Policy into practice

A programme for parents managing pre-school children’s behaviour

IN THIS ISSUE

- We should all work in Eastbourne
- NICE work on good practice in mental health
- Mothers’ perceptions of community health professional support
- Impetigo
Ollatum Junior Cream joins Ollatum Junior Bath on the Nurse Prescribers’ Formulary

Formulated specially for them

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Prescribing Information
Ollatum Junior Cream
Presentation: Topical ointment, softening, soothing agent. Cream containing light liquid paraffin 60.0% w/w and white soft paraffin 15.9% w/w. Also contains: macrogol 1000 monoglyceride, cetylstearyl alcohol*, glycerol, potassium sorbate, benzyl alcohol, citric acid and monohydrate, polyvinyl 42-52, purified water. Uses: For the treatment of atopic eczema, contact dermatitis, eczema pruritus, and dry, sensitive skin including infants. Dosage and administration: Ollatum Junior Cream may be used as often as required. Apply to the affected area and rub in well. It is especially effective after washing when the sebum content of the stratum corneum may be depleted resulting in excessive moisture loss. Contraindications: Should not be used in patients with known hypersensitivity to any of the ingredients. Precautions and warnings: *Cetylstearyl alcohol may cause local skin reactions (eg contact dermatitis). Hospital users should follow local procedures and policies for using topical products on patients. For external use only. Keep out of the sight and reach of children. Interactions: None known. Overdose: Accidental ingestion may cause nausea and vomiting. Administration of copious quantities of water as required. Excessive topical application should cause no untoward effects other than greasy skin. Further information: Additional details are described in the Summary of Product Characteristics. Legal category: GSL. Shelf life and storage: 30 months. Do not use the product after the expiry date. Store below 25°C. Package quantity and NHS price: 500ml 10.59, 1000ml £14.67. Product licence number: PL074/03/18. Marketing authorisation holder: Stiefel Laboratories (UK) Ltd, Hotspur Lane, Wooburn Green, High Wycombe, Bucks HP10 0AU, UK. Date of preparation: August 2009.

Ollatum Junior Fragrance Free
Presentation: Emollient balm additive containing Light Liquid Paraffin 63.4% w/w. Uses: Treatment of contact dermatitis, atopic dermatitis, eczema pruritus, ichthyosis and related dry skin conditions. Dosage and administration: Use as frequently as necessary. Daily use is recommended. Always use with water. Add 1-3 cupsful (16-50ml) to an 8 inch bath of water, soak for 10-20 minutes. For infant baths use 1-2 cupsful (5-20ml), apply over entire body with a sponge. Pat dry. Caution: Take care to avoid slipping in the bath. Legal category: GSL. Pack sizes and NHS price: 250ml £12.29, 500ml £13.75, 1 litre £11.59. Product licence number: PL074/01/18. Product Licence holder: Stiefel Laboratories (UK) Ltd, Hotspur Lane, Wooburn Green, High Wycombe, Bucks HP10 0AU, UK. Date of preparation: May 2008.

Adverse event reporting: Information about adverse event reporting can be found at www.yellowcard.gov.uk. Reports may also be emailed direct to Stiefel Laboratories (UK) Ltd at adverse.reaction@stiefel.com.

Contact ollatumtester@stiefel.co.uk for your 25g tester packs. While stocks last.
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Cerazette® (See SPC before Prescribing)
Presentation: Calendar pack of 28 tablets each containing 75mg desogestrel. Deaths and contraception. Design: One tablet at about the same time each day. Do not leave a gap between packs. Contraindications: Known or suspected pregnancy, active venous thromboembolic disorder, presence or history of severe hepatic disease with concurrent abnormal liver function tests, progestogen-dependent tumours, unexplained vaginal bleeding, hypersensitivity to ingredients. Precautions and warnings: There is a slightly increased risk of having breast cancer diagnosed in women currently using oral contraceptives (OCs). The risk is in users of progestogen only pills is possibly of the same magnitude as that associated with combined OCs. These observations may be due to an earlier diagnosis of breast cancer in OC users, the biological effects of the OC or a combination of both. Epidemiological studies have associated the use of combined OCs with an increased incidence of venous thromboembolism (YTE, deep venous thrombosis and pulmonary embolism). It is unclear whether desogestrel used alone carries the same risk. Discontinue in the event of a thrombosis. Consider stopping prior to long term immobilisation due to surgery or illness. Benefit/risk assessment should be made in women with liver cancer. Caution patients with a history of thromboembolic disorders. Patients with diabetes should be carefully monitored. Effects on bone density are unknown. Choose. Use in pregnancy and lactation: Not recommended for use during pregnancy. Cerazette does not affect the production or quality of breast milk. Small amounts of the metabolite estroneglone are excreted with the milk. Long term follow-up data are not available, however, 7 month data do not indicate a risk to the nursing infant. Interactions: Enzyme inducing drugs may result in increased clearance and lead to breakthrough bleeding and contraceptive failure. This may be seen with phenytoin, barbiturates, primidone, carbamazepine, rifampicin, oxcarbazepine, diltiazem, felbinac, thiourea, griseofulvin and products containing St John’s Wort. Reduced absorption of estroneglone may be seen with medical charcoal. Adverse reactions: Common: Irregular bleeding, amenorrhoea, headache, weight gain, breast pain, nausea, acne, mood changes, decreased libido. Less common: Vaginosis, dysmenorrhoea, ovarian cysts, vomiting, alopecia, fatigue, difficulty wearing contact lenses, acne rash, urtica, cryoglobulinaemia. Nodules: No serious deleterious effects have been reported from overdoses. Other symptoms may include nausea, vomiting and in young girls, slight vaginal bleeding. Treatment should be symptomatic. Legal category: POM. Product licence number: PL 0056/0119. Price: Retail: NHS cost at 3 x 8 tablets £8.45 Further information is available from: Organon Laboratories Ltd, Science Park, Milton Road, Cambridge CB4 0FL. Telephone: 01223 432 700. Date of revision of prescribing information: December 2009.

Date of preparation: June 2006
Item Code: 090600

Help safeguard public health and support medicines yellow card reporting. www.yellowcard.gov.uk Alternatively, adverse events can be reported to Organon Laboratories by calling 01223 432740

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COMMENT

We should all work in Eastbourne

The NHS, which cares for us all, is responsible for one of the biggest fatalities ever — the death of common sense. And it is over-promoted NHS managers who are in the dock over this alleged killing.

On almost a daily basis, we hear of their idiotic decisions.

There was the crazy demand that staff at Maidstone and Tunbridge Wells NHS Trust, already clocking up massive amounts of unpaid overtime, should donate a day’s work for nothing to pay for a bloated Private Finance Initiative (PFI).

And then the expectation that a Cornish school nurse should — or could — grapple with a caseload of 9,000 school children, and the NHS chaplains in Worcestershire whose salaries were to be paid for by the proceeds of jumble sales. The list goes on...

Earlier this year, business guru Gerry Robinson tried to sort out Rotherham General Hospital for the BBC’s Can Gerry Robinson Fix the NHS? In one magic moment, the quietly spoken, but ever-so-steely Robinson suggested that the chief executive might learn something if he left his office and went walkabout, asking staff for their views. This dose of common sense was a desperately alien concept for the office-bound bureaucrat. The scales slid away from his eyes.

But with an annual average salary of £126,561, these chief executives of primary care trusts are paid enough to take sensible decisions.

Worse still, when it all goes pear-shaped, there always seems to be money available to arrange grotesque ‘goodbye’ packages.

And who can but wonder in ‘shock and awe’ at the PFIs — the equivalent of buying a hospital over 30 years on Barclaycard?

Who can but wonder in ‘shock and awe’ at the PFIs — the equivalent of buying a hospital over 30 years on Barclaycard; and allowing private contractors to charge hundreds of pounds to change a light switch for bulbs that have been taken out anyway as a green economy measure.

The NHS was founded when Clement Attlee was Prime Minister. When a minister asked the premier why he had been sacked, Mr Attlee told the hapless ex-colleague tersely: ‘You are not up to the job’.

And what price such straight talking for some of today’s senior NHS managers?
Bitter disappointment at pay awards for community nurses

Below inflation increase will not help recruitment and retention of staff

The Pay Review Body award and the government’s decision to stage it have left community practitioners ‘bitterly disappointed’, Kevin Coyne, Amicus/CPHVA head of health, said recently.

Speaking in the wake of the publication of the PRB report, and of the government’s subsequent announcement to stage the award, he said, ‘We are sorry that the PRB has ignored our evidence on the age profile and other issues relating particularly to the difficulties facing community practitioners.’

The evidence submitted by Amicus/CPHVA, based on the DH’s own figures, showed that nearly one fifth of health visitors were over 55, training places had been cut and the numbers of health visitors under the age of 35 had fallen.

‘We wanted the Pay Review Body to lend their support to our additional problems and we are bitterly disappointed that this has not happened,’ Mr Coyne said. He also attacked the government’s decision to stage the award.

The PRB recommended an increase in the Agenda for Change (AfC) pay rates of 2.5% from 1 April 2007. But Health Secretary Patricia Hewitt said that 1.5% would be paid from 1 April and the remainder from 1 November, bringing the awards in line with the rest of the public sector.

She said, ‘We appreciate that nurses will be disappointed by the staging of their award. However, overall earnings growth in the NHS will be around 4.5% in 2007/08 as a result of this pay award, the government’s pay reforms and opportunities for career progression. For nurses, I expect the average earnings of nurses to rise by 4.9% next year, above the national average.

‘It is also expected that inflation across the year will be much lower than it is now.’

But Kevin Coyne said: ‘The award is below current inflation. Furthermore, the government made great cause out of the use of incremental points. This was facile: we had already included that in our evidence. Not everyone is going to get incremental points and the PRB had already taken account of the award.

We do not know this year what the true picture on staffing is, because of trusts’ reactions to the NHS’ current financial problems...Given the importance of the Knowledge and Skills Framework (KSF) to the success of AfC and to restructuring to meet the future agenda of the NHS, we would strongly urge the parties to ensure that the KSF is fully implemented and appropriately resourced as soon as possible.

We also urge the health departments...to take a longer-term view of training and development of trainees and of staff in post,’ the report said.

As Community Practitioner went to press, the Scottish Health Minister, Andy Kerr, announced that nurses in Scotland would receive the full 2.5% from 1 April.

Older people harder hit

A leading charity says that the government must take urgent action to stem the tide of cuts in mental health services for elderly people

Cuts in mental health services are hitting older people especially hard, according to the Royal College of Psychiatrists.

Figures published recently by the college’s Faculty of Old Age, showed heavy cuts in mental health services for older people; some have lost 50% of their inpatient beds, up to 75% of their wards and 30% of their funding.

The faculty says that hospital beds, whole wards and day treatment services are being closed and clinical posts are being lost in at least 26 local mental health services throughout England.

Commenting on the figures, Gordon Lishman, director general of the charity Age Concern, said: ‘While many parts of the NHS need to balance their budgets, it would be completely wrong if older people’s access to mental health services was further undermined in the process.

‘At any one time, around 10-15% of over 65s have depression. One in four of all suicides in the UK are people over 50. Yet older people are already systematically ignored or denied mental health services because of their age.

‘The government must keep its commitments and stop the butchering of these chronically under-funded services.’

The charity said that the cuts come on top of chronic under-funding of mental health services for older people and the systematic discrimination older people face over access to mental health.
Green light for food labelling

Colour-coded food packaging should be made compulsory across Europe

The campaign for a 'traffic lights' system of food labelling is calling for European-wide legislation to make the scheme compulsory across all member states.

Under the scheme, foods are labelled red (high), amber (medium) or green (low), indicating relative salt, sugar and fat content.

Only the European Union has the power to pass laws on front-of-pack food labelling, according to the Children's Food Campaign.

'We hope that the breadth and depth of support for traffic light labelling among parents and health, medical and consumer organisations will persuade food manufacturers and supermarkets to put these easy-to-understand labels on their products,' said Richard Watts, co-ordinator of the campaign.

A report by the National Heart Forum (www.heartforum.org.uk) has found the Guideline Daily Amounts (GDA) system, preferred by major supermarkets, to be 'fundamentally flawed' and sometimes deliberately misleading.

A survey by Netmums (www.netmums.com) found that four out of five of parents supported traffic light labelling over the food industry's 'per cent of GDA' system.

The Children's Food Campaign is also calling for legislation from the UK Parliament to ban all junk food advertising on television before the 9pm watershed.

'Ofcom's failure to protect children from junk food adverts is hardly surprising given their insistence on trying to balance the physical health of kids against the economic health of broadcasters,' said the campaign.

'The responsibility to protect children from junk food adverts now rests with the Government.

'The campaign for a 9pm watershed will continue with the 'Advertising on Television of Food Bill,' which Baroness Thornton has introduced into Parliament. It is supported by over 160 MPs.

'Given Gordon Brown's support for a voluntary 9pm watershed, we remain confident that children will soon receive the protection from junk food adverts they deserve.'
NPSA launches new report on patient falls in hospital

The National Patient Safety Agency is tackling the growing concern over slips, trips and falls in hospital.

Patient falls can have a significant impact on patients, their relatives and hospital staff and it is estimated that the overall direct healthcare cost to the NHS is estimated at £15 million every year. In view of this, the National Patient Safety Agency (NPSA) has published a new report aimed to reduce the number of incidents.

Slips, trips and falls in hospital aims to improve NHS organisations’ understanding of the scale and consequences of patient falls in hospitals, identifying areas where efforts to reduce falls and injury are needed most and direct NHS staff to some of the evidence-based resources for preventing falls.

Patient falls, including slips and trips, are the most common patient safety incident reported to the NPSA via its national reporting and learning system (NRLS). Despite the majority of falls (96%) resulting in little or no harm, there is a small minority that result in a serious injury or even a fatality. Of over 200,000 falls reported, 26 resulted in the patients’ death, with further deaths likely to have occurred following hip fractures.

Speaking on the launch of the report, Professor Richard Thompson, the NPSA’s director of epidemiology and research, said: ‘Preventing patients from falling is a particular challenge in hospital settings because a patient’s safety has to be balanced against their right to make decisions and retain dignity and privacy, and there will always be a risk of falls given the nature of the patients that are admitted to hospital. However, this piece of work aims to support the NHS in reducing these risks.’

As well as recommendations that can improve the care of patients vulnerable to falling, the report includes a summary of research evidence on preventing falls, along with practical suggestions such as reviewing medication associated with falls, physiotherapy and providing safer footwear.

To access a full copy of the report, log onto: www.npsa.nhs.uk/health/resources/ps0.

No figures hampers obesity fight

With childhood obesity increasing in Wales, the government have been criticised for not providing up-to-date information on children’s weight and height.

