Communitc practitioner

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The Journal of the Community Practitioners’ and Health Visitors’ Association

Smiles better

Promoting oral health in children with Down syndrome

IN THIS ISSUE

› Housing: forgotten in public health?
› Arabic-speaking students: primary care experiences in Scotland
› ‘Quality’ in providing NHS services
› MacQueen Award winner: family violence with a child perpetrator
› Window blinds and risk of hanging

Return health visiting to statute: see page 3
Oilatum® – new 600 ml pack sizes help your patients achieve complete emollient therapy

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The new packs represent a 20% increase in size, but only a 2% increase in price for Oilatum® Junior Bath and Oilatum® Emollient, while Oilatum® Plus has a price increase of 15%.*1

*compared with existing 500 ml packs.

New 600 ml pack sizes

Oilatum® Plus contains light liquid paraffin, benzalkonium chloride solution and triclosan.

Prescribing Information (Please refer to full Summary of Product Characteristics for Oilatum Junior before prescribing)

Oilatum® Junior (Light liquid paraffin 63.4% w/w)
Uses: Liquid bath additive for the treatment of contact dermatitis, atopic dermatitis, senile pruritus, ichthyosis and related dry skin conditions.
Dosage and administration: Topical use only. Use as frequently as necessary. Oilatum Junior should always be used with water, either added to the water or applied to wet skin. Adult bath: Add 1-3 capfuls to an 8-inch bath of water, soak for 10-20 minutes and pat dry. Infant bath: Add ½-2 capfuls to a basin of water, apply gently over entire body with a sponge and pat dry. Contra-indications: None. Precautions: Patients should be advised to take care to avoid slipping in the bath. If rash or skin irritation develops treatment should be stopped. Drug Interactions: None known. Pregnancy and lactation: Safety in human pregnancy or lactation has not been established. Side effects: None. Legal category: GSL. Presentation and Basic NHS cost: 150ml £2.82, 250ml £3.25, 300ml £5.10, 500ml £5.75 and 600ml £5.89. Product Licence (PL) number: PL 0174/0182. PL holder: Stiefel Laboratories (UK) Ltd, Eurasia Headquarters, Concorde Road, Maidenhead, SL6 4BY, UK. Last date of revision: Oct 2009. Oilatum Junior is a registered trademark of Stiefel, a GSK company.

Prescribing Information (Please refer to full Summary of Product Characteristics for Oilatum Emollient before prescribing)

Oilatum® Emollient (Light liquid paraffin 63.4% w/w)
Uses: Liquid bath additive for the treatment of contact dermatitis, atopic dermatitis, senile pruritus, ichthyosis and related dry skin conditions. Can also be used to cleanse the skin in conditions where the use of soaps, soap substitutes and colloid or oatmeal baths prove irritating. Dosage and administration: Topical use only. Oilatum Emollient should always be used with water, either added to the water or applied to wet skin, and may be used as frequently as necessary. Adult bath: Add 1-3 capfuls to an 8-inch bath of water, soak for 10-20 minutes and pat dry. Infant bath: Add ½-2 capfuls to a basin of water, apply gently over entire body with a sponge and pat dry. Skin cleansing: Rub a small amount of oil onto wet skin, rinse and pat dry. Contra-indications: None. Precautions: Patients should be advised to take care to avoid slipping in the bath. If rash or skin irritation develops treatment should be stopped. Drug Interactions: None known. Pregnancy and lactation: Safety in human pregnancy or lactation has not been established. Side effects: None known. Legal category: GSL. Presentation and Basic NHS cost: 250ml £2.79, 500ml £4.57 and 600ml £4.68. Product Licence (PL) number: PL 0174/0070. PL holder: Stiefel Laboratories (UK) Ltd, Eurasia Headquarters, Concorde Road, Maidenhead, SL6 4BY, UK. Last date of revision: Oct 2009. Oilatum Emollient is a registered trademark of Stiefel, a GSK company.

Prescribing Information (Please refer to full Summary of Product Characteristics for Oilatum Plus before prescribing)

Oilatum® Plus (Light liquid paraffin 52.5% w/w, benzalkonium chloride solution 12% w/w, triclosan 2% w/w)
Uses: Bath additive for the prophylactic treatment of eczemas at risk from infection. Dosage and administration: Topical use only. Oilatum Plus should always be diluted with water. Adults and children: Add 1 capful to a 4 inch bath or 2 capfuls to an eight inch bath. Infants: Add 1ml and mix well with water. Do not use for babies younger than 6 months. Contra-indications: Hypersensitivity to any of the ingredients. Precautions: Avoid contact of the undiluted product with the eyes. If undiluted product does come into contact with the eye, reddening may occur. Eye irrigation should be performed for 15 minutes and then the eye examined under fluorescein stain. If there is persistent irritation or an uptake of fluorescein, then refer for ophthalmological opinion. Do not use with soap. Drug Interactions: None known. Pregnancy and lactation: No restrictions on the use of the product in pregnancy and lactation are proposed. Side effects: None known. Legal category: GSL. Presentation and Basic NHS cost: 500ml £6.98 and 600ml £8.05. Product Licence (PL) number: PL 0174/0070. PL holder: Stiefel Laboratories (UK) Ltd, Eurasia Headquarters, Concorde Road, Maidenhead, SL6 4BY, UK. Last date of revision: Oct 2009. Oilatum® Plus is a registered trademark of Stiefel, a GSK company.

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.

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October 2009.
CONTENTS

COMMENT

3 In from the cold?
Maggie Fisher
Momentum is building to restore health visiting’s statutory status

NEWS & FEATURES

4 NEWS

10 Housing: a forgotten factor?
Kin Ly
The many and complex links between housing and health

14 Not a ‘done deal’ after all
Health B4 Profit campaign:
Success for staff in two trusts

32 Quality in practice
Ros Godson
What does the emphasis on ‘quality’ mean for services?

34 A violent child
Deborah Rountree, Diane Gray
Good practice in tackling family violence perpetrated by a child

36 Families: financial crisis
Fiona Glenn, Jan Mitcheson, Lester Coleman
The recession’s impact on relationships and parenting

CLINICAL

38 Clinical papers
June Thompson
Solid foods delay may increase allergies risk
Routine screening for postnatal depression not cost effective?
Children more likely to catch swine flu

40 Clinical update
Siba Prosad Paul, Ravendra Singh Bhadoria
Window blinds: hanging risk

REGULARS

16 Front line
Cheryl Adams
Reflections on progress

44 Your rights at work
Dave Munday
The NHS: from good to great?

48 Network
Fortisip Compact
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COMMENT

In from the cold?

Momentum to restore health visiting’s statutory status has been building and members are urged to continue supporting this campaign

Following on from the momentum and strength of feeling expressed so eloquently at conference, the children’s minister Ed Balls promised to look at the issue of returning health visiting to statute, as this was having an impact on recruitment, status, pay and progress.

Delegates provided ample evidence from practice and statistics that left both the health and children’s ministers in no doubt of the negative impact that the closure of the term ‘health visitor’ has had on health visiting. This is clearly unsafe and unsatisfactory for the protection of the public.

The title of our regulatory body, the NMC. Health visitors have effectively been sidelined and not recognised as a discrete profession, but included under the banner of nursing. Professional concerns have been expressed at the lack of parity and representation that SCPHNs have at NMC Council level. This part of register is operated as a post-registration qualification, which undermines both the regulation and profession of health visiting.

The title of the register has had on health visiting. The title ‘specialist community public health nurse’ (SCPHN) has not won hearts and minds, nor found favour with the public. It is unwieldy and has not won hearts and minds, nor found acceptance, and requires urgent action to return health visiting to statute and in from the cold

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As the title is no longer protected in statute or law, anyone can call themself a health visitor – this has serious implications for the protection of the public. Unite/CPHVA’s campaign to return health visiting to statute is on-going – together, we can bring health visiting back into statute and in from the cold.

Maggie Fisher
Unite/CPHVA Health Visitors Forum chair

Together, we can bring health visiting back into statute and in from the cold

References
4 Conley S. Say health visiting. Community Practitioner, 2010; 83(1): 30-1.
Unite: avoid ‘knee-jerk’ NHS cuts

Unite has highlighted the importance to frontline services of protecting NHS staff training and development budgets and of avoiding the use of grade mix.

Unite has warned of potential risks to services in relation to proposals that 95% of spending on patient care should rise in line with inflation from 2011 to 2013, leaving 5% ‘unprotected’.

Unite assistant general secretary Gail Cartmail stated: ‘Distinctions are made between “frontline” and “backroom” services. In health, the chancellor Alistair Darling deems this “front line” to be 95% of current expenditure. However, such distinctions could be risky. What must be avoided at all costs are the knee-jerk cuts that we saw across the NHS in England under the former secretary of state Patricia Hewitt’s regime of balancing the books. Ironically, over-the-top measures dating back to that “slash and burn” era has resulted in an overall NHS surplus in England of £800million.’

She added: ‘Health minister Andy Burnham has taken a much more measured approach than his predecessor and aims to use this surplus in a planned and managed way. Unite’s concern is that NHS organisations will make decisions locally without consulting unions and staff.’

Gail Cartmail raised concerns that this could affect primary care and community health services: ‘Experience tells us that it is primary care, preventative services and health promotion that are judged to be “easy cuts”. With commissioning now at arm’s length, the real danger is that savings will be found through grade mix and reduced funding for staff training and development, which will create a toxic mixture resulting in longer term problems, such as those we see with health visiting.’

King’s Fund chief economist Professor John Appleby stated: ‘Clarity is needed about what is at risk if the “unprotected” 5% is cut – equivalent to around £5billion for the NHS in England. There may be savings made in administration costs, but if training or research are cut this could have consequences for future productivity.’

The Department of Health (DH) NHS operating framework 2010 to 2011 for England stressed that NHS resources must be used ‘wisely’ over the coming year, and proposed the deployment of the current surplus ‘in a planned and managed way’ from 2009 to 2011.

The DH five-year plan for the NHS – NHS 2010 to 2015: from good to great: preventative, people-centred, productive – promises to make prevention a priority. Within it, Andy Burnham stated: ‘It is time to set a new ambition: to take our improving NHS from good to great. For me, this means a new drive toward a more preventative need- and people-centred service – better for patients, but also more productive.’

Unite calls for pay cap to be reconsidered

Unite has stated that chancellor Alistair Darling’s proposed across-the-board 1% public sector pay cap needs to be reconsidered as a matter of urgency, because those on the lowest salaries will suffer the most.

Unite assistant general secretary Gail Cartmail stated: ‘We know the Treasury and Number 10 are targeting high earners in the public sector, but we urgently need to talk to the Treasury about an across-the-board pay cap. A pay cap would hit the lowest paid hardest. 1% for the lower paid is a pittance, but the highest earners would get significantly more cash.’

She added: ‘The proposed cap also compromises the independent pay review bodies, which were set up to take the politics out of public sector pay. Labour’s implementation of the review bodies has been a success, and to ride roughshod over them is a step in the wrong direction.’

Unite has welcomed the chancellor’s clarification that the government remains committed to recently reformed public sector pension schemes, which include caps and cost sharing.

She added: ‘We know that the Tories’ plan for our public services are far worse than Labour’s. The Tories will slash our public sector and we could see up to a million job cuts. This is precisely why Labour must make a stand for our public sector workers, and make the wealthy pay their fair share rather than place the burden on low-paid public servants.’

The pre-budget report stated that in order to deliver savings of £3.4billion a year by 2012 to 2013, a 1% cap on public sector pay settlements from 2011 to 2013 would be needed, and that to save £1billion a year from 2012 to 2013 onward, reforms to public service pensions would need to be made.

Return Health Visiting to Statute: www.unitetheunion.org/cphva
Annual conference: call for papers

The theme for the Unite/CPHVA Annual Professional Conference 2010 will be ‘Healthy Family, Healthy Child’, and the event will take place on 20 to 22 October at Harrogate International Centre.

Unite/CPHVA professional officer Gavin Fergie stated: ‘We are encouraging as many members as possible to attend what is the number one conference and exhibition of its type in the UK. The conference provides the unique opportunity for delegates to explore key public health issues and learn from fellow practitioners and their approaches to practice.’

Although the deadline for conference abstracts has not yet been confirmed, Gavin Fergie stated: ‘We are issuing a call for papers to reflect the conference theme “Healthy Child, Healthy Family”. This is an excellent opportunity for members to be that innovative practitioner sharing their practice. I would also urge members to visit the Unite/CPHVA website regularly and follow the conference link to discover more about conference 2010.’

Day one of the conference will explore economic and demographic impacts on practitioners, day two will look at achieving behavioural change in families and day three will examine behavioural change in the community.

For further details and to register for conference updates, please see: www.neilstewartassociates.com/sh269

Kingston: ‘£578 000’ service transfer

Unite has protested against NHS Kingston’s plans to transfer services to social enterprises, after ascertaining through a Freedom of Information request that this could cost £578 000.

Unite national officer Karen Reay stated: ‘Given the relatively small 150 000-strong population of Kingston, the sums that the primary care trust is spending on promoting the market dogma of social enterprises is staggering. We estimate that possible expenditure is £578 000 – and still rising.’

Unite found that £181 000 has been spent in 2008 and 2009 on becoming ‘an autonomous provider’ and ‘business ready’. A further £79 000 has been earmarked for the ‘externalisation of provider services’ for 2009 and 2010, and if social enterprises are not eligible for VAT refunds on the purchase of goods and services, the additional cost will be £300 000. Additionally, £18 000 has already been spent on marketing and branding.

Unite has stated that the money could instead be spent on frontline services such as health visiting, community nursing and speech and language therapy.

For an update on the successes of local Health B4 Profit campaigns, see page 14.
Health visitor suspended for poem

Unite will be defending Unite/CPHVA local accredited representative and health visitor Penny Ballinger, who has been suspended by NHS Gloucestershire for writing a festive poem that highlighted poor working conditions when inviting members to a union meeting.

Unite regional officer Christine Starling stated: ‘Her employer has over-reacted to what was a light-hearted pre-Christmas poem inviting Unite/CPHVA members to a legitimate union meeting. It is a great shame that, at a time when there is a national shortage of health visitors – Unite estimates 8000 more are needed in the next five years to avoid more tragic Baby Peter cases – Penny, who is a very experienced health visitor, has been suspended and unable to help families with young children, a job she loves doing.’

She added: ‘We call on the trust to maintain a sense of proportion and lift this suspension immediately.’

An investigation into the case is on-going and a meeting with the trust to discuss the facts is due to take place this month.

NMC consultations: education and whistle-blowing

The NMC is holding two consultations – a review of pre-registration nursing education (phase two) and developing guidance about raising concerns at work.

Unite/CPHVA is encouraging members to submit views on the pre-registration programme consultation before 19 February by email: rita.newland@unitetheunion.org and to feed back on the guidance on raising concerns at work by 23 February to email: info@cpwha@unitetheunion.org

The consultation on pre-registration programmes will look at new standards for education, examining skills that all graduate nurses must demonstrate. The new standards are due to be published in the autumn, and the consultation deadline is 23 April. The NMC will also be holding consultation events in Belfast on 23 February, Edinburgh on 25 February, London on 2 March, Cardiff on 3 March and Manchester on 5 March. For more details, email: consultations@nmc-uk.org

The other consultation focuses on processes for raising or escalating concerns at work. It follows controversy over the NMC's treatment of nurse Margaret Haywood after her involvement in a TV programme last year. The deadline for this consultation is 31 March. To take part in both consultations, please see: www.nmc-uk.org

Formula milk reports ‘ill considered’

Unite/CPHVA has refuted media reports of a study that have suggested that formula milk is as good as breastmilk. Unite/CPHVA lead professional officer Obi Amadi stated: ‘The conclusion is ill-considered and does not take into account the health benefits associated with breastfeeding. The health outcomes related to breastfeeding have been well evidenced, reducing the chances of the developing childhood obesity, heart disease, diabetes and breast cancer in mothers.’

She added: ‘Sustaining breastfeeding can be difficult, but the benefits speak for themselves.

Health visitors and other community practitioners should, as part of their preventative and health promotion role, continue to support mothers in initiating and maintaining breastfeeding.’

The study, published in Acta Obstetricia et Gynecologica Scandinavica, investigated the association between gestational hormones and breastfeeding among a random sample of 63 pregnancies and 118 in which an increased risk of low birthweight for gestational age had been identified. It found that maternal androgen levels in mid-pregnancy were negatively associated with breastfeeding.

IN BRIEF...

Return health visiting to statute
Unite/CPHVA is urging members to continue showing their support for the return of health visiting to statute by signing their name to its new poll. To support the campaign, see: www.unitetheunion.org/cphva and click on ‘Unite/CPHVA Campaign: Return Health Visiting to Statute.’

New Unite/CPHVA website
Unite/CPHVA has migrated the content of its site to the Unite health sector website. Online resources have been streamlined within a user-friendly format. See: www.unitetheunion.org/cphva

Travel bursary for public health
The CPHEd (Community Practitioner Health Education Development) Trust is inviting applications for its annual MacQueen Travel Bursary for Public Health, a one-off sum of £1000 to cover travel costs of undertaking a public health project abroad. The deadline is 31 March. For further information, please see the advert on page 17.

Wales conference
The Unite/CPHVA CYMM conference themed ‘Safeguarding: diligence and understanding’ will be on 19 March in Wrexham. For more details, see page 17.

