Safe from cuts?
Effects of cuts on child services

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- The Solihull Approach: supporting emotional health and wellbeing
- Enuresis service: progress so far
- Band 4 skill-mix staff
- Detecting neonatal jaundice
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Date of preparation: June 2010
CET0610761

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*Made to Measure*
Protected and stable?

The coalition government’s promises to protect NHS funding and avoid further health service reorganisation are sounding increasingly hollow.

The new coalition government has made a clear commitment to the NHS by ring-fencing its funding, despite opposition from both Conservative and Liberal Democrat backbenchers. It has also promised no reorganisation or changes to the NHS structures. So everything is okay and we can relax... or can we?

NHS funding is allegedly protected from the slash and burn principle that will apply to most other government spending.

Does this mean that frontline healthcare professionals will not be affected? The requirement to reduce management costs was accompanied by a change in the definition of ‘management costs’ to include clinical managers – we are faced with cuts that capture frontline clinical staff.

There was general rejoicing when the new administration said it envisaged no further NHS reorganisation. What do we have instead? Strategic health authorities – the 1990 concept of GP commissioning consortia – the 1990 concept of GP fund-holding made universal across England. GPs will be in the fortunate position of holding a £60billion budget to commission services for their patient population.

The new health secretary, Andrew Lansley, has reminded us that although the government has committed itself to ‘real term’ increases in health spending, it will get a less than 1% real term increase when less than 3% will not meet the needs of the NHS to stand still. A major part of the NHS management costs.

This ‘non-reorganisation’ of NHS England has been described... as the biggest change in the history of the NHS.

This is the beginning of the end of the system we know and love. Whether this is common sense or the result of political expediency is debatable, but it is a brave new world, and we need to move forward. The challenge is to ensure that the NHS remains the cornerstone of our health and social care system.

Barrie Brown
Unite Health Sector lead officer for nursing

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There was general rejoicing when the new administration said it envisaged no further NHS reorganisation. What do we have instead? Strategic health authorities – the 1990 concept of GP commissioning consortia – the 1990 concept of GP fund-holding made universal across England. GPs will be in the fortunate position of holding a £60billion budget to commission services for their patient population. This pivotal role will be supported by a proposed NHS Management Board with regional offices across the country. A cynic might ask if this mirrors the early 1990s’ establishment of the NHS Executive, its regional offices and GP fund-holding. But there is no place for cynicism in the NHS. Andrew Lansley’s White Paper will recreate the Department of Health as the Department of Public Health and require all trusts to be foundation trusts, while switching from the NHS as preferred provider to ‘any willing provider’. This is welcome news for the private health sector, but not to our members.

This ‘non-reorganisation’ of NHS England has been described by academics, professionals and employers as the biggest change in the history of the NHS. Whatever developments take place over the next few years, some things are certain – the uncertainty of continued NHS employment for professionals, the impact of GP commissioning consortia and the devastation of the £20billion of efficiency savings required by Andrew Lansley over the next four years.

To meet these challenges, Unite has launched the Unite 4 Our NHS campaign – see: www.unitetheunion.org/health

Barrie Brown
Unite Health Sector lead officer for nursing
NHS impact despite assurances

The emergency Budget is likely to affect NHS jobs and finances, despite the pledge to protect frontline services

Public sector cuts will affect NHS frontline services, according to Unite, even though the coalition government has promised to protect them, and posts across the UK may be threatened.

Unite assistant general secretary Gail Cartmail stated: ‘Public services are interlinked, so cuts to local authority budgets with their large emphasis on social care will have an adverse ripple effect on health provision nationally. Unite will be mounting a multilayered Valuing Public Services campaign in the coming months against the savage austerity measures that the coalition government announced in the emergency Budget in June and which are expected in this autumn’s comprehensive spending review.’

The NHS Confederation has identified ‘myths’ about NHS cost saving in a new paper titled Dealing with the downturn: using the evidence.

It warned that assumptions over how the NHS could make £15 billion to £20 billion in efficiency savings over the next five years – such as cutting back on management costs or from changes to acute services – are ‘prone to error’.

Savings ‘will have to be found across the whole NHS including primary care and prescribing’, and NHS Confederation acting chief executive Nigel Edwards noted: ‘VAT increases mean a simultaneous rise in the cost of goods and equipment.’

An estimated 10,000 NHS posts in England have been earmarked for cuts, according to the RCN. The college examined board papers from over 100 NHS trusts and found 9,973 posts were earmarked for redundancies, vacancy freezes, the downgrading of job roles, and ceasing to use agency and temporary staff.

It highlighted figures from the Department of Health, Social Services and Public Safety that 1300 health and social care jobs in Northern Ireland could be lost, and calculated that 1500 nursing and midwifery posts in Scotland could also be cut. Referring to the NHS Wales operating framework, the RCN worked out that there could be a loss of 2247 NHS jobs by 2013. It stated that the framework ‘ commits NHS organisations to a 3% cut in staff at Agenda for Change band 5 and above by 2013 per annum. If this 3% cut is applied to nursing staff it represents a cut of 739 registered nurses every single year – which in turn equals a loss of 2247 by 2013.’

The Office for Budget Responsibility, set up to make an independent assessment of public finances for the Budget report, stated that 490,000 public sector jobs could be lost by 2015 and 600,000 by 2016.

The government has launched a ‘spending challenge’ inviting public sector staff to submit ideas for how savings can be made. However, Unite is urging members to reject the challenge. Gail stated: ‘What members are telling us is that they want an end to the expensive privatisation of public services. They do not want the axing of vital local services.’

The Department of Health has published a report providing examples to nurses and midwives of how they can reduce costs. A number of organisations were involved in the developing the publication, including Unite/CPHVA. To access a copy, see: www.institute.nhs.uk/building_capability/general/aims

NMC restructure: New health visiting role

The NMC is introducing a new team of three assistant directors that will include an assistant director for midwifery and health visiting. The assistant directors will work under the senior management team, advising them on areas such as policy.

Unite/CPHVA chair Angela Roberts stated: ‘Unite/CPHVA and the National Professional Committee are pleased to note that the new management structure pays attention to health visiting. However, it has caused great concern that in recent years health visitors have had no voice on the Council. It remains the intention of Unite/CPHVA to press for a return to statute for health visiting, and with this in mind, the NMC should be mindful of the need to ensure that the similarities and differences between midwifery and health visiting are clearly understood.’

She added: ‘It is not the case that midwifery and health visiting are interchangeable and it will need to be a very special person who, as assistant director of midwifery and health visiting, is able to give the appropriate focus to both professions. Although some very basic skills are generic, it is vital that those specific to the individual profession are clearly understood and articulated by the NMC whose role it is to set the standard.’

The other two posts will be an assistant director for nursing and one for policy, of which only the assistant director for policy will be an external appointment.

The NMC confirmed that further assistant director posts to represent other professions on the third part of the register will not be created, but that it will be reviewing aspects of this part of the register. The new assistant directors have been created as part of the restructuring of the senior management team, which will also see the recruitment of a director for education. The NMC stressed that this restructuring is not for cost-saving purposes.

STOP PRESS:

NHS White Paper a ‘Trojan horse’

Government plans to reorganise the NHS were released at the time of going to press, branded by Unite as an ‘untested, expensive Trojan horse in political dogma that will give private companies an even greater stake in the NHS’. Strategic health authorities and primary care trusts are due to be phased out, and GPs will be responsible for commissioning local services. Look out for further coverage in future issues.
Unite GS election: nominations open

Four people have so far declared their intention to seek nomination to stand in the election of Unite general secretary (GS), the ballot for which is due to take place in October and November. They include Unite assistant general secretary for public services Gail Cartmail, assistant general secretary for industrial strategy Len McCluskey, assistant general secretary from the Amicus section Les Bayliss and Unite member and former Rolls Royce worker Jerry Hicks. The closing date for nominations is 12pm on 6 September.

Whistle-blowing guidance published

The Social Partnership Forum and Public Concern at Work have published guidance on whistle-blowing in the NHS, providing advice on setting up arrangements that encourage an environment where staff feel comfortable reporting bad practice.

Unite Health Sector lead officer for nursing Barrie Brown stated: ‘The report reminds our members that they have the right and duty to speak out on concerns about services in their health organisation. A new section will be added to the NHS terms and conditions handbook outlining the whistle-blowing rights for staff.’

The document provides a step-by-step guide on how to raise concerns, and specific tips for managers on how best to respond to these issues, including suggested staff survey questions. To access the report, please see: www.socialpartnershipforum.org/CurrentWorkProgrammes/Pages/Launchofnewwhistleblowingguide.aspx

Update: concurrent conference sessions

Concurrent session topics at this year’s annual professional conference have been announced. Unite/CPHVA professional officer Gavin Fergie stated: ‘As members will know, each month brings more detail to the conference programme. The detail of the concurrent sessions, which provide much of the “meat” of the conference “sandwich”, has now been shared. There is something for everyone regardless of their community practitioner background. When the practice environment is so pressured, “getting more from less” and “working smarter” are the stock phrases, and attending conference could provide you with that clinical edge.’

Concurrent session topics include:
- ‘Nourishing the future’, which will include a session on growth charts
- ‘North and south’, providing examples of best practice from across the UK
- ‘Prevention is better than cure’, exploring a range of preventative approaches such as NHS Blackburn with Darwen safety first scheme
- ‘It’s a family thing’, where there will be a presentation on the provision of mental health school nursing
- ‘We’re the same under the sun’, which will include a talk on providing community nursing to asylum seekers in Scotland
- ‘Challenging bullying in the workplace’. For updates and to book a place, please see: www.neilstewartassociates.com/sh269

A First Choice Treatment For Nappy Rash

Nappy rash is a common skin condition experienced by most babies. As the first point of contact for new parents, community practitioners are ideally placed to offer valuable advice on both prevention and treatment. Morhulin is a dual action nappy rash cream containing zinc oxide, a known barrier cream, enhanced with the natural benefit of cod liver oil, which promotes the healing of wounds, whilst soothing and moisturising the skin. Cod Liver Oil also contains Vitamin A which contributes to its healing effects.

Morhulin is available in 50g and retails at £2.99

For further information on nappy rash prevention and treatment, visit www.morhulin.co.uk. The site contains a section dedicated to healthcare professionals, where an educational leaflet containing nappy rash advice can be downloaded or ordered to distribute in your surgery. Additional leaflets can be requested free of charge by simply visiting www.leaflets2u.co.uk.
UK swine flu response ‘effective’

An independent review of the UK’s response to the influenza A/H1N1v (swine flu) pandemic has found that the UK spent £1.2billion on preparing for and responding to the pandemic, and that this was ‘proportionate and effective’.

The report was positive about Department of Health (DH) arrangements for the advance purchase of the swine flu vaccine, stating that there was ‘significant flexibility’ in the amount that the UK could purchase, but that there was less flexibility once contracts had been signed with drug companies.

It recommended that the DH should negotiate agreements that allow flexibility over the eventual quantities purchased.

In June, the Parliamentary Assembly of the Council of Europe (PACE) had criticised the World Health Organization’s management of the pandemic at the international level. PACE found that large sums of money had been wasted, and that the organisation’s response had led to unjustified public fear.

Carbon monoxide testing debate

The National Institute for Health and Clinical Excellence has issued guidance entitled Quiting smoking in pregnancy and following childbirth, recommending the use of carbon monoxide tests to identify pregnant women who smoke, and as a tool to monitor women’s smoking status during and beyond pregnancy.

Skills for Health workforce resource

Skills for Health has published a catalogue of its products and services that aims to provide practical solutions to drive up productivity and improve quality within the healthcare workforce. The document provides information on resources and services, such as templates for a flexible workforce and workforce career frameworks. To access the catalogue, see: www.skillsforhealth.org.uk/

HPG abolition plans

HM Revenue and Customs has issued instructions on issuing the Health in Pregnancy Grant (HPG), following the government’s announcement that it will be abolished. GPs and midwives have been asked to sign HPG claims for women who reach their 25th week of pregnancy before 1 January 2011. Women who reach their 25th week of pregnancy or after this date will not be eligible for the grant, but women seen after this date who have reached their 25th week of pregnancy before 1 January 2011 will be eligible. The time limit for women making a claim is 31 days after the form has been signed.

Standing against lease car imposition

Unite is defending members who receive a regular mileage allowance but whose employers are imposing lease car arrangements on them, and has issued an e-bulletin with advice on how best to act in these circumstances.

Unite national officer Karen Reay stated: ‘If an employer offers a lease car, it is reasonable for an employee to refuse if they already use a car to carry out duties at work. The imposition of lease cars is a blatant attempt by employers to reduce their mileage payments, since the public transport rate is significantly below regular user rates.’

Unite stated that any proposal must be discussed with a union representative, and that car users should be surveyed on their opinions in relation to the employer’s proposal.

Where appropriate, a ballot of affected members should be undertaken on whether or not to accept the proposal.

Members who find themselves in this situation are advised to contact Barrie Brown at Unite on email: barrie.brown@unitetheunion.org

IN BRIEF...

Children’s centre engagement tool

The National Childminding Association has developed a children’s centres engagement tool that provides advice on how children’s centres and registered childminders can best work together to provide a range of childcare services. The toolkit includes a checklist providing examples of good practice and a range of action plans. To access the tool, please see: www.ncma.org.uk/partnerships/childrens_centres/engaging_childminders.aspx

Adolescents with multiple needs

The Revolving Doors Agency has published two guides as part of its work with Transition to Adulthood Alliance. Both focus on services for young adults who have multiple problems such as mental health issues, drug and/or alcohol misuse, homelessness and contact with the criminal justice system. The Aiming high guide is specifically for practitioners who work with adolescents with multiple needs, and ‘Towards a shared future’ is targeted at commissioners. To access ‘Aiming high’ see: www.revolving-doors.org.uk/documents/aiming-higher and to download ‘Towards a shared future’, please see: www.revolving-doors.org.uk/documents/towards-a-shared-future

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‘Change of approach’ to health promotion

Health secretary Andrew Lansley has announced that there will be less government funding for Change4Life, and that the commercial sector could help to fund the programme.

Speaking at the UK Faculty of Public Health annual conference, he stated: ‘There has been a change of government and there will now be a change of approach. We will be progressively scaling back the amount of taxpayers’ money spent on Change4Life and asking others, including the charities, the commercial sector and local authorities, to fill the gap.’

He added: ‘To date, industry has made “in kind” contributions. I will now be pressing them to provide actual funding behind the campaign. And they need to do more. If we are to reverse the trends in obesity, the commercial sector needs to change their business practices, including how they promote their brands and product reformulation.’

Unite/CPHVA lead professional officer Obi Amadi stated that the credibility of Change4Life could be weakened and that practitioners might be reluctant to promote it. She stressed that commercial advertising linked with Change4Life needs to be properly regulated by a validated agency if not the Department of Health, in order to ensure that it is appropriate and sends out the right public health message.

The news came amid reports that the health secretary plans to abolish the Food Standards Agency, though the Department of Health has said that no decision has yet been taken, but that ‘all arms length bodies will be subject to a review’.

Responding to comments from Andrew Lansley stating that Jamie Oliver’s healthy school meals campaign did not work and that fewer children were eating school meals, Unite/CPHVA professional officer Ros Godson stated: ‘Jamie Oliver’s campaign was against the awful ingredients that used to be allowed into school dinners, as there were no government nutritional standards. His campaign has partly succeeded because now there are nutritional standards. It is vitally important that school meals are nutritionally balanced, otherwise there is no point in serving them. All children and young people should leave school able to cook and prepare tasty, healthy food for themselves.’

