council officials in charge of children’s services will be able to place children out of area and only when they judge it to be the right decision for a child to be moved away from their home area. There will be one individual in each local authority who is directly accountable for these decisions.

The changes will come into force at the end of January, and are part of wider measures, which include:

- introducing rules so homes must tell councils when children move into and out of the area
- changing the regulations so new homes only open in safe areas, and that they are run by competent providers
- ensuring homes already open in less safe areas evidence that they can keep children safe, or face closure
- putting much greater information on the quality and location of children’s homes into the public domain.

There is national guidance in place for health professionals to follow in these cases.

She added: “Rates remain highest in under 25-year-olds and while often these infections can be simple to diagnose and treat, if left untreated they can have serious health consequences.

“Regardless of age, everyone should use a condom with new and casual sexual partners, which significantly reduces the risk of getting an STI. We also advise young adults to get screened for chlamydia each year.

“The National Chlamydia Screening Programme is in place in England ensuring access to free testing from a range of convenient locations.”

More than 5,000 children diagnosed with sexual infections

More than 5,000 children and young people under the age of legal consent were diagnosed with sexual infections last year, figures released by Public Health England (PHE) revealed.

In total, 5,386 youngsters under the age of legal consent were treated for chlamydia, gonorrhoea, herpes and other conditions. This is more than double the reported cases a decade ago, when 2,474 cases of sexual infections in minors was reported.

Over the last three years more than 16,000 children have been diagnosed with sexual infections, according to figures released to the Daily Mail following a Freedom of Information request. In each of the last three years, girls made up around 87% of the children diagnosed with STIs.

Dr Gwenda Hughes, head of STI surveillance at PHE, said: “Data on infections primarily transmitted through sexual contact are routinely collected, across all age groups, by PHE.

“With regards to those under 13 years old, the number of infections reported each year is very low. In this age group, using the term ‘sexually transmitted infection’ is problematic as it is very rare for children to be sexually active at this age.

“Moreover recent research suggests most of the infections reported are not acquired sexually; and of the few that may have been, sexual abuse was implicated.

Tackling domestic abuse

The Home Office has published a range of new materials to help young people ensure they don’t become victims and/or perpetrators of domestic abuse.

Their campaign and publication entitled This is Abuse aims to get teenagers to re-think their views of controlling behaviour, abuse, violence and what consent means within their relationships. The guide has been produced so it can be used with a wide range of organisations, including schools, who work directly with young people.

For more information, and to access a range of associated documents, visit http://dmtrk.net/HSS-214IF-BJ060J-UASFK-1/c.aspx
ChildLine reports increase in cyberbullying

The number of children contacting ChildLine about cyberbullying has nearly doubled in 12 months, the charity has revealed.

In 2012–13 it saw 4,507 cases of cyberbullying, compared to 2,410 cases in 2011–12. Other major issues were self-harm, depression and difficulties with relationships inside the family.

In total, ChildLine counselled 278,886 children and teenagers, with 59% of cases dealt with online, compared to 41% over the phone. This is the first time more counselling has taken place online than over the phone in the charity’s 28-year history. Suicide, self-harm and mental health issues were the most common topics for online counselling, with abuse counselling taking place more often over the phone.

Peter Wanless, chief executive of the NSPCC charity, which runs ChildLine, said: “The issues facing children today are very different from those that faced us as children.

“Stranger danger, for example, rarely comes up in contacts to ChildLine but depression, self-harm, online bullying and even suicide contacts are increasing exponentially.

“If we are to help young people we need to listen to what they are telling us about the issues they are facing.

“ChildLine is one of the most important sources of information about vulnerable children in the UK and these regular snapshots will help us keep one step ahead and focused on the areas that are really concerning them right now.”


A further report, by academics at the universities of Warwick and Bristol, has found links between bullying and psychosis in later life.

“Looking at a cohort of 4,720 children between the ages of eight and 11, the researchers found that children who were bullied over a number of years were four-and-a-half times more likely to have suffered from psychotic experiences by the time they reached 18 than their peers who had never experienced any type of bullying. Those who were bullied themselves during primary school were also more likely to suffer from a psychotic experience later in life.

Lead author professor Dieter Wolke, a chartered psychologist, wrote in the journal Psychological Medicine: “We want to eradicate the myth that bullying at a young age could be viewed as a harmless rite of passage that everyone goes through – it casts a long shadow over a person’s life and can have serious consequences for mental health.”

Independent School Nurse Survey winners announced

We were delighted with the response to our Independent School Nurse survey – and we’re even more pleased to announce the winners. The following people were selected at random to receive £25 worth of Marks and Spencer gift vouchers each.

The winners are:

Claire Robinson - Scarborough Medical Centre
Lisa Tanser - Oakbrook School
Ellen Dean - The Glasgow Academy

Details and analysis of the survey will be available soon, and we will also be hosting focus groups to inform our thinking further. Again, further details will follow soon.

Anaphylaxis Campaign plans big 2014

To celebrate its 20th anniversary, the Anaphylaxis Campaign is planning a series of high profile campaigns to raise awareness of the condition and to benefit people with severe allergies and their families.

The campaigns will ensure that:

- all schools will hold stocks of adrenaline auto-injectors
- two adrenaline auto-injectors will be available at all times to everyone who is prescribed these devices, and
- improved GP and primary care knowledge about severe allergies and resultant care.

Lynne Regent, chief executive of the Anaphylaxis Campaign, said: “2014 is a very special year for the Anaphylaxis Campaign. We wish to celebrate all the great work the Campaign has achieved since its formation in 1994 by doing what we do best – campaigning for better care for severe allergy patients. You have told us that these are key issues and change in these areas will make a positive change to your lives. If the Campaigns are successful they may save lives too.”

For more information on the Anaphylaxis Campaign visit http://www.anaphylaxis.org.uk

Hygiene in school kitchens needs improvement

Scottish schools have been urged to improve the hygiene in their kitchens, after 23 improvement notices were served last year.

In total, 83 orders to improve food hygiene have been issued in the past five years, leading to the Scottish Conservatives, which collated Food Standards Agency reports, to call for an improvement in hygiene standards. The Food Standards Agency (FSA) issued the notices after inspecting schools, nurseries and after-school clubs.

A Scottish government spokesman said: “Local authorities are ultimately responsible for standards of hygiene in school kitchens, which should be of the upmost importance, and school premises should be also inspected by councils’ own environmental health services.”

The news on the FSA inspections was followed by Scotland’s First Minister, Alex Salmond, announcing that all Scottish P1–P3 pupils (children aged 4–8) will get free school meals from January 2015.

The move, which would benefit 165,000 youngsters, would boost health and was worth £330 a year for each child to families, he said. It matches a plan being introduced from September 2014 in England.
The School and Public Health Nurses Association (SAPHNA) is currently recruiting new members to our Executive Committee. We are seeking applications from both student and qualified school nurses who have a passion to improve the health and well-being outcomes for children and young people.

Your role will require a time commitment of approximately one day over the period of a month, regular tele-conferences, attendance at four Executive Committee meetings each year and the SAPHNA annual conference. As a member of the Executive Committee, you will play a key role in helping to develop and provide regional links with school and public health organisations and professionals, collate and contribute to policy and practice developments, contribute content to our journal, encourage new membership and, most importantly, drive forward the agenda for the school nursing workforce.

In return you will form part of a highly influential and respected professional association; the only one totally dedicated to school nursing. You will play a key role in representing the voice of school and public health nurses across the UK and supporting the professional development of our members.

If you are interested in becoming a member of the SAPHNA Executive Committee, please apply by sending in a one page A4 application to sharon@saphna-professionals.org by 17th February 2014. Your application should give a pen picture of your experience, knowledge, skills and examples of involvement in innovation which demonstrates improved practice and outcomes. Outline any specific areas of expertise; e.g. sexual health, emotional health etc. and finally, why you feel you would be able to play a key part in our crucial work.

We look forward to hearing from you!

sharon@saphna-professionals.org
Twitter: @SaphnaSharon

www.saphna-professionals.org
The lost generation

It is well documented that poverty can have a huge impact on the health and well-being of children and young people. Larissa Pople from The Children’s Society shows how the latest evidence proves it is more vital than ever that school nurses target and support the most vulnerable.

There is a wealth of research evidence to demonstrate the links between childhood poverty and poor outcomes for children. Children in low-income households are more likely to experience a range of health problems such as low birth weight, childhood obesity, other physical health problems and poor mental health. They are also more likely to have lower levels of educational participation and attainment, and to live in worse housing and neighbourhoods. Furthermore, the links between poverty and poor outcomes extend into adulthood, with young people who have grown up in low-income households more likely to be unemployed or to work in unskilled and poorly paid positions (Griggs & Walker, 2008; Bradshaw 2011).

