COMMUNITY PRACTITIONER

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Shaping the Future

IN THIS ISSUE

- It doesn’t add up
- Obesity rules
- Barriers to and facilitators for preventing shaking and head injuries in babies
- Benign breast conditions in women
Formulated specially
for them

now prescribable by you

Oilatum Junior Cream joins Oilatum Junior Bath on the Nurse Prescribers’ Formulary

Oilatum Junior Cream
Prescribing Information
Active ingredients: Light liquid paraffin 8%, and white soft paraffin 15%. Uses: For the treatment of atopic eczema, contact dermatitis, and other skin conditions. Dosage and administration: Apply topically to the affected area. Side effects, precautions and contraindications: Should not be used in patients with known hypersensitivity to any of the ingredients. Consult the SPC for further details. Legal category: C3. Package quantities and NHS price: 150g £3.10, 300g £4.65, 500ml £5.35, 1000ml £11.67. Product licence number: PL 0174/0107 (150g), 0174/0108 (300g), 0174/0109 (500ml), 0174/0110 (1000ml). Marketing authorisation holder: Stiefel Laboratories (UK) Ltd, Holtspur Lane, Woxham Green, High Wycombe, Bucks HP10 0AU, UK. Date of preparation: April 2007.

Oilatum Junior Emollient Bath Additive Prescribing Information
Active ingredients: Light liquid paraffin 63.4%. Uses: For the treatment of atopic eczema, contact dermatitis, lichenification and related skin conditions. Oilatum Junior Emollient Bath Additive is particularly suitable for infant bathing. Dosage and administration: Suitable for use in infants and children. Oilatum Junior Emollient Bath Additive should always be used with water, either added to the water or applied to wet skin, and may be used as frequently as necessary. Add 1–3 capfuls to an 8-inch bath of water, soak for 10–20 minutes, and pat dry. Side effects, precautions and contraindications: Take care to avoid slipping in the bath. If rash or skin irritation occurs, stop using the product and consult the doctor. Consult the SPC for further details. Legal category: C3. Package quantities and NHS price: 150ml £2.82, 250ml £3.26, 500ml £5.10 and 1000ml £5.75. Product licence number: PL 0174/0102. Marketing authorisation holder: Stiefel Laboratories (UK) Ltd, Holtspur Lane, Woxham Green, High Wycombe, Bucks HP10 0AU, UK. Date of preparation: April 2007.

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

Oilatum Junior Cream white soft paraffin, liquid paraffin

Contact oilatumtester@stiefel.co.uk for your 25g tester packs. While stocks last.
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PROFESSIONAL
All professional papers have been double-blind peer reviewed prior to publication
BREAST MILK PROVIDES BABIES WITH THE BEST SOURCE OF NOURISHMENT

Real change isn’t just adding something... ...it’s creating something fundamentally new.

Protein is particularly important for infants, for whom growth is rapid. Infants usually double their birth weight by 6 months and triple it by 1 year of age. Proteins are composed of amino acids. There are about 20 different amino acids commonly found in nature, 9-10 of which are considered essential in infants. Essential amino acids cannot be made by the body, and must therefore be provided in the diet.

The first whey-dominant infant formula

SMA Nutrition recognises the importance of protein and in the 1970s were the first to significantly change the protein composition of infant formula. This change was a move away from the original casein protein-dominant formula to a whey protein-dominant formula.

New SMA Gold – a new protein formulation

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Through developments in technology, major advances have enabled the proportion of the specific key whey proteins in New SMA Gold to be significantly improved.

New SMA Gold now contains elevated levels of alpha-lactalbumin (α-protein), the predominant whey protein in breast milk and source of essential amino acids, and reduced levels of beta-lactoglobulin (β-protein), the predominant whey protein in cows’ milk. β-protein is not usually present in breast milk.

This means New SMA Gold now has a significantly improved protein profile compared to other typical whey-dominant formulas in the UK and ROI.

How will protein profiles compare?

Typical whey-dominant formula

New SMA Gold

α-protein

β-protein

How will infants benefit?

SMA Gold’s new protein formulation offers infants key benefits over typical whey-dominant formula including:

- Improved essential amino acid profile
- Reduction in total protein content
- Reduction in renal solute load
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To find out more about this exciting advance in infant nutrition, please call our special free dedicated advice line on 0800 089 4050 (UK) 1 800 931832 (ROI) or visit our website at www.smahcp.ie

Comparison of casein:whey ratio of cows’ milk and typical whey-dominant formula

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<th>SMA Gold</th>
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IMPORTANT NOTICE: Breastfeeding is best for babies. SMA infant milks are intended to replace breast milk when mothers do not breastfeed. You should always seek the advice of a doctor, midwife, health visitor, public health nurse, dietitian or pharmacist on the need for and proper method of use of infant milks and on all matters of infant feeding.

α-casein:α-lactalbumin:α-lactalbumin 1:1 1:1

SMA Nutrition, Huntercombe Lane South, Taplow, Maidenhead, Berkshire SL6 8PH.

*Trade Mark
It doesn’t add up

Why does it cost so much to save money on management?

Unite/CPHVA recently helped to publicise the fact that in one primary care trust, the board had agreed to spend £360,000 on Meridian Productivity, a management consultancy which, over the course of 418 days, will be reviewing the PCT’s services.

Many of our members will not be surprised at this, as they will have been through a similar process locally. In fact, in the financial year, 2005/06, £578 million was spent on such consultants (an increase of 18-fold over the 2003/04 figure). Oh, to be a manager, when you can use public money to negate your need to manage.

As a practising health visitor, I took perverse pleasure sitting in front of a PCT board and hearing the organisation had to be made ‘fit for purpose’. When this sentence was challenged, with staff pointing out that we had won awards and been recognised as a three-star trust, the sentence was modified: now we needed to be fit for a ‘new’ purpose.

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I have, however, identified one area where the new structures are making a massive impact on NHS spending. While touring the country, meeting members for the health visitor review Unite/CPHVA roadshows, one health visitor said that she now brings her own envelopes in from home, as it is impossible to get any ordered through their clinic.

I’ll leave you with a thought of what £718 million could buy: an unstaged pay award four times over, with a bit of change left in the DH pocket; over 24,000 band 6 community nurses or 17,950 million 4p envelopes. Maybe their ‘new’ purpose isn’t as great as they think it is!

Dave Munday
Professional Officer, Unite/CPHVA
Community practitioners across the UK are concerned at the role of a firm of management consultants in reducing trust deficits.

Unite/CPHVA’s investigations show that management consultants Meridian Productivity has links with at least 26 NHS trusts.

A report by the National Audit Office published at the end of last year, criticised the increased use of such organisations by the NHS.

A recent report in Nursing Standard highlighted concerns reported directly by members to Unite/CPHVA. These included: lack of understanding of professional practice; lack of professional input; collection of inappropriate and/or irrelevant information and bullying tactics.

Sheffield PCT had 95 Whole Time Equivalent health visitors, but Meridian advised it to cut that establishment to 84.86 WTE.

It was reported to CPHVA that the company asked some staff to come up with broad categories, but was unwilling to recognise the health visitors’ role in child protection. Instead the focus was on Time and Motion type studies.

In Gwent NHS Trust last year, Meridian completed a study of district nursing and health visiting services. The report went to the trust board, who decided not to use Meridian. The trust engaged another consultant to implement ‘efficiency projects’ across both services, using data collated by Meridian. The purpose of the health visiting project was to implement cost savings of £750,000, the equivalent of 24 WTE posts.

Unite/CPHVA members in Salford have raised their concerns locally and with the union over Meridian’s work with the PCT, which is looking for savings totalling £1 million over the next two years. Meridian Productivity is being paid £360,000 for the work, calculated on the basis of £800-£1,200 per day.

Commenting on the consultancy’s role, Dean Marsh, Salford PCT’s Associate Director for Provider Development, said,

‘Time and Motion is a rather old term for what they are doing.

‘They are putting in place systems that allow staff and managers to monitor what the staff are wanting to do.

‘We do not have those systems and NHS managers do not have the experience to do this sort of thing. It helps us in terms of capacity planning and has a range of other benefits, especially when you include the impact on service redesign as it affects not just our trust but the hospital services too.

‘We were very keen from the start to manage the behaviour of Meridian. Every two weeks, I and others within the trust make ourselves available to staff to come forward anonymously and in confidence if they wish, to voice any concerns they have about Meridian’s approach, in terms especially of the clinical perspective.

‘We have had no serious or significant complaints so far.’

Community Practitioner approached Meridian Productivity to discuss the issues raised by Unite/CPHVA members. The results, over six working days were: seven telephone calls to the company’s press office, one e-mailed list of questions sent five times, and one interview postponed and then cancelled by Meridian.

Acorn award for health visitors

A team of health visitors from Gosport PCT won the runner-up title in the recent Acorn awards.

The awards recognise excellence in NHS primary care in all the areas vital to NHS success, but which get little official recognition.

The team established a professional forum focusing on evidence-based innovations in practice, which produced new protocols and guidelines to identify and spread best clinical practice.

As a result of their work, the protocols and guidelines drawn up by the group have been widely implemented. Their resuscitation guidelines have been placed in every child health record and the hygiene standards are being used in every baby clinic.

The group have now been integrated with the children’s services clinical governance structure, underwriting interaction with other disciplines.
Concerns about productivity and lifestyle choices must be addressed to make the NHS a first-class service.

That is the view of Derek Wanless, the former Natwest chief who advised the Treasury on investment in 2002. In *Our Future Health Secured?*, a new report for the King’s Fund, he reviews NHS spending since 2002 and its achievements in resources, services, productivity and health benefits.

‘The five years since 2002 have witnessed unprecedented levels of government investment in the NHS—there has been average annual real term growth of 7.4% over the five years to 2007/8. Over that period, real spending on the NHS has risen by nearly 50%—a total cash increase of £43.2 billion—while the proportion of the UK’s gross domestic product (GDP) devoted to health care spending has grown to 9-10%, within striking distance of the European Union average,’ it says.

The report says that staff numbers are at their highest and have exceeded the NHS Plan adopted by the 2002 review. The NHS has more equipment, reduced waiting times and offered better access to care.

However, progress on lifestyle changes had been slower than expected.

While the findings revealed that England is on target to reduce overall adult smoking rates to 21% or less by 2010, obesity rates among adults and children have increased dramatically since 2002.

The proportion of obese boys and girls has risen by 65% and 51% respectively. The report predicts a continuing rising trend within the population.

‘We are not on course to deliver the sustainable and world-class health care system, and ultimately the healthier nation, that we all desire,’ Sir Derek said.

‘Without significant improvements in NHS productivity, and much greater efforts to tackle obesity in particular, even higher levels of funding will be needed over the next two decades to deliver the comprehensive, high-quality services envisaged by my original review.’

Unite/CPHVA acting lead professional officer Cheryl Adams said, ‘Where there have been increases in staff, public health, activity and outcomes have improved. The reverse has happened where staff in public health have been cut.’

To obtain a copy of the full report, go to the website: www.kingsfund.org.uk/publications.
The number of children eating a minimum of five portions of fruit and vegetables a day has increased by 13% in two years. The findings, released in a report by the Department of Health, show that the national school fruit scheme is working and could contribute to reductions in heart disease, stroke and cancer later in life.

Under the scheme, all four- to six-year-old children in LEA-maintained infant, primary and special schools were entitled to a free piece of fruit or vegetable each school day. The Further Evaluation of the School Fruit and Vegetable Scheme found that the number of children achieving five-a-day increased from 27% in March 2004 to 44% in November 2006, and the number of portions consumed had also increased, where an average 50% of children were close to achieving their five-a-day target.

There were no significant differences between boys and girls or between white UK and ethnic minority pupils. However, consumption of fruit and vegetables decreased with age.

The report also said that children who had packed lunches consumed more fruit and fruit juice than children who had school dinners, but ate fewer vegetables and a lot more snacks and desserts.

The report can be downloaded from the Department of Health website: www.dh.gov.uk/publications.

IN BRIEF...

Updated pack
The Who Cares? campaign pack has recently been updated and will be handed out at this year’s annual conference. For members who cannot wait until then, the packs can be downloaded from the CPHVA website, www.amicustheunion.org

Date for a demonstration
Members are encouraged to join colleagues and Unite staff at the NHS Together national demonstration on Saturday 3 November in London. The demonstration will call for a halt to the ongoing privatisation and fragmentation of NHS services. As the demonstration will take part on the eve of the 60th Anniversary of the NHS, it will also be a celebration of the past 60 years of the service. For more information, please contact Saba Mozakka at saba.mozakka@unitetheunion.com

Pay up
Despite widespread anger at the staging of their pay award in England, members of Unite have voted to accept the staged pay offer for NHS staff in England. Devolved governments in Scotland, Wales and Northern Ireland have decided that NHS staff will receive the full award recommended by the Pay Review Body, of 2.5%, backdated to 1 April 2007. Members voted by a margin of three-to-one to accept the staged award, which works out at 1.9% over 12 months. Unite Head of Health, Kevin Coyne, commented: ‘Our members remain extremely angry at the government for failing to uphold the recommendation of the Pay Review Body.’

NICE to hear from you?
NICE (the National Institute for Health and Clinical Excellence) is producing guidelines on bedwetting (enuresis), and are keen to have good representation from health visitors and school nurses. Unite/CPHVA would like to encourage health visitors and school nurses to contribute to this guidance, which will be relevant to many community practitioners’ practice. If you have a particular interest or expertise in this area, and would like to become involved please contact Irene Fynch, admin department at: irene.fynch@unitetheunion.com.
Generations of healthcare professionals have put their trust in Sudocrem. And generations of parents have found that a little Sudocrem goes a long way to soothe the soreness of nappy rash and protect delicate skin from further irritation.

Sudocrem Prescribing Information
Please refer to Summary of Product Characteristics before prescribing. Presentation: A white emulsified cream containing as active ingredients Zinc Oxide 15.25%, Lanolin (hypo-allergenic) 4%, Benzyl Benzocate 1.01%, Benzyl Alcohol 0.38%, Benzyl Cinnamate 0.15%. Uses: in the treatment of nappy rash, bedsores, minor burns, eczema, acne, chilblains, surface wounds and sunburn. Dosage and Administration: To be applied in a thin layer over the affected area with suitable covering where necessary. Renew application as required. Contra-indications: Hypersensitivity to any of the ingredients. Warnings and Precautions: Avoid contact with eyes and mucous membranes. Side Effects: Occasional local hypersensitivity. Legal Category: GSL, Basic NHS Coast: 60g £1.13, 125g £1.70.

250g £2.89, 400g £4.08. Marketing Authorisation Holder and Number: Forest Toosa Limited, Unit 148 Baldrye Industrial Estate, Baldrye, Dublin 13, Republic of Ireland. PL 06160/0003. Sudocrem and Toosa are registered trademarks. Date of Preparation: October 2009. For further information, or to request a copy of the Summary of Product Characteristics (SPC), please contact: Forest Laboratories UK Ltd, Bourne Road, Beesley, Hart, DAS 1WC, UK. Tel: +44 (0) 1222 550 550.