Resource list for school-age health
Unite has published a reading list for healthcare professionals who are new to public health or those anticipating an interview for a job in specialist community public health nursing. It is aimed at those working or intending to work with those aged five to 19.

Stop smoking kit
The Department of Health has launched a free ‘Quit Kit’ to help smokers to quit. The kit contains a willpower assessor to identify smoking triggers, two mp3s to help reduce cravings, a stress-relieving distraction tool for the hands, a toothbrush reminding of the benefits of fresher breath and wallcharts to note progress in quitting. To order, please see: www.smokefree.nhs.uk

Chlamydia. Worth Talking About
The Department of Health has introduced a new phase in its sexual health campaign – ‘Chlamydia. Worth Talking About’ – to encourage those under the age of 25 to get tested. It highlights health issues related to undiagnosed cases, such as infertility in women and urethritis in men.

Health outcomes related to breastfeeding have been well evidenced, reducing the chances of the developing childhood obesity, heart disease, diabetes and breast cancer in mothers.’

She added: ‘Sustaining breastfeeding can be difficult, but the benefits speak for themselves.

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GPs agree plans to vaccinate under-fives

All primary care trusts in England have made agreements with GPs to deliver the influenza A/H1N1v (swine flu) vaccine to children aged under five.

Unite/CPHVA lead professional officer Obi Amadi stated: ‘Providing that all local arrangements are accessible and appropriate to those administering the vaccine, and quality is not compromised, then this is a positive way forward.’

In December, some GPs had signed local deals with individual local medical committees and regional deals with strategic health authorities, after the British Medical Association and NHS Employers failed to agree on a UK-wide strategy.

All local health boards in Wales have arrangements to vaccinate this priority group, and all NHS organisations in Scotland and Northern Ireland have begun this second phase of the vaccination programme.

The Health Protection Agency (HPA) will no longer be producing a weekly pandemic flu media update, but stated: ‘Should the position change in relation to the course of the pandemic then the updates will be resumed.’

In its last update, the HPA stated: ‘The rate remains low and well within the baseline zone. Any increase should be interpreted with caution, however, as flu indicators may have been influenced by the holiday period in recent weeks.’

CAMHS in schools

The Department for Children, Schools and Families (DCSF) has set out a number of proposals to bring child and adolescent mental health services (CAMHS) to schools, in response to the review of these services published last year.

Unite/CPHVA professional officer Ros Godson stated: ‘We welcome the government’s proposals. Bringing CAMHS to schools will help make the service much more accessible to children and young people who may need this help. A wider roll-out of the mental health in schools programme will facilitate partnership working with school nurses and mental health professionals.’

The DCSF has allocated £58million to help co-locate health services and mental health provision alongside schools or youth centres, and promises to roll out its £60million targeted mental health in schools programme to every local authority from April 2010. In addition, the DCSF intends to provide a programme of action to support the workforce, including the announcement of new training relating to children with learning disabilities and children at risk of self harming.

The initial CAMHS review stated that children and young people thought that services were not accessible or child-centred. Additionally, there were variations in the quality of services between regions.
IN BRIEF...

‘Healthier babies without tobacco’
The Queen’s Nursing Institute will be holding a conference titled ‘Healthier babies without tobacco’. The event aims to provide updated information on the health problems associated with smoking and passive smoke, to provide information on stop-smoking support for women, and how to reduce exposure to smoke. The conference will take place at Best Western Park Hotel in Falkirk on 5 March.

For further information, please email: jennifer.black@ashscotland.org.uk

Young facilitator programme
The Expert Patient Programme Community Interest Company is urging healthcare professionals to refer young people with long-term health conditions to its young facilitator training programme. The programme is aimed at people aged 15 to 23, and will enable them to work with other young people in their local area. The young facilitator will receive a certificate after running their first workshop and will be paid an honorarium of £40 for each workshop that they deliver. To refer a young person or for further information, please contact Jo Langley on Tel: 01225 731324 or email: jo.langley@eppcic.co.uk

Children In Need grants
BBC Children in Need is inviting applications from organisations that work with disadvantaged children and young people aged 18 years and under for its rolling grant programme. The application deadlines are 15 April, 15 July and 15 August. For details, see: www.bbc.co.uk/pudsey/grants

HCP e-learning resource
The Royal College of Paediatrics and Child Health will be leading a consortium of organisations, including Unite/CPHVA, to develop an e-learning resource to support the Healthy Child programme (HCP). It will be free to all NHS staff and is expected to be launched by December 2010.

Dialogue and Mutual Understanding
The United Nations (UN) has proclaimed an International Year of Youth, which will star

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Dialogue and Mutual Understanding
The United Nations (UN) has proclaimed an International Year of Youth, which will start on

12 August 2010. The theme is ‘Dialogue and mutual understanding’, and it will aim to promote the ideals of peace and respect for human rights and freedoms. The UN has called on governments, communities and individuals to support activities at local level to mark the event.

Press release

The Department of Health (DH) has launched Start4Life, targeting pregnant women and parents of babies to encourage healthy feeding habits.

Unite/CPHVA professional officer Ros Godson stated: ‘Start4Life is an excellent initiative, and would clearly tie in with the proposed Healthy Child programme. Unfortunately, most mothers are not going to be able to be supported in this by the health visiting service, as in many places throughout the UK, the service is completely under resourced and no one sees families regularly to follow this through.’

Start4Life will focus on six ‘building blocks’:

■ ‘Mum’s milk’, promoting breastfeeding
■ ‘Every day counts’, informing on how each day of breastfeeding can benefit the baby
■ ‘No rush to mush’, on introducing solids
■ ‘Taste for life’, promoting variety in foods
■ ‘Sweet as they are’, with tips to avoid developing a sweet tooth
■ ‘Baby moves’, with guidance on active play.

The DH has published a number of resources to promote the initiative. To access these, see: www.dh.gov.uk/en/News/Currentcampaigns/Change4Life/DH_107727

Unhealthy packed school lunches

Unite/CPHVA has stated that it is not surprising that only 1% of packed school lunches have been found to meet nutritional standards for school meals.

Unite/CPHVA professional officer Ros Godson stated: ‘There is no reason why parents would know about healthy packed lunches, as there has never been a campaign or publicity to educate the public. It is understandable that parents give children the food that they know they will eat, and which is less expensive than school lunches.’

She added: ‘Day after day of food high in fat and salt or low in protein and vegetables will inevitably have a negative effect on the child. It is especially important that children get plenty of protein, carbohydrate and minerals during their growth spurt. The long-term solution is to persuade many more parents to opt for the nutritionally balanced hot school lunch.’

In a study published in the Journal of Epidemiology and Community Health, researchers compared 1300 packed lunches of children aged eight and nine at 89 schools across the UK with government standards.

One in three sandwich fillings were found to be low in protein, while one in 10 contained salad or vegetables. Only one in 10 packed lunches included a separate portion of vegetables.

Child performance regulation review

The Department for Children, Schools and Families (DCSF) has commissioned Royal Television Society chair Sarah Thane to review the regulations on child performance in order for them to include reality TV shows.

Unite/CPHVA Health Visitors Forum chair Maggie Fisher stated: ‘We are delighted that the DCSF will be reviewing the rules that regulate child performance to include the use of children on reality TV shows. Unite/CPHVA and other organisations have been campaigning for this for some time, and now the issue is being recognised by the government.’

She added: ‘Child actors get much more protection than children who appear on reality TV shows. The review must consider issues around informed consent – parents and children must be thoroughly briefed on the potential harm of featuring in such programmes. Additionally, an ethics committee of experts in the field of children’s emotional and physical health should be developed, and it should be a requirement for programme-makers to seek approval from this committee before commencing with any filming.’

An independent report on the impact of commercialisation on children has also been published by the DCSF, which concludes that while there is a need for appropriate safeguards, the media and commercial world can also offer opportunities for learning and social development.
Health visitor shortages: Scotland and London

Unite/CPHVA has raised concerns over severe health visitor staff shortages in NHS Glasgow and Clyde and in NHS Lothian.

Unite/CPHVA professional officer Gavin Fergie stated: ‘In common with other parts of the UK, there are increasing difficulties being faced by health boards throughout Scotland regarding the recruitment of health visitors. The twin factors of an ageing workforce and reduced educational opportunities for suitable candidates to develop their professional future within primary care do not help.’

He added: ‘However, with the formation of the new Modernising Community Nursing board in Scotland, Unite hopes that answers will be found through a partnership approach to the perennial problems of generalist versus specialist, a national versus a local way forward and the need to make community practice a professional path that newly-qualified nurses would want to follow in the future. The challenges are great, especially in these financially stringent times, but I would encourage members to share their views and opinions with myself as their representative and engage in what is being discussed – their professional future.’

GPs in Glasgow and Clyde have signed a letter to health minister Nicola Sturgeon about poor health visiting conditions. The letter states that the service is being ‘propped’ up by nursery nurses, staff nurses and other assistants, and though acknowledging their support, stressed: ‘They can in no way replace health visitors.’ In Lothian, members have highlighted workload pressures due to a lack of numbers.

To feed back on community health services in Scotland, contact Gavin Fergie on email: gavin.fergie@unitetheunion.org

In London, Unite attended a scrutiny committee meeting with Waltham Forest Council, where local health visitors Deborah Green, Sally Edwards and Chris Monksfield – all of whom have over 20 years’ experience – raised issues of high caseloads.

Unite/CPHVA local accredited representative and health visitor Elaine Baptiste stated: ‘There are not enough generic health visitors on the ground to attend to the complex needs of those who live in deprived areas of London.’

She added: ‘We will continue to campaign for improved services. We have had a number of meetings and have raised the issue with NHS Havering service operational manager Lynne Swiatczak and Outer North East London Community Services interim chief executive Ralph McCormack.’

Updated pregnancy and baby books

The Department of Health (DH) has updated its pregnancy and Birth to five books with information on how to store breastmilk and advice on the best medicines to take during pregnancy.

Unite/CPHVA professional officer Gavin Fergie stated: ‘These books are an important resource, containing up-to-date and well-evidenced advice. Members should ensure that they are able to access copies and that clients have their own copies to add weight to the valuable service already supplied by practitioners.’

The new updates provide the latest Food Standards Agency advice that eating peanuts during pregnancy is safe but that babies should not be given them for the first six months of life, and that pregnant women should not consume more than 200mg of caffeine a day. A step-by-step breastfeeding guide is also included.

The DH has also published a leaflet for healthcare professionals on how to use last year’s new child growth charts.

A new national Personal Child Health Record has also been introduced in Scotland, which includes the revised charts and replaces any local versions.

To access The pregnancy book, see: www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_107302
For Birth to five, see: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107303
To download the leaflet on using the child growth charts, see: www.dh.gov.uk/en/Healthcare/Children/Maternity/Maternalandinfantnutrition/UK-WHOGrowthcharts/index.htm
Housing: a forgotten factor?

The many and complex links between housing and health are at risk of being forgotten

Kin Ly
Assistant editor

Housing in crisis

The health determinants associated with poor social housing and temporary accommodation have been well evidenced, with numerous studies finding that such living conditions are detrimental to child development and to physical and mental wellbeing. However, community practitioners and housing charities suggest that the issue is a ‘forgotten’ public health problem that is forecast to worsen with public sector spending cuts.

UKPHA Housing and Health Special Interest Group chair Jenny Hacker states: ‘Housing is one of our basic human needs, like warmth and food – but despite some progress, we still face a situation where thousands of households in this country do not live in homes with adequate heating, or live in severely overcrowded conditions, or do not have access to affordable housing. Housing is in many ways the forgotten public health issue, and needs to make its way back up the agenda.’

Surrey Primary Care Trust health visitor Debbie Davison, who has been involved in housing and health for the past 25 years, states: ‘It is of particular concern when health services, feeling compelled to cut costs, see services to homeless families or proactive services as a luxury and not absolutely fundamental to equity.’

She adds: ‘Decent, affordable housing is absolutely essential, especially to children and babies. For one, homeless and poorly
housed people start off with a much lower threshold than others – GP provision, access to primary health care, schools, dentists and cooking facilities are not a given for people in temporary accommodation, and are factors that can further exacerbate health inequalities.

**Community power**

Debbie stresses that health visitors can help move housing and health higher up the political agenda, as they did in the 1980s when the Conservative government’s right to buy legislation – offering council tenants a discounted buying price – resulted in a shortage of social housing.

She states: ‘I used to think that in the 1980s, housing was just a matter of political will, but health visitors were instrumental in helping to bring about change and were powerful in lobbying for that over the last 20 to 30 years.’

Debbie highlights some of the triumphs of Unite/CPHVA’s predecessor – the Health Visitors’ Association (HVA) – and charity Shelter, which set up the Special Interest Group for Housing, Homelessness and Health (SIGHH) in the 1980s. She states that community practitioners can be just as influential today: ‘SIGHH was very active at all levels, from individual support, service and advocacy to national lobbying and raising the problem with managers and colleagues. It was also very much involved in promoting good practice, helping with research and legislation.’

She adds: ‘Attending to individual problems is fine, but you cannot tackle the wider problem of health inequalities individually. It has got to be at a community and national level, and extra provisions and support for residents need to be in place. It is about community work – old fashioned health visiting.’

However, with health visiting numbers at an all time low, housing and health has become a neglected issue.

Unite/CPHVA lead professional officer Obi Amadi states: ‘It is very important that health visitors are aware of their clients’ living conditions and are given the opportunity to home visit in order to perform their public and preventative role. In recent years, this has been played down because health visitors are spending their time on crisis intervention cases.’

She adds: ‘Under the Children’s Act, all children in need should get the required help, but this is not just about safeguarding, it is about all children in need, including those living in poor or temporary accommodation. Sadly, due to understaffing a lot of these health issues are not being addressed properly.’

**Lower life chances**

According to Shelter, over one million children in England lived in overcrowded homes in 2009 – a rise of 54 000 over the previous two years. The Department for Communities and Local Government states that 64 000 households were living in temporary accommodation at the end of 2008, and over 49 000 of these households had dependent children.

**Health visitors were instrumental in helping to bring about change and were powerful in lobbying**

Jenny Hacker warns that such living conditions can affect a family’s physical, social and mental wellbeing. She states: ‘People can become ill or even die due to poor housing – cold homes are linked to heart attacks and other serious illnesses. Overcrowding is linked to the spread of diseases such as meningitis.’

She adds: ‘Mental health problems such as stress, anxiety and depression are also linked with poor living conditions and bad local environments. Aspects such as noise, antisocial behaviour, lack of greenery and fear of crime have a detrimental impact.’

Consequently, children living in such conditions have lower life chances. Debbie states: ‘If you’re living in temporary accommodation, you’re affectively living in chaos. It impacts directly on health in terms of social and educational development and there are studies suggesting a relation between poor housing and long-term if not permanent effects, with some stating that children may never catch up.’

Unite/CPHVA professional officer Ros Godson says that temporary accommodation may be unsatisfactory, particularly for young people who are on their own: ‘Often, the young person will be sharing the temporary facility with a number of adult occupants. This could open the opportunity for the young person to become influenced by drug users, or they could be drawn into crime.’

She adds: ‘Ideally, young people under the age of 18 should be in foster care. However, this can be very difficult with the scarcity of foster families prepared to take in children aged 17. The best alternatives are youth hostels such as the TMCA, but there are a limited number of these places.’

**Ghettoised communities**

The quality of social housing facilities continues to come under fire, and is blamed for contributing toward social exclusion. Many areas have high crime rates and are poorly resourced.

Debbie states: ‘Where new estates are built, there has frequently been a failure to address infrastructure, such as the extra school and nursery places needed, communal space to meet, safe play space and access to shops, GP, clinics and parent-and-toddler groups, especially for people without personal transport.’

She adds: ‘Young families can become very isolated, with a big impact upon maternal and infant mental health, child development and so on. Lack of facilities, resources and communality can be factors in estates becoming ghettoised.’

Obi Amadi adds: ‘Unfortunately, the stigma attached to housing estates can institutionalise new people who move to the area. These vulnerable groups are often too afraid to leave their homes.’

**Health: at the centre of housing**

Jenny Hacker stresses that there must be a stronger focus on the link between housing and health, and the recently formed UKPHA Housing and Health Special Interest Group will be developing a framework for change.

She states: ‘We want to put health at the centre of housing, and housing at the centre of health. Health and housing professionals do not work always work closely together. We want to change that.

We are starting by bringing the two together in this group, and are developing a framework to describe the many links between housing and health, in languages that all groups will understand.’

She adds: ‘We will be looking at three aspect of health – physical, mental and social health issues – and three aspects of housing – access, quality and local neighbourhoods, including support. We will also be collating information on good practice to promote widely.’

With public sector spending cuts, there is a fear that health and housing will remain at the back of the political agenda, and low numbers of community practitioners can make it difficult to campaign locally and attend to these health issues.
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Staff in two NHS trusts have succeeded in challenging plans to transfer services to social enterprises.

Following staff opposition in a ballot, West Essex Community Health Services (WECHS) has stated that it will review its plans, while members in Greenwich have successfully used a survey to get staff views heard.

Success in Essex
Unite regional officer Ian Maidlow stated: ‘The result of the ballot is clear – members in West Essex are absolutely committed to remaining in the NHS and the public sector.’

He added: ‘Employers must take members seriously and give them the right to express their views – and the only way to do this is through a ballot.’

