CONI: preventing another cot death

NHS cuts and reforms: breaking Britain

Evaluation: health services received by homeless families

New role: assistant practitioner – parenting
The NEW Cetraben bath additive dispenser for almost* complete control at bath time

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Contra-indications: Hypersensitivity to any of the ingredients.
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January 2011 Volume 84 Number 1

COMMUNITY PRACTITIONER

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The journal of the Community Practitioners’ and
Health Visitors’ Association (Unite/CPHVA)

5 May: a crucial date
for the NHS
Shaun Noble on the elections
and referendum on 5 May

News
Public health White Paper and
health visitor implementation
plan, local fund concerns, school
nursing vision, disappointment
over Frank Field’s comments

Association
NPC welcome and farewells,
New Year Resolution: Save Our
NHS, CPHVA Education and
Development Trust call for new
award ideas

Antenna
New SAFER referral tool,
research evidence, resources,
child maintenance information
and support, letters about
educational supplements

Cuts: breaking Britain
Kin Ly on how cuts and NHS
reforms are affecting members

Remember: CHIN
Lynette Harland on supporting
attachment during breastfeeding

Evaluation of health
services received by
homeless families
in Leicester
Maxine Jenkins, Craig Parylo

CONI: confirmation of
continuing relevance after
20 years
Alison Waite, Angela McKenzie,
Charlotte Daman-Willems

Discussion of the health
benefits of breastfeeding
within small groups
Monica K Clarkson,
Ruth A du Plessis

Secure mother-infant
attachment and the ABC
programme: a case history
Christine Puckering,
Julie Webster, Philip Wilson

Adding to the team
Wendy Burton on a new role:
assistant practitioner – parenting

Employment
A new simplified KSF guide,
the case for re-banding health
visiting roles

Index 2010

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annual professional conference,
see the inside back cover
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Nurofen for Children can be used from 3 months old and weighing at least 5kg (11lbs).

Effective relief you can trust
5 May: a crucial date for the NHS

As the battle to save the NHS from privatisation hots up, the most crucial date in that campaign could be 5 May 2011. This will be the electorate's biggest opportunity to date to pass its verdict on the coalition's performance. Not only will voters cast their ballot papers in the English local elections and for devolved institutions in Scotland, Wales and Northern Ireland, but they will decide the fate of the Liberal Democrats’ most cherished policy and raison d’être – whether to adopt the alternative vote (AV) system in general elections.

An upset in the local and devolved elections will cause the consummate PR man David Cameron to rethink the austere right-wing path that the coalition is treading. And a defeat of the AV proposal will cause even deeper fissures in the chaotic intellectual edifice that masquerades as modern Liberal Democrat ideology. Government policy could be up for a dramatic U-turn following such an electoral kicking – and that includes the NHS, where changes may have started but won't have become irreversible. Indeed, there might be a Conservative minority government next summer as the disparate Lib Dems peel away from the coalition.

As the proverb goes: 'May you live in interesting times'. All times are interesting, but in 2011 they will be especially so.
Health visitor numbers: implementation plan expected

The Department of Health (DH) has stated that a new implementation plan will detail how the promised 4200 additional health visitors will be delivered, though concerns have been raised about some aspects of this following the publication of the recent public health White Paper.

The DH did not provide information on the detail of the health White Paper nor the DH has given assurances over numbers of practice teachers. When asked whether it thought levels of qualified practice teachers needed to rise in order to train the 4200 health visitors, a DH spokesperson stated: ‘Concerted action would be required by NHS service and workforce commissioners, community service providers, higher education institutes and others, including return-to-practice schemes and exploration of more flexible training routes.’

Obi responded: ‘We are keen to ensure that appropriate mentoring and signing-off trainee health visitor methods are devised, as some alternatives may not be safe. Those with responsibility are aware of this concern and are working with the NMC to hopefully find a resolution.’

FNP staffing
There is also apprehension that the proposal to double the capacity of the family nurse partnership (FNP) programme, as discussed in the public health White Paper, may reduce the health visitor workforce.

Obi stated: ‘Some of the practitioners working on FNP are trained health visitors, meaning that FNP expansion could further reduce the current health visitor workforce if they move across to the new FNP programmes. We need to monitor what happens so we understand the workforce figures in the future.’

She stressed that the expansion of FNP should not be delivered by using pledged additional health visitors: ‘FNP practitioners are not practising as health visitors, though many health visitors go into FNP with additional training. The distinction needs to be clear, particularly where finance is concerned. FNP complements health visiting and ought to have its own funding stream.’

The DH did not provide information about how the FNP expansion would be funded or clarify whether funds would come from the ring-fenced public health budget, which has been estimated in the public health White Paper to be around £4 billion.

In addition to the health visiting implementation plan, the DH said a consultation on public health funding and commissioning will be published, but was unable to confirm a date.

Practice teacher numbers
However, neither the public health White Paper nor the DH has given assurances over numbers of practice teachers.

Obi responded: ‘If they are strengthening local power, the public must have a say, and before funds are given there will need to be a clear steer on how it is going to be used.’

She added: ‘As the experts in public health, health visitors and school nurses should have early dialogue with local directors of public health.’

New organisations including Public Health England and the NHS Commissioning Board (NHSCB) will be created, with more details to be provided throughout 2011.

Local health will be placed in local government. Directors of public health will be placed in local government to ‘lead public health efforts’, with responsibility over these local ring-fenced funds. The public health White Paper outlines plans to give local government ‘new freedoms’ and greater public health responsibilities, stating that councils will be ‘at the heart of improving health and wellbeing for their populations’.

Obi responded: ‘Some of the practitioners working on FNP are trained health visitors, meaning that FNP expansion could further reduce the current health visitor workforce if they move across to the new FNP programmes. We need to monitor what happens so we understand the workforce figures in the future.’

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School nurses: ‘key public health workers’

Unite/CPHVA has welcomed Department of Health (DH) assurances that the school nurses will be defined as ‘key public health practitioners for older children and young people’, following publication of the public health White Paper.

The DH stated that a new school nursing vision would include a role review and anticipated that school nurses would be the ones to deliver the five-to-19 Healthy Child programme. However, the association stressed that the only way to make this vision a reality is to increase specialist community public health nurse (SCPHN) qualified school nurses.

Unite/CPHVA lead professional officer Obi Amadi stated: ‘School nurses can only be at the heart of local plans and significantly contribute to the health outcomes of children and young people if there is a significant increase in qualified school nurses. Without improving numbers, it would be difficult to increase the level of service that they offer.’

Unite/CPHVA professional officer Ros Godson added: ‘The pledge from the previous public health White Paper to provide one qualified school nurse for every secondary and cluster of primary schools was not realised, and attention needs to be given to that by the present government.’

The DH provided details of the work that they have done so far in developing a school nurse service model, in which Unite/CPHVA is also involved: ‘We recently held a workshop involving senior school nurses in education and local authorities to consider the contribution of school nurses to the development of a fully integrated child public health service. Participants identified that the development of a “vision of service” for school nursing was needed, and that they considered that the model developed for health visiting could be adapted to reflect that required for the school nursing service.’

Ros added: ‘We will continue to work with the government to develop the service model, but this must be matched by a commitment from commissioners.’

In addition, the public health White Paper said that the school nursing service would work with other professionals to support schools in developing health reviews to improve pupils’ wellbeing and manage long-term conditions, as well as developing schools as health-promoting environments.

It included a number of aims for children and young people’s health and wellbeing:

- To reduce susceptibility to harmful influences in areas such as sexual health, teenage pregnancy, drugs and alcohol
- For schools to be active promoters of health in childhood and adolescence
- To improve self-esteem and develop positive social norms.

Despite these ambitions, the DH did not provide any acknowledgment of the need to increase numbers of SCPHN-qualified school nurses, and there are concerns over who will deliver this.

Obi commented: ‘School nurses complement aspects of education services, but they have a specific role. It should be done by practitioners who are competent and confident to carry it out and in the most appropriate setting. It is about providing a holistic approach and not carrying out a list of tasks – the only appropriate practitioner to do this is a qualified school nurse.’

Postnatal care still poor

Breastfeeding support in England continues to be poor and few mothers are provided with information on emotional changes after birth, according to a Care Quality Commission survey.

Unite/CPHVA professional officer Gavin Fergie stated: ‘Unite/CPHVA members provide a well-identified resource in dealing with mothers’ emotional wellbeing. Perhaps this finding highlights that support is not what it should be due to the erosion in practitioner numbers and expertise.’

Gavin added that a cross-government approach is needed to address the lack of progress made to improve breastfeeding rates in the UK: ‘Despite the efforts of our members, breastfeeding rates in the UK are not changing quickly enough. The benefits of breastfeeding to the child and the mother are well documented, and more impetus should be applied. Westminster and devolved administrations need to work together to provide more of a breastfeeding-supportive culture.’

Over 25,000 mothers who had given birth in January and February 2010 responded to the survey. Of these, 89% reported that they had received a postnatal check-up of their own health. However, 21% of the respondents were not provided information about emotional changes that they might experience after birth.

In addition, 52% received help and advice about feeding, which was down from 56% in 2007.
**Improving services for female victims of abuse**

A cross-government approach to tackling sexual assault and violence against women, including piloting domestic abuse protection orders and improving early intervention services, has been welcomed by Unite/CPHVA.

However, professional officer Dave Munday stated: ‘We have seen good examples of how health visitors have been involved in “routine and selective enquiry” and where school nurses support teenagers in learning about respectful relationships. But we have also seen that these services have reduced with cuts in the public health side of community nursing work. It is important that support services continue to improve.’

The Home Office stated that it would explore how health visitors could have a greater role in identifying the signs of domestic violence in the women that they visit, and how the teaching of sexual consent within the school curriculum could be improved.

It will fund domestic abuse protection injunctions in June for one year, which will be piloted by Wiltshire, West Mercia and Greater Manchester police.

As part of the cross-government approach, the Department of Health has launched an action plan that includes improving workforce education and training. It aims to develop a training ‘matrix’ describing learning outcomes, mapping out existing training courses and outlining training pathways for different professional groups.

It has also developed a number of resources including posters, leaflets and credit-card sized flyers in order to raise awareness of violence against women and children. These can be accessed at: www.dh.gov.uk/en/Publichealth/ViolenceagainstWomenandChildren/DH_119216

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**Educate parents about child sexualisation**

Education on the effects of commercialisation and premature sexualisation of children and young people should be given to parents in settings such as children’s centres, Unite/CPHVA Health Visitor Forum chair Maggie Fisher has stated.

Responding to an announcement that the government has commissioned an independent review about commercialisation and sexualisation, Maggie recommended that health visitors and midwives could provide valuable information about the negative effects of advertising, particularly on the internet.

She added: ‘Specialist community public health nurse-qualified school nurses play an invaluable role in promoting positive body images in schools, but there are simply not enough of them.’

King’s College London professor of community practice development Sarah Cowley emphasised the importance of providing parents with this type of information: ‘Not every mother will have the will power or awareness of the links between behaviour and toys to face down the angry wails of their children, so there should be some kind of regulation and parental guidance.’

The Department for Education has commissioned Reg Bailey, chief executive of the Christian charity Mothers’ Union, to carry out the independent review. The review aims to look at areas including the barriers that parents face in exercising their parental responsibility, and how the ‘Big Society’, communities and youth groups can influence change. It intends to better define the terms ‘excessive commercialisation’ and ‘premature sexualisation of children’.

Unite/CPHVA Health Visitor Forum members have highlighted other parental difficulties, including a lack of appropriate toys. Speaking of when she used to work with the National Association of Toy and Leisure Libraries, forum member Elizabeth Duff stated: ‘Some professionals were desperate to find suitable toys that did not seem to push children toward these aspirations, but allowed them to mature at their own pace.’

Sarah added that toys should also include age-restriction ratings.

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**Private healthcare study**

The Office of Fair Trading (OFT) will be conducting a study into the private healthcare market and quality of patient care in Spring 2011, and is seeking views to help inform its scope of study.

The study will look at areas such as barriers preventing private healthcare providers from entering or expanding in the market. The OFT said the study was important because of government proposals to enable NHS patients to seek private treatment.

The initial consultation deadline is 1 February. A scoping document of the proposed study can be accessed at: www.oft.gov.uk/OFTwork/markets-work/current/private-healthcare

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**Palliative care funding interim report**

An interim report on the funding of palliative care has highlighted consultation responses, including the need for 24/7 community services. It states that palliative care in England is ‘inadequate’, ‘poorly co-ordinated’ and ‘difficult to navigate’.

Final recommendations are expected in the summer, with details of children, young people and adult palliative care funding.

The independent review, commissioned by the government, is led by Marie Curie Cancer Care chief executive Thomas Hughes-Hallett.

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**Health Committee public expenditure report**

Unite has stated that the government’s NHS efficiency plans will ‘privatise much of the NHS by cutting services to the bone’, following the publication of the House of Commons Health Committee report on public expenditure.

The report said that the government has not provided a ‘clear narrative on its vision of how these savings are to be made’.

It concluded that the comprehensive spending review and pay freeze proposals would not allow councils to ‘sustain care levels without restricting eligibility criteria’.
Disappointment over review chair’s comments

Health visitors have expressed disappointment over Labour MP Frank Field’s comment that they prefer to visit families who offer them cups of tea rather than those who may have greater needs, following the publication of his poverty and life chances review for the coalition government.

Unite/CPHVA local accredited representative Anne Hawkins said that the MP’s comment to The Times undermined his report’s representation of the health visitor as one of the key professionals to assist in improving the life chances of under-fives.

Anne has written to the MP asking for clarification and stated: ‘This comment is appalling. I cannot believe that Frank Field – who would have supposedly investigated in great depth the issues that we face and the positive health outcomes that we deliver in order to inform his review – could make such an unprecedented comment. His report says one thing yet verbally he has said another. It is not just me who is disappointed, every health visitor who has read his ill-informed report says one thing yet verbally he has said another. It is not just me who is disappointed, every health visitor who has read his ill-informed views has said that they too are disappointed.’

Frank Field told The Times: ‘Health visitors often go to the families who offer them a cup of tea rather than the more difficult homes who sometimes reject them.’

The journal asked the MP to comment but he failed to respond. His report proposes a move away from anti-poverty measures based on increasing material income to a focus on improving the life chances of children aged under five.

In his report, Frank Field stated: ‘I no longer believe that the poverty endured by all too many children can simply be measured by their parents’ lack of income. Something more fundamental than the scarcity of money is adversely dominating the lives of these children.’

Unite/CPHVA professional officer Gavin Fergie responded: ‘Let us not kid ourselves – financial poverty is hugely important – but it is not the only determining factor in a child’s development. Some of the proposals aired here are well recognised as being beneficial, but with public service cuts being implemented the devil will be in the detail.’

He urged members to contact their local MP to protest about local cuts to services and jobs that would make it difficult for practitioners to improve the life chances of under-fives: ‘There are some hard debates and decisions that have to be made and Unite/CPHVA members have to ensure that their voice is heard at the local level where so many of these decisions will be made.’

The report acknowledged that health visitors are key workers in engaging vulnerable families, but highlighted challenges including high caseloads preventing many of them carrying out the two-year health review. The report stressed that in order to deliver one of its key recommendations to develop local and national life chance indicators to measure a child’s physical, emotional and cognitive development, the two-year health check should be mandatory.

It suggested introducing rewards for those Sure Start children’s centres that have improved outcomes for disadvantaged children, and proposed outsourcing these centres to GP practices, housing associations and the voluntary sector. Other early intervention approaches would include parenting lessons in schools.

The Trades Union Congress agreed that anti-poverty policies should pay more attention to improving the health and wellbeing of babies and toddlers, but stressed that the report understates the importance of families’ incomes.

Q
What guidelines are there for managing constipation in infants?
A
Constipation is present in 5-30% of children, depending on the criteria used for diagnosis.1 Symptoms for both children below 1 year of age and older children include fewer than 3 complete stools per week (not applicable for exclusively breastfed infants), large hard stools (‘rabbit droppings’), distress and straining on defecation, bleeding with hard stools, anal fissures and in the older children poor appetite that improves with passage of stool.

