Infant reflux
Clinical and dietary management of GOR/GORD in infants

IN THIS ISSUE
- Unlocking careers for CNNs working within the NHS
- Diversity: making a difference
- Link workers and family support: a local evaluation
- ADHD: a new way forward?
- Monitoring infant growth

Health B4 Profit campaign update on page 10
"Eczema, I’m fully covered"

Childhood eczema can be distressing for the whole family. Children need protection and parents need reassurance. With eczema incidence increasing by 41.8% between 2001-2005, as many as 20% of school children are now affected.

For optimum patient outcomes, NICE recommends complete emollient therapy—an everyday, regular routine of a wash product followed by a topical emollient.

Olatum® Junior Bath and Olatum® Junior Cream offers a complete emollient solution against childhood eczema, helping to ensure that bath time is playful not tearful.


Olatum Junior Cream Prescribing Information
Active ingredients: light liquid paraffin 6.0% w/w and white soft paraffin 15.0% w/w. Uses: For the treatment of atopic eczema, contact dermatitis and dry sensitive skin including ichthyosis. Dosage and administration: Apply topically to the affected area and rub in well. May be used as often as required. It is especially effective after washing. Side effects, precautions and contraindications: Should not be used in patients with known hyper-sensitivity to any of the ingredients. Hospital users should follow local procedures and policies for using topical products on in-patients. Keep out of the sight and reach of children. Consult the SPC for further details. Legal category: GSL. Package quantities & NHS price: 500ml £3.49, 1050ml £8.99. Product Licence number: PL 0174/0219 Marketing Authorisation Holder: Stiefel Laboratories (UK) Ltd, Eurasia Headquarters, Concord Road, Maidenhead, SL6 4BY, UK. Date of preparation: June 2009

Olatum Junior Emollient Bath Additive Prescribing Information
Active ingredients: light liquid paraffin 63.4% w/w. Uses: For the treatment of contact dermatitis, atopic dermatitis, ichthyosis and related dry skin conditions. Olatum Junior Emollient Bath Additive is particularly suitable for infant bathing. Dosage and administration: Suitable for use in infants and children. Olatum 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 capsules to an 8-inch bath of water, soak for 10-20 minutes, and pat dry. Infant bath: Add ¾-2 capsules to a basin of water, apply gently over entire body with a sponge, and pat dry. Side effects, precautions and contraindications: Take care to avoid soaping in the bath. If a rash or skin irritation occurs, stop using the product and consult with the doctor. Consult the SPC for further details. Legal category: GSL. Package quantities & NHS price: 150ml £3.90, 250ml £3.25, 300ml £3.10 and 500ml £3.75. Product Licence number: PL 0174/0192 Marketing Authorisation Holder: Stiefel Laboratories (UK) Ltd, Eurasia Headquarters, Concord Road, Maidenhead, SL6 4BY, UK. Date of preparation: June 2009

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk.
Adverse events should also be reported to Stiefel Laboratories (UK) Ltd at adverse.reaction@stiefel.com.

References:
CONTENTS

COMMENT
3  Great expectations
Karen Reay
This conference is an opportunity to influence the future of the NHS

NEWS & FEATURES
4  NEWS
10 New Unite national petition
Health B4 Profit campaign: next steps planned by Unite

12 Unlocking CNN careers
Kin Ly
Barriers to career progression for CNNs in the NHS

18 ANPF: update from the chair
Angela Roberts
Annual National Professional Forum 2009 and work done since the last

18 Remembering last conference
Anita McCrum
A member whose place was funded by Ten Alps Publishing

20 Monitoring growth
William Johnson, Noël Cameron, Pauline Raynor, Cathy Woffendin, John Wright
Integrating the Born in Bradford research project into practice

CLINICAL
40 Clinical papers
June Thompson
Variations in infant and perinatal mortality rates
IPV screening may not be effective
Impact of prison on women’s health

42 Clinical update
Jackie Falconer
GOR and GORD in infants

REGULARS
16 Platform
Yvonne Coghill
We need to make time to consider how we can make a difference

44 Letters

46 Your rights at work
Dave Munday
Promoting the health and wellbeing of NHS staff

52 Network

PROFESSIONAL
All professional papers have been double-blind peer reviewed prior to publication

22 A whole-child perspective assessment guide for early years settings
Sinéad Hanafin, Anne-Marie Brooks, Fiona McDonnell, Helen Rouine, Imelda Coyne

UNITE/CPHVA MEMBERSHIP
Membership-related enquiries from existing members should be made to regional offices (see contact on page 52).
To join Unite/CPHVA, apply online at www.unite-cphva.org or contact a Unite regional office.

JOURNAL SUBSCRIPTIONS
(For non-members of Unite/CPHVA)
UK individual yearly rates:
Payment by direct debit £90.00
Annual payment £99.50
Student £69.50
UK institutional yearly rate £105.00
Rest of the world yearly rates:
Individual £104.00
Institutional £109.50
Subscription enquiries should be made to:
Community Practitioner subscriptions, Ten Alps Publishing Subscriber Services, Alliance Media Limited, Bournehall House, Bournehall Road, Bushey WD23 3YG
T: 020 8950 9117
tenalps@alliance-media.co.uk
www.cairnsbookshop.co.uk

PUBLISHERS
Published on behalf of Unite/CPHVA by:
Ten Alps Publishing, 9 Savoy Street, London WC2E 7HR
T: 020 7878 2300 F: 020 7379 7155
Ian Carter Managing director

ADVERTISING
Bob Jalaf
T: 020 7878 2344
bob.jalaf@tenalpspublishing.com

PRODUCTION
Ten Alps Publishing (design and production)
Williams Press (printing)
© 2009 Community Practitioners’ and Health Visitors’ Association
ISSN 1462-2815

Community Practitioner is indexed in the Cumulative Index to Nursing and Allied Health Literature (CINAHL) and the Applied Social Science Index and Abstracts (ASSIA).

The views expressed do not necessarily represent those of the editor nor of Unite/CPHVA. Paid advertisements carried in the journal do not imply endorsement by Unite/CPHVA of the products.

GUIDE FOR CONTRIBUTORS
Community Practitioner welcomes relevant contributions. Articles on professional issues are double-blind peer reviewed and should be 2000 to 3500 words. Author guidelines are available from the editor. Submissions should be made in electronic format by email to: danny.ratnaike@tenalpspublishing.com
Supporting you on the frontline

NHS resources at the click of a mouse.
Visit www.nhs.uk/childhealthteams

Features include:
Birth to 5 guide to parenting | Child health 0–5 | Immunisation information
Parent self-assessment tools & videos | Child disabilities | Childhood illnesses
Great expectations

This month's annual professional conference in Southport will be an opportunity for members to influence debate about the future of the NHS.

There will be a strong gust of US politics blowing off the Irish Sea as delegates gather for the Unite/CPHVA conference in Southport later this month.

The harsh and unsparing criticisms of Barack Obama’s plans to provide a safety net for the estimated 46 million Americans without health insurance will focus delegates’ minds on the great benefits that the NHS has provided, free of charge, since its foundation in 1948.

Our blueprint for the future can only happen within a unified, non-privatised NHS, free at the point of delivery for all those in need.

The US health insurance companies that are attacking Obama would like to gain more than the toe-hold that they have already established in the UK – they are looking to take over large and lucrative sections of the NHS in the interests of their shareholders.

This is why what is happening in the US – and I know many of you will be disgusted by some of the attacks on the NHS as ‘socialised medicine’ – has increasing resonance here. Unfortunately, others such as Conservative MEP Daniel Hannan endorse these right-wing US views.

It was to halt and defeat the forces of NHS privatisation that Unite launched its Health B4 Profit campaign earlier this year.

Delegates will be able to make their feelings known as for the first time, two cabinet ministers – health secretary Andy Burnham and children’s secretary Ed Balls – will be addressing the annual professional conference (see pages 32 and 33).

The appearance of these two political ‘big hitters’ is a tribute to a number of factors:

- The incessant campaigning on health visitor and school nurses numbers
- That Unite is the largest trade union in the country, with the influence to match
- That community nursing has seeped deeply into the national consciousness, particularly in the wake of the tragic ‘Baby P’ case.

And Unite has been positive in offering solutions – we have not simply sat there and wrung our collective hands.

The US health insurance companies that are attacking Obama would like to gain more than the toe-hold that they have already established in the UK – they are looking to take over large and lucrative sections of the NHS in the interests of their shareholders.

This is why what is happening in the US – and I know many of you will be disgusted by some of the attacks on the NHS as ‘socialised medicine’ – has increasing resonance here. Unfortunately, others such as Conservative MEP Daniel Hannan endorse these right-wing US views.

It was to halt and defeat the forces of NHS privatisation that Unite launched its Health B4 Profit campaign earlier this year.

Delegates will be able to make their feelings known as for the first time, two cabinet ministers – health secretary Andy Burnham and children’s secretary Ed Balls – will be addressing the annual professional conference (see pages 32 and 33).

The appearance of these two political ‘big hitters’ is a tribute to a number of factors:

- The incessant campaigning on health visitor and school nurses numbers
- That Unite is the largest trade union in the country, with the influence to match
- That community nursing has seeped deeply into the national consciousness, particularly in the wake of the tragic ‘Baby P’ case.

And Unite has been positive in offering solutions – we have not simply sat there and wrung our collective hands.

The US health insurance companies that are attacking Obama would like to gain more than the toe-hold that they have already established in the UK – they are looking to take over large and lucrative sections of the NHS in the interests of their shareholders.

This is why what is happening in the US – and I know many of you will be disgusted by some of the attacks on the NHS as ‘socialised medicine’ – has increasing resonance here. Unfortunately, others such as Conservative MEP Daniel Hannan endorse these right-wing US views.

It was to halt and defeat the forces of NHS privatisation that Unite launched its Health B4 Profit campaign earlier this year.

Delegates will be able to make their feelings known as for the first time, two cabinet ministers – health secretary Andy Burnham and children’s secretary Ed Balls – will be addressing the annual professional conference (see pages 32 and 33).

The appearance of these two political ‘big hitters’ is a tribute to a number of factors:

- The incessant campaigning on health visitor and school nurses numbers
- That Unite is the largest trade union in the country, with the influence to match
- That community nursing has seeped deeply into the national consciousness, particularly in the wake of the tragic ‘Baby P’ case.

And Unite has been positive in offering solutions – we have not simply sat there and wrung our collective hands.

Our blueprint for the future can only happen within a unified, non-privatised NHS, free at the point of delivery for all those in need.

The US health insurance companies that are attacking Obama would like to gain more than the toe-hold that they have already established in the UK – they are looking to take over large and lucrative sections of the NHS in the interests of their shareholders.

This is why what is happening in the US – and I know many of you will be disgusted by some of the attacks on the NHS as ‘socialised medicine’ – has increasing resonance here. Unfortunately, others such as Conservative MEP Daniel Hannan endorse these right-wing US views.

It was to halt and defeat the forces of NHS privatisation that Unite launched its Health B4 Profit campaign earlier this year.

Delegates will be able to make their feelings known as for the first time, two cabinet ministers – health secretary Andy Burnham and children’s secretary Ed Balls – will be addressing the annual professional conference (see pages 32 and 33).

The appearance of these two political ‘big hitters’ is a tribute to a number of factors:

- The incessant campaigning on health visitor and school nurses numbers
- That Unite is the largest trade union in the country, with the influence to match
- That community nursing has seeped deeply into the national consciousness, particularly in the wake of the tragic ‘Baby P’ case.

And Unite has been positive in offering solutions – we have not simply sat there and wrung our collective hands.
Assurances over frontline services

Unite says that its Health B4 Profit campaign is ‘genuinely making progress’ with the government in working to influence how future public sector savings may be made

Unite has welcomed government assurances that it does not intend to cut ‘vital frontline services’, following prime minister Gordon Brown’s speech at the Trades Union Congress (TUC) conference.

Unite assistant general secretary Gail Cartmail stated: ‘The prime minister pledged no cuts to frontline services and emphasised government’s commitment to the NHS and education. It is fair to say Unite’s Health B4 Profit campaign is genuinely making progress and health minister Andy Burnham seems to be listening. We have sought his assurance that there will be no return to the “slash and burn” actions of the past.’

In his speech, Gordon Brown stated that ‘we will cut inefficiencies, cut unnecessary programmes and cut lower priority budgets’, but stressed that cuts will not be made to ‘vital frontline services’.

Unite has also spoken out against recommendations from management consultant McKinsey, which recommended a 10% cut to NHS staff in order to make savings of £20billion.

Gail Cartmail stated: ‘Government policy is placing emphasis on disease prevention and health promotion, a boost for the poor relation primary care within which the community nursing workforce is vital. Take for example the link between Sure Start children’s centres and health visitor leadership. Our concern is not the number of health visitors and school nurses but rather the large volume nearing retirement with record low numbers of trainees and newly qualified.’

She added: ‘McKinsey was rightly brushed aside by the government, now we need the government to deliver on increasing the number of health visitors and school nurses and to pull back on the various privatisation exercises that will effectively waste £20billion through the cost of transactions to oil the emerging market in health care.’

A report by the TaxPayers’ Alliance stated that by abolishing Sure Start children’s centres, a saving of £1456million from 2010 to 2011 onward could be made. It also proposed that ContactPoint and the investment programme Building Schools for the Future should be abandoned.

Unite/CPHVA lead professional officer Cheryll Adams stated: ‘There is no doubt that individual Sure Start children’s centres have helped many families, but there is a need to examine whether the outcomes might have been better and cheaper if the investment had gone into improving health visiting services, as the health component seems essential to Sure Start effectiveness.’

Progress in fight against staff shortages

NHS London has agreed to meet with Unite/CPHVA in order to discuss how it will increase health visitor numbers.

Unite/CPHVA London region chair Norma Dudley stated: ‘We have requested this meeting to find out what has been put in place to address the serious health visitor shortages in London. We want to identify the direction at local level. Lord Laming has recommended that strategic health authorities commit to increasing health visitor numbers, and the Department of Health together with Unite/CPHVA has launched the Action on Health Visiting programme. However, the reality for NHS trusts is that they must make year-on-year efficiency savings, which could mean that their priority may not be to increase health visitor numbers. Already, NHS London has refused requests from NHS trusts for retention and recruitment premia.’

She added: ‘We will be recommending a ring-fenced budget, that will be unaffected by the year-on-year efficiency savings, for the training of new health visitors and community practice teacher-training for experienced health visitors. NHS London should also provide trusts with annual student health visitor recruitment targets.’

As part of the Action on Health Visiting programme, Unite/CPHVA will be publishing a report for frontline staff to help them make a case for health visiting to commissioners.

Unite/CPHVA lead professional officer Cheryll Adams stated: ‘The new document will also confirm the roles of the health visitor in a modern NHS, and where these can not be delivered, it is hoped they will be better able to make the case for additional resources.’

Meanwhile, concerns have been raised that practice nurses are not being paid for working extended hours. A poll of 301 GPs by GP newspaper found that more than one-fifth of GP practices employ practice nurses to work extended hours, however only 8% of these practices are funded to pay for this service.

Unite Health Sector lead officer for nursing Barrie Brown stated: ‘Extended hours in primary care are a welcome development, but this needs proper financing and resourcing, which is recognised in Scotland and Wales but not in England.’

He added: ‘Practice nurses and their colleagues cannot be expected to contribute to extended hours working unless they are willing to do this and receive the appropriate remuneration.’

Journal correction: new birth visits in NHS Richmond and Twickenham are only conducted by qualified health visitors, and the journal apologises for misinterpreting information that the trust had supplied to us for last month’s news feature.
Lead professional officer says farewell

Unite/CPHVA lead professional officer Cheryll Adams has announced that she will be leaving the association at the end of this month after 10 years of commitment and hard work.

Her fellow lead professional officer Obi Amadi stated: 'Cheryll will be sorely missed by the association, and on behalf of our staff and members we would like to thank her for her dedication.'

Unite/CPHVA Health Visitor Forum co-chair Maggie Fisher said: 'I have never known anyone as committed as Cheryll to pushing the health visiting agenda. She has been instrumental in influencing policy and will be irreplaceable.'

Unite/CPHVA professional officer Ros Godson added: 'Cheryll has worked like a dynamo to persuade a reluctant Department of Health that early intervention from health visitors is essential to improve children’s health outcomes. She has been equally passionate about working to influence National Institute for Health and Clinical Excellence guidance, to the extent that I have to file emails from her separately in order to prevent my inbox from overflowing!'

In her 10 years, Cheryll has led improvements in interventions for postnatal depression, campaigned against health visiting cuts and initiated work leading to the launch of the Academy for Nursing, Midwifery and Health Visiting Research.

Cheryll commented: 'I hope that I have been effective in raising member’s concerns at a national level. I will remain a member and expect to stay closely associated with health visiting. Members should stay true to their public health roots and use the principles of health visiting to ensure that the inevitable service redesigns always meet the needs of their clients. Get together and speak up for what you believe in and you will have a proud history of making a difference.'

Last chance to book conference places

Places are still available for Unite/CPHVA’s annual professional conference on 14 to 16 October in Southport.

Unite/CPHVA lead professional officer Obi Amadi stated: ‘This year, we have a fantastic line-up of speakers, including two lords and two ministers. The conference programme will provide delegates with the resources and inspiration to undertake and develop leadership roles and members should book their places as quickly as possible.’

Unite/CPHVA will be launching a number of new resources at the conference on a range of subjects including skill mix, community staff nurses in health visitor teams, the contribution of school nursing, community nursery nurse handbook and new birth visits.

To book a place, see pages 32 to 33 or:
www.profileproductions.co.uk
The British Medical Association (BMA) has published a report entitled *Under the influence* that calls for a complete ban on alcohol advertising.

Unite/CPHVA professional officer Gavin Fergie stated ‘The abuse of alcohol and the effect that this can play on society is an element of practice that our membership observe on a regular basis. The need to tackle the negative aspects of this evolving culture is becoming more apparent, not only to healthcare professionals, but now to politicians and the general public.’

He added: ‘Unite/CPHVA welcomes any considered views on how to affect positive change with regard to the public health of the UK and will participate in the debate with our usual diligence and expertise.’

The report states that alcohol advertising has damaging effects on young people and estimates that the UK alcohol industry spends £800 million annually on the marketing of their products.

Drinkaware Trust has launched a campaign aimed at 18- to 24-year-olds to tackle alcohol misuse. The campaign is funded by the drinks industry, and 13 million products such as alcohol bottles, cans and multi-packs will contain the campaign logo and the strapline ‘Why let the good times go bad?’
Leading the way in managing CMA

Nutramigen® provides you with a complete range of CMA management.