Of 676 WECHS staff who voted, 498 (73.7%) were against service transfer. At the time of going to press, the NHS board was due to hold a meeting to discuss the future direction of local services.

WECHS managing director Vince McCabe stated: ‘It is important that we continue the work that has been started on transforming community health services across West Essex. I would like to thank staff and the trade unions for their involvement in the engagement and consultation process to date. We want the involvement to continue as we take forward the Transforming Community Services agenda in the coming months.’

Keeping up pressure in Greenwich
The board of NHS Greenwich agreed to ‘focus on’ an NHS option, after 79% of surveyed staff opted for having the public sector as their preferred provider, and only 15% for a social enterprise.

However, individual departments will still have the right to request a transfer to a social enterprise.

Unite/CPHVA regional officer Richard Munn stated: ‘If you are faced with the threat of turning into a social enterprise, and even if it appears to be done deal, it is not! Members should work with their local officers, NHS staff-side and other unions to get the result that they want.’

He added: ‘If there is going to be a ballot, keep the pressure up in order to win it. If there is not going to be one, as we did in Greenwich, direct the pressure to management and encourage a survey. If you are well organised and push to keep services in the NHS, you are likely to get the results that you want.’

Initially, NHS Greenwich had planned to survey their staff after refusing a ballot, but Unite and other unions contended that the survey would be impartial. The survey was later revised and approved by the Electoral Reform Society, containing specific questions on the ‘preferred provider’ option.

Richard Munn stated: ‘The board is giving a clear steer that it has got to be the NHS, and this is as a result of our Health B4 Profit campaign. This means that terms and conditions and pensions schemes are preserved, and we do not have to move into an area of uncertainty with social enterprise services.’
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Reflections on progress

Much is now in place to enable practitioners to lead local change

Cheryl Adams
Former Unite/CPHVA lead professional officer

As I reflect on 10 years working nationally for Unite/CPHVA, I realise that much of that work has come together in developments for our professions in recent months.

Perhaps most importantly, we can now call on a greatly enhanced evidence base. No longer should it be necessary for health visitors, school nurses and their teams to justify many of their interventions, as more are now recognised as evidence based, and the number grows daily.

Indeed, I have been privileged to work with the National Institute for Health and Clinical Excellence (NICE) in various capacities, including as vice chair of the National Collaborating Centre for Primary Care. NICE amasses and disseminates relevant evidence via clinical guidelines, making it more accessible to practitioners – do not forget to check its guidance from time to time, as it is now substantial.

Tools for the front line

In some areas, the NHS still seems very reluctant to invest in health visiting and school nursing, despite the growing evidence base and superb body of children's policy in place.

For example, a clear rationale to invest in health visiting is set out in the Department of Health (DH) document Getting it right for children and families. Providing Unite/CPHVA leadership to the partnership we had with the DH to develop its content was a rewarding experience, as everyone was so committed to getting it right. It was launched at last year’s annual conference, and is available from the Unite/CPHVA website, along with many other vital resources.

The government has also published new guidance for the two-year check (which was supported by our Health Visitors Forum members), and an updated nought-to-five and new five-to-19 Healthy Child programme (HCP). There is a contractual obligation for primary care organisations to deliver the evidence-based nought-to-five HCP for every child – conspicuously vulnerable or otherwise – so do hold them to account to ensure the resources are made available for this. The five-to-19 HCP provides new opportunities for school nurse leadership.

Last year, I led a flurry of other new work by the Unite/CPHVA professional team, often in partnership with government and others. Unite/CPHVA has published new guidance on routes through health visitor education, returning health visiting to statute, getting the mix right in health visitor and community nursing skill mix teams, the role of the staff nurse working with health visitors, a handbook for nursery nurses, and guidance on practice teachers.

All these documents offer blueprints to guide investment and structural decisions as we move into an era where we may see a change in government, and there will be spending restraints. Their value will depend on whether members use them to lobby for and lead change at a local level. Only so much can be achieved nationally – it is members who must win hearts and minds locally. You have been given the tools, now you must demonstrate the leadership you are all so capable of, to ensure they are used to improve outcomes for children and families.

Partnerships for public health

The role of a lead professional officer is multifaceted, and I feel very privileged to have held it. Other responsibilities in the last year included organising the content of the annual conference, giving evidence to the Children’s Select Committee, and contributing to many national committees as varied as the chief nursing officer’s Next Stage Review group, Department for Children, Schools and Families children’s stakeholder board, NSPCC health liaison committee, Modernising Nursing Careers coalition and NMC stakeholder group. I also led on partnerships with the RCN and RCM to launch the Academy of Nursing, Midwifery and Health Visiting Research, with Netmums to deliver the Parent Know How online counselling and information project, and with the Royal College of Paediatrics and Child Health to develop online learning for professionals to underpin the HCP. More recently, I liaised with Unite colleagues and members to design the campaign to get health visiting back into statute, which would strengthen the contribution of health visitors to children’s health and wellbeing.

I feel honoured to have had these opportunities. On leaving, I knew that all those working nationally on your behalf – the Unite Health Sector team, National Professional Committee (so ably chaired by Angela Roberts) and our president Lord Victor Adebowale – will continue the ‘head of steam’ we have all worked so hard to build up. Public health practice is truly on the government’s map.

Ensuring local investment

Please start planning how you can ensure that public health is also invested in by your local children’s commissioners. Working with government and members, we have provided the tools – do use the union, local industrial teams and publications to make your case.

I would like to extend good wishes to my many Unite colleagues and those in government and elsewhere, Unite/CPHVA members and others who have helped provide me with such a special period in my life.
The Welsh CPHVA Committee is holding a professional Conference at the Ramada Hotel, Wrexham on March 19 2010.

The conference title, Safeguarding: Diligence and Understanding will reflect the need for health professionals to ensure they demonstrate this in all aspects of practice. The Conference is aimed at Health Visitors, School Nurses and Community Nursery Nurses involved in working with families and children, but will also be of relevance to any healthcare staff member who works with families.

Confirmed speakers include:
- Edwina Hart, Minister for Health and Social Services
  09.30 – 10.00 Registration and coffee
  10.00 – 10.10 Chair’s introduction: Obi Amadi Lead Professional Officer, Unite health sector
  10.10 – 10.25 Welcome Steve Sloan Unite Regional Officer
  10.25 – 10.30 Minister’s introduction – Angela Roberts, Chair Unite/CPHVA
  10.30 – 11.00 Keynote speech, Edwina Hart, Minister for Health and Social Services
  11.00 – 11.40 Health Needs Assessment and Safeguarding, Professor Sarah Cowley, Professor of Community Practice Development, Kings College, London
  11.40 – 12.00 Refreshment break
  12.00 – 12.30 Prevention of Child Sexual Abuse in Wales. Rebecca Wasinski, Stop it Now! National Campaign Manager
  12.30 – 1.00 Avis Williams-McKoy, Consultant Nurse, Designated Nurse Safeguarding, Lambeth PCT. Safeguarding and Service Improvement (Invited)
  1.00 – 1.15 Panel questions
  1.15 – 2.10 Lunch and exhibition
  2.10 – 2.15 Chair’s Opening Angela Roberts, Chair Unite CPHVA
  2.15 – 2.45 Strategy for Infant Mental Health. Dr Aideen Naughton, Consultant Paediatrician and designated Dr for Child Protection, National Public Health Service
  2.45 – 3.15 The Future of Community Nursing In Wales. To be confirmed
  3.15 – 3.45 Child Sexual Exploitation in Wales. Jan Coles Barnardo’s Cymru (SERAF)
  3.45 – 4.00 Panel questions
  4.00 – 4.15 Chair’s closing remarks

Conference cost: Full £60.00 Concession/Student £30.00

To book your place contact
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Mobile: 07790 628755
Oral disease in children with Down syndrome: causes and prevention

Introduction
Down syndrome is a congenital genetic disorder characterised by a triplication of material on chromosome 21. It is associated with a number of medical problems, including cardiac defects, gastrointestinal anomalies, autoimmune and dermatological disorders, and a significantly increased risk of acute leukaemia (most pronounced in the under fives). Additional but less well-recognized conditions associated with Down syndrome are periodontal disease and dental caries (tooth decay), both of which contribute to significant morbidity.

Periodontal disease is an inflammatory and progressively destructive condition of the supporting structures of the teeth, which contributes to systemic ill health and has negative repercussions on quality of life. It is more prevalent, more severe and more rapid in onset in people with Down syndrome than in those without and can be observed in children as young as six years of age. By 35 years, up to 96% of individuals are affected.

Conversely, opinion is divided on whether Down syndrome is a determinant of a higher or a lower caries risk, or if there is no difference in risk compared with the general population. Indeed, caries is a multifactorial disease and causative factors may interrelate (see Box 1). A more accurate assessment of risk is likely to be obtained by evaluating factors such as a high sugar or acid diet, frequency of snacking, low social status, poor oral health in close relatives, low dental awareness and past dental history, in addition to other specific factors (see Table 1). The association between these and morphological and host abnormalities seen in Down syndrome should be examined. By using this information, a strategy may be developed that reduces adverse dental outcomes significantly.

Morphological anomalies
Down syndrome is associated with a spectrum of an estimated 80 phenotypes that vary in severity and presentation, and which are by no means unique to it. However, a variable degree of intellectual impairment is present in all individuals. This is a risk factor for caries formation and impacts to some degree on the ability to self-care. Orofacial phenotypes are discussed in this paper, particularly those pertinent to periodontal disease and caries.

Key words
Down syndrome, periodontal disease, dental decay, caries, prevention

Abstract
While healthcare professionals may be familiar with the social and medical management of Down syndrome, dental issues have traditionally been somewhat neglected and are important causes of morbidity. The aims of this review are two-fold. Firstly, to draw attention to the environmental and host factors associated with periodontal disease and dental caries (tooth decay) in children with Down syndrome. Secondly, to highlight key yet largely modifiable risk factors in the causation and progression of these chronic oral conditions, many of which also apply to other children with learning disabilities. The review focuses on the role of community and school-based healthcare professionals in promoting good oral health using evidence-based preventative strategies, and in encouraging early, regular contact with dental services.

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Pat Ansell PhD, RVH
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Journal

Skeletal and soft-tissue features
Underdevelopment of the bones of the midface compared to those of the mandible (midface hypoplasia) is common, causing a shortened palate in the anteroposterior dimension. However, the dental arch shape does not differ significantly from age- and sex-matched children without Down syndrome.

The small palate causes a relative enlargement of the tongue (macroglossia) so the tongue’s increased pressure against the teeth may result in a scalloped appearance,
though this is clinically unimportant. The tongue has poor tone, as do the oral muscles and muscles of mastication. These are exacerbated by a pronouned underbite, largely a result of midface hypoplasia, which often causes an open-mouthed posture and tongue protrusion. Mouth breathing ensues from difficulty breathing through narrow and sometimes occluded nasal passages, worsened by frequent upper respiratory tract infections.

These skeletal and soft-tissue features contribute to increased drooling, angular cheilitis (cracked corners of the mouth), a dry mouth and an increased prevalence and severity of fissured lower lips and the tongue.1,14,18

Dental features
Delayed tooth eruption, in part from delayed tooth formation, may be the first feature noted and can apply to both primary and permanent dentitions. The sequence of eruption is also affected more than in children without Down syndrome. Hypodontia, the congenital absence of one or more teeth, and microdontia, abnormal smallness of the teeth, are other features of largely genetic origin. Missing teeth contribute to malocclusion, most often an underbite.

An anterior open bite and a posterior cross bite are other notable characteristics. Not only are the teeth small, sparse and misaligned, but they may also show variation in crown morphology. Crowns may be short, small and conical. Tooth roots may also be short in some teeth, causing a suboptimal crown-to-root ratio that may increase tooth mobility and tooth loss secondary to periodontal disease.

Bruxism (tooth-grinding) is a behavioural manifestation displayed by some children, and may further contribute to alterations in tooth morphology and mineralisation.1,15,16

Other host factors
Host immunity: periodontal disease
Plaque is strongly implicated in the causation and advancement of periodontal disease,19 but systemic predisposition to infection – and therefore to periodontal disease – as a result of the chromosomal aberration has also been investigated.

Qualitative and quantitative defects have been reported in both neutrophils and T lymphocytes, resulting in impairment of the immune system as reviewed by Morgan.20 Zinc has been shown to have an important role in the promotion of immunocompetence, and is thought to be deficient in individuals with Down syndrome after the age of five years.21 A recent study has also found that zinc deficiency contributes to periodontal disease in rodents.22

Saliva: dental caries and periodontal disease
Saliva plays a crucial role in the defence against periopathogenic and cariogenic bacteria in the oral cavity, and in maintaining cleanliness of the oral cavity and the equilibrium between demineralisation and remineralisation of enamel and dentin. Consequently, the protective effects of salivary constituents, salivary flow rates and the salivary buffering capacity are essential.23,24 It is agreed almost universally that the salivary flow rate is significantly reduced in individuals with Down syndrome25,26 and that caries and periodontal disease risks are significantly increased in patients with a dry mouth.

While salivary stimulants and substitutes are in clinical use, their predominant function is to provide moisture and lubrication to the oral cavity, though there may be modest effects on maintaining oral health in conjunction with other protective strategies.24

Preventative strategies
Evidence suggests that people with learning disabilities experience poorer oral health and have greater unmet oral health needs and lower uptake of screening services than others, despite having the same right to equal standards of health and care.27

Parents of adults with Down syndrome have suggested that oral healthcare information received in the early years of their child’s life was suboptimal, and more information – given sensitively before and/or during the eruption period of the deciduous teeth – would have been welcome.28 It has been reported that oral health care is a lower priority than other healthcare issues, demonstrated perhaps by the lower proportion of children with Down syndrome who have visited a dentist before the age of five when compared to other children.29
Contact with dental services.29,30 The and by recommending early and regular effective preventative oral hygiene strategies sequelae, by consistently encouraging preventing poor oral health and its regular contact, can play a key role in professionals, with whom there is early and February 2010

Although parents may realise the importance of brushing teeth as soon as they erupt, it is critical to ensure that parents are aware of the marked variation in fluoride concentration levels of toothpastes marketed at children. Many of these toothpastes are unsuitable for use by children with Down syndrome, as the concentration levels of fluoride are considerably lower than those recommended for protection against dental caries. Parents should be advised of high fluoride alternatives that do give adequate protection (see Table 3), and be made aware of fluorosis. Although dexterity aids such as Gripmate® may be used to improve control of manual toothbrushes and therefore enhance plaque removal, evidence from a Cochrane systematic review strongly suggests that powered toothbrushes with an oscillating or rotating action are optimal for both caries prevention and prevention of periodontal disease.31

Medication
Many children with Down syndrome have complex medical needs that require regular medication, for example to treat gastroesophageal reflux disease, which in itself contributes to caries formation. Emphasis in recent guidelines is placed on ensuring that medications given to high-risk individuals are sugar-free, though using a non-sugar free preparation may sometimes be unavoidable and advice should be given on how to minimise its cariogenic potential. Prescribers and parents should be encouraged to use sugar-free formulations wherever possible, to be aware of the cariogenicity of these products if sugar-free formulations are not available, and to adhere to administration schedules that minimise cariogenic effects.32 The price difference between many commonly used sugar-free and non-sugar free over-the-counter products is negligible.

Prevention of periodontal disease
The preventative strategies outlined above predominantly refer to prevention of dental caries, but a number of measures may also be put in place for those individuals with a predisposition toward periodontal disease. In addition to the approaches described (see Table 2), plaque control is further mediated by using a toothpaste containing triclosan with either a copolymer or zinc citrate as opposed to fluoride alone, and a chlorhexidine mouthwash (10ml of 0.2% or 15ml of 0.12%) as an adjunct to tooth brushing. There is a strong evidence base to support these recommendations.32

Table 2. Prevention of dental caries in children with Down syndrome32

<table>
<thead>
<tr>
<th>Age</th>
<th>Advice</th>
<th>Professional intervention</th>
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<tr>
<td>Up to three years</td>
<td>Strong evidence:*&lt;br&gt;■ Use a smear of toothpaste containing 1350 to 1500 ppm fluoride&lt;br&gt;Other evidence:&lt;br&gt;■ As soon as teeth erupt, brush twice daily</td>
<td>Strong evidence:*&lt;br&gt;■ Prescribe fluoride supplement and advise on maximising benefit&lt;br&gt;Other evidence:&lt;br&gt;■ Investigate diet and assist to adopt good dietary practice&lt;br&gt;■ Ensure medication is sugar-free or given to minimise cariogenic effect&lt;br&gt;■ Apply fluoride varnish to teeth three to four times yearly&lt;br&gt;■ Reduce recall interval</td>
</tr>
<tr>
<td>Three to six years</td>
<td>Strong evidence:*&lt;br&gt;■ Brush last thing at night and on one other occasion each day&lt;br&gt;■ Use a pea-sized amount of toothpaste containing 1350 to 1500 ppm fluoride</td>
<td>Strong evidence:*&lt;br&gt;■ Fissure seal permanent molars with resin sealant&lt;br&gt;■ Apply fluoride varnish to teeth three to four times yearly&lt;br&gt;■ For those aged 10 years and over with active caries, prescribe 2800 ppm fluoride&lt;br&gt;■ For those aged 16 years and over with active caries, consider prescription of 5000 ppm fluoride toothpaste</td>
</tr>
<tr>
<td>Seven years and above</td>
<td>Strong evidence:*&lt;br&gt;■ Brush twice daily using fluoridated toothpaste (1350 ppm fluoride or above)&lt;br&gt;■ Use a fluoride mouthwash daily (0.05% sodium fluoride) at a different time to brushing&lt;br&gt;■ Consider recommending an oscillating or rotating power toothbrush</td>
<td>Strong evidence:*&lt;br&gt;■ Investigate diet and assist to adopt good dietary practice</td>
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* ‘Strong evidence’ refers to that from at least one properly designed randomised controlled trial.
Conclusion

Periodontal disease and caries result from complex multifactorial interactions, both environmental and host-dependent. Some of these factors – such as plaque levels and oral hygiene regimens – are more readily modifiable, while others are inherent and far more difficult to change. Early and continued preventive intervention and adjustment of modifiable factors in children is likely to avert, or at the very least delay, the formation and progression of dental caries and periodontal disease in later life.