Efforts to combat childhood obesity in Wales are hampered by a lack of up-to-date information on the weight and height of children. Professor of epidemiology at Swansea University, Rhys Williams, was last month due to meet National Assembly Members to discuss compiling new figures. "There are some places, like Swansea, where almost all the children are measured in terms of height and weight, but in, for example, Gwent, it is not possible to get measurements of anything like 100% of children," he said in an interview with Wales on Sunday. Professor Williams said: "We’ve so far been unable to contrast in any meaningful way what the differences between children in Swansea are and, say, children in Anglesey. ‘I will be telling them that they will have no way of knowing if they are being successful in tackling obesity unless they sort out this problem.’

The assembly has set aside £20m to tackle the problem, of obesity in Wales. A World Health Organization survey in 2004 revealed Welsh children were the second most overweight in Europe and fifth most obese in the world.

Commenting on the findings, Amicus/CPHVA professional officer for Wales Gill Devereaux said: ‘This highlights the importance of advice and guidance to families from health visitors in the pre-school period. Prevention is crucial in tackling this huge public health issue.’
MOVICOL ALTERNATIVE PRESCRIBING INFORMATION
Refer to full Summary of Product Characteristics (SmPC) before prescribing.

Presentation: Packet of powder which dissolves in about 125 ml (approximately half a glass full) water to make a lemon-flavoured drink. Each sachet contains 12.15g macrogol (polyethylene glycol) 3350, 178.5mg sodium bicarbonate, 359.7mg sodium chloride and 46.6mg potassium chloride. Uses: Treatment of chronic constipation and faecal impaction. Dosage and administration: Constipation: Adults, adolescents and the elderly: 3-6 sachets daily divided doses according to individual response. For extended use, adjust dose down to 1 or 2 sachets. Children (below 12 years): Not recommended. - see MOVICOL Paediatric Plain. Extended use may be necessary in patients with severe chronic or resistant constipation, secondary to multiple sclerosis or Parkinson's disease, or induced by regular constipating medicine, in particular opioids and antispasmodics. A course of MOVICOL treatment does not normally exceed 3 weeks, but can be repeated if required. Faecal impaction: Adults, adolescents and the elderly: 8 sachets per day. A course of treatment for faecal impaction does not normally exceed 3 days. The 8 sachets should be taken over 6 hours (2 sachets per hour maximum in cardiovascular impairment). The 8 sachets may be dissolved in 1 litre of water. Children (below 12 years): Not recommended. - see MOVICOL Paediatric Plain. Contra-indications, warnings, etc. Contra-indications: Intestinal perforation or obstruction due to structural or functional disorders of the gut wall, and severe inflammatory conditions of the intestinal tract, such as crohn's disease, ulcerative colitis and toxic megacolon, hypokalaemia, hypomagnesaemia, hypocalcaemia, hypernatraemia, hyperglycaemia, phenylketonuria, severe liver or renal disease. Warnings: Symptoms indicating fluid/electrolyte shift. Interactions: Medicinal products taken within 1 hour of administration of large volumes of macrogol preparations (as used when treating faecal impaction) may be flushed from the gastrointestinal tract and not absorbed.

Adverse events should be reported to Medical Information at Norgine Pharmaceuticals Limited on 01925 826006. Information about adverse event reporting can also be found at www.yellowcard.gov.uk

MOVICOL macrogol 3350, sodium bicarbonate, sodium chloride, potassium chloride
A 4-dimensional laxative
Amicus/CPHVA members were out in force recently around the United Kingdom, taking part in a nationwide protest to protect the NHS, as part of the NHS Together campaign.

NHS Together is a campaign alliance of 16 health service unions and staff associations with the TUC, including Amicus/CPHVA.

As well as campaigning against cuts being made to key services and jobs because of trust deficits, NHS Together also campaigns against the dash to the private sector, the pace of introduction of untried and untested reforms and the failure to consult adequately with health service employees.

While the unions acknowledge the increased investment in the NHS, there are concerns that improvements are being jeopardised. Amicus/CPHVA members attended events held across England, Wales and Northern Ireland.

In Manchester, the march and rally included 250 mental health workers who had been on strike against jobs cuts and services, downgrading of jobs and threats of privatisation.

There have been extensive cuts to NHS services in the north west, including widespread job losses, ward closures and the loss of hundreds of beds in over 20 hospitals.

Over £100 million has been taken out of the region’s health economy and gone into private companies running private finance initiative schemes.

In Yorkshire and Humberside, members gathered in Leeds City Centre for a march and rally.

There have been extensive cuts to NHS services in the region, including hundreds of jobs loses and ward closures.

The south east region has also witnessed extensive cuts to services, including 1,000 job losses.

In Kent, a march and rally took place followed by leafleting in Folkestone and Maidstone city centres.

In Belfast, speakers at the rally included: Patricia McKeown, vice president, Irish Congress of Trade Unions, Mary Hinds, Royal College of Nursing and Kevin McAdam, chair, Staff Side Health Trade Unions.

Plans for secretaries to weigh babies in Bexley have been withdrawn after a campaign by Amicus/CPHVA.

In a bid to help save £12.3 million by the end of March 2007, a health visitor manager in Bexley Care Trust had floated the proposal that untrained administrative staff should take over some of the clinical duties of experienced health visitors or trained health care assistants.

Amicus/CPHVA said this was ‘frightening’, as it meant health visitors risked being struck off the Nursing and Midwifery Council register, if something went wrong.

Following intervention by Amicus/CPHVA, Bexley Care Trust backed down on its proposals that administrative staff should weigh babies in clinics.

In a statement, the trust said that following a meeting of lead nurses ‘this option is not being pursued further by the care trust at this time.’
Still under construction.

A baby’s immune system is still developing during the first few years of life. That’s why we’re here to help.

Prebiotics are one of the components of breastmilk that naturally strengthen a baby’s immune system. After breastfeeding, babies can still get the support they need thanks to Cow & Gate follow-on milks with prebiotics. To learn more about what we’ve found in our 10 years of research, simply call 08457 623 624 or visit in-practice.co.uk.

Important notice: Breastfeeding is best for babies. Cow & Gate follow-on milks should only be used as part of a mixed diet and not as a breastmilk substitute before 6 months.

References:
Race equality and health service management: the professional interface

Penny Franklin outlines the importance of educating and supporting issues of equity and diversity in the workplace by focusing on the race equality agenda

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University of Plymouth

Summary
The Amicus/CPHVA Equalities Committee is working to educate and support the workforce on equity and diversity. There is a strong focus on the race equality agenda. A work pack has been developed to help members challenge racism in the workplace. It can be argued that racism remains endemic within the NHS and within professional employment structures. Policy and strategic development has so far done little to challenge the situation. Practitioners must be accountable for challenging their own stance on race equality and must be active in supporting equity within the workplace.

Introduction
The Amicus/CPHVA equalities committee works to keep race equality at the forefront of members’ thinking.

The committee has commissioned various projects, including Pamela Shaw’s work on welcoming diversity and a project by Bradford University examining the health effects of the onset of early retirement on nurses from Black and Minority Ethnic (BME) backgrounds.

The committee also looks at how racism impacts on those who experience it within the workplace. It has developed a teaching tool (talk pack), which is to be used to raise awareness of racism and race equality. The tool has now been extended so that it can be applied to all six areas of the equality agenda.

Mandakini (Mandy) Amin (committee chair) submitted her ideas to develop the teaching tool for health professionals to the Mary Seacole Award Committee and went on to win the development award.

Within the NHS, the number of nursing directors from BME backgrounds is still an underrepresentative. Racism is often covert, deeply rooted and endemic within the system. Institutional racism is directed towards patients, and is highlighted, for example by the inquiry into the death of David Bennett. But it exists at all levels within the NHS.

Snowy peaks
In 2003, Trevor Phillips, chair of the Commission for Racial Equality, described the NHS as a snow-capped mountain that was white at the top and black at the bottom. There is a dearth of members from BME cultures in senior posts. The management proportions in the NHS do not proportionally represent the workforce. In 2005, only 1% of chief executives and 3% of executive directors were from BME backgrounds.
The Department of Health launched an action plan in 2004, challenging managers to give greater prominence to race equality.

Health minister Rosie Winterton, in response to the census conducted by the Health Care Commission, said that ‘Racism or discrimination in any form has no place in modern health or social care.’ This can be taken to mean not only in the care of patients, but also in the care of staff.

Change towards greater equality has been driven by the fear of litigation. There is still a chasm of racism and although policies and mandates are in place, there is a failure to confront this in a systematic and co-ordinated way. Much of what we do in the NHS is measured by outcome and in the current economic and political climate of reconfiguration, it is difficult to keep sight of the financial benefits and of the benefits to patients of a co-ordinated approach to tackling racism. Esmail et al. makes a case for increased monitoring of the NHS workforce with comprehensive data collection to combat institutional racism.

There are basic statistics on the number of BME staff employed by the NHS but very little on their access to training courses, leadership programmes and promotional opportunities. NHS leadership programmes do not actively identify the types of leaders who would be best suited to delivery of a diverse workforce, which will support a culture of change within the NHS. Senior managers, should be selected because they will be transformational leaders and change agents and they should be made responsible for diversity targets. Esmail et al. argue for the creation of NHS beacon sites in areas where there is a high BME population.

Joanna Bennett, of the Sainsbury Centre for Mental Health, reviewed race-related training and found it fragmented, with many different approaches and models. There was no definition of cultural competence and no evidence that the training works in improving the experiences of BME service users. Bennett, who led research on workforce development at the centre, concluded that although cultural awareness training is important, it had no effect on power relationships. The key was to get staff to focus on their own attitudes and actions towards colleagues within the workplace. In order for attitudes to change in the workplace and in management practice, diversity training must address NHS staff’s individual attitudes and relationships with both colleagues and service users.

Cultural awareness must move beyond diversity training. It must identify under-represented minorities and target interventions to address their needs. Leadership needs to value diversity. Diversity in senior management needs to be encouraged and nurtured and leadership taken from examples of good practice. Change can then be brought into the workplace and into NHS management.

Although it is useful to address cultural awareness, diversity training does little to support interactions with service users and even less to support changes in the power relationships at managerial levels. What does work is getting NHS staff to respect the individual patient, rather than focusing on his/her culture and ethnicity.

Community practitioners must question their own stance on equity and diversity and their attitudes to service users, colleagues and to the NHS’ managerial structures.

References


Acknowledgement

The author would like to thank members of the CPHVA equalities committee for their contribution and support.
The new NICE guideline on antenatal and postnatal health will change health visitors’ practice. Ruth Rothman, Clare Taylor and Rachel Burbeck look at the recommendations relevant to health visitors

The new NICE guideline covers the care and treatment of mental health problems during pregnancy and the first postnatal year. This includes depression, anxiety disorders, eating disorders, and severe mental illnesses such as bipolar disorder and schizophrenia.

One in seven women will have some kind of psychological problem during this period; the impact of a mental disorder on the woman and her family can be greater than at any other time. There is an increased risk of women who already have a mental health problem having an episode antenatally or in the first postnatal year.

In addition, psychotic disorders may develop more rapidly and severely after giving birth than at other times. There is also the risk that a woman who is being treated for a mental health problem when she finds out she is pregnant will immediately stop her medication without consultation with her doctor. This can make the problem worse or lead to a relapse. The guideline recommends that healthcare professionals discuss with the woman the treatment options as quickly as possible.

The role of the health visitor and the new guideline

The health visitor will look after women during pregnancy and the first postnatal year.

There is an increased risk of women who already have a mental health problem having an episode antenatally or in the first postnatal year.

Visitors have the most frequent contact with women in the six weeks after childbirth, continuing throughout the first year postnatally. Health visitors support women during the psychological adjustment to motherhood, identify mental health problems and help women to overcome the challenges of caring for their infant, other children and themselves.

Health visitors are also involved in the initial assessment and referral of women with depression during this time. The guideline acknowledges that listening visits by health visitors are helpful in treating milder depressive disorders by recommending non-directive counselling. The health visitor will monitor the mother and family, identifying any difficulties with the mother-infant relationship and will listen to what the mother says about her infant. The detection and management of depression by health visitors has been recommended in various reports and policy documents.

When a mother has a serious mental illness, most of the care will be taken over by secondary mental health services. However, the health visitor still has a role to play in supporting the whole family, including monitoring the infant and observing mother-infant interaction.

Vignette: A woman with depression in the postnatal period

When I got home after the birth of my son, a pattern evolved. My husband went to work and I sat on the sofa, with my son in my arms, making sure I had phone, remote control, pillows and drinks at hand. I would feed and doze all day, to be found still on the sofa at the end of the day when my husband returned. I dared not put my son down because I knew that he would cry. I left the front door open so that my health visitor could just come in. She suggested that I write a list of ten things that I wanted to achieve, which really helped. It gave me something to aim for, even if it was just having a hot bath or making a roast dinner. During this time, she was my saviour, my friend, my confidant, my counsellor, my shoulder to cry on, the reason I am still here.
Melt away the misery of bedwetting

Bedwetting can make a child feel sad and ashamed. It can also be stressful for the whole family.

DesmoMelt is preferred to tablets, especially in young children. A DesmoMelt placed under the tongue at bedtime dissolves in seconds and can help keep a child dry at night.

Unlike tablets, DesmoMelt doesn’t need to be washed down with a glass of water.

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Identifying problems
Some of the guideline's key priorities for implementation relate to the prediction and detection of mental health problems in the antenatal and postnatal periods. Health visitors are often in the best position to pick up early signs of new episodes of mental health problems, and ask questions about previous mental illness or a family history of it.

Women who already have a mental disorder have an increased risk of an episode antenatally or in the first postnatal year. The guideline recommends that all healthcare professionals involved in the woman's care should ask her about her experience of serious mental illness.

One recommendation of particular importance, that will change health visitor practice, is in the use of the Edinburgh Postnatal Depression Scale (EPDS). The guideline recommends that when a woman makes initial contact with services, and postnatally (usually at four to six weeks and three to four months), healthcare professionals should ask:
- During the last month, have you often been bothered by feeling down, depressed or hopeless?
- During the last month, have you often been bothered by having little interest or pleasure in doing things?
- If a woman indicates that she has been affected by such feelings, a third question should be asked: ‘Is this something you feel you need or want help with?’

The guideline advises that after initial detection, the EPDS, Hospital Anxiety and Depression Scale (HADS) or Patient Health Questionnaire-9 (PHQ-9) may be employed in any ensuing mental health assessment.

The evidence supports asking three brief questions, rather than longer and more complex methods, because they are as effective and are more compatible with routine use in busy primary and secondary care settings. The other advantage is that they can be used both antenatally and postnatally.

The EPDS has enabled health visitors to develop their role in detecting women with depression. It has long been understood that the EPDS needs to be supported by a clinical interview.