Constipation may be related to a variety of factors, including pain, fever, dehydration, dietary and fluid intake, psychological issues, toileting training, medicines and familial history of constipation. In some cases no anatomical and physiological aetiology for constipation can be found, and this is known as idiopathic constipation.2 In May 2010, NICE guidelines were published on both the diagnosis and management of constipation3, recommending the combined use of dietary and medical interventions. The main dietary interventions included the modification of dietary fibre intake within a balanced diet combined with sufficient fluids.4

Foods with high fibre content (e.g. fruit, vegetables, high fibre bread, baked beans and wholemeal breakfast cereals) are recommended. If formula feeding, parents should use the correct formula concentration, as reduced fluid intake can exacerbate infant constipation. Changing to a whey based formula with prebiotics may increase bowel transit time and soften the stools.5 Excessive consumption (> 550ml) of cow’s milk can lead to constipation in younger children due to high casein content, and should be avoided.6 In children with idiopathic constipation, research has found that 30-55% may also have cow’s milk protein allergy.7 However, dietary exclusion of cow’s milk should not occur without consulting a relevant specialist (i.e. gastroenterologist, dietitian).8

Q
What is the difference between soy formula, extensively hydrolysed formula and amino acid formulae as treatments for cow’s milk protein allergy (CMPA)?
A
Both extensively hydrolysed (EHF) and amino acid formulae (AAF) are hypoallergenic formulae and suitable for treatment of CMPA. Soy formula is not a hypoallergenic formula and should only be used after 6 months of age in children that are not soy allergic.9 There are also distinct differences between EHF and AAF: the first consists of cow’s milk protein that has been hydrolysed to small peptides (small protein segments) which should be suitable for the majority of cow’s milk allergic infants. Amino acid formulae consist of amino acids only, which make them suitable for children who experience unresolved symptoms on an extensively hydrolysed formula and those with severe gastrointestinal allergies or infantile atopic dermatitis.10

Q
What nutrition advice can I give to mothers to reduce their infant’s risk of dental caries?
A
The first year of life marks a time of rapid nutritional changes from an exclusive milk diet to a modified adult diet. It is important that even at this early age, parents consider the future impact of the food they offer on dental health. Research has shown that frequent consumption of dietary sugars (e.g. in unfluoridated fruit juice, added to weaning foods or in “sugar treats”) is associated with a significant risk of dental caries. Parents should clean teeth properly, introduce a beaker from six months and avoid allowing their infant to fall asleep with a bottle.11

References:

For more information on child nutrition
Visit www.aptamilprofessional.co.uk
call our hotline on 08457 623 676
e-mail questions@aptamilprofessional.co.uk

This column is brought to you in association with Aptamil

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Important Notice: Breastfeeding is best for babies. Breast milk provides babies with the best source of nutrients. Infant formula milk and follow on milks are intended to be used when babies cannot be breastfed.

The decision to discontinue breastfeeding may be difficult to reverse and the introduction of partial bottle-feeding may increase the risk of dental caries. The decision to discontinue breastfeeding should only be considered before bottle-feeding is initiated. Failure to follow preparation instructions carefully may be harmful to a baby’s health.

Infant formula and follow on milks are intended to be used when babies cannot be breastfed.

*Important Notice: Breastfeeding is best for babies. Breast milk provides babies with the best source of nutrients. Infant formula milk and follow on milks are intended to be used when babies cannot be breastfed.
NPC: welcome and farewells

Two new members are welcomed onto the NPC and goodbyes are said as four members step down

Kin Ly
Assistant editor

Two new elected members have joined the National Professional Committee (NPC), while four have stepped down.

Unite/CPHVA lead professional officer Obi Amadi gave a warm welcome to the two new regional chairs – Hilary Levan for the South West and Sandra Humphrey for London: 'We look forward to working with Sandra and Hilary and welcome their contribution to the running to the NPC and professional debate.'

Hilary is replacing Christine Arnold, who stated: 'Hilary is an active local accredited representative, and I am sure she will prove a most worthy chair to carry on the work for us here.'

Looking back at her time on the NPC, Christine added: 'The best moment for me was when I was elected as chair and had the backing of so many areas to do this. We also appointed a deputy chair Angela Reed and it is her who has done most of the work, therefore branches do need to consider the importance of a deputy chair.'

Norma Dudley, the former London Region chair, welcomed Sandra into the position: 'I’m delighted that Sandra will be the new London regional chair – it would be great to have some new energy.'

During her time as chair for the London region, Norma has been dedicated to improving health visiting in this area.

She said: ‘One of the biggest achievements while on the NPC was getting NHS London to understand that there is a severe shortage of health visitors in London, and getting them to acknowledge our very high workloads. Through meeting other colleagues and lobbying together, NHS London has now started the return-to-practice scheme. ‘

Other members who have stepped down from the association’s sub-committees include Margaret Wade, who has been the chair of the Education Sub-Committee for the last four years. She said: ‘My involvement with Unite/CPHVA has been challenging at times, but has also been an extremely rewarding experience. Education is at the forefront of the association’s activity and I feel privileged to have had the opportunity to influence health visiting and school nursing education at a national level.’

She added: ‘I encourage all members to get involved through local, regional and national professional forums and committees, or attending the practice teacher fringe meeting at conference.’

Neisha Fielder, who has been a member of the Equalities Sub-Committee since its inception, stated: ‘One of the great benefits of being on the NPC has been networking and meeting colleagues.’

Anyone interested in finding out more about becoming an NPC member should contact Leona Sanders on email: leona.sanders@unitetheunion.org

Wanted: your ideas for a new award from the CPHVA Education and Development Trust

The chair and trustees of the CPHVA Education and Development Trust are inviting Unite/CPHVA members to propose ideas for a new annual award. Please let us know your ideas including the proposed category and its purpose. The new award will be launched at the annual professional conference in 2011.

Please note that the trust will not support requests for fees toward courses, attendance to conferences, study tours or exchange visits. Currently, the trust has three annual awards. These are:

- MacQueen Award for excellence in practice, research, leadership or education, worth £3000
- Travel Bursary for Public Health activities abroad, worth a maximum of £1000
- The best research and practice posters displayed at the annual professional conference, each worth £100.

If you have ideas for the creation of a new award, we would like to hear from you. There is a £50 prize for the member whose suggestion is adopted by the trust. Send your ideas by 30 April to trustee Vina Mayor on email: mayorv@yahoo.co.uk with your name, job title, professional group, Unite/CPHVA membership number and contact details.

Vina Mayor, trustee
New Year’s Resolution: Save Our NHS

As part of its Unite 4 Our NHS campaign, Unite is urging members to take part in its New Year’s Resolution: ‘Save our NHS’ initiative, having designated January as its constituency lobbying month. A six-step activist briefing and a toolkit for constituency lobbying have been developed in order to send the government a loud and clear message: ‘Don’t destroy our NHS!’

Unite national officer Sally Kosky stated: ‘Throughout January, we will be actively demonstrating our opposition to job cuts and the proposals of the Liberating the NHS White Paper. We will be highlighting the cuts already made in local areas and targeting MPs with a clear message that there is no mandate for the changes proposed in this White Paper. We will also be getting further stories from members, photographing their local campaigns and interviewing them to illustrate the wide opposition against these proposals.’ Members are encouraged to support the campaign by following Unite’s six simple steps:

1. Add your name on Unite’s NHS supporters’ map
2. Stick up campaign posters in the workplace
3. Write to local newspapers explaining how privatising the NHS will damage local services
4. Tell local MPs why the government’s NHS plans are a bad idea
5. Get colleagues, friends and family involved
6. Book transport to London through your regional officer to take part in the Trades Union Congress demonstration on 26 March.

To further prepare members for successful lobbying, Unite has developed a toolkit comprising a guide to constituency lobbying, a Q&A briefing, an ‘ask your MP for action’ guide and a document of the promises that the coalition government had made prior to the general election and that have not been delivered.

Kin Ly, assistant editor

MacQueen Award 2011

Applications are being invited for the MacQueen Award 2011, which this year will recognise excellence in practice that demonstrates innovation and new ways of working in public health.

The winner will receive £3000 – £1000 for personal use and £2000 for professional use – in recognition of their personal achievement and to enable dissemination and publication of their work.

A ticket and travel and accommodation expenses will be provided to attend the Unite/CPHVA annual professional conference in Brighton on 19 to 20 October.

All applicants for the award should:

- Demonstrate innovation in practice – the project must be near completion or recently completed
- Show evidence of evaluation and the difference the project has made to peers, clients or service users in the project.

The deadline for applications is 5pm on 5 August. Shortlisted applicants will be notified on 19 August, and interviews will be held in London on 23 September (for which travel expenses will be recompensed).

Left to right: Lord Victor Adebowale and Jane Dauncey with last year’s MacQueen Award Excellence in Leadership winner Jayne Botham, and (right) with MacQueen Travel Bursary for Public Health winner Felister Heeley

MacQueen Travel Bursary for Public Health

REMINDER: the deadline for the CPHVA Education and Development Trust’s MacQueen Travel Bursary for Public Health 2011 is 28 February.

The travel bursary provides a one-off sum of up to £1000 to be used for travel connected with undertaking a public health project abroad.

For further information about the bursary or to receive an application form, please email: Ikenward@open.ac.uk

Make a New Year’s Resolution
Keep 2011’s New Year Resolution and download Unite’s constituency lobby materials:
www.unitemetheunion.org/health
Breastmilk

Aptamil

Cow & Gate

HiPP

SMA

LCPs* Nucleotides Galacto-oligosaccharides Fructo-oligosaccharides Antibodies Other

*Small balls represent LCPs at minimum expert recommendations. Large balls represent LCPs in excess of minimum recommendations.

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

A new tool produced to support urgent referrals of children who may be at risk of significant harm

Cheryll Adams
Independent advisor, health visiting and public health practice

Jane Barnard
Communications Department, Department of Health

Pauline Watts
Clinical lead community practice, Department of Health

The SAFER tool was launched at the Unite/CPHVA conference to support health visitors making appropriate, quality and efficient referrals to children’s social care when children are considered to be at risk of significant harm. It provides a process to prepare to make an urgent telephone referral, and communicate key information about the health visitor’s concerns when the referral is made or the child discussed.

The tool was developed by the Department of Health in liaison with national safeguarding experts, including senior health visitors and social workers working in child protection. It was tested with health visitors, social workers and others working in safeguarding. It is based on the SBAR (Situation-Assessment-Recommendation) model for urgent hospital referrals. That tool was originally developed by the US Navy, and adapted for use in health care by Dr M Leonard and colleagues at Kaiser Permanente, Colorado and the NHS Institute. The SAFER tool reflects current safeguarding policy, research and practice.

Need for the tool

Many health visitors are coping with very large caseloads with a significant number of very vulnerable children. Equally challenged are many social care teams, and it is essential that both sets of professionals are helped to ensure that information about any child at risk of significant harm is communicated efficiently and effectively.

The SAFER tool includes a checklist to help ensure that all necessary information has been assembled before making any referral. It then provides a framework to facilitate the easy transfer of information and enable the person receiving the referral to take any necessary action as quickly as possible.

The tool can aid health visitors and safeguarding lead or designated nurses in discussing concerns for the safety of any child. Those involved in the development of the tool felt that it would also provide a useful framework for written referrals to children’s social care.

Checklist and framework

The initial section of the tool states all questions to consider prior to making the referral:

- Have I assessed the child and documented my findings?
- Is there any evidence of substance abuse, domestic violence, mental illness, chaotic lifestyle or missed appointments?
- Has the situation been discussed with the child’s parents, GP, named nurse or allocated social worker (if there is one)?
- Who else is in the household? These questions were generated from the outcomes of serious case reviews and consultation to support urgent referrals of children who may be at risk of significant harm.

Box 1. SAFER five-step framework

- **Situation** – the health visitor gives their name, the name of the child and why they are calling
- **Assessment and actions** – the health visitor provides evidence for their concern and details of actions already taken
- **Family factors** – additional family factors that need to be passed on, including any strengths in the family
- **Expected response** – the health visitor may express the scale of their concern and request an urgent social care assessment
- **Referral and recording** – the health visitor should exchange names with the person taking the referral, request that they get back to them with the intended course of action, and put the referral into writing and record their actions

To download the tool, see: www.unitetheunion.org/pdf/NHS_Safer_tools.pdf

‘Each health visitor must take individual responsibility for sharing the tool’

Sharing and using the tool

Health visitors should work with their safeguarding leads to make sure that the local children’s social care departments are made aware of the tool and know to expect referrals using the SAFER process, and that these should be treated with particular urgency.

For this tool to be effective, each health visitor must take individual responsibility for sharing the tool with social care colleagues so that they understand and are familiar the tool and the benefits it can bring.
Research evidence

Changes in child development

Effects of smoke from neighbours
Children living in flats have higher exposure to second-hand smoke from smoking neighbours. Wilson et al. Pediatrics doi: 10.1542/peds.2010-2046

Military veterans: risk of suicide

Health, activity and gardening
A Netherlands comparative survey of allotment gardeners and their neighbours without an allotment. van den Berg et al Environ Health 9: 74

Immigration as pathogenic
A systematic review of the health of immigrants in Canada compared to the native population and over time. De Maio. Int J Equity Health 9: 27

Newborn deaths and deprivation

Child mental health: barriers
Qualitative study of influences on parents seeking help for children with emotional or behavioural difficulties. Sayal et al. Br J Psychiatry 197: 476-81

Talking sex: sons and daughters
Gender differences in factors associated with parent-child communication about sexual topics. Wilson and Koo. Reproductive Health 7: 31

‘Pee-in-a-pot’ screening days
Study of the acceptability and uptake of on-site ‘pee-in-a-pot’ chlamydia screening among students in Ireland. Vaughan et al. BMC Infect Dis 10: 325

Child maintenance information
The Child Maintenance and Enforcement Commission (CMEC) provides information and support for parents, and Unite/CPHVA is promoting awareness of its services among its members.

Professional officer Gavin Fergie stated: ‘Problems relating to child maintenance can have a huge impact on the lives and wellbeing of families – even more so when times are hard anyway – and it is important that practitioners are aware of the resources that are available to help with this.’

The CMEC can take parents through their options following a relationship break-up, and help them to arrange amicable private maintenance arrangements without going through the Child Support Agency.

The association is working with the CMEC and RCM to ensure that professionals have access to the resources that they can use with parents, which are available through the Child Maintenance Options website.

These include a template private agreement form, maintenance calculator, benefits table and budgeting tool, as well as leaflets on legal, housing and employment rights, emotional wellbeing and for grandparents. For these and other resources, see: www.cmoptions.org

For more information, both practitioners and parents can contact the service for free on Tel: 0800 988 0988, from 8am to 8pm on Monday to Friday and 9am to 4pm on Saturday.

Danny Ratnaike, editor

New resources
Unintentional injuries among under-15s
New guidance from the National Institute for Health and Clinical Excellence: www.nice.org.uk/PH29

Bog Standard School Toilet Awards
To recognise and develop good toilet provision for pupils to a nationally approved standard: www.bog-standard.org

Hello: encouraging communication
Year-long campaign with monthly themes exploring aspects of children’s communication development: www.hello.org.uk

Safeguarding training evaluation tool
NSPCC toolkit to evaluate outcomes of inter-agency child safeguarding training: www.nspcc.org.uk/inform (‘Training and consultancy’, then ‘Piat – Promoting inter-agency training’)

Scotland: national anti-bullying approach
New national framework to deal with the bullying of children and young people: www.scotland.gov.uk/Resource/Doc/330753/0107302.pdf

People in Public Health
Briefing on approaches in England to developing and supporting lay people in public health roles: www.leedsmet.ac.uk/PublicHealthRoles/PublicHealthRoles.pdf

E4E: Energise for Excellence in Care
Quality framework to support the delivery of safe and effective care: www.dh.gov.uk/en/People/Health/Pages/E4E.aspx

January 2011 Volume 84 Number 1 Community Practitioner 13
Letters: Educational supplements – impartial and reliable?

During our recent clinical supervision session much discussion arose around the recent educational supplements. Colleagues noted each supplement was sponsored by a company with an interest in the subject area – Nurofen for management of fever, Johnson & Johnson for skincare and Pampers for enuresis.

Colleagues concluded that although the supplements appeared to be well researched and were well presented, easy to read and interesting, their sponsorship by interested parties made us reluctant to change our practice based on their proposals. In the words of one colleague, ‘it would be like taking breastfeeding advice from a formula company’.

Also, I note that each supplement bears the statement ‘The CPHVA does not endorse any particular products from any manufacturer’, which appears to contradict the sponsorship of supplements.

Interestingly, the supplement concerned with nocturnal enuresis also makes reference to research obtained from the charity ERIC, which would appear a more appropriate source of relevant information.

It has been equally interesting to read the responses from readers to these supplements in the past two issues of the journal, which question the evidence base and proposals for practice within them, and also the responses from Gavin Fergie. However, this has added to my lack of clarity about the validity of the supplements, which as a newly qualified health visitor I welcomed as an easily accessible source of information for keeping practice up to date and continuing professional development.

My questions are therefore: How impartial is the evidence presented within the educational supplements, and as practitioners can we rely on the supplements to inform our practice with unbiased, evidence-based information?

Charlotte Smith
Health visitor, Cumbria PCT

The educational supplement (November 2010) on fever in babies recommends first-line treatment with ibuprofen. This ‘best practice’ recommendation is at variance with NICE guidelines that either ibuprofen or paracetamol be given if necessary to treat babies’ distress.