Despite decades of research into periodontal disease and dental caries, there remains a paucity of information relating to Down syndrome and its associated chronic oral conditions, but the Children with Down’s Syndrome Study33 aims to help improve this.

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20 Morgan J. Why is periodontal disease more prevalent and more severe in people with Down syndrome? Special Care in Dentistry, 2007; 27(5): 196-201.

Table 3. Readily available toothpastes by fluoride concentration level*

<table>
<thead>
<tr>
<th>1350 to 1500 ppm</th>
<th>1000 to 1350 ppm</th>
<th>550 ppm or less</th>
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<tbody>
<tr>
<td><strong>Aquafresh:</strong></td>
<td><strong>Aquafresh:</strong></td>
<td><strong>Smile Kids</strong></td>
</tr>
<tr>
<td>Little Teeth 4-6 years (1400 ppm)</td>
<td>Milk Teeth 0-3 years (1000 ppm)</td>
<td>0-2 years (1000 ppm)</td>
</tr>
<tr>
<td>Big Teeth 6+ years (1400 ppm)</td>
<td></td>
<td>2-6 years (260 ppm)</td>
</tr>
<tr>
<td>Extreme Clean (1350 ppm)</td>
<td></td>
<td>6+ years (525 ppm)</td>
</tr>
<tr>
<td>Complete Care (1400 ppm)</td>
<td></td>
<td>2-6 years (500 ppm)</td>
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<tr>
<th><strong>Boots:</strong></th>
<th><strong>Smile Kids</strong></th>
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<tr>
<td>Expert Enamel Protection (1450 ppm)</td>
<td>Smile Total Care (1000 ppm)</td>
</tr>
<tr>
<td>Expert Stain Control (1450 ppm)</td>
<td>Smile Kids 0-2 years (1000 ppm)</td>
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<td>Expert Sensitive (1450 ppm)</td>
<td>Smile Kids 6+ years (260 ppm)</td>
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<th><strong>Colgate:</strong></th>
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<tr>
<td>Total Advanced Fresh (1450 ppm)</td>
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<td>Total Fresh Stripe (1450 ppm)</td>
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<td>Sensitive Multi Protection (1450 ppm)</td>
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<th><strong>Key points</strong></th>
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<tr>
<td>■ Periodontal disease and dental caries are two less-well recognised conditions associated with Down syndrome.</td>
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<td>■ They are important causes of morbidity, yet key risk factors in their causation and progression are largely modifiable.</td>
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<tr>
<td>■ Community and school-based practitioners can play an important role in promoting good oral health using evidence-based preventive strategies.</td>
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This review discusses the key risk factors and preventive strategies.

For comparative purposes only and not an endorsement of any particular product. A more comprehensive list is included in Delivering better oral health.32 The minimum preventative fluoride concentration recommended in toothpaste for children with Down syndrome is 1350 to 1500 ppm.
Following research at Guy’s Hospital, which identified transient lactase deficiency as one possible causative factor in Colic, Colief Infant Drops are increasingly being recommended as a management option.

The research shows that transient lactase deficiency in the upper digestive tract may be corrected by adding lactase enzyme to the infant’s feed before the baby is fed. Treatment protocols based on managing lactose in the baby’s feed are now recognised as a primary treatment option for Infant Colic.

This management strategy can be applied equally to breast-fed and formula-fed infants: in formula-fed babies by pre-incubating the formula with Colief (lactase enzyme), and with breast-fed babies by adding lactase to a little expressed breast milk (10 – 15ml) and feeding this to the baby immediately before breast-feeding.

1 Review at www.jr2.ox.ac.uk/bandolier/booth/family/colicup.html
2 NHS-Prodigy Clinical Guidance www.cks.library.nhs.uk/colic_infantile
Arabic-speaking students’ primary care experiences in Scotland

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Abstract
International research has highlighted health disparities among different demographic and socio-economic subgroups, and across racial and ethnic groups. These disparities result in wide variations in knowledge of health status and use of health services. There is limited evidence relating to the utilisation of healthcare services among different minority ethnic groups, though many barriers facing these groups regarding health care have been reported, including lack of access to healthcare services, and language and cultural barriers.

Individuals’ cultural beliefs, values and experiences are bound intimately to their concepts of health and health care. Recognition that different cultural groups may have different views about illness and disease prevention and treatment is particularly relevant to the higher education sector due to its rapid internationalisation. There is increasing cultural and ethnic diversity among the university student population. Relating this to student health care and issues relating to student lifestyle and health – such as smoking, substance misuse, mental health issues and sexual health – there are commonalities across the student population. Students have identified barriers to seeking health care, including lack of time, lack of knowledge and misinformation about health services.

Both in their own culture and in more Western contexts, Arabic-speaking students within higher education have similar health needs to other students and can experience the same behaviour, such as smoking during adolescence. The Arabic-speaking population originate and mainly inhabit a geographical area extending from the Atlantic coast of Northern Africa to the Persian Gulf. The majority of Arabs are Muslims, and as such, there are specific religious and cultural influences on the provision of health care. Individuals’ reactions to illness, their concepts of health, and their help-seeking is intimately bound up with these cultural beliefs, values and experiences.

Introduction

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Individuals’ cultural beliefs, values and experiences are bound intimately to their concepts of health and health care. Recognition that different cultural groups may have different views about illness and disease prevention and treatment is particularly relevant to the higher education sector due to its rapid internationalisation. There is increasing cultural and ethnic diversity among the university student population. Relating this to student health care and issues relating to student lifestyle and health – such as smoking, substance misuse, mental health issues and sexual health – there are commonalities across the student population. Students have identified barriers to seeking health care, including lack of time, lack of knowledge and misinformation about health services.

Both in their own culture and in more Western contexts, Arabic-speaking students within higher education have similar health needs to other students and can experience the same behaviour, such as smoking during adolescence. The Arabic-speaking population originate and mainly inhabit a geographical area extending from the Atlantic coast of Northern Africa to the Persian Gulf. The majority of Arabs are Muslims, and as such, there are specific religious and cultural influences on the provision of health care. Individuals’ reactions to illness, their concepts of health, and their help-seeking is intimately bound up with these cultural beliefs, values and experiences.

What are the challenges that face Arabic-speaking students in primary care settings in Scotland?
What are the views of these Arabic-speaking students about how primary care services could be improved?

Method

The research adopted an exploratory descriptive design to reflect the limited knowledge related to the perceptions and experiences of Arabic-speaking individuals in using primary care services. Ethical approval was obtained from the university ethics committee, after full consideration of issues of informed consent. Participants were also assured that they were free to withdraw from the study at any stage without having to give a reason.

Participants

A convenience sample of Arabic speakers studying at one university was identified. Anonymous university statistics identified 34 persons who might meet this criterion. All were invited to participate via a global email sent on the university email system, to which 20 responded and subsequently agreed to participate in both a questionnaire and interview. All participants were studying health-related programmes.

Data collection

A questionnaire was used to identify some demographic data, and detail about any primary care services used.

Interviews were also used, in which it was accepted that the approach should be flexible and that further research questions might arise. There was also acknowledgment that in descriptive studies there is a need to obtain clarity and lack of bias in the way data are collected and analysed.

The tools were piloted with three Arabic-speaking volunteers from outside the university community but with similar demographic characteristics to the study population. The wording of the tools was amended only slightly for clarity. The data collection period spanned the end of one academic year and the start of another, to ensure the widest possible participation.

Participants who volunteered were asked to complete a short questionnaire and participate in a brief tape-recorded semi-structured interview. It was the choice of the majority of participants to be interviewed in Arabic, with some additional statements made in English. One participant chose to speak in English only. All data were anonymised, with names replaced with a participant number.

Data analysis

Thematic analysis was used to explore participants’ descriptions of their experiences with primary care services in Scotland. The interview transcripts were analysed to search for common themes and similarities, and variations among participants’ views. As the interviews were mainly conducted in Arabic – the native language of the principal investigator and the participants – the data were subsequently translated into English. Field notes provided complementary data on this aspect and other issues identified by the researcher to encourage reflexivity.

Data was coded, identified under categories and subcategories, and organised together under common themes. To aid validity, the whole research team held five meetings to review the findings and clarity of the principal investigator’s analysis in relation to emerging categories and themes. The demographic data was analysed using SPSS program version 9.

Discussion of findings

The purposive convenience sample of Arabic speakers consisted of 12 female and eight male participants, all resident in Scotland for up to seven years. The majority of participants were 30 years old, and their ages ranged from 19 to 34 years.

All respondents were volunteers and studying health-related programmes, and so presented both a personal and professional perspective.

The health demands of a community differ according to the characteristics of its population, with certain factors influencing such as knowledge, information, cultural beliefs, indirect financial costs, and patients’ time and preferences.

However, this study’s findings present the important perspectives of Arabic-speakers with respect to primary care services in Scotland. The results of the qualitative analysis of participants’ experiences of primary care services were divided into the accessibility and acceptability of physical resources and structures, and the accessibility and acceptability of interactions with services. Quotations illustrating each section are presented with the identifier (A) if the original quote was in Arabic, and (E) if the original was in English.

Physical resources and structures

There was no consensus among participants about the accessibility of services, despite there being a university nurse on campus. The university nurse is employed by a local medical practice where resident students are encouraged to register. Only nine out of the 20 participants registered at local medical and health centres. The remaining participants accessed medical and health centres across the city. While nearly one-third of participants described the location of health centres as easy to access, a quarter (n=5) felt that their choice was difficult geographically.

I did not know how to reach the GP. There is a lack of information resources (A).

One-quarter of participants (n=5) felt unclear about the process of accessing primary care. Some participants went to a number of different practices because some GP lists were full. Participants of this study – similar to the findings of Davies et al22 – reported some lack of information about access to services, and lack of time to seek health advice.

While about one-third (n=7) of participants did not find arranging appointments to be flexible, others mentioned that receptionists and healthcare professionals did their best to arrange appointments at a time preferred by participants: When I asked for a specific time that was not available, they told me they would call me if somebody cancelled an appointment (A).

Favourable comments were made about appointments running on time. The majority of participants (n=14) found the duration of the appointment to be acceptable, with one participant reporting that the doctor promised a longer meeting at their next appointment. Some participants (n=4) reported that they did not access health care because of their busy lifestyle: Time hinders me from seeking health care (A).

This is confirmed by the findings of O’Donnell et al22 in their qualitative study of asylum-seekers’ access to health care. They identified problems with a lack of continuity of care, and difficulty in getting timely appointments.

In general, participants were able to access professionals of the gender they preferred if this was requested prior to attending the appointment, but not in an emergency. Most of the female participants preferred to see female doctors. The majority of male participants did not express a preference for a particular gender of professional for themselves, though one male participant preferred to be seen by a male nurse. However, all male participants insisted that...
women in their family should be seen by female healthcare professionals. In contrast to the findings of a survey by Zainal et al,23 whose respondents among Arabic speakers in Glasgow identified a lack of female doctors, the majority of participants in this study were satisfied with seeing a professional of their preferred gender, only complaining about the absence of female doctors in emergency situations.

A theme in relation to cost emerged, as most of the respondents (n=16) considered medication and dental care to be expensive. One participant postponed accessing dental care until returning to their home country due to cost. Other studies have found that financial issues – the cost of medication and expense of some services – hindered people from seeking health care.24,25

Interactions with primary care services
The majority of participants (n=17) found the process of registration to be long and complex. One reported: Arranging [an] appointment takes more than three weeks (E).

However, many participants reported that receptionists were very helpful in meeting their needs. The perception that the process of registration and appointment booking was difficult meant that many participants (n=11) sought health care for emergency conditions only, or put off seeking help until they were back in their home country. One thought that an appointment was required even in an emergency.

More than two-thirds of participants (n=14) described healthcare professionals positively, as ‘helpful’, ‘flexible’, ‘kind’, ‘cheerful’, ‘caring’, ‘responsible’ and ‘competent’ (A). Communication skills were identified as being important: Healthcare professionals always smile as if they know you before, which makes [the] patient optimistic for [a] care (E).

Language skills did not appear to be a problem for most participants (n=13): I can explain my complaints (E).

It was noted that ways of expressing feelings and complaints differ from one country to another, and that some medical terminology was difficult to understand: Language itself is not considered a barrier, but expression of feelings and complaints is difficult and may lead to misunderstanding and misdiagnosis (A).

Healthcare professionals took potential communication barriers of accent and fluency into consideration, aiming to talk in a slow and friendly manner. Two participants had poor experiences during a consultation, in terms of lack of communication skills. One reported: They do not listen to your complaints... The doctor tried to explain my symptoms and said that what I was saying had not happened... They did not consider communication barriers (E).

Another sensed discrimination in the professional’s non-verbal communication: Feeling of discrimination which... appear[ed] in facial expression and manner (E).

Communication and language barriers have been found to affect the satisfaction of healthcare consumers negatively and decrease the time spent with healthcare professionals.26 The duration of time spent in consultation affected patient satisfaction strongly.26,27 Too little time can result in feeling that a doctor has not listened or understood the patient’s emotional needs.27 Zainal et al23 identified a need to provide an interpreting service to culturally different groups within healthcare settings. In contrast, most participants in the present study did not experience language barriers and were satisfied with the length of contact with healthcare professionals. This might be because this group all had some expertise in English.

There was explicit variation in participants’ perceptions relating to cultural respect. Some participants found that most healthcare professionals respected their culture and religion, while others reported non-verbal discrimination. This variation may be due to personal perceptions and characteristics of both participants and healthcare professionals. Most of the participants suggested the need to introduce cultural competency to undergraduate and continuing professional development programmes, supporting the findings of a previous study:28 It is necessary to [teach] healthcare professionals about different cultures... dealing with people from different cultures (E) To involve culture competency in medical education (E).

Cultural differences were not considered to be a major issue, with the majority of participants (n=14) considering that most healthcare professionals were culturally sensitive in terms of privacy and gender restrictions. The practice of a female being present during a physical examination performed by a male doctor was welcomed: The system fits my culture, when the male doctor started a physical examination, he told me that a nurse should observe him... These are our rules...’ (A).

However, there were some cultural differences in terms of the acceptability of health care provided. There was an expectation that patients would receive a physical examination automatically, and that omission of this meant that a diagnosis had not been made: The GPs did not perform physical assessments or diagnostic measures, they just took a history (A).

Two participants thought that this omission had led to a misdiagnosis: I had earache. The doctor told me it may be wax and it did not need antibiotics. When I came back home it was diagnosed as otitis (A).

Dissatisfaction was expressed about the speed of results, apparent lack of technology and lack of specialist referrals, though this was complemented by one view that: Follow up is not routine, it is according to the needs of the patient, in terms of his condition and health knowledge (A).

There appeared to be an expectation that antibiotics would be prescribed routinely. The majority of participants (n=17) brought their own medication from their home countries, and they felt that painkillers were the most prescribed medication in Scotland. However, two participants mentioned that treatment with less medication is more useful. This study’s findings confirm those of several previous studies concerning the importance of offering medication.24,25 Although the prescription of antibiotics is not always appropriate, a delay in prescribing them has been found to reduce patient satisfaction in several

Key points

- Participants were generally satisfied with the primary health services provided
- Participants were satisfied with the availability of their preferred gender of healthcare professional and with professionals’ communication skills and attitudes
- Specific information regarding Scottish health services in appropriate languages would be helpful for different cultural groups
- Practitioners need current and relevant cultural information
Health education was also described as efficient by most participants (n=18). Some participants felt unable to trust the care provided, and so looked for other sources of consultation or postponed seeking health care until they returned to their home countries. The present results support the findings of O’Donnell et al., who reported that Arabic speakers may be disappointed in their expectations of health services, based on cultural and traditional factors, and influenced by their home country’s healthcare systems. In addition, in the Middle East there is an expectation that medical staff will perform procedures such as clinical tests and prescribe medications or be perceived as incompetent.

When asked about possible improvements in this service, suggestions included an increased flexibility in how healthcare services are provided, availability of translators, female healthcare professionals and providing adequate information about the healthcare system for people who have arrived in the UK recently:

Providing adequate information for the newly-arrived Arabic speakers about healthcare resources, policies and the documents required (A).

Previous studies have noted that culturally sensitive interventions are the starting point to reduce disparities in health, and effective evidence-based practice should incorporate the views of service users.

Implications and recommendations
Practice and on-going education
Information about Scottish healthcare policies and resources could be printed in Arabic and offered as a first point of contact with health services, perhaps by the university nurse. This information could be available to students via university email.