Despite the nutritional benefits of school lunches, the Department for Education has confirmed that it will be stopping the expansion of free school meals in England.

Against this background, new guidance from the National Institute for Health and Clinical Excellence on preventing cardiovascular disease is recommending that TV advertising restrictions on food and drink high in fat, salt and sugar be extended to 9pm. It also states that local authorities should restrict planning permission of take-away outlets situated within walking distance of schools.

Obi stated that these recommendations were a good way forward, but parents and school children must be provided with education on nutrition.
IN BRIEF...

ElderCare Week 2010
Counsel and Care will be holding its annual ElderCare Week on 6 to 12 September, and the theme will be ‘Everyone needs to know about ElderCare options’. The charity will call for advice and information on social care to be made more accessible for older people, their families and carers. The charity plans to publish updated guides and factsheets for the week and is calling on as many people as possible to plan activities and to support the week. For further information, please see: www.counselandcare.org.uk

ICCHNR abstract deadline
The Faculty of Nursing at the University of Alberta is calling for abstracts to be submitted for the International Conferences in Community Health Care Nursing Research (ICCHNR) Symposium 2011. The symposium will be held in Canada on 4 to 6 May. Abstracts must not exceed 250 words and should be on the symposium themes, which are critical challenges in health equity, maternal, child and family health, indigenous health and immigrant and refugee health. The deadline for abstracts is 15 September. Those who book a place to the symposium by 1 December will be entitled to a discount. To submit an abstract or for further details, please see: www.nurs.ualberta.ca/icchnr/abstracts.html

QNI TCS film
The Queen’s Nursing Institute (QNI) will be producing a short documentary about the transformational attributes outlined in the Department of Health’s Transforming Community Services (TCS) programme. The documentary will focus on several Queen’s Nurses and will demonstrate how they apply these attributes in everyday practice to benefit their patients. For more on TCS transformational attributes, see: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_101425

Reach Out for Sick Children appeal
WellChild has launched Reach Out for Sick Children appeal to increase the number of WellChild children’s nurses and expand its services to more cities and towns across the UK. The charity has produced a dedicated website for information and resources to support the appeal, including fundraising ideas and guidance, and testimonials from families and healthcare professionals. For further details, see: www.wellchildnurseappeal.org

NHS targets to be scrapped

Many NHS targets are to be abolished, according to the revised NHS Operating Framework for England, including those relating to access to primary care.

Unite/CPHVA professional officer Gavin Fergie stated: ‘While targets may not suit all practitioners, there have to be national standards to aspire to, ensuring that the NHS is based on equality and equity rather than down to postcode. This is another example of the deconstruction of our NHS. Our NHS feels under threat. Efficiency is a term easily used but rarely understood by politicians in relation to the healthcare needs of a family, and we hope to meet with the government to discuss and ensure that they are fully aware of the concerns of our members.’

The targets will be replaced by quality standards, comprising statements that describe what high-quality care should be for a given condition. The National Institute for Health and Clinical Excellence has developed three so far, on stroke, dementia and blood clots.

The revised operating framework also confirms that the government will be continuing with the commissioner-provider split, and urges NHS organisations to make arrangements for this by April 2011.

Unite Health Sector lead officer for nursing Barrie Brown responded: ‘This reflects the move from the NHS as preferred provider to “any willing provider” and will add momentum to the push to involve the private sector and third sector as providers of NHS health services.’

He added: ‘Where services are transferred to other organisations to meet this deadline, this will mean short-term vertical integration with acute and mental health trusts which will create uncertainty for our members and potentially undermine the effectiveness of services provided. There is also the uncertainty of the longer term provider arrangements and the likelihood that our members will be working in non NHS organisations’.

Public sector pensions reduced

Concerns have been raised that a change in the price index used to increase public service pensions in line with inflation will result in smaller pensions.

Unite Health Sector lead officer for nursing Barrie Brown stated: ‘This is another example of attacks on public sector pensions which are not justified. Our members should not be deprived of the current benefits of their hard earned pension.’

The emergency Budget stated that public sector pensions will now go up in inflation with the consumer price index (CPI) instead of retail price index (RPI), because it provides a more ‘appropriate’ measure that excludes housing costs faced by homeowners.

However, the Trades Union Congress (TUC) stated that it fails to take council tax into account, and that the CPI is usually lower than the RPI, which will mean that public sector pensioners will usually get smaller increases.

The TUC stated: ‘An 80-year old pensioner on the average public sector pension of £5500 who has been retired for 20 years would now have a pension of £4845 a year – 12% or £655 less – if CPI uprating had been in force since their retirement.’

Health inequalities target missed

The National Audit Office has published a report on Department of Health (DH) attempts to tackle health inequalities in England, noting that the DH did not meet its target to reduce the health inequalities gap by 10% by 2010.

NAO head Amyas Morse stated: ‘The DH has made a concerted effort to tackle a very difficult and longstanding problem. However, it was slow to take action and health inequalities were not a top priority for the NHS until 2006.’

The report stated that the DH’s health inequalities strategy published in 2003 lacked an ‘effective mechanism’ to achieve the target. It was only in 2006 that it focused action to tackling health inequalities, which the report stated ‘left little time for these actions to have an impact before the 2010 target’.

The NAO also found that although life expectancy had increased overall, the gap between national average life expectancy and that for those living in deprived areas continues to widen.
Charting a change:

Why infant growth charts now reflect the healthy growth pattern of breastfed infants

In May 2009, the Department of Health launched the new UK-WHO growth charts, emphasising that when it comes to infant growth, bigger is not always better.

It has long been observed that bottle-fed infants tend to gain weight at a faster rate than those who are breastfed. However, UK growth charts have previously been based predominantly on data from bottle-fed children, leading to a tendency for breastfed babies to miss their predicted trajectories.

For this reason, the Department of Health have recently revised their advice on the ideal rates of growth for infants. The new UK-WHO growth charts now reflect the slower rate of growth seen in babies who are predominantly breastfed, an acknowledgement that this is in fact the healthiest pattern of growth for all infants.

…it was recognised that the breastfed infant exhibits a desirable pattern of growth, which is associated with healthier outcomes.

Protein: less is more

What creates these differences in growth between breast and bottle-fed babies? Given protein’s crucial role in tissue growth and development, the amount of protein provided in an infant’s diet is considered a major determinant of growth. The accelerated growth typically seen amongst bottle-fed infants may in part be due to the increased protein content of standard infant formulas compared with breast milk.

However, although parents are often pleased to see their baby gaining plenty of weight, there are potential health consequences to excess protein consumption and rapid weight gain. Importantly, fast growth during infancy is thought to be associated with obesity later in life. This means that providing appropriate amounts of protein in infancy can benefit a baby’s health, both now and in the long-term.

A growing body of evidence suggests that a higher plane of growth during infancy is associated with increase in the risk of obesity in childhood.

Type of protein matters too

Breast milk is naturally rich in alpha-protein, which typically makes up around 27% (2.4 g/L) of the total protein content. Alpha-protein provides key essential amino acids in breast milk. However, cows’ milk is richer in beta-protein, a whey protein not normally present in breast milk, and only contains an alpha-protein content of 4%. For this reason, infant formulas based on cows’ milk must contain a higher quantity of protein in order to provide adequate amounts of essential amino acids.

Comparing protein composition

Cows’ milk

Breast milk


In a clinical study, with this decrease in protein quantity and improvement in protein quality, SMA First Infant Milk was shown to result in weight gain at a rate that was closer to that of breastfed infants.

Two important goals in the improvement of infant formulas are to more closely match the total protein content and the protein profile of breast milk.

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Welfare reforms affect poorest the most

Unite/CPHVA has raised concerns that welfare reforms detailed in the emergency Budget could widen the gap between rich and poor.

Unite/CPHVA professional officer Dave Munday stated: ‘Even though the emergency Budget has been proclaimed as a “fair budget”, there are very, very strong reasons that suggest this is not the case. According to research for the Trades Union Congress (TUC), if we include public sector spending cuts and how this could affect public services to families, the overall combined average annual loss in household income and services for the poorest tenth of households is £1514, which is equivalent to 21.7% of their household income. For the richest tenth of households, the annual loss in income and services is £2685, which is equivalent to just 3.6% of their household income.’

He added: ‘The disadvantaged rely greatest on public sector services – as we can see from this research, the Budget is not only affecting their income but it is also affecting the public services that they receive – and evidently is unfair on people who earn the least.’

The report, commissioned by the TUC and Unison and entitled Don't forget the spending cuts! The real impact of Budget 2010, uses a new model of how public spending is allocated across households in the UK to estimate the distributonal impact of the spending cuts. The researchers then combine this with government data about the impact of the Budget’s welfare changes to calculate its overall impact.

The report stressed: ‘Assessments of Budget’s impact, and how fair or unfair it might be, have centred on the impact of the tax and benefit changes announced, while ignoring the impact of spending cuts.’

In a briefing on the emergency Budget, Institute for Fiscal Studies director Robert Chote emphasised: ‘Perhaps the most important omission in any distributional analysis of this sort is the impact of the looming cuts to public services, which are likely to hit poorer households significantly harder than richer households.’

A number of welfare changes were announced in the emergency Budget, and these include:

- Child Benefit payments frozen for three years
- Child Tax credits reduced for families earning more than £40 000, but increased by £150 above inflation for low-income families
- £190 Health in Pregnancy Grant scrapped from April 2011
- Sure Start payment of £500 to low income families to be restricted to the firstborn child.

Blind cords: RoSPA pilot scheme

The Royal Society for the Prevention of Accidents (RoSPA) has launched a pilot safety scheme in Scotland that aims to prevent accidents involving children and window blinds.

RoSPA stated that it hears of one to two children dying after being tangled in blind cords in the UK each year, and stressed that there are likely to be more near misses.

Sudhir Sethi, a consultant paediatrician with Leicester’s Specialist Child Health Services, stated that the death rate is higher: ‘Over the last 18 months, child deaths involving blind cords have escalated. There have been at least 10 deaths in the last 18 months. As far as near misses are concerned, it must several times this figure.’

He added that health visitors could help by assessing blinds cords in homes and other settings to ensure that they cannot be reached by toddlers.

The six-month RoSPA pilot will involve the distribution of leaflets on the dangers of blind cords, and cleats to secure blind cords will be distributed in North Lanarkshire.

Home safety concerns have also been raised about ‘safety socket covers’, which are sold as devices to make plug sockets child safe, but which could present a range of dangers to babies and young children.

Lobbying group FatallyFlawed co-founder David Peacock said that only devices with the correct dimensions for a 13-amp plug should be inserted into a socket, but that available covers are not the correct size: ‘Because there are no standards for socket covers in this country, and they are not regulated by the government in the way that sockets themselves are, Trading Standards are unable to take action.’

The group has developed a number of fact sheets informing on the dangers. For further information, please see: www.fatallyflawed.org.uk

Training to spot domestic abuse

The Scottish Government has launched a new initiative to tackle domestic abuse, which will include the training of 5000 NHS staff in how best to initiate conversations in a sensitive way that will encourage victims to open up.

Unite/CPHVA professional officer Ros Godson stated: ‘This is a good idea, as lots of domestic violence goes unreported. There have been similar schemes in England, particularly via midwives and accident and emergency staff, though not universally across the country. I hope that later it will be rolled out to cover children and young people who witness domestic abuse.’

Health visitors and sexual health professionals will be among a number of healthcare professionals due to be trained over the next year and a half.

An NHS domestic abuse team has been put in place to support local health boards to implement the initiative by developing specialist training packages, highlighting best practice and issuing guidance.
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Cuts and child services

There are widespread concerns about the effects that government cuts will have on recruitment, pay and service provision – particularly on safeguarding

Kin Ly
Assistant editor

Although the government has made statements saying that the effect of cuts will be minimised for NHS and frontline staff, there are widespread concerns about how they will affect already struggling services. These relate to employment conditions, but also to the ability of practitioners to provide a safe and effective service, especially in respect of child safeguarding.

Pay and recruitment

The emergency Budget will put a freeze on the salaries of all public sector workers earning more than £21,000. Not only could this make it difficult for the government to deliver on its promise of 4,200 more Sure Start health visitors, but it could encourage existing health visitors to take early retirement.

Unite/CPHVA professional officer Dave Munday states: ‘Any pay freeze is in reality a pay cut. A pay cut across public sector services is not a good idea in terms of moving the health service forward, and that is especially true in areas that are finding it hard to recruit staff.’

Talking specifically about health visiting, Dave states: ‘This is a profession where a large proportion of the workforce could retire today, and some of our members are considering bringing their retirement forward. In light of further service cuts that could add more to caseloads and increase the level of stress, we are worried that there will be little incentive for people to stay.’

These changes could affect campaigns to improve health visiting recruitment and retention. Dave says: ‘We have already raised concerns that people do not want to do the health visiting training because they have to do it on a lower wage. This pay cut will compound that further.’

Pay issues could also have an impact on school nurse recruitment, which is already far short of the previous government’s goal of one full-time qualified school nurse per secondary school in England.

Unite/CPHVA professional officer Ros Godson states: ‘The pay cut will be accompanied by a recruitment freeze, so where school nurses leave, they probably will not be replaced. As our members are already completely overstretched, they will not be able to take on any more work, and so the result will be that increasing numbers of school children and young people will not have access to a school nurse service.’

Ros stresses that this could result in a situation where fewer children and young people will be able to access the help that they need, ‘with the result that many children and young people will not receive on-site support, and there will be fewer referrals of cases related to child protection, obesity, teenage pregnancy, self-harm, depression, enuresis and a host of other issues. We already have reports that many trusts are unable to guarantee funding for school nurse training, which means that it will remain difficult to improve the quality outcomes from school nursing services’.

Workplace stress and bullying

According to Treasury documents obtained by The Guardian, the emergency Budget could result in a loss of 1.3 million jobs across both the private and public sectors. Inadequate staffing levels could be expected to lead to increased pressure and stress at work, and one of the likely consequences of this is workplace bullying.

Dave says: ‘Bullying in the workplace is a real issue, and there is a probability that this could increase, particularly as the emergency Budget puts increased pressure on organisations to save money. Staff who are being bullied are more likely to take sick leave, and it will become increasingly difficult to work efficiently.’

He added: ‘The other thing that will compound this is that local accredited representatives who are well placed to resolve these issues may not be able to do that because their facility time has been eroded. We have already seen examples where representatives have been refused permission to attend meetings.’

Contact with families

A survey conducted by Unite/CPHVA, 4Children and Netmums provides further evidence of how families suffer due to an
under-resourced service. The survey suggests that many mothers would not contact their health visitor despite experiencing problems, and Unite/CPHVA stresses that one of the reasons for this is because not enough parents know their health visitor. This could lead to cases of postnatal depression and domestic abuse left undetected and untreated.

A total of 1687 mothers responded to the survey, of whom 56% stated that they had experienced postnatal depression, difficulty bonding with a child or domestic violence. In addition, 82% had experienced problems related to child development, weaning and minor child health problems, yet only 35% of mothers said that they had a health visitor they could trust and contact, while 26% said they did not.

Unite/CPHVA lead professional officer Obi Amadi states: ‘Parents need to be able to access healthcare professionals before their issues turn into problems that are more complex and time consuming to resolve. Health visitors are well placed to lead and work in teams to provide the service that parents need. Where parents know their health visitor and have an understanding of their role, they do use them appropriately and effectively. This research supports our position that we need to have sufficient numbers of health visitors for parents to be able to access them in an appropriate setting.’