However, household-based measures of children’s economic circumstances like household income have a weaker relationship with well-being than might be expected, and may not get to the heart of how poverty is experienced by individual children. For this reason, we worked with the University of York to devise a more child-centred measure of material circumstances:

Larissa Pople, senior researcher, The Children’s Society
an index of 10 material items and experiences (see box entitled ‘List of desirable experiences in a child’s life) that we developed from focus group and survey research with children aged 8 to 15 years.

**Children’s sense of well-being**

At The Children’s Society, we have also found a number of associations between children’s economic circumstances and their subjective well-being. For example, we found a relationship between children’s subjective well-being and the income of the household in which they live. As shown in Figure 1, children living in the poorest quintile were twice as likely to have low subjective well-being as those living in the richest quintile (Rees et al., 2011).

As public health practitioners, school nurses need to target their work to those who have the greatest health needs. This article clearly identifies children and young people living in poverty as experiencing poorer health and well-being outcomes. In partnership with schools, families and other agencies, school nurses have a key role to play in providing identification, referral, advocacy, support and advice to some of our most vulnerable.

The links between children’s subjective well-being and this 10-item index are much stronger than they are for household measures. For example, children lacking five items or more from our index were more than five times as likely as children lacking no items to have low subjective well-being (Main & Pople, 2011).

This group of children – which constitutes about five per cent of 8 to 15-year-olds – also reported a range of other issues in their lives, including bullying, problems in their friendships, unhappiness with their home, lower self-esteem and lower aspirations for the future, as can be seen in Figure 2 (The Children’s Society, 2013).

**The long-term impact of poverty**

Qualitative research supports these findings and adds further insights into how poverty is experienced by children. Studies that focus on children’s own accounts of living in poverty, such as Tess Ridge’s landmark study of childhood poverty (Ridge, 2002) and review of 10 years of research with children living in low-income households (Ridge, 2009), show that the impact of poverty can be felt across all areas of children’s lives. It affects their economic well-being, mental and physical health, social relationships and the opportunities and choices that are open to them. To be poor in an essentially wealthy society is a very particular and stigmatising experience, and children are well aware of this (Ridge, 2013).

**The importance of hearing children’s views**

In July 2013, The Children’s Society held the first meeting of its Children’s Commission on Poverty, an initiative that aims to place children’s views at the heart of the debate on childhood poverty. Alongside the Commission, The Children’s Society instigated a nationwide, rolling programme of research and consultation to hear from a wide range of children and young people with experiences of poverty. In August 2013, The Children’s Society also carried out a survey of around 2,000 children aged between 10–17 years old to ask about their views and experiences of poverty.

---

1 These findings relate to household surveys with children whereby we are also able to capture information on household income from adults in the household.
This recent research with children has given us important insights into how poverty is experienced by children in the UK, and highlights a number of key themes.

Firstly, and not unexpectedly, our research has showed that children in poor households are keenly aware of the financial pressures facing their families and worry about the amount of money coming into their homes. More than three-quarters of the children in our survey who said that their family was ‘not well off at all’ said that they often worry about how much money there is to go around in their family.

The children that we spoke to in interviews also indicated that times are especially tough at the moment. Many of the children that we interviewed had at least one parent in paid employment, but for these families, employment was not enough to guard against poverty:

‘Both my parents have steady jobs, but it is tighter… there is less money, it is getting harder.’

Some of the children that we spoke to were affected by debt, either owed by their families, or themselves in the case of young people living independently:

‘I get paid it goes, it pays debt, I have more debt.’

‘A couple of years ago we were in debt, our family helped us. The bailiffs used to come knocking on the doors… It’s not like that now, but you never know, it might be next month or the month after. Mum tells me not to open the door in the evening if I am here on my own, in case it might be them.’

Christmas and birthday presents and celebrations were beyond the means of some of the children that we spoke to, especially the young people that were living independently:

‘I am dreading Christmas, I feel bad that I can’t afford my own rent so can’t afford to give presents, I feel ashamed.’

Some of the younger children also reported having very few toys to play with, or limited space to play.

Secondly, our research confirmed that children in poor households face a range of problems in their housing and neighbourhoods. For example, over half (54%) of children who said that their family was ‘not well off at all’ reported living in a home that was ‘a bit’ or ‘much colder than they would have liked’ last winter, and just over a quarter (26%) reported damp or mould in their home.

Thirdly, poverty can make it difficult for children to maintain friendships and social networks when the cost of clothing and social activities that others take for granted are beyond their reach. In our survey, we asked children if they had ever felt embarrassed or experienced bullying because their parents do not have enough money. Over half (54%) of the children saying that their family is ‘not well off at all’ said they had felt embarrassed, and 14% had experienced some form of bullying.

‘Some people say ‘Oh it’s a council house kid’… they judge on their appearance or how clean they are. I just think maybe they are struggling or their shower is broken. It makes me feel quite angry, maybe their family hasn’t got enough to buy them clothes straight away, maybe they can’t afford the water bill.’
In our interviews, children described not being able to afford new clothes and finding it difficult to keep up with their classmates on ‘mufti’ days:

‘If my trousers are too short then people notice and call it ankle biters, I feel self-conscious then... Mufti days can be a problem as people come in their designer clothes and then I feel bad.’

The cost of leisure activities was also an issue for the children that we spoke to.

‘I do go out with my friends, go to the park, we don’t pay for stuff usually, cinema, sports centre is all too expensive. We spend time at each other’s houses or at the park.’

Fourthly, our research highlighted the disadvantage that poor children face at school, with many reporting being left out of activities and opportunities that their peers take for granted.

‘They say they are free schools, but they are not really, you have to buy all the right things, and if you can’t or you don’t have it then they won’t let you go, so it’s not really free.’

‘School uniform has got so expensive now... like the jumpers and stuff, they are not very well made and break quite easily, so I have to be careful and make them last.’

Poverty may also make children uncertain and fearful about their futures, which is a difficult burden to carry in childhood.

‘I am working hard at school as I want to do well... I want to get a good job and have money and for it not to be difficult. I want to do child psychology, I want to get a job and save up for uni, but it is so expensive so I will have to save lots.’

Conclusion
Research evidence, including evidence from our own programme of research, confirms that childhood poverty can have a deep and lasting effect on the quality of children’s lives. However, children living in poverty are not all the same. Some children fluctuate in and out of poverty, while others experience poverty throughout their childhoods, and there is still much to learn about how gender, ethnicity, disability, geography, family circumstances, and other factors affect children’s experiences of poverty.

The Children’s Society will be exploring some of these questions through its Children’s Commission on Poverty and associated research programme, which includes a qualitative longitudinal study of poverty. Our aim is to place children’s voices at the heart of the debate on childhood poverty and to enable children and young people to discuss their own perspectives and priorities, and propose ideas for change to help to improve the lives of children living in poverty.

If we are to make a difference to the lives of children living in poverty then organisations such as ourselves and SAPHNA need to pool our resources in creative and responsive ways.

Further information
www.childrenssociety.org.uk/

The Children’s Society is a children’s charity who help children of all faiths and none, including children at risk on the streets, disabled children, young refugees, young carers or those within the youth justice system. Through our lobbying and research, we seek to influence child protection policy and perceptions at all levels so young people have a better chance in life.

http://www.childrenssociety.org.uk/

References
For more than 20 years the Journal of Family Health Care has been providing the latest research and up-to-date information on a huge range of topics concerning the health and well-being of infants and young children. These exciting new books bring together a selection of articles from the Journal’s recent archives for the first time to provide comprehensive, informative and convenient reference tools for community health professionals, including health visitors and their teams, midwives, school nurses, practice nurses, dieticians, practice teachers, tutors and students, as well as community paediatric nurses.

The CD-roms that accompany the books supply a number of factsheets that cover many of the issues discussed, which can be printed out and left with parents, schools or anyone else affected by the issues covered, enabling community health professionals to easily provide re-assurance and advice.

Volume One covers:
- Healthy eating in children
- The power of vitamins
- School food and the role of the school nurse
- Weaning – when to do it and the best approaches to introducing solids
- Diabetes
- Anorexia
- Childhood constipation

ISBN: 978-1-908-993-41-0

Volume Two covers:
- Allergies in children – the causes and management of many common conditions
- Living with food allergies
- Managing anaphylaxis
- Coeliac disease
- Asthma and its impact on the everyday lives of children


Please visit www.pavpub.com or call Pavilion on 01273 434 943
The welcome publication of CHiMat’s initial Child Health Outcomes Framework means there is a wealth of material to analyse and help school nurses identify key areas of need.