Healthcare professionals should be informed about the culture and norms of Arab people, including communication preferences in terms of showing warmth and respect and potential communication barriers in expressing feelings and complaints. In addition, there should be greater awareness of the concepts and norms of Arab people regarding the importance of receiving physical assessments, medication and routine referrals.

Research
Further research is recommended to explore these experiences in greater depth, and those of other students from different cultural and minority ethnic groups who do not have a healthcare background. More research is recommended to explore health-care provision in Scotland in comparison with service users’ previous social norms.

Conclusions
The studied population was generally satisfied with the primary health services provided. The majority were satisfied with the availability of healthcare professionals of their preferred gender, and their communication with and the attitudes of healthcare professionals. However, the students need to be more clearly informed about the Scottish primary healthcare system.

In addition, the study participants mentioned that healthcare practitioners need current and relevant cultural information to enable them to provide acceptable services for specific populations. More specific health information in Arabic, improved cultural competency among healthcare professionals and further research are recommended.

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28 O’Donnell C, Higgins M, Chauhan RMK. ‘They think we’re OK and we know we’re not’: a qualitative study of asylum seekers’ access, knowledge and views to health care in the UK. BMC Health Services Research, 2007; 7: 75.
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Qualitative health needs assessment of a former mining community

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Abstract
This paper reports on a health needs assessment that set out to elicit the perceived and expressed health and wellbeing needs of the residents of a former mining village in Kent. Data was principally collected from residents, professionals and stakeholders through focus groups and interviews. Open days enabled key themes to emerge and provided verification of the research findings.

A wide range of services and improvements that would have an impact on wellbeing were identified, requiring a multi-agency approach to delivery, but primary health care services were regarded as the priority. The outcome of the study has been a commitment from the primary care trust to provide a part-time nurse practitioner/prescriber in the village and to employ a community centre manager to support health promotion activities and thereby address the concerns raised by the residents and stakeholders.

Key words
Health needs assessment, primary care provision, social inclusion, nurse practitioner/prescriber

Introduction
Undertaking a health needs assessment (HNA) has been identified as a systematic way of examining the health issues facing a population, it has the potential to direct the focus of priority setting and the allocation of resources in order to improve health and reduce inequalities. Health is a complex, dynamic concept involving every aspect of human life, psychological, social, spiritual as well as physical, and in order to undertake a comprehensive analysis of the health needs of an area information must be collected from a variety of sources and often in a number of ways.

A previous quantitative HNA indicated that residents of one former mining village in Kent were dissatisfied with the health services offered. This paper reports on a qualitative HNA undertaken by a team of investigators from Canterbury Christ Church University. It was commissioned by the primary care trust (PCT) to elicit and document the detailed expressed health needs of residents in order to provide appropriate primary health care services.

This small former mining village is eight miles from the nearest major town, and with the adjacent village forming a ward of approximately 4500 people. However, the two villages have a separate identity, with the former mining community having the highest level of deprivation. As noted in the Elvington and Eynhorne Health Needs Assessment, the ward is relatively deprived and has an average rank of 122 within Kent and Medway, scoring particularly poorly in the economic and health domains. From its inception in the 1920s until the 1970s, the village developed as a thriving mining community, housing miners who worked at the nearby mine. Pit villages developed in very isolated rural areas, and so these villages often developed a very strong identity and self-sufficient close-knit sense of community. Elvington Oral History Group (EOHG) reported that prior to the mine closure in 1987, the village was self sufficient for shopping, leisure and social events, and it had many community based projects and activities. The mine closure resulted in profound social consequences for the area, which had inevitable negative implications for the health of the population. EOHG stated that in many ways, the village ‘lost its sense of purpose, mining as well as the close-knit community spirit’ (p63).

In the 1990s, social housing in the village was further developed and individuals and families were moved into the village, often from urban areas. Even today, this part of the village is referred to as the ‘new town’.

Until 2000, primary care services were provided by a single GP based in the village, and 1300 patients were registered with the surgery. Prior to his retirement, the GP entered into a partnership with a practice based in the main town, which extended its provision to include branch sites. The provision of GP and primary care services in the village has become increasingly fragmented and at the present time – based on postcode data – residents are registered with 26 different GPs, with the majority being registered with practices in nearby towns and villages. District nursing services are provided by teams attached to the patient’s GP. The health visiting service in the village is based in the children’s centre at the primary school and a part-time health visitor is supported by the locality health visiting service.

Aims of the HNA
This qualitative HNA of the village took place between June and September 2008. The aim was to carry out a public consultation with the residents to elicit their views about their health and wellbeing needs. Additionally, views about perceived health and wellbeing needs were invited from professionals and other stakeholders providing services in the area.

Methodology
Qualitative methods were employed to allow the voice of people living in the area to be heard and to gain stakeholders’ views. Data was principally collected by the investigating team through semi-structured...
focus groups and interviews with groups and individuals representing the wide range of residents and stakeholders (see Box 1).

Key informants and access points in the community were identified and, following permission from gatekeepers, the investigators provided information and invitation to residents and stakeholders to participate. Interview schedules were devised to guide the interactions and ensure that there was a uniform and equitable approach to the data collection. Krueger and Casey highlighted that focus group discussions are especially effective in producing data about the reasons why people think or feel about the issues identified in the focus of the discussion. The interviews permitted the gathering of information in an open and informal way in a conversational manner, even though a set of prompt questions were used to guide the interaction.

All focus groups and interviews were conducted at a place and time convenient to the participants. In the case of focus groups, this may be where the groups met – for example, at the community centre or primary school – while for the interviews this was often in the participant's home. With the verbal consent of the participants, all of the focus groups were tape-recorded as were 14 of the interviews. Two other participants were interviewed in a short break at their place of work where it was not convenient to record the interview, and one further participant did not wish his interview to be recorded, though he was very willing to contribute his views to the project.

Additional data were collected via open days at the community centre at the beginning and end of the project, where local residents were invited to give their views on health and social care in the village on the ’Talking Wall’ (words and phrases from participants offering their views, all pasted onto a display board) provided by the PCT. In all, 70 residents attended these events, 37 at the first and 33 at the second.

Miles and Huberman argued that ‘qualitative data analysis is a continuous, iterative enterprise’ (p12). Eisenhardt felt that by having a constantly critical reflective approach to analysis, a sharper focus of the key issues is allowed to emerge. In this project, the tapes were subjected to thematic analysis by the research team who immersed themselves in the data with a constantly critical perspective. Key themes were elicited, reflected upon and cross-checked by the team to confirm the major findings.

### Box 1. HNA participants

Focus groups:
- 12 older women at bingo
- Seven mothers at the primary school
- Eight parents at the school fair, including four fathers
- Eight mothers at the mother-and-toddler group
- Three working-age women at the hairdresser
- Eight young people at the youth club
- A stakeholder group at the children’s centre with the primary school head, children’s centre manager, two health visitors, midwife, social services representative and convener of the mother-and-toddler group

Interviews:
- 16 people (eight men and eight women) aged from 17 to 78 in venues including the bowls club, pub, village shop, working men’s club and at a dog show
- Five interviews were also conducted with stakeholders and professionals working in the village, with a community warden, GP, police constable, church leader and a retired couple who are parish councillors

As this study involved gathering data and information from human subjects, it was crucial that ethical principles were taken into consideration at all stages. The participants offered verbal voluntary informed consent and were aware of their right to withdraw from the study at any time, and were not subjected to any harm or risk as a result of being involved in the study. The ethical processes and policies of the university were adhered to strictly.

### Findings and discussion

The key themes identified were the strong sense of place and community, high level of bonding social capital, and lack of perceived control, services and facilities for teenagers, but most importantly lack of access to primary care provision in the village exacerbated by social and physical isolation (see Box 2). Although the wider health and social care issues, such as housing and employment, formed another pervasive theme of the HNA, it is outside of the remit of this paper. Several comments were made that people in the village lacked belief in themselves and felt let down by health and social care services – they had ‘lost their trust’ that anything would be done for them:

We’ve had seven different community development workers in 11 years and I don’t think they have empowered the community.

### Living in the village

Most people liked living in the village. They felt that it was a good community, a friendly village safe for children and everyone knew everyone else. This was true of people in all age groups, even though some young people had mixed feelings about living in the village: I absolutely love living here, it’s a quiet, lovely village (person in shop).

It’s a village, kids can play out, you know who everyone is so you don’t have to worry about kids too much. There are the odd families but you get that anywhere. I wouldn’t swap it... there aren’t any downsides to living here.

The role of social support in improving health is increasingly emphasised in a diverse range of literature. Based on the Whitehall studies of British civil servants, Wilkinson, Bosma et al and Ferrie et al consider the role of social support in modifying the damaging effects of stress that results when individuals or communities grapple with high demands while having low perceived or real control. More
directly, Putnam identified that high social capital, measured by community involvement, was associated with good health. Social capital has been divided into bonding social capital and bridging social capital. Bonding social capital focuses on intimacy and neighbourly social interaction, while bridging social capital is about networking interactions that cross boundaries. It seems that residents of the village generally experience a high amount of bonding social capital, which may reduce the risk of poor health.

However, Mohan et al add that bonding social capital can have negative consequences: ‘Membership of groups which are socially exclusive, inward looking, and hostile to outsiders (consider teenage gangs, for instance)... may therefore prevent individuals developing’ (p7). Indeed, the antisocial behaviour of teenage gangs was often seen as a negative side of living in the village.

Adolescence is often a time of transition and rebellion and it would appear that this is the case in this village. Many people of all ages strongly felt that more needed to be done for teenagers:

Teenagers should be looked after better, they do have money to spend in the shop but seem to run around with nothing to do.

There was a feeling that when young people are unemployed and bored, they can easily get into trouble and cause problems for the whole village:
The village does not get the policing it should – children and teenagers rampage around the village at night, there’s drugs drinking fighting and vandalism.
The young seem at war with the older population and they don’t care how they affect people.

Another commented that the village was fortunate to have a youth club, but that some young people abuse it:
Kids moan that they have nothing to do, but they have a ball court they don’t use much... it’s the community’s own kids who are causing problems, in the evenings you see groups of kids, mostly not doing anything.

Many of the young people themselves felt that it was a boring place with nothing to do but ‘just to hang around and smoke weed’, but they thought that drugs were not really a problem.

Members of the community were motivated to get involved and help, but need to be enabled and supported. One mother said that she had tried to find a course that addressed the behaviour of teenagers, but the only one she could find was on a Saturday in another village, which was impossible for her to get to. She felt that most of the services were aimed for young children and she said:

I’m worried my older children will get bored and act up.

Specific health and wellbeing issues
One GP commented that, as an ex-mining community, there were a fair number of people who had lung disease and chest infections and diabetes. He thought that the community had multifaceted health needs resulting from poverty and needed a less fragmented system to offer health promotion services, as well as more traditional forms of health care. He thought that economic needs were greater than health needs in this village.

A woman in the shop also thought that there was quite a lot of ill health in the area associated with people being ex-miners with lung problems. Having moved to the village recently, she felt smoking levels were high in the village, which is likely to have an impact on health generally. The perception was that people in the area suffered from breathing difficulties, chest infections, arthritis and other illnesses associated with an ageing population. One couple were of the opinion that in the middle-aged and older groups there was a fair amount of drug and alcohol dependency issues and mental health problems.

Isolation
The World Health Organization declared that primary care services should be ‘universally accessible’ and ‘as close as possible to where people live and work’ (piv). The implication is that better health will be achieved through improved access to services.

Lack of primary health care provision in the village was a major problem, particularly for older people and young families who had to use public transport. Some people had major issues in accessing GP services and one mother said:

Travel is difficult if you don’t have transport. I’ve got four boys – trying to get to the doctor is hard. Sometimes you have to wait an hour or so to see the doctor and miss the bus while waiting. Going to get repeat prescriptions travelling on the bus with children in the rain is difficult.

Many felt that residents had been let down by the fact that the GP service had been withdrawn several years ago. Several people mentioned that they would change their GP if there was even a part-time regular surgery in the village, as it would be much more convenient. However, in contrast, several residents (most of whom had access to a car) indicated that they would not change their GP, as they were very satisfied with the service that was provided and had developed a good relationship with their GP over a period of time.

Services
One of the older residents stated:
This is the largest collection of people in the area who do not have a surgery.

One man who had been a miner and lived in the area for 40 years summed up his feelings about wanting a doctor’s surgery in the area:
We are not asking for the world, just two or three times a week... nothing big, doesn’t have to be a doctor, just someone to provide general healthcare services.

Residents suggested that there should be a chemist or a prescription service, vaccinations, annual check-ups, NHS dental service and physiotherapy service in the surgery at the community centre. One retired ex-miner said:
We are like any community, there are those who are disabled, people with blood disorders, they need somewhere locally to go for a check-up and reassurance.

Most people felt that different ways to provide primary care services should be
explored with a team approach and the involvement of different professionals: Fantastic to have a nurse, get a nurse practitioner in [the community centre] at least three times a week. If there was a doctor here I'd probably change surgery.

One working woman commented:
When you are working full time you need a nurse locally for smears, family planning and blood tests. We rarely see the GP, but if the surgery was here it would get used, doctor, nurse and dentist would be good.

One man interviewed in the shop said that health was a major problem, and that as he had a car he had helped people out by collecting prescriptions. He thought that there should be a doctor and a nurse practitioner who could change dressings for people who needed it, as well as a prescription service and a chiropodist, particularly for the elderly.

Young people said that they got information about sexual health from school and most knew where to go for advice about health. When asked, the 15- to 16-year-olds in the youth club all confirmed that they knew how to have safe sex. However, a recent study has confirmed that what young people say they know and how they act – particularly in the heat of the moment and when under the influence of alcohol – may be very different.22 One young woman stated that she was quite happy to buy condoms from the shop and was not concerned that friends or neighbours saw her buying them, but she is likely to be in the minority.

The Department of Health has stated that it is crucial to provide trusted and confidential services for young people: ‘Nearly three quarters of young people attend their GP each year. However young people are often reluctant to use services where their needs have not been taken into account’ (p4).23

Adolescence is a time when health-related behaviours are developed, such as smoking, drinking and sexual activity. Patterns of behaviour that are developed at this time, either health promoting or health damaging, may last a lifetime: ‘Trends in adolescent health are strongly linked with health and social inequalities with increasing risk behaviours during the transition from adolescence to adulthood’ (p4).23

There is clearly an enormous opportunity for health promotion to be provided for this group, but it must be presented in a confidential, non-judgmental manner that protects the young person’s privacy. Some young people thought there should be a Connexions service in the village for young people to provide advice about health, growing up and life in general.

Conclusions
The residents of this former mining village were very willing to contribute to this consultation, and were very welcoming of the research team despite years of battling to improve access to primary care. However, it was evident that after many years and surveys, findings had to be acted upon and a sustainable solution provided to address the health and wellbeing needs of this community.

The village has a strong sense of community and demonstrated a high level of bonding social capital – an important factor in health improvement, but which can have negative consequences in encouraging socially exclusive groups and a community that is inward looking. Antisocial behaviour of teenagers was an issue and there was a perceived lack of control, services and facilities for this age group. There were members of the community who were willing to get involved, but this resource remained untapped. The constant change of community development worker has led to a lack of continuity in relationships and project building. Access to training, support, facilities, services, work and other communities and a more sustainable approach to community development are needed to empower a community that has lost trust in health and social care services and developed a lack of belief in itself.

Some of the dangers of carrying out HNAs are that they can raise expectations, result in a long wish list that cannot be met, and if no action is taken, disillusionment with the process and wasted effort. Communities such as this one can suffer from survey fatigue and lose trust when numerous assessments are carried out over several years but nothing is done. A commitment from all stakeholders has to be made at the start that recommendations will be addressed.

Primary health care provision in the village was seen as a priority in dealing with health issues associated with an ageing former mining community, such as lung and chest infections as well as diabetes, smoking, drug and alcohol dependency and mental health problems. Access to a range of medical and health promotion services was proposed, making use of the existing surgery in the community centre.

In order to deliver improvements, it is clear that partnership working will be imperative, as many of the services require multi-agency approaches to delivery. A strategic action group set up at the start of the project has continued to meet to find solutions to the recommendations emanating from the study. It has concluded that the role of a nurse practitioner/ prescriber will be the most appropriate to address the concerns raised.

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Quality in practice

What does the continued emphasis on ‘quality’ within NHS services in England mean for health visitors, school nurses and community nurses?

Ros Godson
Unite/CPHVA professional officer for school health and public health

‘High quality care for all – an NHS fit for the 21st century’ was the rallying cry from Lord Darzi one and a half years ago,1 promoting yet more change in the NHS provision of services in England. There was an audible and incredulous gasp from many frontline community practitioners who have been struggling for years with both burgeoning caseloads and increasing demands on their resources. When would school nurses, health visitors and community nurses have time to stand back and review their systems, and where was the workforce to do this?

‘Quality’ and NHS reform
The first Labour government moved quickly to establish quality at the heart of NHS reform, and in 1998 launched a consultation setting out a three-part approach to improving quality:
■ New national standards
■ Dependable local delivery systems
■ Improved monitoring and performance assessment.2
Initially, the emphasis was on capacity building in secondary care to reduce waiting lists and improve clinical outcomes, such as in heart disease, stroke, cancer and health inequalities. A framework for performance was established and monitored through NHS performance indicators in order to focus on the quality of services as well as the efficiency of service delivery. National Service Frameworks were published to bring equity to clinical services. Then the spotlight was turned toward the Next Stage Review and primary care.