There are validated tools only for the prediction and detection of depression, but healthcare professionals should be vigilant for other mental health problems in the antenatal and the postnatal periods, such as anxiety, eating disorders, post-traumatic stress disorder (PTSD) and obsessive-compulsive disorder. The guideline advises that when a problem is identified, management should be discussed and planned with the woman's GP. If it is a severe mental illness, however, referral should be made to a secondary mental health service or a specialist perinatal mental health service.

The GP must be informed if a mental disorder is suspected or it is known that a woman has a history of severe mental illness. If a woman does have a current mental disorder or a history of severe mental illness, healthcare professionals should enquire about her mental health at every contact. A care plan covering the antenatal and postnatal periods and delivery and including increased contact with specialist mental health services should be developed in the first trimester, in collaboration with the woman and with other professionals. Health visitors can be actively involved in the implementation of care plans.

Preventing problems
Sub-threshold symptoms of depression and anxiety can be distressing and can have an impact on day-to-day functioning and the baby’s development. If the woman has had depression or anxiety in the past, cognitive behavioural therapy or interpersonal therapy may help; if there is no such history, individual or group-based social support may be appropriate.

Methods that may have been used with the aim of preventing other mental disorders are not effective and may cause harm. The guideline recommends that, following a traumatic birth, women should not usually be offered a single session of formal debriefing. Instead, they should be encouraged to seek support from family and friends, and should have regular health visitor and midwife support. Mothers of stillborn infants, or infants who die shortly after birth, should not be routinely encouraged to see and hold the dead infant. There is evidence that women who had done so had increased rates of symptoms of depression, anxiety and PTSD. A follow-up appointment in primary or secondary care should also be offered.

Drugs during pregnancy and while breastfeeding
A major part of the guideline is on balancing the risks and benefits of treatment during pregnancy and while breastfeeding. It is important that health visitors are familiar with the woman's treatment regime, particularly if she is taking medication. Some psychotropic drugs taken in pregnancy carry risks for the unborn baby. One of the key priorities is that women should be offered psychological therapy within one to three months of assessment.

The guideline contains recommendations about the risks of individual drugs, however it should be emphasized that many of the risks are still poorly understood by researchers because the evidence base is limited. In some cases, the guideline simply informs professionals of the risks so that they can reach a decision suitable for the individual. The guideline also recommends that professionals should explore with the woman treatment options that will allow her to breastfeed if she wishes to do so, rather than advising against breastfeeding.

Useful links
http://www.nice.org.uk/guidance/CG45

Would you like to write for Community Practitioner?
Family complete?

Recommended by NICE as a cost-effective, long-term contraceptive.

The NICE Guideline on long-acting reversible contraception (LARC) recommends that women should be offered wider access to methods such as Mirena, which is a highly effective, long-term contraceptive. Therefore, when her family is complete, recommend Mirena.

Fit and forget contraception.
**LETTERS**

**Letter of the month**

No short cuts to good quality care for community nursery nurses (CNNs)

As a member of the Amicus/CPHVA Community Nursery Nurse Forum, I feel that I must respond to the negative comments made in January’s issue of the journal.

In the article by Halpin and Nugent on health visitors’ perceptions of their role in autism spectrum disorder, a health visitor compared a CNN’s ability to a health visitor’s when carrying out child development assessments.

She commented, ‘I accept...nursery nurses can do developmental screening, but that’s task-oriented, and I feel that a health visitor isn’t just doing that...you are looking at far wider issues, and have a much greater resource of skills to help the family...’

Nursery nurses study full time for two years, gaining not only abstract knowledge in child development, but also crucially empirical knowledge. This is only the start. Many years are spent gaining valuable practical experience with children of various ages and abilities. There are no short cuts to good quality care. Many CNNs continue their professional development with higher-level study throughout their careers, despite limited career opportunities for them within health visiting.

Childcare is a vocation and as such it is difficult to quantify the exact skills and knowledge used.

The CNN forum has tried to address this issue recently by producing the Amicus/CPHVA Competency Framework and Best Practice Guidelines (Oct 2006), which attempts to inform those outside our discipline about who we are, what we do and why we do it.

Perhaps, if the person making the remarks had read this, she would have avoided causing any unnecessary offence.

Pam Heslop
Vice chair
Amicus/CPHVA Community Nursery Nurse Forum

The song remains the same

How I have enjoyed the articles on Agenda for Change (AfC) by Barrie Brown. These, combined with my knowledge of the Knowledge and Skills Framework (KSF) enabled me to assist a colleague recently. A client reminded her of the planned treatment for the day, and she was embarrassed to have forgotten. I was able to intervene and explain that in fact she had enabled the client to exercise autonomy in taking responsibility for his own planned care pathway. Fantastic! We wrote it up and put it in her portfolio.

I love the language; Roald Dahl would be envious of the marvellous construction of concepts; ‘Make it clear that workforce issues will be dealt with systematically and in partnership over a period of time’. What a fabulous piece of gobbledygook, what exactly does it mean to those of us wearing out our shoe leather providing the service? Surely that doesn’t mean the ‘freezing’ of posts without consideration for service need and provision, without consultation of other clients or staff?

I am puzzled that nowhere in the articles was I able to find the words ‘expensive’, ‘demoralising’ or ‘divisive’. ‘Destructive’ was also missing although there are many of us who wonder what could have been achieved had the funding for the implementation of AFC been allocated to clinical services. It is surely thanks to such propaganda that myself and my colleagues believe that we must be working in the only part of the NHS that appears to be in danger of imminent collapse.

Thank goodness for the reporting of the victory of the health visitors in Staffordshire (Feb 2007 p5).

Every day I have a song playing in my head that won’t go away. For so long, Pink Floyd have been mournfully asking, ‘Is there anybody out there?’ but now, thanks to the marvellous Danny Kaye hit, which told of a visitor isn’t just doing that...you are looking at far wider issues, and have a much greater resource of skills to help the family...’

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Julia Nash
Health visitor
Baldock

I agree with all the points made by Julia. What was presented in the two articles could be interpreted as a tunnel vision approach to the benefits of AfC, auguring the NHS version of heaven on earth. Not surprising, given that except for the opening paragraph in the first article, almost the entire text was taken from the NHS Employers’ report, from pay reform to system improvement – making the most of Agenda for Change. The report was not written in partnership with the unions, but was intended by the NHS Employers to demonstrate the range of benefits arising from the impact of AfC. Julie and her colleagues are clearly not impressed, but I would take comfort from another great Danny Kaye hit, which told of the development (without the benefit of KSF) of an ugly duckling into a beautiful swan.

Barrie Brown
Lead officer for nursing
Amicus Health

Have your say...

Your letters are welcome but please keep them brief. Write to the Acting Editor, Carol Harris, Community Practitioner, 33-37 Moreland Street, London EC1V 8HA Fax: 020 7780 4141 Email: carol.harris@tenalpspublishing.com

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The provision of primary care interventions by community health support workers in Pakistan

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Introduction
This article presents the findings from a four-week field trip to Pakistan in November 2005, to explore the role of the support worker in primary health care. Using a series of semi-structured interviews, the views of health care professionals, support workers and service users were sought. The study was carried out in four centres: two cities, Karachi and Lahore, and two towns, the latter serving largely rural populations in Sindh province.

Putting the patient at the centre of health care delivery is fundamental to modernising the NHS. At the same time, there has been recognition of the need to provide culturally and linguistically appropriate services to people living in the UK, in order to improve access to health services and reduce health inequalities. Such recommendations suggest that there is a need for these services and imply that, as health professionals, we are not adequately addressing these issues.

One way of attempting to remedy the gap in the provision of effective and appropriate health care to those from minority ethnic groups has been to employ support workers from a similar ethnic and cultural background to the client group. The employment of support workers to deliver frontline health care to the whole population has become common practice in the UK, particularly since the move towards ‘skill mix’ gathered momentum in the early nineties.

Although this study is written from a health visiting perspective and focuses on the use of support workers in the provision of health care in Pakistan, the issues raised will probably resonate with health workers from most disciplines and it is hoped that the application of learning will extend to communities beyond the confines of this study.

Box 1. Reasons for the study

| Aim: To gain an overview of the role of community health support workers in providing primary health care interventions in Pakistan |
| - Explore the varying roles of community support workers, their training and supervision |
| - Examine the effectiveness of the interventions from the perspective of healthcare professionals, community support workers and recipients of the intervention |
| - Access written reports of the primary care interventions studied |
| - To explore the relevance and transferability of these findings to Luton’s population |

Potential benefits of the study to the NHS

Two factors stimulated the visit to Pakistan. An appreciation that the role of the support worker was fundamental to the delivery of health care, both in hospital and community settings in rural Pakistan and the demography of Luton’s rich and diverse population, which includes 9.2% who trace their origins to Pakistan. We hoped the visit would enable us to explore the way that the support worker role has developed in recent years, learning approaches that would be transferable to the local and national health context in the UK. Box 1 summarises the aims of the study, the final point relating to the study’s purpose.

The support worker role: national and international perspectives

The debate in primary health care concerning the introduction of skill mix teams now includes the role redesign of its members, involving staff of all grades. This study is concerned with the role of those who do not hold a professional qualification and are, therefore, not registered with a professional body. It is primarily about the role of a support worker.

In England this person may be known as a health care assistant or support worker. In other countries the terms community or lay health worker may be used. When discussing the role, this study will use the term ‘support worker’.

Key words
Support worker, skill mix, primary care, training, Pakistan

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The issues that have prompted the development of the support worker role in the UK are not dissimilar to those that have encouraged the expansion of this workforce internationally, especially in low and middle-income countries, like Pakistan. It is recognised that there is an acute shortage of appropriately trained health workers in many countries, leaving populations without an effective healthcare system. Buchan is primarily writing of developing countries, but his comments that ‘health is labour intensive (p.1)’ and its consequent impact on expenditure are familiar to all health care providers. In the UK there is a growing awareness of the need to provide targeted health care. The recommendations of the Acheson report have been the stimulus in recent years for reviewing the provision of health care in order to reduce inequalities in health. This has resulted, in common with other industrialised countries, in the development of the support worker role to provide health care to targeted groups.

Evaluation of the effectiveness of this role has been undertaken at an international level. A recent Cochrane Systematic Review of lay health workers in primary and community care examined 43 randomised controlled trials in answer to the question: ‘Are lay health workers effective in improving the delivery of health care and health care outcomes?’

The review found that the lay health worker was effective in certain programmes, such as improving immunisation rates. However, the gaps in methodology and the lack of detail in some of the studies of the training and support given to the lay health workers prevented an exploration of the relationship between training and effectiveness of outcome.

The external evaluation of the work of the lady health worker (LHW), a support worker role in Pakistan, by Oxford Policy Management is of particular interest to this study. The findings suggested that in some areas this programme of providing health promotion, preventative and simple curative services in the community has improved some basic health indicators. The report acknowledges the complexities of such a national programme and engages with the process of the programme, attempting to elicit what makes the programme successful in one context and not in another.

The findings from both studies suggested that it was important to compare different types of interventions and explore what elements contributed to their success or otherwise. As a backdrop to the study, the next section summarises the structure of primary health care in Pakistan as observed during the study period.

**An overview of primary health care in Pakistan**

Primary health care within Pakistan is provided by many agencies. There are both governmental and non-governmental organisations (NGOs). The numerous non-governmental organisations contributing to health care in Pakistan range from private clinics to charitable organisations.

The government programme is structured around rural health centres (RHCs) and basic health units (BHUs), which are staffed by doctors, lady health visitors (LHVs) and lady health workers (LHWs). Key points relating to these structures are outlined in Box 2.

**Methodology**

The need to provide effective health care to families for whom there may be cultural and linguistic barriers associated with the increase in the employment of ‘unqualified’ support workers in the NHS provided the catalyst for this study.

The study was undertaken using a broadly qualitative methodology, which involved the use of semi-structured interview schedules, the observation of projects and informal discussions. A discussion by Greenhalgh et al of the influences that result in diffusion of innovations in service organisations, suggests that the research question should look at the process of the innovation rather than asking whether it works. Therefore, the context in which the service was offered and the features that made it effective were examined.

**Ethical considerations**

Ethical issues were considered in the preparation of the study and the proposal discussed with the research management coordinator at Luton PCT. It was important that those interviewed understood the voluntary nature of participation as well as the purpose of the study. In order to facilitate this, non-English speaking interviewees were invited to participate by a local person, who having obtained consent, arranged a mutually convenient appointment.

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**Box 2. Population guidelines for provision of primary health care**

- **RHC**: one per 25,000 population – 24 hour service
- **BHU**: one per 5-8,000 population – restricted hours only
- **LHW**: one per 10,000 population (27 month training in midwifery and public health, ‘X’ level equivalent education)
- **LHW**: one per 200 houses or 1,000 population (eight years’ education required)

**Recording data**

Given the time involved in transcribing data it was decided not to tape record interviews. All interviews that were conducted in English were written down. Interviews in other languages were either simultaneously translated, or notes were made during the interview itself.

Following the interviews, the notes were checked for accuracy, the interview reflected upon and additional notes made which were then typed up on a laptop. For purposes of clarity, the data obtained through interviews and observation of field trips have been separated into three broad categories representing health care:

- **Strategic**, from the perspectives of government and NGOs
- **Intermediate**, which were the views of project managers
- **Grass roots**, the opinions of support workers as well as service users.

**Findings**

**Strategic level**

The interviewees in this section represent a leader in the field of public health, a paediatric consultant specialising in the field of preventive paediatrics and, from the private sector, a senior doctor who combines academic study with community health practice. Each person provided an insight into how primary health care was structured and their perspectives on its functioning in practice. They ably communicated their expert knowledge and commitment to improving health care, in spite of difficulties that might seem insurmountable in the UK.
It was demonstrated that it was important for those in positions of power to remain in close touch to the communities they serve; to recognise that health care has to meet the communities’ needs, and that staff must be supported in their work.

It was apparent that the community health worker’s role was seen as integral to the work undertaken in the community. All three interviewees recognised the potential of the support worker’s contribution to health care, but all of them also expressed their misgivings relating to the government LHW programme thereby, sharing similar perspectives. Their main concern was centred on the lack of supervision or monitoring, which in turn resulted in inadequate training.

**Intermediate level**

Some of the programmes at this level were outstanding in their work to improve health and social care in areas of great poverty. The majority of staff came within the category of support workers who have received ‘on the job’ training.

A programme for the control and treatment of tuberculosis is run from four centres in rural Sindh, one centre situated in the Thar desert. Two doctors visit the clinics to provide consultancy to the paramedics (support workers), who are responsible for the day-to-day management of the clinics and treatment of patients. The paramedics have matriculated (10th class) and are then trained to diagnose tuberculosis by testing sputum for tubercle bacillus, to prescribe and to dispense medicine, and to follow up patients and their relatives. Staff and patients were interviewed at two of the centres and the role of the lady health assistants is described in the next section.