A new Health Intelligence Network issued by CHiMAT will give regions the opportunity to identify areas for improvement.

The Child and Maternal (ChiMat) Health intelligence Network has published an initial version of the Children and Young People’s Health Outcomes Framework.

The framework brings together and builds upon health outcome data from the Public Health Outcomes Framework and the NHS Outcomes Framework. It responds to the Children and Young People’s Health Outcomes Forum’s recommendation that a version of these frameworks be created which highlights areas of particular relevance to improving the health outcomes of children and young people.

The data has been published on the Public Health Outcomes Framework and the NHS Outcomes Framework for different geographical areas. Further important indicators and additional detail to existing indicators will be added to the framework tool as they become available over the next 12 months.

These indicators, when viewed together, will inform discussions and encourage improvements in services and health outcomes for children and young people.

Professor Ian Lewis, co-chair of the National Children and Young People’s Healthcare Outcomes Forum and chair of the ChiMat Health Intelligence Network said:

“I welcome this single site that brings together all children and young people’s outcome indicators in both the NHS and Public Health Outcomes Frameworks in an easily accessible and meaningful way. It highlights many important areas for improvement but also the need to expand the scope of the currently available indicators in line with the recommendations of the Children and Young People’s Outcomes Forum.”

Dr Ann Hoskins, director for children, young people and families, Public Health England said: “The Children and Young People’s Health Outcomes Framework is an important new tool that brings together all the outcomes for children in the NHS and Public Health Outcomes Frameworks. It is an essential new resource to support joined up commissioning of services for children, young people and families at a local level.”

The Children and Young People’s Health Outcomes Framework is available here – http://fingertips.phe.org.uk/profile/cyphof.

After successful lobbying to ensure school nurse representation, SAPHNA are now members of the Children and Young People’s Outcomes Framework Forum.

We welcome this tool from ChiMat which we will be able to utilise to further inform our targeted public health activity. Being able to compare and contrast with other areas also gives scope for the sharing of good practice and learning lessons.

As part of the children’s workforce we have a key role to play in improving the health outcomes of children and young people, this excellent tool will support us in achieving this.
Making a difference

The ‘GP Champions’ project shows there’s considerable potential in bringing together young people, GPs and the voluntary sector to find new ways to help improve young people’s health. Frances Perrow explains more

School nurses are fully aware of the importance of keeping young people healthy and have first-hand experience of dealing with the specific problems in this age group.

But nationally, adolescents have the smallest ‘patient voice’, they are the least satisfied with visits to their GP and The Lancet reported there have been ‘no significant health improvements’ in this age group, compared to others.

Adolescent health

We know that adolescence is a critical time for health, when risk-taking begins and young people experiment with alcohol, smoking, drugs and sex. It’s also the stage when serious long-term conditions may present for the first time. Added to that, the effects of poor healthcare or the impact of good healthcare in adolescence can last a lifetime.

These factors have been the driving force behind a project run by charities the Association for Young People’s Health (AYPH) and Youth Access along with the Royal College of GPs’ Adolescent Health Group. With funding for three years from the Department of Health, the partners have developed the ‘GP Champions for Youth Health Project’, which aims to find new ways of meeting health needs for this age group.

Frances Perrow, project lead, The Association for Young People’s Health

Pilot projects

Ten pilot sites have been set up around the country, each with a lead GP practice, coupled with a voluntary sector organisation which provides information and counselling services to young people.

The sites in Liverpool, Washington Tyne and Wear, Bristol, Southampton, Brighton, Sheffield, Manchester, Cornwall and two in London, are exploring the advantages of sharing experience, ideas and service delivery. They are also trying to get funding from (CCGs) under the new commissioning arrangements.

Each pilot site is working with young people to find out their views about current health provision as well as finding out what they would really like to see commissioned.

In some cases young people want their GP practice to be more accessible to young people and appointments easier to make. In others, they want GP ‘pop-up’ services in colleges or their youth centre.

The sites are also looking at the problems faced by hard-to-reach young people in accessing primary healthcare. Ex-offenders and the homeless cannot even register with a GP if they haven’t got an address, so our pilots are looking at this issue and working with the local healthcare bodies to find a solution.

Positive engagement

The results, over half-way into our ‘GP Champions’ project, are proving exciting.

One of the biggest achievements so far has been getting GP practices and the voluntary sector working together. The GP practices say they are benefitting in many ways. They are learning about all the excellent voluntary sector services in the local area and some have started referring young people to their partner organisation for counselling under new pathways.

Young people have been ‘training’ GPs on better ways to listen and help them and have been getting involved on Practice Patient Panels. The voluntary sector’s experience of engaging young people and building relationships with them via text and messaging, has also helped GPs in reducing ‘Do Not Attend’ cases.

Improving access

In Bristol, our voluntary sector partner Off the Record has set up an Improving Access to Psychological Therapies (IAPT) service in the GP practice to create a seamless process for patients between referral and treatment.

The voluntary sector partners are learning from the GPs about the referral and commissioning issues and have worked together to raise the profile of young
people’s health needs. In Southampton the organisation No Limits and their partner GP have jointly presented to the CCG. In Washington, the pilot partners secured a slot to talk to 300 GPs about young people’s well-being at a Continuing Professional Development (CPD) event in Sunderland’s Stadium of Light. Convincing GPs about the importance of young people’s health is vital to the success of the project and future improvements in care.

In Liverpool, the project partners have worked together to win an innovation grant from the CCG to develop a health drop-in at the Young Persons Advisory Service, with funding to equip a clinical room and provide a GP and practice nurse one day a week, for a year.

In Cornwall, where there is a scattered, rural population, the ‘GP Champions’ pilot site is taking a different approach, trying out one-to-one online consultations via social media.

All the models of innovation and joint practice are being evaluated and will be brought together in a toolkit for national roll-out in 2015.

The ‘GP Champions’ project is proving that there is considerable potential in bringing together young people, GPs and the voluntary sector to find new ways of providing services, with the ultimate goal of improving young people’s health.

To find out more about the project visit www.ayph.org.uk or find us on twitter at #gpchamps

School nurses often have occasion to refer young people to their GP for additional support and care; past experiences have not always been positive. This project will not only serve to improve access, quality and health outcomes for young people but also support development of an effective partnership between school nursing and GPs, in responding to young people’s health issues.

Sharon White, professional officer, SAPHNA
**Introduction**

Vaccination is the single most effective way to prevent the morbidity and mortality associated with influenza.\(^1\) However, only 73.4% of people aged 65 or over in England were vaccinated during the 2012/13 season.\(^2\) Vaccine uptake among patients aged 6 months to less than 65 years in a clinical risk group was just 51.3%.\(^2\) Both figures are below the World Health Organisation’s (WHO) recommended coverage of 75% and neither has changed markedly in recent years.\(^3\)

So, in July 2012 the Joint Committee on Vaccination and Immunisation (JCVI) recommended the routine annual influenza vaccination of children aged two to less than 17 years.\(^4\) The JCVI suggested that the change would avoid many influenza cases in children. In addition, vaccination would indirectly prevent influenza in unvaccinated young children, people in clinical risk groups and older adults. Immunising children will be “highly cost effective” by “substantially” reducing flu-related illnesses, GP consultations, hospital admissions and deaths, and will raise public awareness of vaccination’s benefits.\(^4\)

Initially, NHS England will offer routine vaccination to two and three year olds and plan pilots for four to ten year olds to ascertain the most effective way to implement the new programme.\(^4\) Most children will receive Fluenz\(^6\) live attenuated influenza vaccine (LAIV), a nasal spray vaccine.\(^4,5\)

Fluenz has been used in clinical practice since 2003 in the U.S and at-risk children in Northern Ireland have received Fluenz since 2012.\(^4\)

---

**What is Fluenz?**

Fluenz delivers a suspension of LAIV strains that are genetically altered in three ways to maximise efficacy:

- Cold-adapted – the LAIV strains in Fluenz stimulate the immune system in the nose, where cooler temperatures are found.\(^4,7\)
- Temperature-sensitive – the LAIV cannot infect the lungs or other areas that are warmer than the nasal passages.\(^4,7\)
- Attenuated – the LAIV replicates to provoke a full immune response but does not cause clinical symptoms.\(^4,7\)