An article in The Times (4 December 2010) ‘How safe are children’s painkillers?’ quotes research published in the BMJ showing that one in 20 children developing cough or wheeze within three hours of being given ibuprofen.

Ian Bell, health visitor, Cwmerwyth

Joint response:

Thanks for writing in about this – it is really useful to get this feedback from readers who have been discussing the journal and these educational supplements.

As the responses to the letters in the December issue state, these supplements are made possible because of the support given by commercial partners, but they are approved as information based on available evidence by Unite/CPHVA.

Of course, there are (and always will be) some aspects of practice where there may be conflicting evidence or where the interpretation of the evidence does not agree, and the journal is the right kind of forum for professionals to discuss these issues.

The evidence presented in the supplements is certainly intended to be impartial, though it might include areas where disagreement exists and of course no evidence can be expected to be infallible.

As to whether practitioners can rely on the supplements to inform their practice, the answer would be yes, but ‘inform’ is the right word rather than dictate. Practitioners will no doubt use their own professional skills and judgement to appraise the evidence and decide how it may or may not affect their practice. We would also hope that discussing these issues both within the journal and in other ways among fellow professionals would assist this.

With regard to the supplement on fever in babies, this does not recommend that ibuprofen should be considered as a first-line treatment. It states that the decision tree should be followed, and is clear that the NICE guidance recommends either paracetamol or ibuprofen if the use of an antipyretic is then judged to be the appropriate course of action. It does question whether ibuprofen should be preferred over paracetamol in this situation, but it does not present this as a closed case.

There will be a hiatus between educational supplements in January and February, and Unite/CPHVA and the journal will use this time to explore ways to address issues relating to greater transparency about their authorship and editorial processes. We will of course take on board feedback from these and earlier letters in doing this.

Gavin Fergie, Unite/CPHVA
Professional officer and
Danny Ratnaike, editor

CPhVA Research Student Weekend: 5 to 6 March in St Albans

Are you a postgraduate research student (full or part time)? Studying for a master’s by research, or a doctorate? Why not join a group of like minded individuals studying topics around community practice for our CPHVA Research Student Weekend?

This will be held from lunchtime on 5 March to lunchtime on 6 March at All Saints Pastoral Centre, St Albans, with 24 hours’ full board, and expert facilitation from Professor Sally Kendall and Professor Pauline Pearson (Unite/CPHVA Research Forum).

The cost with all meals included is £110, and feedback from previous weekends has been very positive.

For further details and to book, email: s.kendall@herts.ac.uk or pauline.pearson@northumbria.ac.uk
The latest ESPGHAN opinion on the composition of preterm formulae

Latest ESPGHAN* 2009 opinion

* ESPGHAN states “In conclusion, there is not enough available evidence suggesting that the use of probiotics or prebiotics in preterm infants is safe. Efficacy and safety should be established for each product. We conclude that the presently available data do not permit recommending the routine use of probiotics or prebiotics as food supplement in preterm infants” 1

** “It is concluded that there is not sufficient evidence to generally recommend addition of nucleotides to preterm infant formulae” 1

- Nutrients such as sugars, amino acids, salts, minerals do not readily diffuse across membranes, increasing the length of time in an infant’s immature gastrointestinal system. The number of these nutrients contributes towards the feed’s osmolality

- When feeds are hyperosmolar, they have been shown to empty more slowly from the stomach than isotonic solutions,4, 5 and are associated with an increased risk of nausea, vomiting, diarrhoea, gastroesophageal reflux1 and have also been linked with necrotising enterocolitis (NEC) (inflammation of the gut)4, 7

The Committee on Nutrition of the American Academy of Pediatrics has considered the risks associated with hyperosmolar feedings and has recommended 400 mOsmol/kg as the recommended safe osmolality for infant formula8

The latest Tsang guidelines recommend that hyperosmolar feeding should be avoided, but do not provide a maximum level of osmolality for low-birthweight (LBW) formula9

SMA has the lowest osmolality of all the preterm/LBW formulas in the UK & ROI but still while providing a nutritionally complete low birthweight formula that is in line with the latest Tsang guidelines4

For more information on the SMA Gold Prem Range, visit www.smahcp.co.uk or www.smahcp.ie

IMPORTANT NOTICE:
Breast milk is best for babies. This product must be used under medical supervision. SMA Gold Prem 1 is a special formula designed for the particular nutritional requirements of preterm and low birthweight babies who are not solely fed breast milk.

References:
As we enter the New Year, many NHS staff are facing their biggest fight to oppose job cuts and further privatisation. The Office for Budget Responsibility has predicted that with the implementation of the comprehensive spending review, 490,000 public sector jobs will be axed by 2014 to 2015. There is uncomfortable uncertainty over the future and stability of health services as primary care trusts and strategic health authorities are due to be scrapped, and the *Liberating the NHS* White Paper reforms have been described as doing away with the founding principles of the NHS with increased threats of privatisation.

The number of people signing up to Unite’s online supporters map continues to rise. So far, nearly 11,000 have declared their support, and many have included their stories of how job cuts and reforms are forcing them to give up their careers.

**Resignation decisions**

All across the UK, many long-serving community practitioners are struggling to cope with increased work pressures bought on by further job cuts.

In Plymouth, one health visitor said: ‘I no longer get much satisfaction out of my job, as I feel I cannot provide the service I want to. Instead, we are just “fire fighting” and ticking boxes. If this carries on, I will be looking to leave a job that I have wanted to do since I was 19 years old.’

This is echoed by those who work in the school nursing service. A school nurse in Ealing stated: ‘I just want to retire. Because of cutbacks, over the years and especially now, we feel we are treading water and getting nowhere. We despair for the services we are giving young people now.’

In Cheltenham, school nurse Helen Somerville commented: ‘I believe that the NHS was a wonderful institution and have worked as a nurse for 30 years. I left my school nurse job this summer partly due to bad management, low morale, uncertain future, increasing workload and the prospect of moving to a social enterprise.’

**Job losses surfacing**

For some, it is not a case of deliberating over whether to leave the NHS. Some members are having to face the reality of losing their jobs.

Wrexham health visitor Moya Hughes, who started her career in 1979, said: ‘I have recently been asked if I would like to take a voluntary redundancy, and this is after David Cameron said he wanted to see more health visitors employed as part of his election campaign.’

In Edgware, London school nurse team leader said: ‘My band-8 manager has been made redundant. There have been two vacancies for over one year and I have just received a letter stating that due to reorganisation, I will be laid off in July.’

**Job-freeze frustrations**

In some areas, the newly-qualified struggle to find local employment due to efficiency savings. A health visitor in Wiltshire said: ‘I have just trained as a health visitor in the south. I could not get a job in that area when I qualified, despite there being a number of vacancies. This is due to recruitment freezes, despite that the government wants to increase the numbers of health visitors.’

There are worries that the school nursing service, which currently lacks sufficient numbers of specialist community public health-qualified and full-time school nurses, will be further diminished by these cuts.

All across the UK, many long-serving community practitioners are struggling to cope with increased work pressures bought on by further job cuts.
Show your support
Sign up to the campaign: www.unitetheunion.org/health

Unwelcome reforms
Members who will be directly affected by the Liberating the NHS White Paper reforms are apprehensive about its implementation. In Teddington, south-west London, health visitor Jane Murphy stated: 'I am concerned that if GPs take over the budgets, health visitors will be reduced to being handmaids to the GPs. Additionally, we have come under a hospital in Tooting and we are worried about money for the community being swallowed up by an acute trust. There are also concerns over the educational part of our role. If diminished, this may result in more children and young babies being admitted to hospital."

She added: 'What is very worrying is that this new government seems to have set out their stall with little or no consultation with the people who are doing NHS work and are very experienced. All they think about are cuts, cuts, cuts and nothing is negotiable.'

There are concerns about how the quality of services, particularly child protection services, will be affected if health visitors are asked to locate to GP practices. Moya Hughes says: 'The GPs have said that they want to work more closely with health visitors regarding child protection, which is commendable. However as child protection cases are usually very complex, these cases should quite rightly stay with their current health visitor.'

Moya is apprehensive that GP’s expectations for the change will be met with disappointment: 'It will take about five years until all the families will have a GP-attached health visitor – all the disruption and associated costs will not bring about the change that the GPs want and the price of losing close working connections with the children’s centre is a high price to pay. All my colleagues feel the same.'

Fighting power
There has been an increase in social enterprises, with the Department of Health announcing last year that a further 15 have been set up through the Right to Request scheme. It is clear that a lot of members do not want to be transferred to a social enterprise, and many have shown a great deal of fighting power to resist plans that could lead to further NHS privatisation.

A Cornwall health visitor stated: 'From 1 April, the district nurses, community hospitals and community therapy staff leave the NHS and transfer to a social enterprise. Decisions are still being made about where children’s community NHS services (health visitors and school nurses) are to be located. I go back to the basic tenet of Anwerin Bevan, who said the NHS ‘will last as long as there are folk left with the faith to fight for it’. We are rightfully proud to be part of the NHS workforce. The day to stand up and be counted has arrived.'

Somerset health visitor Lindsey Roth is another member who has fought long and hard to ensure that local services remain within the NHS. She says: ‘I have organised a campaign to stop our trust from becoming a social enterprise. We sent an open letter to our trust and asked as many staff as possible to sign it. We lobbied our local Conservative MPs and one of them wrote to the trust on our behalf. The local trades union council helped organise a lobby of the trust meeting, and we also had local radio and press coverage.’

She added: ‘As a result, the trust is now looking much more closely at merging with another NHS provider rather than social enterprise. We still have to carry on campaigning, but it shows that if you put up resistance and campaign you can have an influence on policy.’

January: lobbying month
Unite continues to support its members against the negative impacts of the government’s deficit plans and reforms to the NHS. It has stepped up its campaign,designating January as its constituency lobbying month with the theme ‘New Year’s Resolution: Save our NHS’. As part of this, Unite will be organising groups of members to lobby every MP.

To give further ammunition to local campaigning, Unite has developed a six-step campaign briefing and a constituency lobbying toolkit.

Unite national officer Sally Kosky states: ‘These resources will fully equip members to lobby their MP. We urge our regional campaign teams, regional officers and activists to organise groups of members to lobby their MPs’ surgeries. All members are encouraged to get their friends and families involved in the fight to defend our NHS.’

‘If you put up resistance and campaign you can have an influence on policy’

Get involved
For an update on Unite’s campaign see page 9, and to access the resources see: www.unitetheunion.org/health
Remember: CHIN

Breastfeeding is recognised as ideal for infants (World Health Organization, undated), but formula feeding has become the norm in many parts of the UK. The initiation rate for England is 73.7% but 56.9% is reported for the North East (Department of Health, 2010), and some health visitors report having few or no breastfeeding mothers on their caseloads.

Health visitors have a key role in promoting and supporting breastfeeding, but there is no specific requirement for this within specialist community public health nursing (SCPHN) education (NMC, 2004). There is variation in theoretical content between programmes, and some students may qualify with little or no experience of working with breastfeeding mothers.

North East drive

Victoria Head was appointed obesity delivery manager – infant feeding and North East regional infant feeding co-ordinator in October 2008. She successfully bid for funding to support the three health visitor training institutions in the region to be accredited by UNICEF as part of the Baby Friendly Initiative. This will hopefully ensure that newly trained health visitors have the theoretical knowledge as well as practical skills to promote and support breastfeeding.

Through this regional drive, I attended the UNICEF Train the Trainer training course. Learners delivered a brief session to peers demonstrating how they would teach an aspect of theory on breastfeeding. As part of my presentation, I developed the mnemonic CHIN (see Box 1).

This was based on the theory covered during the training and captured the main principles of good attachment. I have often used mnemonics within my practice and as a student to help remember key information, and there is much evidence to support their effectiveness (Bloom and Lamkin, 2006; Keshavan, 2010). Many memory experts use a range of mnemonic strategies to aid memory and recall (Collins, 2007).

Using the mnemonic

I hope that the CHIN approach may be of use to practitioners, but also to mothers, particularly in the early days of breastfeeding. Good attachment is essential to prime milk producing cells and stimulate production, and prospective and new mothers should receive support and advice on positioning and attachment (National Institute for Health and Clinical Excellence, 2008). The UNICEF trainers were impressed with the mnemonic and it has since been incorporated within UNICEF training programmes.

The approach has also been cited within regional resources used to support healthcare professionals and promote breastfeeding. In addition to this, Janette Westman (a midwife and lactation consultant, as well as working for UNICEF) has been using the approach in practice, with some positive feedback from breastfeeding mothers.

As pathway lead for health visiting at Teeside University, I am keen to embed breastfeeding education and training within our programme, and we are working toward having the SCPHN health visiting pathway accredited by UNICEF. I would like to investigate the value of the CHIN approach further before incorporating it within the programme. Wallace and Komsala-Anderson (2007) found that only 54% of practitioners felt competent or expert in positioning and attachment, and so the CHIN approach may be useful.

References


**Box 1. CHIN: Close, Head free, In line, Nose to nipple**

- **Close** – babies need to be held close during breastfeeding. This allows them to attach to the breast, but is also more comfortable for the mother
- **Head free** – the baby’s head should be supported, but free to move so that they may tilt their head to a good angle to attach to the breast
- **In line** – the baby should be held in line with the mother’s stomach. This is a guide for good positioning
- **Nose to nipple** – a good way to ensure that the baby is in a good position to be able to attach to the breast

We welcome feedback and interest from practitioners, email: l.harland@tees.ac.uk
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new baby toiletries

We couldn’t ask babies their opinions. So we did the next best thing, consulting an independent panel of mums and midwives. The result is All We Know, a range of baby toiletries designed to gently and safely care for baby’s skin.

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Evaluation of health services received by homeless families in Leicester

Maxine Jenkins QN, BSc, BA, RHV, RGN
Specialist health visitor - homeless families, Leicester City Community Health Service, NHS Leicester City

Craig Parylo BSc
Audit and information programme co-ordinator, Leicester City Community Health Service, NHS Leicester City

Correspondence: maxine.jenkins@lcchs.nhs.uk

Abstract
This paper reports on a survey of homeless families in 11 hostels in Leicester that aimed to inform improved services for them. Of 167 families, 49 agreed to participate. Health was important to the families, and respondents had mixed experiences of attitudes from healthcare staff. Some reported very supportive attitudes, while a small number perceived rude or unhelpful behaviour. While families had a high opinion of their health visitor, one-third did not know how to contact the service and 40% (n=21) did not know where their local children’s centre or Sure Start was. When asked about difficulties accessing health care, not being listened to and not having the time to explain themselves were the two most frequently cited problems. When asked what they would like from their healthcare, the two most frequently cited problems. When asked what they would like from their healthcare services and drop-in services were the next most important, though only 35% (n=17) had this facility. Flexible services and drop-in services were the next most frequently desired services. From the survey, recommendations have been developed that will guide the service over the coming year.

Key words
Homeless families, survey, health visiting, primary care, out of hours

Introduction
Leicester city saw the development of a new role for a health visitor working directly within the two main family hostels in August 2009. As a new service, it was important that service users’ opinions were elicited regarding the services they currently received in order to help identify any barriers to their health care. A survey was undertaken in response to the desire to develop a service that is responsive to the client group. However, homeless families understandably concentrate their resources on addressing their housing needs, and completing surveys is low on their priority list (Martin et al, 2005). A small grant was obtained from the Queen’s Nursing Institute (QNI) Homeless Health Initiative, enabling a participation incentive to be offered through a chance to win a £20 gift voucher.

Background
Despite living in the fourth richest country in the world, millions of people in Britain wake up every morning in housing that is run down, overcrowded or dangerous. Many others have lost their home altogether (Cullen, 2007). Homeless families often then move into temporary accommodation such as a hostel, but hostel life will continue to have a significant impact on a child’s health. Living in overcrowded accommodation or housing with shared facilities puts children at greater risk of infectious diseases (Office of the Deputy Prime Minister, 2004). Homeless children have six times as many speech and stammering problems compared with non-homeless children (National Center on Family Homelessness, 2003) and mental health problems such as anxiety and depression are increased (Vostanis et al, 1998). The research suggests that both short-term, severe housing deprivation and sustained poor housing experience can have a long-term impact on health (Marsh et al, 1999). In short, homelessness costs the NHS and there is growing evidence to demonstrate how these costs can be reduced or prevented by improvements to bad housing (Warwick School of Law, 2006).