Impact on safeguarding

These accumulating issues could add up to a situation in which child protection work suffers. Dave states: ‘All child protection services are going to be put under huge pressure. In health visiting, we have already seen many examples where a stretched service has led to situations where staff are doing work that they are not trained to do and where they do not have the capacity to see all families, and this has already affected child protection. This could only be made worse with a pay cut that forces people to leave.’

Although Lord Laming has reportedly warned against interpreting all shortcomings in child protection to low resources, Dave states: ‘There may have been investment across children’s centres while Labour was in government, but if we look at safeguarding services such as health visiting and social work, then we can see they face real problems in terms of staffing – both professions have to rely on bank staff and that is not appropriate.’

He adds: ‘If we look at primary care trusts that are struggling to make 10% to 15% savings, sadly their priorities are not how best to implement safe service reviews, but looking at ways that they can save costs.’

Numbers over location

The government’s announcement to provide a further 4200 health visitors in Sure Start children’s centres has stimulated debate as to where these health visitors should be based.

These accumulating issues could add up to a situation in which child protection work suffers

While the Royal College of General Practitioners welcomes the additional health visitors, its chair Professor Steve Field stresses: ‘It is important that we have a good skill mix – it’s not just about the number of health visitors. Care needs to be focused on the mother and the child. Communication is essential, and it is important that the health visitor and GP work very closely together, and that will mean in some areas health visitors spending more time in GP surgeries as well as children’s centres.’

However, Unite/CPHVA states that locality is not as pressing an issue as providing adequate staff.

Dave states: ‘It would be nice to imagine that this is just an issue of where a member of staff is located, but it is much more fundamental than that. The fact is that there are too few health visitors for too many children. If, for example, we put all health visitors in GP practices, we would still have problems with low numbers, and so the service would still not be perfect.’

From Laming to Munro

Since the coalition government was established, two of Lord Laming’s recommendations in his 2009 progress report have been dropped – ContactPoint is due to be scrapped and the National Safeguarding Delivery Unit has been abolished.

Dave stresses: ‘The government has stated that it wants to improve civil liberties by not having ContactPoint. If that is the case, the government must be clear that if abolishing ContactPoint does put children’s safety at risk, then the coalition must acknowledge that they are responsible for that. Healthcare professionals should not be in a situation where they cannot do their job to the degree that they may have been able to if ContactPoint had been delivered and are then held accountable for this.’

An interim, scaled-down version of the database will include national birth and death registration data.

Dave states: ‘The other worrying element is that the government may turn ContactPoint into a sort of computer program pseudo-type child protection register, which could have a lot more negative points than the original system and be more damaging in terms of people’s civil liberties.’

Talking about safeguarding policies, Unite/CPHVA lead professional officer Obi Amadi states: ‘We are unsure of what direction Laming’s recommendations will now take. However, it is very disappointing to note that the National Safeguarding Delivery Unit has ceased to exist, as this was very good and supportive of staff. The government has issued another review into child protection services, and it will be expensive to conduct another review to a similar scale as Laming’s. However, we hope that the review will be able to address our concerns.’

The new review will be led by Eileen Munro, professor of social work at the London School of Economics. The government has stated that it will build on Lord Laming’s progress report, and the Department for Education called on frontline staff including health visitors to submit evidence on areas such as strategies for shared working by 30 July (see: www.education.gov.uk/munroreview).

An initial report is due in September, followed by an interim report in January next year and a final report in April.

The emergency Budget could exacerbate situations where child health and safeguarding services are struggling due to high caseloads and insufficient staffing. Unite/CPHVA continues to look at ways to increase numbers, and is encouraging members to submit evidence to the Munro review in order help improve child protection services.
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Applications are invited for the MacQueen Award 2010, which this year will recognise excellence in leadership in public health that demonstrates innovation and new ways of working in public health.

The winner will receive £3000 in recognition of their personal achievement to enable further development, dissemination and publication of their work. A ticket and expenses (travel and accommodation) will also be provided to attend the Unite/CPHVA Annual Professional Conference in Harrogate on 20 to 22 October 2010.

The winner will be supported in submitting a report on their project for publication in *Community Practitioner*. The project should:

- Demonstrate innovation in leadership
- Be either on-going or recently completed
- Show evidence of evaluation and the difference it has made.

All applicants should demonstrate:

- How they have motivated colleagues and/or clients to influence change and provide independent evidence of this with their application
- How they will disseminate or communicate their work to colleagues and the wider health community.

All CPHVA members are eligible and welcome to apply. Please contact Kitty Lamb, chair of the Professional Advisory Committee on email: kittylamb1@live.com – the closing date is 1 September 2010. Short-listed applicants will be notified on 10 September and interviews will be held in London on 16 September (travel expenses will be recompensed).

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**LAR of the Year Award 2010**

Branches invited to nominate local accredited representatives

Unite/CPHVA is calling for nominations for this year’s LAR of the Year Award, which is due to be presented at the Unite/CPHVA Annual Professional Conference 2010 in Harrogate on 20 to 22 October.

Branches are encouraged to nominate suitable candidates for this important annual award, using the nomination form available via the Unite/CPHVA website, see: www.unitetheunion.org/cphva

All nominations must be returned by 10 September by email to: barrie.brown@unitetheunion.org or by post to:

Barrie Brown
Unite/CPHVA
128 Theobald’s Road
London
WC1X 8TN

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**MacQueen Award 2010 for Excellence in Leadership**

Applications are invited for the MacQueen Award 2010, which this year will recognise excellence in leadership in public health that demonstrates innovation and new ways of working in public health.

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User involvement: children’s participation in a parent-baby group

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Abstract
According to the National Service Framework, children have a right to participate in the development of healthcare services and yet research suggests that young children are at risk of exclusion from user involvement initiatives. This paper outlines the findings of a participatory action research project conducted with families attending a health visitors’ parent-baby group. A combination of participatory research methods were used to ascertain the infants’ perspectives of the service and this led to a number of changes in terms of professional attitudes, service provision and working practices. Changes in professional attitudes included acknowledging the importance of social interaction to the children, recognising young children’s views as embodied and produced within social interactions, and respecting children as active contributors and not simply as passive recipients of healthcare services. Changes in service provision resulted in redistributing resources, structures and spaces to take account of children’s perspectives. Finally, reciprocity and responsiveness were seen as key components in enhancing young children’s participation.

Key words
User involvement, children’s participation, participatory action research

Introduction
User involvement has long been a priority in UK health policy and has gathered pace over the last decade as concepts such as ‘consultation’ ‘participation’, ‘patient voice and choice’ have entered the lexicon of NHS legislation. This is seen, for example, in section 242 of the NHS Act 2006 and the statutory guidance, Real involvement.1 While the rhetoric of user participation encompasses individual decisions about treatment and care, service development and research, in practice this is often viewed as a marginal activity,1 and until recently, seen to be the preserve of adult users.2 Nevertheless, the ‘duty to involve’ pertains to children as well as adults. Indeed, community practitioners have a responsibility to promote the active participation of the children they work with and to ensure that participation leads to change.3-5 This reflects a legal imperative that children have a right to express their views on all matters that affect them and to have those views taken into account, as enshrined in the UN Convention on the Rights of the Child (UNCRC)6 and Every child matters (ECM).7 However, although children’s participation in decision-making, service development and research may be an important aim for practitioners, it can present many challenges, both theoretically and practically, especially for those working with the youngest of children.

This paper outlines how one team of health visitors and support staff – including one PhD student – sought to address such challenges within the context of a health visitors’ parent-baby group for postnatal mothers, babies under the age of one, and their older siblings.

Children’s participation
In the theoretical literature, the concept of ‘children’s participation’ is contested as it is dependent on cultural interpretation. Boyden and Ennew8 identify two aspects of participation – ‘passive’, in the sense that children are taking part and engaging in some sort of activity, and ‘active’, in the sense that children are empowered to express their views, influence decision-making and bring about change. Various authors have constructed taxonomies of participation9-11 to describe a progression from children taking part in an event with no real understanding of the issues, to children expressing their views, initiating action, and sharing in decision-making with adults. For example, Shier’s12 model has five levels (see Box 1).

While typologies are useful in highlighting different levels of empowerment afforded to children, these models have been criticised for being too hierarchical12 and because they have been used as a ‘disciplinary technology’ to bring children under increasing institutional control.13 Furthermore, the models tend to be applied to research and practice with older children, and have failed to take account of social context and of the different competencies of very young children.

Translating policy rhetoric and theoretical models of children’s participation into practice is also problematic. Research evidence suggests that children’s participation in health care is limited and patchy, particularly within service development, and for certain groups of children who are at greater risk of exclusion – notably, young children and children with impairments.14 Alderson15 suggests reasons for this include: adult assumptions about children’s levels of (in)competence – lack of confidence, resources or relevant training, and concerns about placing undue responsibility upon children. Alderson argues that, instead of viewing children simply as passive recipients of healthcare services, they, like adults, are active social agents who participate in shaping and constructing themselves and the services they engage with. Indeed, Alderson et al’s16 research with neonatal babies in intensive care units found numerous examples of staff and parents viewing babies as active collaborators in their own care, expressing views such as happiness or discomfort through their bodies and vocalisations. They conclude that giving due weight to babies’ views is not only necessary for recognising them as...
people with rights but it is also essential for sensitive and economically efficient care. These twin purposes – participation to afford children citizenship rights and participation to improve services – are reflected in current healthcare policies relating to user involvement. While these policies might appeal to democratic ideals of social justice for children, they are also couched in consumerist terms of individual choice and enhanced responsiveness to needs. The National Service Framework (NSF) for children, young people and maternity services\(^5\) applies a consumerist valuation to user involvement. While these frameworks bring together verbal and visual tools to explore young children’s perspectives, the researcher is an ‘outsider’ who attempts to engage with imbalances of power and divergences of interest between users and providers of services’ (p258).

Aware of the problems at both conceptual and practical levels, but also of the possibilities for children’s democratic participation, we decided to embark on a research project that sought to explore young children’s participation in a parent-baby group.

**Study aim**

Standard three of the NSF sets out a vision of professionals ‘communicating directly with children, listening to them and attempting to see the world through their eyes’, with ‘the views of children, young people and families being valued and taken into account in the planning, delivery and evaluation of services’ (p87).\(^5\)

With this in mind, the aim of the research was to carry out an evaluation of the group, incorporating children’s perspectives alongside parental views, and to take action based on our findings. The group is a universal service that takes place on a weekly basis in a children’s centre. It was established with the following aims – to reduce the isolation of postnatal mothers, share healthcare advice, provide a drop-in clinic, and offer a safe space for babies and their older siblings to play. The research questions were:

- What are the children’s perspectives of the group?
- How can we use the children’s perspectives to develop the group further?
- How can we enhance children’s participation in the group?

**Methodology**

Given the focus of our research topic and our aspiration to enhance children’s participation we decided to draw upon the traditions of participatory action research (PAR).\(^18\) PAR involves the active participation of a group of people – in this case, two health visitors, two support staff, a community midwife, a doctoral researcher, and 18 children and their mothers – in examining practice with the aim of taking action to change or develop practice. It involves a cycle of ‘observe, plan, take action and evaluate’ (see Figure 1). PAR differs from traditional research in which the researcher is an ‘outsider’ who attempts to adopt an ‘objective’ stance. Rather in PAR, the practitioner-researchers and service-users, as ‘insiders’, actively collaborate as partners, sharing and learning together.

Prior to the commencement of the study, ethical approval and research governance was sought from the local NHS research ethics committee and health and social care consortium. Informed consent was sought from the parents of the participating children. Care was also taken to remain responsive to the children’s assent to participate. Thus, data generation was paused or stopped if children appeared distressed or disinterested.

We employed a number of qualitative methods adapted from the Mosaic Approach\(^19\) over a three-month period. The Mosaic Approach is a multi-method framework that brings together verbal and visual tools to explore young children’s perspectives. It was originally designed to access the views of three- to five-year-olds attending nurseries. We applied the framework to our healthcare setting and adapted it to focus on babies as well as their older siblings aged between one and four. We employed six methods:

- Participant observation to ascertain babies’ and pre-verbal children’s interests and dislikes about the group, followed by staff and parents reflecting together on the data gathered.
- Informal conversations with verbal children and parents.
- Parents and children were given cameras to take photographs of things they liked or appreciated about the group, which were then used as a tool for further reflection and discussion.
- Focus groups with parents.
- Parents and children were invited to make books using the observations, photographs and comments generated during the data gathering phase.
- Practitioner team meetings were recorded and transcribed to reflexively consider power differentials, conflicts of interest between adults and children, professional practice and researcher subjectivity, and to plan and evaluate the action we took.

**Findings and discussion**

Three main themes were constructed from the data, and this led to changes in our practice and in the way the group was organised. The first theme highlighted the importance babies and young children attached to social interaction. The second pertained to how the physical environment and the resources enabled and constrained children’s participation. The third concerned how the research process had an impact upon professional practice.

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**Box 1. Shier’s\(^{11}\) model of children’s participation**

- Children are listened to
- Children are supported in expressing their views
- Children’s views are taken into account
- Children are involved in decision-making processes
- Children share power and responsibility for decision-making

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**Figure 1. The cycle of participatory action research**

- Observe, reflect, discuss
- Plan
- Take action
- Analyse, evaluate, report
- Identify research problem or focus

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Social interaction

Observations and photographs of the babies' body language suggested that social interaction was very important to the babies and children, both adult and child-child. Babies were most animated during the group when another child or adult interacted with them, and seemingly unhappy when left with no-one or nothing to engage with. This was particularly apparent during activities involving adult and baby together such as baby massage or reflexology, as opposed to adult-focused activities, such as healthcare talks or craft sessions, where the babies were uninvolved until they expressed distress or boredom. This would suggest that from the children’s perspectives, bi-generational experiences that promote social interaction between adults and babies are more enjoyable than some other activities. This has important implications for service planning, but also requires practitioners to consider carefully how to promote greater levels of baby involvement during adult-focused talks and activities. Similarly, observations suggested that play experiences that encouraged child-child social interactions were also important to the children. These observation notes written by a health support worker illustrate the importance of this: Adnan (two years four months) is kneeling on the mat next to Ella (eight months). Adnan is picking up toys one by one, showing them to Ella and then offering each toy to Ella to hold, or if Ella declines putting the toy down in a pile next to and on top of Ella’s legs. This is a non-verbal interaction but both children look at each toy in turn, and look at each other. Adnan particularly seems to enjoy interacting with other children. They spend a few minutes engaged in this.

Based on this observation and others like it, as well as parental comments, the baby-mat area was enlarged to encourage further child-child engagement. Clearly, close observation that takes account of children’s perspectives is vital to influence and inform practice, as this practitioner remarked: These observations help me to tune in to the children and what this experience is like for them. [They] help me think about my work... You can focus on what the children are doing and how they are interacting... and then you can pick up on things we could probably improve on.

There were some examples of older siblings becoming unhappy. These tended to be either when adults did not respond to cues the children were communicating or when there was a conflict of interests. One child became restless having been strapped in a buggy for some time while her mother waited for her younger infant to be weighed. This led to a staff discussion about whether to intervene in these situations and encourage the mother to respond to her daughter’s cues or to respect her decision not to take her child out of the buggy to play. This example, among many others, helped us to consider that, within our context, encouraging pre-verbal children’s participation involves adults actively observing, listening and responding to the cues children communicate through body language, eye movements, gesture, vocalisation and posture. It involves recognition of the multimodal ways young children communicate their likes, dislikes and needs, as well as respect for infants as sensitively attuned, interactive beings from birth. We concluded that very young children’s participation is embodied, in the sense that their views are expressed through their bodies, and produced within social interactions. Thus, recognition and response to embodied infant cues is a key mechanism for enabling young children’s participation.