**Fluenz indication**

Fluenz is indicated for influenza prophylaxis in children aged 24 months to less than 18 years. Patients receive 0.1 mL of the suspension in each nostril (see Figure 1).\(^5\)

According to the approved schedule, children who were not previously vaccinated against seasonal influenza should receive a second dose after at least 4 weeks.\(^5\)

**Fluenz: A highly efficacious vaccine**

Eight randomised clinical trials, including children and adolescents aged between 2 and 17 years, compared LAIV against placebo or the standard trivalent inactivated vaccine (TIV).\(^5\)

Compared with placebo, year 1 efficacy of 2 doses of LAIV was 85% (95% CI 78.87), (absolute change in efficacy 13.3%)\(^5\) against antigenically similar strains. Classifying B variants as dissimilar, efficacy against all similar strains was 87% (95% CI 83.91), (absolute change in efficacy 12.7%).\(^5\)

Compared with TIV, LAIV recipients experienced 44% (95% CI 28.56), (absolute change in efficacy 1.8%) and 46% (95% CI 38.57), (absolute change in efficacy 3.9%) lower rates of influenza illness caused by similar strains and all strains, respectively.\(^5\)

**How is Fluenz administered?**

Before administration, you should complete the check list (overleaf). Fluenz is administered as a divided dose to eligible patients, one actuation in each nostril (Figure 1).\(^5\) Patient can breathe normally during administration and does not need to actively inhale or sniff.\(^5\) Health care professionals can reassure parents that LAIV is very quickly absorbed and so remains effective.\(^5\)

**What are the contraindications for Fluenz?**

Fluenz should not be given to children or adolescents who are clinically severely immunodeficient, including those:\(^5\)


**PRESCRIBING INFORMATION can be found on the next page**

---

**Figure 1: Administration of Fluenz**

1. **Check expiry date**  
   Product must be used before date on applicator label.

2. **Prepare the applicator**  
   Remove rubber tip protector. Do not remove dose-divider clip at the other end of the applicator.

3. **Position the applicator**  
   With the patient in an upright position, place the tip just inside the nostril to ensure Fluenz is delivered into the nose.

4. **Depress the plunger**  
   With a single motion, depress plunger as rapidly as possible until the dose-divider clip prevents you from going further.

5. **Remove dose-divider clip**  
   For administration in the other nostril, pinch and remove the dose-divider clip from plunger.

6. **Spray in other nostril**  
   Place the tip just inside the other nostril and with a single motion, depress plunger as rapidly as possible to deliver remaining vaccine.

Any unused product or waste material should be disposed of in accordance with local requirements for medical waste.

- with acute and chronic leukaemias
- with lymphoma
- with HIV infection who are not taking highly active antiretroviral therapy (HAART)
- with cellular immune deficiencies
- with high-dose corticosteroids.

In addition, Fluenz is contraindicated in children and adolescents:\(^5\)

- younger than 24 months of age
- receiving aspirin or another salicylate: Reye’s syndrome is associated with salicylates and wild-type influenza infection
- with egg allergy
- pregnant.

Fluenz is not recommended for children who are actively wheezing at the time of vaccination or those with severe asthma (BTS SIGN step 4 or above). Safety data is limited in these groups.\(^5\)

Fluenz is not contraindicated for children or adolescents:\(^5\)

- with asymptomatic HIV infection who are receiving stable antiretroviral therapy
- who are receiving topical/inhaled corticosteroids or low-dose systemic corticosteroids
- who are receiving corticosteroids as replacement therapy, e.g. for adrenal insufficiency.

The small proportion of children for whom Fluenz is contraindicated should be offered an inactivated injected flu vaccine.\(^5\) If you have any queries regarding a patient’s eligibility please contact Astrazeneca’s Medical Information department: 0800 783 0033.
Can Jess receive Fluenz? Jess, who is 13 years old, has moderate asthma that is well controlled with a combination of inhaled corticosteroid and long-acting beta-agonist. Jess is generally in good health but takes aspirin to treat period pain. Can Jess receive Fluenz?

Is there a risk of transmitting influenza to immunocompromised contacts? LAIV contains live viruses. Therefore, there is a small risk of transmitting the LAIV to contacts for between one and two weeks following vaccination. However, as LAIV is attenuated, transmission is unlikely to result in severe disease. Not all contacts with whom LAIV was associated have been immunocompromised patients (e.g. bone marrow transplant patients requiring isolation) is likely or unavoidable (e.g. household members) healthcare professionals should offer children inactivated influenza vaccines.14-16 No transmission of LAIV has been reported in the US in healthcare settings (e.g. hospitals) and there are no confirmed cases in any setting (e.g. care homes).

Can Tommy receive Fluenz? Tommy is 4 years old. His older sister has leukaemia and is currently in hospital recovering from a bone marrow transplant. In the past, he has had an anaphylactic reaction after eating eggs. Can Tommy receive Fluenz?

What are the side-effects of Fluenz? Safety data collected from more than 28,500 people aged 2 to 17 years of age from clinical studies and more than 52,500 children and adolescents from post-authorisation safety studies suggest that Fluenz is generally well tolerated.2 Over the 10 years LAIV has been available across the world no unexpected tolerability risks have been identified when used according to its approved indication.13,14

In clinical trials, nasal congestion/nasopharyngitis was the most common adverse reaction. Other adverse events that were very common (≥ 1/10) or common (≥ 1/100 to < 1/10) associated with LAIV were: reduced appetite, weakness, headaches, fever or myalgia (Figure 2).17 Please refer to the SmPC for further information about side effects and report any adverse events to AstraZeneca’s Medical Information department: 0800 783 0033, or by using the yellow card system.

Advice for faith communities LAIV contains porcine gelatine, a product used globally in pharmaceutical products. The full list of LAIV ingredients is found in the Summary of Product Characteristics except for information not available from EMA. Please go to: www.gov.uk/government/medicines-and-gelatine-response

Members of faith communities concerned about gelatine in LAIV are recommended to seek guidance from their Rabbi or Imam.

FLUENZ® nasal spray suspension Influenza vaccine (live attenuated, nasal) PRESCRIBING INFORMATION Consult Summary of Product Characteristics for full prescribing information. Use Use Prophylaxis of influenza in individuals 24 months to less than 18 years of age. Prevents live virus, spray, suspension Dosage and administration 0.012 ml (administered as 0.01 ml) per nostril. Children not previously vaccinated against seasonal influenza should be given a second dose after an interval of at least 4 weeks. FLUENZ should not be used in individuals who are 24 months of age because of safety concerns. Method of administration: Nasal administration only.

Do not inject FLUENZ. Contraindications Hypersensitivity to the active substances, any of the recipients (e.g. gelatine), gentamicin (a possible trace residue), eggs or to egg proteins (e.g. ovalbumin). Children and adolescents who are clinically immunodeficient due to conditions or immunosuppressive therapy: jaundice and chronic leukenaemia; lymphoma; systemic HIV infection; cellular immune deficiencies; and high-dose corticosteroids. Not contraindicated for use in individuals with asymptomatic HIV infection; or individuals who are receiving topical or systemic corticosteroids or those receiving corticosteroids as replacement therapy, e.g. for adrenal insufficiency. Contraindication for use of LAIV is not for children younger than 18 years of age receiving radiation therapy because of the risk of reactivation of latent tuberculosis. Precautions Treatment and supervision should be given in case of an anaphylactic event following administration. FLUENZ should not be administered to children and adolescents with severe asthma or achy breathing because these individuals have not been adequately studied in clinical studies. Do not administer to infants and toddlers younger than 12 months. Not recommended to administer to infants and toddlers 12 months of age. In a clinical study, among hospitalised infants it was observed in infants and toddlers younger than 12 months after vaccination and an increased rate of re-infection was observed in infants and toddlers 12-23 months of age after vaccination. Vaccine recipients should be informed that FLUENZ is an attenuated live virus vaccine and has the potential for transmission to immunocompromised contacts. Vaccine recipients should attempt to avoid, close association with severely immunocompromised individuals (e.g. bone marrow transplant recipients requiring isolation) for 1–2 weeks following vaccination. Where contact is unavoidable, the potential risk of transmission of the influenza virus vaccine should be weighed against the risk of acquiring and transmitting wild-type influenza virus. No data exists regarding the safety of children with unresponsive cranial nerve abnormalities. Introductions: Sacyclates must not be used for 4 weeks following vaccination unless medically indicated. Co-administration of FLUENZ with the live attenuated vaccines: No clinically meaningful changes in immune responses to measles, mumps, rubella, variella, mumps-parotitis-adenovirus or FLUENZ have been observed. Immune response to rubella vaccine was significantly altered. This might not be of clinical relevance with the two dose immunisation schedule of the rubella vaccine. Co-administration of FLUENZ with inactivated vaccines has not been studied. Concurrent use of FLUENZ with interferon-α has no adverse effects. No adverse effects have been observed. However, based upon the potential for influenza antiviral agents to reduce the effectiveness of FLUENZ, it is recommended not to administer the vaccine until 48 hours after the cessation of influenza antiviral therapy. Administration of influenza antiviral agents within two weeks of vaccination may affect the response of the vaccine. Influenza antiviral agents and FLUENZ are administered concomitantly, re-NACH it should be considered when appropriate. Pregnancy and Lactation Not recommended during pregnancy. Should not be used during breastfeeding. Undesirable effects Very common: decreased appetite, headache, nasal congestion/nasopharyngitis, malaise. Common: myalgia, pyrexia. Uncommon: hypersensitivity reactions (including facial oedema, urticaria and anaphylaxis) may have also been observed in the post-marketing setting. Consult SmPC for a full list of adverse events. Legal category C52. Marketing authorisation number EU/2016/001-002 Basic NHS cost £10.14