Homelessness also affects access to health care. Traditional services tend to engage poorly with socially excluded people and vice versa (Department of Health/DH, 2010). Frequently, the complex challenges they face can mean many lead chaotic lives. Reducing lifestyle risks or maintaining the relationships with primary care providers that lead to continuity of care is not commonly a priority. Children and their families therefore often face the double disadvantage of both health inequality and difficulty of access to health services. Research has shown that many socially excluded clients have low health aspirations, poor expectations of services and limited opportunities to shape their care. They often report feeling invisible or discriminated against (DH, 2010). Given the health outcomes experienced by these children and their families, the ethical case for trying to improve services is clear.

Aim and objectives
The aim of the survey was to seek the views of clients who are homeless or in temporary accommodation regarding health services and how they would like them developed. This would provide a benchmark against which future surveys can monitor changes in service delivery. The objectives were to:

- Conduct a survey among families who are homeless or in temporary accommodation on opinions and use of healthcare services
- Where appropriate, identify areas of practice where improvement is needed and develop a remedial action plan

Method
As a quality improvement project, this service evaluation was within the remit of community health services to improve the care provided to homeless families, so required no research ethics review. However, ethical principles were adhered to throughout the study. The questions were based on a survey designed by the QNI (Tansley, 2008a).
Community Practitioner

Analysis

Completed surveys were returned to the specialist health visitor (SHV) for collation and then passed to the audit and information programme co-ordinator for descriptive and thematic analysis. This was done using Microsoft Excel and an online application to generate ‘tag clouds’ – visual representations where words that occur more often are displayed in darker and bolder type (TagCrowd, accessed 2010). The findings were discussed and evaluated, and specific recommendations for practice were developed.

Results and discussion

A total of 49 responses were received out of 167 hostel residents who were approached to take part (29%). The figure of 167 is an approximation, since a proportion of hostel residents were single adults, so not eligible for inclusion within this family-focused survey. A number of families were also moving in and out of the hostel at the time, so it is difficult to specify exactly how many families were in the 11 hostels and available for inclusion.

Of the respondents, 90% (n=44) were female, chiefly aged under 30 years (85%, n=42) and most (65%, n=32) had been homeless or in temporary accommodation for less than a year. In total, 43% (n=21) of respondents were aged under 20 years.

General aspects and attitudes

Nearly all respondents commented that their health was important to them. When asked about which aspects of health in particular, healthy eating, mental health, the health of their children and physical health were among the more popular responses.

Respondents had a mixed experience of attending health visiting centres, with ‘ok’ or ‘friendly’ towards their healthcare staff, with ‘ok’, polite, friendly and respectful being frequently cited.

It seems that despite some mixed feelings about staff attitudes, staff are professional when it comes to the respondents’ health, with positive comments being predominant.

Contacting the health visiting service

Respondents would contact their health visitor via hostel staff, phone them directly or via Sure Start. Not all respondents had children under the age of five, while the health visiting service is commissioned to provide services to under-fives. In future, a question should be added to identify families with children aged under five.

A large proportion of respondents knew who their health visitor was (71%, n=35), with fewer having had contact with them since their arrival at the hostel (67%, n=33). Despite this, 82% (n=40) knew how to contact their health visitor if they needed to.

Impressions of the health visiting service

Most respondents (51%, n=25) were positive about the health visiting service (see Figure 2), rating it as ‘excellent’ or ‘good’. A further 14% (n=7) felt it was ‘okay’ and 10% (n=5) ‘poor’. None rated it as ‘very poor’.

Reasons for rating the service as ‘poor’ included it being ‘hard to register’ and only receiving one visit from the health visitor despite their child being seven months old.

Reasons for rating the service as ‘okay’ included difficulty communicating with the health visitor, and preferring to see the health visitor away from the hostel.

Children’s centre and Sure Start

Of the respondents, 60% (n=28) knew where their nearest local children’s centre or Sure Start was, though only 43% (n=21) had attended.

Of those who had attended, their main reasons included activities such as stay and play, cook and eat and child-related activities (antenatal classes, baby-weighing sessions and breastfeeding group). Frequency of attendance included weekly, fortnightly and ‘when I can’.

Where respondents had not attended any of these centres they commented that there was no intrinsic barrier, citing instead busy schedules and simply ‘not been yet’.

Access and barriers

Access to health care appeared to be quite good, with no barriers cited by respondents. Most people described their GP (67%, n=33) as their main source of help with health care.
followed by family or friends (37%, n=18). Four respondents (8%) indicated that they had nobody who could help with their health care. However, these respondents later indicated that their first port of call for health care help was their GP.

Over 70% (n=35) of respondents would seek help in the first instance from their GP if they were ill. This was followed by family or friends (12%, n=6), the hospital or midwife (8%, n=4) or hostel staff (4%, n=2).

Most respondents (53%, n=26) sought health care when ill, rather than for information (8%, n=4), pregnancy care (4%, n=2) or emergency care (4%, n=2).

**Ease of accessing health care**

Most respondents (78%, n=38) had adequate access to health information, with only 6% (n=3) reporting difficulties with this. Positively, 71% (n=35) found it straightforward to find out where to access health care, and 76% (n=37) found registering with a GP uncomplicated. This contrasted with single adult services, where a dedicated GP service is not available and GP registration is often cited as being difficult (Crisis, 2002; Tansley, 2008b).

That families report few difficulties accessing their GP is remarkable given the disparity of service, in that residents of the two largest family hostels in Leicester are offered only temporary registration with the local GP.

Getting an appointment with nurses and other health professionals was relatively trouble free for most (66%, n=32 and 64%, n=31 respectively). Four respondents found this very difficult, but gave no reasons why.

While 67% (n=33) of respondents had no problems being listened to, a sizeable proportion (14%, n=7) said they had some difficulty. Also, 24% (n=12) found it difficult to get the time to explain themselves when seeking health care, with only 57% (n=28) confirming that they had this time. The dedicated single adult homeless service in Leicester provides GP appointment times of 20 minutes, whereas most GPs in the community provide appointment times of less than 10 minutes.

Over half of respondents (53%, n=26) had not needed to seek help for alcohol or drug problems. Of those who had, nearly all found this trouble free (95%, n=22). Similarly, 47% (n=23) had not needed to access help for a mental health problem, and of those who had 88% (n=23) found this straightforward. No reasons were given to explain why three respondents had difficulty with this.

In all, 90% (n=18) of those who accessed help for another reason found it unproblematic. Examples included getting support from hostel workers, getting appointments and general health issues. Where people found accessing help difficult, they gave specific examples of finding a school for their child, getting help talking to their family and accessing counselling.

Two barriers to accessing health care stood out – ‘not being listened to’ and ‘not having the time to explain myself’, both relating to aspects of communication with professionals.

**Threshold to seeking health care**

Most people (90%, n=44) waited until they were fairly or very unwell before they went to see someone. Only three (6%) felt they would seek help when slightly unwell. This is in line with the single adult homeless population (Quilgars and Pleace, 2003).

**Desired services**

People were asked to select from a list services they would most like to receive, and also to indicate whether they received them or not. By comparing the percentage difference, areas of unmet need were identified.

Respondents acknowledged that all of the services listed were not fully meeting their needs. The most unmet need was same-day appointments, with 84% (n=41) wanting this service (the most popular from the choices listed), yet 35% (n=17) received it.

Next followed a ‘flexible service’, which 55% (n=27) indicated they would like, yet 18% (n=9) received. A drop-in service was third most unmet (57%, n=28 wanting, 27%, n=13 receiving) followed by helpful staff (59%, n=29 wanting, 31%, n=15 receiving).

When asked for any other services, respondents provided the following comments:

- Midwives should be more helpful towards patients and have more time for people.
- Being taken seriously.
- If not registered, I still should be able to see a doctor.
- Drop in more often and person by person separately.
- Sexual health drop-in.
- [At] my local GP, the one near the hospital, the staff don’t give accurate information.
- It’s good to have someone to help if I have got a problem.

On reflection, the layout of the questionnaire was slightly unclear, leading some respondents to either bypass this section entirely or to tick the services they would like and not those they received. In any case, there are clear indications that same-day appointments and flexible services are the two most desired services that are not being fully met.

**Likes and dislikes**

When asked what they liked about services, some respondents identified the friendliness or approachableness of staff, being able to talk openly and having staff who listen, are helpful and friendly (see Figure 3). Another frequent comment was ease of access to the service, such as availability of same-day appointments and support in person or over the telephone.

When asked what was missing or what could be better, some respondents commented they would like better treatment from staff – there...
was perceived rudeness from some doctors and reception staff. Others felt that they would like better access to same-day appointments. This is strengthened by the positive comments from respondents who did have access to them. Same-day appointments may be valued more highly by homeless families, since when allocated a property they have only seven days’ notice to arrange to move in, so an appointment two weeks away would be too late. Others commented that there was nothing they would like improved.

Service improvement

Nearly half of respondents (49%, n=24) left this question unanswered. In all, 14% (n=7) agreed that the service had improved, while 37% (n=18) disagreed. One commented that accessing the service out of hours had improved, whereas another indicated that this had remained the same. From the other comments provided, it appears that most respondents who left the question blank did so because they had not been receiving services long enough to notice any changes.

Attendance at accident and emergency

Of the respondents, 53% (n=26) had used the accident and emergency (A&E) department and 43% (n=21) had not. Reasons for seeking help from A&E included injury, illness and emergencies when they could not contact their regular GP.

Use of A&E services was mainly infrequent or as required. It is interesting to compare this with data collected by the homeless health visiting service, which suggest that families use A&E services when urgent care could have been accessed more easily, such as using an ambulance to transport a child with a high temperature when a taxi could have been a viable alternative. A&E usage is low among homeless families in contrast to the single adult homeless population (Crisis, 2002).

Attendance at urgent care or walk-in centre

Only 27% (n=13) of respondents had used the urgent care centre or walk-in centre. They cited being unable to access their regular GP as the main reason for attendance, followed by typical responses such as when they or their children were ill. Anecdotally, it is noticeable that knowledge of these services among hostel children were ill. Anecdotal reports of homeless people with multiple needs have suggested that knowledge of these services among hostel children were ill. Anecdotal reports of homeless people with multiple needs have suggested that knowledge of these services among hostel children were ill. Anecdotal reports of homeless people with multiple needs have suggested that knowledge of these services among hostel children were ill. Anecdotal reports of homeless people with multiple needs have suggested that knowledge of these services among hostel children were ill. Anecdotal reports of homeless people with multiple needs have suggested that knowledge of these services among hostel children were ill.

GP out of hours services

Only 29% (n=14) of respondents had used the GP out-of-hours service, and 18% (n=9) had difficulties being discharged from hospital. Once again anecdotally, hostel staff have indicated they are unaware of how to access these services, especially where residents are only temporarily registered with the local GP.

While use of alternative out-of-hours facilities such as the urgent care or walk-in centre was much lower than that of A&E, it is clear from the comments that many A&E visits could have been treated equally well at services that were often more convenient in terms of location and waiting times.

Implications for practice

Based on this work, the following recommendations are planned:

- Disseminate the findings of this survey to encourage a more positive approach from staff toward service users and help to improve communication
- Promote local health services to hostel residents and hostel staff, as they are an important resource for health information
- Provide these findings to GP practices offering services to homeless families so that they can investigate ways to provide more flexible and same-day appointments.

The barriers to health care that homeless families face are not the same as those of homeless single adults. Registering with a GP is less of an issue. There are some similarities, such as needing time to explain complexities of the impact of social problems on health and gaining access to same-day appointments. However, this is the first survey of homeless families’ opinions of healthcare services in Leicester and further work is needed in order to gain a clear and accurate understanding.

Limitations of this work

Two main limitations were literacy and confidence. Some families would find coming down to talk to someone daunting in itself. Although literacy should have been resolved to some extent by having the volunteer available to support clients filling in the form, it takes confidence to admit that you need help and this may have deterred some from participating. Having someone present to assist may also have been off-putting, since they might have known how they responded to the questions.

Although the times to visit – mostly during office hours – were chosen by hostel staff as being when most clients would be around, it may have restricted participation. Since the size of the survey was small, care also needs to be taken when referring the findings back to the whole population. The following changes are recommended for future surveys:

- Revise the layout of the survey tool to clarify how respondents should respond to the questions, particularly with respect to the sections on unmet service needs and access to health services
- Add a question to identify which families have children under the age of five years.

Conclusion

The survey found that health was important to the families and respondents had mixed experiences of attitudes from healthcare staff, with some reporting very supportive attitudes and a small number of others perceiving rude or unhelpful behaviour. Knowledge of local health services could be improved. While families had a high opinion of their health visitor, one-third did not know how to contact the service and 40% (n=21) did not know where their local children’s centre or Sure Start was. When asked about difficulties accessing health care, being listened to and having the time to explain themselves were the two most frequently cited problems. When asked what they would like from their health care, 84% wanted same-day appointments and only 35% received this. Flexible services and drop-in services were the next most frequently desired. The recommendations from the survey will guide the service over the coming year.

Acknowledgments

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References


CONI: confirmation of continuing relevance after 20 years

Introduction
Sudden unexplained infant death (usually referred to as cot death) is the leading cause of post neonatal mortality. There were 312 cot death registrations in the UK in 2008 (0.39/1000 live births) (Foundation for the Study of Infant Deaths/FSID, 2010). The death of a child has a lasting impact on parents and certain life events will draw the loss to the fore even years later. One such is the birth and infancy of subsequent children about whom parents are additionally and understandably anxious. A research study (Emery et al, 1985) was funded by FSID to evaluate whether apnoea monitors reduced or prevented deaths in siblings of cot deaths. Monitors or weighing scales were randomly allocated but mortality was not significantly different between the two groups of babies. The results suggested that at least 6000 babies would need to be enrolled to properly evaluate the study, which became the Care of Next Infant (CONI) programme.

CONI involves the paediatrician, health visitor, GP and midwife. Each family is enrolled onto the programme by a specially trained local CONI co-ordinator, usually a health visitor. Parents choose from weekly or weekly weighing and room thermometer. In most areas, babies on the programme are offered fast access to a paediatrician. CONI is offered to women who have, or whose partners have had, a previous cot death. Support is offered until six months after birth, or until two months after the age at which the sibling died, whichever is the longer. CONI is currently available in about 90% of England and Wales and 100% of Northern Ireland, covering an estimated 49 million (89%) of the population in these areas.

CONI was originally informed by studies involving parents bereaved by cot death in the 1980s or earlier. The cot death rate has fallen by 75% since 1990, mainly attributed to the introduction of the Reduce the Risk campaign in 1991 that promoted back sleeping and other advice. This reduction is most noticeable among families in the occupational groups I, II and III non-manual and thus proportionally more deaths now occur in group V and the unemployed (Blair et al, 2006). We also have a greater understanding about how to reduce risk. CONI has been adapted over time, but given its origins one may ask whether the programme remains relevant and appropriate two decades later.

Rationale for support methods
The rationale for the support measures remain undisputed and in some cases it has been strengthened by later research. The support is offered for at least six months, as 90% of cot deaths occur under this age with a peak at two to three months. Risk falls away significantly beyond six months (FSID, 2010).

Health visitor visit
In Sheffield, a scoring system was used to identify babies with a statistically higher risk of death. Their health visitor visited these babies more frequently and the mortality in this group was less than predicted (Taylor et al, 1993). A similar outcome was shown in three other centres (Carpenter et al, 1988).

Symptom diaries
One-fifth to one-third of cot death babies were unwell in the 24 hours before death (Ward Platt et al, 2000; Blair et al, 2009), and symptom diaries are used to help parents identify significant changes in health.

Baby Check
Since 2009, CONI parents have been offered Baby Check (Morley et al, 1991). This comprises 19 simple checks to assess signs and symptoms in a young baby and is compatible with the symptom diary. Each check has a score and the higher the total score, the more unwell the baby is likely to be.

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Abstract
The Care of Next Infant (CONI) programme is offered through health services to provide extra support to families with babies born following a cot death. Audit of centrally collected data about families registered with the programme and feedback from parents show that compared with national data, families on CONI have more factors associated with an increased risk of cot death, confirming that a history of cot death identifies a particularly high-risk group. The programme, first offered to parents in 1988, remains attractive and helpful to parents in the 21st century. The CONI programme, including provision of a movement monitor, enables health visitors to deliver a targeted programme of extra care to a vulnerable group of babies.

Key words
Cot death, vulnerable families, targeted health visiting, respiratory movement monitor


Declaration of potential competing interests: Charlotte Daman-Willems is a trustee of FSID and chairman of its Information and Support Committee.
be. The total score is banded into four recommended actions, from unlikely to need medical advice to requiring urgent examination. Ward Platt et al (2000) applied Baby Check retrospectively to babies who had died suddenly, and found that 49% of those whose deaths were ultimately explained showed significant markers for illness in the 24 hours before death.