A comprehensive consultation exercise with strategic health authorities and the public culminated in the publication of Our health, our care, our say: a new direction for community services.2 This brought in the concept that patients could choose their GP, who in turn would commission the right services for their healthcare needs. The idea was that if patient choice and practice-based commissioning were in place, then this would deliver what patients want – safe, high quality health care closer to home. This was meant to encourage innovative approaches to service delivery and quality. However, in some deprived areas, patients had limited choice as there were few services, and so third sector and independent service providers were encouraged to bid for contracts.

A focus on quality would move the NHS toward concentrating on prevention as well as cure

NHS quality framework
Lord Darzi’s report was the final part of the Next Stage Review.1 He engaged with patients, public and staff to develop a vision that quality would be the organising principle for everything and would result in services being more efficient and staff becoming more innovative – a quality framework. He waxed lyrical about the silk thread that was being stitched into the very fabric of the NHS. Interestingly, he thought that a focus on quality would move the NHS toward concentrating on prevention as well as cure.

His report heralded Transforming Community Services (TCS)4 and the establishment of social enterprises, which – despite their innocuous sounding name – are in fact private businesses. He defined three dimensions of quality based on what matters to patients:
■ Patients’ entire experience of the NHS and being treated with compassion, dignity and respect in a clean, safe and well-managed environment
■ Protecting patient safety by eradicating healthcare-acquired infections and avoidable accidents
■ Effectiveness of care, from the clinical procedure the patient receives to their quality of life after treatment.

One year on, there were improvements and many innovations.5 For example, over nine million people with long-term conditions had personal care plans, and 70 pilot sites were looking at a range of ways to improve the experience of patients in areas from mental health disorders to long-term conditions such as diabetes. NHS Evidence – a new internet portal managed by the National Institute for Health and Clinical Excellence (NICE) – was also set up to ensure that professionals can access the best available knowledge,6 and an innovation fund of £220 million was established.

Acute trusts now have to provide an assessment of their performance in safety, effectiveness and patient experience. This will be published as a quality account alongside their financial accounts for the first time this year, and will make the NHS the first health system in the world to systematically measure, record and openly publish the quality of care that it achieves. Quality improvement will be financially recognised and rewarded.4

Implementing quality improvement
The ambition to make ‘everywhere as good as the best’, delivering real improvements in quality, innovation and productivity is the overarching goal of the TCS programme.4 Empowering staff to redesign services is not a radical idea, and other versions of this have been tried before. However, this is more of a wholesale overhaul of the way services are delivered, with the emphasis on the patient’s care pathway rather than the NHS service. There is a definite emphasis on co-ordinating health and social care – as has been done in Northern Ireland – and a welcoming of third sector (voluntary) organisations and private healthcare companies, as well as other NHS providers to bid for the work. The
NHS would thus become a ‘brand’ that the patient identifies as supplying the service, but other organisations may provide the care under a contract. The Commissioning for Quality and Innovation (CQUIN) payment framework aims to embed quality improvement and innovation within discussions between commissioners and providers.7

Quality framework: elements
The quality framework supports frontline practitioners in putting quality at the heart of services. There are seven elements:
- Bring clarity to quality
- Measure quality
- Publish quality
- Recognise and reward quality
- Leadership for quality
- Safeguard quality
- Stay ahead.

However, community services are to concentrate on the first two, since data systems are not robust.

Bringing clarity to quality
Quality standards of (health) care will be set by NICE through NHS Evidence. Each standard will make clear what quality care looks like.

Six service transformation guides have been drawn up to share good practice:
- Health and wellbeing and reducing health inequalities
- Services for children, young people and families
- Acute care in the community
- Services for long-term conditions
- Rehabilitation services
- End-of-life care.8

There will be improved commissioning specifications from using the joint strategic needs assessment (JSNA).9

Measuring quality
Lord Darzi stated that ‘we can only be sure to improve what we can actually measure’.1 There is an evolving list of 76 ‘indicators for quality improvement’,4 which are being field-tested and evaluated, and a draft list of these has been published.10 The list is not comprehensive, and they are not targets, but a way of benchmarking across services. Community services need to ensure that the indicators reflect the needs of their vulnerable clients and can measure the effectiveness of their services in improving access, experience and outcomes for them. A dedicated user questionnaire for community services is being planned by the Care Quality Commission (CQC). Patient-recorded outcome measures (PROMs) are also becoming more prevalent.

The National Quality Board will ensure that the whole NHS and social care are properly aligned around the quality agenda, and the CQC will use tough enforcement powers to help ensure high quality care for service users.

The challenge now is how we are going to deliver better services, when we are faced with a deteriorating financial climate. The answer from the Department of Health is that all services should be examined for Quality, Innovation, Productivity and Prevention (QIPP), and that changes should not simply be considered a cost-cutting exercise.11 By introducing innovative approaches, managers and practitioners should be able to increase productivity and prevent future ill health.

Community practitioners must seize the opportunity to show that they deliver quality services

Conclusion
Community practitioners must seize the opportunity to show that they deliver quality services, with measurable improved health outcomes and reductions in health inequalities. Demonstrating the difference between employing a qualified public health practitioner or community nurse and a less qualified colleague is difficult but not impossible.

The best way to show this in the short term is to work with the local public health director to develop user experience data. Regional quality observatories will also support local improvement. Those working with children and young people need to benchmark their service against the You’re Welcome criteria.12 Primary care nurses must demonstrate their added value to the Quality and Outcomes Framework (QOF).13

Transforming Community Services is not simply another reorganisation – it heralds a complete change in the way practitioners will want to think about delivering the service.

References

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A violent child

The winner of the 2009 MacQueen Award for Excellence in Practice shares good practice in tackling family violence perpetrated by children

Deborah Rountree
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Domestic violence is a major public health issue. However, research into children who are violent toward their parents and siblings is sparse. The subject can be too difficult for parents to talk about, and professionals can feel ill equipped to deal with it. At the Family Action Support Team (FAST), our data suggests that for every adult perpetrator of violence there are two child perpetrators (this must be treated with caution, since family violence tends to be under reported as families are not always willing to discuss this topic openly).

Family violence directly affects the wellbeing of all family members and also impacts on the wider community, creating high personal, societal and economic costs. FAST provides a whole-family approach to supporting families of children with enduring challenging behaviour, including hidden disabilities such as autistic spectrum conditions, attention deficit hyperactivity disorder and other complex needs. FAST uses a proactive, dynamic approach to promote emotional health and wellbeing, drawing upon a range of theories including social learning, cognitive behavioural, developmental and systemic theory. An eclectic mix of models enables staff to individualise interventions to meet families’ expressed needs.

This article shares good practice about an innovative approach to tackling ‘family violence’ where a child is the perpetrator, through the use of a case study (see Box 1).

Assessment and engagement
FAST uses a range of validated and service-developed tools to measure outcomes. These include Goodman’s Strengths and Difficulties Questionnaire (SDQ), Snaith’s Adult Wellbeing Score and service-developed parent and child perception.

Box 1. Case study: one family’s journey

The family consisted of mother Jane, referred child Annie aged 10 years and older sibling John aged 12 (names have been changed). They attended FAST following a referral from school, who were reporting difficulties in managing Annie’s bullying and violent behaviours. Frequently, she refused to attend or truanted, and was on the brink of permanent exclusion. When the team first met Annie, she was reported to have escalating aggressive outbursts at home that had culminated in police involvement. Police reported that Annie had been restrained and placed in a police cell and her mother had attended hospital with physical injuries.

Annie had also started to self-harm, and Jane expressed concerns for her daughter’s mental health. The violence frightened her and she felt unable to cope and requested that Annie be taken into care. Jane expressed feelings of guilt, shame and anger at her perceived inability to manage her daughter. Her GP was treating her for depression.

Family relationships were reported to be strained, John felt angry and left out, perceiving that Annie be taken into care. Jane expressed feelings of guilt, shame and anger at her perceived inability to manage her daughter. Her GP was treating her for depression. Annie to receive all of his mother’s attention and this had a negative impact on the sibling relationship, further adding to family stress.

Annie’s violence, the impacts on the whole family and in particular on Annie’s relationships, education and general health. Through skilled observation, discussion and gradual engagement of Annie, it became apparent that she had significant social skills and communication impairments that could be implicated in the challenging behaviours she was displaying. At first, Jane and Annie attended FAST’s 10-week parallel programme ‘Empowering Parents Enabling Children’, designed to:

- Improve understanding and management of behaviour
- Develop social and communication skills
- Improve or restore relationships, self-esteem and confidence in both parent and child.

During this time, Jane reported that Annie’s physical aggression ceased and that her self-harm had reduced.

However, Jane reported that Annie still had difficulties in controlling her anger and verbal aggression, and Jane felt that maintaining boundaries and structure within the home remained a challenge. As a result of this review of need, Jane, Annie and John were supported to put strategies in place at home.

Progression
FAST referred Annie to a paediatrician following observations of social and communication impairments. Annie was subsequently diagnosed with autism.

Jane attended further training at FAST to support her understanding and management of Annie. This included the use of visual supports to assist effective communication, boundary setting and establishing structure within the household. Jane also accessed workshops on understanding and managing anger and challenging behaviours, to build her skills in managing both Annie and John. Jane also attended FAST’s autism awareness training course to help her to understand Annie’s specific needs. Annie continued attending the service on a regular basis, working on social skills development and understanding herself and her needs better.

John attended the sibling support group to increase his knowledge and understanding of autism, and to give him the opportunity to express his feelings within a supportive environment.
Outcomes
Annie’s SDQ scores (see Box 2) showed a significant reduction from 28 to 18, an improvement in all areas of behaviours and emotional wellbeing. She was no longer physically violent or self-harming.

Annie attended school regularly, supported by a statement of special educational needs, and was no longer bullying other children or being bullied. There had been no further police involvement.

Jane’s Adult Wellbeing Score (see Box 2) showed a reduction in all areas – depression, anxiety, irritability outward and inward – demonstrating an improvement in her mental health and emotional wellbeing, and in her responses toward Annie’s behaviours. Anger and arguments had reduced. FAST perception scores demonstrated greater confidence in parenting skills and increased effectiveness in parenting, a reduction in stress and anxiety in managing Annie and improvements in family relationships.

Evaluations of the FAST service
Annie reported that she enjoyed attending FAST ‘because [staff members] are really ace... and really good to be with.’

Through the service-developed child perception tool, Annie expressed that attending had helped her a lot, and that things were ‘a great deal’ better at home and ‘a little better’ at school. Annie also stated that she was managing her anger ‘quite a lot’ better.

Annie felt things had improved because of the help she was receiving – she reported that FAST ‘stop[s] me from getting into trouble.’

Jane reported the value of feeling listened to, stating: ‘I have learnt a lot about autism to understand... Annie.’ The most important areas of improvement for Jane were a reduction in arguments and an end to violent outbursts in the home.

John reported that he valued meeting other siblings who were in the same situation, enjoying a range of activities. In his evaluations, John said that attending the sibling group gave him time away from his sister and made him ‘feel special’. John also stated that it was ‘better at home now’.

Conclusion
This case study illustrates immediate family outcomes from FAST’s innovative triangulated approach, working within Every Child Matters principles to promote wellbeing in its widest context to empower parents and enable children to reach their full potential.

This preventative service has a significant impact on public health national indicators, and contributes significantly to reducing the need for future services that would be necessary should these needs go unmet. Research shows that preventative parenting interventions are a more cost-effective method of intervention than a longer-term approach to managing antisocial and violent behaviour.\(^5\)

This case demonstrates many positive outcomes for just one family. Family violence was reduced, reducing associated risk factors for anti-social behaviour and criminality. There was a significant positive impact on mental health and emotional wellbeing, for the referred child, her mother and other family members. There was also a reduction in isolation, social exclusion and bullying for Annie and her family. Annie and Jane were able to access learning in a supportive environment, enabling them to better understand their own needs and leading to greater potential for achievement. As a result of these outcomes and restored family harmony, Jane was able to access employment.

FAST offers targeted, family-centred public health provision to children, families and communities. Given that emotional wellbeing is ‘everybody’s business’, this model of working is transferable to other areas of community practice.

References
Families: financial crisis

The recession is likely to have impacts for relationships, parenting and children, but tools are available for practitioners to help support families

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Since the first financial quarter of 2008, the UK has experienced a recession. Some elements of this particular recession will have specific risks for families. Using data available to date, redundancies appear to be highest in male-dominated industries of construction, manufacturing, and banking, finance and insurance.1 Furthermore, re-employment rates appear to be favouring women.2 According to research, this may present a particular challenge for families, since male unemployment presents a greater risk for relationship separation than female unemployment.3-5 Together with the increased likelihood of conflict between parents and the associated poorer outcomes for children, this is undoubtedly a vulnerable time for many families.

Who is affected by the recession?

Across the UK, areas where there is a higher proportion of low-skilled workers have been worst hit by unemployment – Wales, the North-East, Glasgow, the area between Liverpool and Hull, and Swindon.6

Families living in the areas most affected by the recession and associated unemployment may have additional difficulties:
- Finding accessible work
- Greater social deprivation and potentially stigmatisation
- Poorer local services due to council cuts

As a result of reduced incomes across these most affected areas, financial difficulties are likely to become entrenched and these areas may struggle to recover as quickly as the rest of the UK.

Some polls have been conducted in the UK to capture the current situation. A YouGov online poll of 2000 individuals found that 22% of respondents were arguing more because of money worries. Additionally, one in 10 men and one in 20 women were worried that money concerns would cause them to break up with their partner.7 An earlier poll from November 2008 indicated a range of effects on family life:
- 29% of parents reported arguing about family finances
- 10% feared that the main ‘breadwinner’ would be made redundant in the next six months
- 27% of respondents feared that they would not be able to pay the bills in six months’ time.8

These surveys provide agreement over the impact on families of the recession – with increased anxieties for family life as a whole, more relationship conflict and greater fears of separation and divorce. However, only longer-term research is likely to provide more rigorous data on how the recession that commenced in 2008 has affected UK family life and relationships.

How families might be affected

One model of how families might be affected by the recession was developed in the US at a time of agricultural decline. The Family Stress Model9 (FSM) suggests that economic circumstances affect an individual’s psychology, impacting upon their behaviour, with their behaviour affecting the larger family system. In this model, low income, high debts and negative financial events – such as redundancy and home repossession – combine to produce family economic pressure. For example, families are unable to purchase necessities such as clothes, are unable to pay bills and have to cut back on necessary expenses. This stress leads to a rise in psychological problems, such as depression and behavioural problems, including increased alcohol consumption. Relationship conflict may increase as a result, and support toward the other parent may decrease. Individuals’ problems and marital difficulties may combine to affect the quality of parenting, and children’s outcomes may be affected through this.

Recession and divorce

During and shortly after the last recession of the early 1990s, divorce statistics reached a new high. Factors that could lie behind this include the impact of financial pressures on families, broader changes to attitudes around divorce, and other unknown factors. Some theorists have argued that although relationships may become unhappier, the cost implications of divorce may be prohibitive at times of financial difficulty, so families may be more likely to stay together despite being unhappy.10 It is therefore difficult to be sure of the effect of the current recession on future divorce statistics.

Influences on family outcomes

Effects of the recession, such as unemployment and reduced income, effects on housing and conflict, may all impact cumulatively upon an individual’s psychology, through the mechanisms indicated by the FSM. By considering each of these in turn, a clearer picture may emerge of the various pressures relationships face when living in a period of recession.

In examining the effects of recession on a relationship, it is important to consider general pressures that relationships face...
with money, as this can be a difficult area to resolve even when couples are not particularly struggling. Recent research was conducted in the US to examine whether arguing about money posed particular challenges for relationships.12 Researchers asked 100 husbands and 100 wives to complete diaries about every disagreement that they experienced over two weeks. Money was not the most frequent of all topics of argument, but these conflicts were the most recurrent, the most difficult to resolve (despite more attempts at problem solving), and more pervasive – discussed alongside other topics such as work, friends, and children. Male partners reported being angrier about this topic than others, and there was a tendency for both partners to act in a more depressive manner. It is reasonable to suggest that where financial distress is particularly high, conflict between partners is likely to be raised, and to become more recurrent.

One of the most concerning elements of recession is the inevitable loss of jobs that occur through contraction of the markets. These have the potential to impact on the family in a number of ways – loss of income, reduced self-esteem and sense of worth, increased depression and increasing isolation for the unemployed partner – with psychological impacts developing over time. There is a long history of robust evidence showing that unemployment, particularly of men, is associated with divorce. This has been supported across countries and among different occupational groups.3-5 Those who have experienced significantly reduced income may struggle to afford the mortgage or rent on their homes. This may result in an increase in repossessions, and a greater number living in inadequate or cramped housing. Recent evidence has suggested that housing conditions have worsened since the recession began – the Council of Mortgage Lenders predicted more repossessions last year than in the last recession, with 2009 data to be released this month. Evidence suggests that poor housing conditions of damp, overcrowding and shared facilities all have significant potential to impact upon individuals’ mental health, especially where choice over conditions is limited.4,13 According to the FSM, poorer mental health can affect family outcomes by impacting upon behaviours such as alcohol consumption and poorer communication with spouse.