Environment and resources

The physical environment and resources enhanced or hindered the children’s participation in terms of their ability to make decisions and choices. The original layout of the room had a large central area for babies and smaller toddler play spaces. Participant observations where we attempted ‘to see the world through the child’s eyes’ suggested that the central baby area took on a higher status, than other areas, as this was where most of the adults were. This seemed to exclude the toddlers from the main area, and hindered their interaction with some of the adults and younger babies. A mother was heard to send her toddler away from the baby area.

The high status afforded to this space was also reflected in the photographs some of the older children took. All of their photographs were of people and activities taking place in the central baby area, whereas the clinic corner, information area and toddler play spaces were notably absent. From this, we concluded that power relations were structurally embedded within the physical organisation of the room, and that part of our role as practitioners seeking to encourage more responsive, democratic services was to work to overcome these structural barriers in order to increase the children’s participation. This finding echoes Mannion’s assertion that children are often marginalised by structures and spatialities. As a result we experimented with changing the original layout to increase the inclusion and freedom of movement of the older children.

We also aimed to increase opportunities for children to be able to choose and express preferences. Horseshoe cushions were provided to help babies sit up. Once supported by the cushions, babies could actively choose their toy from those within reach, whereas babies lying down or on a lap were reliant on others to choose. The following field note illustrates this: A baby was moved from lying down to sitting supported. You could see his whole demeanour changed... suddenly it was, ‘I can do something’.

Another simple intervention which increased opportunities for children’s decision making was moving the plate of fruit to a different table so that it was at child height. This meant that mobile children could help themselves, choosing what they would like to eat and when. Children were also able to express in non-verbal ways their feelings about the toys and resources, as this vignette illustrates: I have been crouching beside Kasalina as she fits pieces into a jigsaw puzzle until it is almost complete. Then Kasalina repeatedly...
points and taps to a hole in the board where there is a missing piece. She looks at me rather frustrated, as if to tell me that there is a piece missing... We need to ensure all the toys are in good working order.

Finally, in the clinic area, a few babies appeared unhappy while being undressed and placed on the weighing scales. As a consequence, dangling ribbons and cellophane were introduced to engage the babies while being weighed.

Impact of the research process on practice

The research process affected professional practice in a number of ways. Firstly, reflexive thinking, based on observations of professional interactions with babies, led to staff letting babies take more control by picking up cues from the baby to initiate and terminate interaction, and not taking children’s attention away from what they wanted. Practitioners commented on how their practice changed. Reciprocity, in which baby and adult mutually influence action and show sensitivity to the signals of the other, was key to this: I actually stopped to think about my interaction with baby, and whether I had baby’s attention or not. It is easy for us as adults to get the attention of babies, but I thought about letting the babies initiate and use their attention as a cue to interact and when their attention has gone to stop and not interfere with what the babies want to do next. It is important to greet the children... wait for them to reciprocate... respecting they may not want to interact with you.

Secondly, knowledge gained about children’s preferences for particular toys, activities and developing schemas was incorporated into planning for future sessions and home visits. In this way, service evaluation became a means of service development. Thirdly, the need to review the original parent-focused aims of the group became evident as practitioners met to evaluate the project. The aims were broadened to include taking young children’s perspectives into account when planning, delivering and evaluating sessions, thus extending user involvement to the children as well as the parents.

Kirby et al 23 argue that genuine participation is a process and not an isolated event, and this requires organisations to change in attitude, procedures and styles of working. The impact of this project upon professional attitudes, working practices and procedures for increasing children’s opportunities to express their perspectives and make choices is evidence of such changes within our service. The challenge for healthcare practitioners in general, and for us in particular, is to embed participatory ways of working with children within our practice at an operational and strategic level, avoiding the dangers of tokenism and of one-off user consultations and evaluations, which often do little to alter power inequalities or to enact children’s participatory rights.

Conclusion

According to the UNCRC, NSF and ECM, babies and young children, like adult service users, have a right to participate in the planning, delivery and evaluation of healthcare services. This paper has described how one team of practitioners has sought to ascertain the perspectives of the infants attending their service, and to use those perspectives to affect change. As a result of the research, a number of modest but significant changes took place in terms of professional attitudes and behaviour, service provision and working practices. Changes in professional attitudes included:

- Acknowledging the importance of social interaction to the children
- Recognising young children’s views as embodied and produced within social interactions
- Respecting children as active contributors and not simply as passive recipients of healthcare services.

Changes in service provision resulted in redistributing resources, structures and spaces to take account of children’s perspectives. Finally, reciprocity and responsiveness were seen as key components in enhancing young children’s participation.

As with any research project, there were limitations with our study. A major issue concerns subjectivity – the children’s perspectives were often filtered and interpreted through adult perspectives. Rather than viewing these different perspectives as problematic, we gave up the pretence to be able to uncover any objective understanding of ‘children’s views’ in favour of understanding children’s perspectives as embodied and produced within social interactions. Consequently, the research became a process of meaning-making rather than truth-finding. Thus, we acknowledge that the findings present can only offer us inferential, partial and partisan reflections of children’s perspectives of the group. Nevertheless, it is our contention that our desire to seek children’s perspectives has led to more responsive, participatory and equitable practices within our service.

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References

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Supporting emotional health and wellbeing: the Solihull Approach

Introduction

To have emotional health and wellbeing is a condition to which we all aspire. It nurtures us in times of trouble and enables us to enjoy life and to make the most of our potential. The aim of this paper is to emphasise the idea that the foundation for our emotional health is in the ‘millisecond world’ of the early relationship with our parents or carers. Yet in the UK, we do not make the most of opportunities to support parents in their relationships with their children. We do not support parents in the antenatal period to prepare to have a relationship with their child and we do not do enough on this issue subsequently, even though this focus can be carried out within the current role of many practitioners. This paper will describe the contribution of the Solihull Approach to emotional health and wellbeing through supporting the relationship between children and parents and between practitioners and parents.

The Solihull Approach promotes the emotional health of children and their families from the antenatal period onward, through supporting practitioners in their one-to-one work with families and in providing parenting groups. It also works to support the emotional wellbeing of practitioners, increasing job satisfaction through the training, providing resource packs for easy access to material and encouraging the provision of support to the practitioner. It makes key messages from different academic fields accessible and usable for practitioners, in order to provide a language to describe the building blocks of relationships and to provide a focus for intervention.

Emotional health and relationships

In 2001, the Department for Education and Employment described a range of factors that either help or hinder our emotional health, divided into the three categories of individual, family and community. Individual resilience factors include being female, intelligent and having a sense of humour. Boys are more at risk from conception onward to a range of negative outcomes. It is not yet clear why that is, though Kreamer suggests that one factor may be that the double X in the female chromosome may have some protective value. Family resilience factors include having at least one good relationship with an adult, while family risk factors include all those things that can make parents less available to their children such as mental health difficulties or substance abuse problems. The family risk and resilience factors indicate how important the relationship is between parents and their children for the development of their children. The Children’s Society surveyed 7000 children and young people aged 10 to 15 years for their report on Understanding children’s well-being. The report found that family conflict was the largest factor in causing unhappiness in children. UNICEF in its poll of thousands of children, found that the primary cause of happiness of children (nine to 13) comes from being with their family, while being with friends is the first thing identified by young people (14 to 17), with family life a close runner-up. Relationships within their family were identified as the major source of unhappiness for children. These reports support the findings that the quality of relationships available to the child will be the most influential factor on the degree of emotional health and wellbeing of that child. Supporting the development of emotional health will make it more likely that the person will be able to enjoy future relationships and be economically active. There are now many studies available that show the importance of early intervention in this area. For instance, the follow-up studies by Olds and a review of the work of Olds and other researchers indicate that supporting parents with their children in early life is likely to give that child a more positive life trajectory. In addition, we know that the silver bullet against poverty is educational attainment, but in order to make best use of education children need to be able to have their optimum number of brain connections together with the ability to concentrate. The foundation for
this is laid down in the first three years of life, with most brain development occurring before the age of three, with another time of plasticity and growth in adolescence. Although further development occurs during the rest of our lives, the stage is set in the first three years. And the single largest influence will be the quality of the relationship with the parents or carers. Government health and education policy has recognised this for several years, with the establishment of the Early Years Foundation Stage. Sure Start and children’s centres, the Family Nurse Partnership programme, dissemination of evidence-based parenting programmes and now a focus on antenatal services. It is always difficult to shift the emphasis from where things have already gone wrong, to drain the swamp rather than expending all resources on saving people drowning in it. However, the argument has been convincingly made that the cost of not intervening early is a very high one. Action for Children8 has shown that investing in prevention could save £486 billion over 20 years. Scott9 calculated that the financial cost of an antisocial young person is 10 times that of an average child. However, these are the financial costs to society. The costs to the individual include the developmental time lost for each of these young people, the implications for their adulthood and their life trajectory.

What is the Solihull Approach?
The Solihull Approach is a theoretical model supported by a comprehensive resource pack and training programmes. The Solihull Approach provides a model and a language to explain how emotional health and wellbeing develops within the child’s main relationships. The theoretical model integrates ideas from disparate academic areas, from the psychoanalytic field, child development research and behaviourism. Together, these provide a useful lens through which to gain a clearer view of relationships and the effect of relationships on the development of emotional health and wellbeing. Behaviour management is an integral part of the Solihull Approach, but the emphasis is on customising techniques for the specific situations of the parents and child, and to help the parents to acquire this ability as a lifelong skill.

The Solihull Approach provides support for parents through the Solihull Approach parenting group (‘Understanding your child’s behaviour’), from the postnatal period to late adolescence. The specialist antenatal group integrates a focus on the relationship between the baby and their family with the usual parenthood, and has been designed to be delivered in a hospital setting and within children’s centres.

For the workforce, the Solihull Approach creates a common language and a coherent approach to supporting the relationship between parents or carers and their children. Where it is used for whole team training, for example in children’s centres, families comment on the consistent positive nature of the interaction with staff, from the receptionist to everyone else.

The Solihull Approach training encourages practitioners to use reflective practice and to access supervision. Comprehensive resource packs support practitioners, outlining the theory, integrating theory with practice and with a wide range of handouts for parents. There are resource packs for practitioners working with children aged under five and their families, practitioners working with school-aged children and their families, fostering and adoption practitioners and for midwives and the antenatal team.

Although the Solihull Approach developed through training health visitors and then school nurses, it is now used across the children’s workforce in many areas of the UK.10,11

How the Solihull Approach supports emotional health
The Solihull Approach aims to contribute to the emotional health of children and their parents, by providing key messages from research to enable the practitioner to focus on specific elements of the relationship that will impact on the development of the child. This is done through access to training and resource packs for the whole of the children’s workforce.

Containment, reciprocity and behaviour management are the cornerstones of the model, together with an understanding of brain development. Containment comes from the psychoanalytic tradition.12 It is where a person receives and understands the emotional communication of another without being overwhelmed by it, and communicates this back to the other person. The implications of this one process for a child’s emotional health are profound. The importance of containment for parents and those who work with them is that containment restores the capacity to think. That is, when the parent is full of emotion and anxiety, it is very difficult for them to have a space to think about and interact with their child. Yet it is through the interaction that the child will develop emotional health. Parenting programmes, children’s centres and practitioners working with parents can all support the emotional health of both the parent and the child when they work to support the relationship.

A parent who can help their child manage and process their emotions contributes to the architecture of their child’s brain.13 Emotions and impulses are centred in the midbrain. They are regulated through links with the cortex, but these links are developed after birth through processes such as containment. The most aggressive time of a person’s life will be in their toddlerhood.14 The intensity of the toddler’s raging emotions are expressed in hitting, kicking, spitting and biting. Gradually, if the child is in a containing relationship, the structure of the brain is built up to process emotions and to think about the situation rather than reacting. Impulse control is extremely important in order to function well within society, with its inherent need for compromise and inevitable frustrations. Some of those who have not developed the ability to control their impulses are in prison. The state of Madhya Pradesh in India is shortening sentences for prisoners who attend yoga classes – ‘The prison authorities believe yoga will not only improve their fitness, but make them calmer, less violent and more positive when they are finally released’.15 In terms of brain development, the prisoners are learning how to control the reactions of their midbrain, through developing links with the cortex. This means that, as well as perhaps having a lower baseline reactivity so that they are calmer anyway, they may also be able to manage their emotions and impulsivity better, through thinking instead of reacting.

An understanding of containment can inform the practitioner’s work in helping the parent to process emotions, in order to be able to access their skills as a parent and to work with their child’s emotions. It can also inform the supervision process and emphasise the importance of supervision and reflective practice.

Reciprocity describes the sophisticated interaction between a baby and an adult...
where both are involved in the initiation, regulation and termination of the interaction. Reciprocity can be used to describe the interaction within all relationships. The rhythm of reciprocity provides the underlying drumbeat for social interaction – when we look at each other, when we look away, when we pause in a conversation, and when we interject into a conversation. The basic rhythm in the interaction between babies and their mothers was documented by Brazelton and colleagues. These rules are subtle and complex, as those on the autistic spectrum know only too well. Most babies are born with the ability to interact within a ‘millisecond world’. A father and his baby will adjust to each other, switching contact back and forth within the timeframe of a second. The baby is waiting for a partner in the dance, and when they meet parents who will interact reciprocally with them this is a fundamental process for the development of the baby’s emotional health and wellbeing. If they meet a blank face or parents who do not take the time to interact, the consequences are all too obvious as they begin nursery or school, with delayed language development, a lower level of social skills and a need for extra academic support.

Reciprocity is another process through which parents become the architect of their baby’s brain. Through the pattern of the interaction, with the parent generally in tune with their child, the parent will help the child regulate themselves, another important contributor to impulse control. The child learns to both upregulate (children drumming on their desk in school, the phrase ‘chewing helps you concentrate’ or tangy, hard sweets for drivers are all examples of upregulation) and downregulate (counting to 10, moving to a quieter space, breathing slowly are all examples of downregulation). This ability is vital for impulse control, managing our emotions and being able to either relax or to become more animated.

Another aspect of reciprocity is called rupture and repair. This describes the common situation of a rupture in the pattern of the dance between two people or a baby and a parent. When this happens, the parent will – without thinking about it – know at some level that this has happened and will then either wait for the baby or speed up the interaction in order for them to get back in step (the repair). The importance for a child’s emotional health and wellbeing is not so much the fact that ruptures occur, but that repairs happen. This is very important for emotional health, since the experience of repairs provides the basis for optimism and hope in life, the experience that things can get better in the world. It also provides the experience of being able to manage relationships, to make up after falling out, sustaining friendships and relationships.

A knowledge of the process of reciprocity can help the practitioner to understand the relationship between a parent and a child and to work with the parent or family on the relationship. This can be done on an individual basis or within a parenting group. Parents appreciate this knowledge too, and are often able to change their behaviour and improve their relationship with their children when the pattern of interacting is brought to their awareness.

The Solihull Approach uses the concepts of containment and reciprocity to explain how the brain develops within relationships. The concepts also provide a language for the practitioner to describe the interaction within a relationship and provide a focus for any intervention. Together, they also provide the foundation for more effective behaviour management, customised to the particular situation and the current capacity of the parent.

The concepts can be seen to underpin the development of attachment, so understanding the concepts can provide a focus for improving the quality of an attachment. In turn, the quality of an attachment will have a significant effect on the subsequent emotional health and wellbeing of the child into adulthood.