Information about adverse event reporting can be found at www.yellowcard.gov.uk. Adverse events should also be reported to Forest Laboratories UK Ltd. Tel: +44 (0) 1222 550 550.

Sothes, heals, protects
We are now counting down the days to the Unite/CPHVA annual conference, which is shaping up to be the best ever.

The conference is taking place at the Riviera Centre in Torquay, Devon, from 31 October – 2 November. Delegate bookings are up on last year and the exhibition will be bigger and better than ever.

For the first time, a dedicated school nurse programme will run throughout the three days of the conference. Ros Godson, Unite/CPHVA School Nurse Professional Officer has put together an excellent programme to reflect the current school nursing agenda. The plenary programme will be of interest to all community health practitioners and there are workshop sessions throughout the programme, some of which will specifically target issues surrounding school health.

Confirmed speakers include, Viv Crouch who will present on ‘Below the Belt and Above the Shoulders’, Alison Leask, who will present on a pilot taking place in South Birmingham PCT, which examines the needs of vulnerable children and Babs Young, Nurse Advisor at the DoH, for the Children and Young People’s Public Health Programme, who will discuss the 14th Biennial International School Nurse conference held in Singapore in July.

The conference will provide a wonderful opportunity to get a real flavour of what the future holds for health visiting in the coming decade. The health visiting review in England will dominate much of the debate among health visiting delegates informally and in the plenary sessions.

Ros Lowe, who chaired the review in England will be on the main conference platform during a plenary on this subject on Thursday morning.

Don’t miss out on the opportunity to be part of this exciting annual event, meet up with friends and see what the English Riviera has to offer.

The social programme will include plenty of opportunities for networking, sharing experiences and discussing the issues raised in the sessions.

For booking details and more information about the programme, contact the conference organisers, Profile Productions, and see our advertisement on the inside back cover. See you in Torquay!

Come to Torquay and shape the future

Briege Coyle on your chance to join the professional event of the year

The CPHVA has produced this new booklet to help new mums and dads keep their baby healthy during their first six months. The booklet contains lots of useful tips to remind parents how important hygiene is in protecting babies from harmful infections and other health problems. Members can download copies of the booklet by logging onto the members area of the CPHVA website at: www.amicus-cphva.org. Healthcare professionals can also obtain hard copies by contacting Pat Cole at: Hartford Cottage, 1 Longstaff Way, Hartford, Huntingdon PE29 1XT. There is a £15 delivery charge for a box of approximately 175 copies.
Understanding

We know how uncomfortable it can be when eczema, nappy rash, dermatitis, pruritus and other problems make skin dry and scaly.

And we understand that skin in these conditions needs careful handling, so we made Unguentum M amphiphilic.

It has the high lipid content of an ointment combined with the water miscible characteristics of a cream so it glides on and smooths in easily.

Unguentum M. Works like an ointment, feels like a cream.
Singapore story

Ros Godson reports on events from the 14th Biennial School Nurse Conference in Singapore

Ros Godson
Professional Officer for school health and public health
Unite/CPHVA

Monday morning in Singapore is a strangely laid back affair, but I am already hot and sticky by the time I arrive at the conference venue, where I freeze in the air conditioning.

The keynote lecture is an update of Health Promoting Schools; a WHO initiative from the early 1990s. A new framework, the ‘Nutrition Friendly Schools Initiative’ has been rolled out because of the global pandemic of obesity and the multiple challenge of malnourished, undernourished and over-nourished children in many countries, including those in economic transition. It will work alongside the School Food and Nutrition Education Programme (Unicef), Child Friendly Schools.

I am alarmed by one presentation, which shows that among high academic achievers in Singapore, overweight adolescents have worse verbal memory performance than their normal weight class mates. This could scupper our attempts to educate overweight youngsters to eat less and exercise more; they may just forget!

There is an element of ‘death by PowerPoint’ today, as we go on to 5pm, however I can only admire nurses who present their project in a foreign language (English) and those others who simultaneously translate for colleagues. I find myself wondering about tautology when faced with the question ‘is it evidence-based practice, or practice-based evidence?’

As the week progresses, we learn about preparations for an influenza pandemic, which triggers a discussion about how to cough and sneeze. Our habit of covering our mouths with our hands, encourages the spread of germs. In America, they are teaching children to sneeze into their elbow, and to cough down their shirts!

Interestingly, there is a definite split between medically-based screening models, such as those in Singapore, Brunei, United Arab Emirates, and socially-based public health models, as in Hong Kong, USA, Europe and Australia/New Zealand, in relation to WHO guidelines. Thailand has recently developed a school health strategy similar to that of the UK. They are even battling with poor quality food in school canteens! We were delighted to hear that American school nurses have 750 children on their caseload. They are currently reviewing this, now that students enter school with increasing healthcare needs, as special needs schools are closing.

In Sweden, the ratio is 400 pupils per school nurse; they have access to sophisticated data about children’s physical and psychological health, to enable them to meet their targets around mental health and suicide. Research has shown that in order to give young people the resilience they need to cope with life events, they need seven good therapeutic conversations during their adolescence. Additionally, there are student safety controllers, whose job includes checking on the condition of the toilets and seeing how many children do not use them during the day. Everyone in Sweden who works with children has to work within the UN convention on the rights of the child and this is taught to children in schools. Dutch ‘social’ nurses in Rotterdam, (the delegates were both men), work in multi-agency teams, making best use of an advanced child data system. Regular, indepth questionnaires during primary and secondary school contribute to a long-term study of health behaviour and feelings. They monitor sickness absence, sexual behaviour and drug use, and are involved with a food and sports project, and youth drop-in services. They also offer an holistic public health package, concentrating on vulnerable children up to the age of 19, focussing on fast intervention and then sustained working with the family. There are plans to extend this service to young people up to the age of 23 years.

The social programme has been well designed, and includes visits to local health projects and a primary school. The school is for 7-12 year olds and caters for 2,400 children in two shifts, as there is a shortage of school buildings. The facilities, teaching and discipline were excellent, and needless to say, all the children achieved good grades. This was suspicious, and naturally we asked about the special needs children and vulnerable children. It appears that they are not integrated into mainstream schools.

The unofficial strap line for the conference comes from the Danish contingent: ‘Prevention is caring; curing is costly’ which is one for us to promote.

In between sessions, there were plenty of opportunities for networking and a varied programme of educational, social and sightseeing events. Pity the young man with the responsibility of taking us around the night zoo. Trying to round up in the dark a party of women who are variously distributed between the restaurant, shop, bar, loo and photo opportunities, is like herding feral cats.
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macrogol 3350, sodium bicarbonate, sodium chloride, potassium chloride
A 4-dimensional laxative

No interactions with other medicinal products reported. Pregnancy and lactation: No data on use in pregnancy and lactation and should only be used if considered essential by physician. Side effects: Common: Abdominal distension and pain, borborygmi, nausea and diarrhoea are common side effects in high dose use when treating faecal impaction, and are less common in lower dose use for treating constipation. Very rare: Allergic reactions. Refer to the Summary of Product Characteristics (SmPC) for full list and frequency of adverse events. Overdoses: Severe abdominal pain or distension can be treated by nasogastric aspiration. Excessive fluid loss by diarrhoea or vomiting may require correction of electrolyte disturbances. Pharmacological particularities: Do not store above 25°C. Reconstituted solution should be stored covered in a refrigerator (2-8°C) for up to 6 hours. Legal category: UK: P; Ireland: OTC. Contain 20 sachets: UK: 0.55g, Ireland: 0.99g. 30 sachets: UK: 0.55g, Ireland: 1.125g.

Marketing authorisation number: UK: PL 00220/007; Ireland: PL 102/232. For further information contact: Norgine Pharmaceuticals Limited, Moorhill Road, hereford, Herefordshire, UK: 0800 208085. E-mail: medicalinfo@norgine.com © MOVICOL® is a registered trademark of Norgine BV. Date of preparation/revision: September 2000. Date of literature preparation/revision: December 2006. MOVICOL®

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NEWS FEATURE

Team time

Ed Balls, Secretary of State for Children, Schools and Families, on plans for children’s services

The Department of Children, Schools and Families brings together, for the first time, all policy on schools and standards, children’s health, sport, youth justice and wider policy for children and families.

We have made progress on child poverty, teenage pregnancy and youth re-offending rates.

Child poverty did double between 1979 and 1997 to the highest level of any European country, but over the past decade, we have seen the fastest fall of any European country.

Significant barriers to progress remain.

There’s an exceptionally large achievement gap, that is strongly correlated with poverty, gender, ethnicity and disability.

We need to do more to join health services with other services for children and young people.

Despite a concerted effort, both centrally and locally, there are still disabled children who have to wait six months or more for a wheelchair or a toilet seat.

Some children in care still don’t get the support they need to deal with acute mental health problems.

Too many young people, who start by truanting and causing disruption in school, only come to the attention of the authorities when they start offending – children for whom an ASBO or juvenile detention is the beginning of their interaction with the state, rather than the last resort, when all other measures have failed.

The Treasury/DFES children’s services review concluded we needed to get better at early intervention and to get under the skin of some of the very deep-rooted, complex challenges that many families are facing. This is not to stigmatised them as problem families, but to support and respect them and their children.

Every Child Matters cannot work if some parts of children’s services work on principles of early intervention and others are in crisis management mode.

I recognise that there will always be challenges over resources – particularly in social care and in health services. However, this isn’t just about money and staffing: it is also about leadership, judgment and effective partnership.

If you compare outcomes for children in care across different local authorities, it is not the authorities that spend the most money on children in care who get the best outcomes. Similarly, when you compare performances on reducing teenage pregnancies in different local authorities, the defining factor is not money; it is whether PCTs, local authorities and schools are strategically focused on outcomes for children and young people, and different services work together seamlessly.

We must remember that by far the most powerful influence on children’s lives is family. What parents do (or don’t do) will always be the defining influence in a child’s life.

There are no simple solutions and a family policy that penalises and stigmatises children and families is not fair and will not work.

Just as there should be no first and second class schools, there should be no first and second class kids.

We should reject the pessimism that would tell us that there has never been a worse time to be a child and that many children are doomed before they even start.

Our task is to improve the life chances of all children and young people. This is how we will build fairer, safer communities, a more prosperous economy, and the future of our country.

In your opinion

Unite/CPHVA members are being urged to get involved in a series of major consultation exercises on the future direction of services, to be held across the country in the next few months.

The Safeguarding Strategy Team of the Department for Children, Schools and Families is currently discussing future policy and provision in its series of consultation events.

“These are really important consultation events as they touch on so many areas of safety,” Cheryll Adams, acting lead professional officer for Unite/CPHVA said.

“Health visitors, school nurses and community nursery nurses need to be represented. Please consider attending yourself and feeding into our Unite/CPHVA response via Ros Godson, professional officer.”

The meetings are: 2 October - London; 4 October - Brighton; 8 October - Manchester; 11 October - Bristol; Monday 15 October - York, and Thursday 18 October - Newcastle Upon Tyne.

Members can get in touch via their local Local Safeguarding Children Board chair, or email the organisers directly at stayingsafe@glasgows.co.uk or call them on 01772 767744.

The views of healthcare professionals are also being sought within local trusts and via meetings across the country attended by Lord Darzi and the health secretary, Alan Johnson. To find out about events taking place in your area, go to www.ournhs.co.uk or email your comments to: ourNHS@dh.gsi.gov.uk.
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Development and growth of the child should be carefully observed

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Reference
S. Bjørnæs, et al., Contraception 2007; 75:1374-86.

Presentation: Calendar pack of 28 tablets each containing 75μg desogestrel, 28 or 21 oral contraception. Desogestrel free tablet at about the same time each day. Do not leave a gap between packs. Contraindications: Known or suspected pregnancy, active or previous thromboembolic disease, presence or history of severe hepatic disease with current abnormal liver function tests, pheochromocytoma, undiagnosed 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 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 (VTE, deep vein thrombosis and pulmonary embolism). It is unclear whether desogestrel used alone carries the same risk. Discourage in the event of a thromboembolic event stopping prior to long term immobilisation due to surgery or illness. Benefit/risk assessment should be made to 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. Oligomenorrhea. Use in pregnancy and lactation: Not recommended for use during pregnancy. Cerazette does not affect the production of quality of breast milk. Small amounts of the metabolite estrone sulfate 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: Cytochrome P450 inducers may lead to increased clearance and lead to breakthrough bleeding and contraceptive failure. This may be seen with hydantoins, barbiturates, primidone, carbamazepine, rifampicin, omeprazole, rifaximin, frusemide, fenaleb, nitrofurantoin, propranolol and products containing St John’s Wort. Reduced absorption of oestroprogest might be seen with highly discounted medications. Adverse reactions: Common: Irregular bleeding, amenorrhoea, headache, weight gain, breast pain, nausea, acne, mood changes, decreased libido. Less common: Vaginitis, dysmenorrhoea, ovarian cysts, vomiting, alopecia, fatigue, difficulty wearing contact lenses, Acne: Rash, pruritus, urticaria, angioedema. Overdose: No acute deleterious effects have been reported from ingestion. Other symptoms may include nausea, vomiting, and in young girls, slight vaginal bleeding. Treatment should be symptomatic.

Legal category: P08H
Product Licence number: PL/0062/079
Price: Basic NHS cost 3 x 28 tablets £3.85 Further information is available from: Organon Laboratories Ltd, Science Park, Milton Road, Cambridge CB4 0XB. Telephone: 01223 428 790 Date of revives of prescribing information: December 2005.
Obesity rules

The NICE guidelines miss the point

says Dr Wendy Wills

Dr Wendy Wills
Registered public health nutritionist
Centre for research in primary and community care
University of Hertfordshire

The NICE (National Institute for Health and Clinical Excellence) guidance1 was long awaited by all those interested in assessing, preventing and managing obesity among children and young people. It offers little, however, in terms of practical recommendations and presents a narrow, medical perspective on obesity.

First, there is the issue of assessment. Many children defined as obese by their BMI (body mass index) do not feel ‘ill’. This puts the onus on practitioners to use their judgement about whether, and how, to raise the issue with families who do not see themselves as having ‘symptoms’ that need treating.

The NICE guidance suggests practitioners stress to patients that obesity is a clinical condition, and not a judgement about how they look. However, for many obese young people, it is about how they look – research shows that many teenagers assess whether they are ‘too fat’ by comparing themselves to their peers.2 The guidelines note that practitioners should be aware that people from certain ethnic and socio-economic backgrounds may hold different opinions about what weight they consider acceptable.

Children – and their parents – often hold attitudes to weight which are different from those of health professionals. This puts the onus on practitioners to use their judgement about whether, and how, to raise the issue with families who do not see themselves as having ‘symptoms’ that need treating.