Another community development programme, which has been established for over 30 years, works effectively in diverse projects such as the training of traditional birth attendants, clean water and sanitation, agro-forestry, and a saving and credit programme.

The leaders of both these programmes identified common themes that contributed to the strength and success of their work and are transferable to other situations. The importance of employing local people who are well respected and already have a relationship with the community was emphasised. Crucially, such employees possess an understanding of, and sensitivity to the expectations of local people. They are also accountable to the community, with their personal standing within the community affected by the service provision both they and their organisations offer. Qualities that included motivation, commitment, care and pride in the outcomes of care delivered were seen as crucial to an effective programme.

Strong leadership was clearly demonstrated in both these programmes. Although the majority of employees were support workers, they were allowed independence in their work and were actively encouraged to contribute to the improvement of the programme. Both in-house and external ongoing training were a feature of these programmes. In addition, importance was attached to the monthly team meetings, which in the case of the TB control programme involved a round trip of 150 miles for one paramedic.

Leaders were realistic and acknowledged weaknesses in their programmes. One specifically mentioned that a lack of trust between team members was a barrier to effective working, as was an instance of dishonesty among staff.

**Grass roots**

This section describes aspects of healthcare delivery observed during the course of the study. Non-governmental organisations in Pakistan have a long history of training female health workers to undertake health care, usually with a particular focus on maternal and child health. The first description, however, is of a government programme. In the 1990s, the government of Pakistan introduced the role of LHW into its structure for primary health care.

The strengths of the LHW programme stem from its status as a national programme with clear areas of responsibility for maternal and child welfare. The LHW is identified by the local community and is part of a team, although in reality, she often works in isolated rural situations. The programme’s weaknesses, however, may also be traced back to the complexities inherent in a national programme. Health professionals and potential recipients of the service were aware that many communities do not have an LHW. This may be partly explained by the requirement for the post holder to have satisfactorily completed a minimum of eight years’ education. Many rural communities do not have secondary school educational facilities for girls and therefore cannot meet this standard.

The next two examples are taken from non-governmental organisations. The first describes the role of lady health assistants working in clinic settings within a TB control programme. Three lady health assistants were interviewed. They possessed very little formal education, but all of them had tried to learn to read as adults, with varying levels of success. Only one was able to write. The issues they raised focused on the importance of an adequate training programme. Two women had received in-house training and demonstrated competence in their subject area with a good basic knowledge of the signs and symptoms of TB, its spread and its treatment. The third was new to her role, but keen to receive training. One did not consider her training to be official because the learning had been acquired informally, suggesting the need for a formal recognition of training. The women had successfully raised levels of awareness in their communities by referring friends and relatives.

**Box 3. Role of female health assistant**

- Greeting women
- Showing them where to register
- Talking with the patients, listening to them
- Teaching the patients about TB using cards (a set of semi-professionally produced photographs showing how TB is spread and its treatment)
- Asking about menstrual history. If appropriate, advice on family planning is given (the health assistants obtain sensitive information that patients would be reluctant to share with a male doctor or paramedic)
with suspected TB for treatment, suggesting that higher levels of formal education are not necessarily appropriate for this type of role. The lady health assistants described their role, which is summarised in Box 3.

The final example is of a community health workers programme run under the auspices of the Department of Community Health Sciences, Aga Khan University, Karachi. An urban health project encourages the training of support workers (community health workers) to improve basic health and social care in two deprived areas of Karachi. The support workers from these communities are trained by the qualified nurses and LHV’s who visit the communities five days a week.

A visit to a fishing ‘village’ of 35,000 people provided an opportunity to observe first hand the incredible difficulties that face the community health workers. There is no clean water supply and the entire area is dirty and littered with rubbish. The small government clinic is dilapidated and opens for just a few hours each day. The community is also experiencing severe social problems since their fishing rights were sold to other countries. A high divorce rate inflicts absolute poverty on the most vulnerable.

**Discussion**

**Learning transferable to UK health context**

The study has highlighted some of the pitfalls that may be associated with the employment of support workers.

As the NHS encourages the diversification of roles and the development of a sizeable workforce ineligible for professional registration, we should be aware that this can lead to a fragmented service. This seems to reflect something of Pakistan’s experience. An article in *Dawn Magazine*, part of a national daily newspaper, compares India’s health care system with that of Pakistan, commenting that ‘Pakistan has no organised healthcare system’1 (p.5).

**Implications for practice**

A comparison of interventions has enabled the identification of those factors that contribute to effective health care and those programmes where there is a high level of satisfaction on the part of the worker and the service user. Arguably, some of these interventions in the UK context will involve risk-taking in a risk-averse environment. A highly effective intervention was the result of allowing the support worker freedom to act independently, and of demonstrating a high degree of trust in managing patient care, as in the TB control programme. The programme provides a service that is ‘a one-stop shop’. Perhaps the UK context does not permit this level of independence, but issues of delegation and trust need to be debated, while recognising professionals’ concern for accountability.

The amount of training and on-going development is important to the effectiveness of interventions. Programmes that work well visibly demonstrate that individuals are valued. It is seen in regular team meetings, where team members are encouraged to contribute to service development and take ownership of their programme. This remains a challenge to an essentially hierarchical structure like the NHS.

The LHW programme is an example of a national intervention with varying levels of results. The issues are complex, but emphasise the importance of examining the process that influences outcomes, rather than looking merely at the intervention itself.

The study was an important reminder that people arriving from Pakistan have experienced a very different system of health care to the UK. Understanding and acknowledging this seems to be an essential consideration when developing primary care services for minority ethnic groups.

One aim of the study was only partially fulfilled, namely that which related to obtaining written reports on programmes. Projects that were dependent on donor funding were more likely to be able to supply reports. The additional value that a report offered also reinforced the importance of well-produced reports, including programme evaluations.

**Other outcomes**

It was a surprise and encouragement that two of the interviewees suggested working collaboratively, either in writing articles or in undertaking research.

The Aga Khan University offers short courses (two to three weeks in duration) in various aspects of primary care.

They are relatively inexpensive and could provide an opportunity for health professionals in the UK to attend a relevant course and gain an introduction to life in Pakistan.

**Key issues in the role of support workers**

- The need for rigorous evaluation of how support workers enhance service delivery
- Evaluation of programmes should explore the context and attempt to identify the factors that contribute to the programme as well as the actual intervention
- Appropriate language and cultural knowledge are important, but should not be viewed as the only skills required when employing a support worker to work within minority ethnic communities
- Training and supervision are fundamental to the success of the role of the support worker.

**Conclusion**

This study has provided a snapshot of health care in Pakistan. It comprises perspectives from many angles, urban and rural, health care provider and user, consultant and illiterate support worker.

The findings demonstrate a remarkable consistency in what makes health care effective and what erects barriers. The issues for Pakistan and the UK surrounding healthcare provision and the use of support workers may not be identical, but the challenge of providing effective primary health care using support workers is not dissimilar. The importance of supervision and training as fundamental to the successful implementation of the role has been repeatedly emphasised.

Employing support workers is not necessarily a cheaper option, but it may be a more effective way of improving access to health care to those who need it.

The opportunity to explore the role of the support worker has enabled a greater understanding of the implications of the further extension of this role in primary health care, while contributing to this topical area as the UK Government continues to support the move of health care delivery from hospital to the community.

It has highlighted the unique role that people from a similar background have in communicating with empathy and understanding, and reinforces the invaluable role of a support worker in today’s NHS.
**IN THE PICTURE**

Impetigo (ringworm)

This month, *In the Picture* illustrates a skin condition that can affect both adults and children. It highlights how the condition develops and suitable forms of treatment.

Mike Wyndham, GP in Edgware, Middlesex and course organiser, Barnet GP Vocational Training Scheme

**Impetigo**

Impetigo is a superficial infection of the skin caused by the haemolytic streptococcus or *Staph. Aureus*. It commonly affects young children under five years, but may occur in adults. It comes in two forms: bullous (blistering) and non-bullous forms. Both organisms can invade broken skin, e.g. eczema, insect bites, but the bullous form may develop in unbroken skin.

It has a higher incidence in the summer. 30% of people carry *Staph. aureus* in their nose and they are at risk of developing recurrent infection in the moustache area.

**Formation**

The non-bullous form starts as a small pustule that breaks down to release fluid that dries and forms a crust, which may have a golden yellow appearance. The patches may expand and satellite lesions develop with the face and hands most commonly affected.

The infection may be easily spread to other individuals who come in close contact and sharing towels should be avoided.

**Treatment**

Treatment needs to be intensive to prevent the problem spreading and to ensure resolution. A swab should be taken, as MRSA is more prevalent. A small localised area may be treated topically with fusidic acid.

The British National Formulary (BNF) suggests reserving mupirocin for MRSA infection. Where the problem is more extensive, oral flucloxacillin should be added. Clarithromycin can be used in the penicillin sensitive.

The author has also found that this combination may not always be successful in children, as they may pick at the lesions. In this group, covering the affected areas with dressings may assist cure.

In recurrent impetigo, the nose of the sufferer should be swabbed to exclude carriage of *Staph. aureus*.

Children with the infection should be excluded from school till the infection has settled.
Food for Thought

Healthy Start has replaced the old welfare food scheme

Ask anyone at Farley’s and we will tell you that breast milk is undoubtedly the best nourishment for babies.

A decision not to breast-feed is probably one of the toughest decisions a mother will have to make, as it can be difficult to reverse.

Having made that decision, the cost of an infant formula is an important consideration when deciding on how a mother feeds her baby, particularly now Healthy Start has replaced the old welfare food scheme.

There is a misconception that all infant formulas cost the same, this just isn’t the case.

Formula milks substantially vary in price and so depending on a parent’s brand choice they may be required to pay the difference between the Healthy Start Vouchers and the cost of infant formula.

Listed below is the cost of a 900g tin of the 4 main brands of infant formula.

<table>
<thead>
<tr>
<th>Infant Formula Brand</th>
<th>Cost per 900g tin</th>
<th>Additional cost required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Farley’s First Milk &amp; Second Milk</td>
<td>£4.98</td>
<td>None (£2p extra to buy fruit and veg)</td>
</tr>
<tr>
<td>Cow and Gate Premium &amp; Plus</td>
<td>£5.98</td>
<td>+38 pence</td>
</tr>
<tr>
<td>SMA Gold &amp; White</td>
<td>£5.98</td>
<td>+38 pence</td>
</tr>
<tr>
<td>Milupa Aptamil &amp; Aptamil Extra</td>
<td>£6.96</td>
<td>+£1.36</td>
</tr>
</tbody>
</table>

Source – Tesco, March 2007

The cost of infant formula has never been so important

Important Notice:

Breast-feeding is best for babies. An infant formula should only be used on the advice of a doctor, midwife, health visitor, public health nurse, dietician or pharmacist.
Mothers’ perceptions of community health professional support

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Abstract
This qualitative study aimed to explore mothers’ experiences of the support they received from community health professionals. Every third mother was selected from an NHS Trust’s database of women whose health visitors had used the Solihull Approach. Forty-two women were sent information packs and consent forms. Nine mothers who returned consent forms were interviewed. The interview transcripts were analysed using interpretative phenomenological analysis. The results expand on previous research and contribute additional ideas to the existing evidence base. The findings explore the concepts of trust, expertise and understanding within the working partnership. In addition, the results address mothers’ need for reliability, and a preference for professionals who understand women’s beliefs about what it means to be a ‘good mother’. The results and recommendations are pertinent to those community health professionals who work in the area of early childhood intervention, including practitioners who use the Solihull Approach.

Key words
Early childhood intervention, community health professionals, infant mental health

Acknowledgements
We would like to thank all the participants for agreeing to discuss their experiences.

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Introduction
Motherhood can present many challenges. Mothers often have to manage difficulties with their children, such as delayed toilet training or sleeping problems. In 2004, the Office of National Statistics reported that around 7% of three-year-olds showed moderate to severe behaviour problems, and a further 15% showed mild difficulties. Community health professionals, such as health visitors, can provide valuable support to mothers of young children. Health visitors have successfully used psychological interventions such as the Solihull Approach. The Solihull Approach is an early intervention model for professionals working with pre-school children with sleeping, feeding, toileting and behavioural difficulties. Previous research has shown that the Solihull Approach has taught health visitors new clinical skills and improved the consistency of practice between them.

The Solihull Approach integrates the concept of containment from psychoanalysis, with reciprocity from child development theory and behaviourism from the behaviourist tradition. This integration of psychoanalytic concepts with behaviourism makes the Solihull Approach unique in the field of early intervention.

The Solihull Approach differs from traditional health visiting where the emphasis is often on giving mothers behaviour management strategies to help alleviate their children’s difficulties. By contrast, professionals trained in the Solihull Approach are taught to help mothers manage their overwhelming feelings, by the process of containment, so that mothers can begin to solve the difficulties for themselves. When behaviour management advice is given it is tailored to the needs of each individual.

Recent research compared outcomes for mothers following the Solihull Approach intervention with outcomes following standard health visiting practice. The results showed a strong positive trend favouring the mothers who received the Solihull Approach. There was a reduction in mothers’ stress levels and a reduction in child behaviour problems following the Solihull Approach intervention that was further enhanced at the three month follow-up.

Current government policies emphasise the importance of strengthening the parent-child relationship and intervening early. Every Child Matters states that: ‘the bond between the child and their parents is the most critical influence on a child’s life.’ (p.39) The Solihull Approach provides a model for early childhood intervention. It can be utilised by community health professionals to improve the reciprocity between parents and their children, and thus strengthen the bond between them.

A number of qualitative research studies have explored the professional-client relationship. De La Cuesta’s study analysed the role of this relationship in health visiting, and concluded that the function of the relationship is to encourage the client’s co-operation in work. Ghate and Hazel interviewed parents who lived in poor circumstances and found that parents wanted to feel understood by the professionals they worked with. Bidmead and Cowley carried out a literature review on the concept of partnership working within nursing, counselling and health visiting. They identified a number of factors that were important to a supportive relationship, including trust and sharing expertise. Bidmead and Cowley concluded that more research is needed in this area in order to improve the consistency of practice between them.

The Solihull Approach integrates the concept of containment from psychoanalysis, with reciprocity from child development theory and behaviourism from the behaviourist tradition. This integration of psychoanalytic concepts with behaviourism makes the Solihull Approach unique in the field of early intervention.

There was a reduction in mothers’ stress levels and a reduction in child behaviour problems following the Solihull Approach intervention that was further enhanced at the three month follow-up.
'uncover the detail of the interaction and further demystify the elements' (p.208) involved in supportive professional-client relationships.