Further information is available from AstraZeneca on behalf of the Medicines Community/AstraZeneca UK Limited, 600 Capability Green, Luton, LU3 3UX, UK. Medline is the global business licence for FLUENZ. FLUENZ is a trade mark of the AstraZeneca group of companies. 02/2012

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to AstraZeneca on 0800 783 0033.


www.medicines.org.uk/data/medicine/Fluenz_2013-05.pdf
In our regular feature Sharon White, professional officer for SAPHNA, shows how vital feedback from school nurses is helping to shape the profession.

1. **YOU SAID...**
   Since reorganisation, we can’t get funding for some immunisations.

   **WE LISTENED**
   We raised this issue with Public Health England (PHE).

   **WE DID**
   Area teams are working locally to resolve this issue. Any specific areas are to be highlighted directly to PHE via SAPHNA. Additionally, new guidance regarding the commissioning of immunisations via NHS England and PHE is imminent. More information will be available on the SAPHNA website when it becomes available.

2. **YOU SAID...**
   Why isn’t there a national award for school nurses?

   **WE LISTENED**
   We agree! We have championed this cause for many years and at every opportunity.

   **WE DID**
   The first ever national school nurse award is launched this month (January 2014) and will be awarded in May.

3. **YOU SAID...**
   Will health care assistants be expected to administer immunisations?

   **WE LISTENED**
   We raised this at the Department of Health/PHE flu project board meeting.

   **WE DID**
   We have worked with the Royal College of Nurses and other partners to produce guidance.

4. **YOU SAID...**
   We need a review of our school nursing services to ensure we provide safe, quality and cost-effective services.

   **WE LISTENED**
   We have been involved in numerous mainstream, independent and special school nursing service reviews.

   **WE DID**
   Reports and recommendations from the reviews are being used to influence, shape and drive forward school nursing services and the profession. If there is an issue facing school nursing that you would like featured in our You Said, We Did column, please contact Sharon White at sharon@saphna-professionals.org
The past shapes the future

The care of children and young people has always been an integral part of community nursing. Matthew Bradby from the Queen’s Nursing Institute (QNI) delves into the past and looks to the future.

In the days before greater specialisation in nursing roles, district nurses were often trained as midwives and health visitors, and sometimes acted as school nurses as well – particularly in country areas. Although health protection and public health are still integral to the current school nurse role, it has changed significantly to accommodate the ever changing and complex needs of children and young people.

Looking into the archives

Going back in time though, the May 1925 issue of the Queen’s Nurses’ magazine records how one school headmaster had set an essay question on the subject of ‘The Nurse’. Several of these short essays were printed. One reads as follows: ‘The necessity of our school nurse is that some of the children are clean and some dirty. Her duty is to pick out the dirty ones and send their parents a card. Diseases spread very quickly and the clean children are in danger of catching them from the dirty children. She comes once a month to thoroughly examine our heads and see if our nails and teeth are clean. If she finds out some of us are dirty she sends a white card to our parents. If the orders on this card are not carried out, she sends a green card and then a red one, and after that comes punishment.’

The challenges of nursing today

Today, far more nursing roles are located within the community, and the healthcare being delivered there is increasingly complex and specialised. To help nurses, in training or already qualified, to make that transition into the community, the QNI has developed a new educational resource: Transition to Community Nursing Practice.

Written by Queen’s Nurses Sharon Aldridge-Bent and Agnes Fanning, and Kate Potter, it is aimed at newly qualified nurses, and those who are in the process of moving from a hospital to a community nursing setting. It will also be useful to nurses who have a mentoring role, or those who wish to review their learning. The 10 chapters include working safely, patient focus, team working, working with vulnerable groups, carer support, policy context, and developing your career.

The authors write: ‘In the changing landscape of healthcare there has been a significant shift of emphasis into the community setting. The experience of the nurse making the transition from hospital to community can be stressful, and for some the decision whether or not to work in the community can be a daunting one. This transition is different for each individual nurse.

‘On the most fundamental level it is the change in the location of the patient that provides the challenge. Community nurses very quickly need to become familiar with the wider community, geography, and environment. With these changes also comes a change in the philosophy of care. It is a privilege to be invited into someone’s home, as a guest as well as a professional. As health and social care professionals we need to be able to acknowledge that building trust and promoting patient choice is very important.’

Further information

www.qni.org.uk

All of these skills and qualities will sound familiar to school nurses and those working with children and families. To download the resource for free, visit the QNI’s website at www.qni.org.uk/for_nurses/transition_to_community or to buy a printed copy, go to: www.qni.org.uk/shop/qni_branded_goods

Matthew Bradby, QNI
SAPHNA is the leading professional organisation representing the voice of school and public health nurses across the UK.

Our growing community of more than 2,500 professionals are dedicated to promoting excellence in practice and improving the health and well-being of the communities in which we work.

Benefits of SAPHNA membership include:

• A professional officer
• Free subscriptions to The Journal of School and Public Health Nursing and The Journal of Family Health Care
• Discounted entry to The Journal of School and Public Health Nursing annual conference
• Dedicated enquiry and support line
• ‘Members-only’ website content
• Free and member-only discounts for events and publications

For more information, contact Sharon White, professional officer on 07702 871 922 or email her at: sharon@saphna-professionals.org

www.saphna-professionals.org
Join SAPHNA now!

Special Introductory Offer
Membership fee discounted to £50 (normal rate: £65)

Membership of SAPHNA is open to any individual or organisation working in the field of children and young people’s health across the UK. It provides an excellent way to keep up-to-date with key issues, developments and shape the future of children and young people’s health.

Phone our membership hotline on 01273 434 943 or fill in the application form below and post to: Pavilion Publishing, Rayford House, School Road, Hove, East Sussex BN3 5HX.

Section 1: Contact information

Title  □ Mr  □ Mrs  □ Miss  □ Ms  □ Other, specify: ..........
First name: ............................................................................................... Surname: .......................................................................................................................  
Organisation: .......................................................................................... Position: ........................................................................................................................  
Address: ............................................................................................................................ ............................................................................................................................
Town/City: ............................................................................................... Postcode: .......................................................................................................................  
Tel: .............................................................................................................. Mobile: ...........................................................................................................................  
Email: ..............................................................................................................................

Section 2: Method of payment

Code: JSPHN_launch  
Amount: £ ..........................................................................................................................

Paid in Cash □

Total: £ ..........................................................................................................................

Payment by Credit/Debit Card

Type of Card:  □ Mastercard  □ Visa  □ Maestr/Solo  □ Visa Debit  □ Electron  □ American Express

Please debit my credit/debit card number:

Valid from: ......................................................... Expiry date: ................................ Last 3 digits: .........................

Registered Cardholder’s Name: .......................................................................... Signature: ..................................................................................................

Cardholder’s Address: ..................................................................................................................

Postcode: ..................................................................................................................

Telephone: ..........................................................................................................................

Payment by Cheque □

I enclose payment of £ ..................................................................................................................

Pavilion Publishing and Media Ltd
T: +44 (0) 1273 434943
F: +44 (0) 1273 227308
E: info@pavpub.com

www.saphna-professionals.org
What about the boys?

An impressive number of professional and patient organisations, including SAPHNA, believe there is a strong case for gender-neutral HPV vaccination. Peter Baker from HPV Action explains why.