The NICE guidance suggests practitioners stress to patients that obesity is a clinical condition, and not a judgement about how they look. However, for many obese young people, it is about how they look – research shows that many teenagers assess whether they are ‘too fat’ by comparing themselves to their peers.2 The guidelines note that practitioners should be aware that people from certain ethnic and socio-economic backgrounds may hold different opinions about what weight they consider acceptable.

Teenagers from lower socio-economic groups – and their parents – are satisfied with fatter bodies.3 This is a major barrier to lifestyle change and for the salience of public health messages about obesity.

NICE says that a person-centred approach is more likely to be effective than a ‘top-down’ education strategy. It suggests primary care practitioners can help older children set goals for weight management, for example. Many practitioners, in general practice, schools and other community settings, are ideally located to help young people do this but I would strongly encourage health professionals to work closely with young people to identify what it is that they perceive will help them manage their weight. Young people are rarely asked for their views on diet and obesity and they do not like to be coerced into changing their behaviour. Taking an holistic approach with young people may also be more likely to result in weight loss. For example, many teenagers need help to improve their confidence and self-esteem, rather than advice about eating five-a-day or getting more exercise.

All primary care trusts (PCTs) should have an obesity strategy and resources for interventions. But many do not prioritise action, partly because of the high cost of obesity services to local families, but also because of a lack of consensus about what interventions to offer.

Josefine Magnusson, from the Centre for Research in Primary and Community Care (CRIPACC) at the University of Hertfordshire, is conducting a survey of GPs and practice nurses in Hertfordshire and Bedfordshire to explore current procedures for dealing with young people who are obese. She says there is a lack of evidence on how this issue is managed in general practice and also whether practitioners’ own perceptions about obesity impact on service provision. Magnusson adds: ‘it is unlikely that interventions aimed at helping obese adolescents to lose weight will be successful before these issues are fully investigated.’

NICE wants local authorities to evaluate and monitor their interventions so that they can be added to the local and national evidence base. However, Kostakis Christodoulou, health development manager at Enfield PCT, comments that, ‘PCTs are not research institutes and need to focus their attention on implementing interventions’. PCTs need to offer suitable training to practitioners working with obese children. Health professionals often point to a lack of specific knowledge and training on diet and obesity messages; there are many misconceptions about the causes of obesity, which few training resources address. Families need consistent advice.

NICE, rather than offering much needed solutions, has highlighted many more questions for practitioners working with children, young people and families.

References


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.

That’s why it makes sense to give people who can’t swallow solid medicines a more appropriate formulation such as a liquid - and the sooner this is done the greater the difference it can make in terms of improved compliance and patient welfare.

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.
Could do better – but doesn’t

The Rowntree report contains some
stark truths about why children fail,
says school nurse Jessica Streeting

Jessica Streeting
School nurse

‘Sometimes you feel that the rest of the
world is catching you up, that the rest of the
world is beginning to listen.’

Much wise nodding as Estelle Morris
introduced the Joseph Rowntree
Foundation report Tackling Low
Educational Achievement. I nod along in
exalted company, at the launch hosted by
the Work Foundation.

It is evident that most are present at Ms
Morris’ invitation; directors of institutes,
professors of education, Members of
Parliament…..

The organisers have prudently left my
job title (school nurse) off my name
badge, but once in, the ground is familiar
enough. We see inequalities first hand,
right here in London, in schools just a few
streets from where these worthies sit
wringing their clever hands.

These days the air buzzes with the
iniquity of our ever steeper social gradient,
the injustice of inequality. Maybe the
world is waking up to Wilkinson, Marmot
the injustice of inequality. Maybe the
wringing their clever hands.

But in the UK we are bottom, regarding
education linked to poverty, something we
should, she conceded, ‘be frantic about’.

The report draws on data from Pupil
Level Annual School Census and the
National Pupil database, employing four
specific measures to compare results; those
children who achieve no passes in
GCSE/GNVQ, those who obtain nothing
better than a D, those who pass neither
maths nor English and those not achieving
five passes in any grade.

As well as statistical data, Robert Cassen
adopts a qualitative approach, interviewing
authority officials and educationalists,
attending conferences, and setting data in
the context of other public documents.

The results of this clear meta-analysis are
depressingly unsurprising. They marry
recent Sutton Trust findings; those born
disadvantaged do increasingly less well –
we fail them in their crucial early years and
go on failing them through school.

Nearly half of all low achievers are white
British males, boys outnumber girls as low
achievers by three to two, with Chinese
and Indian pupils the most successful in
avoiding low achievement. (Only in
South Korea does boys’ achievement
exceed girls’).

...those born disadvantaged do
increasingly less well, we fail them
in their crucial early years and go
on failing them through school

Eligibility for free school meals is strongly
associated with low achievement, especially
in the hapless white British child.

Looked-after children and those with
special educational needs, fair inexcusably
badly and could be assisted through
schooling far more than they are.

Poor reading and writing at primary
school level is strongly associated with
later low achievement, but interestingly,
not having English as a first language
makes no difference by Year 11.

This is a frank report, a ‘could do
(MUCH) better’. It remains to be seen how
much the government will embrace its
recommendations for policy, which, like
the report of a tired old head teacher on
an impossible pupil, seem woolly and
faintly despairing; ‘Early years provision
must do better…need for relocation and
enhancement of expenditure…reform of
the school system…..’

Estelle Morris comments that in the
1980s, schools were too ready to blame
home life, that of course schools make
some difference, but what is needed now is
understanding of both home and school.

Co-writer Geeta Kingdon points out
that only 30% of results are explained by
these data. Asked about the remaining
70% she suggests; ‘Better characteristics
in teachers, head teacher quality, school
ethos, other intangibles?’

Comparing results with others had been
observed to be important, but only
within cultural groups. So might we not
raise standards by fostering a culture of
increased competition all round – ‘cool
to be clever’?

I have a pithy comment prepared, along
the lines of ’more joined up thinking
between education and health please,
increased resources for community
practitioners at the front line…’, but the
high achievers hog question time and all
too soon Estelle is off, to deliver a speech
in the House of Lords.

Acknowledging all is not well may go
some way to addressing faults. The
political climate differs from that which
welcomed the 1980 Black Report on Health
Inequality; commissioned by Labour, it
was famously suppressed by the subse-
quent Conservative government, when
truths about 1980s Britain proved too
uncomfortable. Truth does not come
much more uncomfortable than this
school report.

If every child really does matter there is
much hard work to be done.

Tackling Low Educational Achievement is
available as a free download from the Joseph
Rowntree Foundation. Go to:
www.jrf.org.uk/bookshop and type in the
report title.
"All children between 6 months and 5 years could benefit from taking drops containing vitamin A, C and D."

Food Standards Agency 2007

- **Abidec** multivitamin drops is the brand most recommended by Healthcare Professionals.*

- In fact, more than half of UK GPs and Health Visitors will have prescribed or recommended **Abidec** in the last month.*

- With over 60 years’ experience, who else would you recommend to help build healthy kids?

---

**ABIDEC HAVE BEEN HELPING YOU TO BUILD HEALTHY KIDS FOR OVER 60 YEARS**

Product Information: Presentation: Abidec Multivitamin Drops
Multivitamin supplement containing retinol, orgonoinfort with vitamin A, thiamine, riboflavin, pyridoxine hydrochloride, nicotinamide, ascorbic acid, calcium and iron. Indications: Multivitamin supplement providing vitamins deficiencies and maintaining normal growth and health during infancy and childhood.
Dosage and administration: Infants and children up to 12 years. Infants under 1 year: One 0.3ml dose taken daily. Children aged 1 to 12: One 0.6ml dose taken daily. Contra-Indications: Hypersensitivity to the product or any component, including peanut oil. Precautions and Warnings: Food supplements are intended to supplement the diet and should not be regarded as a substitute for a varied diet. Allowances should be made for vitamins obtained from other sources to prevent hypervitaminosis. Should not be taken by patients with a known allergy to Arachis oil (peanut oil), or by patients with an allergy to nuts as there is a possible relationship between allergies to nuts and peanuts. Keep out of sight and reach of children. Store in a cool dry place. Side effects: Not anticipated with the quantities present. Interactions: None known. Pregnancy and lactation: Not indicated. Packaging quantity and cost: 25ml £3.99 (RSP) MA number: PL 01855/0015 MA Holder: Chelsea UK Ltd, Tower Close, Hertford, Herts, EN19 3DR. Further information is available from Chelsea UK Ltd. T: 0044 (0)1480 438901 Date of preparation: January 2007

*NS August 2006
The time of year has come around when the big case, no the BIG case comes out of the cupboard. Yes, it’s conference time. I don’t know about you, but I need the BIG case because of all the essential items that have to be packed to enjoy the Unite/CPHVA conference to the full.

There are the usual suits, shirts, socks and the little black number for the conference social. I do think I should try and find one of those bags they have in Harry Potter... the kind that holds everything without showing anything. Every year is the same. Whoever is in the house is employed to sit on the case while I strain every muscle and sinew to close the damn thing.

Of course this year’s programme brings additional pressure on the luggage, as I have packed bathers, the woolly pair because it’s winter. Not a normal thing for me to take, but as we are at the seaside this year in sunny Torquay, I will be on the beach with the rest of the hardy souls who, like me, will be indulging in pre-breakfast fringe events run by the Community Practitioners Purity special interest group (SIG). They are a bit secret this lot, not unlike Jedi Knights. These hardy souls swear by a regime that many of us would usually balk at, including the rigorous deep breathing of sea air followed by a bracing dip.

The Sisters of the SIG also follow a strict dietary regime in order to assist in their pursuance of community practice enlightenment and will be running a food kitchen during conference. This nutritionally-balanced diet should provide an excellent riposte to the usual conference excesses.

Finally, of course, there is the SIG positive thinking workshops where all attendees are educated on a meditative programme during which ‘the principles’ are rhythmically chanted. There is a continual ideological debate on whether the 1977 or the 2006 edition is the true word. The group draws strength from the collective energy to withstand the pressures encountered in today’s community practice. Altogether now ‘ummmmm...’

The end result of course is a group of practitioners, empowered to take control of events yet to happen. See you in Torquay.
Letter of the month

Mirror image

I was delighted to read Sue Schutz’s overview of ‘Reflection and Practice’ (RP) in last month’s journal. Its pertinent use by community practitioners extends beyond physical isolation from teams, structures and organisations, which Sue highlights.

The myriad of individual experiences in community practice can be complex and sophisticated, often characterised by multi-agency and multi-disciplinary work. Sources of knowledge which contribute to the skills required to practice effectively at this level may not be fully appreciated.

RP is a remarkable, systematic process, which not only embraces effectiveness and expertise in the community practice arena, but also demonstrates how that expertise is achieved.

In an illustration of the transformative power of guided reflection in child protection, for example, Latchford’s paper (cited in Johns)1 marks a valid contribution to health visiting research and practice, providing significant insight into the value of RP.

In my own practice as a health visitor, and more recently in my specialist role in homelessness, I have used Johns’ ‘Six Layers of Dialogue’ 2 as narrative in guided reflection, embracing diverse sources of knowledge not only from literature, but also from other arts.

Collage is also useful as a tool in reflection, as are photographic techniques. Similarly, my fellow student Louise Garrod’s observations of the sculptures of Barbara Hepworth in RP have led her to develop improved models of care for people with disabilities.

RP is full of potential and can be fun. I have found it to be a creative and exhilarating process.

Sue’s overview provides sound advice. It is crucial to recognise the pivotal role of the facilitator because of the personal and professional nature of reflective processes, which peel back constraints in individual perceptions. However, it is this very element which provides the paradigm shift required for practice.

Successfully facilitated, RP will make visible the contradictions in ethos and practice caused by the current restraints imposed in health visiting. However, it should also create a supportive environment in which practice can flourish within these limitations. As such, it is a profound process for professional growth and transformative care.

Maria Fordham
Specialist nurse/ HV – homelessness
Bedfordshire PCT

References:
Barriers to and facilitators for preventing shaking and head injuries in babies

Lisa Coles  PhD BA RHV RGN
Research fellow in child health
Wales College of Medicine
Cardiff University

Lynne Collins  RGN RHV RM OND DN BSc (Hons)
Health visitor
Cardiff and Vale NHS Trust

Introduction

Non-accidental head injury in babies under six months
Abusive head trauma is a leading cause of death in children under two years old. In a study of 90 cases of subdural haemorrhage, 65 were non-accidental head injuries (NAHI), mostly in babies under six months of age with one as young as ten days old, of whom one third died and half the survivors were severely disabled. Male carers were responsible in 75% of cases of shaking and or impact head injuries.1

The number of hospital cases of injuries from shaking per year is small and although not all cases die, it is not dissimilar in scale to Sudden Infant Death Syndrome. However, NAHI includes a high incidence of morbidity as well as mortality and a consequent burden of long-term costs for conditions like cerebral palsy, visual, speech and language problems, seizures, autistic trait, hyperactive or aggressive behaviour, and the cost of criminal compensation, special education and looked-after social care.

It is likely that the spectrum of degrees of injury is wider than hospital cases alone and there is more to prevent than diagnosed cases indicate.2

First, it is difficult to know the real incidence of NAHI, as shaking has similar consequences to serious accidental head injuries from falls, or from a car accident. Statistics from the neurosurgery clinics of North America suggest that 20-25% of early childhood traumatic brain injury may be inflicted and in 64% of infants less than one-year-old, it is probably caused by abuse.3 Other studies of A&E attendance find a higher level of head injuries in babies under one year presented by the carers as being accidental, with only a small number judged as being NAHI.4

The uncertainties associated with diagnosis mean cases can be missed. Second, predicting cases of NAHI for potential prevention interventions is unreliable. In the subdural study, the associ-
Box 1. When might shaking or head injury happen?

<table>
<thead>
<tr>
<th>Shaking: situations which a carer feels unable to control</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Often a baby may be shacked out of frustration or anger</td>
</tr>
<tr>
<td>■ A common trigger is when the baby won't stop crying</td>
</tr>
<tr>
<td>■ Other triggers include feeding and toilet training problems</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Accidents:</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Negligent watchfulness</td>
</tr>
<tr>
<td>■ Falls are the most common cause.</td>
</tr>
</tbody>
</table>

Context for injury and prevention

The main source of knowledge for the reasons why a shaking injury occurs is from confessions by a perpetrator when confirmed by radiology or post mortem findings. This knowledge is reflected within the social situational understanding of physical child abuse where a consensus of opinion is that it is a loss of control, rather than an intentional violent action, that results in shaking and impact injuries to a babies' head. In susceptible carers, persistent crying is one recognised trigger for shaking. See Box 1. Many of the explanations given by parents for the injuries in the subdural study related to unsafe child care practices, faulty use of nursery and transport equipment. These observations influenced the design of this research through an understanding of failure to protect a baby's head both from accidental and non-accidental injury.