In the light of previous research, the aim of the current study was to explore further the support provided by community health professionals, from the perspective of the service users, in order to enhance knowledge in this area. It aimed to contribute to the clinical practice of health professionals who provide early intervention for infant mental health problems, and to give direction for future research.

Since the Solihull Approach is a validated framework for early childhood intervention, mothers whose health visitors had used it were interviewed for the study. Interpretative phenomenological analysis (IPA) was chosen as the methodology, because it allows exploration of themes in participants’ dialogues, and therefore provides an insight into their experiences.15 In addition, IPA permits patterns within the data to be analysed, and tensions and connections between themes to be explored.15

Method
Participants
Nine mothers were recruited through the NHS trust’s database. The database comprised mothers who had received the Solihull Approach from their health visitors for their preschoolers’ difficulties between 1 April 2003 and 31 March 2004. The demographic details are summarised in Table 1. Names have been changed to maintain confidentiality. Mothers’ ages ranged between 26 years 2 months and 44 years 7 months.

<table>
<thead>
<tr>
<th>Mother’s code name</th>
<th>Children’s code names and ages at time of interview (years:months)</th>
<th>Community health professionals involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zoe</td>
<td>Chloe (3:7) *William (1:4)</td>
<td>Midwife, health visitor, doctor</td>
</tr>
<tr>
<td>Amy</td>
<td>*Ben (1:11) *Becky (0:1)</td>
<td>Midwife, health visitor, doctor</td>
</tr>
<tr>
<td>Kathy</td>
<td>Kerry (9:5) *Simon (2:8)</td>
<td>Midwife, health visitor</td>
</tr>
<tr>
<td>Caroline</td>
<td>Peter (7:8) Nick (3:10) *Lucy (2:1)</td>
<td>Midwife, health visitor</td>
</tr>
<tr>
<td>Lesley</td>
<td>*Torn (3:10)</td>
<td>Midwife, health visitor, doctor</td>
</tr>
<tr>
<td>Ellen</td>
<td>Emma (15:3) *Tony (3:4) Sue (1:7)</td>
<td>Health visitor, clinical psychologist</td>
</tr>
<tr>
<td>Bethany</td>
<td>*Chris (3:4)</td>
<td>Midwife, health visitor, doctor, other health professional</td>
</tr>
<tr>
<td>Tamsin</td>
<td>Judith (10:10) *Mark (4:10)</td>
<td>Health visitor, doctor, clinical psychologist</td>
</tr>
<tr>
<td>Janet</td>
<td>Steven (9:6) *Nathan (5:8)</td>
<td>Health visitor, doctor, other health professional</td>
</tr>
</tbody>
</table>

* = child identified on database

Table 1. Names have been changed to maintain confidentiality. Mothers’ ages ranged between 26 years 2 months and 44 years 7 months.

Procedure
Ethics
Ethical approval was obtained from the local research ethics committee and from Coventry University ethics committee.

Data collection
Since there were a large number of entries on the database (n=382), every third mother on the database was selected to receive an information pack. The packs contained details about the study. Forty-two packs were sent out initially. It has been stated by Jonathan Smith16 (founder of IPA) that an IPA study averages between five and ten participants. Since ten mothers returned consent forms to indicate that they would like to be interviewed (one mother later declined to participate), it was not deemed necessary to continue recruiting further participants.

Interviews were conducted at the mothers’ homes. At the beginning of the interview the boundaries of confidentiality were explained to each mother and she was given a copy of her consent form. A semi-structured interview was then carried out and recorded on to audiotape. See Table 2. The questions in the interview schedule focussed on mothers’ experiences of their health visitors’ use of the Solihull Approach. The schedule was intended as a starting point from which to explore mothers’ general experiences of the support they received from community health professionals for their young children’s difficulties. The interviews lasted between 35 minutes and two hours. At the end of the interview the mother was given information sheets containing details of organisations she could contact if she needed any help concerning issues raised.

Validity
IPA acknowledges that the researcher’s own world-view has an impact on data analysis.11 There are six stages in an idiographic approach to IPA: looking for themes in the first case, looking for connections between these themes, creating a table of these themes, using the table of themes to analyse the remaining transcripts, creating a master list of themes for the group, and writing up the analysis.12

IPA: looking for themes in the first case, looking for connections between these themes, creating a table of these themes, using the table of themes to analyse the remaining transcripts, creating a master list of themes for the group, and writing up the analysis.15

IPA: looking for themes in the first case, looking for connections between these themes, creating a table of these themes, using the table of themes to analyse the remaining transcripts, creating a master list of themes for the group, and writing up the analysis.15
themes. The independent researchers agreed that they could follow the audit trail.

Findings
The analysis of the nine transcripts produced a master list of ten sub-ordinate themes clustered under four super-ordinate themes. See Table 3.

Superordinate theme: Faith in self
The women in this study often appeared to be hard to achieve their own ideal of a ‘good mother’.
Mothers also frequently commented on their perceptions of the severity and impact of their children’s difficulties. There was sometimes a tension between the woman’s image of a ‘good mother’, and how difficult she perceived her child: high expectations and a difficult child often resulted in the woman feeling that she was not coping.

Mothers often stated that this belief in their ability to cope influenced whether or not they sought help from health professionals.

Perception of self as a ‘good mother’
The majority of participants appeared to have an idea of how a ‘good mother’ should behave and how close they were to that ideal. This image was usually of a woman who completely understood her children’s needs and who put those needs ahead of her own. Amy said:

“I’m the kind of person that, especially with children, it’s my job to get it right… I wanted to provide everything for him” (Amy, 2: 634-43).

Perceived child difficulty
All of the mothers described how stressful they perceived their children’s problems to be, with respect to their perceived severity, and the impact on themselves and the rest of the family. Zoe commented on the impact that her son’s sleeping problems had on her relationship with her daughter:

“William would start crying… he wasn’t a very good sleeper so he’d wake up, and he wouldn’t give us that much time (referring to herself and her daughter) …then I just sort of got frustrated” (Zoe, 1: 209-18).

Perception of ability to cope
All of the participants tended to make judgments about how capable they felt to deal with their children’s problems. Mothers who felt that they were not capable of coping with their child’s problems often approached professionals for help:

“The reason I went down…(to the clinic was because)… there was a lot of shouting at Tom… and we were shaking him… and I wanted it to stop… I just felt like as a family... we were under that much pressure… we were just spinning out of control” (Lesley, 5: 73-82).

Superordinate theme: Mother’s trust in relationship with health professional
All the mothers received input from health professionals, and the majority said that they preferred professionals who were reliable, for example in terms of informing them about future appointments and planning for endings. In addition, mothers often made a judgement about health professionals’ expertise, and this influenced whether or not they accepted professionals’ advice.

Professional’s reliability
The majority of the mothers said that they needed professionals to offer reliable support, particularly with their first child. Many mothers stated that they had more confidence with subsequent children and therefore they had less need for professional involvement, although this was not always the case. They also particularly appreciated being informed about when the health professional planned to see them next, and being involved in the decision to end contacts.

Kathy said that she believed her health visitors had made an assumption about her need for support:

“If you have a second child they think… you’re a dab hand at it and don’t come out as stringently as they did like the first time round… I thought they could have come out a bit more… just really to sort of reassure me about things” (Kathy, 3: 434-7).

Belief in professional’s expertise
All of the mothers expressed their beliefs about professionals’ level of expertise. Mothers who trusted health professionals’ expertise were more likely to follow their advice.
advice. Occasionally, mothers felt empowered to share their own expertise and work jointly with professionals.

Ellen said that the Solihull Approach had made her an expert in terms of identifying her child’s difficulties, which then gave her the confidence to make contact with health professionals when she needed additional support:

Parents that have used Solihull Approach know...how to read the child and...we probably would recognise if there was any problems, and...if you work together...you know where they are, and you wouldn’t be afraid to approach them...for help or information (Ellen, 6: 1103-20) (4: 455-60).

Superordinate theme: Health professionals’ appreciation of the mother’s perspective

Mothers reflected on the importance of health professionals understanding their beliefs and perceptions. In particular, mothers seemed to find the most successful relationships were those in which the professional appeared to be aware of, and responsive to, their beliefs about being a ‘good mother’, as well as being able to appreciate their perceptions of their children’s problems. Perceived social similarity with the professional in terms of age, gender, social class or the shared experience of being a parent, appeared to have an impact on mothers’ opinions of the professional’s ability to understand their difficulties.

Understanding mother’s beliefs about being a ‘good mother’
The majority of the participants spoke of their need to find support from someone who understood their beliefs about being a ‘good mother’. Sometimes health professionals did attempt to explore mothers’ beliefs. At other times professionals did not appear to identify these beliefs and would make suggestions that conflicted with them, which the mother often found difficult to implement. Bethany said that her health visitors’ advice to ignore her son’s tantrums was difficult to carry out:

I feel so self-conscious that I sometimes come home crying...because there’s people staring at me thinking...why aren’t I controlling him?...I’ve been told by the health visitors how to behave with him...and that’s what I’m doing even though...it’s difficult (Bethany, 7:257-74).

Understanding mother’s perception of child difficulty
The majority of mothers stated that it was also important that health professionals appreciated their perceptions of their children’s problems.

Mothers often attributed professionals’ ability to understand to a shared characteristic, such as age, gender, social class or the experience of motherhood:

‘She just basically sat and listened and sort of empathised with me, and tried to make me laugh. She was...really good because I think she’s...a similar sort of age to me (Zoe, 1: 108-11).

Superordinate theme: Perception of outcome after health professional’s input
Mothers frequently reflected on the outcome of their work with health professionals, indicating whether or not it had had a positive impact on their children’s problems. In addition, mothers discussed the personal impact of any emotional support given. A successful outcome was often perceived to be linked to a trustworthy relationship with the health professional (superordinate theme two) where the mother felt her perspective was acknowledged (superordinate theme three).

Perceived improvement
The majority of the mothers reflected back on the process of seeking help and acknowledged those professionals that they perceived had improved their children’s problems. Mothers often linked a good relationship with the professional to a successful outcome after health professional’s input:

Perceived lack of change
Many of the mothers discussed health professionals whose involvement had not resulted in any real change. There was a number of reasons for this, including health professionals and mothers having different ideas about the solution for children’s problems.

Perceived negative impact
Some mothers said that involvement from certain health professionals had a perceived negative impact, usually because the professional concerned had reportedly failed to understand the mother’s perspective.

Caroline said that one professional did not appear to appreciate her lack of experience with children, and how difficult she
found it to carry out advice, as well as look after her child:
She...didn't sort of understand that this was my first baby and...I hadn't got any cousins...or sisters that had had babies (Caroline, 4: 1292-317).

Discussion
This study aimed to explore mothers' experiences of the support provided by community health professionals in their children's early years. Mothers discussed how they decided to seek help, the factors that they considered to be important in their relationships with professionals, and their perception of the outcome of work with those professionals.

Mothers appeared to go through a process before they sought help. They often assessed how difficult they found their child to be, and also whether they felt close to their ideal of a 'good mother'. Mothers with demanding children, who were finding it hard to meet their own personal expectations, often felt that they were not coping and sought additional support. Ghate and Hazel noted that having a 'difficult' child was one of the strongest predictors for mothers feeling that they were not coping.

The results of the current study suggest that being a long way from their own ideal of a 'good mother' might also play a part; an interaction between this and child difficulty might be a better predictor of mothers' perceptions of coping. Further research would be necessary to test this hypothesis.

Many of the participants in the current study appeared to have quite a high ideal of a 'good mother'; being someone who completely understands her child's needs, and who puts those needs ahead of her own.

Cross-cultural research has found variation in ideas about what makes a 'good mother'. With the exception of the current study, there has been little research into what defines a 'good mother' and between different age groups.

This concept of a 'good mother' has clinical significance, in terms of mothers' ability to carry out certain techniques given to them by professionals. Participants sometimes commented that they appreciated advice that helped with their children's problems but that did not conflict with their own beliefs about being a 'good mother'. For example, carrying out controlled crying can be difficult if mothers believe they must tend to their children immediately when they are distressed. An alternative technique, like 'the disappearing chair,' might be easier for some mothers to carry out. The Solihull Approach recommends tailoring any behaviour management given to the needs of each individual. This should mean that mothers are more willing and able to carry out the behaviour management strategies offered.

Previous and current research has identified the importance of clients feeling understood. The current study explored what helps mothers to feel understood. Mothers often linked professionals' understanding to being the same gender, social class or age as the professional, or sharing the experience of parenthood. This would suggest that clients might find it easier to build relationships with professionals with whom they share at least some personal characteristics.

In addition to feeling understood, mothers wanted professionals to offer reliable support. Some mothers seemed to find it unsettling when they were unclear about when (or indeed if) their health visitors were planning to see them again. These mothers appeared to want to talk to their health visitors, but they were unclear whether or not contact had officially ended.

They also particularly appreciated being told when the health visitor planned to see them next, and being involved in the decision to end contact. It is therefore recommended that health professionals inform clients if they go on leave, and also discuss jointly with them when discharge might be appropriate.

De La Cuesta interviewed health visitors and concluded that, 'once a working relationship has been established with a particular client, health visitors are confident that the client will seek help or contact them if in need or doubt.'

(p.454) The current research suggests that this might be an incorrect assumption to make for some women, who might be less proactive in seeking help, but might be still in need of support. Some mothers said they felt that their health visitors had made an assumption that they were confident to cope on their own once they had more than one child. These mothers said they would have liked consistent support with all their children. It therefore appears important that health professionals check with mothers they work with about their need for ongoing support.

Judgements about professionals' expertise in the realm of parenting also seemed to play an important part in a trusting relationship. Whether or not they trusted the professionals' expertise affected whether or not the mothers accepted the advice that they were given.

Successful partnerships often appear to be based on willingness for parents and professionals to work together, sharing their own areas of expertise, in the interests of the children. For example, one mother said that she believed that she was the expert at 'reading' her child, but she recognised that her health visitor had more medical knowledge than she did. This finding concurs with Bidmead and Cowley's view, of the importance of valuing clients' own expertise, and working together towards a common goal.

In terms of the outcome of professional involvement, mothers cited many different reasons for lack of change, including mothers and professionals having conflicting ideas about the solution for the children's problems.

However, perceived improvement was most often linked to trust and understanding within the relationship. In particular, it was often associated with working with professionals who were reliable, who were willing to acknowledge the client's own expertise, and who were responsive to the client's own beliefs and experiences.

Perceived social similarity with the professional also helped. Perceptions of negative impact were usually connected to the professional failing to understand the mother's perspective. The quality of the relationship between mothers and professionals therefore appears to be central to the success of early childhood intervention.
Conclusion
This study explored the mothers’ views of the support provided by community health professionals for their young children’s difficulties. All the mothers had received the Solihull Approach from their health visitors.