A strategic view

A great deal of research has already been carried out on the importance of relationships to development and the importance of early intervention. Many movers and shakers in our society know of the research. Many of the pieces are in place to create a shift in the population toward emotional health and wellbeing. At this stage in the growth of our civilisation, financial wellbeing is not the only measure of our society’s success. The UK has some ground to cover judging from the outcome of UNICEF’s report in which it was at the bottom of a league table of 21 developed nations for indicators of wellbeing. It can be no accident that one of the findings was that UK children had a greater number of unhappy relationships with both their families and peers.

Most of the antenatal parenting courses in the UK today hardly mention the relationship between parents and the baby. This is the ideal time to begin the process of supporting the relationship between the parent and child, but as a nation we are not yet doing it. This is a relatively easy and inexpensive option that would have an impact on the wellbeing of children and their families. Health visitors are ideally placed to provide individual antenatal visits and antenatal groups in children’s centres. Many NHS trusts have reduced numbers of health visitors, making this intervention difficult to achieve, but it is to be hoped that this trend can be reversed in order to contribute to the wellbeing of the nation.

Midwives and the antenatal team have many opportunities along a family’s antenatal journey to support the relationship between the family and the unborn baby. We are not capitalising on these opportunities, and the antenatal team needs support and training to do this. Although the focus in antenatal teams is mainly on reducing risk, it is likely that risk can also be reduced, job satisfaction increased and better outcomes for mothers and their babies created through a more relationship-based focus during the intervention.

The Department for Children, Schools and Families (now the Department for Education) has already made more evidence-based parenting programmes available to parents through training more practitioners to provide them. Parents want to know more about their children and will queue to join well run programmes that help them move forward with their parenting. The newer relationship-based parenting programmes – such as Mellow Parenting and the Solihull Approach parenting group (‘Understanding your child’s behaviour’) – provide evidence of how behaviour difficulties in children can be tackled through parents learning lifelong skills about managing their child within an improved relationship. Even the best Sure Start programmes are only managing to run about 10 parenting programmes a year, reaching approximately 100 parents. In Solihull (population approximately 200 000), we are working to increase the number of parenting programmes from 12 to 120 per year, with targeted schools having parenting programmes available to all parents of Year 1 children, to try and
practitioners to support families in the antenatal period onward. This requires appropriate resourcing, together with clear aims and objectives within the local strategy. Health visitors are a precious resource within the UK and their work should be encouraged and built upon, promoting their work with relationships both in their basic training and in post-qualification training. School nurses, nursery nurses, children’s centre staff and all community practitioners who work with children and families can enhance the impact that they have on the emotional health and wellbeing of families, through focusing on the relationship and also by contributing to the provision of parenting groups that include an emphasis on relationships. Teachers would perhaps also appreciate having a greater understanding of their pupils’ behaviour, through having more knowledge about how we relate to each other, in order to encourage behaviour for learning.

Conclusions
This paper has outlined the idea that the quality of early relationships is an important factor in the development of emotional health and wellbeing. Early relationships act as the scaffolding within which the brain develops. The architecture of the brain moderates emotions and impulse control, as well as language and social skills – all implicated in emotional health. Programmes like the Solihull Approach that have relationship development as a core part of the model, can assist practitioners to support families in the development of their emotional health from the antenatal period onward. Although the recent upheaval in the financial sector may have negative implications for the provision of services to children and their families, it is still an exciting time to be working as we become increasingly aware of more effective ways to increase the emotional health and wellbeing of children and their families.

References

Key points
- The quality of early relationships is an important factor in the development of emotional health and wellbeing
- In the UK, we do not currently integrate support for the relationship between the baby and parents into antenatal parentcraft
- There is not enough focus within basic or post-qualification training for health visitors and other practitioners on working with the relationship
- The Solihull Approach provides one model for working with the relationship between parents and the child and between the parents and practitioner

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A novel parent-supported emotional literacy programme for children

Introduction
The importance of children’s social and emotional wellbeing is widely recognised.1 Wellbeing has an effect on physical health (both as a child and an adult) and can determine how well a child does at school. Some emotions (such as sadness and anger) can block learning, while others (such as a sense of wellbeing, feeling safe and valued) promote it – learning to manage emotions can assist learning.2 Good social, emotional, behavioural and psychological health can protect against emotional and behavioural problems, violence and crime, teenage pregnancy and drug and alcohol misuse.3

Supporting children to develop socially and emotionally is the responsibility of all professionals who work with children.4 UK schools are supported in this through the Social and Emotional Aspects of Learning (SEAL) curriculum, which aims to provide ‘an explicit, structured whole-curriculum framework’ for developing all children’s social, emotional and behavioural skills.5

Research in the UK identifies that intervention to improve emotional literacy needs to start early and take a long-term developmental approach, in a flexible, low key, non-labelling way as part of the broader whole school approach to positive mental health in children.6 Although many programmes to support emotional literacy have been developed in the UK, few have been evaluated. This may be partly a consequence of a lack of consensus about the definition and assessment of ‘emotional literacy’, which has implications for how this work is disseminated and promoted.7

Within this paper, emotional literacy is defined as ‘The ability to perceive accurately, appraise and express emotion; the ability to access and/or generate feelings which facilitate thought; the ability to understand emotion and emotional knowledge; the ability to regulate emotions to promote emotional and intellectual growth’ (p267).8

The role of parents and carers in promoting emotional, social development and resilience factors in their children is vital. They are the experts on their own child, and their knowledge about their child’s developing skills can provide enormously valuable information about what is working and what is needed.4 Home discussion between parents and their children has been found to have a significant effect on children’s attainment and positively influences achievement.9

This paper describes a preliminary evaluation of a novel parent-supported child emotional literacy programme – the Parents and Children Together (PACT) programme.

PACT programme
The PACT programme was developed in Cornwall, following local research with parents to investigate parents views about:

- Their contribution and knowledge of the personal social and health education (PSHE) curriculum in school10
- How they could be supported in developing or enhancing communication with their children around emotional literacy, with particular reference to sex and relationships education (SRE).

These findings shaped the development of the programme, with an aim to develop a collaborative partnership between schools and parents and carers in the personal development of their children, particularly in relation to SRE at ages eight to 11 years.

The Neighbourhood Renewal Fund (NRF) Local Area Targets to which the programme aimed to contribute were to reduce educational under achievement and teenage conceptions. The project also attempted to engage ‘hard to reach’ families.7 Deprivation generally reflects poorer attainment in children’s social and emotional outcomes.

A small-scale pilot study took place during the autumn term of 2005 in three demographically different Cornish primary schools already teaching the SEAL curriculum. By collecting the views of parents, through a variety of methods, initial problems with the process and materials could be corrected prior to the main study.

Aims of the study
The primary aim of the study was to test whether children who participated in the PACT programme would experience a
significant improvement in emotional literacy and self-esteem compared with children who continued to receive a standard SEAL curriculum, as measured by two psychometrically validated tools.

The secondary aim was to explore the experiences and responses of parents and children in using the PACT family materials, through qualitative and quantitative analysis of their responses.

Method

The research method and process was overseen by an advisory group of health and education sector expert professionals. Ethical approval was given by Cornwall County Council Ethics committee.

Participants

A total of 12 schools were invited to take part in the research during the same year – eight to receive the PACT intervention and four demographically-matched comparison schools. The eight intervention schools were located among the 20% to 30% most deprived wards in England and situated in NRF areas in the West of Cornwall. The four comparison schools were not covered by NRF funding and not eligible for the intervention. In agreeing to take part, the comparison schools were promised the intervention the following year. The comparison schools only delivered the standard SEAL curriculum.

All parents received a letter from the school about the research and how the data would be used. They returned a slip to school if they did not wish their child to take part. The head teachers took ownership of the research process, acting ‘in loco parentis’ for the children. Advice from the expert panel and ethics committee agreed that individual written consent was not necessary, though children could opt out discreetly if they wished.

All of the children in the chosen year groups of the intervention schools took part and all of their families received the PACT family materials. The year groups were selected by the researchers, based on available evidence about which ages would be most appropriate to target.

Intervention

An initial PACT ‘launch’ event was held in each intervention school to give parents more information about the programme. Weekly lesson plans, with clearly stated outcomes linked to the SEAL, PSHE/Citizenship and SRE curriculum, and detailed resources were produced for upper and lower Key Stage 2. Each school teacher devoted approximately one hour of curriculum time to PACT each week for nine weeks during the autumn term of 2007. Since all children in the class were involved, PACT was delivered in a ‘low key’ and non-stigmatising way.

Following the launch event, all parents received a pack of resources including a DVD and written information about the programme. Each week, a ‘family chat time activity’ was taken home by the children from school after the taught classroom lesson. This activity included topics for discussion, activities to do together and information on the lesson outcomes.

A ‘thought diary’ booklet travelled to and from school, which enabled parent and child participants to write comments about PACT family activities weekly throughout the intervention.

Assessment tools were chosen to facilitate a pre and post comparison of the PACT programme with the standard SEAL programme over a period of four months.

Psychometric questionnaires

Two psychometric measures were piloted successfully in two schools with a separate cohort of children, to ensure acceptability with children, staff and parents, though no changes were necessary following this.

The NFER Emotional Literacy questionnaire is a psychometrically validated tool for pupils and their parents. It covers aspects of children’s emotional literacy including self-awareness, emotional resilience, motivation and handling of emotions and relationships. Children are asked 25 self-rating questions with four answer options that range from ‘very like me’ to ‘not like me at all’. The questionnaire was completed by children without a time limit within lesson time. Parents are asked 24 questions with four answer options asking how true these statements were of their child, for example: ‘can name or label his/her feelings’ or ‘can recognise the early signs of becoming angry’.

The Culture-Free Self Esteem Inventory is a self-report assessment of self-esteem in students aged six to 18 years. It is psychometrically validated and explores self-esteem in a culturally fair manner. It has 30 questions and identifies those who may be in need of further psychological assistance.

SEAL Parent Questionnaire

A questionnaire was designed by the research team to elicit parents’ views on their children’s emotional development and relationship education. It was either sent home with children or distributed at the PACT launch, and was completed by:

- Parents of children at comparison schools
- Parents of children at intervention schools prior to the intervention
- Parents of children at intervention schools following the intervention.

Parents at the comparison schools did not complete the second questionnaire, since they had not had a change to the parent support for the SEAL curriculum.

Data analysis

The two psychometric questionnaires and the thought diaries were analysed by Cornwall’s Children’s Research Service. Thought diary comments were analysed thematically to identify core themes that were named and organised with supportive quotations drawn directly from comments made. All data were anonymised by substituting the children’s names for code numbers linked to school and sex of child.

Responses to the SEAL Parent Questionnaire were analysed by an independent market research company, overseen by the expert group. Likert scale and nominal data were coded and summed as appropriate.

Results

From the eight intervention schools, 686 children in Years 3 to 6 and their families participated in the study. In the comparison schools, 186 children and their families took part. The year and age groups involved were the same in each school. All of the schools had already implemented the SEAL curriculum.

Psychometric questionnaire results

In intervention schools, 147 parents completed the NFER Emotional Literacy measure both before and after their child’s participation in the PACT Programme. There was an increase in total parent score after the intervention (mean=75, standard deviation=10.2, range=50 to 93) compared with before (mean=72, standard deviation=9.6, range=35 to 93). This increase was statistically significant (Student’s t-test=2.23, p<0.05, effect size=0.3).

Of the children, 332 in intervention schools and 123 in comparison schools
completed NFER Emotional Literacy self-rating scales both before and after participating in the intervention. Children in comparison schools were nearly two times more likely than those in intervention schools to rate themselves in the 'clinical' range for emotional literacy (where further specialist intervention is recommended) after the intervention when compared to before it (odds ratio=1.9608, 95% confidence interval: 0.5269<OR<7.292). This effect was seen equally in boys and girls.

There were no significant overall differences in self-esteem scores between participants in the intervention or comparison schools after the intervention, based on children's self-rating.

**SEAL Parent Questionnaire results**

Among intervention parents, 25% said that their child chose to talk to them about their feelings 'very often' at the beginning of the intervention, and this increased to 35% by the end of a full term of PACT. Over the same period, the proportion of intervention school parents who said their children spoke to them about their feelings 'not very often' decreased from 23% to 13%.

After the intervention, 61% of parents said they found the family chat time activities to be 'useful' and a further 13% 'very useful'. When asked whether the activities helped them to talk more to their child about their feelings, 45% said 'yes, somewhat' and 21% 'yes, definitely'.

By the end of the first full term of the PACT programme, the proportion of parents who said they normally talk with their children about a range of topics either 'often' or 'very often' increased by 9% or more (see Figure 1).

In comparison schools, 8% of parents reported knowing what their child was taught in school about SEAL. The figure for parents in intervention schools was 20% pre- and 48% post-intervention. Intervention parents' awareness increased in what their child's school taught about emotions (50.2% pre- to 76.4% post-intervention), relationships (45.6% to 72.3%) and sex (33.0% to 42.6%).

**Qualitative findings**

Comments on PACT from 299 intervention school parents and children through the thought diaries enriched the data: It was very good, fun and helpful. This comment suggested that overall the materials were enjoyed and considered a positive experience. It made us feel more like a proper family. It lets us have more time together.

This feedback suggests that PACT helped to bring families together and provided opportunity for more family time. Understanding and learning about one another was a clear theme to emerge: Made me understand why mum gets annoyed as well as my brother! The topics discussed through PACT were generally considered to be important to discuss and personally relevant:

> I feel this is a good subject for the kids to discuss as they face some of these changes very soon.

There was an increased understanding about the topics discussed, and families felt that they were now better equipped to share and deal with different emotional and social issues together: I think the discussion was very productive and my child now seems to understand a lot more about peer pressure and the wrongs surrounding it.

A minority of families (approximately 3%) felt the PACT sessions were either not applicable to them or that they did not have time to discuss the topic at home: We already do this a lot as a family unit. We don't need help with this. My son didn’t want to do it – fine by me and his dad – he has enough to do already.

**School feedback**

Overall, teachers reported a high level of satisfaction with the teaching resources used during the programme. Schools also reported how helpful PACT had been to facilitate the embedding of the SEAL curriculum in schools, as it provided a more structured approach for teachers that got the whole process going.

**Discussion**

Parents of children participating in PACT reported a statistically significant improvement in their child's emotional literacy after the programme, compared with those of children in schools receiving the standard SEAL curriculum, suggesting that they viewed their children as more able to understand and express their feelings. The effect size for the improvement in parent-reported emotional literacy (0.3 standard deviation units, or three-point standard score points) is considered to be 'moderately large' according to effect size convention, though this statistical result needs to be interpreted in light of an average three-point improvement in NFER Emotional Literacy standard score.

Nevertheless, this positive outcome suggests that participation in PACT is
associated with an increase in the emotional literacy of the children taking part, as well as offering parents additional resources and skills to support their children with this development, thus building their child’s resilience.15 This enhanced level of engagement is evident in the increase in the proportion of parents who reported talking with their children about issues such as coping with anger, puberty and peer pressure following participation in PACT.

There is an increasing body of evidence that effective early intervention has a long-term and positive effect on antisocial behaviour, employment prospects and other measures of wellbeing.3

Many parents reported a general increase in knowledge and understanding about the topics covered and what was being taught at school about emotions, relationships and sex. A minority of them reported that the family activities were not helpful, either because they were already familiar with discussing the issues, or considered them to be irrelevant.

To the extent that PACT and similar programmes are effective in improving emotional literacy in young people, this could contribute to a reduction in mental health and behavioural problems in childhood, adolescence and adulthood. As well as improving social and emotional learning, the skills learned in understanding and expressing emotions could enhance inclusion, improve academic learning and contribute to greater social cohesion.