A theoretical perspective of prevention finds a range of options for prevention from macro system, actions of a political and legal nature – for example, it is against the law in Scotland to hit a child across the rear. These findings are supported by the fact that in the UK, it is against the law for a baby to be shaken. In the USA, a hospital-based post-natal education intervention for mothers claimed a 47% reduction in cases of abusive head trauma admitted to hospitals over a 5.5 year study period. In New York State, it is now mandatory to inform all new parents of the dangers of shaking a baby as a timely reminder of earlier public awareness initiatives, a situation not matched in the UK. It is understood that education on its own cannot be expected to prevent the most complex of cases, since the causes of physical abuse are multi-factorial and not isolated to one determinant. In shaking injuries, for example, causes range from unsafe handling practices, parenting behaviour and violent action. However, reaching the general population of new parents in the UK with prevention interventions is likely to reduce cases.

The research premise from this background review is that preventing accidental and non-accidental head injury in babies works because parents may not know about the dangers of shaking and impact injuries to babies' heads, and they can learn this and be supported to act preventively.

Method

The study aims were:

■ To find out health visitors' perceptions about the barriers and facilitating factors for preventing accidental and NAHI
■ To develop intervention strategies to protect babies' heads from shaking and injury.

The research design

The study complied with research governance in having ethical committee and NHS trust research committee approval. All participants gave written informed consent. Semi-structured interview schedules reflecting the research aims were designed for focus group use. The data were collected by two moderators using a guide for consistency. Each focus group had an observer using a notes schedule to monitor the progress. The views of 22 health visitors in three focus groups were collected. This method was repeated with six further focus groups of mothers and fathers and is reported elsewhere.

Sample

Health visitors were recruited from across the geographic and social range of practice in a large South Wales NHS trust to give...
Box 4. Barriers to working preventively

1. Service and training barriers
   ▪ Lack of time, knowledge and skills
   ▪ Poor teamwork and lack of professional resources
   ▪ Audit problems
   ▪ Lack of regular updates of child protection learning
   ▪ No strategy related to clients’ learning needs
   ▪ Lack of a standard and a policy to integrate head protection.
2. Hard to reach parents
   ▪ Fathers who are marginalised by lack of groups to attend
   ▪ Parents who are illiterate or disinterested in reading about health
   ▪Transient groups of travelling people and frequently relocating families
   ▪ Parents who avoid the health visitor’s home visit or fail to attend clinics.
3. Cultural differences
   ▪ Traditional cultural behavioural practices are sometimes unsafe
   ▪ Wider family influences can be more powerful than the safe message
   ▪ Ignorance, poverty and depression as barriers to listening to health messages.

Findings

Five key areas provided a structure for the findings. The participants’ words are indented in italics as examples of the attributes and debates about these themes.

1. Lack of knowledge
2. Prevention
3. Effectiveness
4. Barriers
5. Facilitating factors.

1. Lack of knowledge to prevent head injury

As part of the development of a self-learning toolbox Protecting babies’ heads, all health visitor participants had reviewed a draft copy of this tool. Their views on its applicability to practice were sought. They felt that for themselves and many parents, more information would be beneficial.

The questions pulled me up. As a mother myself no one had stressed this problem to me at all. Personally I had a real screaming baby, dreadful, how very near I came to shaking her. (FG2HV1)

The learning tool fulfilled its aim of passing on knowledge and was revised from the health visitors’ suggestions to make it more accessible for practice with parents antenatal- and in the first six months of life.

Yes, great (the toolbox). I don’t think that parents realise. You reminded me about the neck bones and the damage it can cause. You don’t realise the damage that you can do to the head. It could be very useful. (FG1HV1)

2. Understanding prevention in practice

The aim of discussing prevention of shaking and head injuries with every new parent, to achieve universal prevention coverage, was seen as achievable. Although prevention was difficult to define, four attributes were described, and as child protection was involved, sensitivity was needed. See Box 2.

If we had a handout describing what your health visitor does and it says that we promote health, I think at some point probably that it should be written in there delicately that we actually deal with child protection issues because that is an area where we are quite reticent to discuss with mothers, but I feel that it is important that they are aware of it. (FG1HV2)

Being aware that prevention includes coping with stress and sharing this with parents was common to many, and was thought to be an acceptable strategy, especially if introduced when discussing managing a crying baby:

It only takes that one time for a parent to lose it. Everybody can be really vulnerable if a baby cries continually, regardless. I think as long as we teach parents to cope with that, for instance, don’t be frightened to put them in the cot and leave them. (FG1HV3)

3. Effectiveness: audit and evaluation

Making head protection the norm

The Parent Held Child Health Record (PHCHR) was thought to be the best vehicle to reach all new parents with information on protecting babies’ heads. Discussion focused on an insert for the record, which would personalise the delivery, encourage reinforcement and assess recall of information. It would also bring the idea into the public domain, making giving this information the norm, to help overcome any associated taboo and remove a sense of blame.

I think it needs to be included (in the PHCHR) and aimed at everybody. Maybe parents feel then that when you are talking about child protection, child abuse, you are not singling them out, putting them in a category, but talking about heads, how easy it is for a baby to have a head injury. (FG1HV4)

Assessing impact

How would it be known that any good was being done? Audit means were suggested to assess universal coverage, but this raised uncertainties. See Box 3. Does signing to say information has been received make a difference? How would it be interpreted? How long might any impact last?

I just wonder if parents would feel a bit threatened – sign here that you have received this information and if anything happens to your baby... (FG1HV5)

Some health visitors questioned how practical it is to evaluate hazard reduction for accidents or to assess parent use of written information.

That is an ongoing problem in the area in which we work. Because it is qualitative it is quite a difficult thing to measure. (FG3HV1)

Further discussion with the moderators gave rise to some means of evaluating effectiveness after delivering prevention information to parents.

Subsequently, a question could be asked: Did that help at all? In what way?

Ask mothers if they passed the information on to fathers, and the response?

Observe and record a change in a mother or father’s behaviour, eg response to a crying baby, or better support of the head and an under-
Standing of why.

- Observe negative responses where, for example, depression is impeding learning.

When to assess?

Participants described an empathic health promotion model as a process that begins with the first new birth visit where parents are informed about priorities, such as cot death prevention through risk reduction, and are supported to achieve this. However, the timing of assessing impact of interventions presented difficulty, as no one point in time in the process could be identified for generic use. The participants’ experience was that providing important health messages took priority over evaluating effectiveness because of this limitation. It was suggested that an independent inquiry to evaluate the intervention could provide a baseline for practitioner evaluation.

4. Barriers to working preventively

Participants identified stumbling blocks to universal implementation of preventing both accidental and non-accidental head injuries. These barriers related to areas of management and training, hard-to-reach parents, and cultural differences in how clients care for their babies. See Box 4.

It was observed that these barriers defined groups at risk of missing out on receiving the intervention who may be the people who most need to reach. For example, 75% of cases of NAHI were caused by male carers in the subdural study and this is a group described by health visitors in this research as marginalised in receiving preventive care.

5. Facilitating factors to working preventively

Professional facilitating factors related to desirable strategies. See Box 5. These included the delivery of health messages aided by a structured approach such as a care pathway, shared within and between disciplines as in domestic violence interventions, with additional time for home visits.

I agree with the time aspect. Especially in the area I work we call it fire-fighting; most of the time we are reactive rather than being proactive and that frustrates me because I would like to do more proactive work but it takes time. (FG1HV5)

In health promotion, ambitions were for access to resources for all health visitors, more group working and a model of focused health promotion topics applied equitably and able to be evaluated.

This would be more targeted health promotion, which I would love to do. This is what health promotion is and so I think it is fantastic. That would be the ideal way of tackling public health. (FG1HV6)

Equitable care did not mean universally applied interventions being spread too thinly to be effective with the more vulnerable, but included using risk assessment within universal prevention to identify those needing more concentrated attention.

Facilitators for parents

First-time parents were described as the most receptive to learning. In the health visitors’ experience, mothers passed information on to fathers, who could be difficult to involve directly. Some parents might not find it easy to understand the idea of prevention. Examples of reducing the risk of injury, using everyday baby care activities, were thought to be helpful with simultaneous public awareness from posters and leaflets.

Health visitors wanted national standardisation of the toolbox parent information on head protection for use in the PHCHR to empower an equitable service. Research has found the PHCHR is used by a high proportion of all mothers throughout the UK although the few mothers who did not use it were from more disadvantaged backgrounds and use by fathers was not included in the research. To be universal, coverage would have to consider these points.

Participants described the need to cultivate a more collaborative approach to prevention with mothers and fathers, a two-way process, along with deciding who is the most vulnerable for priority.

Box 5. Facilitating strategies

1) Professional
- Practice guide with standard definitions and audit section
- Using existing work patterns and a team approach
- Inter professional collaboration with shared tools
- Sharing the process of information giving and use of resources.

2) Parents
- A tool that teaches individuals and can be used in practice was valued
- Learning could be facilitated by going over written information with the parent
- Combining this with a home visit provides the opportunity to raise all issues.

3) Service
- Early intervention is essential in collaboration with midwives and reinforced at the new birth visit and on subsequent births
- Groups such as fathers who may slip through the net of universal coverage need addressing with new skills
- Time to work proactively needs to be sanctioned in policies and standards.

Service facilitators

Economic aspects of prevention

Parents value quality materials which need costing. Time is also needed for professionals to prepare to answer questions and reflect on appropriate communication skills for individual cases. Participants thought these costs could be found by reviewing current interventions and choosing head protection as a priority.

I think looking in depth at what visits we do and see if the benefits of doing this will outweigh maybe something else we do, or it may die away. (FGHV2)

Timing of intervention: pre or postnatal?

The earlier information to parents on protecting babies’ heads was given, the better informed parents would be to act preventatively at a baby’s most vulnerable age for head injuries. The view was that the prenatal period was ideal, but debate ensued as to how possible this was with a stretched midwifery service and with health visiting being selective rather than universal in the antenatal period.

The postnatal period was seen as a good time for health visitors and other community staff to reinforce messages given earlier. Working fathers were more likely to be seen at new birth home visits than at antenatal clinic, but the new birth visit was busy and memory dense. Consideration was needed, in terms of caseload and staffing, of a separate visit for this prevention intervention, perhaps combined with the cot death prevention programme.
but currently vulnerable to fragmentation. In relation to physical abuse, of which NAHI is one type, it is generally recognised that attempts to target prospective abusers is ethnically challenging. This is due to the low prevalence of abuse and the lack of precision in knowledge about risks for abuse. Great caution should be exercised in claims to predict risk in child abuse.26,27 Although targeting scarce resources to families where there are dysfunctional relationships, poor interfacial interaction and known violence is a necessary economic risk strategy to prevent child abuse, specific risk assessment in relation to NAHI is rarely carried out. This means that prevention may well not be targeted and intervention not provided to protect a child from head and shaking injury. Taking into account the positive power of building resilience to improve risks, services which reduce risk for head injury, in all its forms, and therefore attempt to protect prior to injury, seem to offer the best chance of prevention. In this research, health visitors were clear that they could integrate head protection messages into their usual dialogue with parents about home safety and managing crying babies. Despite being difficult to articulate, this research has added to an understanding of prevention in health visiting as being:
- Ambitious but achievable;
- Dynamic and responsive to need;
- A process, and therefore difficult to evaluate.

Health visitors saw the ability to work preventively affected by external aspects of a social and cultural nature and internal aspects of time, available resources and lack of a fully-staffed workforce. These caveats add a realistic perception to the concept of prevention. Theoretically, an empathic approach to prevention was demonstrated in that before discussing the prevention of head injury with parents, the views of mothers and fathers on the subject needed to be understood, as well as the resources available to them and how they see the health visitor’s role in health promotion and child protection. It may take many changes from committed individuals to develop good practice in preventing shaking and head injuries, especially with fathers. A champion for fathers in each area is a model to consider.

The transferability of this research is limited but a generalisation can be made that prevention of shaking and head injuries in babies cannot be an effective universal service unless fathers are included and staff have appropriate knowledge, skills and time to deliver such work.

References
1 Coles L, Kemp AM. Cues and clues to preventing shaken baby syndrome. Community Practitioner 2003; 76(12): 459-63
6 Magregor DM. Accident and emergency attendances by mothers and fathers. A champion for fathers in each area is a model to consider.

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With a better taste and adapted nutritional profile, **Nutramigen 2** provides a solid base to meet the challenge of weaning infants with cow’s milk allergy.
Health visitors’ and school nurses’ perspectives on child protection supervision

Abstract
Recent child abuse inquiries have cast doubt upon the quality of safeguarding children work provided by front-line agencies. These inquiries, the associated public outcries in addition to the Department of Health on-going audit of child protection services, have led to scrutiny of the supervisory service provided. This scrutiny has included the supervision of health visitors and school nurses. A literature review demonstrated a dearth of published research into health visitors’ and school nurses’ perspectives of child protection supervision. A focus group approach was utilised to study this phenomenon. Focus groups are a qualitative technique that can be used to obtain data about feelings and opinions. They can provide access to tacit, previously un-coded and experiential knowledge.

Findings from the six health visitor and five school nurse participants demonstrated that they require child protection supervision to be a challenging and sensitive area is known to increase practitioner’s anxiety levels. In order for practitioners to function effectively, these feelings need to be constructively contained. A literature review was therefore undertaken to consider what these key practitioners perceive to be the purpose and value to them of child protection supervision.

An extensive literature review failed to locate published research into how these practitioners perceive child protection supervision. If, as discussed, these practitioners are crucial to the safeguarding of children, then there is a need to consider their perception of the supervisory service provided.

The literature on child protection supervision suggests that regular proficient supervision helps practitioners manage their stress. This then leads to a more accountable practitioner, with supervision being described as the vehicle to enable the sharing of good practices. Therefore, supervision needs to be of a quality that meets the needs of the practitioner, the organisation and ultimately the clients to whom practitioners owe a duty of care. Unfortunately ‘regular’ and ‘quality’ supervision are not defined in the published literature.

The need to be accountable for practice has never been more evident than following the public outcry after the death of Victoria Climbié. The report on her death led to the then Chief Nursing Officer, Sarah Mullally, reiterating the need for nurses to accept this and be held professionally accountable. She highlighted the need for front-line professionals to be supported by appropriate specialist services. This included the need for supervision that would enable and support the worker in taking responsibility for being an advocate for vulnerable families.

Supervision is provided by organisations in recognition of the effect working with concerning families can have upon the practitioner. Currently there are no nationally-agreed policies in health regarding the model of child protection supervision to be utilised, only agreement on how necessary it is to the safeguarding of children. Authors on child protection supervision call it the ‘cornerstone’ of effective safeguarding.