The HPV vaccination programme is now well-established with 86% of girls in England now receiving all three doses of the vaccine, mostly at school. But while the vaccination protects an increasing number of women against cervical and other HPV-related cancers, as well as against genital warts, more doctors, nurses, parents and patient groups are starting to ask whether enough is being done to protect the other half of the population against HPV infection. So is it time to vaccinate the boys too?

The case for vaccination

The 23 professional and patient organisations that have joined together as HPV Action to advocate vaccination for both sexes certainly think so. As well as SAPHNA, HPV Action’s members include organisations with a focus on cancer, public health, sexual health, oral health and men’s health. The vaccination of boys is now also supported by Cancer Research UK, the Faculty of Public Health and the British Dental Association. The Australian government has already implemented such a policy, as have two Canadian provinces. The call for gender-neutral vaccination is now one with significant mainstream support.

Some have suggested that vaccinating boys is unnecessary because, once a high proportion of girls has been vaccinated, virtually everyone (the ‘herd’) is protected from HPV infection (Cushieri, 2009). This argument has several major flaws, however. First, there are areas and communities within the UK where vaccination rates for girls are well below the critical
threshold of 80%. In London in 2012–13, under 80% of girls received all three doses of the vaccine in over half of the PCT areas (Public Health England, 2013). A recent study also found that while 85% of white girls said they had received three doses this was the case for 78% of Asian, 74% of ‘other’ ethnicity and just 69% of black girls (BBC, 2013).

A second problem with the ‘herd protection’ theory is that people do not have sex only with those who are part of the herd. Recent sexual behaviour survey data found that eight per cent of men of all ages had sex with at least one person from outside the UK in the last five years; for 25–34-year-old men, the proportion was 14.5% (Mercer et al., 2013). Many of these sexual partners will be unvaccinated. A study of the impact of HPV vaccination of girls in Denmark found that vaccination, which is at a level similar to the UK, significantly reduced the incidence of genital warts in women but that the incidence in men remained stable (Baandrup, 2013). This may be because young Danish men continue to be infected with HPV by non-vaccinated women within Denmark and from other countries.

So vaccinating boys would help to protect women who have not been vaccinated and it would also protect men who have sex with non-vaccinated women. But it would also protect a group that is completely outside of any herd protection created by the vaccination of girls: men who have sex with men (MSM). Anal cancer rates are particularly high in MSM: the incidence is estimated to be 15 times higher than for heterosexual men – equivalent to the rate of cervical cancer in an unscreened population of women – and is even higher in HIV-infected MSM (Stanley, 2012).

Extending HPV vaccination just to MSM via sexual health clinics would be unlikely to reach most of this population. Moreover, optimal protection occurs only when the vaccination is administered before sexual

“July 1 2010 was the day I first learned about Human Papillomavirus. Until then, I had been blissfully unaware of HPV and had no idea of the damage it could cause. That all changed when Mr Richard Adamson, an ENT consultant, told me that the lump in my neck was as a result of oropharyngeal cancer.

I was completely floored by this news. I had never smoked in my life, was not a heavy drinker and I could not understand how this was even possible. Mr Adamson then asked me if I had heard of HPV. He explained how this extremely common virus had caused my cancer. Then began months of painful and debilitating treatment: surgery, chemotherapy and radiotherapy. Fortunately, I went on to make a good recovery, though I still suffer the side effects.

Once I was on the mend, I started to learn about HPV and was disturbed at the damage it does and the illnesses it can cause. I was even more shocked to learn that there was a safe and effective vaccine which could prevent HPV that was not being used for everyone – boys are excluded from the UK vaccination programme. I then resolved to try to change things.”

Jamie Rae, chief executive, Throat Cancer Foundation

“I founded the HPV and Anal Cancer Foundation with my two sisters, Justine and Camille, following the death of my beloved mother Paulette to HPV-related anal cancer in 2010.

She was extremely healthy and aged only 51 years when she was diagnosed, but she did have a clear risk factor. Like many women in her late 20s, she had an abnormal cervical smear, meaning that she had high-risk HPV in her anogenital region. Despite this risk, she was never screened for anal cancer. 90% of anal cancer is caused by HPV.

While the vaccination and screening programme in the UK in women is excellent for cervical disease, those who suggest that HPV-related disease is controlled via such screenings such as Pap smears are ignoring the fact that no standard screening protocols exist for anal, oral and penile cancer. Individuals with advanced HPV-related cancer are often diagnosed in difficult-to-treat later stages.

Often lost in the discussion of mortality and incidence is that those who do survive have to suffer for decades from permanent changes in bowel and sexual function and a much reduced quality of life.

I am convinced that universal vaccination would have prevented the devastation our family went through when Paulette developed HPV-related anal cancer.”

Tristan Almada, founder, HPV and Anal Cancer Foundation
overwhelming and decisive argument.

improving public health, tackling inequalities and creating a stark health inequality. The delivery of a national HPV vaccination program.

SAPNHA fully supports the immunisation of boys, alongside girls, against HPV. The evidence speaks for itself and, in not doing so, we are creating a stark health inequality. The delivery of such a programme could build on the success of the predominantly school based/school nurse delivered HPV programme and, while it will place huge additional demands on school nursing resources, we feel confident that with the correct investment we could obtain high uptake rates.”

Sharon White, professional officer, SAPNHA

How common is HPV?

Human papilloma virus (HPV) is the name for a group of viruses that affect the skin and the moist membranes lining the body, such as in the cervix, anus, mouth and throat. HIV types 16 and 18 are the high-risk types that most commonly cause cancer. HPV types 6 and 11 cause most cases of genital warts.

HPV is most commonly passed on through genital contact, usually during vaginal, oral and anal sex. It can be passed on when the infected person has no signs or symptom and between straight and same-sex partners.

HPV is very common and almost every sexually-active person will get HPV at some time in their lives. Most people with HPV never develop symptoms or health problems. But sometimes HPV infections persist and may cause a variety of serious problems.

HPV is estimated to be the causal agent in five per cent of all human cancers, including cervical, vulval, vaginal, penile, head and neck cancers. HPV also causes genital warts and, rarely, a condition that causes breathing problems in children and adults known as recurrent respiratory papillomatosis (RRP).

HPV Action estimates that, each year in the UK, almost 4,000 men develop cancer linked to HPV and over 800 die. In addition, over 40,000 men are diagnosed with genital warts each year and about 600 boys and men live with RRP.

References

Further information

www.hpvaction.org

The Joint Committee on Vaccination and Immunisation (JCVI) is currently considering whether the current HPV vaccination programme in the UK should be extended beyond its current target group (12/13-year-old girls). HPV Action hopes this will lead to a decision to vaccinate all boys. For more information about HPV Action’s work, visit www.hpvaction.org. Supporters of gender-neutral vaccination can also sign HPV Action’s petition to Health Secretary Jeremy Hunt MP (the link is on the HPV Action website) and write to the Minister for Public Health, Jane Ellison MP at Department of Health, Richmond House, 79 Whitehall, London SW1A 2NS.

References


A thirst for knowledge

This spring journal readers will be able enjoy our third JFHC Live event, with a varied programme of FREE talks relevant to all school nurses and community health professionals working with families and children.

On the 25th March London’s ILEC centre will be buzzing with exhibitors and delegates, keen to hear experts deliver CPD-accredited talks on subjects relevant to their learning, practice and development.

We decided to build this year’s programme around the theme of resilience in children and young people so were delighted when Eustance de Sousa, the deputy director of children, young people and families from Public Health England, agreed to be our keynote speaker.

Here are some selected highlights:

**Foundation stones for mental health and resilience**
- **Dr Cathy Laver-Bradbury**, consultant nurse in the School of Psychology at the University of Southampton, co-developer of the New Forest Parenting Programme (invited)
- ADHD – a holistic approach to managing behaviour
- **Kim Aumann**, co-director, Resilience Research and Practice, visiting fellow School of Nursing and Midwifery University of Brighton
- Building resilience with disadvantaged children/families; the resilience framework

**Physical well-being through healthy food and exercise**
- **Marjon Willers**, specialist dietitian for schools, Islington Healthy Schools Team, Whittington Health NHS Trust
- How do we know what children are eating is healthy?
- **Sarah Kitchen**, senior research director, children and young people, National Centre for Social Research
- Evaluation of free school meals pilot

**Managing medical conditions**
- **Julie Van Onselen**, JVO Consultancy
- Common childhood skin conditions from 0–12 years
- **Libby Dowling**, clinical advisor, Diabetes UK
- The impact of diabetes in a child on the family

**Safeguarding our children**
- **Dr Neil Fraser**, independent chair of the Daniel Pelka serious case review
- Serious case review: what lessons have we learnt from the Daniel Pelka review?
- **Simon Blake OBE**, Brook
- Safeguarding the sexual health of children with learning disabilities

Diary of a SCPHN student

In his second diary piece, Paul Watson confesses with honesty how he found the going a little bit tough, but then got inspired again

Welcome back to my diary and a Happy New Year!