Relationship effects

There is a wealth of evidence indicating how the quality of parental couple relationships affects children’s outcomes. These include the presence of internalising and externalising behaviour problems, mental and physical health, educational outcomes, and their own later relationships.14

Parents are much more likely to ‘turn to’ frontline practitioners than relationship counsellors

Research has indicated that during recession and economic hardship, conflict between parents rises, as does the use of harsh and rejecting parenting styles. The process of conflict has a significant impact upon children, with conflict that is unresolved, verbally or physically aggressive, very intense and non-verbal significantly damaging to children.15-17 The key features of arguments about money show significant overlap with those that are most damaging to children.11 This specifically highlights issues for families and the support that children may need in times of economic uncertainty.

Conclusion

It is clear that the recession is likely to have a significant impact on families and parental relationships. Health visitors and community teams are well placed to recognise and respond to the relationship difficulties. Indeed, parents are much more likely to ‘turn to’ front-line practitioners than relationship counsellors in seeking help.18 Health visitors trained in Brief Encounters19 – a simple helping model based on active listening and strengths-based practice – can support parental relationships in a time-managed way.19,20 A short, timely intervention at a time of stress has the potential to prevent a longer term decline and crisis.21 An interactive web-based resource funded by the Department for Children, Schools and Families is also available to help couples strengthen their relationship and manage conflict.22 This service has specific content about relationships and the recession that will be useful in supporting families.

References


Late introduction of solid foods into the infant diet may increase the risk of allergic diseases in children, according to the results of a study that challenges current recommendations.

Feeding recommendations propose exclusive breastfeeding for the first six months for the prevention of allergic diseases in children. This has been based mainly on the premise that the gut mucosal barrier of the infant is immature, and early introduction of solid foods may instigate sensitisation against foods and inhalants. However, families with a positive family history of allergic diseases, or in whom infants have early signs of allergy, may delay introducing solids into the infant diet, thereby masking any temporal relationship between the introduction of solid foods and the development of allergies.

To examine the relationship between age of introduction of solid foods and allergic sensitisation at five years, researchers in Finland analysed data on breastfeeding, age of solid food introduction and allergen-specific immunoglobulin E (IgE) levels in 994 children with susceptibility to type-1 diabetes mellitus. Logistic regression allowed analysis of the association between age of introduction of solid foods and allergic sensitisation.

Allergic sensitisation to any food allergen was present in 17% of the children, whereas 23% of the children were sensitised to any inhalant allergen. Sensitisation to cow’s milk allergen was present in 12% of the children, egg allergen in 9%, wheat allergen in 5% and fish allergen in 1%. The median duration of exclusive breastfeeding was 1.8 months (range: 0 to 10 months). After adjustment for potential confounders, late introduction of potatoes, oats, rye, wheat, meat, fish and eggs was significantly directly associated with sensitisation to food allergens. Late introduction of potatoes, rye, meat, and fish was significantly associated with sensitisation to any inhalant allergen. These findings support earlier reports that delayed introduction of solid foods may not prevent the development of allergic diseases in children.

Limitations of this study included a short median duration of exclusive breastfeeding in the study population, selection of a birth cohort based on susceptibility to type-1 diabetes, and the inability to determine effects of timing of the introduction of solid foods on asthma, atopic eczema or other clinical outcomes. Despite this, neither exclusive breastfeeding nor late introduction of any of the solid foods was related beneficially to allergic sensitisation. The authors conclude that late introduction is associated with increased risk of allergic sensitisation.

Routine screening for postnatal depression not cost effective?


Routine screening for postnatal depression (PND) in primary care does not appear to represent value for money for the NHS, a study has concluded. Although clinically- and cost-effective treatments are available, less than half of PND cases are detected in routine clinical practice. The National Institute for Health and Clinical Excellence (NICE) recommends the use of brief case-finding questions (Whoeley questions), and use of self-report measures such as the Edinburgh Postnatal Depression Scale (EPDS).

To evaluate the cost effectiveness of formal methods to identify PND in primary care, researchers used a decision tree, considering the full treatment pathway from possible onset to identification, treatment and possible relapse. Routine application of either postnatal or general depression questionnaires did not seem to be cost effective compared with routine care alone. For example, the EPDS had an incremental cost-effectiveness ratio of £41 103 per quality-adjusted life year (QALY – a combined measure of quantity and quality of life) compared with routine care. The ratio for other strategies ranged from £49 928 to £272 463 per QALY compared with routine care, well above the NHS cost-effectiveness threshold of £20 000 to £30 000 per QALY. These findings suggest NICE guidance and widespread practice do not result in value for money for the NHS, and do not satisfy National Screening Committee criteria for the national adoption of a screening strategy, conclude the authors. They call for further research to quantify the cost of incorrect diagnosis and the wider impact of PND treatment strategies on the quality of life of mothers and families.

Children more likely to catch swine flu


Young people aged under 18 years are more likely than adults to catch 2009 influenza A(H1N1) virus (swine flu) from an infected person in their household, according to a new study, though young people are no more likely than adults to infect others.

Most people with swine flu are advised to stay at home until they have been afebrile for at least 24 hours. This puts other household members at risk of infection, but risk factors for transmission are largely uncharacterised. To determine how age, symptoms, size of household and time after first-reported symptoms affect transmission, researchers analysed data from 216 people believed to be infected with swine flu and 600 people living in their households. The average length of time between one person displaying the first symptoms and someone else in their household having symptoms was found to be 2.6 days. Children were twice as susceptible to infection from a household member as adults aged 19 to 30 years, and those aged over 50 were less susceptible than younger adults. No particular symptoms were more associated with transmission between household members than others. Transmissibility within households is lower than in past pandemics, conclude the authors, and most transmissions occur soon before or after onset of symptoms in a case patient – it may be unnecessary for patients to stay at home for longer than four days after they start to have symptoms.
IN BRIEF...

Breastfeeding may protect against metabolic syndrome

Gunderson E, Jacobs D, Chiang V, Lewis C, Feng J, Quineberry C, Sidney S. Duration of lactation and incidence of the metabolic syndrome in women of reproductive age according to gestational diabetes mellitus status: a 20-year prospective study in CARDIA—the Coronary Artery Risk Development in Young Adults Study. Diabetes, 2009; doi: 10.2337/db09-1197 (3 December 2009).

Breastfeeding may protect women from metabolic syndrome (MetS), according to the results of a study. MetS is a clustering of risk factors related to obesity and metabolism that strongly predicts future diabetes and possibly coronary heart disease during midlife for women, and early death. The childbearing years may be a vulnerable period for its development. To prospectively assess the association between lactation duration and incidence of the MetS among women of reproductive age, researchers followed up 1399 nulliparous women. Participants were free of MetS at baseline from 1985 to 1986 and before subsequent pregnancies. At seven, 10, 15 and/or 20 years after baseline, participants were re-examined and incident cases of MetS identified. Of 704 parous women, 84 had gestational diabetes. During 9993 person-years, there were 120 incident cases of MetS – an overall crude incidence rate of 12.0 per 1000 person-years. Increasing duration of lactation was associated with lower incidence rates of MetS from nought to one month through to nine months or more of breastfeeding. Women with a history of gestational diabetes experienced the greatest risk benefit from a longer lactation duration. Lactation may have persistent favourable effects on women's cardiometabolic health, conclude the authors.

High salt intake directly linked to stroke and CVD


High salt intake is associated with significantly greater risk of both stroke and cardiovascular disease (CVD), a study has concluded. The link between high salt intake and high blood pressure is well established, and it has been suggested that a population-wide reduction in dietary salt intake could reduce levels of CVD substantially. The World Health Organization recommended level of salt consumption is 5g (about one teaspoon) per day, but daily dietary salt intake in most Western countries is close to 10g. To assess the relation between the level of habitual salt intake and stroke or total CVD outcome, researchers analysed 13 prospective studies involving over 170 000 people in six countries. The analysis showed that a difference of 5g a day in habitual salt intake is associated with a 23% difference in stroke and 17% in total CVD rates. The authors estimate that reducing daily salt intake by 5g at population level could avert 1.25million deaths from stroke and almost 3 million deaths from CVD each year.

Protein hormone associated with lower dementia and Alzheimer’s risk


People with higher levels of leptin – a protein hormone produced by fat cells that controls weight and appetite – may have an associated reduced incidence of Alzheimer’s disease (AD) and dementia, according to a study. Previous studies have shown overweight and obesity in mid-life to be associated with poorer cognitive function and increased risk of dementia, while leptin may have beneficial effects on brain development and function. Researchers examined the relationship between plasma leptin concentrations and incidence of dementia and AD in 785 people without dementia. A subsample of 198 dementia-free survivors underwent volumetric brain MRI approximately 7.7 years after leptin levels were measured. Higher leptin levels were prospectively associated with a lower incidence of AD and dementia, and also with higher total cerebral brain volume. The authors conclude that circulating leptin is associated with a reduced incidence of dementia and AD and with cerebral brain volume in asymptomatic older adults.

Parents overestimate child activity


Most parents of inactive children wrongly consider their children to be sufficiently active, a study has found. Literature reviews highlight the limited success of physical activity interventions for young people, but reasons for this are largely unknown. One may be that children and parents overestimate the child’s activity levels. To assess awareness of child physical activity levels among children aged nine to 10 years and their parents, researchers used an accelerometer in a cross-sectional study of 1892 children from 92 Norfolk schools, assessing agreement between child- and parent-rated and objective physical activity. In all, 39% of girls and 18% of boys were inactive – 80% of their parents wrongly thought their child to be sufficiently active and 40% of these children overestimated their activity level. The lower the child’s fat mass index, the more likely it was that parents overestimated the activity level. Increasing awareness of health benefits of physical activity beyond weight control might help to reverse misperceptions of physical activity levels and encourage behaviour change, say the authors.

How smallpox kills


While smallpox has been eradicated, its deliberate release still represents a threat. Researchers have discovered that the virus kills by attacking molecules made by the body to block viral replication, laying the foundation for the development of antiviral treatments, should smallpox or related viruses re-emerge.
Window blinds: hanging risk

A case report highlights the potential danger of hanging posed by some window blind cords

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Hanging injuries and resulting mortality in infants and young children are usually accidental. Deaths and complications such as long-term neurological consequences are rare but potentially serious.

A case of a 31-month old boy who almost killed himself after an accidental hanging from the cord of window blinds is described here. It emphasises the need for adequate safety regulations for manufacturers, as well as for home safety awareness among healthcare providers and parents.

General guidelines are provided that can be discussed during routine visits by the primary healthcare providers, based on British Blind and Shutter Association (BBSA) guidance.

While strangulation and hanging injuries in children are not common presentations in the emergency department, they can have devastating outcomes. They can also be prevented with increased home safety awareness, and there is a case for stricter regulation of the design, manufacture, supply and installation of window blinds.

Case report: clinical course

A 31-month old boy was discovered by his twin brother hanging from a window blind cord. The young boy alerted his father, who found the child with the cord around his neck, pale, unresponsive, blue, tongue protruding and apnoeic. His father managed to cut the cord and performed mouth-to-mouth resuscitation for 30 seconds, following which the child became responsive and cried.

The child was brought to the hospital in an ambulance. Physical examination in the emergency department revealed a conscious child with a patent airway, breathing spontaneously and haemodynamically stable. Neurological examination was normal, with a Glasgow Coma Scale score of 15/15. There was a visible ligation mark around the neck (see Box 1). The trachea was in the midline with no palpable subcutaneous air, and there was no audible stridor. A cervical spine X-ray and CT scan ruled out any fracture or dislocation.

Most of the causes are preventable, so parental education on home safety is necessary

The child was admitted for neurological observation and remained stable overnight. He was discharged home the following day with appropriate advice and a review of home safety arrangements scheduled with the health visitors.

His subsequent progress has been uneventful. His good outcome was due to prompt initial resuscitation initiated by his father – guided over the telephone by the paramedic team – and subsequent care by the multidisciplinary team.

Discussion

Epidemiology of child hanging injuries

Hanging injuries and fatalities are quite rare among infants and young children. In most instances, they are caused by common objects of everyday use. Most of the causes are preventable, so parental education on home safety is necessary. Health visitors, community nurses and practice nurses have a crucial role to play in providing parental education regarding home safety measures.

In the UK, there has been one child death per year from strangulation associated with blind cords, though the probable under-reporting of near-misses suggests that it should be given greater priority than it has. According to the Consumer Product Safety Commission (CPSC), more than 200 infants and young children have died in the US since 1990 from accidentally strangling themselves in window blind cords.

A literature review found that strings attached to toy perfume bottles have been another cause of near-hanging injuries – most of the toys sampled had a warning in small print stating that they were ‘unsuitable for less than three-year-olds’.

Strangulation has also been reported as the cause of death in more than 50% of all playground fatalities in children.4

There were four reported cases of death and one near-death from hanging in which children had pulled down a loop of cloth towel in school lavatories, wrapped the cloth around their neck and hung from it.5 All of these accidents involved boys aged seven to 12 years of age, probably in thrill-seeking play. In Canada, these incidents have resulted in the changes in the design of and legislation relating to cloth-towel dispensers.

Non-releasing plastic garden ties have also been reported as causing near-hanging in children’s play activities without adequate supervision.6 One of the authors has had the unpleasant experience of a toddler die following a strangulation injury by an older sibling, with a religious thread present around the neck.

Clinical aspects of hanging injuries

The boy in this case study experienced a hanging injury accidentally while playing with the window blinds in his home. In comparison to adults, children are at a low risk of vertebral and laryngeal fractures during hanging incidents, but are more susceptible to airway oedema.

Neurological damage and death are caused by airway obstruction and venous congestion, leading to hypoxia, acidosis, brain congestion and brain-cell death. Airway injury in survivors is an exception and spinal cord injury has rarely been documented in survivors.

The mortality rate in strangulation injuries is high. For children presenting in cardiac arrest, survival is unlikely and full neurological recovery has never been reported. However, all resuscitative efforts should be undertaken in patients with a residual circulation, because intact neurological survival is possible even in deeply comatose patients.

CLINICAL UPDATE
Prevention: regulation
Various kinds of corded window blinds present a range of potential hanging hazards for children (see Box 2). In 2009, new regulations were introduced in Canada to make corded window coverings safer for children, and in the US, the CPSC and Window Covering Safety Council (WCSC) also announced a voluntary recall of millions of window blinds to prevent the risk of strangulation.

For reasons of climate and custom, indoor blinds are typical in the UK, but external blinds are more usual in other European countries, which are safer for children. There have been calls for stricter regulation of the manufacture of window blinds in the UK. The BBSA has embarked on a national trade campaign to promote the adoption of BBSA recommendations for child safety by businesses involved in the specification and installation of window blinds. The BBSA is also trying to ensure similar safety measures are followed in other European countries. Information on their ‘Make it safe’ campaign is available online.

Prevention: home safety
These types of accident can reflect a lack of awareness of strangulation hazards among the parents and childcare provider. There may also be a belief that, although strangulation injuries may occur, it will never occur to their own child.

The Royal Society for the Prevention of Accidents (RoSPA) recommends that to avoid child strangulation, parents should buy window blinds without looped cords, or cut cords on blinds that use them.

Many millions of blinds are sold every year in the UK and looped blind cords can pose a potential hazard for babies and small children. Guidance from the BBSA, CPSC and Parents for Window Blind Safety (PFWBS) includes:

- Advise parents to use cordless products as the safest approach
- Any cords should be kept as short as possible and out of reach of children
- Use one of the many available proprietary cleats, cord ties, clips or tie-downs
- Use an alternative blind operating system that does not have cords or chains that can cause a potential hazard
- Do not place a child’s cot, bed, playpen or high chair near a window so they may reach a blind cord
- Do not place furniture near a window that a child could climb on to reach a blind cord
- Make sure that a safety device is fitted to keep the cords taut or out of reach.

Role of healthcare providers
Primary healthcare professionals can play a vital role in identifying home safety issues during visits to families, and also in recommending changes to individual families. The following helpful strategies are based on BBSA, CPSC, WCSC and PFWBS advice, and from managing cases and advising the parents involved.

- Do not allow cords to hang loose – wrap cords around a cleat or hook that is high off the floor out of a child’s reach
- Avoid long strings in baby pull-toys – in the US, pull-toy strings are restricted to a length of about 18cm (7.25 inches)
- Install only cordless window coverings in all homes where children live or visit, especially in children’s bedrooms
- Move all cribs, beds and furniture away from windows
- Avoid any kind of loose cord around baby’s cribs or push strollers
- Safety straps in high chairs and strollers should be fixed under adult supervision
- Follow manufacturers’ safety advice regarding age limits before buying toys
- Loose electrical and telephone cords are potential strangulation risks for children learning to crawl and toddlers
- Avoid religious threads or necklaces used as part of traditional practices by some communities
- Child abuse concerns need to be raised if suspicious ligature marks are found
- Printed leaflets summarising home safety measures may be distributed by professionals in antenatal clinics
- School and playgrounds should be made aware of possible strangulation risks and make sure adequate adult supervision is always provided.