The mothers talked about their health visitors’ intervention, but they also commented more broadly on the support they received from other community health professionals, including their midwives, doctors and clinical psychologists. Some of these professionals had been trained in the Solihull Approach but many had not.

The findings of this study therefore have clinical relevance both to practitioners trained in the Solihull Approach, and also to community health professionals who use other models of early intervention for infant mental health difficulties.

Although developing trust and understanding within the professional-client relationship are not new ideas, this research helps to clarify the meaning behind these concepts. It also raises some relatively new phenomena that can be used both in clinical practice and in future research, such as the importance of understanding and responding to women’s beliefs about trying to be ‘good’ mothers.

One way of being responsive is by tailoring any behaviour management advice given to the needs of each individual, as recommended in the Solihull Approach.”

References
Managing unwanted behaviour in pre-school children

Introduction
This paper describes a service innovation, instigated by community nursery nurses (CNNs) to bridge a gap in the service provided in primary care settings for parents who need help in handling their pre-school children's behavioural problems. The 'behaviour group' was a pilot project set up in Southall, one of seven neighbourhoods in Ealing Primary Care Trust, where community nursery nurses work within the skill mix team of health visitors, school health advisors, staff nurses and health care assistants. The group is led by two nursery nurse facilitators. Referrals are made to the 'behaviour group' by health visitors and school health advisors from the children's services team.

The key focus of this pilot project has been joint working with parents and their children in a group setting, to offer theoretical and practical support in behaviour management. Children accompany their parents to all group sessions and parents are shown practical examples of how to manage their child's misbehaviour, using strategies of positive and negative reinforce-ment. The aim has been to support parents and children, to change targeted behaviours that are undesirable, rather than attributing blame to parents. The focus has been on empowering parents, promoting their self-confidence and competence to make use of positive management strategies. In the programme, topics included play, how to ignore unwanted behaviours, praise, triggers, setting limits, discipline and giving consistent instructions. Temper tantrums, aggression and fighting are all part of normal development and can help children learn to be assertive and defend themselves. Such behaviours are first played out in family homes among siblings.1,2 However, persistent poorly controlled antisocial behaviour often affects children's education and parent-child interaction. Government and researchers have presented evidence that such children are at particular risk of failing at school, child abuse, later juvenile delinquency and early drug and alcohol misuse.3 The govern-ment's belief in the centrality of parenting for the health and well-being of the nation has been much in evidence in recent years. It is seen in a series of policy directives which highlight the need for services to support parents and thereby improve outcomes for children.4,5

The 'behaviour group' programme
With this policy agenda in mind, the behaviour group programme was written and developed by the senior community nursery nurse (SCNN), in consultation with a community child psychologist. The programme was established in response to a local audit, which had highlighted a gap in

The programme was established in response to a local audit, which had highlighted a gap in services for parents who were desperate for help in handling their children's behavioural problems.
Skinner postulates that behaviour operant conditioning paradigm put used in the group sessions are based on the unwanted behaviour. Being aware of triggers/signs that may cause the unwanted behaviour, parents were asked to complete an agreement form, indicating their willingness to accept the CNNS’ involvement with the family. A pre-group questionnaire rating scale was completed to obtain a baseline for the behaviour. During the visit, children were present and observed by the CNNS. Parents were advised about the programme’s emphasis on a consistent approach by all family members, to be conscious of triggers/signs that may cause the unwanted behaviour. A behaviour management plan was completed by defining the behaviour to be decreased, increased or maintained. The importance of the role of parents/carers was explained in terms of the degree of involvement expected and in recording unwanted behaviours. At that visit, a date was confirmed for the commencement of the group sessions.

The behaviour group sessions
The behaviour group sessions ran weekly for five weeks and sessions lasted for one and a half hours. Sessions were organised as follows:

- First 30 minutes – feedback and theory
- 15 minutes – free play with discussion and observation
- Last 15 minutes – snacks and songs/story to finish.

The first 30 minutes was theory based, explaining children’s behaviour in developmental and cognitive/behavioural terms. At that stage, parents were also encouraged to give verbal feedback of events during that week. Children were kept occupied with suitable tabletop activities by one of the facilitators (CNN) in the same room as the parents.

The theoretical aspect of session two described the core tenet of the programme, which was the ABC functional analysis of behaviour. It was explained that parents or carers need to pay close attention to A and C of the target behaviour and that consequences often involve the adult changing their behaviour.

In order for facilitators to assess the unwanted behaviour, parents were asked to complete a ‘management of behaviour’ chart at home, recording what the child did, what provoked the behaviour and what happened as a result of the parents’ effort. This chart was then analysed in terms of antecedent, behaviour and its consequences. Parents were also asked to record...
on a tally sheet, each time the targeted behaviour occurred. These were all explained to parents using an overhead projector.

Positive and negative reinforcement strategies were used to demonstrate the core tenet of the programme, that is, how parents can reduce their child’s unwanted behaviour. Therefore, parents were asked to be aware of the triggers that caused the targeted behaviours and to try to prevent them (antecedent).

On completion of the theoretical aspect, children’s behaviour during free play was observed. Again, during this period, some of the misbehaviour occurred as children were engaged in play that required turn taking, sharing and following instructions. The behaviours that were observed depended on the concerns each parent had identified as their child’s targeted behaviour.

The facilitators demonstrated practical strategies in handling unwanted behaviours. Parents were also encouraged and shown how to play effectively with their children. Facilitators discussed with individual parents their plans and charts, and arranged further home visits, if required.

Parents also had an opportunity to interact with each other.

Drinks and snacks were offered during the last 15 minutes of the session, which was also more structured. This structure was important, as it encouraged listening skills, socialising, sitting still, concentration and imitation of good role models. After drinks, a circle was formed with parents and children for songs or stories and a good-bye song to finish. Parents were given pre-prepared handouts on the topics covered during the sessions. The final group session concluded with a party and certificates of attendance for families who attended four or more sessions.

The pilot evaluation
A simple evaluation of the pilot ‘behaviour group’ was conducted using the following methods:

Pre-group questionnaire
Baseline information was obtained from parents using the pre-group questionnaire.

Management of behaviour chart
Parents recorded their child’s behaviour over the week. This enabled the facilitators to analyse behaviours in terms of antecedent, behaviour and consequences.

Tally sheet
Parents maintained a daily record of the target behaviour. This was analysed to identify an increase or decrease of the targeted behaviours.

Post-group questionnaire
During sessions, parents completed a post-group questionnaire rating scale, to assess parents’ views about the severity of the behaviour difficulty once they had completed the ‘behaviour group’ programme.

Test
A test containing questions relating to topics covered in the group was carried out as a group exercise, to find out whether parents had understood the core tenet of the behaviour programme.

A register was kept to monitor attendance of families at the sessions and the CNNs were able to make direct observations of parents’ and children’s behaviour. All these methods were used to assess whether the programme showed improvements in parents’ perceived coping skills and whether the parents’ perceived that their children’s unwanted behaviours had reduced.

Behaviour group pilot – evaluation
From the 37 families referred to the group, 34 attended. Out of the 34 children, seven were females and the remaining 27 were males. The mean age of the children was two years, seven months; the range was between two years and five months to four years, eight months. Of the families who did not attend the programme, one mother had returned to work, while the other two families were related and decided their children’s behaviour had improved.

Waiting times for families were within eight to ten weeks upon receipt of referrals. Six groups were completed with an average of six families in each group. Families were from a range of cultural background. The majority of families were of Asian origin, with a variety of other ethnic groups such as Afro-Caribbean, white British and Albanian. The groups comprised of three single mothers, two cohabiting couples, five married and the others married and living with extended families. Families were of varied socio-economic status.

Pre-group questionnaire
Table 1 illustrates the types of behaviours parents wanted to change about their children, drawn from the 33 pre-group questionnaires completed by parents and carers. The graph indicates that ‘ignoring/not listening’ and ‘not sitting still’ were behaviours which the majority of parents wanted to change about their child. However, Green13 suggests that 100% of two-year-olds, 48% of three-year-olds and 40% of four-year-olds did not comply with those behaviours. The findings indicate that
the frequency with which such behaviours occur in pre-school children are most likely to reflect common developmental behaviours. Likewise, the pre-group questionnaires showed that for the majority of parents/carers, their targeted behaviour was 'to be more patient'. This was understandable, because if parents were unprepared and frustrated in dealing with such common behaviours, their reaction may be one of anger, which is more likely to escalate the problem rather than solve it.  

**Group attendance**

Out of a possible 204 parents and children, 162 attended regularly over the six groups, making it an average of five families per group. From examining the register, a low attendance in one group was due to having three families using interpreters at the same time. This in turn slowed down the pace, resulting in a decline of four families in some sessions.

The diversity of the languages spoken illustrated the need for interpreters. The families who were using the interpreters had a 100% attendance record, showing the need for such a group. One mother, who used an interpreter, completed the management of behaviour chart in her spoken language and the interpreter translated the information. Terminology was sometimes problematic, especially during interpretation of the word 'antecedent'. Parents were encouraged to remember 'A' (what happened first), before the behaviour occurred. This was also explained to the interpreter before the group commenced.

Immediately following completion of the group, the feedback from parents or carers was very positive. Parents appeared to have enjoyed attending the group because ideas and problems were shared during group discussion. Parents also articulated that they could apply the child management skills in a consistent manner, while accepting their child as an individual.

Another parent reported that this group had enabled both her and her husband to attend with their child. She added that they both heard the same message of the benefit of being consistent in their approach. One mother, who had attended a parent group elsewhere, mentioned this was the first group where she was actually shown how to distract and ignore effectively.

Learning about the developmental stage of their child and the behaviours consistent with that stage, coupled with appropriate coping strategies, benefited parents by helping them to understand their own frustration with their pre-school child's behaviour. This enabled parents to apply some of the suggested strategies in a calm and controlled manner.

**Post-group questionnaires**

Twenty-nine post-group questionnaires were completed by parents. These questionnaires showed an improvement from the parents’ perspective about the severity of their child’s original behaviour problem. Not all parents or carers completed the management of behaviour chart or the tally sheet, so it was difficult to ascertain from the collection of these data whether children's behaviour problems had reduced. However, from observation, verbal feedback and the pre- and post-group questionnaires, it is clear that there were improvements in parents and children's behaviours.

**Discussion**

The evaluation of the pilot behaviour group was carried out for families of pre-school children displaying behavioural problems. It showed that by and large, the intervention appeared to be successful. Parents gained skills in managing children's difficult behaviours and the programme also produced behaviour improvements in most children. However, parents must be motivated by their need to make changes in their own behaviour and be supported by other family members for the benefits of attending such a group to be realised. Of the children who attended the group, two were referred to the child development team, three to the community clinical psychologist and three to speech and language therapists. These referrals do not necessarily indicate a long-term problem, but they do highlight a need for early intervention before behaviour becomes entrenched and families have to be referred to CAMHS.

Arguably, relapses in behaviour may occur in different settings, such as the home environment or nursery, but it was hoped that the chances of relapse would reduce with the intervention programme. Additional home visits were made where required, and parents were involved in observing and playing an important participatory role in the practical sessions over the six weeks. Follow-up visits were also offered to a small number of families to offer support following completion of the behaviour group.

In terms of service delivery, the programme was tailored to suit the individual child and family needs. It was cost-
effective, as it took place in a group setting\textsuperscript{14} and was facilitated by members of the skill mix team. The atmosphere was friendly and informal with the option of further home visits by the CNNs at any time during the six weeks. The service provided support for parents in terms of its accessibility to all users in the community.\textsuperscript{6}

It was also in keeping with the Trust’s vision of wanting to promote confident parents and carers in ways that promote positive health, development, social and emotional well being. The group’s key focus and defining feature was that parents and children attended together, which is a different approach from other parent-training programmes for pre-school children.\textsuperscript{15,16}

This group appears to meet a gap in the local community service. The group provided a service for supporting parents and educating them in ways that appeared to build their confidence in dealing with children’s unwanted behaviours. The behaviours that were dealt with in the group were to some extent normative and often reflected normal child developmental stages.

Families were able to access a locally-based service, in a relaxed and friendly environment that explained and demonstrated to parents how to handle such developmental behaviours. The behaviour group intervention could also be used as the first stage of a tiered approach to CAMHS.\textsuperscript{17,18} This would increase the number of families who could possibly benefit from the behaviour group, releasing specialist services for more complex cases and reducing the waiting times for such families.

In this small-scale pilot, more males were referred to the group than females. While no generalisations can be made, this is in line with Woodhead’s\textsuperscript{11} claim that boys tend to display more ‘irritable’ behaviours than girls do.

Therefore, educating parents to view children in an holistic manner (physical, intellectual, linguistic, emotional and social) should equip them with the knowledge that other factors such as environmental circumstances, temperament, age and stage of development can affect children’s behaviour. In addition, not all undesirable behaviours are common ones. Children who displayed behaviours that might have medical or serious psychological implications, beyond the group’s remit, were referred to the appropriate child development team or CAMHS service.

A further consideration for delivering such a service is that at least two facilitators are required to run a group. Having children in the same room as parents can also be noisy, but the benefits of not having to find childcare and working with their own children outweigh such disadvantages.

Importantly, the evaluation showed that the demonstration of practical and coping strategies to parents in handling children’s prevalent behaviours, can foster understanding and patience,\textsuperscript{14} motivate parents to improve their parenting skills and reduce their children’s unwanted behaviours.

One limitation of this pilot study was that not all families completed the pre- and post-group questionnaires. This would need to be addressed in future research to gather a more accurate picture of the short and long-term benefits of the

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**Table 1. Parents’ feedback from post-group questionnaires**

<table>
<thead>
<tr>
<th>Examples of children’s behaviours parents identified at pre-group</th>
<th>Feedback parents gave about children’s behaviour at post-group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not listening</td>
<td>‘I stop and talk to her, instead of getting angry. Distraction works well.’</td>
</tr>
<tr>
<td></td>
<td>‘This group allows me to bring my child along and show me how to ignore without getting angry.’</td>
</tr>
<tr>
<td>Ignores me</td>
<td>He listens to me more, whereas before when I called him, he used to ignore me, when he cries for things I ignore him, eventually he stops.</td>
</tr>
<tr>
<td>Temper tantrums</td>
<td>‘I am more patient, stay calm and stopped hitting him.’ ‘The group sessions were reassuring as it made me feel less isolated as I met other parents with similar concerns. However, I did find it difficult to follow some of the suggestions, as they really tested my patience.’</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Examples of behaviours parents wanted to change about themselves at pre-group</th>
<th>Parents feedback about their changed behaviour at post-group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Be more firm</td>
<td>‘Distraction works well and I can use it with my other children.’</td>
</tr>
<tr>
<td>Be more confident</td>
<td>‘I am more confident in letting her cry, when I say ‘no’ without feeling guilty.’</td>
</tr>
<tr>
<td>Be more patient</td>
<td>‘I stay calm for longer, more patient and do less hitting.’ ‘I was happy my mother-in-law was able to come and hear what I’ve been told, because she looks after him when I’m at work.’</td>
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</tbody>
</table>

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programme. Since this pilot study, the behaviour group has continued to run in two neighbourhoods in Ealing PCT. Managers are currently looking at how the model can be rolled out as part of an integrated service. The behaviour group programme is being developed further.