Despite there being acknowledgement of the need for good quality supervision there remains confusion as to its purpose. Academics and practitioners continue to confuse clinical supervision with specialist child protection supervision. Both types require the supervisor to be skilled in supervising practitioners. However, clinical supervision does not require them...supervision needs to be of a quality that meets the needs of the practitioner, the organisation and ultimately the clients to whom practitioners owe a duty of care.
that participants were comfortable with the process and able to speak candidly about their perception and experiences.10

Nineteen health visitors and school nurses were identified as eligible to participate. Eighteen expressed an interest, 11 of whom were able to attend on the arranged date. Of these, six were health visitors and five were school nurses. All participants received one-to-one supervision, from a trained child protection supervisor, on a three-monthly, planned basis. Their experience as community practitioners, ranged from a few months to over 30 years. All work with children and families of concern.

**Method**

All health visitors and school nurses employed by the primary care trust, except those directly supervised by the author, were invited by letter to participate. Practitioners supervised by the author were excluded to prevent, as far as possible, bias in their responses. Along with the invitation, practitioners received an information sheet, a consent form and an outline of their required participation. The right not to participate was also fully explained. Informed agreement was essential to ensure capable of generating data on feelings and opinions.7 It allows participants to appreciate one another’s views, thus generating new information.10

The aim of this study was to appreciate how health visitors and school nurses perceive child protection supervision. The objective being to ensure that the supervision provided locally is based upon identified needs and not just perpetuation of what already happens.

**Table 1. Focus group questions**

1. What effect does child protection supervision have upon you personally?
2. What do you see as the purpose of child protection supervision?
3. Are you aware of what your fellow practitioners feel is the purpose of child protection supervision?
4. Safeguarding children and families can evoke stressful emotions in some practitioners. What, in your opinion, can the organisation do to support practitioners?
5. As a key health practitioner how do you feel child protection supervision could be improved?

**Table 2. Categorising raw data**

1. Establish categories based on content
2. Compare each category for integration into a unified role
3. Examine the properties for underlying uniformity that may reduce the number of categories
4. Produce analytic memoranda to summarise the theory.

**Table 3. What effect does child protection supervision have upon you personally?**

<table>
<thead>
<tr>
<th>School Nurses</th>
<th>Health Visitors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focusses you</td>
<td></td>
</tr>
<tr>
<td>Helps to prioritise work</td>
<td>Time consuming but necessary</td>
</tr>
<tr>
<td>Improves practice</td>
<td>Valuable</td>
</tr>
<tr>
<td>Helps me learn</td>
<td>Time for reflection</td>
</tr>
<tr>
<td>Requires protected time and organising</td>
<td>Opportunity to discuss families of concern</td>
</tr>
<tr>
<td>Time consuming but worth it</td>
<td>Not just for families on the register; can discuss issues of concern to them</td>
</tr>
<tr>
<td>Opportunity to offload</td>
<td>Lots of additional paperwork</td>
</tr>
<tr>
<td>Stops my head from spinning</td>
<td>Useful to debrief with an experienced person</td>
</tr>
<tr>
<td>Provides moral support</td>
<td>Stops me taking concerns home</td>
</tr>
<tr>
<td>Ensures you are functioning at correct level</td>
<td>Bonus, as it provides us with an expert to learn from and with</td>
</tr>
<tr>
<td>Keeps me focused and aware</td>
<td>Opportunity to talk through work</td>
</tr>
<tr>
<td>Helps me learn and develop</td>
<td>Support in decisions</td>
</tr>
<tr>
<td>Influences me in my decision-making process</td>
<td>Keeps me focused and aware</td>
</tr>
<tr>
<td>Helps me learn and develop</td>
<td>Support in decisions, offers alternatives</td>
</tr>
</tbody>
</table>

**Study design**

The benefits of a group interview were felt to outweigh the benefit of individual interviews; groups often generate more discussion.7 Therefore, the research design best suited to this study was a focus group interview. From the outset, the potential to drift into conversations needed to be considered.8 Open-ended questions were formulated, as these prevent drift and ‘can produce unexpected or unanticipated answers’; p.272. Semi-structured questions strike a balance between allowing richness of discussion and not censoring the conversation.11

The questions were formulated with the support of the university and the local peer review body. They were designed to provide flexibility with questions being asked in sequence so as to develop and build upon the participants thought processes.7 The questions asked are recorded in Table 1.

Primary data were collected on audiotape, transcribed utilising coded names for each participant and returned in hard copy for each participant’s approval. Participants were aware of only their own code name. Individual permission was sought to include any data provided, including identification of designations.

Raw data were categorised and thematic analysis undertaken. The findings were then presented back to the participants for validation, accuracy and to allow for any additional comments. The process for categorising data followed an adaptation from Polit et al.9 See Table 2.
Consideration to ensuring that the research was ethically sound was given from the outset. This included ensuring that the work was necessary. The literature review highlighting the gap in nursing knowledge around health visitors’ and school nurses’ perception of child protection supervision meant that the time taken on this subject was ethically justifiable. Conversely, child protection supervision, having no standard format nationally, has meant that the research undertaken is limited in its generalisation. Ethically, the need to know if the service provided locally met the needs of practitioners outweighed any ethical dilemmas.

Ethical consideration was given to the questions being asked. They were open and did not pre-suppose answers. The questions were supplied prior to participation in the focus group to provide participants with the opportunity to reflect upon them individually or in teams prior to interview.

Ethical approval was sought from the primary care trust (PCT), the university and the local and national research bodies. The national research ethics committee had much deliberation regarding the sensitive subject matter; the university’s research and governance department and the local research peer review body struggled with the difference between clinical and child protection supervision. Following written and verbal submission to the ethical committees, permission to proceed was granted.

Model of supervision utilised
Locally, supervisory sessions are a one-to-one structured process that provides an opportunity to discuss openly families of concern, as well as children and families on the child protection register. Time is given to consider difficulties or successes occurring between the three-monthly mandatory sessions. With consideration being given as to how this work makes the practitioner feel. Sessions also incorporate discussions on training and any identified gaps in knowledge.

Results
The focus group interview generated much discussion around each question. Results are illustrated verbatim in Tables 3 to 7. In Table 3, 5 and 7, the results have been split into responses from health visitors and school nurses.
school nurses to allow the reader to consider similarities and differences between the two professional groups.

Findings
Table 3 illustrates that the overwhelming consensus from participants was that supervision, while time-consuming, is essential, as practitioners ‘need to feel safe, in order to function effectively’ (HV5). Practitioners clearly expressed the need for support and mediation. As well as naming vision, namely, education, management, the previously identified purpose of supervision, while time-consuming, is essential, as practitioners ‘need to feel safe, in order to function effectively’ (HV5).

Table 4, the majority of practitioners referred, with the remainder agreeing, to the previously identified purpose of supervision, namely, education, management, support and mediation. As well as naming the four published categories, participants provided additional responses as to the purpose of supervision. However, on analysis, these sat comfortably within the published categories.

Table 5 illustrates participants’ views about how fellow health visitors and school nurses viewed child protection supervision. The key message from the health visitors was summed up aptly by HV1, who stated that health visiting colleagues found supervision to be ‘a threat and a bonus all in one.’ The threat being that work was closely scrutinised but, as acknowledged in Table 6, this is regarded as non-punitive. School nurses generally regarded supervision as an opportunity to focus upon their work, with several describing the need for a training pathway or competency framework to support them in their development.

Table 6 illustrates how participants felt the organisation was already supportive of them in their role of safeguarding children. Participants took the opportunity to highlight areas where they felt the organisation could consider improvements. In relation to child protection supervision, they felt that the organisation delivered them a good service, with training and accessibility to guidance made available to support their development. However, participants felt that child protection documentation and clerical support needed more consideration from the organisation. Question five was somewhat misinterpreted. Participants, as can be seen in Table 7 illustrated areas where participants felt safeguarding children workload could be improved. A recommendation for improving supervision taken forward was to have strict time-limited sessions. Strict two-hour sessions are allocated with additional sessions arranged if more time is required.

Considering the transcript as a whole, there were emerging themes that require additional research and consideration by the PCT. These were:

- The opportunity to consider team-based child protection supervision across disciplines, in addition to one-to-one supervision.
- The organisation to utilise the framework for the assessment of children for all routine assessments of children and their families. This is being taken forward by the universal children and young peoples services.
- Closer links between new practitioners, mentors and child protection supervisors. Consideration is being given to implementing a formal support contract between all parties including line managers.

Participants were keen to point out that child protection supervision was challenging, and that work was scrutinised ‘under the spotlight’ (both HV and SN terminology). This was not seen as a negative comment; experienced and less experienced practitioners stated that ultimately reflecting upon their work in a safe environment was a positive experience.

The need for additional clerical support to type reports for child protection conferences was highlighted on a number of occasions. However, the reasons for this were not explored in this study.

Discussion
In this study, a concerning gap in training was highlighted by school nurses, namely their lack of general paediatric training. The participants felt this added to the stress associated with safeguarding children, particularly when new in post as a school nurse. Locally, school nurses have the same central role in safeguarding children as health visitors. Therefore, they have the same access and rights to child protection supervision. This was the rationale for both designations being invited to participate in this study.

The school nursing service and its safeguarding role currently has a high profile with central government; training and development of the service being seen as key to the modernisation agenda. As a consequence of this study, additional
Table 7. How can child protection supervision be improved?

<table>
<thead>
<tr>
<th>Health visitors</th>
<th>School nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Debriefing after difficult visits</td>
<td>Consideration to be given to routine transfer into school nursing and a competency framework leading into safeguarding work</td>
</tr>
<tr>
<td>Making sure someone is in the office after conferences to discuss any concerns</td>
<td>Closest links between new practitioners, mentors and child protection supervisors</td>
</tr>
<tr>
<td>Clerical support</td>
<td>Protected time</td>
</tr>
<tr>
<td>Group supervision around cases</td>
<td>Moral support</td>
</tr>
<tr>
<td>Post child protection conference support from colleagues and supervisor, face-to-face contact preferable</td>
<td>Clerical support with report writing</td>
</tr>
<tr>
<td></td>
<td>Strict time limited session.</td>
</tr>
</tbody>
</table>

According to several participants, as well as challenging practice, the role of the supervisor is to help the nurse to make the ‘right decision’. Solum and Schaffer in their study of six Minnesota public school nurses, recorded that school nurses resolved their problems in a variety of ways and did not formally utilise a decision-making model. However, Schaffer et al stated that nurses would feel less stress if they utilised a decision-making model in their work. All participants discussed how the supervisor aided them in their decision-making, with one school nurse reminding colleagues that ‘you need to feel safe, and know the ground rules, particularly with difficult cases’ (SN4). Participants did not overly identify the use of a decision-making tool to resolve difficulties. However, after analysing the data, practitioners do appear to utilise a decision-making model, even if they do not perceive it as such.

The results demonstrate that participants utilise a decision-making model identified by Heron. Heron’s decision-making model utilises the four principles of autonomy, non-maleficence, beneficence and justice in making their decisions. Examples of this model being utilised can be seen in the following:

**Autonomy** – to be self-governing. This is seen by practitioners as needing to have an expert practitioner listen to their concerns, to provide feedback both positive and negative, and to acknowledge the difficulties they have in their day to day work.

**Non-maleficence** – to avoid inflicting harm. Practitioners, in this study, valued the opinion of an experienced colleague who was able to discuss policies and procedures and offer an expert view on complex situations. One very experienced health visitor described the time before she received child protection supervision as stressful, but more productive now that a supervisor’s advice could be sought on procedural issues (HV3).

**Beneficence** – to promote good. Participants wanted to discuss, in a safe environment, different methods and to consider alternative approaches with clients, other agencies and colleagues.

**Justice** – to live up to what is acceptable. Participants wanted to learn as much as possible to ensure that clients received the most appropriate advice. They also wanted to ensure that colleagues were well supported in hostile or difficult cases.

According to researchers Levitt and Taylor, models for justifying decisions are always present in nurse’s decisions on complex child abuse or neglect cases. Future research should give consideration to child protection supervisors making decision-making models more explicit to practitioners to enable them to articulate their judgements more readily.

**Strengths and limitations of the study**

The strength of this focus group was that participants gave freely of their opinions. The limitation is that while it has given access to tacit, experiential information, it is impossible to generalise the data to other PCTs as there remains no comparable model of child protection supervision reported in the literature. This is despite several high profile child abuse inquires which have highlighted the need for frontline health practitioners to receive effective supervision.

Use of a focus group capitalised upon practitioners’ wide range of experiences. This focus group consisted of a ‘small homogenous group purposefully selected to address a specific topic’ p342. The strength of the study was that it gave the opportunity to reflect on the service delivered in one specific PCT. As discussed previously, the limitations are that lessons are not easily transferable.

To verify responses, a transcript of the group interview was returned to all participants; according to Robson this adds to the credibility of the study by providing participants with the opportunity to validate their responses. Unfortunately, the limitation is that the data relate to health visitors and school nurses only. It does not consider other designations involved in child protection supervision. The PCT studied now needs to consider the child protection supervision service it provides to other discri-
In this qualitative study, practitioners’ believed that child protection supervision was of real value to them, providing that management acknowledge that it is time-consuming.

Health professionals are often the first to identify safeguarding issues in families. The findings have been carefully considered in context, in order to evaluate the child protection supervision service. Practitioners in this study identified the need to be supported and have the opportunity to discuss families of concern to them. Brandon et al, in their analysis of 20 serious case reviews, concluded that: ‘Practitioners who are well supported, receive supervision and have access to training are more likely to think clearly and exercise professional discretion,’ p174.

The findings from this study demonstrate that the practitioners’ perception of supervision is that their needs are similar to the ones identified above and are currently being met by the model for supervision utilised locally. However, we cannot be complacent about key practitioners’ needs and must continue to seek best practice.

Further work is required into provision of child protection supervision nationally. This needs to include what makes practitioners feel safe and supported. Besides a safe environment, participants focused upon the need for supervision to be challenging, with the teaching/learning element clearly appreciated.

Further research is required into the impact child protection supervision has upon practice and how often supervision should take place. However, the biggest unanswered question is whether there should be a national standard in health for child protection supervision. This would allow researchers to compare and contrast different areas, ensuring that this ‘essential’ service is grounded in theory and best practice.

References

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How can she still love him? Domestic violence and the Stockholm Syndrome

Introduction
Stockholm Syndrome is recognised as a psychological phenomenon, where hostages identify and ally with their captors. Graham et al suggested that the Stockholm Syndrome experienced by hostages provided a useful model for understanding the experience and behaviour of women living with domestic violence. It shows that the psychological characteristics often observed in these women result from being in a life-threatening situation and are not pre-existing characteristics that may have contributed to the violence. It also illustrates how the power imbalance between abusers and victims/survivors can result in strong emotional bonding. Research has shown that the effects on women include low self-esteem, dependence upon the perpetrator, feelings of hopelessness about ending the violence, a tendency to minimise or deny the violence.

The bond between hostage and captor, or woman living with violence and perpetrator
It has been observed that victims of abuse, whether children or adults, can become locked into a strong alliance with their abuser, defending them against criticism and denying the abuse. The authors are often asked to explain such seemingly bizarre and inexplicable behaviour by women living with domestic violence: ‘Why does she defend him?’, ‘How can she still love him after what he has done?’, ‘Why doesn’t she leave?’, ‘Why doesn’t she accept our help?’