Weekly weighing
Poor weight gain is a feature in babies who die suddenly (Sinclair-Smith et al, 1976) and unexpectedly and regular weighing is recommended (Blair et al, 2000). The Sheffield Weight Chart has been designed to detect significant changes in weight over two- and eight-week periods.

Room temperature
Sweating and high rectal temperatures are described in cot death (Kinmonth, 1990) and simple room thermometers help parents to be aware of ambient temperature.

Method for evaluation and monitoring
CONI was not set up as a research study but with the consent of parents, data for audit purposes are collated in the CONI office based in the Academic Unit of Child Health at the University of Sheffield. These include a registration form giving details on the birth of the CONI baby, ethnicity, parity, parental smoking, employment and marital status. A symptom diary in the form of a tick chart is kept by the parents and a record card is kept by the health visitor logging all contacts with health professionals or agencies. A questionnaire for parents to feedback their views on the programme, is offered when CONI support is complete. These were mailed direct to parents until 2004 and subsequently via the local co-ordinator. Records for the first 10 000 babies enrolled were analysed. An additional 407 families (4%) were eligible but declined participation. As forms have been changed and adapted over the years not all variables are available for every baby and due to financial constraints data were not collected for a period. For 363 babies, only registration data was available, while symptom diaries and/or health visitor records were returned for 4761 babies (49%). Questionnaires were sent to 9361 families and 4742 questionnaires were returned (51%). SPSS 16.0 for Windows was used to calculate p-values.

Findings
Centres were recruited to the CONI programme from 1988 onward. Enrolments to the programme increased initially as new centres were recruited, and then decreased following the decline in the number of cot deaths (see Figure 1). The years of death for the siblings of the CONI babies ranged from 1970 to 2006, and the median interval between the death and the birth of the first baby in a family to be enrolled on the programme was 142 weeks.

CONI parents
Where possible, information on CONI parents and babies has been compared with general national data on parents and babies and/or data on cot death babies and their parents. Information on the ethnicity of the mother and father of the CONI baby, the marital status of the mother and employment of her partner has been recorded from 2002 (1326 registrations).

The major ethnic group is white British (see Table 1). The ethnicity of the CONI mothers is similar to the UK population as shown in the 2001 Census, in which 92% were white, 4% Asian and 2% black. A case controlled study to investigate the epidemiology of SIDS was conducted in five regions in England between 1993 and 1996, and this
found similar distributions of 94% parents white and 2% black (Fleming et al, 2000).

The majority of CONI mothers are unmarried, but only 11% are unsupported at the birth of the CONI baby (see Table 2).

In England and Wales in 2007, 7% of babies were born outside marriage and registered by the mother only. The cot death rate in this population was 1.42/1000 live births, nearly eight times the rate for babies born inside marriage (0.18/1000 live births) (Office for National Statistics/ONS, 2009). These two groups may not be strictly comparable, but it is probable that CONI single, unsupported mothers are a similar high-risk group.

Unemployment among CONI families since 2002 is 31% (see Table 3). Unemployment in the UK in the period 2003 to 2006 has averaged about 5% (ONS, 2010a). The CESDI SUDI studies (1993 to 1996) showed that unemployment in the cot death families was 25% compared with 8% in controls (Fleming et al, 2000). More recently in Avon between 1992 and 2003, unemployment in cot death families was 48% (Blair et al, 2006).

Risk of cot death increases with parity (Smith and White, 2006), and 41% mothers had three or more previous live births when enrolling on CONI for the first time.

Average number of children per woman in the UK has ranged from 1.63 to 1.96 between 1991 and 2008 (ONS, 2010b).

Taking into account that CONI mothers have suffered an infant death (unless history was through the father only) one might expect a history of two previous live births whereas 41% exceed this.

CONI babies

The mean birthweight of the CONI babies declined about 120g, from 3270g in 1988 to 3149g in 2006 (p<0.001). Correspondingly, the proportion of low birthweight CONI babies (<2500g) increased from 10% to about 17% (p<0.001) (see Figure 2), though in England and Wales, the proportion of low birthweight babies has remained constant over the same time period at about 7% (ONS, 2010c).

The percentage of CONI babies with a gestational age less than 37 weeks has shown a slight increase over the years (0.01<p<0.05) with a mean of 12%. Where known, the gestational age for all CONI births may be compared with the gestational age for all live births in England and Wales in 2005 (see Figure 3). In 2005, 7.6% live births in England and Wales were less than 37 weeks gestation (ONS, 2007).

Smoking

Information on smoking in CONI mothers is available from 2002. This has been consistent at about 55%. The proportion of SIDS mothers in the CESDI SUDI study who smoked during pregnancy was 66%. For 2005, in Great Britain, the General Household Survey reports 32% smoke in the age group 20 to 24 years and 31% in the age group 25 to 34 years (ONS, 2005). From 2003, the numbers of cigarettes smoked by the mother and her partner are available (see Table 4).

Breastfeeding

There has been a decline in mothers initially breastfeeding their CONI babies from over 45% in 1988 to 1990 to around 40% in 1993 to 2006, (p<0.01). Figures for England and Wales (NHS Information Centre, 2007) report 65% mothers breastfeeding in 1985 and 77% in 2005. However, the national figures relate to both first and subsequent births whereas about 97% of CONI babies are second or later in birth order. First births are more likely to be breastfed than subsequent births.

Table 4. Smoking by mother and partner

<table>
<thead>
<tr>
<th>Smoking</th>
<th>Mother</th>
<th>Partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>554 (45.5%)</td>
<td>429 (38.8%)</td>
</tr>
<tr>
<td>One to nine cigarettes per day</td>
<td>282 (22.3%)</td>
<td>213 (19.3%)</td>
</tr>
<tr>
<td>10 to 19 cigarettes per day</td>
<td>271 (22.3%)</td>
<td>268 (24.2%)</td>
</tr>
<tr>
<td>20 or more cigarettes per day</td>
<td>91 (7.5%)</td>
<td>158 (14.3%)</td>
</tr>
<tr>
<td>Smoking but number not stated</td>
<td>19 (1.5%)</td>
<td>38 (3.4%)</td>
</tr>
<tr>
<td>Total</td>
<td>1217 (100%)</td>
<td>1106 (100%)</td>
</tr>
</tbody>
</table>
Thus risk factors associated with cot death given by the health visitor at four or five. Prior to 2002, parents ranked the different elements of the programme in order of how much they had helped. Those using an apnoea monitor consistently placed the health visitor second to the monitor, but for the remainder, the health visitor was ranked first. Before 2002, parents were asked how the health visitor helped and they consistently identified listening as most important.

**Paediatrician**
At the start of the CONI programme nearly 70% of the babies were seen by the paediatrician after discharge from the postnatal ward and before the age of six months. This has declined to about 35% in recent years, (p<0.001). Of parents who saw a paediatrician between discharge from the maternity unit and six months of age, 86% graded this contact as four or five on the five-point scale.

**Support measures**
Use of the various support elements has changed over time (see Table 5). The monitor is graded four or five by 91% parents. Prior to 2002, parents ranked the different elements of the programme in order of how much they had helped. Those using an apnoea monitor consistently placed the health visitor second to the monitor, but for the remainder, the health visitor was ranked first. Before 2002, parents were asked how the health visitor helped and they consistently identified listening as most important.

**Overall view of programme**
The changes made to the parents’ questionnaires over the 19-year period, mean no single question on parental satisfaction has been asked of all parents. Up to 2002, 93% of the parents felt, in summary, that the programme had been helpful to them and 99% would recommend CONI to other parents who have had a cot death. From 2002, 79% of the parents returning questionnaires rated the CONI programme as ‘Very helpful’ i.e. ‘five’ and 14%, ‘Helpful’ i.e. ‘four’ on the five-point scale. Thus since the start of the programme a consistent 93% have rated the programme helpful or very helpful.

**Helping vulnerable families**
The Department of Health (DH, 2007) recognises the need for primary care trusts to provide support to families at risk of cot death and particularly where there has been a previous cot death. Epidemiological studies show that cot death is now predominantly occurring in social classes III manual, IV and V and the unemployed (Blair et al, 2006). Families living in deprived circumstances and with multiple problems can be difficult to engage in risk prevention strategies. Take up of the CONI programme is high. Parents are attracted by the monitor which provides parents with minute-to-minute reassurance that the event they most fear – the death of the CONI child while sleeping – has not occurred. Parents are told monitors do not prevent death and the monitor is used as a temporary tool to develop parental confidence. The provision of a monitor to this high-risk group is relatively low cost, and as part of the programme creates opportunities for health professionals to engage with parents. Compliance with safe sleeping advice, reducing smoking and breastfeeding will reduce the risk to the baby.

The health visitor support has been consistently highly valued by the parents. Recently health visitors have tended to move away from a universal service to a service targeted at the most vulnerable families (DH, 2004). We argue that the bereaved CONI families are some of the most vulnerable and socio-economically deprived families and should be among the groups targeted. We have used an Internet discussion forum to talk with a group of CONI parents. From the discussions it is clear that while anxious about their new baby their thoughts are also focused on the child that has died. The new baby is a reminder of the baby that is lost and for some their identities are confused. These parents are coping with a maelstrom of emotions encompassing anxiety for their baby, feelings of inadequacy and bereavement and in addition are more likely to have financial concerns and other social stresses. This is likely to explain the importance to the

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**Table 5. Change in use of support elements and parents’ grading**

<table>
<thead>
<tr>
<th>CONI surveillance</th>
<th>Change in proportion families used 1989 to 2006</th>
<th>Percentage parents grading 4 or 5 from 2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptom diary</td>
<td>90% to 75%</td>
<td>58%</td>
</tr>
<tr>
<td>Movement monitor</td>
<td>84% to 92%</td>
<td>91%</td>
</tr>
<tr>
<td>Sheffield weight chart</td>
<td>Constant 85%</td>
<td>77%</td>
</tr>
<tr>
<td>Room thermometer</td>
<td>Constant 85%</td>
<td>86%</td>
</tr>
</tbody>
</table>

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**Figure 4. Health visitor contacts per week**

- Total health visitor contacts
- Home visits
- Clinic visits

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parents of the health visitor listening to them. Home visits provide the best environment in which to listen to and advise parents. It is important that CONI families are visited initially by the same health professional. This reduces the need for the parents to repeat their history, which parents tell us they find distressing and frustrating and allows them to develop a trusting relationship such that they will share their confidences. Continuity enables the professional to gain a better understanding of the issues that are important to the parent or pose a risk to the child and allows advice to be offered with consistency and progression. In most instances the person best qualified to work with a family with complex needs is the family health visitor who can provide and orchestrate care for the whole family. Many health visitors now work in teams with community staff nurses and nursery nurses. Incidence of cot death peaks at two to three months (ONS, 2010d), parents report anxiety typically lessens past the age of the previous cot death (Bluglass, 1981). After these thresholds there should be a planned gradual reduction in contacts. This may include the introduction of other members of the team or a move to clinic contacts.

On-going analysis of babies on CONI who have died suggests that these infants were generally at even higher risk than the general CONI population (Carpenter et al, 2005). These risk factors will be readily identifiable by health visitors and in addition to those already mentioned include history of mental illness, substance abuse, domestic violence and children on the child protection register. These may not be easy families to help. We should be developing more intensive intervention for particularly vulnerable sub-groups.

Conclusions

The sudden death of a baby is a devastating loss for a family. The CONI programme is designed to help these parents during the anxious months after the birth of subsequent babies. The programme remains relevant for and valued by the high-risk target population. It is widely available and is taken up by the majority of eligible families to whom it is offered. The provision of a movement monitor and the involvement of the health visitor are central to this. The key aspects of the health visiting role are to:

- Listen
- Show empathy and enable parenting
- Optimise compliance with Reduce the Risk advice
- Encourage parents in objective assessment of baby’s health
- Identify and react to changing family circumstances
- Use monitor as a temporary tool to develop parental confidence
- Work toward withdrawal support at appropriate predetermined time
- Agree and deliver contact regimen.

Acknowledgements

The authors are grateful to the parents and health professionals involved with CONI for their co-operation. They acknowledge the valuable contribution of Professor Robert Carpenter, Dr Robert Coombs, Dr Marta Carpenter, Dr Robert Coombs, RC et al. (2005) Prevent sudden unexpected and unexplained infant deaths: natural or unnatural? Lancet 365(9453): 29-35.


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Discussion of the health benefits of breastfeeding within small groups

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Abstract
Breastfeeding is a key target in Sefton as rates fall well below the national average. This paper reports on an evaluation that set out to examine the usefulness of an interactive group session designed to explore the health benefits of breastfeeding. The session used a tool called the Breastfeeding Treasure Box, developed in the US but not previously evaluated. It consists of a box containing 14 items, each chosen to indicate a benefit of breastfeeding, together with a lesson plan. The evaluation was conducted in parentcraft sessions. Five staff with experience of delivering the session completed qualitative questionnaires and 48 clients completed questionnaires about their experiences.

Introduction
The 2005 Infant Feeding Survey (Bolling et al, 2007) showed that nationally 78% of babies were breastfed at birth. In Sefton, a borough of Merseyside, breastfeeding initiation in 2008 to 2009 was 55%. Only three of the 22 wards in the borough achieved a figure near to the national average. In wards with high deprivation indicators, initiation was as low as 31%. Sefton is one of the five metropolitan boroughs of Merseyside and covers an area larger than Liverpool or Manchester. In the south of the borough, people experience above average mortality from a variety of preventable causes (Sefton Community Voluntary Services, accessed 2010).

The Healthcare Commission (2007) identified breastfeeding initiation as a good proxy indicator for infant health, because infants who are not breastfed are five times more likely to be admitted to hospital with infections during the first year of their life. Increasing breastfeeding rates is one of eight operational plans (2008) to stem and reverse the increasing levels of obesity.

UNICEF’s Baby Friendly Initiative (BFI) states: ‘Inform all pregnant women about the benefits and management of breastfeeding’ (BFI, accessed 2010). Promotion of positive discussion about breastfeeding for those families and even practitioners where bottle-feeding is deeply embedded is challenging.

The Infant Feeding Survey (Bolling et al, 2007) found that mothers who said they intended to breastfeed were more likely to be aware of the health benefits. This suggests that raising awareness of the health benefits may be a motivating factor for the population of Sefton to support breastfeeding.

Social marketing data collected on behalf of three primary care trusts in North West England (Sefton, Liverpool and Knowsley) indicated that even those who felt ‘breast was best’ were easily swayed and believed bottle-feeding was almost as good, lacking knowledge of the actual health benefits (Alchemy Research Associates, 2008).

Sefton’s joint strategic needs assessment points to the need for a shift in culture where breastfeeding is seen as the first choice in infant feeding (Wilson, 2008). It identifies the need for better education for the whole family and across the age ranges.

Breastfeeding Treasure Box
In Sefton, breastfeeding was discussed during parentcraft sessions but no specific format was used. A staff change in 2008 provided an opportunity to develop a new approach. A search for resources found that tools enabling the development of discussion in small groups were limited.

A lesson plan for a ‘Breastfeeding Treasure Box’ was found on the internet, designed for use within a socially deprived community in Arkansas as part of a series of workshops for a Special Supplemental Nutrition Program for Women, Infants and Children (Arkansas Department of Health, accessed 2010). The project ran from 2002 to 2004, but it was never evaluated.

The lesson plan contained a list of 14 items that were selected to indicate a benefit of breastfeeding, along with instructions on how the session should be run. This was accepted as detailed enough to enable delivery without any specific training.

One session in which participants take an object from the box and put forward a possible benefit of breastfeeding is intended to encourage discussion, increase knowledge and stimulate participants’ interest to find out more. The interactive nature of the session allows members of the group and the group leader the opportunity to build upon experience and knowledge to help begin debriefing any preconceived notions or prejudices that individuals may have, helping people in the process of making an informed choice. Initial trial use of the tool proved successful with the group leader and the participants, so it was shared with the breastfeeding group to increase its use.

This paper describes a local evaluation of the use of this resource.
Aim and objectives
The aim of the evaluation was to examine the acceptability of the Breastfeeding Treasure Box in parentcraft sessions and consider its potential for other settings. The objectives were to assess:

- Opinions of staff regarding their experience of delivering this session
- Opinions of staff regarding the effectiveness of the session in different settings
- Opinions of participants regarding their experience of this session
- Whether participants’ experiences have resulted in learning
- Whether session participation resulted in any changes in personal belief or thinking.

Methods
Two questionnaires were designed, one for staff who delivered the sessions and one for clients who attended them. The validity of the client questionnaire was tested with staff who had experience of delivering the session and altered accordingly.

Staff questionnaires
Questionnaires were sent to staff electronically and collected by hand or email during May 2009. The small number of staff involved allowed the use of open questions (see Box 1). This enabled the collection of more in-depth answers and identification of common themes.