Well, what a hectic 13-week period the Primary Care Trust last term has been. The SCPHN course seemed to take full hold of all its students and seems to have taken no prisoners.

I initially thought I’d have no “issues” doing a PgDip, starting as I did immediately after the completion of my nursing degree... but how wrong was I?! The step up is massive and for anyone who does not like reading, this course will not let you rest on your laurels. On the positive side this is good, because if you want to achieve the best then you have to know the subject matter inside out. Well, this certainly seems to have been the message passed down between my fellow course peers.

When the going gets tough...

Personally, I’ve found the transition hard at times and at one point, due to travel and a family crisis, I nearly deferred my course. That was until I read my last diary entry prior to it going to print and it brought back to me all the reasons I want to become a school nurse in the first place. It also made me re-focus and to start to really enjoy the theory of this specialist field and understand what a difference it makes to children, young people and their families.

Although the course, for anyone wishing to consider it, is undeniably tough the academic support at Teeside University is second to none. Their enthusiastic approach to public health is infectious and has filtered down to all my fellow SCPHN students. The academic year started by looking at four modules, three that had to be completed around Christmas and one that runs throughout the year, which really sorts out your time management skills!

Learning the theory

During the first term we have been introduced to a plethora of public health theory and models, which to be honest have blown my mind. I didn’t even know half of them existed, let alone how I was meant to retain all of this information and put it into practice! I must say the Advancing Public Health module was pretty intense on a personal level, too. This module encompassed the health needs assessment which, as you may be aware is a 5-step systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities.

This module also took into account the work of Bradshaw (1972) in relation to the perspectives of need, The Black Report (1980), Acheson’s Determinants of Health Model (1998), and Marmot’s report in 2010 called Fairer Society, Healthier Lives. This latter module really brought it home to me how much the SCPHN is really needed, especially when determining what the needs of their community are and how they can be and facilitate being a change agent, using the Prochaska and DiClemente (1997) model of change, to name but one trans-theoretical model.

Practice days

The SCPHN course is not solely university-based. We spend two days a week in practice, which I really enjoy. Being in practice has given me the time to look at how my school nursing teamwork, what they do and what I think could be improved or even not used. My practice teacher is constantly telling me I give her a headache as I make her think! But she assures me this is a good thing, as this enables service improvement and different perspectives on client contact.

While in practice we also have to do 15 alternate practice days, which is set in stone by the Nursing and Midwifery Council (NMC). Between you, me and my cohort, 15 seems quite a lot when you’re trying to understand the area you are working in two days.
On the positive side, you can choose to go anywhere. So far I have spent the day with the CAMH's team (I would though, ay?!), the looked after children team, the commissioning team and a children's ward, to name but a few. I was received very positively within these alternate disciplines, which was a very good sign.

As part of this I'd like to offer my reflection from being on the children's ward in relation to the role of the school nurse. What became apparent during my time there was time -- the staff nurses had very little time to do anything but their best with their own job role. However, I'd argue that they would go out of their way if they needed to, in any given situation. I would hope that by developing a greater understanding of the role of the school nurse that they would feel more confident about utilising the school nursing service. Indeed some staff said that although they knew that some of the information from their ward was cascaded to school nurses, they didn't know what was subsequently done with it!

Additionally, the advertising boards within the ward were packed with very useful information about a plethora of services for a number of different organisations and conditions; however, there was nothing in relation to health visiting and school nursing. I guess if you don’t understand a role then you can’t advertise it!

**Lessons for the future?**

In summary, what I have taken from this alternate practice day is that if the services of the school nursing team are to be utilised effectively, there needs to be a greater link between ward staff, community practice
Every picture tells a story

Superheroes and a cute puppet are transforming the ways children and young people receive vital health care information and messages. Rob Mair and Penny Hosie report

Communication is a powerful medium that can change hearts and minds. In today’s world that can be seen most powerfully and succinctly by the use of Facebook, Twitter and other forms of social media.

Although the healthcare profession is increasingly catching on to this new medium (see JSPHN, April/May, issue 1) there are some who are embracing other innovative ways to effectively communicate health messages to children and young people.

Medikidz and Monkey are fine examples of this. Medikidz uses superheroes, whereas Monkey is a well-travelled puppet who helps put children at their ease in hospital settings.

Inspiration in a medical setting

Medikidz (www.medikidz.com) was set up by a young Kiwi doctor called Dr Kate Hersov alongside business partner Dr Kim Chilman-Blair. Kate felt, while working with children in hospital paediatric departments, frustrated by the dearth of good medical information available to them. She believed this to be inadequate in helping to allay child and parental fears or feelings of confusion over their illness or hospital experience.

She sought to address this and in 2008, she and Dr Kim formulated an idea that would see “cool” superhero characters provide clear information to kids in an entertaining, age-appropriate and educational manner, like Marvel meets medicine.

Comic superheroes to the rescue

Medikidz was launched the following year at the Evelina Children’s Ward at St Thomas’s Hospital in London. The comic book range, designed by comic book creatives, currently covers over 100 different health topics. At the heart of each title are comic superheroes with names such as Skinderella, Axon, Chi, Pump and Gastro. Skinderella knows all about skin and bones, Axon the brain, Chi the lungs, Pump the heart and what Gastro doesn’t know about the intestinal system and all the associated tubes probably isn’t worth knowing about.

In terms of credibility each Medikidz title is written by doctors and peer reviewed by the world’s leading professors within that specialty. Not relying solely on eminent professors, the Medikidz Youth Advisory Board (a group of 30 young people aged six to 16 years old, affected by illness) regularly voice their opinions to positively influence and shape the direction of Medikidz.

Readers of the Medikids range visit Mediland (a living, moving planet shaped like the human body). Every time they visit they are taken on a tour of the different illnesses by the superhero characters to learn more about their condition. This is done in a way children can best understand and process. For example, children with asthma are taken on a tour by the Medikidz around the respiratory system and walls around the lungs, while children with ADHD visit the brain. The breast cancer book features little characters which represent cancer cells – these split in half at a fast pace, taking over the milk ducts.

One child with Type 1 diabetes explained how difficult medical conditions were made clearer to her, saying “I had heard of hyperglycaemia before, but they broke it down and explained it, which really helped.”

Archbishop Desmond Tutu has publically praised the Medikidz concept, saying “It is extremely important that children feel reassured, informed and included during the diagnosis and treatment process. This initiative should be supported for helping to
achieve this… it will make the child, the patient, the focus and I think this emphasis on the patient, this empowerment, is one of the most splendid things to have emerged in modern medicine.”

Kate’s aim is to create a global community of informed, empowered and health-aware children. She said: “Medikidz is committed to creating a global community of young people who are informed, empowered and health aware. We’d like our comic books to provide a platform for school nurses to reach out to pupils to explain medical conditions in a way that is both easy to understand and educational. We are very proud to be able to work alongside the school nurses to enhance the incredible job that they do in supporting the younger generation in both health and social issues.”

“I found the comics fantastic. The characters had big, hilarious personalities, and the illustrations wouldn’t have looked out of place on Pixar’s drawing boards. More to the point, I learnt a lot from reading them. The language wasn’t in the slightest bit condescending, and the larger than life medical superheroes taught me a lot… making the illness seem 10 times less daunting and, ultimately, manageable.”

14-year-old boy with chronic illness, patient of Great Ormond Street Hospital, London

“Medikidz is just a great resource! There is such a gap for information which is not only accessible for teenagers but which is also age appropriate. We use this resource to help parents too; they know the information which their child is receiving is trustworthy and these books create shared conversations – all too important when people don’t always know what to say.”

CEO Braintrust Charity, UK
PRACTICE

The Monkey journey

Monkey is the brainchild of Helen Sadler, and was created to help relieve her daughter’s anxiety before a major operation. Doctors and nurses were stunned by her recovery, and led Helen to set up AhHa Publications to get the Monkey story out there and help other children in a similar situation.

Parental inspiration

The monkey journey started with a handmade storybook after Helen couldn’t find any suitable books or resources which would help her then 18-month old daughter understand what was going to happen in hospital.