- Most Documented and Trusted with over 65 years of expertise.
- Clinically proven to be Safe and Effective.
- Excellent nutritional profile tailored to infants needs.
IN BRIEF...

New Unite/CPHVA resources
Unite/CPHVA will be launching a number of new resources at its annual professional conference held in Southport on 14 to 16 October. Free resources will be available on subjects including community staff nurses in health visitor teams, the universal health visiting service, the unique contribution of school nursing and new birth visits. In addition, a handbook on community nursing is expected to be launched at the conference and a new book on skill mix will be available for purchase at the event and online, see: www.cairnsbookshop.co.uk

Big fatherhood debate
The Fatherhood Institute is calling on health-care professionals to take part in its ‘Big Fatherhood Debate’ in order to collect views on the future of fatherhood. To take part in its survey, please see: www.bigfatherhooddebate.com

Violence against women taskforce
The Department of Health is seeking views to help inform its new taskforce on the health aspects of violence against women and girls. It is seeking views on: service delivery including early identification, service commissioning including needs assessment, and partnership working including information-sharing. The deadline is 14 October. To take part, email: VAWGTaskforce@dh.gsi.gov.uk or see: www.dh.gov.uk/VAWG

NI alcohol and drug outcomes grant
The Public Health Agency for Northern Ireland (NI) is inviting applications from community organisations for proposals that target the 25% most disadvantaged areas identified by the Northern Drugs and Alcohol Co-ordination Team (NDACT), demonstrate community involvement, and address outcomes outlined in the NDACT action plan. The application closing date is 16 October. To access an application form, see: www.publichealth.hscni.net/NDACT/index.html

Sharing high impact action
The Department of Health, RCN, NMC and NHS Institute for Innovation and Improvement have launched a new initiative enabling nurses and midwives to share examples of how they have improved quality of care and reduced service costs, and to vote for their favourites. To share examples of practice, see: www.institute.nhs.uk/hia

More get MMR catch-up jab in Wales
The National Public Health Service (NPHS) for Wales has reported that 6500 parents have arranged for their children to receive a catch-up measles, mumps and rubella (MMR) vaccine since April.

Unite/CPHVA professional officer Gill Devereaux stated: ‘The NPHS and local health boards need to make it their priority to ensure that all unvaccinated children receive a catch-up MMR jab. It is important that the NPHS push ahead with its plan to work with local health boards and school nurses to ensure that those children who are not protected will receive the MMR jab as early as possible.’

She noted: ‘There has been an increase in the population, the study states that 452 children and adolescents were prescribed orlistat, sibutramine or rimonabant from 1999 and 2006, and prescriptions rose 15-fold over eight years from 0.006 to 0.091 per 1000. Meanwhile, nutrient-based standards for schools to provide healthy nutritionally balanced lunches, which came into effect for primary schools in England last September, are now being rolled out for all secondary schools in England.

Under-18s access anti-obesity drug
A study published in the British Journal of Clinical Pharmacology has reported that an estimated 1300 people under the age of 18 have been prescribed the anti-obesity drugs that are only licensed for use in adults.

Unite/CPHVA professional officer Ros Godson stated: ‘Any anti-obesity drug is a short-term measure. Support for lifestyle change must be given at the same time and for a long time afterwards as that is the only long-term solution.’

Using data from the UK General Practice Research database, which covers around 5% of the population, the study states that 452 children and adolescents were prescribed orlistat, sibutramine or rimonabant from 1999 and 2006, and prescriptions rose 15-fold over eight years from 0.006 to 0.091 per 1000. Meanwhile, nutrient-based standards for schools to provide healthy nutritionally balanced lunches, which came into effect for primary schools in England last September, are now being rolled out for all secondary schools in England.

Teenage girls in abusive relationships
The NSPCC has found that one-third of teenage girls in relationships suffer from sexual abuse and one-quarter from physical violence, but school nurses may find it difficult to deal with the issue as their time is taken up elsewhere.

Unite/CPHVA professional officer Ros Godson stated: ‘Primary care trusts have reduced school nurses’ work to child protection and immunisations. Consequently, school nurses are not holding drop-in clinics for teenagers where they can access this type of help.’

She added: ‘More needs to be done in personal, social and health education, but there is a time limit on these lessons. These issues can also be explored during other lessons such as English, drama and religious education.’

The NSPCC recommended raising awareness of the harm caused by physical and sexual abuse in schools, school peer support programmes to provide support to those suffering from such abuse, and that healthcare professionals working on child protection cases should check the safety of young people in intimate relationships.

The journal invites new professional papers for a themed issue on emotional health and wellbeing. Papers should be submitted to the editor by the end of February 2010. For details or to submit a paper, contact Danny Ratnaike Tel: 020 7878 2404 or email: danny.ratnaike@tenalspublishing.com

The journal invites new professional papers for a themed issue on emotional health and wellbeing. Papers should be submitted to the editor by the end of February 2010. For details or to submit a paper, contact Danny Ratnaike Tel: 020 7878 2404 or email: danny.ratnaike@tenalspublishing.com
NEW

dairy free & delicious

At Pure we know it’s not always easy finding foods that fit with your lifestyle. That’s why we have introduced a new range of cheese alternatives so you can still enjoy the food you love.

✓ dairy free ✓ gluten free ✓ vegan
www.puredairyfree.co.uk
National petition to Gordon Brown
Unite has launched a national petition against increased privatisation and fragmentation of the NHS. The petition was due to be launched on 21 September, and will be delivered to prime minister Gordon Brown.

Unite assistant general secretary Gail Cartmail stated: ‘As chancellor of the exchequer, Gordon Brown did a wonderful thing when he put 1p on National Insurance to pay for investment in the people’s NHS. Now as prime minister, he can build on this by calling “time” on the healthcare companies that seek to make a handsome profit from the sick, the elderly and the vulnerable.’

She added: ‘To create these so-called market mechanisms that the British people have repeatedly said in opinion polls they do not want, it will cost an estimated £20billion. This is money better spent on frontline services – more health visitors, more hip replacement operations, and more day surgery.’

Unite plans to develop local campaigns and will be encouraging members to write letters of protest to their MPs. It will also produce a questionnaire to collect data on whether members are being consulted on in trusts’ decision-making processes.

This is money better spent on frontline services – more health visitors, more hip replacement operations

‘We must avoid fragmentation’
Campaign plans were agreed after Unite received a letter from health minister Andy Burnham in response to its initial letter of protest, which was signed by 3000 members and delivered to the Department of Health (DH) in August.

Unite noted that the minister’s response appeared to contradict itself in its attitude to the continued privatisation and fragmentation of the NHS. It highlighted DH support for plans to establish separate providers and commissioners, and for setting up social enterprises to reflect its commitment ‘to develop the role of the “third sector” in the provision of public services.’

However, Andy Burnham also wrote: ‘We must avoid fragmentation of provision and ensure standards. The Constitution responds to this challenge by safeguarding the future of the NHS in terms of the core values and the rights that patients and staff can expect from the NHS, irrespective of the type of provider.’

Gail Cartmail stated: ‘Andy Burnham, by his own mouth, stated that the NHS should not be privatised or fragmented, however this was not addressed in the rest of his letter, which instead outlined a more privatised NHS.’

She added: ‘We are continuing discussions with the minister who does seem to be listening to our concerns. It is very important to get genuine clarity as to the government’s policy and what actions will take place to stop the present fragmentation we know will damage services.’

At the Trades Union Congress conference last month, Unite supported a motion calling for an end to the increase in privatisation in the NHS.
The recipe for success is not more ingredients. It’s better absorption.

Infant nutrition is complicated. Infant formula milks contain many ingredients, some of which may not be easily absorbed. Heinz understands that for healthy development in the first 6 months a baby needs to effectively utilise all the nutrients present in the formula. Heinz Nurture Infant Formula Milks have been specifically designed to ensure optimal absorption of fatty acids and calcium,1 to increase energy supply and build bones, while also helping to reduce constipation2-6 and colic.8 If you would like to discuss how Heinz can help you as a midwife or health visitor, call our dedicated HCP Careline on 0800 692 6009.

The science of good digestion

Important notice: Breast-feeding is best for babies. Infant milk is suitable from birth when babies are not breast-fed. Always ask your doctor, midwife, health visitor, public health nurse, dietician or pharmacist for advice about feeding your baby.

Unlocking CNN careers

The gates to career progression for CNNs within the NHS appear to be locked, with few opportunities for promotion and little motivation to train and develop.

Kin Ly
Assistant editor

Band-5 community nursery nurse (CNN) roles, offering leadership opportunities, have been established in some primary care trusts (PCTs). But despite interest from many CNNs in routes to progress their careers, these remain scarce within the NHS. According to Unite/CPHVA’s CNN Forum, there are a very small number of senior CNNs in England, and no record of them in Scotland, Wales or Northern Ireland.

A reason to train
Margaret Turner-Bone is one of the UK’s few band-5 CNNs, and states: ‘No matter how much extra training a CNN undertakes, it is not recognised and she will continue to be paid at the rate of a band-4 nurse. This could deter CNNs from undertaking any sort of extra training that could be of benefit to the wider community.’

Unite/CPHVA CNN Forum chair Barbara Evans notes: ‘Some PCTs have created band-5 senior CNN roles, with greater leadership responsibility, and this includes supervision and mentorship. However, PCTs are providing nowhere near enough of these roles. A CNN would need to change jobs or leave the NHS entirely if they wanted more opportunities for career progression.’

She adds: ‘Some CNNs have applied for other childcare roles in Sure Starts and children’s centres. Often, there is less responsibility, they are paid at a higher rate, and there are more chances for promotion to children’s centre manager. These centres are usually managed by local councils, but the lack of opportunity is a major problem within the NHS.’

CNN leaders
Theresa Taylor was appointed as a band-5 senior CNN after NHS Ealing recognised a gap in its community health service. She states: ‘There was an increase in CNN applicants, who were needed to help target the large numbers of hard-to-reach families in Southall neighbourhood. The trust therefore developed the senior CNN role in order to deliver induction training to new CNNs and to help provide a universal family programme.’

Theresa provides support and advice to band-4 CNNs, health visitor assistants and the children’s services team. She provides supports to CNNs in cases where there may be a complaint, and represents them in senior management meetings.

Senior CNNs would be able to effectively push forward the community nursery agenda

Theresa has helped in the redesign of community services in NHS Ealing and has developed CNN competences framework at a strategic level. She also mentors, supervises and provides personal development plans and appraisals for CNNs and health visitor assistants, conducts risk management assessments, assesses health services and interviews for new posts.

She notes: ‘There is less health visitor input due to staff shortages and because they have large caseloads to manage. In this instance, collaboration between the senior CNN and health visitors is important. Senior CNNs are not used to replace health visitors in any shape or form – essentially, we help to enhance their role.’

Margaret Turner-Bone agrees: ‘Senior CNNs usually mentor, train and supervise other CNNs, which relieves some of the pressure that health visitors experience. But only a few PCTs have employed a senior member.’

Theresa states that her PCT has decided to roll the senior CNN role out across the whole of Ealing. She says: ‘NHS Ealing recognised the necessity and benefits of having a senior CNN, and the PCT has so far employed two more senior members. In addition, other trusts have shown an interest and I have spoken to a number of other PCTs about my role.’
Although Margaret Turner-Bone was appointed as a band-5 CNN, she says: ‘Such opportunities for CNNs usually only come by chance – there is no standard route for career progression.’

For her, it was after being appointed as a healthy weights project lead at NHS Sefton. She notes: ‘There was a lack of availability of health visitors at the time that the trust was recruiting for this post. The PCT therefore decided to open the position to those who had the relevant experience. I was appointed to the role because I carried the relevant skills, knowledge and experience, having worked in this area alongside a health visitor in the past.’

Barbara Evans stresses the significance of employing senior CNNs: ‘As well as providing induction training, supervision and advice, senior CNNs would be able to effectively push forward the community nursery agenda and represent the service. Senior CNNs will no doubt provide the necessary support, especially in health visiting and skill-mix teams.’

Registered service
Many CNNs seem to support the idea that the service should be registered, emphasising possible outcomes such as post-registration training.

Margaret Turner-Bone states: ‘Community nursery nursing should be a registered service. This would provide a standardised route into community nursery nursing and it could even open up more opportunities for us to progress our careers, where post-registration training could be considered.’

Concerns have been raised that a nursery nurse with insufficient training in child care and early years education could consider themselves to be a CNN.

Margaret Turner-Bone states: ‘Because community nursery nursing is not registered, many people can undergo any childcare training and then call themselves a nursery nurse.’

She adds: ‘But this does not necessarily mean that they have the relevant skills and knowledge to work in the community.’

Training and conduct
The Qualifications and Curriculum Authority recommends four qualifications for community nursery nursing, providing the necessary theoretical and practical training in child development:

- Diploma in child care and education (DCE) awarded by CACHE (previously the NNEB) and the HNC in child care and education (Scotland)
- Level 3 BTEC national diploma in early years, awarded by EDEXEL
- NVQ Level 3 in early years and education, awarded by City & Guilds, CACHE, EDEXEL and the OU.
- To access the voluntary CNN code of conduct, see: www.unite-cphva.org then click on ‘Professional groups’ and then ‘Nursery nursing’.

Barbara Evans comments: ‘Unite/CPHVA has developed a voluntary CNN code – but this is only voluntary. Not only could registering the service provide a recognised level for training and raise the professionalism of community nursery nursing within the NHS, it could provide greater protection for the public.’

She adds: ‘Nurses and midwives have a professional code of conduct that they must adhere to and are held accountable to, and if community nursery nursing was registered, then the service could be better regulated. This would mean that CNNs, who often work in skill-mix teams and make home visits, could be held accountable for their actions or omissions, and not just delegated to.’

New handbook
The Unite/CPHVA CNN Forum has developed a new handbook for CNNs that points to information on leadership, record-keeping, lone working and clinical supervision, as well as advice on tasks such as infant massage and therapeutic play.

Margaret Turner-Bone states: ‘The handbook can be used as a reference point, which CNNs can dip into for information. There have been many books published on child care, but this handbook compiles all of that information into one book.’

She adds: ‘There is something in here for everybody and it could be used to inform and further reinforce the roles of CNNs.’

The new handbook will be launched at Unite/CPHVA annual professional conference on 14 to 16 October in Southport. It is clear that there are few existing opportunities within the NHS for CNNs to progress their careers, despite the benefits associated with employing senior CNNs. The outlook appears to depend on whether the leadership shown by some trusts in developing these roles is replicated by others.

Further information
- The new CNN handbook is due to be launched at the annual conference, and will be available from Unite/CPHVA
- To access the voluntary CNN code of conduct, see: www.unite-cphva.org then click on ‘Professional groups’ and then ‘Nursery nursing’.
Breastfeeding is best for babies

Helping you to take complete care of bottlefed babies’ nutritional needs

**Completely** committed to providing optimal nutrition backed by clinical evidence

**Completely** tailored range to bring the best nutritional solutions to bottlefed babies in your care

**Completely** supporting you with dedicated information, education and practical resources

...because Cow & Gate babies are happy babies

Visit in-practice.co.uk for more information or call our helpline 08457 623 624

Important Notice: Breastfeeding is best for babies. Follow-on milk is only for babies over 6 months, as part of a mixed diet and should not be used as a breastmilk substitute before 6 months. It is recommended that all formula milks be used on the advice of a doctor, midwife, health visitor, public health nurse, dietitian, pharmacist or other professional responsible for maternal and child care.
Time for difference

We need to make time to consider how we can make a difference

Yvonne Coghill
National programme lead, Breaking Through

Most of us have very busy lives. We put our heads down and just keep going. When we come up for air and have the opportunity to think, that time is precious. I did not go abroad this summer, preferring to stay at home. Staying at home enabled me to come up for air, and for the first time in ages I was able to find the time and space to think. Uppermost in my mind was my current role and what I am trying to achieve.

Having been in the NHS for many years, my overall objective has always been to improve services that would have a direct impact on improving patient care. My role as programme lead for the national Breaking Through programme is a little different to most of the other roles I have had, in that the impact on improved services is not immediately visible. In essence, the job is designed to select and prepare people from black and minority ethnic backgrounds to become productive and effective senior leaders in the NHS.

Slipping down the list
During the last decade, the NHS has made resources available for the programme. This is due to an awareness and acceptance that as a nation we are becoming increasingly more diverse, and that diversity needs to be reflected in the NHS, particularly at the most senior levels.

I believe that, regardless of background, we all have a part to play in improving health services and that everyone has a unique contribution to make regardless of where they come from. My experience is that most members of staff in the NHS believe that too. It is therefore of real interest to me that despite the number of programmes and initiatives like Breaking Through, Pacesetters, Race for Health and others specifically aimed at improving equality and diversity, that the NHS cannot seem to crack the equality and diversity nut. The NHS has been successful in ensuring there is financial balance, reduced waiting times, lower MRSA rates, improved accident and emergency waiting times to name but a few. We are ready, willing and able to make major changes that improve and save lives. These areas have several common denominators:

- Potentially, people will die if changes are not made
- They have the absolute commitment of everyone in the NHS to do something about them

We seldom stop to think about how we can really make a difference to improve services

- They have high-level support and financial commitment
- They are politically sensitive and are therefore ‘must dos’
- Senior people will be held accountable for failure on the issues involved

The equality and diversity agenda does not meet the above criteria, and therefore slips down the list of priorities when ‘must do’ items come to the fore.

Tall order
The NHS is a fast moving, ever changing organisation. We have new policies, procedures, strategies and initiatives almost on a daily basis. We have a commitment to improve the health of our nation and to deliver a first-class service to our patients and their families. We need to do this within a tight financial framework to short deadlines and timescales, and we have a duty to keep the government and the population happy. Without a shadow of doubt, this is a tall order and one that our society demands we get right.

Is it any wonder then that people have very little time to think about the importance of a diverse workforce? Or time to think about how behaviours and systems can impact upon and affect some members of staff?

In the medium to long term, many difficult decisions will have to be made if the NHS is to remain sustainable and free at the point of need.

In light of this, grappling with the inequalities and unfairness inherent in its systems might seem untimely. However, I would argue that making and keeping diversity a priority might not be as inappropriate as it might first seem. The evidence is that if we want to make changes that improve the lives of patients, we can do so successfully. If we found the time to stop and consider the importance of a diverse workforce and how enriched the NHS would be by releasing the talents of all members of the workforce for the benefit of patients, we would improve care at a stroke, raise morale and improve retention rates.