The PACT programme confers a potential cost saving for specialist child and adolescent mental health services who might otherwise need to become involved in the care of these children at a later point in time.16 Further experimental studies are needed to explore the long-term outcomes of children who participate in the PACT programme compared with the standard SEAL curriculum (at this stage of the programme’s development, the authors consider it to still be acceptable to use an experimental approach).

The PACT model of involving parents in children’s emotional and social learning could also be replicated across other curriculum areas, which could further contribute to increased attainment and learning.

The PACT programme was implemented in areas of high deprivation, and schools reported parents getting involved who would normally be difficult to engage. This approach could be built upon by schools and parent support advisers or learning mentors and locality-based services to further engage with these families. Such universal approaches may make parental acceptance and participation more likely, a prediction that could be tested in future studies.

**Limitations**

This preliminary evaluation of the PACT programme faced a number of important constraints. At this stage in the research lifecycle, it was not possible to implement an experimental approach to assigning individual children to PACT or standard SEAL curriculum – instead, the intervention was implemented at school level. It is therefore not possible to exclude between-school factors, such as readiness to engage with new initiatives or systematic differences in teacher motivation. However, the before and after tests could be expected to reduce this effect.

There were also important potential response-bias effects, in that not all parents and children completed all the measures at all time points. It is likely that families who are more positive about the intervention are willing to remain involved and to complete follow-up assessment.

Finally, there may be important differences between statistically significant changes and clinically significant long-term benefits of participation in these sorts of programmes.

**Recommendations**

- **Primary schools**, especially in ‘hard-to-reach’ areas, could consider the implementation of PACT alongside the conventional SEAL curriculum, to engage parents in learning along with their children in a non-stigmatising way.
- **Standardised and psychometrically validated assessment tools** could be used more widely in schools to identify children with additional social and emotional learning needs, though additional resources may be required to address these needs.
- **The PACT model** of improving the school and family learning interface should be developed and adapted to engage parents in other curriculum areas and into Key Stage 3.

**Conclusion**

These preliminary results suggest that the PACT programme has been experienced by parents and children overall as both enjoyable and rewarding, and that it has been successful in working toward its aim. Specifically, the PACT programme may enable parents to feel more supported and involved in the social and emotional education of their children, encouraging this aspect of children’s development. It is predicted that this outcome will contribute to children’s educational attainment.

It would be valuable to continue to develop and evaluate the implementation of the PACT programme as a unique evidence-based primary prevention intervention in emotional literacy, in order to explore long-term psychological, health and economic benefits. Community practitioners – including school nurses – are well placed to play a leading role in the development of school and family-based emotional literacy promotion programmes.

**Acknowledgments**

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**References**

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Lord Victor Adebowale
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Professor Laura Serrant-Green
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Speakers Include:

Carol Landry
International Vice-President at Large, United Steelworkers’ Union, USA

George Hosking
Founder, Chief Executive and Research Co-ordinator, WAVE Trust

Angela Mawle
Chief Executive, UK Public Health Association

Olivia Giles
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Enuresis service review

Progress in the streamlining of school nurse-led nocturnal enuresis services in Cambridgeshire following the merger of three trusts

Norma Wilby
Team manager school nursing and enuresis nurse, Cambridge Community Services NHS Trust

Since the merger of three primary care trusts in Cambridgeshire two years ago, the transition has presented both exciting opportunities and challenges. This has been particularly true in service development and streamlining practice and policies in a new and evolving county-wide school nursing service.

This article focuses on the school nursing enuresis service and the steps taken so far in order to provide a consistent, equitable and high quality service.

Need for consistency
Prior to the reorganisation, there were two different models of school nursing in place. Two areas used a traditional model serving the school-aged population,1 while the other operated a service in which health visitors and school nurses worked as an integrated team serving children and families from birth to 16 years old (19 years for those with special needs). Prior to the formation of the county-wide school nurse team, many health visitors undertook enuresis activity, which has since been a loss to the enuresis service and a disappointment to those health visitors who enjoyed this field of practice.

Cambridge Community Services NHS Trust covers a wide area encompassing Wisbech, Ely, Cambridge City North and South, and Huntingdonshire, with many sub-bases interspersed across the county. This has highlighted a need for an enuresis service review to ensure consistency, equity and quality to all service users.

As with any integration process in a large organisation, it is inevitable that practices will vary, whether in the referral process, assessment, sourcing of equipment (bedwetting alarms), follow up, the discharge process or referral to specialist paediatric urology services. A disparity was clear from the outset in the way school nursing teams operated their enuresis service prior to the merger. This led to staff feeling confused and frustrated about which paperwork they should use, where to order equipment and recording clinical activity via the electronic patient reporting system (SystmOne). These issues were highlighted through emails and various meetings, away days and training sessions, where all staff were able to share their ideas and creating new and innovative ways to improve the service. The service lead and team managers recognised the impact that this was having on staff, service users and ultimately the organisation, hence the need to streamline services.

Identifying issues
As a team manager with over 10 years’ experience in running a nurse-led enuresis service, I was tasked with reviewing the service following the transition. The first step was to meet with the school nurse service lead and the paediatricians we work closely with from local urology and renal services, and to consider ways of improving the service to both users and staff on a county-wide basis.

The next step was to form an enuresis-specific task group to include enthusiastic, motivated school nurses, nursery nurses and healthcare assistants. The aim of the group is to gain an overview of current practices as a baseline in each area, then to explore solutions to developing a co-ordinated, streamlined enuresis service with a county-wide policy to guide practice (see Table 1).

A brief audit of time and activity type spent on enuresis is being undertaken in each area. The information gathered will provide a snapshot of the volume of referrals being made to the service, the time spent monthly running the service and the overall costs, including procuring and servicing equipment and administration where this is available. Once this data has been fully analysed, we expect to have a better idea of where changes should be made and whether the enuresis service should have a separate budget to monitor and control costs, which will include annual training and supervision.

Finding solutions
It was decided that there would be a link nurse for each area, ensuring that feedback and support is given to all staff, especially those undertaking enuresis activity on a regular basis. It was acknowledged and agreed that there should be tiered levels of intervention for bedwetting.

At the first level, parents and carers need low-level intervention from basic information giving, health education, tips and reassurance about managing their child’s bedwetting. The most common tips are to ensure the child has regular access to drinks and toilets during the school day, to stop lifting the child and removing pull-ups or nappies.2 This role can be undertaken by school nurses, nursery nurses and healthcare assistants.

The second level would be to refer children into the school nurse-led enuresis service for an initial assessment, where bedwetting has not been resolved after a three-month period, with a range of treatment options available.

Health education is a key public health role in which school nurses, nursery nurses and healthcare assistants play a vital part in prevention and early detection. In addition to this, they can support, monitor progress, offer guidance and refer as appropriate to specialist services where other continence issues are being encountered. This is especially so for children with complex health needs and particularly those accessing education in special needs settings. Through providing basic...
information to parents and carers, many children achieve success in gaining nighttime continence within a relatively short period of time. This often reduces the need for referral to the enuresis clinic and assists in keeping down waiting-list times. More importantly, the child benefits by freeing them of the emotional turmoil caused by bedwetting, in addition to reducing parental anxiety and intolerance. It also reduces the frustration, time and cost experienced by parents and carers with daily laundering of bed linen, especially where this becomes a financial burden.

Looking ahead
There is a long journey ahead, but with the enthusiasm and support of managers, paediatricians and team members, we aim to re-launch and implement a streamlined, co-ordinated, equitable and high quality school nurse-led service to coincide with the new National Institute for Health and Clinical Excellence nocturnal enuresis guidelines due out in October 2010. The enuresis service will be accessible to all, meeting their needs at the level they require. It will also contribute to reducing costs to families – in terms of travel and time taken to attend clinics – and to the organisation when families do not attend, in addition to reducing carbon footprints.

References
Band 4 skill-mix staff

Considerations in working with and delegating to Band 4 staff are addressed by Skills for Health standards for assistant practitioners

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

There is still a great lack of clarity about the role of Agenda for Change Band 4 staff across the NHS, particularly in the community. Now that budgets are being slashed across the UK, it is even more important that all practitioners understand what work can or cannot be delegated, and where the accountability for practice rests.

Roles and standards
These staff may be called community nursery nurses, midwifery support workers, district nurse assistant practitioners, primary care workers in mental health, expert patient co-ordinators and a host of other names. They work primarily in areas of patient contact – clinics, patients’ own homes, GP surgeries – and are managed by a healthcare professional who is registered with the NMC or Health Professions Council (HPC). It is important to understand that as non-registrants, the professional accountability for the work that they carry out lies with the registrant who delegated the task to them.

Skills for Health has developed core standards for ‘assistant practitioners’,1 which is a generic term for those working at level 4 on the Skills for Health escalator, paid at Band 4. Trainee assistant practitioners will normally be paid on Band 3.

An assistant practitioner is defined as ‘a worker who competently delivers health and social care to and for people. They have a required level of knowledge and skill beyond that of the traditional health-care assistant or support worker. The assistant practitioner would be able to deliver elements of health and social care and undertake clinical work in domains that have previously only been within the remit of registered professionals. They are accountable to themselves, their employer and the people they serve."

Recognition and value
Standard 1 states that the role of the assistant practitioner should be recognised and valued in its own right, as workers who support the work of registered practitioners, and may work under distant guidance and as lone workers.

This is important, as we hear of many instances where Band 4 staff, particularly community nursery nurses, are being used instead of health visitors, to fill a gap rather than complement the service.

The role of the assistant practitioner should be recognised and valued in its own right

Recruitment
Standard 2 states that candidates who have the capability to undertake the job should be recruited to an appropriate post of employment and training programme. This means that a formal selection process should take place, as the employer is identifying recruits who will have the capability for future professional training. Staff can progress through the levels of the NHS career framework by developing skills, competences and qualifications through learning and development.

Education and training
Standard 3 states that the education and training of assistant practitioners should support the development of a practice-focused, competent individual. It is expected that having identified potential recruits into the health professions, employers will allow them to study towards a foundation degree or BTEC higher national diploma-level qualification on a part-time basis while working. They may then be given the opportunity to progress onto further training, such as secondment onto a pre-registration programme, with support from their employing NHS organisation.

Alternatively, for those who do not want to develop their career in an upward direction, they could gain additional experience and responsibility by broadening their existing role and remaining at level 4 of the career framework.

Scope of practice
Standard 4 states that the assistant practitioner should be acting at their appropriate level on the career framework. They should be able to manage their own role under guidance from a qualified practitioner (either a nurse or an allied health professional), plan straightforward tasks and work guided by standard operating procedures, and make some judgements requiring a comparison of options. They also have a role in demonstrating their own work to others, delivering training and supervising the day-to-day routine work of students in their field or healthcare assistants.

The employer’s policies and procedures therefore need to be robust, and best practice is that they are agreed jointly by management and staff-side workplace representatives. Unfortunately, not all employers follow this pattern, and there is a developing culture of ‘management by email’ that is often reactive and dictated by a lack of staff and resources rather than any assessment of health needs. This leaves employees vulnerable, as they are often asked to cover for absent professionals without the training or competencies to do so. However, the accountability for their practice lies with the manager who delegated work to them.

The NMC code of conduct2 states that registrants must:

- Establish that anyone they delegate to is able to carry out their instructions
■ Confirm that the outcome of any delegated task meets required standards
■ Make sure that everyone they are responsible for is supervised and supported.

Anyone who delegates must therefore have evidence that the person to whom they delegate has the relevant knowledge and expertise to work safely and effectively.

For example, it sometimes happens that community nursery nurses are suddenly asked to run the baby clinic, because there is no health visitor available. This raises several vital questions that need to be addressed (see Box 1).

Safeguarding could also be a delegated responsibility, where this entails the associate practitioner making observations and reporting back to the NMC registrant, who is fully accountable for the safeguarding practice of those to whom they delegate this work. Although assistant practitioners must record their work in the client or patient records as per local protocol, they do not have overall responsibility for this record, which remains with the registered professional. It is therefore essential that all protocols are made ‘Friday afternoon-proof’, in order to make sure that vital information is not missed.

NMC registrants must continuously assess the competency of those they delegate work to, and rescind this if necessary. They must also make sure that work is not done unnecessarily or duplicated, and that comments on policy from all staff in the team are taken on board.

If higher management has stipulated that an NMC registrant must delegate work to a Band 4 practitioner, but the registrant does not believe that this practitioner is sufficiently competent, then they must refuse to delegate the work to them.

Midwives cannot delegate their statutory duty to support a woman in labour, and Unite/CPHA policy is that members should not delegate the administration of injections to children. If nurses and midwives fail to follow the NMC code of conduct, then their fitness to practise could be in doubt.

Job descriptions

Standard 5 is the job description, which covers the competencies expected from Band 4 practitioners, who:
■ Must be able to communicate, store and retrieve information by all methods, including using information technology
■ Should use reflection and evaluation to improve their practice
■ Should comply with legal requirements for confidentiality and record-keeping
■ Have a duty for health and safety in the workplace and for clients, and to be trained to provide basic life support

NMC registrants must continuously assess the competency of those they delegate work to

■ Can be trusted to form a professional judgement of an individual’s health condition, but they must act within limits of their own competency and authority.

The assistant practitioner should be able to use their training, knowledge and skills as part of the team around the patient or client. This includes health education and promotion such as smoking, diet and lifestyle, as well as clinical procedures such as changing dressings, taking blood samples or helping mothers to breastfeed.

Development and progression

Standard 6 states that the assistant practitioner should be enabled to develop within their role and that progression routes should be available.

They are expected to maintain their knowledge and skills through continuing professional development (CPD). This might involve attending courses or seminars, for example, and should be part of the annual appraisal discussion.

‘Attitude mix’

Community nursing teams (health visiting, school nursing, district nursing) have for many years worked as ‘skill-mix teams’, but often without any formal understanding of what is expected from each grade of staff. To be honest, skill mix has been used to drive down costs rather than as a tool to make an efficient team. In some instances (and I mean no disrespect, dear reader), there are cases where there is a need for not simply skill mix but for ‘attitude mix’ – who is the best person to do this work? What skills do our Band 4s have? Are we allowing them to develop and follow a career path? Have we identified a mentor for this practitioner?

Further information

I recommend reading Skill mix in health visiting and community nursing teams: principles into practice by Maggie Fisher, which is available from the CPHVA Bookshop, see: www.cphvabookshop.com

References


Box 1. Delegating the running of a baby clinic: questions

■ Do health visitors know the detail of training to become a community nursery nurse?
■ What protocol will be used to ensure this clinic runs effectively and safely?
■ Who is supervising this clinic?
■ What documented training is required to run this clinic?
■ Who is responsible for health and safety of the venue?
■ Who is responsible for advising members of the public that a health visitor is not on the premises as expected?
■ Who is responsible for letting members of the public know what aspects of their care the community nursery nurse covers?
■ Do local GPs know that there is not a health visitor at this clinic?
■ Does this particular community nursery nurse have the competency to pick up and refer adult health concerns, such as postnatal depression?
■ Has this particular community nursery nurse had sufficient training to pick up and refer child protection concerns?
■ Is a qualified healthcare professional available for consultation by telephone if necessary?
■ What system will be used to feed back information from this clinic to the NMC registrant?
Eating burgers and asthma prevalence in children

Consumption of burgers three or more times per week is related to a higher prevalence of wheezing and asthma in children, a large international study has concluded. Changes in the prevalence of asthma and allergy may be related to dietary factors typical of a Western lifestyle. Previous studies have found diets rich in antioxidants, such as in fruits and vegetables, and consumption of fish rich in n-3 polyunsaturated fatty acids might help prevent asthma symptoms, while increasing fast food consumption might contribute to atopic disease.