When developing domestic violence training packages, we needed to examine, illustrate and demystify this psychological bond between a woman living with violence and the perpetrator. We examined the parallels between the Stockholm Syndrome and domestic violence and used this as a training tool.

In Stockholm in 1973, two bank robbers held three women and one man hostage for 131 hours. After their rescue it became apparent that the hostages were not responding in the way that others expected. They showed support for their captors and shielded them from the police. Afterwards, they refused to testify against them, raised money for their defence and even visited them in prison. This phenomena was named the ‘Stockholm Syndrome’ by the media. Now it is a recognised coping mechanism used by people in hostage situations. It can also be used to understand the ‘bonding’ that takes place in other situations, for example, prisoners of war, abused children, cult members and people living with domestic violence.

The Stockholm Syndrome...is a way of disassociating with feelings of anxiety, fear and helplessness by seeing the situation almost through the eyes of the abuser

Key words
Stockholm Syndrome, domestic violence, training

Acknowledgements
We would like to thank all the survivors of domestic violence who shared their stories with us.

Abstract
Working with women living with domestic violence has always been a sensitive and potentially stressful issue for frontline workers. It is essential that workers have a good understanding of the impact that living with domestic violence has on women and that they identify some positive ways to work with women living with domestic violence if they are to feel confident when dealing with this topic.

Stockholm Syndrome is recognised as a psychological phenomenon whereby hostages identify and ally with their captors. This article explores the parallels between this syndrome and domestic violence and explains why women living with violence often behave in a way that seems bizarre to an onlooker. Then it identifies how this can be used in a training context to enable participants to be able to work more effectively with women living with domestic violence.

Pat Wallace BSc RGN RHV
Breaking Free
Independent domestic violence consultant and trainer

How can she still love him? Domestic violence and the Stockholm Syndrome

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Key words
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The Stockholm Syndrome describes the emotional bonding that takes place between the hostage and captor or the woman living with the violence and the perpetrator. It is a way of disassociating with the feelings of anxiety, fear and helplessness by seeing the situation almost through the eyes of the abuser. Therefore, it is a subconscious part of a survival strategy. The victim involuntarily knows the extent of the problem but believes they desperately need the abuser for their survival. The more dysfunctional the situation becomes, the more dysfunctional their thoughts of survival become.\(^3\)

The hostage perceives that their captor totally controls their life and could kill them. In a domestic violence situation, the perpetrator makes the woman believe this by direct or indirect means. He can be physically abusive to the victim or other family members, or can damage property in front of the victim. Threats and emotionally damaging comments also indirectly endanger survival. These can include threats about the consequences of leaving, to commit suicide or to harm the victim. Degrading remarks and manipulative comments such as: ‘You are mad/stupid/useless’ may erode the woman experiencing abuse sense of self until she has little concept of herself as an independent being.

### Perceived inability to escape

The captive believes that they are unable to escape

Likewise, in a domestic violence situation, the woman believes that she is trapped, although to an outsider there may seem to be no reason why she cannot leave/escape. She may believe that she cannot financially survive on her own because she has no money and has had no control over family finances. She may have been threatened that ‘I will find you if you leave and kill you’ or ‘I’ll keep the children if you go’. She may feel too guilty to leave because she has been told ‘I’ll kill myself if you go’ or ‘You are depriving the children of a father.’ The loss of self-esteem and confidence that comes with experiencing psychological abuse may also make the survivor believe that there is no escape. Depression, too, may contribute to this.

### Isolation from perspectives other than that of captor/perpetrator

#### Perceived extreme threat to physical or psychological survival

The hostage perceives that their captor totally controls their life and could kill them. In a domestic violence situation, the perpetrator makes the woman believe this by direct or indirect means. He can be physically abusive to the victim or other family members, or can damage property in front of the victim. Threats and emotionally damaging comments also indirectly endanger survival. These can include threats about the consequences of leaving, to commit suicide or to harm the victim. Degrading remarks and manipulative comments such as: ‘You are mad/stupid/useless’ may erode the woman experiencing abuse sense of self until she has little concept of herself as an independent being.

### Perceived inability to escape

The captive believes that they are unable to escape

Likewise, in a domestic violence situation, the woman believes that she is trapped, although to an outsider there may seem to be no reason why she cannot leave/escape. She may believe that she cannot financially survive on her own because she has no money and has had no control over family finances. She may have been threatened that ‘I will find you if you leave and kill you’ or ‘I’ll keep the children if you go’. She may feel too guilty to leave because she has been told ‘I’ll kill myself if you go’ or ‘You are depriving the children of a father.’ The loss of self-esteem and confidence that comes with experiencing psychological abuse may also make the survivor believe that there is no escape. Depression, too, may contribute to this.

### Isolation from perspectives other than that of captor/perpetrator

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view, because she too is isolated and has no-one with which to discuss her situation or to offer an alternative view. She begins to identify and ally with the perpetrator ‘against the rest of the world’. She may believe his view that the authorities are actually ‘the enemy’ and are more interested in punishing him or removing her children than protecting her from his abuse.

Intense feelings of gratitude toward the captor
‘A person whose survival is threatened perceives kindness differently from a person whose survival is not threatened. For example, a small kindness – one that ordinarily would not be noticed under conditions of safety – appears huge under conditions of threat and/or debilitation.‘

They may be grateful that they have been allowed to sleep, haven’t received a beating, or haven’t been killed.

Likewise, the woman becomes increasingly grateful to the perpetrator for the abuse not being as bad as it could be. It gives her hope that the situation will improve and instils a belief that the perpetrator is not a totally bad person really.

Captive rejects offers of help or rescue, which they perceive could aggravate the captor
Hostages and victims/survivors fear interference by authorities, as they believe it may trigger more extreme violence.‘ As the captive’s survival strategy is to pacify the captor, they must demonstrate that they are allied to him. They fear that failure to do so may provoke further violence.

Consequently, the woman may show hostility to outsiders who try to intervene: they are perceived as a threat to the survival strategy that she has in place. Accepting help may aggravate the perpetrator and trigger an escalation of the violence. From this it is possible to understand why woman are often passive or hostile when the police arrive, why they refuse to give evidence, why they won’t leave and why they return.

Summary
In conclusion, Stockholm Syndrome in a domestic violence context describes an unhealthy bond between a survivor and a perpetrator. It is the reason why survivors hope it will ‘get better’ and why they continue to see the good points (the ‘perceived kindnesses’) and to minimise the abuse they have experienced. It explains how the bond often remains after the relationship is over. The characteristics for survival that are taken on by the survivor also disable her from taking action and later from breaking free emotionally from the relationship.

Influencing practice
We have developed this information into an experiential training package, which we have used very effectively with multi-agency and single agency groups over the last three years. It has been particularly effective for frontline community health workers who may not understand why their clients behave in the way that they do. When visiting clients’ homes, these health workers may be faced with what may seem to be bizarre and incomprehensible behaviour by the survivor.

The aims are to increase participants’ understanding of Stockholm Syndrome and its application to domestic violence, and to identify practical ways of working with survivors caught up in this destructive psychological trap.

In the training situation, the phenomenon is explained, then the participants are encouraged to identify the parallels with domestic violence. This assists them in understanding more clearly why women living with domestic violence often behave in unexpected ways. The use of comments that women may make in these situations (as detailed above) often helps participants to identify women living with domestic violence from their own client group.

The participants are then asked to look at how they could positively intervene to remove, reduce or explain the conditions that are necessary for the Stockholm Syndrome to occur. These include:

- Offering alternative perspectives and reframing the ‘small kindnesses’. If the woman is minimising or excusing what is happening to her, to do this by not colluding but gently challenging her and putting the responsibility for what is happening on to the perpetrator
- Working with the woman where she is now – this may be very much enmeshed in the abusive relationship – and not where the worker would like her to be
- Continuing to provide support even if she appears to be colluding with the perpetrator – this may be part of her coping strategy
- Reducing isolation by encouraging her to keep up links with life outside the home if it is safe to do so
- Discussing her safety and that of her children with her.

In these ways, community health workers are able to identify positive ways of working with women living with domestic violence. Using the Stockholm Syndrome in training not only increases community health workers’ understanding of domestic violence; it also helps them to develop strategies for use when working with women living with domestic violence. This increases the community health workers’ confidence and improves the service that they offer their clients.

References
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The Great Grub Club

The World Cancer Research Fund (WCRF) has launched a website to promote healthy eating and the benefits of an active lifestyle for four to seven-year-olds.

Statistics show that on average, children only eat two of their recommended five portions of fruit and vegetables a day, while 92% of children eat too much saturated fat.

The Department of Health-supported website is the first to aim the healthy lifestyle message at such a young age group.

Children who log on to the website can play games, enter competitions and look at fun ways to incorporate physical activity into their daily routine.

The WCRF launched the website in response to warnings from health professionals about the worsening situation with childhood obesity.

Lucie Galice, general manager of the WCRF said: ‘We have got to this stage where the number of children who are obese in this country is really scary, and this is why it is so important to get the healthy lifestyle message to children as young as possible.

‘At WCRF, we are really excited about this website and I hope it is going to play a big part in the fight against childhood obesity in the years to come.’

www.greatgrubclub.com

Kids in the Syndrome Mix of ADHD, LD, Asperger’s, bipolar and more!

Martin Kutscher
Jessica Kingsley 2007

Kids in the Syndrome Mix is a concise and easy-to-read book and thoroughly enjoyable, bringing an unfamiliar world into sharp focus in a compassionate manner.

The focus on the parent, caregiver or teacher is a no-fault approach to empower them to engage positively with the child. It is these people whose observations will inform and assist the diagnostician to identify whether a problem exists. The book highlights challenges and acknowledges limitations in sorting out the syndrome mix. It seeks to guide the reader through complex interactions with children to understand the full range of conditions, so ensuring positive intervention in a child’s life. The importance of promoting best outcomes for children is a theme evidenced throughout the book by Dr Kutscher.

A minor distraction is the author’s definitions and some language that is American-biased. Get beyond this and you find a book that is well referenced, and which will provide the reader with a firm ground for providing evidencing for practice. The author provides helpful practice strategies and recommendations for those actively involved in the care of children with attention deficit hyperactivity disorder, autistic spectrum disorders, learning difficulties and bipolar disorder.

The first two chapters of the book are a ‘must-read’; they provide general principles of treatment, with informative practice examples that are transferable to other aspects of community practitioners’ work.

Kids in the Syndrome Mix does what it says on the cover. It will be a useful ‘one stop guide’ for any community practitioner and will compliment other resources in this challenging spectrum of practice.

Reviewed by: Adrian Spanswick
Nurse consultant, safeguarding children
Leicester City PCT

‘Wives, daughters, grandmothers, aunts, sisters, mothers and nieces – tell your husbands, sons, grandfathers, uncles, brothers, fathers and nephews’ is the message for the new campaign to raise awareness of prostate cancer among African Caribbean men.

African Caribbean men are three times more likely to develop prostate cancer than their white counterparts.

The campaign believes that empowering African Caribbean women with information could put them in a stronger position to talk to the men in their lives about the condition.

The Prostate Cancer Charity is pioneering the campaign by sending 20,000 free postcards to key locations, including beauty salons, social groups and African Caribbean supermarkets.

The charity is inviting women each to fill in a postcard with their address and in return receive a free guide to prostate cancer with contact details for more information, if they know someone who has concerns. For more about the campaign, log on to the website.

www.prostate-cancer.org.uk

www.greatgrubclub.com

Book of the month

The African Caribbean postcard campaign

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www.prostate-cancer.org.uk
Philips and AVENT, a perfect partnership is born

One of the most recognised names in infant feeding has some exciting news about its award-winning products - they've just got even better! AVENT, a name trusted by mothers and healthcare professionals everywhere, has become part of Philips, a household name worldwide.

The newly merged Philips AVENT will ensure its revolutionary breastfeeding products will continue to set new standards for mums who want to give their baby the very best start in life.

Philips AVENT brings together two leading companies that share a common goal to redefine excellence in mother and child health and well-being by always putting their needs first. AVENT has been refining and extending its range of high quality baby feeding accessories since 1984, using the most advanced manufacturing methods of its kind in the world.

Philips is one of the leading electronics companies in the world, a leadership that has been built by its continual drive to look for better ways to improve people’s quality of life through simplicity and innovative product design.

The Philips AVENT range will continue the existing AVENT product designs that mums have grown to love. Furthermore, Philips AVENT’s commitment to working with healthcare professionals will continue so that, together, they can provide the best support and healthcare products available to mothers and their babies.

www.philips.com/AVENT

To find out more please fill in your details below and send to AVENT Professional Forum, FREEPOST Avent London

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PA Community Practitioners, October
CLINICAL PAPERS

New data links infant mortality to gestational age


Babies born at 37 weeks’ gestation are three times more likely to die in their first year than those born at 40 weeks, according to new government statistics linking infant mortality to gestational age. However, infant mortality in this gestation range was still low, at 4.1 deaths per 1000 live births among babies born at 37 weeks and 1.3 per 1000 among those born at 40 weeks.

Gestational age is highly correlated with birth outcomes, including birthweight and infant mortality, but it has never been possible to produce data on gestation-specific infant mortality. However, collation of the data had been enabled by the introduction in 2002 of the NHS numbers for babies service (NN4B), which created a small data set for each baby, including gestational age, and linked this to a new NHS number. Other key findings of the data, which covered all 645,887 live births in England and Wales in 2005 were:

- 7.6% of live births were preterm, under 37 weeks’ gestational age, 88% were born at term, 37 to 41 weeks, and 4% were born post term, 42 weeks and above.
- Infant mortality was highest at the very low gestational ages: 947 deaths per 1,000 live births among babies born at 22 weeks. It then decreased with gestational age to 1.3 deaths per 1,000 live births among babies born at 40 weeks’ gestation.
- Among babies born at 37 weeks and above, the neonatal mortality rate of those weighing 1,500–2,499g at birth was 5.3 deaths per 1,000 live births, as compared to 0.8 deaths per 1,000 live births for those weighing 2,500g and over. For babies born at 37 weeks and above, the post-neonatal mortality among babies with fathers in routine and manual occupations was almost twice that of babies whose fathers had managerial and professional occupations.
- Overall mortality in the first year of life was five deaths per 1,000 live births.

These new statistics, derived by enhancing birth registration data with the newly available NHS Numbers for Babies dataset, fill an important gap in the routine data on births and infant mortality, say the authors.

Maternal diet may affect cleft palate outcome


A diet with high intakes of red meat, processed meat, pizza, legumes, potatoes, French fries, condiments, and mayonnaise, but low intakes of fruits during the preconception period may increase the risk of a child with a cleft palate, a study has found.