Making a difference
At the beginning of this piece, I highlighted the fact that for most of us life is incredibly busy. Our diaries are full and we are constantly juggling work, family and friends. This leads us to generally put our heads down and ‘get on with it’. We seldom stop to think about how we can really make a difference to improve services within our jobs. We are usually told what needs to be done and we simply press on with doing it. Making the time to think enables us to see the big picture and what we can do personally to make a difference.

With the commitment of senior leaders and a workforce that believes in the benefits of a diverse workforce, the NHS would be world class in the equality and diversity arena. We all need to take the time out to think of innovative and creative ways of instilling a genuine desire in people for making that change.
For effective treatment of eczema and dry skin...

Reach for Cetraben

Cetraben’s patient friendly formulation is available in a range of low price, easy-to-use, conveniently sized pump packs – helping to improve choice, reduce wastage and aid concordance in patients of all ages.

Cetraben emollient therapy – a helping hand for your dry skin and eczema patients.

ABBREVIATED PRESCRIBING INFORMATION
Cetraben® Emollient Cream. Please refer to Summary of Product Characteristics before prescribing. Presentation: A thick white cream containing white soft paraffin 13.2% w/w and light liquid paraffin 10.5% w/w. Indications: Symptomatic relief of red, inflamed, damaged, dry or chapped skin, especially when associated with endogenous or exogenous eczema. Dosage: Apply to dry skin areas as required and rub in. Contra-indications: Hypersensitivity to any of the ingredients. Special Warnings and Precautions: Care should be taken if allergy to any of the ingredients is suspected. Avoid contact with the eyes. Side Effects: (Refer to the SmPC for full list) very rarely, mild allergic skin reactions including rash and erythema have been observed, in which case the product should be discontinued. Marketing Authorisation number: Cetraben Emollient Cream: PL 17330/0001. Basic NHS Price: 50g pump dispenser £1.17, 150g pump dispenser £2.88, 500g pump dispenser £3.39, 1050g pump dispenser £11.11. Legal category: GSL. Date of preparation: January 2009. Further information is available from: Genus Pharmaceuticals Ltd, Benham Valence, Newbury, Berks RG20 8LU. Cetraben® is a registered trademark.

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to Genus Pharmaceuticals on 01635 568400.
ANPF: update from the chair

**ANPF 2009 and the work done since last year’s**

Angela Roberts  
Unite/CPHVA chair

Those of you who attended the Annual National Professional Forum (ANPF) and debated the issues raised at conference in Harrogate last year will be wondering what we have been up to since.

We asked you what you felt were the future education and training requirements for specialist community public health nurses (SCPHNs). The concerns debated were around skill versus grade mix, safeguarding and essential skill sets for school nurses and health visitors.

Unite/CPHVAs National Professional Committee and professional officers have worked very strategically with the Department of Health (DH) in order to realise the Action on Health Visiting programme. Unite/CPHVA is now leading a workstream to clarify specific roles for health visitors to cover the universal aspects of the role in addition to safeguarding. The 2009 conference will see the launch of a toolkit for health visitors and managers, produced in response to our joint concerns.

To add to this major development, a number of publications will be launched at this year’s conference, including a community nursery nurse handbook and guidance on skill mix, competencies for staff nurses working in health visiting teams and a leaflet on the unique role of the school nurse. There is a focus on leadership and safeguarding issues in the conference programme, and the opportunity to take part in leadership masterclasses.

Another concern from last year’s ANPF was the lack of training places and the impact of this on practice.

**Remembering last conference**

**What it meant to go to last year’s conference**

Anita McCrum  
Lead nurse health visiting,  
Mount Vernon Hospital, NHS Barnsley

Last year, I was one of five people whose conference place was funded by Ten Alps Publishing. With this year’s event almost upon us, I have been reflecting on what it meant to go to the 2008 conference and the impact it had on my work.

For me personally, the conference is a package that provides networking opportunities and a vast array of information sessions. All of these at last year’s conference gave a lasting impression, some more meaningful than others. The plenary sessions were well planned in order to set the scene for the conference. It was stimulating to hear a constant message reaffirming the public health role that health visitors, school nurses and our colleagues have, and recognition of our contribution to reducing health inequalities for children and families.

The concurrent sessions are probably the most meaningful aspect of the conference for me, as it is always fantastic to hear about what innovations other health visitors are involved in and their passion for the work that they are doing. Last year’s concurrent sessions were exceptionally outstanding. The theme ‘Focus on Families’ provided the opportunity for practitioners – not only health visitors but from wider children’s services – to come together and demonstrate their shared commitment to addressing the needs of families and communities through practical examples of their work.

As a professional lead for health visiting, the learning from attending the conference is immense. The wealth of knowledge and information gained has been particularly beneficial to progressing developments within practice, especially with regard to the modernisation agenda and partnership working within my own organisation.

Attending conference is not only the perfect opportunity to extend your professional knowledge, it also provides the opportunity to network with colleagues from across the UK in an informal and relaxed environment.

This year’s conference is particularly pertinent, as it will focus on the key issues that affect community practitioners currently, particularly with regards to safeguarding children.
SOOTHING THE IRRITATION OF NAPPY RASH

Parents rely on community-based healthcare professionals as the first port of call when it comes to their baby’s wellbeing.

Nappy rash is a skin condition experienced by most babies at some point and therefore health visitors and community nurses are ideally placed to reassure parents and advise on the best course of treatment. Nappy rash typically causes a mild skin irritation, which results in discomfort as it can irritate the baby’s skin, especially when it wets or dries its nappy. It can be a recurrent problem for some infants, since babies have skin which is much thinner than an adult’s and has a higher pH level, making it more sensitive and vulnerable to skin conditions such as nappy rash. As the first point of contact for new parents, community practitioners are in a position to offer valuable advice on both treatment and prevention.

Signs and Symptoms

Ordinarily nappy rash appears as a red or pink skin rash, made up of small spots or blotches on the area of the skin usually covered by the nappy. In most cases, the baby will otherwise feel well, apart from experiencing a stinging sensation when they wet or dirty their nappy.

Severe nappy rash can cause symptoms including bright red spots and dry, cracked skin, as well as ulcers or blisters on the skin. The baby may be more distressed and irritable due to these more painful symptoms, which may spread further down the legs or up the abdomen. Should the child’s rash be accompanied by a fever or very inflamed skin, this could indicate a sign of a bacterial infection, and should be referred to a GP.

Causes

Nappy rash is primarily caused by prolonged contact of urine or faeces with the skin. Once a nappy is wet or soiled and left unchanged, ammonia is produced from the waste which can interact with the baby’s delicate skin causing soreness and irritation.

Another common cause of nappy rash is the proliferation of the Candida fungus on the baby’s skin. Candida thrives in warm, wet conditions and can irritate the skin in much the same way as ammonia.

In general, nappy rash should clear up with frequent nappy changes, employing a good skincare routine, including the use of a good zinc oxide cream or ointment, such as Morhulin, plus regular exposure of the skin to the air.

Nappy rash is more likely to occur:

- During teething
- If the infant is ill, especially if they have an upset stomach or a cold
- If the child has been prescribed antibiotics which can upset their digestive system, resulting in diarrhoea
- If a mother changes from breastfeeding to bottle feeding
- When solid foods are first introduced into a baby’s diet

Helping New Mums to Soothe Nappy Rash

Health visitors, nurses and other healthcare professionals who come into contact with parents and new babies on a regular basis are in an ideal position to provide advice on common, non-serious infant conditions. As such, these healthcare professionals should be aware of Morhulin, a dual-action nappy cream containing zinc oxide, a known barrier cream, which is enhanced with the natural benefit of cod liver oil. This promotes the healing of wounds, whilst soothing and moisturising the skin.

Cod liver oil contains a natural source of vitamin A and glycerine which promotes the healing of wounds, while zinc oxide helps remove dead skin tissue and has an established value in the treatment of minor skin wounds.

Morhulin won’t stain clothing and has a rich luxurious feel which helps to relieve the symptoms of nappy rash, whilst being kind to the baby’s delicate skin.

Morhulin ointment should be applied directly onto the skin one to three times a day. If the baby has severe nappy rash or if symptoms persist, parents should be advised to speak to the GP.

Providing support to parents through the first months with a new baby is a vital role of health visitors and community nurses, so encourage them to visit www.morhulin.co.uk for more information. The site offers tips for parents on an effective skin care routine for their new baby and advice on nappy rash treatment and prevention.

To download or request copies of a patient leaflet offering helpful advice on nappy rash treatment and prevention, please visit the healthcare professionals page on the Morhulin website www.morhulin.co.uk/healthcareprofessionals. Leaflets can also be ordered from leaflets2u, the healthcare professional’s library. Visit www.leaflets2u.co.uk.

For further information visit www.morhulin.co.uk or call Actavis on 01271 311 200

Top tips for new mums

- Leave the baby’s nappy off for an hour or so each day to give the skin access to the air
- Change the baby’s nappy more frequently to limit the amount of contact the skin has with urine or faeces
- Wash the baby’s bottom with warm water and dry thoroughly at each nappy change. Alcohol-free wet wipes can also be used when out and about
- Use a good zinc oxide barrier cream such as Morhulin on dry skin before replacing the nappy to help reduce the baby’s skin coming into contact with urine and faeces
- Morhulin is a tried and trusted treatment for nappy rash, which has been used by parents for many years. Morhulin contains the added benefit of natural cod liver oil to promote healing whilst soothing and moisturising the skin
- Do not use talcum powder when changing nappies because unlike a barrier cream, talc offers little protection and can cause friction, further irritating the skin
- Visit the GP if symptoms do not clear up within a few days, the irritation gets worse, or if a fever develops. A fever may indicate a bacterial infection or an underlying condition, such as eczema or psoriasis, which may require medical treatment
Breastmilk

Aptamil

Cow & Gate

Nurture

SMA

HiPP

LCPs*
Nucleotides
Galacto-oligosaccharides (GOS)
Fructo-oligosaccharides (FOS)
Other oligosaccharides
Hormones and antibodies

You can count on Aptamil infant formulas

Every month, we provide practical support and share the latest research on infant feeding with thousands of healthcare professionals. To find out more you can visit our specialised HCP website or call our dedicated HCP helpline.

www.aptamilprofessional.co.uk   08457 623 676


Available through all major supermarkets, pharmacies and drugstores.

IMPORTANT NOTICE: Breastfeeding is best for babies. Breast milk provides babies with the best source of nourishment. Infant formula milk and follow on milks are intended to be used when babies cannot be breast fed. The decision to discontinue breast feeding may be difficult to reverse and the introduction of partial bottle-feeding may reduce breast milk supply. The financial benefits of breast feeding should be considered before bottle feeding is initiated. Failure to follow preparation instructions carefully may be harmful to a babies health. Infant formula and follow up milks should be used only on the advice of a healthcare professional.
A whole-child perspective assessment guide for early years settings

**Introduction**

While Ireland has been a relative latecomer to the provision of out-of-home care for children,¹ there has been substantial investment in this area in recent years. Some €1 billion has been spent on capital, staff and quality enhancement since 2000,² and substantial policy development has taken place at a national level.³ Early childhood is a time of rapid growth and development, and the positive and/or negative consequences of care and education during this time can last well into adulthood.⁴ Research based on the findings of longitudinal studies shows that, although parenting is a stronger predictor of children's development than early childcare experiences, good quality child care results in improved children's outcomes across a range of areas.⁵

In Ireland, the legal requirements for pre-school provision are set out in Part VII of the Child Care Act 1991.⁶ In accordance with this Act, pre-school regulations were published in 1996 and amended in 1997,⁷ and a Pre-School Inspectorate was established by the Health Services Executive (HSE) to carry out inspections. Inspection of areas relating to children's development are carried out by pre-school inspectors with professional expertise and experience in this area, and at this time these professionals are drawn mainly from the public health nursing service. Regulations were accompanied by an explanatory guide that prescribed the measures that had to be in place to fulfil the requirements of the Act relating to:

- **Promotion of the health, welfare and development of children**
- **Notifications to be given to a health board**
- **Keeping of records**
- **Standard of premises and facilities**
- **General administration.**

However, the 1996 regulations attracted some criticism for focusing overly on the health and safety of pre-school settings rather than on support for child development and quality of care.⁹ To address this, a revised set of regulations was published in 2006.¹⁰ These were drawn up by a review group led by the Department of Health and Children, and included representatives of other relevant government departments, the HSE, national voluntary childcare organisations and Centre for Early Childhood Development and Education. One of the main changes was the inclusion of Regulation 5, which refers to health, welfare and development: 'A person [providing] a pre-school service shall ensure that each child's learning, development and wellbeing is facilitated within the daily life of the service through the provision of the appropriate opportunities, experiences, activities, interaction, materials and equipment, having regard to the age and stage of development of the child and the child's cultural context' (p9).¹⁰

The explanatory guide published at the same time as the regulations encouraged service providers to take a whole-child perspective in the planning and delivery of pre-school services.

Given the challenge that this regulatory change presented to pre-school inspectors, specific guidance on how the multidimensional nature of the whole-child perspective could be evaluated in practice was required. The purpose of this paper is to report on the development of an assessment guide based on the whole-child perspective, for use by pre-school inspectors.

**Whole-child perspective**

The whole child perspective, first set out in the National Children's Strategy,¹¹ provides a framework through which child development can be understood in both a holistic and child-centred way. The perspective—which is informed and underpinned, by the work of Bronfenbrenner, Ward and others¹²-¹⁶ and in keeping with the spirit and principles of the United Nations Convention on the Rights of the Child¹⁷ —recognises the child as an active participant in their own development, as well as the importance of the ecology in which the child is embedded. There are three broad domains within this:

- **Children's innate capacity**
- **Formal and informal supports**
- **Children's relationships.**
Children's innate capacity
This domain deals with the extent of children's capacities that can be measured by outcomes across nine different dimensions:
- Physical and mental wellbeing
- Emotional and behavioural wellbeing
- Intellectual capacity
- Spiritual and moral wellbeing
- Identity
- Self-care
- Family relationships
- Social and peer relationships
- Social presentation.

Formal and informal supports
This domain deals with essential supports and services that children need and benefit from. These include the primary, social networks of family, extended family and community – known as the informal supports – and the formal supports provided by the voluntary sector, commercial sector and the state and its agencies.

Children's relationships
This domain deals with the complex set of dynamic relationships that are essential to satisfying and successful childhood. These relationships range from the family – the primary source of care and protection for children – to the state, which acts as the ultimate guarantor of their rights.

Assessment guide development
The purpose of the assessment guide is to ensure that the Pre-School Inspectorate takes an explicit and consistent approach to the evaluation of Regulation 5. The guide was developed by an expert working group that comprised the Office of the Minister for Children and Youth Affairs and 10 preschool inspectors who were geographically representative and had a number of years experience in the area.

The expert working group provided direction in identifying appropriate items for inclusion in the assessment guide, offered commentary on its drafting, took part in its pre- and pilot testing in practice, and provided post pilot-test observations on the revised guide. Their work was informed by a review of literature on quality in early childcare and education settings, a review of other validated and widely used assessment guides20-21 and the work of the Irish Centre for Early Childhood Development and Education, in particular Síolta, the national quality framework for early childhood care and education.22

Considered discussion took place around the potential use of a previously validated assessment guide. There was a general agreement that the assessment guide should be consistent with other developments taking place in the Irish context – particularly Síolta – and no previously validated tool met this criterion. Consequently, while the guide took account of previous national and international developments, it was also explicitly linked to other Irish developments. This included underpinning the guide with the six principles incorporated into the National Children's Strategy of being child-centred, family-oriented, equitable, inclusive, action-oriented and

Table 1. Domains and dimensions (version one)

<table>
<thead>
<tr>
<th>Domain</th>
<th>Dimension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extent to which the physical or material environment supports development</td>
<td>Indoor environment is comfortable and pleasant and is laid out to accommodate the needs of all children and adults in the setting</td>
</tr>
<tr>
<td>Extent to which relationships around are supported</td>
<td>Indoor environment provides a range of developmentally appropriate, challenging, diverse, creative and enriching experiences for all children</td>
</tr>
<tr>
<td></td>
<td>Materials are freely available and easily accessible to all children when needed</td>
</tr>
<tr>
<td></td>
<td>Outdoor environment is comfortable and pleasant, and is laid out to accommodate the needs of all children and adults in the setting</td>
</tr>
<tr>
<td></td>
<td>Outdoor environment provides a range of developmentally appropriate, challenging, diverse, creative and enriching experiences for all children</td>
</tr>
<tr>
<td></td>
<td>Facility staff operate in partnerships with parents and are responsive and sensitive in provision of information and support of parents in their key role in the child's learning and development</td>
</tr>
<tr>
<td></td>
<td>Transitions are made as smooth as possible for children</td>
</tr>
<tr>
<td></td>
<td>Opportunities are provided for parents to be involved in activities within the setting, taking into account the range of parents' interests and time constraints</td>
</tr>
<tr>
<td></td>
<td>Provision is made that ensures children can form and sustain secure relationships with adults, siblings, peers and other children and each child receives appropriate support to enable them to interact positively with other children</td>
</tr>
<tr>
<td></td>
<td>Adults demonstrate sensitivity, warmth and positive regard for children and their families</td>
</tr>
<tr>
<td></td>
<td>A strong ethos of teamwork is evident in the setting</td>
</tr>
<tr>
<td></td>
<td>Setting is integrated with local, regional and national community needs</td>
</tr>
<tr>
<td>Delivery of programmes of care and activities</td>
<td>Eating and drinking</td>
</tr>
<tr>
<td></td>
<td>Nappy changing or toileting</td>
</tr>
<tr>
<td></td>
<td>Personal cleanliness</td>
</tr>
<tr>
<td></td>
<td>Sleeping, quiet time or privacy</td>
</tr>
<tr>
<td></td>
<td>Mobility</td>
</tr>
<tr>
<td></td>
<td>Behaviour</td>
</tr>
<tr>
<td></td>
<td>Activities encourage and support stimulation of senses</td>
</tr>
<tr>
<td></td>
<td>Activities encourage and support language development</td>
</tr>
<tr>
<td></td>
<td>Activities encourage and support rhythm and movement activities</td>
</tr>
<tr>
<td></td>
<td>Activities encourage and support dramatic play</td>
</tr>
<tr>
<td></td>
<td>Activities encourage and support reasoning activities</td>
</tr>
<tr>
<td></td>
<td>Activities encourage and support sand and water play</td>
</tr>
<tr>
<td></td>
<td>Activities encourage and support construction activities</td>
</tr>
<tr>
<td></td>
<td>Activities encourage and support art and music</td>
</tr>
<tr>
<td></td>
<td>Activities encourage and support other activities (please specify)</td>
</tr>
<tr>
<td></td>
<td>Each child is enabled to participate actively in the daily routine, in activities, in conversations and in all other appropriate situations, and is considered as a partner by the adult</td>
</tr>
<tr>
<td></td>
<td>Each child has opportunities to make choices, is enabled to make decisions, and has their choices and decisions respected</td>
</tr>
<tr>
<td></td>
<td>Each child has opportunities and is enabled to take the lead, initiate activity, be appropriately independent and is supported to solve problems</td>
</tr>
<tr>
<td></td>
<td>The opportunities for play or exploration provided for the child mirror their stage of development, give the child the freedom to achieve mastery and success, and challenge the child to make the transition to new learning and development</td>
</tr>
<tr>
<td></td>
<td>Planning for curriculum or programme implementation is based on the child's individual profile, which is established through systematic observation and assessment for learning</td>
</tr>
</tbody>
</table>
producing three separate ratings for infants, selected to assess each of the dimensions, were provided by the expert working group. Where examples were not available, these were used to provide examples within the assessment guide. This facilitated coherence between the assessment guide and Síolta. Where available, these were used to provide examples within the assessment guide. This facilitated coherence between the assessment guide and Síolta. Where examples were not available, these were provided by the expert working group.