Conclusion
Overall, the behaviour group was successful in providing an effective and informative service for families and pre-school children with prevalent behaviour problems. Parents reported their satisfaction with the service by their feedback in the post-group questionnaires, and their good attendance records further support their claim. Facilitators also observed changes in parents’ confidence and their applied skills in coping with their child’s targeted behaviour.

The evaluation supports the need for the behaviour group and the role of CNNs within the children services teams, in working with parents or carers to support and offer practical help in dealing with children’s developmental behaviours. Such a group can also be beneficial because it can reduce the amount of less severe behavioural difficulties being referred to the child development team or CAMHS.

References
Teething does not cause clinical symptoms


There is no evidence that teething can be ‘identified’ as the source of symptoms in a child although a number of children develop symptoms that their parents/carers attribute to teething, researchers have concluded.

Doctors from Portsmouth came to this conclusion after reviewing Medline (1966–Sept 2006) for studies examining the link between teething and systemic symptoms in the community. Their analysis showed that although a variety of symptoms may occur contemporaneously with teething, there was no pattern of symptoms manifesting in all the studies that can reliably distinguish teething from any other potential cause of the symptoms. Furthermore, symptoms that might be attributed to teething are not serious, and the presence of fever (>38.5°C) or other clinically important symptoms are very unlikely to be caused by teething. A review of 50 children admitted to hospital with a presenting complaint of teething found that in 48 children, a medical condition was diagnosed, including one case of bacterial meningitis.

Studies from many other countries also demonstrated the widely held secular view that teething can cause many clinical symptoms, for example, in the Guinea-Bissau population, only 33% of parents with ‘severely dehydrated’ children would seek medical help if they thought that the dehydration was secondary to teething. On the other hand, teething may be a label for minor ailments and provide a rationale that parents can accept, say the researchers. This label may also provide confidence to the carers of children that the child can be managed without resorting to formal health care.

The clinical bottom line is that no evidence is available to suggest there are any symptoms or signs specific to teething that allow a diagnosis to be made confidently in a child without excluding other organic pathology. They conclude: ‘We acknowledge this message may conflict with many firmly held beliefs of our patients’ parents and of other colleagues, but this review has shown if a child is ill enough to be admitted to hospital, other organic causes need to be excluded, so that the child is managed appropriately.’

Teething does not cause clinical symptoms

Media nutritionism is a branch of the entertainment industry


Media nutritionism is a branch of the entertainment industry which is there to make money, to create a new market for a new profession, and to distract us from social inequality and the real lifestyle causes of ill health, according to a British doctor, Dr Ben Goldacre.

Writing in the British Medical Journal, he says it is overly complicated, confusing, tinkering and poorly evidenced, whereas basic, uncomplicated dietary advice is effective and promotes health. It’s simply offensive for these nutritionists to assume the moral high ground, as if they were somehow the source of all that is right and good in the management of lifestyle risk factors for cardiovascular disease and cancer, he states. It tarnishes and under-mines the meaningful research of genuine academics studying nutrition. The media are now wading in with programmes such as The Truth About Food, but their efforts are misplaced: it’s the truth about nutritionists that needs to be told.

Dr Goldacre singles out Gillian McKeith, who appears in various Channel Four diet programmes. Gillian McKeith has a Phd in Holistic Nutrition, from a correspondence course run by the American Holistic College of Nutrition, an organisation not accredited by any recognised US accreditation agency. She also claims to have professional membership of the American Association of Nutritional Consultants. To test its credibility, Dr Goldacre signed his dead cat up to this institution.

Extra intervention by health visitors can improve parenting

Bartlow J et al. Role of home visiting in improving parenting and health in families at risk of abuse and neglect: results of a multicentre randomised controlled trial and economic evaluation Archives of Disease in Childhood 2007; 92: 229-33.

Intervention by health visitors during the perinatal period may have the potential to improve parenting and increase the identification of infants at risk of abuse and neglect in vulnerable families, a study has suggested.

Multiple studies attest to the effect of parenting on the development of children and young people, and on their mental and physical health in adult life.

To evaluate the effectiveness and cost effectiveness of an intensive home visiting programme in improving outcomes for vulnerable families, a multicentre randomised controlled trial was conducted comparing home visiting with standard treatment. Participants were 131 vulnerable pregnant women allocated to receive home visiting (n=67) or standard services (n=64) carried out in 40 general practices across two British counties.

All parents randomised to the intervention group received 18 months of weekly visits (six months antenatally to 12 months postnatally) from a health visitor trained in the Family Partnership Model.

The researchers found tentative evidence to suggest that intensive home visiting by health visitors may improve parenting and increase the identification of infants in need of early removal from the home in vulnerable families, for an added cost of £3246 per child.
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High cholesterol levels may cause stroke in healthy women


High levels of total cholesterol, low-density lipoprotein-cholesterol (LDL-C) and other lipid levels are associated with an increased risk for ischemic stroke, even in women who are otherwise healthy, according to a new report from the US Women’s Health Study.

Researchers conducted a prospective cohort study to evaluate the association between total cholesterol, LDL-C, high-density lipoprotein cholesterol (HDL-C), total cholesterol to HDL-C ratio, and non-HDL-C with the risk of ischemic stroke in apparently healthy women.

Nearly 28,000 American women aged 45 provided baseline blood samples. Stroke occurrence was self-reported and confirmed by medical record review. During 11 years of follow-up, 282 ischemic stroke events occurred. All lipid levels were strongly associated with increased risk of ischemic stroke in age-adjusted models. The risk for stroke associated with total cholesterol was only seen in those not taking postmenopausal hormones.

The authors say that their data, the data of the randomised trials, and of others, strongly support the notion that lipids are a biologic risk factor for ischemic stroke and that avoiding unfavourable cholesterol levels may help to prevent ischemic stroke. The results highlight the importance of unfavourable lipid levels as risk factors for first ischemic stroke among apparently healthy individuals.

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Hearing loss in children leads to substantial meningitis risk


Children with severe hearing loss are five times more likely to contract meningitis, a study has found.

Previous research has found children who receive cochlear implants to counter hearing loss are more likely to develop meningitis.

This may be explained in part by a generally higher risk of meningitis in children with severe to profound hearing loss. To investigate whether children with hearing loss have an increased risk of meningitis, Danish researchers conducted an historical cohort study.

The study, conducted over a nine-year period, monitored 663,963 children born in Denmark between 1995 and 2004 and identified 39 children with both hearing loss and meningitis; of these children, five were first diagnosed with hearing loss, and later, meningitis.

Statistically, the authors determined the likelihood of a child developing meningitis after losing their hearing is five times that of other children; their research indicates that factors could in fact be as high as 12 times that of other children.

The study provides evidence of an association of hearing loss and the onset of meningitis, providing physicians and parents with ample reason to be mindful of possible signs and symptoms of meningitis, and allowing for vaccination to be considered as a preventative step.

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Topical lavender or tea tree oil can cause enlarged breasts in boys


Repeated topical exposure to lavender and tea tree oils may result in prepubertal gynecomastia (enlarged breasts) in young boys, endocrinologists have concluded.

The doctors, from Colorado, USA, came to this conclusion after investigating possible causes of gynecomastia in three boys aged four, seven, and ten years’ old who were otherwise healthy and had normal serum concentrations of endogenous steroids. In all three boys, gynecomastia coincided with the topical application of products that contained lavender and tea tree oils, including soap and shampoo. Gynecomastia resolved in each patient shortly after the use of products containing these oils was discontinued.

Studies in human cell lines indicated that the two oils had oestrogenic and antiandrogenic activities.

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Waist circumference a better predictor of respiratory dysfunction than BMI


Obesity is becoming a serious public health issue and is related to lung dysfunction, with intra-abdominal pressure causing a mechanical effect on the diaphragm. Because both weight and height are indicators of body size, BMI may not be an ideal index of obesity in prediction of pulmonary dysfunction.

To determine the predictability of WC and BMI for pulmonary function in adults with and without excess body weight, a cross-sectional study of 1674 adults was conducted. Height, weight, WC, and pulmonary function were measured. Waist circumference was found to be negatively associated with forced vital capacity and forced expiratory volume in one second, and the associations were unchanged by sex, age or BMI category (normal-weight, overweight and obese).

Our results indicate waist circumference as a measure of abdominal fat deposition has a somewhat more consistent predictability for pulmonary function than BMI, the researchers conclude.

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Insulating houses can reduce health inequalities


Insulating houses can significantly improve health and reduce days off work and school, a study has found.

People living in insulated homes were half as likely to take days off work or school, or visit GPs, and had fewer hospital admissions for respiratory conditions, as those in uninsulated properties.
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The spectrum of tic disorders (2)

Differential diagnosis
A good history is usually enough to distinguish tics from other movement disorders such as chorea, myoclonus and stereotypies. Neuropsychiatric disorders associated with tics include autism and Asperger’s syndrome, ADHD, OCD schizophrenia and learning disabilities. Other disorders with a genetic basis, Huntington’s disease, Wilson’s disease and acquired motor tics associated with trauma, encephalitis or Sydenham’s chorea, should be considered. As mentioned in part one, some medicines including stimulants, antipsychotic antidepressants and some anti-epileptics (such as carbamazepine) can induce or worsen tics.1

Attention Deficit Hyperactivity Disorder (ADHD)
ADHD is a developmental condition that is usually present from early childhood, the core features of which include hyperactivity, inattention and impulsivity.1 The condition is pervasive, the symptoms thus occurring both at home and at nursery/school. The ADHD symptoms usually predate the onset of tics in children with Tourette syndrome (TS).

Pediatric Autoimmune Disorders associated with streptococcal infection (PANDAS)
Studies undertaken over the last few years have linked the sudden onset of obsessive compulsive symptoms and/or tics following the infection with a group A hemolytic streptococcus (GABHS). The diagnostic criteria include:2
- The presence of OCD and /or tics
- A prepubertal age of onset
- A sudden onset and remission of symptoms
- A temporal relationship between the symptoms and the GABHS infection
- The presence of neurological abnormalities, including hyperactivity and choreiform movements.2

The evidence that a specific condition is related to streptococcal infection is based on a number of clinical and laboratory (neuroimmunological) findings.4 It has been proposed that an immune mediated mechanism similar to that in Sydenham’s chorea occurs, in which antibodies produced against GABHS cross-react with neuronal tissue in the basal ganglia.5

Despite these studies, there have however, been no prospective epidemiological studies linking tic disorders/OCD directly with streptococcal infection. Further research is needed in this area, but it may be worth documenting whether the onset or worsening of tics coincides with a sore throat infection or related illness. The interested reader is encouraged to research this area.

Management
Reassurance and psycho-education
Most tic disorders, including TS, need little medical input other than help with diagnosis and information. An unusual or severe movement disorder requires specialist advice, and impairing emotional and behavioural problems need referral to mental health services. Once a diagnosis of TS has been made, it is important to explain to the family the natural history of the condition and its related clinical symptoms. Family members and teachers need to be reminded that tics should not be regarded as willful behaviour. A useful analogy to present to parents is that of eye blinking. ‘We all have the ability to temporarily suppress the eye blinking, but eventually and inevitably we do give in to the need to blink’.3 An explanation of the biological basis of TS is important to reinforce the fact that the child does not have full control of the tics, and thus avoid blame. Families often find it useful to hear that TS is by no means a rare condition and it is likely that TS lies at one end of a spectrum of tic disorders that are more prevalent in the community.
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It is also helpful to explain that the prognosis does not necessarily depend on the severity of tics but on other important factors, ie the degree of understanding of the condition at home and the school, the child’s self-esteem and the child’s general coping abilities and outlook on life.

Most individuals with tics lead highly functional lives, and the tics themselves usually wane in teenage years. In mild cases, a diagnosis and reassurance are all that is required, since the child and family may be coping reasonably well without the need for further intervention or treatment.

Psychological intervention

Although many clinicians claim to treat TS successfully with psychological and behavioural interventions, at present there is no consistent evidence-based research suggesting behavioural interventions are successful at reducing tics. Here are a few of the psychological techniques. The interested reader is encouraged to research and explore these areas before committing to a particular technique.

Psychological techniques that help reduce stress may be helpful to reduce the severity of tic symptoms.

Massed practice

Some children find it useful to ‘practice’ the tics prior to going to school or during the school break. This may help the child be tic free for a short period of time and may be helpful prior to stressful situations, such as examinations or performing on stage.

Habit reversal

This technique uses competing behavioural responses to prevent specific tics, ie paced, soft blinking for controlling eye-blinking tics.

Exercise

Some children may benefit from doing exercise and releasing their ‘pent-up’ energy. This can be achieved during time-out breaks at school or by letting the child run around the local playing fields or using a punch bag.

Supportive therapy

The prognosis of this condition depends on a number of factors, including the child’s self-esteem and outlook on life. General support and encouragement should be emphasised within the family.

Parents should be encouraged to develop calm and competing parenting skills, with clear reasonable and achievable boundaries and targets.

Medications

Medication will not completely stop tics. It should thus be stressed to parents that the aim of using the medication is to allow the child to function at school and home at an acceptable level.

The lowest dosage of medication should therefore be used and the dose titrated to achieve a therapeutic effect, while watching out for possible side effects. Parents and children must be reminded of the nature of tics: the condition will ‘wax and wane’, and that it may be necessary to increase the drug dosage during the waxing of tics.

Dopamine antagonists, such as haloperidol and atypical neuroleptics such as risperidone and sulphiride are often effective in reducing the tics, but possible side effects, sedation, weight gain and tardive dyskinesia, may however make parents and children reluctant to use the medication.

Clonidine, an alpha-adrenergic presynaptic agonist, is a useful drug, particularly if there are associated symptoms of ADHD. Possible side effects include hypotension and sedation.

Stimulant medication such as methylphenidate, used in children with ADHD, may precipitate or worsen tics in some patients, but this observation may not necessarily be a contraindication for the use in TS and the co-morbid ADHD.

The patient may benefit enormously if the ADHD symptoms are lessened, but a full explanation should be given to the family and the child, the medication being stopped if the tics worsen. A selective serotonin reuptake inhibitor, such as fluoxetine or paroxetine, may be used to target specific OCD symptoms in patients with TS and co-morbid OCD.

Patients usually take medication for one to two years, with regular reviews. If tics are well controlled, a gradual reduction in drug dosage is possible.