Cleft lip, with or without a cleft palate (CLP), is a serious birth defect. To identify maternal dietary patterns in association with either or both conditions in offspring, Dutch researchers conducted a case-control study of 203 mothers of a child with a cleft lip or cleft palate and 178 mothers with non-malformed offspring. Maternal nutritional intakes were assessed 14 months after the birth of the index child to estimate the preconception intake defined as three months before, until three months after conception of the index child.

Two major dietary patterns were identified: ‘Western’ and ‘Prudent’. The Western pattern, eg high in meat, pizza, legumes, and potatoes, and low in fruits, was associated with a higher risk of a CLP. The use of the Prudent pattern, eg high intakes of fish, garlic, nuts, vegetables, increased vitamin B12 and serum folate levels, was not associated with a CLD risk compared with the Western diet.

The authors conclude dietary and lifestyle profiles should be included in preconception screening programmes.

School hearing screening ‘a serious problem’


The lack of good-quality evidence regarding school entry hearing screening (SES) remains a serious problem.

There is evidence of mixed practice and uncertainty about the value of the SES. Also, recent changes in childhood hearing screening policy have implications for the identification of children with hearing impairment at school entry.

To describe and analyse current practice of SES, a postal questionnaire survey was addressed to all SES leads in the UK, considering current practice in terms of implementation, protocols, target population and performance data.

Primary data from cohort studies in one area were examined, a systematic review of alternative SES tests, test performance and impact on outcomes carried out, and a review of published studies on costs, economic modelling of current and alternative programmes prepared.

The results were: coverage of SES, pass criteria, retest protocols and referral rates variable; written examples of protocols often poor and ambiguous; no national approach to data collection, audit and quality assurance; and variable approaches at local level.

Just under 20% of hearing impairments in six-year-olds or older remained to be identified around the time of school entry.

The researchers said services should improve quality and audit screen performance for identification of previously unknown permanent hearing impairment, pending evidence-based policy decisions based on these recommendations.
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Information about adverse event reporting can be found at www.yellowcard.gov.uk. Adverse events should also be reported to Sanofi Pasteur MSD by calling 01628 785291.

Mould linked to asthma

Removing indoor mould from a house can improve asthma and rhinitis symptoms in both adults and children, researchers have found.

Mould is fairly common in British houses and Asthma UK figures show the prevalence of asthma in Wales is among the highest in the world.

To assess whether asthma improves when indoor mould is removed, researchers from Cardiff University conducted a randomised controlled trial. Participants aged 3–61 years in South Wales who reported symptoms of asthma in the last 12 months and indoor mould were randomly allocated into two groups. In half the houses with mould (84) this was removed (using a fungicidal wash to kill any remaining mould) and ventilation improved by means of a fan in the loft. In the other houses, (83) mould removal was delayed for twelve months. Questionnaires were administered and peak expiratory flow rate was measured at baseline, six months and 12 months. At six months, significantly more of the intervention group showed a net improvement in wheeze affecting activities, improvement of breathing, and reduction in medication. By 12 months, the intervention group showed significantly greater reductions than the controls in preventer and reliever use, and more improvement in rhinitis and rhinoconjunctivitis. The results suggest patients with asthma and rhinitis would be well advised to remove mould from their homes, say the authors.

MMR may cause convulsions but not serious neurologic disease

Six to 11 days after the measles, mumps, rubella (MMR) vaccine there is an increased risk of fever and convulsions lasting under 30 minutes, a UK study has found.

Some primary vaccines can induce simple febrile convulsions in young children. Such convulsions are common in childhood, and there is good evidence that those occurring after the MMR vaccine do not increase the risk of subsequent epilepsy. Nevertheless, there is some suggestion that rarely, more serious neurologic disease, may be associated with MMR immunisation. If this occurs, it is most likely attributable to the measles component of the vaccine.

To investigate the risk of serious neurologic disease after immunisation in early childhood, the results of a three-year prospective study of 157 children (2–35 months old) in Britain and Ireland with encephalitis and/or severe illness with convulsions and fever were linked to each child’s vaccine history. No evidence was found of a risk of serious neurological disease 15 to 35 days after MMR immunisation.

However, six cases were identified as having complex febrile convulsions six to 11 days after MMR vaccine. The estimated attributable risk of serious neurologic disease from MMR vaccine was one in 100,000 doses, similar to that found for the measles vaccine by other studies.

IN BRIEF...

Antibiotics still over-prescribed

GPs in the United Kingdom are still prescribing unnecessary antibiotics for a large proportion of patients with minor infections, according to a study.

The study, carried out by the General Practice Research Database (GPRD) the world’s largest primary care database of consultations and prescriptions, assessed antibiotic prescribing in primary care for all consultations between 1998 and 2001 for conditions that might have resulted in a prescription for antibiotics.

The ten most common causes for prescribing an antibiotic identified in the study were: upper respiratory tract infection, lower respiratory tract infection, sore throat, urinary tract infection, otitis media, conjunctivitis, vague skin infections without a clear diagnosis, sinustis, otitis externa, and impetigo, despite the fact that UK guidance recommends against their use for most of these conditions. The authors conclude there remains scope for further reductions in antibacterial prescribing.

Poor sleep among school-entrants leads to behavioural problems

Children beginning school who get little sleep, are more likely to have behavioural and cognitive problems in the classroom, a study has found.

The study, by researchers from the Sleep Disorders Centre at Sacre-Coeur Hospital, Montreal, investigated the associations between longitudinal sleep duration patterns and behavioural/cognitive functioning at school entry. Sleep, 2007; 30(9): 1213-9.

Obesity in pregnancy may cause birth defects

Researchers say that mothers of babies with certain birth defects are more likely to be obese. The reasons for the link with a spectrum of structural birth defects are unknown. But the researchers from the University of Texas, Houston, suggest it may be related to undiagnosed diabetes.

Clinical papers was compiled by June Thompson
Introducing a new generation of taste

Saturday, 13th October 2007
The Lowry Conference Centre, Manchester

Saturday, 20th October 2007
Queen Elizabeth II Conference Centre, Westminster, London

Event Schedule
Noon Registration and lunch
1.00 Introduction and welcome from Fresenius Kabi’s MD
1.10 Malnutrition in older people: GP talk
1.30 Caring for the malnourished patient: dietitian talk
1.50 Creating a balanced diet in a nursing environment: Paul Rankin
2.10 FRESI STEADY COOK Celebrity Cook off
3.00 Meeting close

This meeting is suitable for Dietitians, District Nurses, General Practitioners, Care Home Personnel, Health Visitors & Community Nurses

Register online at www.eventwise.ie or telephone 0845 6022 484
Please register early, as places are limited.
Benign breast conditions in women

Antonia Dean
Clinical Nurse Specialist
Breast Cancer Care

This article describes the management of several of the most common benign breast conditions

Benign breast conditions affect many women in the UK of all ages. For many, diagnosis brings relief that cancer is not present, but this can give way to concerns about what the diagnosis actually means, and whether the risk of cancer is increased.

The ANDI concept
Benign breast conditions are now classified using the ANDI (aberrations of normal development and involution) framework which incorporates the range of changes within the breast from normal to aberration to disease. Breast conditions are categorised as characteristic of one of three phases of breast ageing: early reproduction (15-25 yrs), mature reproduction (25-40yrs) and involution (35-55yrs).1

Diagnosis
Diagnosis may often require referral to a hospital breast clinic. The Department of Health has produced referral guidelines to aid GPs in appropriate referral. See Table 1. Once referred, the ‘triple assessment’ is recommended. This includes:
- Physical examination
- Mammogram and/or ultrasound
- Fine needle aspiration and/or core needle biopsy.

Mastalgia
Up to 70% of women experience mastalgia (breast pain) at some point during their life,4 making it a problem that many community practitioners may encounter in their patients. For some women, breast pain is mild and manageable, for others it is intense and negatively affects their quality of life. In order to ensure the most appropriate treatment is given, mastalgia should first be carefully assessed.

Musculoskeletal pain from the chest wall may sometimes present as breast pain, so it is helpful to determine the origin of the discomfort. True breast pain can be categorised by cyclical and non-cyclical breast pain. To determine this, patients may be encouraged to keep a pain diary, such as the one provided by Breast Cancer Care in its information booklet.5 Cyclical pain may be treated in a number of ways, including:
- Dietary changes, such as reducing caffeine, chocolate and red wine6
- Anti-inflammatory drugs such as ibuprofen
- Changing make of contraceptive pill (if relevant). Severe cyclical breast pain may also be treated with hormonal agents such as danzol or bromocriptine.

Non-cyclical breast pain may be more difficult to treat and interventions such as dietary changes and anti-inflammatory drugs may be suggested. A well-fitting bra may also be helpful. In extreme circumstances, when breast pain is severe and intractable, mastectomy surgery may be considered. Patients may be reassured to know that pain in the breast is not associated with an increased risk of breast cancer and, on its own, is rarely associated with breast cancer.

Fibroadenoma
Fibroadenomas are extremely common, accounting for approximately 13% of all palpable breast masses7, and are thought to develop from the breast lobule. They normally present as a smooth, solid lump and are often movable, earning them the title of ‘breast mouse’. They are most common in women, with an average diagnostic age of approximately 30 years,1 making them an aberration of the early to mature reproductive years. Fibroadenomas can be classified as:
- Common (1-3cm)
- Giant (over 3cm)
- Juvenile (occurring during adolescence).

Once it has been diagnosed, no treatment is required unless the lump grows or becomes painful, when it may be removed surgically.

Table 1. For urgent referral3

- Hard distinct lump which is fixed
- >30 yrs with a distinct lump that is present after next menstrual period or occurs after the menopause
- < 30yrs with a lump, which is growing, has features linked to cancer or family history of breast cancer
- Other changes, such as skin puckering, ulceration, recent nipple inversion (or changes to shape), nipple eczema which does not respond to treatment, bloody nipple discharge.
- Men >50yrs with firm lump in one breast.

For non-urgent referral
- < 30yrs with distinct lump
- Persistent breast pain (with no other symptoms)
- Unexplained, persistent abnormality.
Fibroadenomas do not increase the risk of developing a breast cancer.

Phyllodes tumours
Phyllodes tumours are thought to have some relation to fibroadenoma, but can be seen to differ histologically. They are most common in the mature reproductive phase, occurring most frequently in women aged 35-55. These tumours may be either benign, malignant or borderline malignant. This can be diagnosed on biopsy, where the level of atypical cells and the mitotic rate are measured. The primary treatment for a phyllodes tumour is usually wide local excision surgery to remove the lump and a clear margin of tissue around the lump. It is possible for a phyllodes tumour to recur: in the case of benign tumours, the recurrence tends to benign, but it is possible for a transformation to malignancy to occur. Malignant phyllodes tumours commonly behave like sarcomas, meaning lymph node spread is unlikely.

Their metastatic potential is lower than an ‘ordinary’ breast cancer, but if they do metastasise, the lungs are the most frequent site of secondary disease.

Because of this risk, those diagnosed with either a benign or malignant phyllodes tumour may attend regular follow-up, including mammograms, every two years.

Cysts
During their reproductive years, around 7% of women will develop one or multiple breast cysts. They are often easily diagnosed using ultrasound (as ultrasound is able to distinguish between solid and fluid-filled lumps). Fine needle aspiration will be able to confirm diagnosis, and the aspirate tends only to be sent for cytological analysis if the fluid is blood-stained. Cysts often recur and can be aspirated as often as necessary. It is not thought that a single cyst will increase the risk of breast cancer. Multiple, recurrent cysts may be associated with a very small increase in the risk of breast cancer.

Duct ectasia
This condition is thought to relate to the breast ageing process (during the involution phase), and may often affect women around the time of menopause. Ducts become dilated and shortened and discharge can collect and be expelled. This condition may cause the nipple to retract, giving it a slit-like appearance. A lump may also sometimes be felt, often caused by scar tissue forming in the ducts. Once this condition has been diagnosed, it is possible that no treatment will be needed. If discharge is persistent or copious, breast ducts may be surgically removed. If any infection develops, antibiotics are usually prescribed.

Intraductal papilloma
An intraductal papilloma is a wart-like growth which can form behind the nipple area at any age, although younger women are more likely to have more than one papilloma, whereas women of a menopausal age more commonly present with a single one. Women with this condition may experience discharge of a sticky clear or blood-stained nature. Ducts may be removed if discharge is persistent or to confirm diagnosis if the triple assessment procedure proves not to be conclusive.

In general, intraductal papillomas are benign and are not thought to increase the risk of breast cancer. Exceptions to this rule include papillomas which are associated with atypical hyperplasia (see below) or multiple duct papillomas where clusters of papillomas occur in a focussed area in the peripheral duct. 

Epithelial hyperplasia
In epithelial hyperplasia, the cells in the ducts or lobules of the breast grow both in size and in number. If these cells have developed an abnormal pattern, this is known as atypical hyperplasia. Epithelial hyperplasia is often found by chance in a biopsy or post breast surgery. Most types of hyperplasia are not thought to increase significantly the risk of breast cancer, with the exception of atypical hyperplasia (AH) which is thought to do so by between two and five times the average. A diagnosis of atypical hyperplasia will often require some degree of follow-up such as mammograms every one to two years. Areas of hyperplasia will often be left untreated but surgery may be offered as an option.

Sclerosing adenosis, complex sclerosing lesions and radial scar
These three benign lesions have similarities, although sclerosing adenosis is histologically distinct from radial scars or complex sclerosing lesions. They may present with pain and/or as a hard lump, or as an incidental find on mammography or biopsy. They can be difficult to distinguish from breast cancer and a biopsy or surgery to remove the area is sometimes recommended to obtain a definitive diagnosis. Once a diagnosis has been reached, no further treatment is usually necessary unless other co-pathologies are present, as sclerosing lesions are not thought to increase the risk of breast cancer.

Resources
The charity Breast Cancer Care provides patient information leaflets and offers support activities. It also runs training programmes for health care professionals interested in breast health.

www.breastcancercare.org.uk Helpline: 0808 800 6000.

REFERENCES
Managing safely – the essentials

The second of two articles looking at ways of assessing appropriate caseloads in health visiting

Staff shortages in the NHS mean that some Unite/CPHVA members are expected to manage excessive workloads. This lends urgency to the need for local strategies to manage this depressing trend; if it is not managed, the consequences for Unite/CPHVA members can be severe.

These guidelines should be used in conjunction with the local safeguarding children guidelines, where applicable.

What should you do?

Your first step is to agree a local definition of an excessive workload and issues affecting your ability to manage safely. These include:

- Inappropriate skill mix
- Staff shortages resulting from excessive sick leave, maternity leave, leave for training courses or secondments
- Additional duties, such as new clinics or sessions without extra resources
- Large or complex caseloads
- Working alone in areas that are perceived to be dangerous
- Lack of support and supervision from management, peers or specialist practitioners, particularly for safeguarding cases
- Low staff morale
- Increased stress levels among staff generally
- Lack of engagement or communication by management when implementing changes to practice.

When does your caseload/workload become unsafe?