Pilot assessment guide

The pilot assessment guide comprised four domains with 32 dimensions (see Table 1). A seven-point rating scale used elsewhere that ranged from ‘inadequate’ to ‘excellent’ was selected to assess each of the dimensions, producing three separate ratings for infants, toddlers, and pre-school or older children.

Sample

The pilot assessment guide was tested in the field by 13 pre-school inspectors in 37 pre-school settings – eight childminder (22%), 16 full daycare (43%) and 13 sessional (35%) settings. Approximately 60% of the settings included infants, 70% toddlers and almost all (92%) pre-school or older children.

On completion of each assessment, inspectors also completed a short questionnaire about the assessment guide. This examined ease of use, time needed to complete it, appropriateness of dimensions, usefulness of examples given for each dimension, appropriateness of the rating scale, usefulness to make a judgement, recommendation and/or write a report, and overall satisfaction.

Data analysis

The end-of-assessment questionnaire provided both quantitative and qualitative information. Quantitative data were analysed using SPSS statistical analysis software, while a thematic analysis was undertaken on the qualitative information. The reliability of dimensions included in each domain on the assessment tool was examined using Cronbach’s alpha. Generally, the higher the Cronbach alpha value, the more reliable the domain is considered to be. A Cronbach alpha value of less than 0.7 would be deemed unacceptable. Results

Overall, there was a high level of satisfaction with the assessment guide (91%) and the guide was generally considered suitable for use in pre-school settings, provided some changes were made (94%). For example, in

| Table 2. Cronbach alpha values for domain scales in the pilot assessment guide |
|---|---|---|
| Domain | Infants | Alpha value | Children |
| Extent to which the physical or material environment supports development | 0.928 (n=15) | 0.912 (n=17) | 0.893 (n=22) |
| Extent to which relationships around are supported | 0.955 (n=13) | 0.956 (n=15) | 0.944 (n=21) |
| Extent to which the personal care provided meets basic needs | 0.879 (n=15) | 0.927 (n=17) | 0.930 (n=22) |
| Delivery of programmes of care and activities | 0.987 (n=9) | 0.985 (n=13) | 0.979 (n=18) |

| Table 3. Domains and dimensions (version two) |
|---|---|
| Domain | Dimension |
| Extent to which the personal care provided meets basic needs of the infants and children | 1. Eating and drinking |
| | 2. Nappy changing or toileting |
| | 3. Personal cleanliness |
| | 4. Sleeping, quiet time or privacy |
| | 5. Mobility |
| | 6. Behaviour |
| Extent to which relationships around children are supported | 7. Provision is made that ensures children can form and sustain secure relationships with adults, siblings, peers and other children and each child receives appropriate support to enable them to interact positively with other children |
| | 8. Adults demonstrate sensitivity, warmth and positive regard for children and their families |
| | 9. A strong ethos of teamwork is evident in the setting |
| | 10. The staff of the facility operates in partnerships with parents and are responsive and sensitive in the provision of information and support of parents in their key role in the learning and development of the child |
| | 11. Setting is integrated with local, regional and national community |
| Extent to which the physical or material environment supports development | 12. Indoor environment is comfortable and pleasant and is laid out to accommodate the needs of all children and adults in the setting |
| | 13. Indoor environment provides a range of developmentally appropriate, challenging, diverse, creative and enriching experiences for all children |
| | 14. Materials are freely available and easily accessible to all children when needed |
| | 15. Outdoor environment is comfortable and pleasant and is laid out to accommodate the needs of all children and adults in the setting |
| | 16. Outdoor environment provides a range of developmentally appropriate, challenging, diverse, creative and enriching experiences for all children |
| Extent to which the programme of activities and its implementation supports children’s development | 17. Activities encourage and support play |
| | 18. Activities encourage and support language development |
| | 19. Each child is enabled to participate actively in the daily routine, in activities, in conversations and in all other appropriate situations, and is considered as a partner by the adult |
| | 20. Each child has opportunities to make choices, is enabled to make decisions, and has their choices and decisions respected |
| | 21. Each child has opportunities and is enabled to take the lead, initiate activity, be appropriately independent and is supported to solve problems |
| | 22. The opportunities for play or exploration provided for the child mirror their stage of development, give the child the freedom to achieve mastery and success, and challenge the child to make the transition to new learning and development |
| | 23. Planning for curriculum or programme implementation is based on the child’s individual profile, which is established through systematic observation and assessment for learning |
a number of cases the assessment guide took too long to complete (32%), and the rating scale was difficult to apply (31%) or inappropriate (13%) – particularly in sessional and childminding settings. In these, the requirement for separate ratings for infants, toddlers and pre-school or older children was challenged as being unnecessary and unduly complex, and one overall rating was proposed instead. Some pre-school inspectors made positive comments about the assessment guide, such as:

The overall tool is very good and achieves more than I expected. It is straightforward and achieves a very good balance between tick box and professional judgment.

In addition to post pilot-test observations from the pre-school inspectors, the Cronbach alpha values (see Table 2) demonstrate a high level of reliability for each domain, though some caution should be exercised in interpreting these values given the small number of assessments that were carried out as part of the pilot test.

Overall, the results of the pilot test suggested that, with some changes, an appropriate assessment guide for Regulation 5 was in place.

Next steps

Based on the pilot test results and following further workshops with the expert group, a number of changes to the assessment guide have been agreed. These relate specifically to the rating scale and the type and number of items used. The revised guide now comprises only 23 dimensions (see Table 3). Each dimension is now assessed using a three-point rating scale:

- ‘Inadequate’ – not compliant
- ‘Minimal’ – compliant
- ‘Good’ – exceeds minimum requirements.

The three separate ratings for infants, toddlers and other pre-school children were replaced by one overall rating. These changes not only addressed concerns raised by the pre-school inspectors during the pilot test, but also harmonise the assessment guide with the overall aim of inspections (to identify where a pre-school setting is compliant or not with the regulations).

Training in using the revised assessment guide has been completed with all pre-school inspectors. Following a trial period, it is anticipated that inter-rater reliability testing and an evaluation will take place to identify if further changes are necessary. The assessment guide will be available via the HSE website.

Discussion and conclusion

The assessment guide was developed to assist pre-school inspectors in evaluating the extent to which individual pre-school settings support children in a holistic way. The intention is to support rather than replace professional decision-making in respect of Regulation 5 of the pre-school regulations, and by doing so to improve consistency and harmonisation across pre-school inspections. It can also help inspectors to be more explicit about the areas that are working well and those that are not. The assessment guide can benefit providers, making overt the areas of practice and provision being assessed in inspections. This can provide them with opportunities to make appropriate changes if required.

The assessment guide is based on a socio-ecological understanding of children’s lives and incorporates the breadth of children’s lives. The guide built on Irish and international initiatives, including the on-going implementation of the national quality framework Siolta across Ireland. The guide is coherent with this framework, so can support good quality practice across the area. As other developments take place, it is likely that the guide will need to be reviewed to ensure that these are incorporated.

The involvement of professionally trained pre-school inspectors with considerable experience in the area of child development ensured construct validity of the guide, and enabled the development to bridge a policy-theory-practice gap in this area.

Regulatory change has placed a whole-child perspective centrally within early childcare and education settings in Ireland. There is substantial national and international evidence on the impact of early years on children’s wellbeing and well-being. The impact of childcare and education settings cannot be underestimated and good quality services are crucial. Regulation and its inspection have a key role in ensuring service quality, and the assessment guide can help inspectors, providers and especially children and their families, by making best practice in this area explicit.

Key points

- Pre-school childcare regulations in Ireland incorporate a whole-child perspective
- Pre-school inspectors have professional training and experience in the area of child development, and almost all have a public health nursing background
- An assessment guide was developed to support professional decision-making in the inspection of the services provided for pre-school children, guided by a socio-ecological theory and national and international best practice, and assisted by an expert group
- The guide can assist inspectors, providers, and children and their families, by highlighting areas that are working well and those that need improvement

References

The Learning Curve is an educational initiative offering interactive study days and research grants to all healthcare professionals involved and interested in expanding their knowledge in pregnancy, childbirth, infants and toddlers (from birth to 36 months).

The Learning Curve runs a multidisciplinary programme throughout the year and is particularly keen to hear from any healthcare professional or other relevant professional who may be interested in speaking at one of our events.

Grant applications are also invited from eligible candidates interested in developing their studies in these areas and in particular are welcome from specialists interested in the development of the immune response, childhood allergies, special care and premature births.

For further information on how The Learning Curve can help develop your skills, visit us at www.learningcurve.uk.net or call 0800 7817195
Young, vulnerable and pregnant: family support in practice

Joyce Halliday PhD, MA
Academic fellow in rural health, School of Law and Social Science, University of Plymouth

Tina Wilkinson MA, BSc
MPhil/PhD student, School of Applied Psychosocial Sciences, University of Plymouth

Abstract
Intervention in the early years, including family support, can reduce inequality and disadvantage across the life course. This paper reports on an evaluation of a local project, which aims to increase resilience and avert crisis among vulnerable young mothers. It suggests that paraprofessional link workers, spanning the antenatal-postnatal period, may contribute to maternal health and wellbeing and increase use of support services and networks. However, challenges for inter-agency and interprofessional working remain.

Key words
Family support, young mothers, link workers

Introduction
The early years are recognised as a critical period when intervention can reduce disadvantage across the life course. National policy also emphasises the need to close the gap between the most disadvantaged children and their peers. Access to child care, pre-school education, family support services, informal support networks and the creation of social capital are all fundamental to this target. However, the evidence base does not always offer the guidance that policy makers and practitioners require when it comes to implementing such programmes locally. Less is known, for example, about the role of family support in primary as opposed to tertiary prevention, strategies for reaching the most disadvantaged families and what determines effectiveness in a local context.

This paper reports on the findings of a service evaluation of a pilot project that is centrally related to this evidence base and these challenges. The Malezi Project aims to work with vulnerable first-time young mothers (aged 17 to 25 years) to increase resilience and avert crisis. It reflects the current emphasis on partnership working and the acceptance that problems such as health inequalities require holistic thinking.

It also develops the notion of the link worker as a contact point for the family who can provide information, signposting and emotional support, help co-ordinate services and empower clients. It shares many of the concerns of the Family Nurse Partnership programme, which aims to provide nurse-led home visiting for vulnerable first-time parents.

One notable difference is that the project is not nurse-led but relies instead on paraprofessionals – health visiting and midwifery staff.

The Malezi Project
The Malezi Project was based on a review of the evidence base relating to maternal and child outcomes, together with consideration of city-specific problems, such as levels of deprivation and under-18 conceptions. Building on the existing family support network, it aimed to:

- Improve the health and wellbeing (emotional and social functioning) of young vulnerable families
- Increase the use made of support services
- Improve inter-agency working
- Drawing on the evidence, it sought to:
- Improve self-esteem and confidence
- Reduce smoking or minimise risks to the baby
- Increase breastfeeding rates
- Reduce isolation and foster support
- Identify service-related problems constraining access

These aims were to be delivered in a year-long pilot phase through five Malezi link workers (three whole-time equivalents). The link workers were health visitor assistants or midwifery assistants who received project-specific training – smoking cessation and smoking in pregnancy, child protection, social attachment and the UNICEF breastfeeding course. They were supervised by a part-time project manager (a senior health visitor, already working in the city) and based in two children’s centres in order to establish the project’s profile with local agencies, community-based healthcare professionals and young families. It was funded from the children’s centre budget and accountable to them and the city council through a strategic multi-agency steering group, including senior health visiting and midwifery staff.

Clients could be referred into the project if they were a first-time mother aged 17 to 25 years at level 1 or 2 vulnerability on the local child concern model (where the carer was under stress that might affect their child’s health and development). Typical problems encountered included isolation, lack of confidence, housing stress, financial problems, unstable relationships and chaotic lifestyles. The intention (determined by funding rather than the evidence base) was that one-to-one support could be delivered until the baby was six months old. Reflecting the emphasis on early intervention, most referrals were from midwives, but the pilot also encouraged referrals from health visitors and other professionals. It was the intention that...
healthcare professionals would remain accountable for their client, with the link workers providing an additional service with project-specific lines of accountability.

Core features of successful home visiting programmes include early identification of families via the health service, together with the early initiation and sustained provision of support services, integration with existing services and voluntary participation.9 However, the effectiveness of professionals as opposed to paraprofessionals remains uncertain in a UK context and the subject of wider debate.10-12 Precedents exist to suggest that empathy, information and support are important in increasing parenting capacity, and are not restricted to professionals.12,13 The pilot project was also subject to evaluation and this paper draws on the findings of this gathered from baseline and follow-up questionnaires, activity sheets, reflexive logs and interviews with clients, link workers and referrers. Specifically, it focuses on work with 38 referrals (the six-month case-load for three workers) to the project in 2007 to 2008, to explore the ability of a local paraprofessional model to improve outcomes for young, vulnerable families.

Improving health and wellbeing

A link worker-administered questionnaire (developed in consultation with Malezi Project staff) recorded clients’ health and health-related behaviour on entry and again at six months or case closure. Comparison of the returns (relating to 22 cases) suggested improvement in several areas that might be attributed, at least in part, to the project.

General health

Health was not a major concern for new clients, with only two rating their health (on a Likert scale) other than good. Nevertheless, six clients recorded an improvement in their health across the course of the project. Movement from pregnancy to motherhood may have been a contributory factor here. However, one-to-one support from link workers and the provision of health-related information may also have contributed.

Wellbeing was similarly investigated through six Likert-scaled questions. These rated levels of satisfaction with life as a whole, pending motherhood, availability of personal time, someone to talk to, and the support received from family, local groups and services. Overall, wellbeing was good both on engagement with the project and at exit. This suggests that the project might not have reached those most in need.14 However, the baseline questionnaire was administered on entry to the project when clients may have been unwilling to admit to problems, while the postnatal challenges anticipated by those who referred them would not yet have emerged.

Indeed, interviews with the young mothers suggested that the project had had a positive effect on their self-esteem and confidence and that, in contrast to their questionnaire responses, motherhood was often an unexpected event with related anxieties that the link workers had countered. This was supported in interviews with referrers, who identified clients who had ‘definitely moved forward... I can see in them that they’re more positive attending things’. It is thus important to triangulate survey results and not rely exclusively on quantitative scales to measure progress.

Smoking cessation

In the UK, teenage mothers are more likely to smoke before or during pregnancy than mothers aged over 20 years.15 It is therefore unsurprising that the majority of the sample (60%, n=13) were either smoking or had been smoking prior to becoming pregnant. Only one client had never smoked either before becoming pregnant or during pregnancy. It was hoped that the second aim of the Malezi Project had been influential in engendering confidence and – importantly for both personal and community capacity – one mother also attended peer support training. The background and experience of link workers had an impact on their confidence and efficacy in this role – a midwifery background helped engagement.

Baby-feeding preferences

The majority of clients (60%, n=13) wanted to formula-feed their baby as opposed to breastfeed. This is again unsurprising, as only 51% of mothers aged 20 or under in the UK breastfeed their baby at stage one, as opposed to 84% of mothers aged 35 and over.15 However, the rates for the Malezi sample are low compared even to the national average.

No significant changes were recorded among this group in terms of baby-feeding preferences but the activity sheets showed about half (n=14) of the young mothers had been given advice on breastfeeding, often including attendance at a breastfeeding workshop with some ‘already set on bottle-feeding’. This highlights the need for both early intervention and a community approach, with feeding preferences often established pre-birth and prior to contact with healthcare professionals.18

While only one-quarter (n=7) initiated breastfeeding, all but one of these attended a breastfeeding support group. In these instances, it was apparent from link worker records and client interviews that the Malezi Project had been influential in engendering confidence and – importantly for both personal and community capacity – one mother also attended peer support training. The background and experience of link workers had an impact on their confidence and efficacy in this role – a midwifery background helped engagement.

Use of available support

It was hoped that the second aim of the Malezi Project – to increase use of available support services and networks – would increase parenting capacity, reduce social isolation and increase self-confidence. All clients had been advised to attend local mother-and-baby groups, and accompanied visits were a vital part of the link workers’ role. This could be a very time-consuming process but one where gains in confidence were apparent: She now knows two faces here so is confident to attend by herself (link worker, reflexive log).

The activity sheets revealed the variety of advice and support provided in relation to benefits, work, education and relationships. Housing was a particular stressor, with 28% of these clients (n=8) receiving help with housing from their link worker. This ranged from completing grant applications to attending the housing office with the family, or accompanying clients on visits to

...
the mother-and-baby unit. In such instances, it was not only a case of offering organisational skills and persistence but also confidence, advocacy and occasionally interpretation of professional terminology. It was obvious from interviews, activity sheets and reflexive logs that the link workers provided not only practical but emotional support. In part, this was attributed to the one-to-one support provided and the trust established with their clients: ‘The link worker] was really easy to talk to, I felt comfortable and she was very welcoming’ (Malezi client 1, interview).

**Improved joint working**

The third aim of the Malezi Project was to develop inter-agency working. A wide variety of agencies were accessed, including social services, housing, mental health services and debt advisers. Mapping these various support services, establishing contacts and sharing information was an important part of the link workers’ role. However, sharing information was not always easy and raised a number of issues for interprofessional working. Maintenance of computerised health visiting records was a particular difficulty, with link workers spending a considerable amount of time getting from one base to another and working in locations with which they were not familiar.