Summary
The authors have reported one case of near-hanging by a window blind cord, in the hope of heightening awareness of these potentially fatal injuries among community practitioners. Parents and childcare providers need to be more aware.
Box 2. Window blind cords: infant hanging and strangulation hazards

The CPSC identifies four key hanging and strangulation hazards with corded window coverings for infants and young children (reproduced here with the kind permission of the CPSC).7

Pull cords:
- Children can strangle when they wrap the cord around their necks, or if they become trapped in the loop created when loose cords get entangled
- Even if cleats are used to wrap excess pull cords, if installed within the child’s reach, the cords above the cleat still present a hazard

Inner cords of Roman blinds:
- Children can pull out an exposed inner cord on the interior side of Roman blinds, wrap it around their necks and strangle
- Children can place their necks in the opening between the fabric and the cord and strangle

Lifting loops of roller blinds:
- If the lifting loops (which raise and lower the blinds) slide off the side of the blind, they form a free-standing loop in which a child can become entangled and strangle
- Children can place their necks between the lifting loop and the roller blind material and strangle

Looped bead chains or nylon cords:
- Children can strangle in free-standing loops of bead chain or nylon cord

References
Public health nursing

A textbook for health visitors, school nurses and occupational health nurses

This book is a basic text that aims to collect together the different roles of nurses in the public health arena. It is written by the relevant experts in each field, tackling the roles of health visitor, school nurse and occupational health nurse. It admits to not being an all-embracing text for each discipline, but correctly encourages each professional group to refer to texts for their own profession. It is however, an excellent text for those who are either new to the public health nursing field as a career, or those managers and commissioners who want to see both the common core of these roles and – more importantly – the differences between them.

The book starts with chapters that detail the development of public health and then moves on to explore the role of public health nurses. There are then two chapters for each specific discipline. The first of these chapters covers the historical development of the profession and the second covers the role in current practice. The final chapter looks at the education and continuing professional development of public health nurses.

Even though each profession is dealt with by different authors, the book has a good standard approach and the history of each profession is especially interesting. I imagine that this will be especially useful to those new to each profession or those who want a quick reminder. It was also good to see that the information was reasonably current, but as is always the problem with any textbook, with quickly changing landscapes there are some omissions. In terms of health visiting, there was no detail regarding the most recent review – the Action on Health Visiting programme – but again, this is through no fault of the authors.

The last chapter may be more useful for nurses already in practice. This chapter brings together lots of important information that NMC registrants should know and presents it in an easy-to-read format. At the least, it would be useful for people to borrow their student's copy and read this chapter alone.

Reviewed by: Dave Munday
Unite/CPHVA professional officer

One in ten: helping 16- to 18-year-olds find employment, education and training
Elizabeth Cooke (Ed.), Research in Practice (2009)
ISBN: 9781904984313, £10

One in ten: helping 16- to 18-year-olds find employment, education and training is a very interesting (and long) CD that describes all aspects of the issue of enabling disaffected youths to get on with their working lives. These young people are often referred to as ‘NEETS’ – not in employment, education or training – which has enormous consequences for them now and for the rest of their lives.

As statistics suggest, one in ten 16- to 18-year-olds are not in education, employment or training at any one time. It has been well-evidenced that those in this situation are more likely than others to become involved with the criminal justice system, become teenage parents without adequate financial resources, or have long-term mental and emotional health problems.

There is a good summary of the sociological and historical background of young people's transition into the workplace and the recent policies and environmental changes that have led to some of the current problems.

There is a clear explanation about how disaffection sets in early and the different types of young people needing help and support.

The audio CD also provides information on how Connexions – a service that provides information on careers, work, money, housing, relationships and education for young people aged between 13 and 19 years – can provide the necessary support. The way that Connexions uses evidence and data appropriately is quite impressive – they are clear about what they are commissioned to do, and they work very well with partners, especially the youth service. However, health services are mentioned in a general way.

This resource is very accessible, as it tells the story of those not in employment, education or training – which has enormous consequences for them now and for the rest of their lives.

Health visitors, school nurses and others who think that their service is not appreciated or understood, would do well with a copy of this audio CD. In addition, it would be of interest to nurses working in youth offending teams, the Family Nurse Partnership, sexual health and teenage pregnancy services, child, adolescent and mental health workers, schools, pupil referral units, youth centres and further education colleges.

Reviewed by: Ros Godson
Unite/CPHVA professional officer

The inclusion of a resource does not imply endorsement or approval by either Unite/CPHVA or this journal.
The NHS: from good to great?

In December 2009, health secretary Andy Burnham produced NHS 2010 to 2015: from good to great: preventative, people-centred, productive. In his foreword, he states: ‘15 years ago, the NHS had sunk to such a low ebb that many voiced doubts over its long-term survival, with it now recognised as being in a strong position with high levels of public support.’ However, he has set a new ambition as we leave behind the first decade of the 21st century, meaning a ‘new drive toward a more preventative and people-centred service – better for patients, but also more productive’. It is helpful to consider this document and its five-year plan in terms of how our workplace representatives both understand it and also use it locally. One thing apparent in 2009 was a real divergence between the messages sent out centrally by government and also use it locally. One thing apparent in 2009 was a real divergence between the messages sent out centrally by government and the Department of Health, and those being given locally. It would have been nice to imagine that this was something that would disappear with the new year, but it is likely that this will not only remain but intensify in 2010.

Funding and ‘postcode lotteries’

On the issue of funding, the health secretary’s message is clear: ‘Next year, the NHS will receive a substantial increase in funding and the Pre-Budget Report has confirmed that this uplift will be locked in to frontline budgets for the two years that follow.’ It is interesting that it is highlighted that ‘in 1997, the NHS was suffering from decades of underinvestment. Waiting times were high, quality in its broadest sense was variable and a “postcode lottery” had developed, as local NHS organisations took different spending decisions’. The improvement of funding in the NHS cannot be argued with. Over the last 12 years, funding has doubled in real terms, putting us on an equal footing with other Organisation for Economic Co-operation and Development countries. This much needed investment has had dramatic effects, leading to 89,000 new nurses, 44,000 more doctors and 10,000 more consultants, and massive improvements in waiting times and targets set around the major ‘killer’ diseases. However, it is interesting to highlight how a ‘postcode lottery’ in 1997 existed with all these local NHS organisations taking different spending decisions. How different is that to the current reality?

The new five-year plan for the NHS in England calls for services to become more ‘preventative, people-centred and productive’, but there are questions about potential local disparities, how savings will be made and effects on staff conditions and pay. However, with the pseudo-marketisation that has been pushed by private companies and local NHS organisations themselves, how close are we to traveling back down this dangerous road?

Efficiency and productivity

NHS chief executive David Nicholson has set a ‘productivity challenge’ that the NHS ‘needs to meet’. At between £15 billion and £20 billion in efficiency savings over the three-year period from April 2011, this could easily be achieved by Unite’s reckoning. We have already outlined how to do this in our Health B4 Profit guide: ‘Professor Allyson Pollock has written that ‘As in the US, billions of pounds, probably approaching 20% of annual NHS funds – estimated to be £20 billion in England in a year – are being squandered on what are called the transaction costs of the market’. Therefore, if NHS commissioning organisations followed the instruction to treat NHS services as the preferred provider, this figure would start to be saved. However, the health secretary believes these savings will come from:

- Creating an empowered, flexible, healthy and productive NHS workforce (£3.5 billion) – this will in part be delivered by the resulting improvements from the NHS Health and Wellbeing (Boorman) Review (for more on this, see the last issue of the journal)
- ‘Putting the front line first: smarter government’, which intends to drive down the costs of management, back office support functions and procurement across public services (£1.8 billion)
- Transforming the way in which care is delivered with ‘truly integrated care [and] efficient and people-centred community services’ (£2.7 billion). It is interesting to consider the idea of reducing costs by putting the ‘front line first’. In response to a recent Freedom of Information request from Pulse magazine, NHS Hounslow returned figures that showed a 116% increase in manager salary costs over the two years (between 2007 and 2008 and 2009 to 2010), while at the same time allowing some of its frontline services to reduce by over 50%.

Further local examples highlight the potential of following Unite’s advice, including: ‘NHS North East Essex, which saw costs soar by 26% in the last year alone, blamed the rise on the cost of separating its provider and commissioning arms.’

Staff: partnerships, conditions and pay

According to the health secretary: ‘Our vision for the NHS therefore includes a strong partnership with staff to provide a high-quality healthy workplace. We will only achieve this goal if staff have the freedom and confidence to act in the interests of patients. To do this they need to be trusted and actively listened to. They must be treated with respect at work, and have the right tools, training and support to deliver care and opportunities to progress and develop. This is not simply about a good deal for staff, it is essential to meeting the productivity challenge: high-quality workplaces make best use of the talents of their people, ensuring that their skills are up to date and their efforts never wasted. The public rightly expect their taxes to be put away’.
to the best use. For those working in the NHS, there is a need to reduce unnecessary bureaucracy, freeing up their time to care for patients within the resource available. Creating high-quality workplaces requires great leadership and good management.

The health secretary believes that, even though the NHS has cause for optimism, ‘we must be under no illusions about the scale of the challenge before us. Services will need to be reshaped if we are to achieve this vision. And, because of this, we will be more dependent than ever on the resourcefulness and commitment of NHS staff.’ He goes on to say that ‘The NHS is all about people and its staff are its greatest asset. I know that it matters to staff at every level that they work for the NHS. So I want to support them through this period of change and empower them to make the changes we need.’

The document talks about looking beyond the 2009 Pre-Budget Report and proposes looking, in consultation with NHS Employers and trade unions, at the pros and cons of ‘offering frontline staff an employment guarantee locally or regionally in return for flexibility, mobility and sustained pay restraint’. It goes on to suggest that this flexibility might require ‘tough choices for staff, including working in a different place or organisation.’

**Concerns over pay and conditions**

Unite is concerned that this approach should not attempt to undermine NHS frontline practitioners in their ability to provide safe and effective services and that they should not be treated unfairly with respect to working terms and conditions.

For example, when it speaks of ‘working in a different organisation’, NHS staff have been used to having to move from one NHS healthcare organisation to another. However, if this is more about staff being transferred out of the NHS into private sector organisations with the threat of job losses if they do not, then this will be totally unacceptable to Unite.

It is also of concern that implementing these ideas is expected to be the ‘largest and most complex programme of change the NHS has ever attempted’: Unite often emphasises to the government that the constant expectation and requirement of ‘change’ expected of NHS workers is both detrimental to patient care and the health and safety of staff.

Another feature of the document in respect of staff is the discussion of pay restraint. Unite has always been clear in its belief that the NHS Pay Review Body should be the vehicle where pay awards across Agenda for Change are determined and awarded. Unite’s view on this has not changed. It is important to note that it is unacceptable for NHS employees to become the people who suffer most simply so that any political party can prove they are the strongest or most keen to reduce national debt. We have seen where this has taken services in the past, and we should not be so keen to return. It is also interesting to see the widespread support that is given by economists and academics to the importance of rewarding ‘lower paid’ public sector staff and how this actually improves the nation’s wealth.

Dave Munday
Unite Health Sector professional officer

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## North Highland Community Health Partnership

**Public Health Nurse Band 6**  
(Health Visitor/School Nurse)  
£24,831 - £33,436 pro rata  
Part time, 30 hours per week  
Covering Eddrachillis/Durness

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The caseload of pre school and school aged children is relatively small, but spread over a very large geographical area covering 3 GP bases and offers challenges particular to a remote and rural setting. NHS Highland is committed to working to the principles of ‘Getting it right for every Child’ (GIRFEC).  
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Informal enquiries would be welcomed by Sandra MacFarlane, Team Leader, West Sutherland, on 01571 844452.  
Application forms/full information packs are available from the Personnel Department, Caithness General Hospital, Wick KW1 5NS, Tel: 01955 880403 or e-mail northchprecruitment@nhs.net  
Closing date: 26 February 2009.

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- Health Mentors (Band 5 Nurses) within 7 of our 8 secondary schools.  
- School Nursing Assistants attached to each of our primary schools.  
- Health Visitors working in Social Care Teams pilot.  
The Health Visiting Service operates within the Children’s Community Health Services Directorate alongside School Nursing, CAMHS, Young People’s Sexual Health Service and the Safeguarding Children Team. This provides excellent opportunities for joint working.  
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Closing date: 26 February 2010.

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This is a unique opportunity to live and work in Europe, while continuing to develop your career in line with established UK standards and best practice initiatives. How? By joining our dynamic Health Service in delivering modern, quality-led integrated healthcare to Service’s personnel and their families domiciled overseas.

We are currently seeking two RGNs who are also Registered Specialist Community Public Health Nurses (Health Visitors), to join our primary care health teams within Germany and Cyprus, to work and contribute to their public health agenda.

To succeed, you will have relevant post-qualification experience and strong communication, group facilitation and IT skills, combined with the ability to work well within a team. For the Team Leader role you will also have evidence of study at level 3, well developed leadership skills and experience in the supervision of staff.

So, if you believe you possess the above and could quickly adapt to providing a service to a population with diverse health care needs, we want to hear from you.

Who are we? We’re SSAFA Forces Help – a prominent national charity, dedicated to helping and supporting those who serve in the armed forces, those who used to serve, and the families of both. Our work is varied and our aims are clear. You could help us succeed.

A full driving licence is essential.

For an informal discussion about the Germany post, please contact Ian McDonald, Locality Manager on: 0049 5241 842621.
For the Cyprus post, please contact Sally McFerran on: 00357 24442203. For an e-application pack, please email millie.f@ssafa.org.uk quoting the relevant reference. Or download the application packs from www.ssafa.org.uk/vacancies.asp

Please note that CV applications will not be accepted.

Closing date for applications is: Friday 12th February 2010.
Interviews will be held in Central London during early March 2010.

SSAFA Forces Help is an Equal Opportunities Employer and is committed to using the Criminal Records Bureau Disclosure Service.

Registered Charity Numbers: 210760 (England and Wales) SC038056 (Scotland).
Established 1885.

www.ssafa.org.uk

Contacts
For Unite/CPHVA members’ first points of contact for their professional association and union please go to www.unitetheunion.org/regions
Diary

Special Interest Group for Children with Additional Needs or Disabilities
19 March, Unite the Union, 128 Theobald’s Road, London
All those working with children with special needs are welcome for the day or part thereof, from 10.30am to 4pm. Speakers from national charities Carers UK and Aiming High. nearest tube: Holborn (Central line).

Lottie Bijth
T 020 7361 3864
E lottie.bijth@rlc.gov.uk

Soft Postnatal Yoga for Mothers and Babies and Young Children
Two-day, teacher training-certificated course with Peter Walker. Easy techniques to show and teach mothers:
- How to relieve their back pain and any stiffness in their major muscles and joints
- Soft solo postures
- How to work with a partner
- How to establish ‘good shape’ through flexibility and good posture
For babies and young children:
- A step-by-step guide to show mothers how to make full use of the baby/young child’s natural love of movement
- How to maintain and encourage good posture
- Retain flexibility and a wide range of natural movement
- Identify any lack of flexibility and remedy in an easy way.
Includes course notes and three DVDs. A perfect follow-on from Developmental Baby Massage. In-house teacher training also available elsewhere.

Peter Walker
E walker@thebabyswebsite.com

Perinatal Maternal Mental Health: Course for Trainers
23 to 25 March,
Reading University Campus
Three-day residential course designed to equip a trainer to deliver a training package to health workers in primary care. Topics covered: awareness of maternal mental illnesses and their impact, and the detection of maternal illnesses and treatments, including supporting the mother-baby relationship.

Updates on Healthy Child, NICE 37 and 45.
Presenters are Professors P Cooper and L Murray from the Winnicott Unit, Reading University, Sheelah Seeley and Dr Jane Hanley. Places limited.

PND Training
T 01803 731093
W www.pndtraining.co.uk

Positional plagiocephaly
26 March, Holiday Inn, Filton (Bristol)
This course includes practical sessions on head shape analysis, preventative repositioning techniques and cranial remoulding therapy.

Guest speaker: Ian Pople MD FRCS, consultant neurosurgeon, Frenchay Hospital
Time: 10.15am to 4pm

The London Orthotic Consultancy
E rachel@londonorthotics.co.uk

Infant Massage: 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 supervised practical teaching so all our students feel confident in empowering families.
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IAIM
T 020 8989 9597
E info@iaim.org.uk
W www.iaim.org.uk

Rhythm Kids Workshop
On-going, across the UK
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T 01889 566222
E el@touchlearn.co.uk
W www.touchlearn.co.uk

Baby Yoga Workshop
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Touch-Learn International Ltd
T 01889 566222
E yoga@touchlearn.co.uk
W www.touchlearn.co.uk

Noticeboard

HCP progressive pathway
We are looking to set out clear guidelines for health visiting teams on the content of what this pathway would look like and how to build on our current core health visiting programme. We have already developed standard operating procedures for the universal Healthy Child programme (HCP) and now want to progress in developing the same for the progressive pathway.

We would be interested to hear from anyone that has been involved in developing their own guidance or is currently working in an area that has this in place.

Any advice or information welcome and we will look forward to hearing from you.

Jo Chessman
T 01509 410228
E joanne.chessman@lcrchs.nhs.uk

Sharon Gregory
T 01530 468565
E sharon.gregory@lcrchs.nhs.uk
The Unite/CPHVA Annual Professional Conference is a vital opportunity for you and your colleagues to hear the very latest developments in best practice in primary care and public health.

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www.neilstewartassociates.com/sh269

To register for updates about the agenda and speaker line-up visit the website or call Nikki Insley on 020 7324 4357 or email nikki.insley@neilstewartassociates.co.uk
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