To assess the association between dietary factors, asthma and allergy, the International Study on Allergies and Asthma in Childhood (ISAAC) conducted cross-sectional studies in 20 countries – both affluent and non-affluent – between 1995 and 2005. Parents completed questionnaires on dietary habits and allergic symptoms of their children, and data from 50,004 randomly selected children aged eight to 12 years (29,579 with skin prick testing) were analysed.

High fresh fruit, fruit juice and cooked green vegetable consumption was associated with significantly lower prevalence of wheezing in non-affluent but not affluent countries. High fish intake was associated with lower rates of wheezing in affluent countries. Eating burgers three or more times per week was associated with a higher asthma prevalence in affluent countries compared with no or occasional consumption. Eating fish or vegetables three or more times per week was associated with a lower prevalence of wheezing. Overall, more frequent consumption of fruit, vegetables and fish was associated with a lower lifetime prevalence of asthma, whereas high burger consumption was associated with higher lifetime asthma prevalence. None of the food items were associated with allergic sensitisation.

Fast food is rich in industrially hydrogenated vegetable fats and meat from ruminant animals that are dietary sources of trans-fatty acids, say the authors. There is some evidence that dietary intake of trans-fatty acids is associated with asthma and atopy. However, meat consumption in general was not associated with any of the study outcomes. Consumption of fish, fruit and vegetables is widely recommended for prevention of cardiovascular disease and cancer, and public health initiatives may be beneficial in reducing the prevalence of wheezing among children in diverse settings around the world.

Bruising a significant marker for other infant injuries at autopsy

The presence of bruising in infants at autopsy is significantly associated with the presence of other injuries, according to a retrospective cohort study. Although inflicted trauma in children often involves the skin and subcutaneous tissues, it is not uncommon to find bruises on the limbs associated with normal non-inflicted ‘wear and tear’ activities, for example, on toddlers learning mobility. However, the likelihood of having a non-inflicted bruise in a child who is not independently mobile has been estimated to be <1%.

To determine the significance of bruises in cases of infant death to ascertain if their presence was associated with other injuries or homicide, all cases of infants aged between seven and 364 days who were autopsied at Forensic Science South Australia were reviewed over a nine-year period from June 1999 to May 2008. Case files including autopsy reports, photographs, and coronial and police records were reviewed. All autopsy reports were initially divided into those infants with external bruising on examination and those without external bruising.

A total of 135 infants were included in the study consisting of 83 boys and 52 girls (age range=seven to 364 days). Of these, 21 (15.6%) had one or more bruises and 114 no bruises. Of the 21 infants with bruises, 17 had other injuries or lesions (81%), with five homicides (24%), 14 aged <182 days and seven between 182 and 364 days. Bruising is a significant marker for other injuries in infants presenting to coronial autopsy, and homicide occurs more commonly in this group, conclude the authors.

Intimate partner violence against mothers associated with child obesity

Children whose mothers report being abused by their partners appear more likely to be obese at age five, according to a study. To examine the impact of chronic maternal intimate partner violence (IPV) on obesity risk among preschool-aged children, US researchers studied 1595 children born between 1998 and 2000. The children’s mothers were interviewed when the children were born and again after 12, 36 and 60 months. The children’s height and weight were measured at 36 months and five years. About half (49.4%) of mothers reported some form of IPV. Children who were exposed to IPV were more likely to be obese at age five than those who were not exposed to any IPV. The association was stronger in girls compared with boys, and also among children whose mothers reported they lived in less safe neighborhoods. The authors suggest that the association could work through several pathways. If IPV influences maternal responsiveness to the socio-emotional needs of the child, then feeding practices may be influenced. Witnessing family violence may be associated with emotional distress and emotion-focused coping using food to self-soothe and address negative emotions. In addition, early-childhood disruption of the neuroendocrine system could increase the risk for disordered eating and changes in fat storage and distribution. Medical and public health practitioners must consider the impact of family violence on obesity risk when designing and implementing primary obesity prevention interventions, the authors conclude.
High fructose diet may contribute to high blood pressure


People who eat a high-fructose diet, in the form of added sugar, are at increased risk of developing high blood pressure (BP) or hypertension, according to a study. Over the past century, a dramatic increase in the consumption of this simple sugar, which is used to sweeten a wide variety of processed foods, mirrors the dramatic rise in the prevalence of hypertension. To examine whether increased fructose consumption has contributed to rising rates of hypertension researchers analysed data from the US National Health and Nutrition Examination Survey (2003 to 2006) which involved 4528 adults 18 years of age or older with no history of hypertension. Participants answered questions related to their consumption of foods and beverages such as fruit juices, soft drinks, bakery products, and candy. It was found people who consumed a diet of 74g or more per day of fructose (corresponding to 2.5 sugary soft drinks per day) had a 26%, 30% and 77% higher risk for BP levels of 135/85, 140/90 and 160/100mmHg, respectively (a normal BP reading is below 120/80mmHg). The results suggest cutting back on foods and beverages containing a lot of fructose might decrease one's risk of developing hypertension.

B vitamins may protect against depression in older adults


High total intakes of vitamins B6 and B12 are associated with a lower risk for depressive symptoms over time in older adults, according to the results of a cohort study. B-vitamin deficiencies have been associated with depression, but there is very little prospective evidence from population-based studies of older adults. US researchers examined whether dietary intakes of vitamins B6, folate, and vitamin B12 with depressive symptoms among older adults over time. Am J Clin Nutr, 2010; doi:10.3945/ajcn.2010.29413 (2 June 2010).

Risk factors for infant hearing loss


Dysmorphic features, low APGAR scores at one minute, sepsis, meningitis, cerebral bleeding and cerebral infarction are associated with sensorineural hearing loss in infants admitted to the neonatal intensive care unit, a Dutch study has found. This study evaluated independent aetiologic factors associated with sensorineural hearing loss in infants who have been admitted to the neonatal intensive care unit compared to normal hearing controls.

Women live longer than men but in a worse condition


Women live longer, but experience more limitations to daily activity and a lower quality of life than men of the same age, a study has concluded. The study was based on health surveys carried out in Barcelona on 4244 people aged above 64 (893 in 1992, 2140 in 2000 and 1211 in 2006). Disability was defined as having difficulty carrying out at least one of seven activities of daily living. The prevalence of disability was found to have increased between 1992 and 2006 among women but not men because of the higher increase in older age among women. Disability prevalence was 30% in men and 53% in women in 2006. The double burden of work that women experience throughout their lives (domestic work and work outside the home) is a key factor in explaining this difference, say the authors.

Diabetic risk of cardiovascular events


Adults with diabetes face twice the risk for cardiovascular events as those without diabetes, according to a meta-analysis. Uncertainties persist about the magnitude of associations of diabetes mellitus and fasting glucose concentration with risk of coronary heart disease and major stroke subtypes. Using an international research database, analysts from the Emerging Risk Factors Collaboration combined data on nearly 700 000 adults from 102 studies that provided information on diabetes status and vascular outcomes. At baseline, 7% of participants had diabetes and no participant had previous vascular disease. During an 11-year follow up, there were almost 53 000 cardiovascular events, including fatal or non-fatal myocardial infarction, fatal or non-fatal stroke and other vascular deaths. Subjects with diabetes had roughly twice the risk for any of these outcomes as those without diabetes. The analysis has shown diabetes confers about a two-fold excess risk for coronary heart disease, major stroke subtypes and deaths attributed to other vascular causes.
Tourette’s: 20 CAMHS cases

Clinical description of 20 consecutive TS cases at a community clinic

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Many studies have examined the clinical features of children with TS in specialist tertiary-level clinics. This article describes the clinical features of 20 consecutive cases of TS referred to a non-specialist child and adolescent mental health service (CAMHS) community clinic in Bedfordshire.

Background
TS is a condition in which individuals develop a range of tics. A tic is an involuntary, rapid, recurrent non-rhythmic movement or sound – ‘motor tics’ produce movement, while ‘vocal tics’ produce sound. Tics are sudden and purposeless. At one end of the spectrum are children with brief episodes of single tics, and at the other are those with chronic multiple tics, including TS. Tics may be described as ‘simple’ or ‘complex’. Simple motor tics are fast and meaningless, such as blinking, grimacing and shoulder shrugging. Complex motor tics tend to be slower and more likely to be referred for professional opinion.

Despite early presence of tics, the main reason for consulting a GP was ‘behavioural problems’

OCD – not surprising considering the behavioural, neuropsychological and genetic links proposed between them.

Other associated difficulties include sleep difficulties, antisocial behaviour, aggression, conduct problems and rage.

Results
There were 18 males and two females in this sample. The age range was 6.4 to 13.9 years (mean age=10.5) when first seen at the clinic. Although the majority of referrals came to the service via GPs, one came from another CAMHS for a second opinion. The mean age at onset of the first tic was 5.6 years, with an average of 3.6 years between this and an official diagnosis of TS. The first type of recognisable tic varied – 40% blinking, 15% each throat clearing and shoulder movement, 10% each neck movement and grunting or snorting, and 5% each head flicking and head shaking.

Despite early presence of tics, the main reason for consulting a GP was ‘behavioural problems’ (37.5%) followed by ‘school-related difficulties’ (25%), worsening of the tics (18.75%), a need for reassurance (6.25%), wanting to know what was wrong (6.25%) and one father who recognised problems similar to his own (6.25%).

When initially seen, 76.5% of GPs did not think symptoms were suggestive of tic disorder or TS. Common responses to parent’s concerns were ‘there is nothing to worry about’ or that the child would ‘grow out of it’. Only 12.5% of GPs referred the child for a more specialist opinion at first consultation despite the presence of tics.

Of the 20 children with TS, 20% had co-morbid OCD and 60% co-morbid ADHD. On examination of family histories, it was found that in 40% of families there was a history of tics in first- and second-degree relatives. In addition, 10% had a family history of OCD and 10% of ADHD.
In all, 60% of patients had been treated with medication – 30% had tried one medication, 10% used two different medications and 20% were on their third.

Although concerns about school were common, only 30% had a statement of special educational needs, and only 40% were receiving any sort of help from their school.

**Discussion**

While children diagnosed with TS in child and family clinics share some characteristics with those referred to specialist clinics (such as blinking being the most common first tic and a similar age of onset), they differ in degree of co-morbidity and severity of the disorder. Although prevalence figures vary widely between studies, the general pattern indicates that co-morbidity of ADHD and OCD increases as the severity of tics increases.\(^4\) The likelihood of having a co-morbid condition when diagnosed with TS is substantially higher than in the general population. Speciality clinics see up to 90% of co-morbid ADHD,\(^3\) but epidemiological studies have found lower figures in children with tics (38.4%).\(^8\) This study found co-morbid ADHD in 60% of the sample, suggesting that prevalence does indeed increase with severity. A similar pattern emerges for OCD, though levels are more in line with epidemiological studies. Incidence of OCD is three to four times higher in TS populations at specialist clinics than at child and family clinics. The fact that only 40% of the sample in this study received any additional help from their school is a cause for concern, since children with TS are known to need additional educational support.\(^10\)

Children with co-morbid conditions have poorer outcomes, particularly if with ADHD. In these cases, there are substantially higher levels of aggression and delinquency compared to children with TS alone.\(^11\) Despite this lack of educational support, most parents were keen to stress that they were more concerned about social outcomes for their child (see Box 1), particularly for the school and others to be more understanding of the condition.

Awareness of the likelihood of TS among children’s GPs was poor. That the main reason for going to the GP in this study was the fact that only 40% of the sample in this study received any additional help from their school is a cause for concern, since children with TS are known to need additional educational support.\(^10\)

**Conclusion**

TS is not rare. The symptoms are often mild but can be physically and socially distressing. Practitioners such as school nurses should recognise the symptoms and signs in order to support families and children. Reassurance and recognition is often all that is needed by the families. Children can benefit enormously if the condition is recognised and teachers are supportive. If symptoms are painful or causing distress, then a referral to a local paediatrician or CAMHS may help.

**References**


Detecting neonatal jaundice

New NICE guidance to recognise and treat neonatal jaundice and community settings

Karen L Ford
Senior lecturer, De Montfort University and specialist practitioner in public health nursing

New guidelines have been developed by the National Institute for Health and Clinical Excellence (NICE)1 to increase accuracy in detection and management of neonatal jaundice, and particularly to prevent kernicterus. Jaundice is one of the most common conditions in the newborn that requires medical care. Around 60% of term babies develop this in the first week of life, and for pre-term babies this rate is higher at 80%. In most cases, there is no fundamental problem – early jaundice is often called physiological jaundice and is usually harmless. Of breastfed babies, 10% can have physiological jaundice present at one month of age. While the mechanism for this ‘breastmilk jaundice syndrome’ is unknown, it is generally harmless.1

This article outlines the practice implications for community practitioners to detect neonatal jaundice.

Background

Neonatal jaundice refers to the discolouration of the skin and sclera resulting from an accumulation of bilirubin in the skin and mucosa. This is due to raised bilirubin in the body, known as hyperbilirubinaemia. Kernicterus is the pathological term to describe the yellow staining of the basal nuclei of the brain due to the acute and chronic effects of hyperbilirubinaemia – it is very rare but usually fatal. Associated morbidity, such as hearing loss and cerebral palsy, is very high.1

It has been custom and practice in the community to use visual inspection to assess the severity of neonatal jaundice, but research shows that this is not a reliable method of assessment and can lead to unnecessary serum bilirubin measurements being taken. Cases of kernicterus still occur with current practice, indicating a need for a more robust system to detect and manage jaundice in order to minimise the occurrence of kernicterus. Babies at risk of developing kernicterus will have the following risk factors:

- High bilirubin levels – greater than 340 micromoles per litre (micromol/l) in term babies
- Rapidly rising bilirubin levels – at more than 8.5 micromol/l per hour.

These babies require specialist monitoring and care. Community practitioners have a key role in assessment and recognition of hyperbilirubinaemia, particularly with the current practice of early postnatal discharge.2 Other non-physiological causes of hyperbilirubinaemia, such as rhesus or ABO incompatibility and haemolysis, need to be identified and are detailed in the full guideline.1

Evidence base

The guidelines were developed by researching published literature, which was evaluated rigorously. Where evidence was not available, consensus was reached within the guideline development group. Traditionally, many practitioners feel confident in assessing the degree of jaundice visually and others may advocate the use of sunlight exposure to reduce jaundice, but neither of these is supported by evidence. Cephalohaematoma, significant bruising and vacuum delivery have previously been considered risk factors, but again there is no significant evidence to support this.

Practice must be informed by available evidence to protect neonates and improve practice, though this may challenge existing opinion. The NMC professional code of conduct3 has clear standards for accountability and working with evidence upon which to base practice, reminding us of our duty as nurses and midwives.

Assessment

Term and near-term babies should be assessed for hyperbilirubinaemia soon after birth. The timing of detection is critical in avoiding more invasive treatment options and to prevent kernicterus. Initial assessment should be undertaken by a healthcare professional who is competent to undertake this, and is not a task that should be delegated within the skill-mix team.

Infants with any of the following factors for hyperbilirubinaemia should receive an additional visual inspection by a healthcare professional in the first 48 hours of life:

- Gestational age of less than 38 weeks
- History of previous sibling with neonatal jaundice requiring treatment
- Mother intends to breastfeed exclusively
- Visible jaundice at less than 24 hours of age.

This additional inspection is required due to the possible rapid rise in bilirubin levels already highlighted. With wide use of early discharge and for those women who choose to have their babies at home, the responsibility for assessment falls largely upon the community team.