There was also on-going concern about the referral process. Not all referrals were at the correct level of need (a problem that spanned both ends of the spectrum) or used the correct procedures, with:

- A midwife, health visitor or other professional completing a Common Assessment Framework form
- A subsequent joint visit by the referrer and the link worker
- An agreed care plan, reviewed regularly.

Where onward referral was needed, delays could mean that link workers were supporting very vulnerable clients. Additionally, healthcare professionals were not always willing to refer clients into the project, and relationships between midwives and health visitors were often an area of tension. As one midwife explained, the original vision was that Malezi would try ‘to tie up the work of midwives, health visitors and children’s centres and get those links established’. But there was little evidence that this had been achieved in the pilot phase. Indeed, the referral process had on occasions caused additional problems and left some feeling that their professional domains had been challenged, despite the extensive efforts of the project manager to visit health visitor and midwife teams and explain how the project might support them in their work.

**Link worker characteristics and response**

The project demanded that link workers draw heavily on their professional early years’ training and interpersonal skills. The challenges of combining a vulnerable client base and an innovative role were nevertheless apparent, with clients’ social issues the aspect of the job that caused link workers most concern. Their logs also made obvious the need to challenge both their pre-conceptions – for example, concerning levels of support from other agencies and clients’ capabilities – and those of the young mothers.

However, interviews with the clients showed that the ‘listening ear’ and approachability of the link workers was a highly valued element of support: ‘I can talk to [the link worker] about anything, I can. It’s like not just being there to help, she’s more like a friend... I can just ring her, text her and just let her know that I need someone to talk to’ (Malezi client 2, interview).

The flexible and intensive input of the link workers was also seen as an important addition to the support base by local healthcare professionals, particularly the fact that they had ‘time that we haven’t got to spend, basically’. However, this close relationship with clients could lead to some overdependency and the requirement to balance intervention with the goal of client independence. Such problems around role definition, boundaries and exit strategies are likely to escalate as the project is evolving, clients were recruited at different stages of pregnancy and monitoring tools were still being established. It is also difficult to attribute causal explanations in any community initiative, because participants are subject to a diversity of often conflicting influences.

This pilot suggested that health issues were not a major concern for many of the clients, yet this was a group where health-damaging behaviours were apparent. Many young mothers showed resistance to the idea of smoking cessation and information, so advice needed to be tempered with a requirement to deliver support and encourage trust. It was similarly difficult to change clients’ views about their preferred baby-feeding methods, but it was important that the project acted as a source of practical and emotional support in decisions to breastfeed.

The project found it easier to achieve its aim of increasing the use made of available support services and networks. Link workers gave advice on an extensive range of issues and this was much valued by the clients. It was also obvious that the process of actively bringing the clients into centres to access mother-and-baby groups was successful. This opens doors to a variety of formal and informal support networks, which are known to increase parenting capacity and reduce risk.

It is more difficult to judge the impact that the project has made on inter-agency working. The referral of Malezi clients into the wider system has reduced individual barriers to information and advice, overcoming problems with confidence, language and process, such as the ability to complete forms. The location of link workers in children’s centres appears to be of mutual benefit to both the project and children’s centre staff, particularly in terms of improving outreach and bringing people into the centres. However, problems around referral and interprofessional concerns about delegation and core competencies were evident. Such concerns do not appear to be limited to projects that utilise paraprofessionals, but are common challenges for innovatory projects operating across organisational and professional domains.

The project has now completed a second phase, and funding has been secured for a further two years, enabling the employment of 11 link workers and an expansion in the number of children’s centres involved. One
of the first challenges for the extended project relates to the ability to establish trust and increase reach among the local health sector, particularly midwives. A further challenge is increasing project identity. This relates not only to raising awareness locally, but also the ability to institutionalise learning so that it is embedded in the system rather than vested in individuals. For example, protocols with respect to referral criteria and safety and a central directory of accessible and maintained information on local agencies, groups and contacts are imperative.

It is hoped that systematic, sustained and responsive data collection will also enable the continued relevance of the project to be assessed, and for practice to be modified appropriately. As in previous research, the link worker role, the skill mix, the perceived informality of the support and the link worker role, the skill mix, the perceived informality of the support and the importance that is attached to home visiting appear to be central to the project's continued relevance of the project to be assessed, and for practice to be modified appropriately. As in previous research, the link worker role, the skill mix, the perceived informality of the support and the importance that is attached to home visiting appear to be central to the project's early achievements.19

References
16 McLeod D, Benn C, Pullon S, Vickers A, White S, Cookson T, Dowell A. The midwife’s role in facilitat-

Key points
- The employment of paraprofessional link workers spanning the antenatal-postnatal period increased the use made of available support services and networks.
- Their ability to contribute to maternal health and wellbeing was less certain, and key barriers included prevailing community norms and stage of referral.
- A focus on home visiting was key to facilitating engagement with the wider support network.
- Challenges for inter-agency and interprofessional working remained, particularly around referral but also interprofessional concerns about delegation and core competencies.
- Key link worker characteristics were their health-related training and credibility together with their empathy, flexibility and availability.

Call for papers

Emotional health and wellbeing

Community Practitioner invites submissions of professional papers to be considered for a special themed issue of the journal about emotional health and wellbeing.

The special issue is expected to be published in summer 2010, and papers should be submitted to the editor as soon as possible, but by the end of February 2010.

For more information or to discuss an idea for a paper, please contact the editor Danny Ratnaike on Tel: 020 7878 2404 or email: danny.ratnaike@tenalpspublishing.com

Image: Marius Largu
With carefully designed cushions that mimic baby’s gentle suckling action, our manual breast pump is so effective that it can express more milk than a hospital-grade electric pump.*

Our pumps are just part of the Philips AVENT breast care range, supporting mothers to breastfeed comfortably and efficiently, for longer. www.philips.co.uk/AVENT

*Based on a clinical trial comparing sequential pumping (per breast) with the Philips AVENT Manual versus the Egnell Ameda Elite double electric pump. Study published in Paediatrics (2001) Vol 107 No 6, Pages 1291-1297. Full study available at www.philips.co.uk/AVENT
The conference is now just 6 weeks away and the programme is now fully confirmed with not one but two ministers;

Both Andy Burnham and Ed Balls have confirmed their participation and will showcase the importance of community practitioners and health professionals in relation to the national agenda.

Focusing this year on safeguarding and leadership: hear the latest research from Lane Strathern linking breastfeeding with safeguarding outcomes and the inspirational Claire Bertschinger will tell her fascinating and moving story about her work in Ethiopia that inspired Band Aid and her work since.

There is also a wide variety of concurrent sessions appealing to all interests including the Community Nursery Nurses Conference and School Nurse conference, PLUS NEW for 2009 a session of Masterclasses on Wednesday 14th October.

The programme is exciting and full of high profile speakers including:

- Lord Laming
- Derek Simpson
- Dame Christine Beasley
- Rosemary Kennedy
- Angela McLernon
- Jane Walker
- Judith Ellis
- Kevin Browne
- Viv Bennett
- Kate Billingham
- many many more...

As usual there is a fantastic party planned, with live band and seaside themed entertainment as well as a chance to win a £1000 holiday.

Don't miss out - book now and join us for the event of the year. Simply fill in the attached registration form, and return to Profile Productions or call 020 8832 7311 for more information, alternatively you can book online at www.profileproductions.co.uk

Message from Dr Cheryll Adams, Lead Professional

'Once again Unite/CPHVA Conference has attracted an amazing line-up. I encourage as many of our members as possible to take part and make the most of our conference to reflect, update their knowledge base and lead in networking with other delegates.'

Plenary session highlights include:

WEDNESDAY 14 OCTOBER

Safeguarding our future
Unite/CPHVA Chair’s introduction
Angela Roberts, Chair, NPC, Unite/CPHVA
President’s welcome
Lord Victor Adebowale, President, Unite/CPHVA
Welcome and Union address
Derek Simpson, Joint General Secretary, Unite the Union

Ministerial address
Rt Hon Andy Burnham, Secretary of State for Health

Video message
Lord Laming of Tewin
The impact of Baby P - a professional perspective
Dr Judith Ellis MBE, Chief Nurse and Director of Workforce Development, Great Ormond Street Children’s Hospital Trust

THURSDAY 15 OCTOBER

Leadership and policy
Chair’s introduction
Leadership
Dame Christine Beasley DBE, Chief Nursing Officer for England
Leadership: how you make changes
Neil Wooding, Director, Public Service Management, Wales

Ministerial address
Rt Hon Ed Balls, Secretary of State for Children, Schools and Families
Why breastfeeding is a priority for safeguarding
Dr Lane Strathern, Assistant Professor of Paediatrics,
Baylor College of Medicine, Texas, USA

DEBATE
Chair: Lord Victor Adebowale, President, Unite/CPHVA
Question time debate - Safeguarding is a public health issue?
- Prof. John Ashton CBE, North West Regional Director of
  Public Health and Regional Medical Officer
- Dr. Jackie Gregg, Consultant Community Paediatrician,
  Alder Hey Children’s NHS Foundation Trust
- Liz Hughes, Consultant Nurse for Safeguarding Children,
  Sheffield
- Heather Gwynn, Director, Chief Nursing Officers
  Directorate, Department of Health

FRIDAY 16 OCTOBER

Unite/CPHVA - Safeguarding your future
Karen Reay and Dave Fleming, National Officers for Health,
Unite the Union

Safeguarding is an international health priority
Prof. Kevin Browne, Professor of Forensic Psychology &
Child Health Institute of Work, Health & Organisations (i-WHO),
University of Nottingham and Head of the World Health
Organisation Collaborating Centre for Child Care and Protection

Leading your professional future
Dr Cheryll Adams and Obi Amadi, Joint Lead Professional
Officers, Unite/CPHVA

The Nick Robin Memorial Lecture
Moving mountains
Claire Bertschinger, Red Cross Nurse who inspired Band
Aid & Course Director, London School of Hygiene and
Tropical Medicine

The full conference programme can be downloaded from:
www.profileproductions.co.uk
Diagnosis and management of ADHD: a new way forward?

Introduction
Recent National Institute for Health and Clinical Excellence (NICE) guidance for the diagnosis and management of attention deficit hyperactivity disorder (ADHD) in children, young people and adults,\(^1\) has attracted media attention and reignited the debate surrounding treatment of the condition. Previous NICE guidance acknowledged the role of alternatives such as behavioural therapy, but recommended that use of medication should not be postponed if such provision was not available or was subject to delay.\(^2\) The latest guidance appears to almost completely reverse the previously recommended approach, with behavioural therapies being promoted as a first-line treatment while medications such as methylphenidate (Ritalin) are recommended for use in severe cases only.

Those who believe that ADHD is over-diagnosed and drug treatments overused will welcome this guidance. Nevertheless, it will inevitably be difficult to implement, as many parents who feel that the medication regime is working for their child will be reluctant, if not resistant, to altering or abandoning it. In addition, parents whose child is newly diagnosed are likely to be aware of the trend for treatment with medication, and to therefore have expectations that their treatment regime will follow a similar path. Since parental understanding has unsurprisingly been shown to affect compliance with treatment for ADHD, whatever that treatment may be,\(^3\) there will certainly be a need for a widespread educational programme in order to effect this change of approach.

There are many who will argue that the motivation behind this guidance is purely financial, bearing in mind that the use of methylphenidate and other stimulants used in treating ADHD cost the NHS £13 million in 2004.\(^2\) Since the ethos of NICE is to examine effectiveness in relation to cost, it is inevitable that these criticisms may occur. However, in this instance it is likely that a redirection of funds rather than a reduction will be the result. The NICE document provides direction to tools and templates that enable the calculation of local costings and savings.\(^1\) Nevertheless, facilitation of the transition is likely to require some additional interim funds in a number of areas – education, setting up satisfactory and sufficient behavioural therapy services to transfer patients into, monitoring mechanisms and continued availability of existing services and treatments for cases where the changeover of interventions is unsuccessful.

This paper seeks to examine evidence that supports differing approaches to the treatment of ADHD. The aim is to provide a balanced view of how both medications and behavioural therapies may be utilised where they are most appropriate.

Diagnosis
The condition of ADHD was originally described by William Still in 1902, and later classified for inclusion in the third edition of the Diagnostic and statistical manual of mental disorders (DSM-III) by Dr Robert Spitzer.\(^4\) A more recent version of this manual (DSM-IV)\(^5\) and the International classification of mental and behaviour disorders (10th revision) (ICD-10)\(^6\) remain the recommended clinical standard for diagnosis.\(^1\) In essence, these diagnostic tools consist of a behaviour checklist through which the patient is deemed to have ADHD if they display a certain number of characteristics in a number of settings over a specified period of time.

While the most recent approach – of behavioural interventions as a first-line treatment for a condition diagnosed on the basis of a behavioural checklist – may appear more logical than the previous penchant for medication, issues relating to definitive diagnosis and the role of stimulants remain. Although the recent NICE guidelines\(^1\) briefly acknowledge the existence of other means of diagnosis such as neuroimaging, they do not explore this fully or make recommendations for further research.

The use of stimulant drugs for the treatment of hyperactivity is not a modern phenomenon. A literature review published in 1977 that explored the efficacy of this practice referred to work dating back to...
levels in the brain and that these levels are increased by stimulants such as methylphenidate. Neuroimaging has been instrumental in fuelling conjecture that the cause of lower dopamine levels is abnormality in the striatal region of the brain and there are many on-going research projects that seek to explore this theory further, such as at the Laboratory of Neuro Imaging, University of California, Los Angeles. If this proves to be the case, there would surely be an argument for treatment with stimulants based solely on a diagnosis of low dopamine levels.

The debate
Debate surrounding the increase in rates of diagnosis of ADHD and the subsequent prescription of medication has been prevalent both in academic literature and the media. However, others involved in supporting children and families affected by the condition dispute this and claim that ADHD is under-diagnosed in the UK and appropriate medication under-prescribed.

While some writers give explanations for over-prescribing such as campaigning parents, the role of the media and the influence of drug companies, other authors offer alternative explanations. For example, the increase in the prevalence of ADHD may actually be due to differences in the diagnostic criteria contained in DSM-IV in comparison to DSM-III. Such authors also acknowledge that the revised criteria may better reflect the heterogeneous nature of the condition. It could therefore be argued that prior to DSM-IV, many children displaying symptoms that are now recognised as indicators for ADHD were undiagnosed because they did not meet the necessary criteria and could not consequently be treated appropriately.

One view that considers multiple factors states that the increase in diagnosis of ADHD is due to a combination of two factors – an increase in identification of the condition together with a change in ‘sociological conditions’ that give rise to disorderly households, increased demands in school and the absence of support systems, such as the demise of extended family. A bibliography and critical appraisal of systematic reviews and meta-analyses carried out in 1999 highlighted that these factors are usually overlooked during the assessment and diagnosis of ADHD.

Claims of over-diagnosis and over-prescribing contradict earlier evidence that states that, while some children are diagnosed and treated without adequate evaluation, there is insufficient proof of extensive over- or misdiagnosis of ADHD or over-prescription of methylphenidate. It is clear from the literature that there is much contradictory evidence surrounding ADHD, which can only add to the confusion of parents, healthcare professionals, teachers and the public in general. Nevertheless, in a culture of evidence-based practice, it seems a little strange that although it seems possible that there may be an identifiable medical cause for ADHD, the latest guidance barely mentions the role of neuroimaging and/or testing for dopamine levels in diagnosis. Neither does it recommend further research in this field.

It has been acknowledged that the symptoms of ADHD are also present in other conditions caused by emotional rather than organic factors. In addition, there is research that demonstrates that children who have coexisting conditions do not benefit from medication. It could therefore be argued that medication may have been given needlessly to children who are already emotionally compromised, and that this would contravene the ethical principle of non-maleficence, especially since those opposed to the use of methylphenidate or similar drugs state that these treatments actually depress the child’s personality and focus to such an extent that they are unable to misbehave or attend to more than one activity at a time. An opposing argument is that behavioural therapy has not always been available due to shortfalls in provision and that it would be contrary to the ethical principle of beneficence to delay giving medication while waiting for such therapy. However, some researchers state that stimulant medication has been prescribed even when alternatives are available.

Behavioural therapies
As long as diagnosis of ADHD is based on a list of behaviours, it would seem reasonable that behavioural therapies are used as part of a frontline treatment. In this sense, the latest guidance is extremely logical. However, in the current climate and culture of the ‘quick fix’ it may be difficult to persuade parents that this is a viable option, particularly when the child’s affected peers may be taking medication that appears to be effective. Some writers go so far as to suggest that a diagnosis of ADHD often has the effect of absolving parents of any responsibility for their child’s difficult behaviour, and this may also impact on success levels in changing expectations and compliance with new behaviour-based regimes.

In addition, many reviews that have aimed to examine the efficacy of behavioural therapies in comparison to medication have been inconclusive. For example, the Centre for Reviews and Dissemination examined a number of reviews and found that it was difficult to assess the benefits of behavioural interventions, because the studies reviewed contained vast variations in terms of participants, interventions and outcomes, thus making it very difficult to draw definite conclusions from the results.

The effectiveness of behavioural therapies for a number of problems, including ADHD, has been examined at length and four main approaches explored: structured family therapy, parent training, coping skills training for children and school-based behavioural programmes. Family therapy is described as focusing on helping families to develop patterns of organisation that are helpful in managing children effectively. Parental co-operation and problem-solving is essential for this approach to be successful. Furthermore, it involves a clear demarcation of child and parent roles and responsibilities, advocating effective communication within a supportive family environment. Parent training involves helping parents to acquire skills that will enable them to objectively examine positive and negative behaviours displayed by the child and the events that immediately precede or follow. By examining influences on behaviours in this way, the training aims to help parents to be able to manipulate interactions and events so as to positively influence the child’s behaviour. In relation to therapies that focus primarily on the child, either singly or as part of a multifaceted programme, the development of coping skills in the child – teaching them how to sustain attention and problem-solving techniques – are seen as key in reducing impulsivity and aggressive behaviour.

Through home-school and parent-teacher liaison, the approaches described above can be extended into the school environment, thus maintaining consistency in the management of the child.
**Family therapy**

Although some authors are positive about the effectiveness of behavioural approaches such as family therapy for the treatment of ADHD, they also stress the importance of combining them with the use of low doses of stimulants, referring to such combinations as 'multi-component treatment packages'.

Others claim that medication is 'superior' to behavioural therapy in addressing the core symptoms of the condition, and that even when medication and behaviour therapy are combined they are still no better than medication alone. However, these authors have recognised that there was a reduction in undesirable behaviours in all the groups studied, and the data collected was based on parents' and teachers' ratings.