- Your caseload is unsafe when the complexity and sheer quantity of the caseload mean that you cannot, in your professional judgment, comply with the NMC Code of Professional Conduct standard for conduct, performance and ethics. The code says, ‘You have a duty of care to your patients and clients, who are entitled to receive safe and competent care’ (1, 1.4, NMC 2004). The challenge for members is to ensure that the services they provide are safe, meet required NHS standards and are acceptable to the public. Community practitioners must not compromise or fail to meet the requirements of the regulatory body in achieving this.

- If the ‘proposal’ turns into a directive which will make the caseload unsafe, invoke the NMC Code of Professional Conduct: standards for conduct, performance and ethics 1.1.4, and inform management in writing.

- Your first course of action is to raise your concerns with managers. When you are not able to reach local agreement within your respective teams or organisation you will need to take action. This may mean invoking your trust grievance procedure. Unite/CPHVA workplace representatives and Unite regional officers can advise on the procedure.

Professional responsibilities when managing an unsafe caseload

Excessive workloads and stressful working conditions will create difficulties for practitioners, which may lead to health problems. Any employing organisation, which allows this, is in breach of its duty of care to employees.

Before a situation develops, or where it exists, members are advised to raise this formally with their line manager, pointing out the employer’s legal obligations and insist that action is taken to reduce the excessive workload. If the situation is not resolved, members will need to pursue a more formal route.

If there are also concerns relating to clinical governance issues, members are advised to remind employers of their duty of care to clients and if they are registrants, their responsibilities as described in the NMC Code of Professional Conduct.

Community practitioners are advised to work with their Unite/CPHVA workplace representatives; informing them of the situation and the progress made at each step, and to call for assistance and advice should problems occur. It will be necessary to inform the Unite regional officer responsible for the relevant employing organisation.

Good practice

Before a situation is reached where workloads become excessive, there should be:

- A plan for reviewing and recruiting to the vacancy or service change, with estimated time scales for activity that

Box 1. Case studies

A health visitor started work for a new primary care trust in 2000, working 28 hours/week. On starting, she was told that her caseload would not exceed 200. By 2002, this had increased to 230-240. Due to increased levels of sickness and absence in the trust, the work demands increased until, after several meetings with her line manager, the health visitor needed to go off sick. She was unable to return to work in that role due to stress and took a more junior post, resulting in a drop of £9,000 a year in salary. In court she received over £81,000 in damages. Full text can be viewed at: www.casetrack.com/ch4pic.nsf/items/6-214-1000. This was also reported in Community Practitioner Feb 2007.

A school nurse in Cornwall complained to the Secretary of State for Health, Patricia Hewitt at the 2006 Annual Professional Conference that it was unreasonable to expect her to be able to manage a caseload of 9,000 children. Unite/CPHVA issued several press releases about these concerns, which were picked up by local newspapers and the wider health press. We also had a meeting with senior trust managers and were delighted to find that extra funds for school nurses had been identified in the local development plan.
should be determined and agreed locally
■ Once this has been agreed, a letter confirming responsibilities and actions should be shared with all staff involved.
■ Clients should be informed of changes by the organisation and be clearly signposted to where they can access services.

Protecting your own health
There are a number of measures you should take to protect your own health:
■ Be vigilant for signs of stress and be familiar with coping strategies as outlined in A Guide to Stress in the Work Place, which can be downloaded at: www.amicustheunion.org/pdf/stressguide.pdf
■ Do not work beyond contracted hours, unless you have negotiated this to facilitate family flexible working
■ Do not take work home with you – this particularly applies to taking home case records, as in doing so you are not only working beyond contracted hours of employment, but may be in breach of your trust policy with regard to confidentiality, which could lead to disciplinary action.
■ Employers have a duty of care to employees. They should not permit working arrangements which endanger the wellbeing and health of employees and a number of significant legal decisions have reinforced this.

All community practitioners should have written contracts of employment outlining their duties and responsibilities. No employer can require an employee to work outside those contractual terms, where to do so would be unreasonable and not in accordance with their job description.

Box 2. Other sources of information
■ Amicus: A guide to stress in the work place
■ Amicus: Bullying and Harassment (June 2005)
■ Amicus: Working time regulations
■ The NMC code of professional conduct: standards for conduct, performance and ethics (2004)
■ Trust policies in relation to work life balance, carers leave, sickness and absence
■ Trust family-friendly policy
■ Unite/CPHVA Briefing: Recordkeeping and the law (to be published August 2007)
■ Unite/CPHVA: Managing Vacant Caseloads (to be published August 2007).

If, after reading this, you require further information, please contact your regional office, where you can obtain the contact details for your Unite/CPHVA workplace representatives and regional officer.

Unite/CPHVA Professional Officers are available to give advice on queries in this fact sheet and can be contacted on: professionalteam@unitetheunion.com or 0207 780 4026.

A list of Unite regional offices can be found on the Unite website www.amicustheunion.org under the ‘regions’ heading.

Unite/CPHVA professional team
CLASSIFIED ADVERTISEMENTS

CPHVA OPPORTUNITIES

Advertisement enquiries Somya Shrivastava, Community Practitioner

Ten Alps Publishing, 9 Savoy Street, London WC2E 7HR, Tel: 020 7878 2314, Fax: 020 7397 7155
Email: Somya.Shrivastava@tenalpspublishing.com

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Specialist Community Public Health Nurse (Health Visitor) – Two positions Ref: 625-JB-324

Salary (Band 6) £22,886 - £31,004 per annum
37.5 hours per week (full-time or part-time available)

Devon Primary Care Trust serves a widespread local population as well as a large number of visitors to the North Devon area each year. So come and join us and be part of a team helping to develop and improve our local healthcare services.

You will be working collaboratively within a Public Health Team to use the full range of Public Health skills to assess and support individual, family and community health needs.

Clinical supervision and development opportunities are available.

For all informal enquiries contact Alison-Lewis Smith, Children’s Lead, Northern Devon on 01769 575192.

Applicants are requested to apply online in the first instance www.jobs.nhs.uk If you are unable to apply online, please request a job pack by calling our recruitment hotline on 01392 449748 leaving the job reference number and your name and address.

Closing date: 17th October 2007.
Interview date: 31st October 2007.

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FAMILY NURSING AND HOME CARE (JERSEY) INC

School Nurse (New Post)

Salary Scale: £37,771 - £40,225

Minimum Qualifications: RGN School Nurse Certificate/Diploma

ENB 998, 730 or Equivalent

Current Licensing Essential

5 year contract

FAMILY NURSING AND HOME CARE IS A REGISTERED CHARITY AND IS THE MAIN PROVIDER OF COMMUNITY NURSING IN THE ISLAND (POPULATION 89,500). WE SEEK TO EMPLOY AN EXPERIENCED SCHOOL NURSE TO JOIN A SMALL BUT BUSY TEAM PRESENTLY COMPRISING OF A SCHOOL NURSE, COMMUNITY STAFF NURSES AND SCHOOL NURSE ASSISTANTS.

Ideally you should have a sound knowledge base, and experience in Child Protection Practice. Knowledge of mental and sexual health issues and experience in working with young people is essential.

We offer an annual appraisal, clinical supervision, relocation assistance, in house training opportunities for professional development, 38 days paid leave (inclusive of Bank Holidays) and the possibility of a lease car.

If you are interested in this exciting new challenge and would like to live and work on a beautiful Island please contact Julie Gafoor, Child and Family Services Team Leader Tel. 01534 443625 for an informal discussion. For an application pack, please contact Amanda de Freitas, HR Secretary, Family Nursing and Home Care (Jersey) Inc., La Bas Centre, St Saviour’s Road, St Helier, Jersey JE2 4HP, Tel. 01534 443626, or e-mail a.defreitas@fnhc.org.je

Closing Date for Applications: 22 October 2007
North Highland Community Health Partnership

Health Visiting – Caithness Community Public Health Nurse – Band 6

Full-time, Job share considered
Fixed Term contract up to 1 year
£22,534 - £31,779

Ref: 041/07.06E51

This is an opportunity to experience living and working in a friendly, clean, beautiful area of the Highlands for up to a year. The area has a very varied landscape from mountain to the lovely flow country and some spectacular coastal scenery. Caithness has regular rail and bus services and daily flights from Wick airport.

We require a pro-active Health Visitor to join our friendly Health Visiting team in Wick. You will ideally be a team player but also work autonomously. This post is for a temporary period to cover maternity leave. A current driving licence is essential and a full car will be available. Temporary accommodation may be available.

Informal enquiries would be welcomed by Anne Cromer, Health Visitor - Tel: 01955 604134.

An application form and job description are available from the Personnel Department, Caithness General Hospital, Wick KW1 5NS – Tel: 01955 604003 or by emailing June.Potter@nhsc.scot.nhs.uk quoting the reference number.

Closing date for completed applications: Friday 19 October 2007.

www.nhshighland.scot.nhs.uk

CPhVA OPPORTUNITIES

Advertisement enquiries
Somya Shrivastava, Community Practitioner
Ten Alps Publishing, 9 Savoy Street, London WC2E 7HR
Tel: 020 7878 2314, Fax: 020 7397 7155
Email: somya.shrivastava@tenalpspublishing.com

Nuk Feeding Advisor/Website Administrator

For over 50 years Nuk has provided award winning baby feeding products and accessories to Mums world wide.

Within the UK, Nuk is rapidly expanding and we’re looking for a new member of the team as a Nuk Feeding Advisor/Website Administrator.

The Role
The role involves receiving inbound customer queries on issues varying from baby feeding advice to product specific advice and complaints via telephone, letters and emails. You will also have day-to-day responsibility for the management and operation of the Nuk on-line shop.

The Skills
We are looking for someone who will be committed to the job and to the brand. Ideally a healthcare professional or midwife, with the following skills:

• Excellent customer service skills
• Experience with general administration duties
• Attention to detail and can multi-task
• Good computer skills
• Has a willingness to learn

The job is permanent with a salary band of £16.19k depending on experience.

If you are interested in this role, please send your covering letter and current CV to val.southwick@sonares.co.uk or for the attention of Val Southwick, Mapa Spokes UK Ltd., Berkeley Business Park, Wainswright Road, Worcester WR4 9YS.

The closing date for applications is the 15th October 2007.

unicef

The UNICEF UK Baby Friendly Initiative is part of a global programme which helps health care facilities to adopt best practice standards for breastfeeding by ensuring that parents receive the support, information and encouragement they need to make informed decisions about feeding their babies.

From October 2007 we are looking for Professional Consultants to join an established dynamic team involved with teaching courses and conducting assessments of health care facilities. The post will initially involve working on an ad hoc basis with the possibility of more permanent employment as service demands increase. Full training and support will be provided.

You will be an experienced trainer who has taken the lead on implementing change or management of a project within your area of work. A good knowledge of the Ten Steps to Successful Breastfeeding and the Seven Point Plan for the Protection, Promotion and Support of Breastfeeding in Community Health Care setting is desirable. A positive attitude, excellent interpersonal and communication skills are essential, as well as the ability to work both as a team member and on your own initiative when required. Flexibility and the willingness to travel throughout the UK which involves nights away from home on a regular basis is a requirement of the job.

If you are registered with the NMC in the field of maternity, neonatal or public health, have a passion for breastfeeding and a desire to help improve standards of care for breastfeeding mothers you could be the person we are looking for.

To receive an application pack, please send a stamped SAE (60p) quoting reference PC to:
Recruitment Support, UNICEF UK, 2 Kindlefisher House, Woodbrook Crescent, Radford Way, Billericay, Essex CM12 0EQ
Email: recruitment@unicef.org.uk or apply online at www.unicef.org.uk/recruitment
(CVs will not be accepted)

Closing date: 26 October 2007. Interviews: 20 November 2007
CRB checks will be carried out on the successful applicants.
UNICEF UK is committed to diversity within its workforce.

www.unicef.org.uk
Events

Promoting healthy eating in infants and young children: feeding and cultural perspectives
28 November 2007, Luton
An opportunity for health visitors and nursery nurses working with British Pakistani and Bangladeshi families to develop skills for supporting families through the weaning process.
Tickets cost £75 for NHS employees and £90 for non-NHS staff.
Please contact:
George Hogman
T: 01582 709125
E: george.hogman@luton-pct.nhs.uk

Courses

Infant massage teacher training
8 October 2007, ongoing
dates available across the UK.
In-house and bespoke programmes available
A five-day accredited course for health professionals and community practitioners with a focus on supporting families, enhancing bonding and attachment and parent-infant interaction.
Please contact:
Touch-Learn Ltd
T: 01889 566222
E: anita@touchlearn.co.uk
W: www.touchlearn.co.uk

Rhythm kids workshop
31 December 2007, venues across the UK
A one day fun-filled workshop for baby massage teachers. Helps with the child’s language, muscle, cognitive and vestibular development, as well as their social skills. Tickets cost £135.
Please contact:
Touch-Learn Ltd
T: 01889 566222
E: rk@touchlearn.co.uk
W: www.touchlearn.co.uk

Infant massage training courses
International Association of Infant Massage, courses held throughout the UK all year
We have been teaching parents to massage their babies for over 30 years worldwide. Our four-day training courses are run by internationally accredited trainers. In-house training is also available.
Please contact:
Wendy Nicolson
T: 01279 304455
E: mail@iaim.org.uk
W: www.iaim.org.uk

How to teach baby massage
24 January 2008, ongoing
dates available. In-house tailored courses in London and across the south of England
Improve mother-infant interaction (Cochrane Review), attachment and infant mental health by learning to teach baby massage to parents on accredited courses for health professionals.
Please contact:
Sally Cranfield
T: 01273 279691
E: sally@massageforbabies.com
W: www.massageforbabies.com

Noticeboard

Bereavement service
I am a health visitor looking to develop a bereavement service for women following miscarriage and death of a baby/child. I would be very grateful for any teams’ ideas, who have already developed such a service.
Please contact:
Fran Griffin
T: 01903 843818
E: fran.griffin@aaw.nhs.uk

Infant massage
Because of limited resources, we are looking to target families to offer infant massage across our PCT rather than offer a universal service which would be the ideal.
I would be grateful for information regarding how this has been managed in other areas and any evidence to support targeting.
Please contact:
Anna Fraser
E: anna.fraser@mkpct.nhs.uk

Focus on results
Unite/CPHVA is carrying out a survey of Agenda for Change pay-bound outcomes to ensure that AfC is being implemented fairly. The survey is on the website: www.unitetheunion.com/health.
Please make sure you complete the survey as it is important as many members as possible provide information.
PRICES SLASHED!
3-day ticket available from £162.50

SUPPORTED BY:

Shaping the Future

Unite/CPHVA 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 Hosking**, 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.

**Call for posters**

This year the CPHVA is seeking papers for presentation as posters, which demonstrate good practice, education or research in community and public health practice.

Apply on-line at: http://profile.conference-services.net

For any further information please contact
Profile Productions on 020 8832 7311 or email cphva@profileproductions.co.uk

Book your place online now: www.profileproductions.co.uk
Silent Night

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