Client questionnaires
The client questionnaire used a five-point Likert scale and included two open questions. The scale was simple to construct, administer and score. It also gave the freedom for clients to have neutral views (Huxham, 2005).

Client questionnaires were completed following parentcraft sessions in children’s centres that were located in deprived wards within Sefton. They were distributed to participants and collected by the leaders during sessions that took place from May to July 2009, placed in a sealed envelope and returned to the researchers.

In line with recognised best practice (BFI, accessed 2010) participants were not asked if they were more likely to breastfeed as a direct result of this session. Instead they were allowed the opportunity to continue considering available information so they could make an informed choice when their child was born.

Research governance
Ethical approval was not required because this was deemed to be a service evaluation. The evaluation proposal and questionnaires were scrutinised by the local research governance and public and patient involvement committees. Amendments were made accordingly. Participants were given a letter informing them of the evaluation and asking for their participation.

Data analysis
The staff questionnaire was analysed to look for common themes using content analysis. The participant questionnaire was analysed using simple frequencies and qualitative data was analysed thematically.

Findings
Staff questionnaires
Six members of staff were surveyed, but one person did not return their questionnaire. The validity of the client questionnaire was tested with staff who had experience of delivering the session and altered accordingly.

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Data analysis
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Findings
Staff questionnaires
Six members of staff were surveyed, but one person did not return their questionnaire. The staff who responded included two midwives, a health visitor, a public health
nurse and an infant feeding support worker. The infant feeding support worker was also a La Leche League peer counsellor.

Four of the members of staff enjoyed delivering the session, and none were aware of any similar tools. One was unhappy at having to deliver sessions, but positive about the Breastfeeding Treasure Box itself.

In addition to parentcraft sessions, the staff had experience of delivering the session during or with:

- Antenatal clinics
- Children’s centre staff
- National Breastfeeding Awareness Week
- Teenage parents
- Reception staff.

In total, the session had been delivered 24 times. One member of staff had delivered it at 12 parentcraft sessions, one had delivered it eight times in four different settings, one at three parentcraft sessions, and one had only used it once. The size of the groups varied from two to 30 participants.

When members of staff were asked about training and preparation, no special training was identified by them as being necessary to run the session. Familiarity with the lesson plan and the items in the Breastfeeding Treasure Box along with observation of a session were identified as helpful. It was agreed that the more background knowledge a session leader had, the better their ability to deal with myths, answer questions and reinforce positive messages. In addition, it was identified that facilitators with less breastfeeding knowledge may need an additional source of support for further information.

All of the staff surveyed agreed that health visitors, midwives and peer support workers trained in breastfeeding could deliver the session. Opinion was mixed regarding the ability of nursery nurses, staff nurses, health trainers, children’s centre workers and teachers to deliver the session effectively. Knowledge, experience and enthusiasm were all identified as equally important to deliver an effective session:

‘Could be delivered by anyone who has background knowledge and is enthusiastic. I think better session delivered by someone experienced in breastfeeding as can give antenatal experience.’

Other appropriate groups identified included antenatal groups, postnatal groups, play groups, reception staff, child minders, child care students, school children, teenagers and groups for older people.

Specific advantages were reported:

- ‘Interactive.’
- ‘A great way to get breastfeeding across in a group session.’
- ‘Enjoyable and easy to deliver.’
- ‘People may only remember minor benefits.’
- ‘It is not sufficient as a stand alone tool in the antenatal period.’
- ‘Not everyone likes joining in.’

Client questionnaires

In total, 48 questionnaires were collected (see Tables 1 and 2). Of the respondents, 16 (33%) reported no family history of breastfeeding, 16 (33%) reported knowing much about breastfeeding prior to the session and two (4%) reported significant knowledge. This suggested that the majority of participants recognised they could learn more.

47 (98%) stated that they would recommend the Breastfeeding Treasure Box session to others.

Table 2. Client questionnaires: questions 9 to 11

<table>
<thead>
<tr>
<th>Statement/question</th>
<th>Yes</th>
<th>No</th>
<th>No response</th>
</tr>
</thead>
<tbody>
<tr>
<td>I want to find out more about breastfeeding as a result of today’s session</td>
<td>60% (n=29)</td>
<td>38% (n=18)</td>
<td>2% (n=1)</td>
</tr>
<tr>
<td>I would recommend this session to others</td>
<td>98% (n=47)</td>
<td>2% (n=1)</td>
<td>0</td>
</tr>
<tr>
<td>Was there something you learned that you did not expect to?</td>
<td>71% (n=34)</td>
<td>25% (n=12)</td>
<td>4% (n=2)</td>
</tr>
</tbody>
</table>

KEY POINTS

- Breastfeeding Treasure Box sessions were enjoyed by both staff and participants
- Participants reported learning and changes in the way they thought about breastfeeding
- The Breastfeeding Treasure Box lesson plan and contents could be developed to include more research based health benefits of breastfeeding
- The Breastfeeding Treasure Box has potential for use in a wide range of settings
- The tool is suitable to be used as part of a variety of approaches and in a variety of settings to increase knowledge and contribute to change in attitudes to breastfeeding

Health benefits for the baby included reducing the risk of diabetes, improving the immune response, the effect on a baby’s vision, the effect of jaw action on reducing ear infections, and reducing the risk of overfilling the baby’s small stomach.

Health benefits identified for mothers included reduction of breast cancer, weight loss and impact of breastfeeding on the menstrual cycle.

Social benefits included the potential for saving money, babies recognise mothers smell and ‘sweeter smelling poo’.

Eight participants stated that they learned many benefits including benefits for mother as well as the baby, long-term benefits and nutritional benefits.

One participant commented:

‘I didn’t realise there were so many benefits to mum and baby.’

Further information was requested on the social implications of breastfeeding and details about the composition of breastmilk, and two people requested information on the benefits of bottle-feeding.

Five people commented:

‘It was a very good session.’

One person commented:

‘It is a very interactive session, much better than leader led sessions.’

Limitations

The evaluation design allowed for distribution of the questionnaire to participants at five sessions, but at one session insufficient
time was allocated and no questionnaires were distributed. The option to return questionnaires by post was not given, but could be considered for future evaluations.

The staff reported that everybody attending the sessions completed questionnaires though the question on gender became invalid as some couples chose to complete one form between them.

Although the participants’ responses to questions were anonymous, staff could have introduced an element of bias because they had an opportunity to see the responses before returning them to the researchers.

The short time frame of the study meant that the total number of questionnaires was small. The evaluation did not extend to determining actual behaviours adopted or retention of information after the session.

Discussion

Overall, the Breastfeeding Treasure Box was viewed by staff and participants as an enjoyable and acceptable way to talk about the health benefits of breastfeeding. It encouraged participation, provided visual reinforcement and was preferred to either a leaflet or a DVD.

The package came with adequate resources, was easy to use and no specific training needs were identified. Staff saw potential for the tool to be used in a range of other settings. The best sessions were delivered by those with the most knowledge, experience and enthusiasm. It is interesting that enthusiasm was seen as important. This suggests that enthusiastic members of the community could be supported to gain the knowledge and skills to deliver the session to a wide variety of groups.

Background knowledge was important to enable the group leader to answer questions effectively, tackle myths and reinforce positive messages. The most highly trained staff should therefore deliver sessions to those who are in the process of making a choice about infant feeding.

Increased knowledge of the health benefits increases likelihood of people choosing to breastfeed (Bolling et al., 2007). It is therefore an important benefit of the session that knowledge is increased. The present lesson plan and contents of the box could be further improved to ensure that the group leader has an opportunity to cover health benefits that are supported by the most reliable evidence (BFI, 2008).

The objects in the box helped people to participate and were a significant aid to learning. This supports research that shows adult learners like to share their knowledge and contribute to the learning experience (Knowles et al., 1998). Regardless of any previous knowledge, the majority of the group learned something they did not expect to show, that the tool reinforces existing knowledge and builds new knowledge.

Although some participants were able to quote benefits of breastfeeding at the end of the session, it was not always clear if they had understood the whole message. This shows the need to reinforce benefits regularly throughout the antenatal period. The findings reflect that learning does not always result in an instant change in thinking (Knolb et al., 1974).

The National Institute for Health and Clinical Excellence (2008) recommends the adoption of a multifaceted approach across different settings to increase breastfeeding rates. The Breastfeeding Treasure Box is a suitable tool to help people through the changes in attitude necessary to achieve this.

Two suggestions were made about how to improve the session:

- Information about practical aspects of breastfeeding, which is now provided in a breastfeeding workshop
- Two people asked for information about bottle-feeding.

This reflects the findings of local social marketing research asking for a comparison of bottle versus breast, and has been provided by the development of a local leaflet and website (Alchemy Research Associates, 2008).

Recommendations for practice

- The most highly trained staff should continue to deliver sessions to those who are in the process of making an informed choice about breastfeeding, in order to ensure that questions are dealt with effectively
- The lesson plan and the box of objects need to be adapted to reflect more specific health benefits of breastfeeding as identified by the BFI
- This tool should be used not only in the antenatal or children’s settings but to educate those who may influence potential mothers, such as fathers, grandparents, childminders and teenagers
- Willing volunteers and workers from settings such as children’s centres should be trained to deliver this session so that a wider variety of people are reached.

References


Secure mother-infant attachment and the ABC programme: a case history

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Abstract
This case history describes the first application of the Attachment and Bio-behavioural Catch-up (ABC) programme in the UK. It illustrates the key role and value of primary care clinicians in early infancy. The health visitor’s careful and reflective observations, and her close links with a GP who shared her understanding of why these were significant, were the only means for this family to access help. The need for interventions in attachment is only likely to be identified by health visitors, with their unique opportunities to see families in their own homes.

Key words
ABC programme, parent-child attachment, parenting, infant mental health

Declaration of potential competing interests:
The programme reported on here was offered by NHS Greater Glasgow and Clyde Academic Department of Child and Adolescent Psychiatry

Introduction
This case history describes the identification of attachment issues in one family and the use of the Attachment and Bio-behavioural Catch-up (ABC) programme (Dozier et al, 2008) to address these. The parents gave permission for their case to be published, and their names and other details have been changed to minimise identifiability.

Early health visitor contact
During a primary home visit at 12 postnatal days to an apparently low-risk family, the health visitor noticed that the baby (Christopher) was asleep in a crib in the corner, where he was out of his mother’s (Jane’s) sight. Although the baby was well kempt and content, Jane did not use his name, referring to him in a detached manner.

During the initial assessment, Jane reported that the pregnancy was a shock because both she and her fiancé (Tom) had agreed that they did not want to have a family. She had not enjoyed the pregnancy but continued with it with Tom’s full support. She showed indifference when discussing Christopher, and blamed him for ruining their future plans. She never made any attempt to check on Christopher during the visit. Although concerned at Jane’s relationship with Christopher, the health visitor was reassured by the way she described her partner and his family’s growing commitment and positive interactions with baby. Jane was not low in mood and was very chatty about other topics, but the health visitor noted that ‘it felt bizarre as she seemed blind to her baby’.

Following this visit, Jane’s general practice case notes were accessed and the GP was asked if there had been any other concerns or relevant history.

At the next visit, the health visitor observed nappy changing and feeding. There was no eye contact and no evidence of reciprocity in the mother-infant interaction. The tasks were carried out with no verbal communication and with minimal touch, and Jane did not seem to recognise her baby’s cues.

Jane disclosed that she was an only child and had felt unwanted by her parents. She had left home at 18 and had little contact with her parents as an adult. She recognised the effect that her parents had on her by making her feel unwanted and unloved, and was anxious regarding the effect this would have on her baby.

She reported feeling nothing for her baby, even suggesting that ‘it’ would be better off being adopted. Both were distressed and eager to access additional help and support.

The GP’s perspective
Jane had a documented history of two previous episodes of mild to moderate depression, but had failed to engage with treatment offered by either a community psychiatric nurse or psychologist. She had not previously been able to disclose the extent of her difficulties in her childhood relationships with her parents to professionals. She had been prescribed antidepressants during these episodes, but had not used them consistently.

During her pregnancy she had initially said she was happy to be pregnant, but by the end of the second trimester she was beginning to show ambivalence and had not used any of the available sources of information or support in pregnancy. She was offered access to the local primary care mental health service. After the birth, she revealed to her GP that she felt negative about the baby and was irritable and low in mood.

‘She reported feeling nothing for her baby, even suggesting that ‘it’ would be better off being adopted’
Attachment and the ABC programme

Mary Dozier’s Attachment and Bio-behavioural Catch-up (ABC) programme is a 10-session manualised treatment that has been shown to enhance relationships and attachment (Dozier et al, 2008). Initially devised to support foster children with histories of adverse parenting, it was later offered to troubled birth families in Baltimore, US. The programme is delivered individually, usually in the home, and aims to develop a secure relationship between the baby and their caregivers. It has been shown to regularise the abnormal diurnal patterns of stress hormones found in children who have been abused or neglected (Dozier et al, 2008).

Attachment relationships in early childhood, first described formally by John Bowlby (1969), have long-term effects, providing a template for future relationships. Secure attachment relationships are protective against later emotional and behavioural disorders, while insecure attachment – most especially disorganised attachment – carries an increased risk for psychopathology. The impact of early relationships is pervasive. Attachment is formally measured through the Strange Situation procedure (Ainsworth et al, 1978) (see Box 1). This is an orchestrated series of separations and reunions involving the mother and a stranger, through elements of the child’s reaction and the mother’s response can be observed in normal clinical practice.

Adult’s conceptions of relationships, classified along the same dimensions as child attachment and assumed to be derived from childhood experiences, have been shown to predict the formation of secure or insecure relationships with their own children (see Table 1) (van Ijzendoorn, 1995). The parent’s adult attachment status also predicts their children’s later behaviour and wellbeing (Cromwell and Feldman, 1988, 1991; Cromwell et al, 1991; Main et al, 1985). The ABC programme explores patterns of attachment with the carer, using prepared videoclips of mothers and infants in the Strange Situation procedure (Ainsworth et al, 1978). The mother or carer is also video-taped interacting with the child and the resulting interaction is explored from an attachment perspective. Structured discussions are steered by the manual, and incidental observations of baby cues and maternal responses are highlighted during visits. The five key topics are:

- Responding to the infant’s need for nurturance even when the baby’s cues may not be clear
- Following the infant’s cues in interaction
- Reading child signals of a wish for engagement or disengagement, including fearful responses
- Exploration of the parent’s ‘voices from the past’, which might interfere with the parent’s ability to accurately read and respond to the baby
- The importance of touch.

Infant mental health: initial presentation
Mother and baby were referred to the local infant mental health programme by their GP, who noted that after an unplanned and emotionally turbulent pregnancy, Jane had no feelings for Christopher. When seen at home when he was eight weeks old, she expressed her detachment from Christopher and said that she had spent the morning ringing nurseries to see how young a baby they would accept so that she could return to full-time work. She said that if asked if she had a son, she would say no as she did not feel connected to him. She contrasted this with the possibility of finding an abandoned litter of kittens in an alley, which she would have no hesitation in adopting instantly.

Since she had disclosed her feelings to both her GP and health visitor, she evidently did have a concern about the relationship, and there was never any concern about Christopher’s safety in her care. However, it was clear that the care provided was instrumental rather than emotionally driven.

Christopher’s father, Tom, was warm and supportive and did all that he could to support his wife and son. It was through his wish that she had continued with the pregnancy, and he and his family proved to be a stable and loving background against which the intervention could develop.

The programme does not begin with any detailed examination of the parent’s emotional wellbeing or background, so there was much that was not known about Jane and her own childhood at first. What emerged was a picture of parents whom she

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Box 1. The Strange Situation (Ainsworth et al, 1978)

The Strange Situation was devised by Mary Ainsworth and colleagues as way to identify the attachment patterns of young children and their mothers or regular caregivers. There are eight episodes, each lasting a maximum of three minutes:

- The mother settles the child in an unfamiliar room
- A stranger enters, begins to chat to the caregiver, and then to the child
- The mother leaves the room
- The mother returns to the room and the stranger leaves
- The mother leaves the room
- The stranger re-enters the room
- The mother re-enters the room and the stranger leaves
- The mother stays with the child.

On the basis of the behaviour of the child at separation and most particularly at reunion with the mother, the relationship is classified as secure, insecure (avoidant or resistant) or disorganised. These classifications have been shown to predict the long-term emotional and social development of the child, with secure children being the most likely to thrive.
described as very young and caught up in their own lives rather than concerned with her welfare. In this context, she had developed a self-reliant, avoidant pattern of relationships, in marked contrast to that of her husband. She remained angry and hostile to her own parents and chose to keep them out of Christopher's life as she did not feel they 'deserved the right' to enjoy grandparental status.