It could be argued that parents and teachers are not necessarily the most objective of data collectors, since they already have a relationship with the child and could therefore be influenced by this.

The above research was one of two studies examined for a Cochrane Review conducted in 2005. The reviewers' literature search considered 24 other studies for inclusion, but they were excluded on various grounds, primarily lack of a control group. The only other study that was found to be suitable for inclusion found that family therapy treatment was slightly better than a medication placebo. The collection of data in this study was conducted in a similar way to that described above, so the same criticisms apply. The Cochrane Review recommends that further research is needed to ascertain whether family therapy is an effective intervention for ADHD, and that this research should compare the success of family therapy in comparison to a no-treatment control group. Although this would be the ideal, it is difficult to see how ethical approval would be obtained, as it would be unethical to deny therapies to children suffering from symptoms that have led to a diagnosis of ADHD. In addition, if the control group was to receive a placebo, it would be difficult to achieve this and any 'pretend' family therapy could have an unintentional positive or negative effect, thus negating the results.

A follow-up of one of the above studies aimed to investigate the long-term effects of medication alone, behavioural therapy alone, a combination of medication and behavioural therapy, and usual community care. However, the treatment period was only an initial 14 months, and these findings indicate choices made following the initial 'treatment' period rather than the long-term effects of these continued interventions. The findings show that the advantage of medication therapy – over a 14-month period – demonstrated in the earlier study was no longer evident after a total of 36 months. The authors state that a decline in ADHD symptoms, changes in medication or breaks in treatment could account for this. They also acknowledge that factors not yet evaluated could also be of influence. Their observation that those who were on the behavioural programme only were more likely to start taking medication once the 14-month programme stopped suggests that these participants viewed medication as a better option (possibly influenced by the report of the earlier study). This finding may also merely illustrate that a trend for the 'quick fix' is likely to prevail in the absence of any widely available and accessible alternatives.

An on-going study is investigating the effects of a patient and family education programme for children and adolescents with ADHD. Although this evaluation focuses on education rather than therapy, its findings once published may be useful in informing the debate around this type of family-based intervention.

It is clear that robust evidence that demonstrates the efficacy or otherwise of family therapy is scarce, and further studies need to be undertaken. However, funding for such studies may be problematic. It is likely that large drug companies, who have a vested interest in the continued use of stimulants, will gladly fund research into neuroimaging that may legitimise them, while funding available to examine behavioural therapies may be much less readily available.

**Parent training**

Parent training is seen as a means of facilitating supportive measures that aim to empower parents to accept their responsibilities. In common with other research relating to behavioural therapies for ADHD, that which examines parent training is primarily inconclusive. For example, a systematic review examining the effectiveness of interventions for children aged six to 12 years with externalising behavioural disorders such as ADHD found that parent training and community-based interventions may be beneficial, but also highlighted the efficacy of medication. Along with many others, they recommend further research into specific interventions.

A literature review of behavioural parent training studies found it to be an effective method of treating the condition, but that it remained largely under-researched in terms of the wide range of factors that may influence incidence and therefore be relevant to interventions. The review gives a useful overview of the components of parent training programmes, which include education about the condition, diaries and checklists, ignoring minor bad behaviour and attending to appropriate behaviour, commands and reprimands, rules, timeout, reward/cost, enforcing contingencies for outside the home, problem-solving and maintenance of the programme. The review examined 28 studies that included 1161 treated children, primarily using parent ratings of problem behaviour as the measure of success or otherwise. It could be suggested that parental perception may be influenced by their feelings about behavioural therapy and their expectations of its likely effects. However, it could also be argued that a parent knows the child better than any other person and therefore may identify very small changes that may not be noticed by an objective, unrelated observer.

Some of the studies included other interventions carried out in the school environment, and although these were few, they may have influenced the results relating to parent training. In terms of resourcing this type of intervention, one useful finding of the study was that group-based activities were comparable to individual sessions and additionally beneficial as they facilitated increased total therapist time with families, peer support and decreased stigmatisation.

However, the authors recognise that individual interventions would be preferable for families with more severe psychopathology.

Despite previous acknowledgement of the effectiveness of parent training or education programmes by NICE and publication of guidance on their use in the management of children with conduct disorders (often associated with ADHD), these programmes are not recommended as 'first-line' treatment. The recommendation within this document – that programmes should have proved effectiveness, but that this should not be confined to randomised controlled trials (RCTs) and could relate to other rigorous independent evaluation methods, such as audit – was the likely catalyst for this change in direction. Previous systematic reviews had often excluded valid forms of evaluation because they were not.
Conclusion and recommendations

In an effort to avoid a blame culture, it is possible that a medical approach has been adopted with all children who demonstrate certain behaviours, rather than seeking to ascertain, without question, the specific and actual cause. Some argue that medication is a ‘quick fix’ that does not enable or empower the child or family to take an active role in the management of behaviour.22 Depending on research relating to neuro-imaging and dopamine-level testing, the future may bring a definitive scientific diagnosis of ADHD that would provide a clearer basis for treatment with medication or behavioural therapy. This would provide practitioners with a marker on which to base their choice of treatment options and clarify the nature of the child’s difficulties for both themselves and their parents or carers.

In the meantime, the latest NICE guidelines promote a change in approach to treating children who have ADHD, particularly those deemed to be less severely affected. The change in culture required to implement this guidance fully is huge. Prescribers are likely to find it difficult to persuade children and parents to alter or abandon medication regimens that are perceived as effective in favour of behavioural therapy. In addition, drug companies have the means to fund widespread research to legitimize continued use of medication for treatment of ADHD. However, the new guidelines may promote research into the area of behavioural therapy. At the very least, if they are implemented, the guidelines will lead to a greater population treated by behavioural therapy, thereby increasing the availability of research subjects among whom effectiveness may be measured.

Whatever the future holds, it is clear that the diagnosis, treatment and management of ADHD will continue to evolve in an interesting manner, and evoke emotive responses from healthcare professionals, children and their families and the general public.

References

13 Roberts M. No such thing as naughty anymore? Available at: http://news.bbc.co.uk/1/hi/health/6302289.stm (accessed 18 August 2009).
17 Amato J. Has there been an increase in ADHD? Available at: www.rps.edu.au/probing/adhd.html (accessed 18 August 2009).
Monitoring growth

The benefits and challenges of integrating the Born in Bradford research project with routine growth monitoring practice

William Johnson
PhD candidate, Loughborough University

Noël Cameron
Professor of human biology, Loughborough University

Pauline Raynor
Born in Bradford project manager, Bradford Institute for Health Research

Cathy Woffendin
Head of children and family services, Bradford and Airedale Community Health Services

John Wright
Director of research and deputy medical director, Bradford Institute for Health Research

Why monitor child growth?
The growth rate of a child is perhaps a better indicator of general health than any other single measure.1 Ill children often grow slowly, so monitoring growth is an important surveillance tool in all children, and more specifically in any child presenting with a suspected health problem.2 It involves repeated cross-sectional measurement to identify size and rate of change. Growth data are compared against a reference population, and if a child’s growth is unfavourable they are referred to an appropriate specialist.3

In the UK, growth monitoring typically involves the measurement of both weight and height.4 It is therefore possible to identify any form of growth disorder involving short or tall stature, and any nutritional problem involving under- or overweight. In 2001, Bundre et al reported an increasing prevalence of childhood overweight and obesity in the UK.5 Growth monitoring may become a useful tool to detect children who are overweight or obese and refer them, along with their parents, to specialist clinics for advice about exercise and diet. Growth monitoring also produces an important source of data for monitoring child health.2 Between 2004 and 2006, there was an increase in the use of routine growth data to produce public health reports.6 Researchers with interests in different aspects of child growth and health have utilised routine growth data – for example, Buchan et al reported substantial findings in obesity epidemiology using routine weight and height data.7

As the benefits are diverse, the NHS invests extensive resources to ensure that child growth is monitored routinely. In Bradford, a collaboration between the Born in Bradford (BiB) research project8 and Bradford and Airedale Teaching Primary Care Trust (PCT) has worked to improve growth monitoring standards, so that routine growth data are developed to research calibre.

Integrating research with practice
BiB is a multi-ethnic longitudinal birth cohort study, which aims to recruit all pregnant women booked to deliver at Bradford Royal Infirmary over a period of two years. The project will follow the development of these babies, utilising routine growth data – for example, Buchan et al reported substantial findings in obesity epidemiology using routine weight and height data.7

Health visitors have been given the necessary tools to measure and interpret child growth

Training and feedback
All community practice teachers and one health visitor from each health centre in Bradford were invited to attend a measurement training workshop, organised by BiB in collaboration with the Child Growth Foundation. Health visitors who attended these sessions then organised training days at their own health centres. A measurement protocol that provides precise step-by-step instruction on how to measure and record each dimension was produced and disseminated. A growth monitoring standard was written to incorporate the new measurement protocol, and to provide detailed information about growth monitoring. Among other things, the standard included a rationale for each measurement, information on how to record and plot data on growth reference charts, and guidance on when an infant should be referred to a specialist.

Growth monitoring data are entered onto an electronic system by the PCT child health department. BiB has worked with this department to set up protocols for data sharing and extraction, so that growth data are more accessible to researchers. The growth data processed at
the child health department could be used to provide audit of performance. For example, BiB has produced statistics reporting the percentage of children who are measured during each prescribed age period. This type of information provides the PCT with a way to assess and improve growth monitoring standards. Discussions are taking place to determine what information provides quality assurance for the PCT and good feedback for health visitors.

Benefits for practice
The changes to growth monitoring practice in Bradford were introduced to improve the ability of growth monitoring to detect health problems, and to develop the quality of growth data that are collected. Health visitors have been given the necessary tools to measure and interpret child growth. We believe that the introduction of the new measurement has been successful, and 80% of children are now measured for abdominal circumference between nought and 28 days of age. BiB has provided training on the importance and interpretation of abdominal circumference, aiming to improve awareness about obesity among health visitors. Growth monitoring has been modified to improve the early detection of childhood overweight and obesity.

The training of health visitors and production of a new measurement protocol have helped standardize measurement techniques in Bradford. This reduces measurement error and increases the likelihood that data are reliable. In Bradford, the reliability of routine growth data has been assessed, and measurement error is comparable to anthropometric literature that reports acceptable levels of reliability. This information has provided the PCT with assurance that health visitors measure child growth reliably, and BiB that routine growth data are reliable enough to use for research. This work has led to proposals for the PCT to commission a routine reliability assessment in Bradford, which will provide regular quality assurance for the PCT and act as a form of anthropometric training. Routine reliability assessments will reinforce the importance of measurement standards, and also act as a quality assurance mechanism with feedback to practitioners.

Research is now part of everyday growth monitoring practice in Bradford. The health visitors are responsible for data collection, while the child health department of the PCT is responsible for data entry, audit and feedback of performance to practitioners.

Challenges of integration
Health visitors monitor child growth in over 90% of PCTs, and any changes to growth monitoring practice ought to consider the competing demands on health visitors and the additional work created by such changes. Aligning research with routine practice without increasing the workload of health visitors – and so losing their support for the study – presented a potential problem for BiB.

The sustainability of high growth monitoring standards relies upon the continued involvement and dedication of health visitors. Without information about BiB, health visitors may not fully understand the importance of their contribution to the project. Similarly, a lack of feedback about routine data collection does not emphasise the importance of routine growth monitoring. If PCTs regularly produce individual performance-related information that can be fed back to health visitors, such information can provide quality assurance and public health intelligence for commissioners.

With the support of Bradford and Airedale Teaching PCT and practitioners across Bradford, a major research programme on child health has been integrated into routine practice, and we believe that growth monitoring in Bradford should be recognised as a national exemplar. The next challenge for BiB is to develop interventions targeting childhood overweight, obesity and other health problems that can be implemented as part of routine practice.

References
Variations in infant and perinatal mortality rates


Rates of infant death remain high in parts of England, largely among deprived communities and ethnic minorities, a study has found. Infant mortality has been steadily declining in England, but this trend belies significant inequalities in avoidable deaths. Young mothers, those from lower socioeconomic groups, and those from some minority ethnic communities have consistently worse outcomes compared with the rest of the population. The latest Confidential Enquiry into Maternal and Child Health report indicates the underlying risk factors of perinatal mortality cluster around young and old maternal age, high levels of social deprivation and minority ethnic groups. To identify predictors of perinatal and infant mortality variations between primary care trusts (PCTs) and to identify outlier trusts where outcomes were worse than expected, researchers obtained data from the National Centre for Health Outcomes Development. This was on the number of infant and perinatal deaths, ethnicity, deprivation, maternal age, spending on maternal services, and ‘Spearhead’ status for all 303 PCTs in England. Spearhead status describes the 30% of PCTs that map on to the local authority areas in the bottom fifth nationally for three or more of the following factors: male life expectancy at birth, female life expectancy at birth, cancer mortality in the under 75s, and cardiovascular disease mortality in the under 75s.

Over a three-year period, infant mortality varied by PCT from 1.4 to 10.83 deaths per 1000 live births, and perinatal mortality from 3.93 to 16.66 per 1000 births. A combination of deprivation, ethnicity and maternal age explained 80.5% of the differences in outcome between PCTs, but variation in PCT spending on maternal services did not explain any. Two PCTs had higher than expected rates of perinatal mortality, but neither had Spearhead status. The reasons for this are not clear, say the authors, and further local scrutiny is required to ascertain likely causes and potential solutions. Most PCTs can be confident on the basis of these findings that the social conditions and ethnicity of the communities they serve are more important determinants of these health outcomes than variation in levels of expenditure on maternity services, they conclude. Nevertheless, absolute infant and perinatal mortality rates remain high in parts of England, and the burden of avoidable deaths remains largely with deprived and minority ethnic communities.

IPV screening may not be effective


Universal intimate partner violence (IPV) screening in health care settings does not result in significant changes in subsequent reports of IPV or quality of life, according to a study. Proponents support screening women for IPV in healthcare settings because of high prevalence of IPV and associated impairment, and availability of feasible screening techniques. However, some organisations have concluded that insufficient evidence exists to recommend it.

To examine the effectiveness of IPV screening and communication of a positive screening result to clinicians – compared with no screening – in reducing subsequent violence and improving quality of life, researchers conducted a randomised controlled trial in Ontario, among 6743 female patients aged 18 to 64 years presenting to healthcare facilities. The women were randomised to undergo screening via questionnaire for the occurrence of IPV in the past year, either just before or after seeing a clinician (those screened beforehand could be referred to social services by clinicians). Follow-up questionnaires assessed recurrent IPV. By 18 months, the rate of recurrent violence did not differ significantly between the group whose clinicians received the results of the screening at the index visit (46%) and those whose did not (53%). The researchers conclude that the results do not provide sufficient evidence to support IPV screening in health care settings, and that evidence regarding effective interventions to assist women who disclose abuse in healthcare settings is urgently required.

Impact of prison on women’s health


Imprisonment is largely perceived by women prisoners as having a negative effect on their health, a study has found. In 2006, almost 12,000 women were in custody in the UK, and prisoners tend to come from socially marginalised backgrounds with persistent health inequalities. Women prisoners report higher rates of violent victimisation and ill health on a range of physical and mental health indicators. The impact of a government health promotion strategy for prisons based on ‘healthy settings’ is unclear. To explore women prisoners’ perceptions of the impact of imprisonment on their health, researchers undertook focus groups and individual interviews with adult women prisoners in two closed local prisons.

The women reported that imprisonment impacted negatively upon their health. The initial shock of imprisonment, separation from families and enforced living with other women suffering drug withdrawal and serious mental health problems affected their own mental health. They complained of detention in unhygienic facilities by regimes operated to disempower them, including in the management of their own health, and described health negating responses to imprisonment such as increased smoking. However, imprisonment could also offer a respite from poverty, social exclusion, substance misuse and violence, with perceived improvements in health. Initiatives such as the government’s response to the Corston Review and the Department of Health offender health strategy make it timely to re-evaluate health promotion efforts to develop more realistic approaches that take the views and experiences of women prisoners into account, conclude the authors.
**IN BRIEF...**

**Women's magazines depict babies in unsafe sleep environments**


Photos in women’s magazines depict babies in unsafe sleep positions and sleep environments, according to a study. To evaluate pictures in magazines read widely by women of childbearing age for adherence to American Academy of Pediatrics (AAP) guidelines for safe infant sleep practices, researchers analysed pictures of sleeping infants in 24 magazines with wide circulation among 20- to 40-year old women. They looked for whether or not the baby was placed on its side or stomach rather than on its back, as well as hazards in infant sleeping environments such as soft bedding. It was found that 16 years after the initial AAP recommendations to place infants in a non-prone position, more than one-third of pictures of sleeping infants in the magazines depicted an inappropriate sleep position. Also, two-thirds of pictures were not consistent with AAP recommendations that sleeping babies be placed on a separate sleep surface from parents and without blankets, pillows or other soft bedding. Messages in the media that are inconsistent with health messages create confusion and misinformation about infant sleep safety and may lead inadvertently to unsafe practices, say the researchers. Magazine publishers and advertisers must be made aware of the potential health impact of messages contrary to healthcare recommendations communicated through magazines.

**Breastfeeding and breast cancer risk**


Women with a family history of breast cancer and who have ever breastfed reduce their risk of premenopausal breast cancer by nearly 60%, a study has found. Some studies have suggested that breastfeeding reduces breast cancer risk, but evidence has been mixed. To assess the relationship between breastfeeding intensity and incidence of premenopausal breast cancer, researchers collected detailed information on lactation history, supplemental feeding and lactation amenorrhea among 60 075 participants in the Nurses’ Health Study II from 1997 to 2005 who had given birth. Breastfeeding history was assessed in detail on the 1997 questionnaire, and on each follow up women were asked to report whether they had been diagnosed with breast cancer. A total of 608 cases of premenopausal breast cancer were diagnosed at an average age of 46.2 years. Women who had a first-degree relative with breast cancer had a lower risk of developing the disease if they had ever breastfed than if they had never breastfed. There was no association between breastfeeding and breast cancer among women without a family history. These data suggest women with a family history of breast cancer should be encouraged to breastfeed, say the authors.

**New pre-eclampsia and diet link**


Ergothioneine, found in unpasteurised dairy products, has been detected in unusually high levels in the red blood cells of pregnant women with pre-eclampsia (PE). Almost 10% of pregnancies after 20 weeks are affected by PE and it is a major cause of maternal and fetal morbidity and mortality. Using H-nuclear magnetic resonance spectroscopy and statistical models, researchers sought to identify ‘biomarkers’ present in erythrocytes to distinguish between women with normal pregnancy and those with PE. Blood samples were taken from 37 pregnant women, and erythrocytes from those with PE and with no symptoms were compared. Significantly higher concentrations of the ergothioneine were found in erythrocytes from women with PE. The authors suggest that ergothioneine may be an indicator of PE and could help in understanding its cause.