School

It is often helpful for parents to discuss their child’s condition with the teachers at their school. This creates a more understanding environment for the child and may prevent the child being unfairly punished for behaviour related to TS.

Children with TS have been found to score below their grade-expected level in oral reading, individual/group reading, comprehension mathematics and spelling. The child with TS may have specific problems related to organisation, memory and handwriting.

If there is co-morbid ADHD, the subsequent problems with poor attention and impulse control are the main causes of educational difficulties. In some cases, special help may be given around examination time, eg giving the child extra time or allowing the child to use a different room, so that they can freely tic without feeling stressed by disturbing others.

A statement of special educational needs may be warranted, and the educational psychologists can help to identify specific strengths and weaknesses.

Further Reading


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References:

* Trademark of Mead Johnson and Company 2006
Private Finance Initiatives (PFIs)

**What does this mean?**

Third sector organisations can be charities, volunteer organisations or social enterprises. Social enterprises are a fairly wide term – it is sometimes used to describe charities and volunteer organisations, but also mutual or co-operative organisations. Broadly though, social enterprises are profit making organisations, with their profits being reinvested in the stated ‘social’ aim of the organisation. The Department of Health (DH) has a £73m fund (spread over four years) specifically for encouraging the development of social enterprises in the delivery of health and social care services. The DH has also been rolling out 25 pathfinder projects, which are able to apply for a share of a £1m start-up fund.

The government’s support and development of social enterprises is part of its wider public services reform, and government has supported the establishment of a £125 million Futurebuilders fund to build capacity of the third sector, including social enterprises, to help deliver public services.

It is argued that by having multiple companies and organisations compete against each other to provide services, and with ‘choice’ for patients creating competition between services, quality and efficiency will be improved. Amicus believe that it will increase fragmentation between health services, increasing numbers of service contracts and decision making will fall under ‘commercial confidentiality’. The restriction of information this results in reduces the local and national accountability of services, democratic oversight and the full assessment and evaluation of services that enable future development. Also, transferring healthcare services to the private sector results in a portion of taxpayers’ money leaving the health service to benefit individual shareholders, rather than being invested in frontline healthcare services.

**How will it affect people’s work and employment**

The most obvious way that people’s work and their employment will be affected is that when the private or third sector organisations win contracts to provide health services, this is an outsourcing of services from the NHS. Staff employed in those services would no longer be directly employed by the NHS. In the short term, if people are outsourced and no longer in direct NHS employ, they will continue to have the same terms and conditions of service under the Transfer of Undertakings (Protection of Employment) regulations, usually referred to as TUPE. However, this protection does not provide a long-term guarantee, does not include pension arrangements and ends if an individual is promoted or moves to another job within the organisation. Amicus is concerned that staff will be removed from nationally agreed frameworks. We also fear that as different organisations and private sector companies compete for services, they will bear down on terms, conditions and pensions to reduce costs to win contracts. Amicus also believes that by placing services and staff in competition with each other to secure their income stream by winning contracts, patients collaboration across services and disciplines will be increasingly undermined.

We are concerned about the impact on training and staff development. At the moment, initial training costs for health service workers are borne by the NHS. As more and more decisions about what services to provide and training are devolved to local commissioners and services are transferred out of the NHS by this local commissioning, a bigger gap may open up at a national level over future workforce training and development. There is concern too that if community practitioner services are divided between a number of relatively small organisations they may not necessarily have the full infrastructure to support practitioners, for example, through providing proper supervision and opportunities for professional development.

**Transferring healthcare services to the private sector results in a portion of taxpayers’ money leaving the health service to benefit individual shareholders, rather than being invested in frontline healthcare services**

Hillingdon PCT has said it wants to outsource all of its commissioning, and South Central SHA have asked PriceWaterhouseCoopers to evaluate whether its PCTs have the ability to commission effectively – in essence, whether they should outsource part or all of the regions commissioning. This would place private companies such as McKinsey, UnitedHealth and BUPA in the driving seat of deciding what local services should be provided and who should provide them.1

It comes after an expanding role for the private sector in the delivery of health services across all NHS disciplines and areas. In particular, a network of Independent Sector Treatment Centres (ISTCs) has been established across the country to perform diagnostic tests and a range of routine procedures, such as knee and hip replacement operations and cataract operations, at a cost of over £5 billion for two ‘waves’.

Private finance initiatives have been used as the mechanism to build and re-develop NHS buildings – private sector companies are estimated to profit by £23 billion in the next 30 years from the PFI NHS building programme alone. The private sector has also been used to run primary care premises and directly provide GP services, management contracts have been awarded to take over the running...
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of financially failing hospitals, and there has been the privatisation of oxygen supply services and the decision to sell NHS Logistics to DHL/Novation.

An opened up health service is therefore a potentially very lucrative market and large multi-national firms have the resources to move easily into a dominant position within this ‘market’. Many have already established themselves ahead of the full roll out of commissioning through the opening up of different sections of the NHS. The South African firm Netcare has already won the contracts for many ISTCs, as, for example, have Serco, who provide out-of-hours GP cover in Cornwall.

How is Amicus opposing privatisation?
Nationally, Amicus is part of the ‘NHS Together’ campaign, which is an unprecedented grouping of all the health unions, uniting to oppose fragmentation and privatisation. On 3 March 2007, NHS Together had a successful day of action, with over 100 protests taking place all over the country, uniting staff and users in sending the clear message to the government that the fragmentation and privatisation of the NHS must halt. Amicus believes that national activity is needed to effectively highlight our concerns.

Responding to members’ concerns
Cheryll Adams, acting lead professional officer, looks at the work programme of the Amicus/CPHVA professional team during 2007

At the National Professional Forum at the Amicus/CPHVA Harrogate conference, members focussed on three key questions:

- What do you need to be a modern Specialist Community Public Health Nurse (SCPHN)?
- Is the potential demise of health visiting and the subsequent loss of expertise in children's public health an issue for the children's commissioners?
- How do we maintain the correct balance between record keeping, updating information systems and professional practice?

Issues in specialist community public health included:

- A lack of training places and the impact that this has on the workforce in general
- The loss and dilution of experienced practitioners. Members told us that this created a feeling of invisibility in community and primary health care.

Our CPHVA professional team is responding with regular meetings with policy makers, MPs and ministers.

Amicus/CPHVA conducted a survey of the changes in the number of training places in the year 2006/7 compared to the previous year for health visitors and school nurses. The results, showing a 40% drop in training places for health visitors and 10% for school nurses, have been widely disseminated and received significant media coverage.

Your concern about the demise of health visiting within SCPH nursing is being addressed through:

- Regular meetings with NMC officials
- A review of the Essential Skills for Health Visitors by Amicus/CPHVA Health Visiting Forum, which has been shared with the NMC and will be widely publicised
- Amicus/CPHVA modelling the title ‘Health Visitor’ in all its work streams
- Publication of The Distinctive Contribution of Health Visiting to Public Health and Wellbeing.

We had a great debate about the management of record keeping and the importance of IT in a climate heavy with child protection issues. Closer guidance from the CPHVA will follow, including a fact sheet on record keeping.

The professional team is also issuing guidance on your concerns that some inspection bodies are using health visiting records when decisions are being made about professionals being fit for purpose.

Do commissioners understand contestability? How can we ensure that quality, rather than value for money, is the primary concern? The professional team share members’ concerns that the ‘art’ of their practice is not as well understood as the ‘science’. Amicus/CPHVA is publishing a document to support the commissioning process, which will be widely circulated to commissioners, and Community Practitioner will run an article on commissioning children's services.

We have collaborated with researchers by Professor Sarah Cowley at King’s College, London. The results have already been shared with policy makers and from the conference platform.

We hope that throughout the year you will see through your journal and the press releases that the organisation has paid attention to your concerns. A more detailed report of our work is on the website at www.amicus-cphva.org.

We now need you to look towards Torquay in October. What would you like to debate at the next National Professional Forum?
Is their medication ending up where it should be?

Dysphagia, or swallowing difficulty, is a much more widespread problem than you might think. It leaves many people, especially the elderly, struggling to swallow their medicine and often leads to it being thrown away.

Such non-compliance has serious consequences in that it can lead to poor outcomes, hospitalisation or even patient death. It also costs the NHS over a billion pounds a year in wasted medicines and the costs associated with adverse clinical outcomes.

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Rosemont specialise in liquid medicines offering solutions across a wide range of therapeutic areas.

References:

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Information about adverse event reporting can be found at www.yellowcard.gov.uk Adverse events should also be reported to Rosemont Pharmaceuticals Ltd on 0113 244 1400.
Secret lives: growing with substance. Working with children and young people affected by familial substance misuse
Fiona Harbin and Michael Murphy
Russell House Publishing, 2006

Secret lives: growing with substance is a thought-provoking book. It offers an insight to the many challenges that workers from a variety of backgrounds can encounter in practice. The name of the book originates from a nine-year-old who, when asked what to call a children's group replied 'secret lives', 'because we can talk about what is really going on at home'. Those who work with families with parental drug and alcohol abuse are aware of the potential negative impact this can have in some families. Also these children may not be cared for adequately, consistently or safely.

The book does not seek to give all the answers, but raises your awareness of the crossover of adult behaviour and its impact on the lives of children. It poses complex and challenging dilemmas for practitioners. The book has a number of contributors from a variety of backgrounds, including practitioners, managers, academics and researchers. Through this collaboration they share their knowledge and experiences across ten chapters. Chapter one provides an overview of the arena of substance misuse and gives a foundation for the reader in what information is available about children and young people growing up in substance misuse households. The chapters complement each other and practitioners will find the information useful to either enhance their skills or provide an insight into new ways of working. My only criticism of the book is that the practice scenarios across the chapters were not numbered chronologically.

The positives are that it maintains a child focus while assisting the reader to understand the difficult dynamics within the family; it is a book that does not have to be read cover to cover, but allows the readers to dip in and out of it at their own convenience. This book will be of interest to drug, alcohol and childcare practitioners and I would recommend it to anyone working with children and young people affected by substance misuse.

Reviewed by: Adrian Spanwick
Nurse consultant/Designating nurse child protection
Leicestershire and Rutland PCT
**British Heart Foundation booklet**

*Taking control of your weight* is the latest booklet published by the British Heart Foundation (BHF). Aimed to help patients and health professionals tackle the risk of heart disease, the free publication is the first of its kind to give a complete guide for obese people who want to get healthier.

Produced in association with specialist charity Weight Concern, the booklet covers key topics, including: food and medical activity, medication, surgery, psychological and emotional issues and helpful questions obese people can ask their doctor or practice nurse. The free booklets can be ordered by calling the orderline.

W: www.bhf.org.uk
T: 0870 600 6566

If you are interested in reviewing either books or resources for *Community Practitioner* journal, please send a copy of your CV and a covering letter to: Lisa Leano, deputy editor, Community Practitioner, 33-37 Moreland Street, London EC1V 8HA
E: lisa.leano@tenalpspublishing.com

The fact that an item or product is mentioned above does not imply endorsement or approval by the CPHVA or Community Practitioner. If you have produced a resource you would like us to include on this page, please contact Lisa Leano at Community Practitioner: lisa.leano@tenalpspublishing.com

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**Mobility cards**

Challenge Me™ is a set of illustrated colour cards for professionals and parents facilitating the rehabilitation of children with neurological disorders and general developmental disabilities.

The cards come with an instruction booklet offering detailed information on each exercise that can help practitioners/parents plan for and extend activities according to the children’s skills.

The cards are grouped into nine categories: sitting, standing, walking, floor ladder, stair, jumping, rolling as well as extra challenges, which progress in difficulty and allow facilitators to gradually build on the child’s abilities.

This valuable tool is useful for anyone working to improve children’s mobility skill, including teachers, health practitioners, conductive education practitioners and parents. Challenge Me™ makes mobility training enjoyable for children and their facilitators.

Amanda Elliott (ed)
Jessica Kingsley Publishers, 2006

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With significant experience of working within a community health setting and a knowledge of Children’s Centres within Every Child Matters, you will need to be skilled in working closely with parents, agencies and professionals, and be committed to bringing about better outcomes for children and families. A professional qualification relevant to health e.g. Health Visiting, is also required.

For an informal discussion, please call Jane Kivlin, Acting Project Manager on 01237 425752.

If you feel you are up to the challenge, please visit our website at www.nch.org.uk To request a postal application write to NCH Recruitment Shared Service, 522 Kilmarnock Road, Glasgow G43 2B1 quoting reference D9702/287. Closing date: 13th April 2007.

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For further information regarding this post please contact Dr Mark Janns, Consultant Community Paediatrician on 01534 622491 or visit www.workingforjersey.gov.je for a full job description and application form.
Closing date: 20th April 2007.

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Closing Date for Applications: 27 April 2007
**Events**

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8 – 10 May 2007
Coventry University – three day conference
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W: www.misa.org.uk

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E: child.studies@kcl.ac.uk
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**Noticeboard**

**Schedule of Growing Skills**
I would be grateful to receive any information from colleagues about the use of the developmental assessment tool *Schedule of Growing Skills*, which is currently utilised within our PCT as an in-depth assessment for children who are subject to a child protection plan or suspected to be suffering from developmental delay.

There is a lack of information available about the evidence base for this assessment tool and I would be grateful for any information about alternative assessment tools which prove to be more effective.

Please contact:
Sue Gunson
T: 0151 478 1827
E: sue.gunson@seftonpct.nhs.uk

**Updating school health plans**
I am a professional development nurse for the school nursing service in Stockport. I would like to update our profiles/school health plans. I am using the *School Nurse: Practice Development* resource pack and a health needs assessment framework.

I would be interested to see how other areas collect data, what data is collected and how it is then used to plan health care delivery. I would be very happy to forward any information I collect.

Please contact:
Marion Hough
E: marion.hough@stockport-pct.nhs.uk

If you would like to include a Noticeboard entry on this page please send details to:
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Shaping the Future

Amicus/CHVA Annual Professional Conference 2007

The Riviera Centre, Torquay
31 October – 2 November 2007

The theme of this year’s conference “Shaping the Future” will highlight the multitude of change at macro level within the NHS and also incorporate the multifaceted changes within children’s services; and at micro level as changing roles emerge within the nursing and health visiting professions throughout the United Kingdom.

This year’s programme will reflect the significance of these changes and how they may impact on the future delivery of children and family health services, public health and community care.

Confirmed speakers include:
• Professor Sir Al Aynsley Green, Children’s Commissioner
• Kevin Browne, Professor of Forensic and Family Psychology & Head of the World Health Organisation Collaborating Centre for Child Care and Protection, School of Psychology, University of Birmingham
• Naomi Eisenstadt, Director, Social Exclusion Unit
• George Hoskins, WAVE Trust

The future of health visiting, school nursing and community nursing will be of key significance and will be a hot topic for lively debate throughout this year’s annual conference.

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