The ABC intervention

Jane and Christopher participated in the programme weekly. The initial video sessions were stressful, with Jane finding face-to-face contact with Christopher very uncomfortable. She took her 'homework' very seriously and faithfully completed all the assignments. As the sessions moved on, she was able to talk about the detachment and unresponsiveness of her parents. She recalled that when she had a minor injury in a road traffic accident as a child, she did not tell them. On the positive side, she had a very warm and loving relationship with her grandparents. She contrasted her family with that of her fiancé, Tom, whose parents lived nearby and were always available for support and family events.

Over time, there were marked changes. Jane became more relaxed and Christopher more engaged. He particularly enjoyed the gentle touch sessions, stretching luxuriantly while massaged. This in turn led to Jane taking delight in his response to her. Jane began to notice when he was seeking contact and company, and would move him to where she could chat to him while cooking or doing chores. He remained good at entertaining himself but also responsive to contact.

At the end of the programme, it was clear that the trajectory of the relationship was set to be positive. Christopher and his mother came to the hospital department for a final session when he was 12 months old, to take part in the Strange Situation procedure. Christopher accepted the first separation without much distress but became distressed at the second. He was somewhat comforted by the entry of the stranger but then crawled toward the door whimpering and seeking his mother. On her entry, she picked him up and his equanimity was immediately restored. The relationship was classified as secure. Jane was gleeful in recounting that since the credit crunch had reduced mortgage payments, she would be able to spend a few extra weeks with him at home rather than returning to work immediately.

Discussion and conclusion

This clinical case, the first application of ABC in the UK, illustrates the key role and value of primary care clinicians in early infancy. The health visitor’s careful and reflective observations, and her close links with a GP who shared her understanding of why these were significant, were the only means for this family to access help. It would have been very easy to dismiss these early signs as being trivial in a family that had few overt markers of deprivation or dysfunction, but the long-term consequences of insecure attachment are well documented and profound. The need for interventions in attachment is only likely to be identified by health visitors, with their unique opportunities to see families.

University of Delaware. Trainees are required to have weekly supervision over the course of a year, which can be done online, and to submit three training cases.

Further information

For more information about the ABC programme, see: www.abcintervention.com

References


Infant mental health: effective prevention and early intervention

Dr Maria Robinson

‘Dr Robinson’s book should be read by every experienced health visitor to affirm and update their practice, and by all students learning the craft. It deserves to become a classic text in this field.’ Professor Sarah Cowley, King’s College London

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Adding to the team

Assistant practitioner – parenting: feedback about and evaluation of a new role within Lincolnshire health visiting teams

Wendy Burton
Neighbourhood lead – families and healthy lifestyles, Lincolnshire Community Health Services

The role of assistant practitioner – parenting (APP) has been established in Lincolnshire to provide early and timely support for pregnant women and vulnerable families with young children. This article reports on initial feedback and evaluation of the role.

National and local priorities
The aim of the role is to promote physical, emotional and mental wellbeing in line with Making it happen (Department of Health/DH, 2001) and the Healthy Child programme (DH, 2009).

The APP provides a package of support as directed by the health visitor, and additional capacity to promote positive and effective parenting in local authority priority areas. This is in line with local parenting, mental health and social inclusion strategies (Lincolnshire Children and Young People’s Strategic Partnership, 2009; Lincolnshire County Council, 2009).

Role and setting
The four APPs are based in two areas of Lincolnshire. Two are in Lincoln City, which was an original phase one Sure Start area and identified as a target area within the local authority and health for addressing inequalities in health. Another APP is based in Skegness, which was also a phase one Sure Start area, a seaside town has a highly transient population. The population of children and families increases in the holiday season when people move in looking for seasonal work. The fourth APP is based in Louth, a rural market town where there are pockets of deprivation and also an isolated rural community with poor travel links.

Under the supervision of the health visitor, the APP uses evidence-based practice to plan, deliver and evaluate interventions in a variety of settings to provide a family-centred service that enables individuals, families, and communities to achieve their optimum physical, psychological, educational and emotional wellbeing through a public health approach.

The APP accepts delegated responsibility from the health visitor for client care appropriate to their role, and delivers interventions in a variety of settings. The APP has a remit to address the key performance indicators for Lincolnshire Community Health Services families and healthy lifestyles services in line with the local agenda as identified in the local children and young people’s plan (Lincolnshire Children and Young People’s Strategic Partnership, 2009). Indicators include the prevention of childhood obesity, reducing the number of visits to hospital for unintentional and deliberate injury and keeping children safe.

Process
● The APP receives referrals from health visitors in an identified area of Lincolnshire
● The health visitor will make the referral following an assessment
● The health visitor identifies the needs of the family in conjunction with the APP and in partnership with the family, and together an action plan is formulated to address the needs identified
● Activities to be undertaken are time limited, with progress reported during and at the end of each programme of work
● If at any time during a programme of work the APP identifies a new need not previously discussed with the health visitor (for example, a safeguarding or mental health issue), they are aware that they must report this to the health visitor without delay.

Box 1. Feedback from parents
● ‘[The APP] has helped me and made me understand a lot more about my child’s behaviour. She also helped me see things from other people’s point of view. Things are a lot better now’
● ‘[The APP] introduced me to new people and has given me confidence to access groups’
● ‘Everything has improved dramatically. I feel much more confident in my abilities. I no longer feel ashamed to take my children out’
● ‘[The APP] has made a big difference in mine and my kid’s lives. Life has changed since I got the support of [the APP]’
Evaluating the new role

It was proposed from the outset that the role of the APP would be evaluated to measure effectiveness against key performance indicators. Evaluation is reported via testimony from parents, health visitors and partner agencies.

Evaluation from parents has been achieved using a pre- and post-intervention questionnaire. The parent reports identified need prior to intervention. At the end of the agreed time, the health visitor records a post-intervention report and the parents self-report their views on the care and support received. The questionnaires asked parents to rate responses on a five-point scale, where one was ‘not good’ and five ‘excellent’. The pre-intervention questionnaires asked:

- How does this problem make you feel?
- What is the overall impact on family life?

The post-intervention questionnaire asked:

- How are you feeling now?
- How has this support made a difference to your family?

Other methods of evaluation include recording and reporting the numbers of parents using the service including:

- Families registering and attending the children’s centre when facilitated by the APP
- Groups delivered by the APP in the children’s centre and other venues, such as baby massage, weaning and parent support.

Feedback from parents

The scores from the parent questionnaires all increased following intervention, suggesting that the APPs were playing a positive role in addressing identified needs for these families. There were 212 completed interventions in the first year. The total pre-intervention score from the parent questionnaires for these interventions was 490, and post-intervention score was 830.

Another important element of the evaluation was the comments from the parents (see Box 1).

Activities

The types of activity that the APPs worked on were many and varied, and most centred around parenting, behaviour, sleep, temper tantrums and children’s centre registration.

The APPs have commented that often they go to work with a family on one identified need to find that other issues come to light once they have gained the confidence of parents.

The level of support provided by the APPs is of a higher level than that identified in the initial scope of the job role. They are initiating and acting as lead professionals in Common Assessment Framework plans and working with families in the Child in Need and child protection arena. Further training has been provided in safeguarding children and also risk assessment. The APPs are supported in this role by the referring health visitor and line manager, and also have access to support and supervision from the deputy named nurse for safeguarding children as required.

The APPs have facilitated access to groups or provided group activities in a variety of settings. These have been on subjects including weaning, baby massage and accident prevention, and for new parents and teenage parents.

Colleague feedback

Testimonies from partner agencies have identified that the practitioners are delivering an effective service in the community (see Box 2). Health visitors in teams where the APPs are working have evaluated the role very positively (see Box 3). It is anticipated that other teams will recruit to this role when vacancies allow.

Conclusion

The APP role has succeeded in its primary objective to provide early and timely support for pregnant women and vulnerable families with young children in order to promote health and wellbeing and community engagement. From the evidence, it is clear that the role of APP has proved to be an innovative and effective addition to health visiting teams in Lincolnshire Community Health Services.

A perceived need of fixed-term low- to medium-level packages of care to support parents was identified and the role has been able to meet the need of families in these situations.

It is anticipated that the APP role will continue to develop, and that additional members of staff will be recruited in the future in order to widen provision across Lincolnshire.

References


Box 2. Feedback from partner agencies

- ‘The APP’s visits offer an excellent opportunity for the babies and toddlers to be seen by a health professional, where in certain cases those young mothers would not attend a clinic, nor remember to do so’
- ‘The work [the APP] has done in getting some of our most difficult to reach families into the children’s centre and attending her group has been nothing short of phenomenal’

Box 3. Feedback from health visitors

- ‘The role has been invaluable in supporting the needs of vulnerable families. [The APP] has been able to access the family quickly, assess the need accurately and thoroughly, delivers the package of care sensitively. Good communication is vital when different roles work when families, professional relationships have been enhanced and strengthened by excellent communication skills demonstrated by [the APP]’
- ‘[The APP] has been a great aid to parents and families, signposting them to appropriate agencies, seeking out funding from charities and encouraging parents to attend Sure Start, thus is resulting in improved parenting’
- ‘[The APP] has saved me many hours, her help has been huge in the last year’
Worth a look: KSF guide

A new guide aims to simplify the use of the KSF to improve appraisal and development reviews for NHS staff

Kate Oultram
Unite Health Sector organiser

Before you cry ‘Oh no, not another relaunch of the Knowledge and Skills Framework (KSF); it would be worth taking a look at the NHS Staff Council and NHS Employers’ new document Appraisals and KSF made simple: a practical guide. It is aimed at managers and staff, and provides useful tips and ideas for development reviews and appraisals, supported by the KSE.

As a barometer of your own experience, which of these statements (see Box 1) reflects your feelings about the KSF?

The next guide follows the Institute for Employment Studies KSF review and National Audit Office recommendations on Agenda for Change (AfC). NHS Staff Survey results on appraisal and review, development and learning have been patchy. The NHS Constitution pledges to support staff so that they know what they are expected to do, how to do it and how they can develop. Targets, objectives, staff development, service improvement and quality should all contribute to good care, and lower patient mortality rates have been linked with better quality appraisal and development reviews.

The guide supplements rather than replaces the KSF Handbook. Your reviews (as a member of staff or as a manager) should be regular, relaxed and reassuring, not stressful, hurried nor lengthy, and certainly not a tick-box exercise. The guide should provide:

- A clear, simple process for carrying out integrated performance appraisal and development reviews using the KSF
- A simplified format for the KSF core dimensions for all staff and managers, to help them use the framework effectively
- Practical tips and ideas to improve the coverage and quality of reviews.

Clear, simple process

Some organisations link their objectives and targets easily to those for teams and individuals, and build them into learning and development plans. Others struggle. Some organisations use completely separate processes for performance and development. When time is precious, it could make sense to integrate them.

Development and learning must affect achieving targets to reduce cost, duplication, clinical or administrative errors, and therefore improve quality and ‘productivity’. Most staff will have heard of the Quality, Innovation, Prevention and Productivity agenda, or taken part in consultancy exercises, especially in the light of the economic situation. Cost-cutting is seen as the main driver, and staff are concerned for patient safety and their own physical and mental wellbeing, often feeling under stress to ‘perform’.

Organisation objectives often appear high level and strategic. There are many factors that determine priorities for chief executives, directors and senior management teams. Budgets and stringent targets often appear at odds with patient care across communities.

It can be difficult for individuals and team managers to recognise how they can contribute to providing excellent services within very tight constraints.

The simplest way to look at objectives for an individual member of staff is to ask ‘why am I doing this?’ If there is something that does not ultimately result in a quality service for patients, families, carers and colleagues, it is probably not worth doing. For most, this simply means getting on with a good job. The KSF core dimensions cover virtually all aspects of what this means in practical terms.

Managers and experienced members of staff have a clearer view of why things are done within the organisation, and how best to make the most of scarce resources. Again, the core KSF dimensions indicate priorities to help everyone work ‘smarter, not harder’.

Simplified format

The simplified format covers the core dimensions – communication, personal and people development, health, safety and security, quality, service improvement, and equality and diversity. These are all relevant to every role across the health service, at whatever level the individual or team is operating. Get these right, and most issues (major and minor) should either be resolved, or not occur in the first place.

Some organisations found the handbook descriptions lengthy and off-putting. Since every KSF role outline needs to use all six core dimensions, this made developing outlines at relevant levels quite a task. The summary core dimensions in the guidance should help managers and staff to think about the levels required for each post.

Where groups of staff have not been used to concentrating on their own on-going

Box 1. Which statement reflects your feelings about the KSF most closely?

- We developed really detailed KSF outlines a few years ago, but don’t actually use them
- Our team decided to use the bits of the KSF we understood, and developed our own version – is that ok?
- Some staff like the KSF as it links their professional learning and portfolio development – why do two different things?
- We don’t have time to do appraisals or reviews, sadly no-one seems to mind
- The KSF handbook is just too complicated, plus we were waiting for job evaluations and the electronic staff record to get finished, so it still hasn’t happened here
- On my team, we each have monthly meetings with our manager, and a longer one every six months
- I’ve not had any learning on or off the job for years, we don’t even complete mandatory stuff
- We share team objectives, if we need training we try to agree so it gets done somehow
- In our organisation we get protected learning time, but we are so busy no-one takes it
- What’s the KSF?
Avoid the evidence paper chase
Regular contact, observation and working with each other day to day as a team should avoid the need to collect vast quantities of evidence. The same pieces of reflection and noting achievement can be used for KSF review and continuing professional development – both are about your practice, show you are doing a good job, and how you are progressing or need to develop.

Be realistic
No-one has infinite protected learning time. Some staff have no formal time given, even for mandatory training, Managers and staff need to be realistic about time, energy and other resources to make sure that everyone is supported and given opportunities to develop within their role. Most staff have a wish list of courses or learning, but caseloads are demanding. It has to be fair and reasonable for everyone to agree priorities with their manager and across the team.

How else can it help?
As well as sections on the process and practice to help with successful review and planning, there are six appendices that offer even more practical suggestions:
- Appraisal and development paperwork – if you do not already have something you are happy using, there are examples here
- An example of a post outline – if you are reviewing those early ones that ran to 60-plus pages, this could help people use them rather than keeping them in filing cabinets
- Objective-setting and appraisal resources – examples used by real organisations
- Summaries of the core dimensions that could be easier to tailor and use than the detail in the KSF handbook
- A new leadership and management dimension – although leadership is woven into the KSF dimensions, a separate dimension might make it easier to develop leaders and managers within your service.

Whether you continue to enjoy using the KSF or if it never quite took off in your organisation, this guide is really worth a look. It is or if it never quite took off in your organisation, this guide is really worth a look. It is not reflecting in the band-6 profile. Without support for a new generic band-7 profile, Unite’s Nursing Occupational Advisory Committee established a subgroup to support band-6 health visitors in submitting re-banding reviews. It found that increased points for at least five factors would produce 476 points, placing the job in band 7.

The national profiles can be accessed online (www.nhsemployers.org), and the third edition of the job evaluation handbook can be found there and via Unite (www.unitetheunion.org/health).
- KTE: the change in role since 2004 should influence this, the critical issue being ‘master equivalent’ – look at postgraduate qualifications with significant years of experience
- Planning and organisational skills: this could provide a score of 3 and an increase of 12 points – on-going planning, early support for children’s plans and child protection multi-agency professional lead
- Responsibility for patient/client care: this could be placed at level 5(c) and give an additional nine points – use of interpreters, and providing public health information and advice to families and specific groups such as asylum seekers
- Responsibility for HR: this should be at 3 and provide an additional nine points – student nurse training and annual mentorship, with on-going responsibilities for students and skill-mix developments
- Responsibility for information resources: this should be at 2 and give an extra five points – move from paper to electronic records and writing reports for other professional agencies and court reports
- Emotional effort: this should be at 3(c) and provide seven more points.