The first storybook featured Uncle Monkey and allowed Helen’s daughter to understand the hospital environment, to see the different machines she would encounter and to relieve any anxieties about the experience. It also helped allay any fears Helen herself had, by knowing Monkey served as an effective way of ensuring the information was understood by her young daughter.

Buoyed by the initial success and the positive feedback from staff at Brighton’s Royal Alexandra Hospital, Helen and a friend looked at the possibilities of creating more adventures for Monkey. The photographic storybooks aim to have a positive impact on children’s emotional well-being, while supporting families during an uncertain and stressful time.

This in turn led to the creation of AhHa Publications, and means Monkey can go on to help lots of other children who face going into hospital.

AhHa has produced a number of generic storybooks featuring Monkey, which provide up-to-date examples of the hospital environment, examples of people they may meet and the machines they might see, and procedures, routines and activities they may encounter.
They can also create customised versions of the experience, tailored to a specific hospital. For example, Helen and Monkey are currently working with Whittington Hospital on Monkey Has Asthma, and with Birmingham Children’s Hospital to produce an Emergency Department guide and Friends and Family tests which will be available to download for free.

**Engaging with children about health is vital**

Kath Evans, head of patient experience, NHS England, praised Monkey for his ability to engage with and to educate children. She said: “Educating children about health, what they can do themselves and how NHS services can support them, is a critical life skill. The range of resources provided by the lesson plan makes this learning fun, interactive and importantly engaging, as we know when learning is fun it sticks!

“If we truly are to change the future and ensure we have a healthier society we have to engage children, it makes sense both ethically and economically. The lesson plan resources provide teachers, school nurses and health visitors with prepared packs that mean they can get on with delivery rather than using valuable time undertaking lesson preparation. Importantly, the packs ensure consistent messages are being shared in schools across the country.”

Sharon White, SAPHNA professional officer, added: “SAPHNA were delighted to welcome Monkey to its annual conference where school nurses overwhelmed Helen with their enthusiasm and ideas on how they could utilise such a medium in their work with children. Some have already used the resource in health education sessions including, healthy lifestyles and promotion of self-esteem, demonstrating the diversity of opportunities offered by the friendly character.”

**Monkey in 2014**

Monkey has a big year ahead, with plenty going on to keep him out of mischief…

**NHS EXPLORER PACK**

Due to changes to the curriculum, the NHS Explorer pack has received an update and a refresh for 2014. Additionally, the children’s activity sheets also now contain learning objectives, making it clear and easy for children and teachers to access it.

The pack, which brings together health and education, is targeted at teachers and school nurses and explains where children can go in case of injury or illness, as well as educating children on how to stay fit and healthy and to avoid accidents. The NHS Explorer pack contains:

- teacher’s lesson plan
- 35 16-page A5 guidebooks for children
- NHS Explorer stickers
- A2 poster
- Monkey hand puppet
- DVD featuring NHS Explorer film clips
- Monkey’s NHS song
- scenario cards
- additional worksheet templates for use in the classroom
- certificates to encourage children to exercise, eat well and join in.

The resources within the NHS Explorer pack will be available to download early in 2014. For more information visit www.monkeywellbeing.com/nhs-primary-resources-pack

**MONKEY GOES INTO POLITICS**

Monkey will also be having a political adventure in 2014, after Helen was invited to be part of the Steering Group for NHS England around the children’s survey which is due out in the summer. “It’s really exciting to be one of the voices for young children. I’m delighted and feel very privileged,” Helen said.

**NHS CHANGE DAY**

Monkey will also be taking part in the NHS Change Day on March 3, after being championed by Kath Evans, head of patient experience at NHS England. Monkey will be appearing in Manchester on the day. For more information on NHS Change Day visit http://changeday.nhs.uk/

---

**Further information**

www.monkeywellbeing.com

We have changed our name to Monkey Wellbeing. To find out more about Monkey online visit http://www.monkeywellbeing.com @monkeywellbeing and search Monkey Wellbeing on Facebook.
New RCN resources
The Royal College of Nursing has published a number of new resources.
The School and Community Nurses Supporting Young Carers online learning resource is now available at http://rcnlearning.org.uk/cms/young-carers/
The standards for the weighing of infants, children and young people in the acute health care setting, is available here: http://t.co/68fjugWya
Finally, the publication Lost in Transition, which looks at the move between children and adult’s services is available here: http://t.co/8ekom7uhaj

Supporting young carers
The Carers Trust and Nottingham Trent University have published a guide on the experiences of young carers in school called Young Adult Carers at School: Experiences and perceptions of caring and education. The report can be accessed here: http://www.carers.org/sites/default/files/young_adult_carers_at_school-8_11_13-1_proof_4_final.pdf

End of the road for domestic abuse?
Manchester University has published research into why boys become domestic abuse perpetrators. Full recommendations of the report, titled From Boys to Men, can be found here http://elm.vc/Ix16ls. While further details on the study can be found here www.boystomenproject.com

Nominate a nurse
The QNI is seeking nominees for its Outstanding Service Awards. To apply or nominate a nurse, go to http://qni.org.uk/for_nurses/awards_for_nurses/outstanding_service_award Deadline is 10th Feb.

Eczema research launched
Notts University are recruiting 300 children to take part in a test on the effectiveness of silk clothing on eczema. For more information contact the trial team on 0115 8844938 or visit www.nottingham.ac.uk/clothes

Appy hunting
A new app has enables young people find a range of services including contraception, homelessness, bereavement and mental health support. Visit http://www.stepfinder.org/

JFHC Live advert 2014.indd   1
01/01/2014   13:06

Cervical Cancer Prevention Week
For more information visit http://www.jostrust.org.uk/get-involved/campaign/cervical-cancer-prevention-week

Sharon White (right) pictured with Michelle Sobande, school nursing field leader at Teesside University
Save the date!

25 March 2014
ILEC Conference Centre, IBIS, London Earl’s Court

Taking a holistic approach to well-being and resilience in children and young people.

JFHC Live is a one day event offering the opportunity for HCPs to keep up-to-date on areas of expertise from 20 seminars delivered by experts in their field.

Themes:
• Foundation stones for mental health and resilience
• Physical well-being through healthy food and exercise
• Managing medical conditions
• Safeguarding our children
Because HPV is the last thing on a girl’s mind

- In 2010/11, over 10% of eligible girls did not start their course of HPV vaccination
- You have an opportunity to change this. Gardasil® is available at no cost for GP practices through ImmForm, for all previously unvaccinated girls aged 12-17

**FIND THEM. REMIND THEM. HELP PROTECT THEM.**

For further information, contact your local Sanofi Pasteur MSD representative or visit www.123againstHPV.co.uk

---

**ABRIDGED PRESCRIBING INFORMATION**

**GARDASIL®** (Human Papillomavirus Vaccine [Types 6, 11, 16, 18] [Recombinant, adsorbed])

Refer to Summary of Product Characteristics for full product information.

**Presentation:** Gardasil is supplied as a single dose pre-filled syringe containing 0.5 millilitre of suspension. Each dose of the equivalent vaccine contains highly purified virus-like particles (VLPs) of the major capsid L1 protein of Human Papillomavirus (HPV). These are type 6 (20 µg), type 11 (40 µg), type 16 (40 µg), and type 18 (20 µg).

**Indications:** Gardasil is a vaccine for use from the age of 9 years for the prevention of pre-malignant genital lesions (cervical, vaginal and anal) and cervical cancer causally related to certain oncogenic Human Papillomavirus (HPV) types and genital warts (condyloma acuminata) causally related to specific HPV types. The indication is based on the demonstration of efficacy of Gardasil in females 15 to 45 years of age and in males 16 to 26 years of age and on the demonstration of immunogenicity of Gardasil in 9 to 15 years old children and adolescents. The use of Gardasil should be in accordance with official recommendations.

**Dosage and administration:** The primary vaccination series consists of 3 separate 0.5 millilitre doses administered according to the following schedule: 0, 2, 4 months. If an alternate schedule is necessary the second dose should be administered at least one month after the first dose and the first dose of at least three months after the second dose. All three doses should be given within 1 year period. The need for a booster dose has not been established. The vaccine should be administered by intramuscular injection. Gardasil must not be injected intravenously. Neither subcutaneous nor intradermal administration has been studied. These methods of administration are not recommended. Refer to Summary of Product Characteristics for full product information.

**Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard.** Adverse events should also be reported to Sanofi Pasteur MSD, telephone number 01628 785291.