**Midlife overweight and dementia risk**


Being overweight in midlife increases the risk of dementia later on, according to a study. Long-term effects of overweight on physical health and survival are well known, and people often lose weight before diagnosis and early on in dementia. To examine whether midlife overweight increases dementia risk later in life, researchers followed up 1152 participants of the Swedish Twin Registry whose body mass index was assessed at the age of 45 to 65 years in 1963. They were later screened for dementia in a prospective study with up to 40 years’ follow up and 312 were diagnosed. Midlife overweight significantly increased the risk of dementia in old age, even after controlling for known factors related to vascular risk. The risk was increased for both Alzheimer’s disease and vascular dementia, and followed the same pattern for men and women. This gives further support to the notion that overweight in midlife increases later risk of dementia, conclude the researchers.

**Sugar substitutes and weight control**


A new study reports that consumption of sugar-free beverages sweetened with low-calorie sweeteners increases dietary restraint. To compare dietary strategies and use of fat- and sugar-modified foods and beverages amongs weight-loss maintainers (WLMs) and an always-normal weight group, researchers analysed calorie, protein, carbohydrate, fat and beverage intake as well as dietary restraint in over 300 individuals. WLMs reported consuming three times as many daily servings of artificially sweetened soft drinks, significantly fewer of sugar-sweetened soft drinks and more of water. The authors conclude that use of artificially sweetened beverages may be a key weight-control strategy for WLMs.

---

Clinical papers was compiled by June Thompson
GOR and GORD in infants

An overview of clinical and dietary management of GOR and GORD in infants and children

Jackie Falconer
Lead paediatric dietitian, Chelsea and Westminster Hospital NHS Foundation Trust

Gastro-oesophageal reflux (GOR) refers to the inappropriate opening of the lower oesophageal sphincter, releasing gastric contents into the oesophagus. In a large percentage of infants it can be considered an uncomplicated self-limiting condition, with up to 70% of healthy infants between the ages of three and seven months regurgitating once or more per day. In most infants, reflux resolves spontaneously by 12 to 18 months of age. In fact by the age of 12 to 15 months, only about 5% of infants regurgitate with an even smaller percentage continuing to have problems beyond two years. However in the more severe presentation of the condition, when an infant does not respond to simple treatment, acid-induced inflammation in the oesophagus leading to oesophagitis may develop. This can be associated with other symptoms such as fretful crying, apnoea, irritability, feeding difficulties, haematemesis and iron deficiency anaemia. It is commonly associated with neurological and cardiac conditions.

For uncomplicated GOR, initial management involves parental reassurance and simple feeding measures such as reviewing volumes and frequency of feeds along with postural advice (keeping the baby upright after feeds for at least 30 minutes) and avoiding exposure to tobacco smoke. Small frequent feeds are often recommended, though these may be difficult to manage practically and the baby may become distressed with a reduction in feeds. Frequent winding is also recommended before, during and after feeding. The prone elevated position of 30° cannot be recommended anymore, due to the studies showing an increased risk of sudden infant death syndrome if infants are placed in the prone position for sleeping. A systematic review concluded that raising the head of the cot was not beneficial to infants lying in the supine position. For the small percentage of infants that do not respond to the above measures, further investigations and management can be undertaken.

Investigations

The gold standard investigation for reflux remains pH monitoring, and the amount of time in which the pH is less than four over a 24-hour period is a useful indicator of GOR. A newer procedure – impedance – measures both acid and non-acid reflux, and is particularly useful for children on a continuous nasogastric (NG) feed or who are unable to come off medications due to the severity of their condition. Upper endoscopy can determine the presence of oesophagitis and may be used in infants who continue to display significant symptoms despite full medical and dietary management. A barium study is helpful to detect the presence or absence of anatomical abnormalities, but is not a procedure that helps to determine reflux severity.

Medical management

Medications used to treat GOR include acid-reducing agents such as ranitidine, proton-pump inhibitors such as omeprazole, and prokinetic agents such as domperidone, which elevate the lower oesophageal sphincter pressure and increase gastric emptying. A combination of these is often given to control symptoms. In extreme circumstances where symptoms have failed to respond to all treatments, medical and dietary surgery may be required. The procedure undertaken is a Nissen fundoplication, which wraps the fundus of the stomach around the lower oesophageal sphincter to create an artificial valve and hence preventing GOR.

A gastrostomy is often inserted at the same time to allow for the venting of excess wind from the stomach. If the child may need nutritional support, the gastrostomy can be used for supplementary feeding.

Thickeners and thickened feeds

Dietetic management focuses on resolution of symptoms such as vomiting and irritability, with feeding and also on correction of faltering growth where applicable. Feed thickeners such as Thick and Easy, Resource ThickenUp, Carobel or thickened feeds (which have starch added to 2g/100mls of infant formula), Enfamil AR (anti-regurgitation) and SMA Staydown decrease regurgitation episodes, but there is no evidence of benefit with respect to acid exposure of the oesophageal mucosa. The European Society for Pediatric Gastroenterology, Hepatology and Nutrition states they should only be used in infants with faltering growth and not in those who are healthy and thriving.

In infants with faltering growth, high-energy formulas such as SMA High Energy and Infatrini could help meet nutritional requirements in a smaller volume of feed.

Food allergy

In more complicated GOR or gastro-oesophageal reflux disease (GORD) that fails to respond to simple feeding measures and medical management, a therapeutic trial of a hypoallergenic formula for one to two weeks should be considered – using formulas such as Nutramigen, Pepti-Junior – as GOR can be secondary to food allergy. In those failing a hydrolysate feed, an amino acid-based formula such as Neocate, Nutramigen AA can be used. Soya and partially hydrolysed formula should not be used, due to the high incidence of cross-reactions of proteins. Infants should be selected to trial hypoallergenic formula if they have a positive atopic history, positive allergy tests, persistent reflux that has not responded to reflux medications or mucosal changes on biopsy such as oesophagitis.

Two studies have found significant improvement in symptoms in 30% to
40% of infants using a hypoallergenic formula, and concluded that a high frequency of cow’s milk allergy was associated with GORD. In food sensitive patients, cow’s milk has been shown to cause gastric dysrhythmia and delayed gastric emptying, which in turn may exacerbate GOR and induce reflux vomiting. If the cow’s milk-free trial is successful, then the infant should stay on the exclusion until their first birthday with milk-free weaning solids introduced at the appropriate time.

**Associated feeding problems**

Feeding problems are common in infants with GOR/GORD and are often associated with negative feeding experiences along with carer anxiety. Extreme texture aversion can be a major problem, with infants failing to progress from puree foods onto lumps and finger foods. Feed refusal and consequently faltering growth can also be a consequence of GOR. Infants with GOR can be more demanding and difficult to feed, and have been shown to ingest significantly fewer calories than in matched infants without GOR.8

Infants and children with feeding difficulties should be managed by a multidisciplinary team comprising a speech and language therapist, psychologist, dietitian, and paediatrician or gastroenterologist. This team can provide support and management strategies to relieve carer anxiety. If possible, managing them in a specific feeding clinic gives a consistent approach across the professions.

Management of infants and children with feeding difficulties should address growth and nutritional assessment, feed changes and behavioural advice.

**Growth and nutritional assessment**

Overall, growth is of paramount importance and a percentage of the infants will worsen with faltering growth. A full dietary history should be undertaken, along with weight and height. Calorie intake should be optimised by discussing food fortification and the use of high calorie milks and supplements.

**Feed changes**

Where allergy is suspected or the infant has failed to respond to medical management, a hydrolysate or amino acid-based formula can be tried for a one- to two-week trial period. If dietary exclusion is successful, then the nutritional adequacy of the diet must be monitored and vitamin and mineral supplements provided if necessary, such as for calcium.

In infants where allergy is not suspected, high calorie feeds (SMA High Energy and Infatrini) or thickeners added to standard formulas are often used, especially if they are showing faltering growth.

**Behavioural advice**

Behavioural advice should include:

- Limit meal duration to 20 to 30 minutes
- Make use of positive praise and avoid negative behaviour
- Provide regular mealtimes and snacks – three meals and two to three snacks

---

**Infants and children with feeding difficulties should be managed by a multidisciplinary team**

- Avoid force feeding
- Psychological support for parent or carer to break the cycle of anxiety or distress around mealtimes
- Use resources such as stickers or charts for the older child
- Consider texture of diet and information on appropriate finger foods
- Eat together whenever possible
- Avoid distractions such as TV and toys
- Encourage self-feeding where appropriate
- Avoid giving alternative food if a meal is not eaten
- Get advice from support groups such as Living With Reflux, Allergy UK.

**Enteral feeding**

With severe feeding difficulties, NG tube feeding may need to be instigated. In infants and children with on-going feeding difficulties, gastrostomy placement may be an option. However, gastrostomy tubes can worsen symptoms of GOR and the severity of the reflux should therefore be quantified prior to percutaneous endoscopic gastrostomy (PEG) placement. The use of enteral feeding via NG or PEG can help with reversing faltering growth, and with relieving parental or carer anxiety around mealtimes. An oral intake should be continued wherever possible, however small. Ideally, the feed can be administered overnight, leaving the day free to establish oral feeding. The overall feed volume may need to be reduced below that expected or desired for the child’s requirements to ensure tolerance, and feeds can be fortified by adding extra calories or changed to high energy formulas to ensure that catch-up growth occurs.

**Summary**

In most infants, GOR is a normal occurrence that is self-limiting and they will outgrow it. However, in those who experience more severe symptoms, a combination of medical and dietetic management under the care of a multidisciplinary team is important. Where feeding problems exist, input should include behavioural and psychological support.

**References**

Maternal mental health and attachment difficulties: promotional interviewing

Milford and Oates\(^1\) have produced a valuable protocol to guide health visitors in early postnatal identification and support of women at risk of mental health problems and whose infants are at increased risk of attachment difficulties. The need for early identification has been highlighted by policy,\(^2\)-\(^4\) and we would suggest some modifications to the pathway, complementary and consistent with the revised Healthy Child programme (HCP):\(^4\)

- Effects of problems such as anxiety, depression, substance misuse and intimate partner violence in the antenatal period\(^5\) mean we should no longer think in terms of identifying postnatal depression, but of promoting psychosocial health and identifying need across the perinatal period. The HCP assumes a health visitor will assess need universally during pregnancy to identify 'moderate' and 'high' levels of need and put support in place. Protocols and care pathways should begin during the antenatal period, with at least one promotional interview repeated after birth by the same health visitor.

- Promotional interviewing is an evidence-based partnership method to support and screen women. The HCP recommends that health visitors be able to meet and conduct an antenatal promotional interview with all mothers at around 28 weeks. This offers an opportunity for parents-to-be to explore feelings, attitudes and expectations about the birth of their child, leading to better informed decisions. It also enables health visitors to begin to build a trusting relationship and to identify possible problems that may interfere with the ability to parent.

- The promotional interview can be modified to include the use of Whooley questions, and other standardised tools of the type referred to by Milford and Oates, and two-day training in its use is now available.\(^6\) The evidence strongly supports the case for the use of such standardised tools, but only as part of a partnership model of working with families.

- Where there is 'moderate' concern during pregnancy, listening visits should be offered before the birth. During listening visits, health visitors should aim to support parents to explore and reflect on what their baby might be like. Aspects of the promotional interview can also be incorporated into the postnatal complementary care packages outlined by Milford and Oates. Women for whom there is 'high' concern should have appropriate care pathways put in place, including referral to specialist services.

- The HCP recommends a second promotional interview by the same health visitor at around six to eight weeks. Listening visits are effective in improving maternal depression, but may not improve mother-infant interaction.\(^7\) Their progressive provision by health visitors to support women with moderate need should include a focus on mother-infant interaction, and perhaps modelling, identifying strengths in the mother’s interactions with her baby, anticipatory guidance, and encouraging play and taking the baby’s lead. The HCP highlights other ways to support mother-infant interaction, such as infant massage.\(^8\)

Training and contact for all health visitors to conduct a promotional interview at around 30 weeks is being piloted in Warwick and Leamington children’s centres. This visit will allow the conduct of a promotional interview and include the use of other tools such as the Social Baby DVD. It will be followed by a further visit by the same health visitor at six to eight weeks.

Jane Barlow, Angela Underdown
Director and deputy director, Warwick Infant and Family Wellbeing Unit

Jane Williams, Theresa Bishop
Head of children, young people and family services and professional lead for health visiting, Warwickshire Community Health

Kirstie McKenzie-McHarg
Chartered clinical psychologist in perinatal psychology, Warwick Hospital

6 Warwick Infant and Family Wellbeing Unit. Training. Available at: www2.warwick.ac.uk/faculty/research/bei/research/hsri/training (accessed 11 September 2009).
BREASTFEEDING IS BEST FOR BABIES

From October 2009
Aptamil Easy Digest
will be called Aptamil Comfort

What do I need to know?
– Packs of Aptamil Comfort will begin appearing on shelves from the end of October 2009
– Only the product name will change, the formula will remain exactly the same
– Aptamil Comfort will be available in 900g Eazypacks at the same price of £8.98 from supermarkets and larger pharmacies

What do I need to do?
– If you’re talking to parents about the product, please remind them that the name will be changing
– Contact our dedicated HCP helpline, or speak to one of our local representatives if you have any questions about the change

For further information please visit our HCP website aptamilprofessional.co.uk or call our helpline 08457 623 676

IMPORTANT NOTICE: Breastfeeding is best for babies and provides babies with the best source of nourishment. The decision to discontinue breastfeeding may be difficult to reverse and the introduction of partial bottlefeeding may reduce breast milk supply. The financial benefits of breastfeeding should be considered before bottlefeeding is initiated. Failure to follow preparation instructions carefully may be harmful to a baby’s health. Aptamil Comfort is a food for special medical purposes and should only be used under medical supervision, after full consideration of the feeding options available including breastfeeding. Suitable for use as the sole source of nutrition for infants from birth, and as part of a balanced diet for babies from 6-12 months. Not for parenteral use.
Seeking wellness in the NHS

In August, Dr Steven Boorman launched the interim report from the NHS health and wellbeing review in England. There was much in the news about the review and how NHS staff are ill more than most other workers, overweight and smoking too much. To discount the report from these headlines would be a mistake, since there is much to be commended within its 104 pages.

The overarching point made in the report is that ‘staff health and wellbeing needs to be seen as central to the NHS and recognised as a crucial issue at board level as much as at ward level’. This point alone identifies a weakness of the work to date, and Unite’s submission to the review welcomed ‘the recognition that there have been lower levels of staff engagement in the “staff perceptions survey” from community staff and support service workers’.

Although not entirely focused on acute hospitals, the report does have the feel of being weighted toward that organisational model.

According to the report, NHS staff have relatively high levels of sickness absence – on average 10.7 days a year, higher than across the public sector (9.7 days) or the private sector (6.4 days). It is highlighted that even though these levels of sickness absence are reducing, they are not reducing as significantly as in other organisations. There are also repeated claims about how much money could be saved by improving on these levels, enough to fund an increase of 14 900 whole-time equivalent staff if levels of sickness absence were reduced by one-third (an estimated annual direct cost saving of £555million).

As part of the background work to the report, a staff survey was commissioned, and this and other evidence found that:
- Respondents reported high levels of presenteeism, with many reporting that they come to work when they feel sufficiently unwell to justify staying at home
- Many staff reported significant levels of stress
- Many staff did not believe that senior managers or their organisational model are taking a positive interest in their health and wellbeing
- Most staff believed that their state of health affects patient care.

Although helpful to have a new survey conducted with over 11 000 respondents, it is unsurprising to hear these results. We have seen similar results in the annual NHS staff survey this was reported at 80% of staff). The trust responded that all staff in the NHS are expected to work more than the time they are paid for – it is unsurprising that it was facing a real and persistent recruitment problem.

Omissions from the report
Throughout the report there are a few areas where there is a lack of information or apparent understanding. Although it discusses the importance of engaging staff via trade unions and professional organisations, and also of involvement with both the NHS Staff Council and its health and safety subgroup – the Partnership for Occupational Safety and Health in Healthcare (POSSH) – there is no mention of Improving Working Lives (IWL).

This is surprising, since Unite raising the importance of IWL at previous consultation events, within its submission and also at the POSSH group, and IWL has more recently been re-endorsed by the NHS Staff Council. Having raised this issue at a POSHH group, Unite was pleased to hear that NHS Employers is still committed to IWL and expects it to be one of the delivery mechanisms of the final recommendations.

It is also unfortunate that the report does not discuss the role of the NHS in supporting staff who suffer from domestic abuse, and this issue will be pursued by Unite.

Recommendations of the report
The report makes 42 recommendations with sensible approaches that may well help to improve the health and wellbeing of NHS staff. However, in Unite’s submission to the review, we highlighted the marketisation and privatisation drive within the NHS, which we believe is counterproductive to better health and wellbeing.

We witnessed one example of this recently when supporting members in a London trust. The report recommends that the long hours culture – where staff repeatedly work over contracted hours – needs to be tackled, with evidence that it increases higher sickness absence rates and has a negative effect on staff perceptions of how much managers care, which again negatively affects staff sickness absence. In this specific trust, the manager was asked what efforts were being made to reduce the level at which community practitioners worked unpaid overtime (in the previous NHS staff survey this was reported at 80% of staff). The trust responded that all staff in the NHS are expected to work more than the time they are paid for – it is unsurprising that it was facing a real and persistent recruitment problem.

Actions for members locally
The first response from Unite members working in the NHS should be to request information from their human resources department about how the interim report is being acted on locally.

One strong recommendation of the report is that a senior executive director should take the lead on wellbeing. This commitment alone would demonstrate how serious the organisation is on improving the health and wellbeing of its staff.

Local safety representatives should take the time to at least read the recommendations in the report to ensure they have a grasp of the information. If members have any questions locally, they should direct these to a local representative.

Dave Munday
Unite Health Sector professional officer

Reference
Health Visitor
Inc of HCAS (pro rata)
Full-time, part-time and job share considered

We are a fully integrated service representing Health Visiting and School Nursing and we are proud of our ongoing work in developing innovative care pathways reflecting client dependency levels of need.

We have also successfully achieved a UNICEF Stage 2 award and are working towards our application for Stage 3, working in partnership with all relevant agencies.