All babies must be assessed for the presence of jaundice in the first 72 hours of life4 and opportunistically at all contacts. If jaundice is present in the first 72 hours, a measurement of bilirubin must be taken and recorded within six hours of identification, followed by action based on the threshold table (see Figure 1). Babies visibly jaundiced at birth require a serum bilirubin level to be undertaken within two hours and an urgent medical review.1

Visual inspection

Babies should always be viewed naked in good, preferably natural, light. For babies with dark skin tones, assessment of visible jaundice is less reliable. The sclera, oral mucosa and blanched skin need to be observed in all babies for the presence of yellow pigmentation (see Box 1).

As already stated, visible assessment is not reliable in terms of severity – a more reliable tool needs to be used if jaundice is visible. Families of newborn infants should be encouraged to check for signs of
jaundice, and they should be given the accurate information needed to do this. The NICE guideline recommends the measurement of transcutaneous bilirubin (TcB) as a less invasive procedure than blood sampling, and the recommended site for this is the sternum. This site will reduce distress for the baby and the potential for eye injury, or for forehead wrinkling to affect the readings. A bilirubinometer is required to measure the level of bilirubin. This is recommended in near-term and term babies over 24 hours old, but serum bilirubin should be taken if under 24 hours old where visible jaundice is present and for babies at less than 35 weeks. Any baby under 24 hours old with visible jaundice requires an urgent assessment of their risk of significant hyperbilirubinaemia, preferably within two hours. To take a TcB measurement first and then a serum bilirubin involves unnecessary delay.1 To summarise:

- Visible or suspected jaundice in first 24 hours – serum bilirubin within two hours
- Over 24 hours in near-term and term infants – TcB measurement
- Less than 35 week gestational age infant – serum bilirubin
- Do not rely on TcB levels above 250 micromol/L.

The guideline recommends that either a TcB or serum bilirubin measurement should be used to assess the level of jaundice in babies who are visibly jaundiced. The TcB or serum bilirubin level should be plotted against the threshold table (see Figure 1), which is also available in the quick reference guideline5 and provides clear routes for further action. It is imperative that practitioners record and plot their findings accurately against the threshold data.

It is good practice to give information to all parents about neonatal jaundice. Asking parents if they think their baby is jaundiced provides an opportunity to include them in the decision-making process and keep them informed of what is happening. This approach acknowledges that parents may be able to make a more accurate judgement, especially where different skin tones could inhibit visual assessment. Continued assessment of feeding behaviour and general wellbeing of the baby continues to be crucial in all contacts with neonates in the first weeks of life.

Other sources of information that can be used for assessment of neonatal jaundice are dark urine and chalky stools. The practitioner must ask the parents about this as part of the assessment and at subsequent contacts. Prolonged jaundice is jaundice that persists for more than 14 days in term babies and 21 days in preterm babies, and requires expert clinical assessment. This will include measurements of total and conjugated bilirubin, urine screening, assessment for G6PD deficiency if appropriate, ensuring the Guthrie test has been performed to exclude congenital hypothyroidism,6 and investigations to determine other possible causes.

**Key points for practice**

The intention to breastfeed exclusively is one of several factors that can increase the likelihood of a baby developing neonatal jaundice. This has the potential to raise concern among community midwives and health visitors. It is important to maximise the opportunity for support and success in breastfeeding7 in the light of these guidelines. Promotion of breastfeeding and support is recommended even when treatment is required to reduce bilirubin levels. It is essential to acknowledge that all opportunities to monitor and assess the neonate for evidence of jaundice requires an experienced healthcare professional. Open discussion about neonatal jaundice should continue at all contacts with new parents, while avoiding raising anxiety.

**Box 1. Recognition of jaundice**

- Naked inspection in natural or good light (not reliable for degree of jaundice)
- Examine sclera, gums and blanched skin
- Ask parents about the presence of dark urine or chalky pale stools
- Ask family opinion about any yellow pigmentation
There are training implications for those healthcare professionals who will use TcB monitors. Accuracy in interpreting and acting upon findings is paramount in the prevention of hyperbilirubinaemia and subsequent morbidity. Accessibility of the recommended tools needs careful consideration within teams to ensure no delay in identifying neonatal jaundice, particularly across a wide geographical area. The guideline recommends serum bilirubin if TcB monitors are not available. Careful consideration of this invasive procedure versus the overall cost savings in using TcB monitoring needs to be undertaken by healthcare commissioners.

The investigation pathway (see Figure 2) clearly shows the steps for healthcare professionals to take in the first 72 hours after birth. The full algorithm, with subsequent care pathways for when jaundice is identified, is available in the guidelines. The historical practice of many midwives, health visitors and other healthcare professionals in making their own judgements about ‘breastfeeding jaundice’ and degree of jaundice is unsafe – continued vigilance and gold standard breastfeeding support should be observed.

Using the NICE clinical guideline

The quick reference guidance is comprehensive in outlining the key steps, while the full guidance will give the team greater insight into the rationale and evidence behind the guidelines. There is also guidance written for patients and carers, and this can be used to support healthcare professionals working with parents and families of neonates.

The guidance is available online in full or quick reference format.

References

As has been covered many times before on these pages, Agenda for Change (AfC) is the national agreement for pay, terms and conditions of all staff in the NHS, apart from senior managers, doctors and consultants.

Unite and the rest of the trade union movement, both inside and outside of the NHS, believe that such national negotiations and agreements place unions in the best possible position to argue for improvements in pay, terms and conditions for staff, and action on issues such as opposing spending cuts, workload, violence at work, achieving equality and tackling discrimination. In addition, national rates of pay ensure greater fairness and provide a certain stability to the NHS.

However, there is concern that this national agreement may be undermined by moves toward local deals, and Unite is keen to hear from members if their employer is presenting proposals that are not in line with AfC.

Threat of ‘localism’

In July 2009, months before he became health secretary, Andrew Lansley said that: ‘In these times of increasing financial pressure, we need to ensure that we move to a situation where pay is instead defined by what is necessary to recruit, retain and motivate the staff, and also what is affordable for local healthcare providers.’

This was widely interpreted at the time as a heavy hint that the Conservatives would like to move toward local pay bargaining in the NHS. Alastair Hatchett, from the respected research organisation Income Data Services, has summarised that: ‘Despite the highly centralised decision to freeze pay, the new government is in practice, not simply a paper document.

He further reflects that under the last Conservative government, the Treasury had been a firm advocate of local pay bargaining in the early 1990s. However, by 1993 it had issued a note stating that: ‘In practice, extremely devolved arrangements are not desirable. There are risks of workers being treated differently for no good reason.’

We cannot assume that these lessons of the past have been learnt by the Conservatives or their junior partner the Liberal Democrats. Doing the rounds recently has been a paper by Alison Wolf for the Liberal Democrat think tank CentreForum, which advocates the break up of national bargaining.

Privatisation and pressure

There are very serious concerns about how privatisation undermines and erodes national bargaining through the transfer of staff out of the NHS, as well as all its other damaging impacts. Here, we are focusing on the possible threats to dismantling national bargaining for staff within the NHS. Changes to the AfC agreement are currently negotiated nationally by NHS Employers and the trade unions with the involvement of the four UK departments of health.

At a national level, we will lobby and campaign to maintain national bargaining and the integrity of the national agreement. However, our ability to be successful in this will in part depend on ensuring that the national agreement is not hollowed out by the accumulative actions of employers at a local level. To be effective, the national agreement as it is now must be what is implemented in practice, not simply a paper document.

In particular, Unite is concerned that employers may use the present strain on their budgets as an excuse to strike local deals and agreements with staff-sides on issues that are covered in the national AfC agreement. This is not a concern without grounds – we already know of local severance deals being offered in an attempt to side-step staff entitlements to redundancy payments under AfC. It goes without saying that the severance agreements we have seen are worse for staff than those provided for under the national AfC agreement.

Drawing a ‘red line’

Unite is asking its representatives to hold and maintain a ‘red line’ around the national AfC agreement. Where an issue is covered by the national AfC agreement or national guidance, workplace representatives should not strike local deals. The national agreement and guidance should be implemented.

As part of this, all Unite workplace representatives should ensure that they have the latest AfC handbook. This can be downloaded from the NHS Employers website.

If a proposal is presented to you and the staff side locally that is not in line with the national agreement, then it should not be signed. Your employer should instead be told that they should be implementing the national agreement.

We want all workplace representatives to inform their regional officers when such proposals are put to staff sides and pass all relevant paperwork onto them. This is important, as it will enable the union nationally to have a full picture of what is taking place regionally and locally.

Siôn Errington
Unite research officer

References

Sex: difficult questions

Great answers to difficult questions about sex: what children need to know
Linda Goldman, Jessica Kingsley (2010)
ISBN: 9781849058049, £10.99

This book appears to be aimed at parents who would like to talk to their children about sex, but are looking for some guidance.

It is divided into a range of topics, and these are then subdivided into different age groups. There are some case studies to illustrate the points made. The book seems very comprehensive and covers areas like anatomical differences between males and females, and same-sex relationships. The way in which the topics are separated into age groups provides a logical structure for the book. It is written in an American style, and can at times be slightly patronising.

The case studies in the book use examples with children aged from five years to 12 years. One criticism I have is that young people will have and ask questions about sex, and these continue until they are much older than 12 years. The questions often get more difficult and personal as they get older. Working in an inner city London borough within a pupil referral unit, some of the questions that I have heard and been asked have been more difficult to answer than those described in the book. However, I do acknowledge that the book is not aimed at professionals, but at parents of children.

As a school nurse, I think this book would be very useful. When I have delivered puberty sessions for Year 6 and sexual health sessions for Year 11, it is often difficult to pitch the answers to questions at the right level. School nurses are wary of saying too much and upsetting the school, or not saying enough and leaving the young person confused. This book would be a useful resource for the school nurse or teachers and teaching assistants to use for any puberty, personal, social and health education or sexual health session with children and young people. One addition that would make this more accessible for the school nurse to make use of would be an index, which is missing from the current edition.

In conclusion, this book originally aimed at parents would be a useful read for those working with young people aged from five to 12 years to help them answer some of the difficult questions that these children can present.

Reviewed by: Rebecca Faal
School nurse for the pupil referral units
Tower Hamlets Primary Care Trust

What’s up with Ben? Medikidz explain autism
Kim Chilman-Blair, Shawn Deloache
Medikidz (2010)

This book, created by Medikidz, is one of a series covering health information aimed at children and young people to access. Fun and facts are blended together to provide information in an accessible format. This particular book explores autism, and highlights the prevalence of approximately one in 100 children being affected.

The main theme of the book follows Ben and his older sister Brooke along with a team of six superheroes, who explore the brain to explain how autism makes people different. The style of the book is a comic strip, making the characters and the plot easy to follow. There is limited text on each page and most of it in speech bubbles, and initially the pages felt very ‘busy’, with lots of colour and an average of four story boxes per page.

The book tackles the common stereotypical autistic traits of playing alone, difficulty in reading body language cues, little eye contact, needing to follow a routine closely and anxious behaviours. The meaning of a ‘spectrum disorder’ is highlighted and both mainstream and special schools are raised. The superheroes help Brooke to appreciate Ben's needs and how she can help him by understanding his limitations, such as not understanding sarcasm and his preoccupation with counting.

The synopsis describes the book as being aimed at ‘kids’, and I would recommend the book for children and young people from ages of eight to 14 years. There is a lot of detail on each page and most of it in speech bubbles, and initially the pages felt very ‘busy’, with lots of colour and an average of four story boxes per page.

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The synopsis describes the book as being aimed at ‘kids’, and I would recommend the book for children and young people from ages of eight to 14 years. There is a lot of detail on each page, making it a book that may need reading more than once for the younger end of this age group. The book also needed to be read front to back rather than as a reference text that could be dipped in and out of.

I felt the book was a useful tool for explaining autism to this age group and could be used in schools to support inclusion and acceptance among a peer group, or for family members to gain understanding, as were the characters of the book.

Reviewed by: Joanne Mears
Specialist practitioner, school nursing
NHS Derbyshire County

Reviewers and resources
If you would like to review resources for the journal, or if you have suggestions for resources, please email: danny.ratnaike@tenalps.com
Named Nurse – Child Protection Band 8b

Everyone agrees on the importance of building the strongest possible system of child protection to prevent future abuse and tragedies. Since the death of Baby Peter, we’ve made substantial changes and invested heavily in our service. The JAR action plan agreed by all agencies in Haringey represents a strong commitment to achieve a high standard of child protection. But we acknowledge that we are not there yet.

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To apply for this position please go to the NHS jobs website at www.jobs.nhs.uk and enter reference number 271-RNS954MJ. Job description and person specification are available on the website.

Closing date for applications: Friday, 27 August 2010.
The Interview date: Tuesday, 14 September 2010.
Applications are invited for the post of Health Visitor in the Department of Health.

The successful applicant will work under the general direction of the Coordinator, Community Health to ensure the provision of community-based public health nursing services in an assigned area. The post holder will be responsible for the provision and co-ordination of health promotion and routine preventive health care services, including anticipatory guidance, health education, and advice on the care and management of children, care for the elderly, and the family. In addition, the post holder will supervise the provision of health care services by community health nurses and home resource aides in the community setting.

Applicants must possess a Bachelor’s of Science degree in Nursing or an equivalent qualification along with certification in Health Visiting or Community Health Nursing. In addition, applicants must be eligible for registration with the Bermuda Nursing Council.

Five (5) years post-qualification nursing experience in Health Visiting is required for this post, one (1) of which must have been in a supervisory capacity.

This position will be offered on a three (3) year contract term. Further details about this vacancy and our terms of employment can be found at our website www.gov.bm

Any persons wishing to be considered for the position advertised may apply by submitting a completed Government of Bermuda application form (which can be downloaded from www.gov.bm) quoting the appropriate reference number, to the Secretary of the Public Service Commission, 3rd Floor, Ingham and Wilkinson Building, Front Street, Hamilton HM12, BERMUDA: email hr@gov.bm or by fax: 441-295-2858 by the specified closing date 3rd September 2010.

We are developing and refreshing the Children’s Service for Brent, North West London as we embark on an integrated care organisation of which Brent Community Services will be a member. This is the opportunity to contribute and make a difference to the health and well being of young children and families. Easily accessible to Oxford, Reading, and the M40/M4 corridor we provide true flexible working. We also have strong links for post registration education with Bucks New University in High Wycombe and Thames Valley University in Uxbridge.

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Please quote reference number A45/INT.
Closing date: Tuesday, 24th August 2010.
Interviews will be held during week commencing 6th September 2010.
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**Noticeboard**

**Asylum and refugee families**

I have recently started working as a specialist health visitor for the asylum and refugee families in Leicester. I would like to make contact with other health workers in similar posts.

I am interested in sharing ideas, support groups set up, and new ways of working with this vulnerable group. In Leicester, there has been a health visitor working with this group for a few years.

**Nalini Patel**
T 0116 2958700
E nalini.patel@leicestercity.hhs.uk

**CNNs at Band 5 or 6**

We are two community nursery nurses working within Hampshire Community Health Care who are looking to develop within our role.

We would be interested in hearing from any community nursery nurses working within child health teams in other areas who are Band 5 or 6.

Any information including job descriptions, how banding was achieved and contact details would be much appreciated.

**Laura Knoll**
T 01329 845694
E laura.knoll@hchc.nhs.uk

**Young offenders’ needs**

We are nurses working with young offenders in the community looking at there physical health needs.

We are keen to hear from other health workers working in this field, specifically physical needs. We are based in Oxfordshire and Hampshire.

**Diane Gamble**
E diane.gamble@oxfordshirepct.nhs.uk

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