Working within our Public Health Community Nursing Service, you will contribute to new ways of working, engage in health inequalities within our diverse population and provide a child centred, seamless service to children, families and young people from 0-18 years.

You will receive professional supervision and support and will also engage in Clinical Supervision and Child Protection Supervision. We are committed to providing all our clinicians with regular learning and development which will enable you to practice at a high standard. There are also opportunities for you to develop your leadership, managerial and professional skills relevant to your role.

For an informal discussion, please contact Helen Day on 020 8489 1140 or Gladys Expo-Danies on 020 8305 7652.

We will also be recruiting to a waiting list for all permanent, fixed term, bank, full and part-time Health Visitor vacancies that will occur across the Trust over the next six months. If you are not available immediately, but expect to be looking for a Health Visiting position within the next six months, then please apply.

To apply, please visit www.jobs.nhs.uk using reference 506-PCT1463G.

Alternatively you can visit our website www.greenwichpct.nhs.uk.

Closing date: 15 October 2009.

Please note unfortunately we no longer accept paper applications.

Applications are welcome from persons wishing to job share. We are an equal opportunities employer.

Peterborough Community Services Health and Social Care

Health Visitors
Peterborough
Band 6: £24,831 - £33,436 p.a. (pro rata for part-time)
Full or part-time - Job ref: PCSP106

"Will provide competitive, high quality, integrated health and social care services which contribute to individual well-being."

Based within our Universal 0-19 Children’s Health Service, you will be innovative, committed, proactive, adaptable and qualified Health Visitors as you will deliver a world-class service to children, young people and their families within Peterborough.

Peterborough is a growing city with a diverse population and excellent transport links.

We have developed a geographical skill mixed team approach to the delivery of services working in line with the ‘Change for Children Agenda’ and integrated with Children’s Centres.

We are a progressive service looking to deliver the best outcomes for children, while ensuring that Professional Development and supervision is integrated into our service plans. Currently we are working on projects at both a regional and national level to support our delivery of the Healthy Child Programmes and regeneration of Health Visiting.

Due to internal movement, there are various different full and part-time opportunities available. Please state on your application preferred hours of working. Job share will be considered and flexible working opportunities exist.

As part of the selection process, you will be required to undertake a Criminal Records Bureau check.

Informal contact: Chris Buzzard, Acting Head of Health Visiting, Peterborough Community Services on 01733 466629 or Roxana Harvey, Professional Lead for Health Visiting, Peterborough Community Services on 01733 466655.

For full details on these and all other vacancies in the Cambridgeshire and Peterborough region and to apply online, please go to: www.jobs.cambs.nhs.uk

If you do not have access to the internet, please call 01480 398652 (24 hour answerphone).

Closing date: 21 October 2009.

Interview date: 6 November 2009.

We are an equal opportunities employer.

The Brazelton Centre

Training Courses

Newborn Behavioural Observations (NBO)
2 and 3rd November 2009,
London, UK

and

Neonatal Behavioural Assessment Scale (NBAS)
25 and 26th January 2010,
Cambridge, UK

Tel: 01223 245791
www.brazelton.co.uk
info@brazelton.co.uk

registered charity number 1086814

Address changes

If your contact details have changed, please get in touch with your Unite regional office as quickly as possible, specifying that you are a member of Unite/CPHVA, to avoid missing out on important communications - including this journal!

(for regional office contacts, please see page 52)
Public Health Nursing/Health Visiting Opportunities in Shetland

Full time and part time positions available

This is an exciting and challenging time to join the services in Shetland. You will have the opportunity to work in a small, supportive island community where you can utilise your public health nursing/health visiting skills to their full potential in the provision of support and therapeutic interventions for vulnerable children and families. Health Visitors are leading various groups and programmes, including support groups for new parents, groups for vulnerable families, offer baby massage sessions and lead the delivery of the counterweight programme.

Health Visitors also deliver the school nursing service in Shetland for the school cluster in their geographical area, which includes Primary and Secondary Schools.

This enables Health Visitors to develop a good rapport with families from the time of birth and to maintain that relationship with the child/ family through their education, until the child leaves school. Multi-disciplinary, interagency working is well established locally. This is reflected in the report of the first inspection of local Child Protection services conducted by Her Majesty’s Inspectorate of Education (HMIE), which is available to view at: www.embie.gov.uk/documents/inspection/ShetlandHealthS2Report.pdf.

Shetland is a wonderful place to live and work. Island life offers low pollution, low crime, excellent schools, great leisure facilities, unique wildlife and amazing scenery, whilst still only a short flight away from the UK mainland. To find out more about living and working in Shetland go to www.shetland.org.

For an informal discussion about your career aspirations and opportunities available locally, please contact Edna Mary Watson, Assistant Director of Nursing (Community) on 01955 743377 or Julia Ferris, Nurse Advisor (Protection) on 01955 743094.

Further information on our current vacancies and how to apply can be found on our website www.nhsnsscotland.com/shb. Our current vacancies close on 7th & 21st October 2009.

In promoting equal opportunities, we welcome applications from all sections of the community.

---

Health Visitors

£30,000 - £40,000 pa Inc.

Ref: HVC564

Newham Community Health and Care services is committed to improving the support of children and families through increased investment and development of an integrated team approach. The diversity in Newham will equip you with excellent skills in public health.

If you are a newly qualified or experienced specialist practitioner (Health Visitor) this is an exciting opportunity to make a difference in “The best borough of the 2012 Olympics.” You will be working within our new operational framework following our service review.

We are offering the right candidates a £2,000 recruitment bonus (£1,000 at start of contract and a further £1,000 at the beginning of year 2) in return for a commitment from you to work for us for a minimum of 3 years.

For more information please contact Patience Osagbue, Integrated Team Manager on 020 7445 7997 or Agnes Adetan, Integrated Team Manager on 020 7445 7094.

Child Overview Panel Co-ordinator

£34,000 - £44,000 pa Inc.

Ref: CBG564

This is a new post co-ordinating the work of Newham’s Child Death overview panel to ensure compliance with Chapter 7 of “Working together to safeguard children” (DfES, 2006). This will include collating and analysing information relating to child deaths, managing the rapid response process in relation to unexpected child deaths and ensuring bereavement support is provided in line with good practice. The post - holder will work with other children/safeguarding agencies within and outside of Newham in supporting the Child Death Overview Panel in analysing the main causes of childhood death within the London Borough of Newham; identify areas of need and informing the work of the LCSB, Public Health and Commissioning for future planning of children’s services.

For more information please contact Anne Mangar, Nurse Consultant for Vulnerable Children on 020 8475 1765.

Closing date for both posts: 22nd October 2009.

To apply for the above vacancies you must log onto www.jobs.nhs.uk

Starting the above reference number,

Working toward equal opportunities.

www.newhamptc.nhs.uk
We’re big on reflection

Specialist Health Visitor Child Protection

The creation of three new Specialist posts is one of the key steps we’re taking to strengthen the front line child protection role of the Health Visitor. We want to provide our practitioners with far greater opportunity for reflection and analysis in practice.

So, you’ll develop an ethos in which reflective practice and self questioning are accepted and actively promoted to help protect children. And, you’ll play a central role in driving improvement - through training and mentoring the team, linking theory to practice and piloting new projects.

Team Leader You will have the vital responsibility of directing, developing, supervising and motivating the team, while providing expert advice on caseload management. Your effective leadership will maximise the positive influence of the new Specialists and increase the impact of reflection on the service. At the same time, you will be ideally placed to develop your management skills.

Health Visitors With the support of our new Specialists, you will be able focus your energies on front line work. We’re looking for talented professionals keen to take advantage of the extra training and scope for reflection we will provide.

You can learn more about all these roles at www.haringeyhvc.co.uk

Haringey in partnership with Great Ormond Street Hospital for Children NHS Trust
Looking for a new life style?
In the Isle of Man we can offer a high quality of life in an area of outstanding natural beauty.

Why Move to the Isle of Man?
It is said that the Isle of Man is like the whole of Britain in miniature and yet with a population of just 55,000 people per square mile there is room to breathe. The Island boasts excellent health care, high educational standards, efficient transport & communications systems, together with a buoyant economy.

Leisure
There are superb cultural and leisure facilities available on the Island for people of all ages. Golf is a feature of lifestyle on the Island and there are 8 courses. Sailing opportunities are excellent with 6 sailing clubs on the Island involved in both cruising and racing. The Island boasts a £20 million National Sport Centre and a £13 million National Entertainment and Arts Centre. If walking is your forte you could not be better situated to appreciate our varied landscape and abundant wildlife.

Education
If you have a young family, you will find the standard of education second to none. Our Department of Education has a combination of the best in traditional and modern approaches to teaching and learning.

Travel
The Isle of Man boasts excellent air and sea links with the UK and Ireland ensuring that you are within reach of the majority of cities within an hour. The airport now handles nearly 500 flights per week and our sea connections are closely linked with Britain’s motorway and InterCity rail networks.

Relocation
The Isle of Man offers excellent tax benefits (income tax 10%, maximum 18% and £9,200 personal allowance and Pension contributions - 3.5%), accommodation and a generous relocation package.

DEPARTMENT OF HEALTH & SOCIAL SECURITY
HEALTH SERVICES DIVISION
PRIMARY CARE DIRECTORATE
Health Visiting / School Nursing
School Nurse (Term Time only)
Band 6
(£27,228 - £36,885 PRO RATA PER ANNUM)
REF: 189N/09

Could you make a difference to the lives of children and young people of school age?
We are looking for an enthusiastic and innovative School Nurse Specialist Practitioner (School Nursing) to join our School Nursing Team.
An ability to communicate well with other professionals and agencies is essential, as is an up-to-date knowledge of recent NHS developments. You should have a positive attitude towards health promotion and will be supported by clinical and child protection supervision.
Car owner/driver essential.

Please note a police check will be required for this post.
A Relocation package will be provided to any successful off Island candidate.

For further information please contact Clare Home, School Nurse on (01624) 642377.

Please note all applications must be accompanied by an Equal Opportunities form and a Health Services Pension Questionnaire or they will not be able to be processed.

Closing date for applications: 5pm, Wednesday 14th October 2009.

Full application pack and job description can be obtained from:
www.gov.im/dhss or recruitment@dhss.gov.im
or alternatively, the Human Resource Directorate, Reayrt Carnane, Westmoreland Road, Douglas, Isle of Man, IM1 4QA telephone (01624) 642419 (24 hour answer phone).
Please quote the above reference no.

Applications will only be considered on receipt of a fully completed application form.

Please note: If you have not heard from the DHSS within 6 weeks of the closing date you may assume that your application has been unsuccessful.
**Record-keeping and documentation: principles into practice**
by Rita Newland
£15 Unite/CPHVA members
£17.50 non-members

**Getting it right: supporting the health of refugees and people seeking asylum**
by Cath Maffia and Steve Conway
How and why people come to the UK in search of sanctuary, what happens to them when they arrive, and the likely health impacts of their unique and varied experiences.
£10 Unite/CPHVA members
£12 non-members

**Tackling child obesity with HENRY: a handbook for community and health practitioners**
by Candida Hunt and Mary Rudolf
An approach to help practitioners engage successfully with parents and carers, and encourage them to give their babies and toddlers an optimal start to life.
£10 Unite/CPHVA members
£12 non-members

**The principles of health visiting: opening the door to public health practice in the 21st century**
by Sarah Cowley and Marion Frost
£10 Unite/CPHVA members
£15 non-members

**Community development: new challenges, new opportunities**
by Catherine J Mackereth
£10 Unite/CPHVA members
£15 non-members

**Discovering the future of school nursing: the evidence base**
by Diane DeBell and Alice Tomkins.
£10 Unite/CPHVA members
£12 non-members

Remember to quote your Unite/CPHVA membership number during checkout in order to qualify for reduced prices.
**Diary**

**Children with Additional or Special Needs**
**20 November, London**
This is a special interest group. All those working with children with disabilities and additional needs are welcome. Please note new venue: Unite the Union, 128 Theobald’s Rd, WC1X 8TN (general reception 0207 611 2500 and nearest tube: Holborn on Piccadilly and Central lines) – we are promised a tour of the site. Speakers: KIDS and complimentary therapies.

**Lettie Blyth**
T 020 7361 3864
E lettie.blyth@rbkc.gov.uk

---

**Infant Massage Course: Courses for Health Professionals and Family Centre Workers**

**Venues across the UK**
Train to be a certified infant massage instructor (CIMI) with the International Association of Infant Massage (IAIM). The only worldwide organisation with over 30 years of teaching experience in over 40 countries. Our four-day highly acclaimed comprehensive course includes theory, the latest research and practical teaching so all our students feel confident in empowering families.

Learning on the course is embedded by reading, further practical teaching and a take-home written assessment. Support is always available. Membership of IAIM UK branch is given to all students, which facilitates:
- Support and networking at a local, national and international level
- Continued professional development – regular educational conferences with expert speakers and trainer-led stroke reviews.

**IAIM**
T 020 8989 9597
E info@iaim.org.uk
W www.iaim.org.uk

---

**Baby Yoga Workshop**

**On-going dates**
**Venues across the UK**
Two-day workshop for qualified baby massage teachers. An excellent course to enhance teaching skills. Supports bonding and attachment, parenting skills, physical development and relaxation.

**Touch-Learn Ltd**
T 01889 566222
E anita@touchlearn.co.uk
W www.touchlearn.co.uk

---

**Rhythm Kids Workshop**

**On-going dates**
**Venues across the UK**
One-day fun-filled workshop for baby massage teachers. Enhances child’s language, muscle, cognitive and vestibular development, as well as their social skills.

**Touch-Learn Ltd**
T 01889 566222
E rl@touchlearn.co.uk
W www.touchlearn.co.uk

---

**Infant Massage Course**

**On-going dates**
**Venues across the UK**
Five-day accredited course for healthcare professionals with a focus on supporting families, enhancing bonding and parent-infant interaction. Bespoke neonatal courses are also available.

**Touch-Learn Ltd**
T 01889 566222
E anita@touchlearn.co.uk
W www.touchlearn.co.uk

---

**Noticeboard**

**Skill-mix team: working from more than one base**
We are a group of health visitors who work in four different GP practices, two in the town and two from rural locations approximately seven miles away.

We have a skill-mix team and are looking to work corporately across the area, but unfortunately we are unable to be based at the same location. We would like to hear from any other teams who have worked corporately in this way.

**Alison Sharp**
T 01205 367367
E alison.sharp@lpct.nhs.uk

---

**Resources for children and young people educated in settings other than school**

We are currently looking at developing a school-age nursing service for children and young people educated in settings other than school. Does anyone have any examples of leaflets or other resources that they have created for the users – parents and young people – of such a service? Any other advice or information would be equally welcome.

**Candy Thompson and Sonal Lea**
E candy.thompson@enfield.nhs.uk or sonal.lea@enfield.nhs.uk

---

**Maternal mental health**

I am a newly-appointed health visitor with a lead for maternal and infant mental health in Hounslow. I would like to hear from colleagues in similar posts to share ideas and plans for the future development of this role. My initial task is to set up a group for women with postnatal depression and their infants. A focus will be mother-infant interaction and maternal sensitivity. It would be interesting to hear from colleagues who have run similar groups.

**Hilary Soobhany**
T 0208 630 3632
E hilary.soobhany@hounslowpct.nhs.uk

---

**Want a listing?**

To include a listing for a course, meeting or event in the Diary (for a minimal fee), Tel: 020 7678 2344 or email: db.juta@tenalpspublishing.com

For a free Noticeboard listing to share information, help and support among readers, email: danny.ratnaike@tenalpspublishing.com

**practitioners in touch**

---

**Unite/CPHVA members’ first points of contact for their professional association and union**

**Region/country**
Yorkshire and Humber
South West
Scotland
Eastern
East Midlands
Ireland
North West
Wales
North East
West Midlands
South East
London

**Regional/country officer and their administrative contact**
Terry Cunliffe – Tina Garbutt on Tel: 0113 236 4830
Dorothy Fogg – Denise Cook on Tel: 01275 370000
Michael Fuller – Joanne Casserly on Tel: 0141 248 7131
Owen Granfield – Barbara Nelson on Tel: 01582 576271
Sally Fairbrace (for Garry Guye) – Ellie Browne on Tel: 01332 454807
Kevin McAdam – Kierron Circuit on Tel: 0845 604 1402
Gary Owen – Jill Moore on Tel: 0161 798 8976
Steve Sloan – Myra Teale on Tel: 020 8315 8460
Jeff Tate – Helen Elliott on Tel: 0191 260 3777
Mark Young – Lorraine Stanfield on Tel: 01782 616020
Sarah Carpenter – Adrian Ratcliffe on Tel: 01622 606760
Tina Mackay – Irene Hill on Tel: 020 3371 2037

---

**Community Practitioner**

October 2009 Volume 82 Number 10
Conference & Exhibition
The leading learning forum for primary care

FREE ENTRY!

PRoImARY CaRe LIVe

• 21 conference streams
• Hundreds of exhibitors
• More than 200 speakers
• Education & Professional Skills Training
• Primary Care LIVE TV
• Other live attractions

Visit our website www.primarycarelive.com and register today!
Silent Night

- Effectively relieves wind, infant colic and gripping pain
- Clinically proven to reduce the frequency and severity of crying attacks associated with infant colic
- Suitable to use from birth onwards
- Sugar, alcohol and colourant free
- Easy to administer - comes with an integrated convenient-to-use plastic dropper

The most widely used infant colic treatment in the UK


Infacol Prescribing Information: Please refer to Summary of Product Characteristics before prescribing. Presentations: An orange-flavoured, colourless, translucent suspension. Each ml contains 40mg simeticone. Indications: An antiflatulent for the relief of gripping pain, colic or wind due to swallowed air. Dosage: Infants - one dropper full 20mg (0.6ml) administered before each feed. If necessary this may be increased to two droppers full 40mg (1ml). Treatment with Infacol may provide a progressive improvement in symptoms over several days. Contra-Indications: None stated. Warnings and Precautions: If symptoms persist, seek medical advice. Side Effects: None stated. Legal Category: C3L. Package Quantities: 50ml plastic bottle fitted with a plastic dropper and excretae test. Basic NHS Cost: £2.26. Marketing Authorisation Holder and Number: Forest Laboratories UK Limited, Bourne Road, Beeley, Kent, DA3 4NX. UK MDD 08/0100 and PA 106/01/1. Date of Preparation: September 2008. For further information, or to request a copy of the Summary of Product Characteristics (SPC), please contact: Forest Laboratories UK Ltd, Bourne Road, Beeley, Kent, DA3 4NX, UK. Tel: +44 (0) 1322 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) 1322 550 550