Barrie Brown, Unite Health Sector lead for nursing
500 miles charity: NF 12.9
acne and suicide risk: CP 12.19
Action on Health Visiting (AHV): C 1.3 NF 3.4, 4.4, 5.4, 6.7, 7.5, 9.10, 11.6, 11.10
adolescents see teenagers, young people
Agenda for Change (AC): Band 4 staff: NF 8.38
handbook: NF 1.6 YR 3.42, 11.44
local deals: YR 8.43
on-call arrangements: YR 12.45
pay scales: YR 6.42
alcohol use
death rates: CP 7.39
health damage: NF 3.8
minimum price per unit: CP 6.10, 7.10, 10.8, 11.8
NMC conviction policy: NF 9.6
parents: NF 10.8
teenagers: CP 12.19
All on a Day's Work, film: R 12.19
allergies
cow's milk: CU 5.40, 11.38
L 6.20
dietary factors: CP 8.36
early growth: CP 12.19
solid foods delay: CP 2.38
analogise use, decreased cancer risk: CP 6.41
Annual National Professional Forum (ANPF): NF 6.5, 10.14, 12.15
antenatal care: NF 11.6, 12.18
anxiety, pregnancy: CP 1.37
aqueous cream and eczema: CP 1.78
Arabic-speaking students: PP 2.23
arm's length bodies (ALBs): NF 9.6
Association for Young People’s
Arabic-speaking students: PP 2.23
assymal seekers: NF 4.4 PP 3.20
attention disorders, pesticide exposure: CP 10.41
autism
children’s information: R 8.44
GMc verdict: NF 3.5
incontinence advice: PP 10.24
older mothers: CP 4.41
parent training programme: PP 10.24
parents’ guidance: NF 5.6
babies see also children, immunisation, infant feeding, infants, sudden infant death
syndrome
communication: R 7.45
DH books: NF 2.9
fever supplement: NF 11.0
massage: L 7.22
passive smoking: CP 10.41
NF 2.8
sleep guide: R 9.43
Baby Café: NF 3.8
Baby Clubs online game: R 12.19
(cancer contd)
ovarian: CP 6.41
race
lease arrangements: NF 8.6
mileage scheme: YR 11.45
carbon monoxide testing: NF 8.6
cardiovascular disease (CVD)
bleeding effects: CP 11.15
diabetic risk: CP 8.37
salt intake: CP 2.39
cerebral screening: NF 6.7, 9.6
PP 6.30
Challenge me! mobility activity
card: CP 4.4
Change4Life: NF 6.10, 8.7, 9.6, 11.6
chilpeaks: NF 3.6
child abuse see also child protection, safeguarding
domestic: NF 8.10 R 4.42
gastrointestinal symptoms: CP 5.43
child and adolescent mental health services (CAMHS): NF 2.7
child development
allergies: CP 12.19
flat head syndrome: CP 4.40
growth charts: NF 2.9
height and weight data: CP 1.36
motor disorder: R 4.43
speech impediments: CP 1.36
child protection see also child abuse, safeguarding
from violence: NF 6.8
Laming report: NF 5.6, 6.4, 9.8
referral case rise: 6.10
Child public health (2nd Edn.): R 7.46
Childline: NF 6.10
childminders: NF 8.6
children see also babies, immunisation, infants, school nurses, children, See Start, teenagers, toddlers,
Unite/CPHA, annual conference, 2010,
young people
cancer awareness: R 11.15
child maintenance: NF 7.10
constipation: CU 7.40 NF 7.8
COPI factors: CP 3.38
dairy-free diet: CU 11.38
death: R 10.66
disabled: CP 6.40 NF 10.6
PP 4.19
eczema clinic: NF 9.36
health records: CP 1.36 NF 2.9, 11.18 PP 1.16
Healthy Child Programme: L 6.20 NF 4.4, 8.46, 5.36, 12.11
homelessness: NF 11.18 R 11.15
mental health: CP 2.7 R 4.42, 11.15
needs assessment: NF 3.36
R 4.43, 9.46
NFP programmes and crime: CP 3.38
obesity: CP 8.36 CU 1.32
NF 4.8, 4.36, 6.10, 7.10, 3.74
PP 6.26
oral disease: PP 2.18
outdoor play injury: NF 6.8
parent-child relationships: CP 9.38 NF 5.32, C 7.22, 8.27
poverty: CP 6.40 NF 6.6
pre-school: CP 4.41 NF 3.6
PP 11.33
Reach Out for Sick Children: appeal: NF 8.8
rights: NF 1.5
safeguarding: FL 3.16 NF 8.12, 9.8, 10.6, 11.4, 11.5 PP 1.16
R 7.46
smoke-free homes: CU 11.42
swine flu: NF 1.6, 2.7, 2.38
toilet seat dermatitis: CP 3.39
TV performance regulations: NF 2.8, 5.8, 10.8
violence: NF 2.34, 6.8 R 4.42
welfare cut effects: NF 11.7
Welsh helpline: NF 6.10
Children in Need grants: NF 2.8
children’s centres: NF 8.6 PP 11.27
Children’s Rights Bill: NF 1.5
children’s services
Basselaw: NF 5.36
competence: R 11.15
cuts: NF 7.4, 8.12, 9.5
NI: NF 1.7
public health: R 7.46
safeguarding: NF 11.4
Child’s world: R 4.43
Chinese medicine: FL 10.18
chlamydia: NF 2.6
copernic additional pulmonary disease (COPD): CP 3.38, 5.43
coffee, reduced diabetes risk: CP 6.41
cognitive Decline: CP 3.39
community nurseries (CNNS): handbook: NF 1.6, 11.11
writing: PP 12.34
HPC registration: NF 10.10,
11.11, 12.10
community nursing see also health visiting, health visitors, NHS,
Unite/CPHA
Band 4 staff: NF 8.34
development: FL 1.26
early intervention review: NF 9.8, 12.4, 12.5
ICCHNR symposium: NF 8.8
leadership: PP 7.24, 9.24
NI review: NF 4.8
quality assurance: PP 117.14
SCPHNs: C 2.3
sustainability: NF 11.16, 12.11
Community Practitioner
archive access: NF 11.48, 12.48
author guidelines: NF 6.18, 9.21, 11.36, 12.46
cover image: L 9.16
Harvard referencing: NF 11.25,
12.36
Supporting your contributions: NF 10.6
new look: C 11.3
Child: NF 10.6, 11.14
commuting and physical activity: CP 12.19
comprehensive spending review (CSR): NF 12.4, 12.7, 12.10
conference posters/papers: NF 12.11 RF 6.16
congenital anomalies: CP 4.41
Commissioning: CF information: NF 10.6 R 2.43
constipation, children: CU 7.40
contact: NF 7.8
ContactPoint: NF 6.4, 8.13, 9.8
continuing professional development (CPD): CP 10.3 NF 9.6, 10.6
contraception: NF 1.8, 7.10
corded blinds, risks: CU 2.40
NF 6.36, 8.10 P 7.16
coronary heart disease (CHD): CP 5.43
dead infants see sudden infant death syndrome
cows milk protein allergy (CMPA): CU 2.15
CPhA see Unite/CPhA
cradle cap: L 1.114
crime, NFP programmes: CP 3.38
dairy-free diet: CU 11.38
contraception: NF 1.8, 7.10
corded blinds, risks: CU 2.40
NF 6.36, 8.10 P 7.16
coronary heart disease (CHD): CP 5.43
dead infants see sudden infant death syndrome
cows milk protein allergy (CMPA): CU 2.15
CPhA see Unite/CPhA
2.40
Military and Civilian Health Partnership Awards: NF 7.6
cow’s milk allergy: CU 5.40, 11.38.6, 1.20
gnat’s milk: CP 5.42
mineral oil: L2.120
MIRI immunisation see also mumps
GMC: autism verdict: NF 13.15 teenagers’ status: NF 5.8
Mumps: FL 5.18
mobility activity: R 4.43
mortality statistics: CP 9.39
waist circumference: CP 10.41
mothers see also parents, postnatal depression, women age/citation risk: CP 4.41
asylum seekers: PP 3.30
Mobile Mums: FL 5.18
singing: NF 5.38
multi-agency teamworking: FL 3.16
NF 4.38, 5.36
Munro Review: NF 9.8, 11.5
mutual agreement: NF 5.38, 12.10
mutually agreed resolution scheme (MARS): YR 11.44
National Breastfeeding Awareness Week (NBFW): NF 6.5, 6.14
PP 4.29
National Childhood Obesity Week: NF 7.10
National Institute for Health and Clinical Excellence (NICE):
alcohol pricing: NF 7.10
antenatal care: NF 11.6, 12.18
blackface management: NF 10.8
chest pain guidance: NF 5.8
childhood constipation: CU 7.40
NF 7.8
emergency contraception: NF 7.10
health cash incentive: NF 11.8
lower urinary tract symptoms: NF 6.10
neonatal jaundice: CU 8.40
NF 6.12
nocturnal enuresis: CU 12.37
outdoor play injury: NF 6.8
National Obstetric Observatory (NOO): NF 7.34
National Pandemic Flu Service (NPSF): NF 3.8
National Professional Committee (NPC): C 5.3 NF 1.8, 4.34, 5.39, 6.43, 10.14, 12.35
National Quality Board: NF 2.33
National Safeguarding Delivery Unit (NSDU): NF 5.6, 8.13
NEET (not in employment, education or training): NF 10.6
R 2.4
neonatal jaundice: CU 8.40 NF 6.10
Nepal, health needs: FL 10.16
Netmums, healthy family eating: NF 4.8
life expectancy: 10.6
NF 2.41
NF 5.12
PP 6.22
NF 12.9
PP 2.27
National Week: NF 7.10
ParentsPlus: NF 1.6
parents see also families, fathers, mothers
Magazine, audit: PP 1.26
alcohol misuse: NF 10.8
in the home: NF 5.8
NMC employers’ guide: NF 5.8
privatisation: NF 3.6, 4.4, 5.8, 6.4, 9.14
return to practice: NF 4.6, 12.44
quality: NF 7.1, 8.7, 8.23
reforms: NF 2.32, 11.5, 17
social enterprises: NF 10.1, 2.5, 21.4, 3.22, 1.31, 4.14, 15.14, 1.78, 9.4, 9.7, 10.5
staff
Band 4: NF 8.34
BME role models: PP 12.30
Boorman Review: NF 11.8
NF 13.1, 7.43
increasing numbers strategies: NF 9.12
mutually agreed resignation scheme: YR 11.44
Open Your Mind Campaign: NF 7.43
cap: NF 2.4
Physical Activity Challenge: NF 11.8
recruitment and retention: YR 12.44
survey: YR 5.44
workforce statistics: C 6.3
NF 5.6
workload: YR 12.44
targets: Unit 4 Our NHS: C 8.3, 9.3
NF 9.4, 11.12, 12.4, 12.7, 12.9, 12.13
Wales: C 3.3
White Paper: C 9.3, NF 9.4, 10.4, 10.38, 11.5, 11.11, 12.4, 12.7
CNC: C 3.3
NHS 2010 to 2015 five-year plan: YR 2.44
NHS Evidence: NF 2.32
NHS SAFER referral tool: R 12.19
Nick Robin Memorial Lecture: NF 6.5, 12.9
nipple shield use: CP 9.39
NMC see also community nursing, midwifery
alcohol and drug policy: NF 9.6
consultations: NF 2.6
director of education: NF 11.5
evidence-based data: NF 7.10
physical activity: CP 12.15
Open Your Mind Campaign: NF 7.43
dental, Down syndrome children: PP 2.18
osteoporosis: CP 6.41
outdoor play injury: NF 6.8
cancer screening: NF 2.12
obesity
Nurse–Family Partnership (NFP): NF 3.8
nursing see also community nursing, NMC
in the home: NF 5.6
NMC employers’ guide: NF 5.8
prescribing: NF 5.6
Nursing and Midwifery Council see NMC
Nursing Times Hall of Fame: NF 4.6
nutrition see also diet, food
values: CP 12.10
November: CU 3.2
Mobile Mums: FL 3.18
mobility activity cards: R 4.43
NHS: C 3.9
Olympics toolkit: NF 10.6
parental influence: CP 11.15
stroke prevalence: CP 1.37
pneumococcal conjugate vaccination (PCV7): CP 10.40
44 Community Practitioner January 2011 Volume 84 Number 1
postnatal care: PP 12.26
postnatal depression (PND): CP 2.38, 10.4, 4.32
poverty
disabled children: CP 6.40
wellfare reforms: NF 8.10, 9.7, 11.7
Welsh children: NF 6.6
primary care trusts (PCTs)
prison, familial impact: PP 10.21
primary health care
public health
Welsh children: NF 6.6
welfare reforms: NF 8.10, 9.7, CP 2.38, 10.40 L 4.32
swine flu risks: CP 7.39 NF 11.8
smoking status: CP 10.41 NF 8.6
gestational diabetes: CP 4.41, PP 2.23
Early Explorer clinics: PP 11.33
pay: YR 6.42
training for non-SCPHN:
swine flu cuts: NF 6.8
social enterprise protests: NF 7.8, 9.7
safeguarding: NF 11.4
Mid-Staffs inquiry: YR 4.44
integration: NF 6.6
Bassetlaw children’s services: PP 2.23
new government: NF 6.4
charities: NF 3.6
Agenda for Change: YR 8.43
White Paper: NF 12.4, 12.7
sustainability: NF 11.16, 12.11
see also
community
see also
school meals: NF 2.8, 8.7, 9.6
schoolchildren
rubella
Royal Society for the Prevention of Respiratory illness: CP 9.40
research
reality TV shows: NF 2.8, 5.8
racial equality: NF 5.10, 12.22
professionals’ resource list: CP 2.39
Munro Review: NF 9.8, 11.5
domestic abuse: NF 8.10 R 4.42
children: FL 3.16 NF 8.12, 9.8, 11.7
Wales: C 3.3, 7.3 NF 7.6, 9.12,
staffing levels: NF 5.6, 9.12
SCPHN practice teachers: P 5.16
NI review: C 7.3 NF 4.8, 12.10
life skills: R 11.15
international conference: NF 7.7
Parliament’s Health 
professions: NF 1.10, 2.14, 3.14, 4.14, 5.14, 7.8, 9.7, 10.5
swine flu cures: NF 6.8
training for non-SCPHN:
NHS staff: YR 12.45
trade union facility time agree-
toilet seat dermatitis: CP 3.39
Tourette syndrome (TS): CU 8.38
together (Scotland): CP 11.15
solid foods, allergic risks: CP 2.38
Somali children, vitamin D
deficiency: CP 3.36
specialist community public health nurses (SCPHNs)
child obesity: NF 3.46
competence: PP 10.34
NMC review: NF 11.8
non-SCPHN training: NF 3.4, 4.5
school nursing: CP 4.39 P 5.16
care in need: R 4.43
recruitment and retention:
NF 7.7
socio-economic status (SES) effects:
CP 11.15
healthyness: R 7.43
UK response: NF 8.6
sex and alcohol: CP 12.19
television, child performance regulations:
NF 2.8, 5.8, 10.8
Telford and Wrekin PCT ballot: CP 10.40
tetanus vaccine: CP 9.40
Think Fathers campaign: NF 1.6
Thompson, Mark, journal contributions:
NF 10.6
To have or to have not: R 4.42
young facilitators: NF 2.8
school nurses: C 7.3 NF 3.10
young facilitators: NF 2.8
Transforming Community Services (TCS): NF 2.32, 4.14, 8.8
trade union facility time agree-
ments: NF 7.10
Trades Union Council (TUC): NF 10.7
traditional Chinese medicine (TCM): FL 10.18
training see also education
autism spectrum disorders:
P 10.22
learning in practice: NF 12.11
NHS staff: YR 12.45
non-SCPHN: NF 3.4, 4.5
rights: YR 9.8
school nurses: C 7.3 NF 3.10
young facilitators: NF 2.8
UNICEF Baby Friendly Initiative: NF 3.8
United facility time agreements: NF 7.10
general secretary ballot: NF 8.5,
non-SCPHN: NF 10.7
Chairman: NF 12.45
health care: NF 8.5, 9.6
health sector reps handbook:
NF 1.6
HIV suspension for poem: CP 2.6
LARs: NF 1.12, 3.14, 7.5, 8.16,
9.6, 9.27, 12.11
lease car arrangements: NF 8.6
membership form: NF 4.6
NHS cuts: NF 4.4, 7.4
pay cap: NF 2.4
working conditions survey:
NF 6.6, 6.12 YR 6.42
stress awareness day: R 11.15
leadership: NF 4.10
low-SES women: CP 11.15
maternal affection: CP 9.39
in pregnancy: CP 4.43
exercise: CP 1.37
salt intake, in infants: CP 1.36
sudden infant death syndrome (SIDS) see also babies, infants
investigations: CP 3.39
sleep position: CP 5.42
sugar consumption: CP 8.37
suicide risk and ace: CP 12.19
sun exposure: NF 5.7
proof

Public health nursing R 2.43
public sector
job cuts: C 6.3 NF 4.4, 6.4, 7.4,
8.4, 10.12, 11.7
leadership: NF 4.10, 5.10
pay: CP 2.4 YR 6.42, 12.44
postnatal care: NF 7.39, 9.11,
maternal occupation: NF 9.39
in pregnancy: CP 4.43

NHS cuts: NF 8.10, 9.7, 9.11, 11.7
Welsh children: NF 6.6
practice nurses: see also general practice
prescribing barriers: PP 1.21
practice teachers: NF 12.11 P 5.16
pregnancy
age at first: CP 12.19
anxiety—infant link: CP 1.37
asylum seekers: PP 3.20
DH books: NF 2.9
disabled parents: NF 9.8
excessive weight gain: CP 1.37,

see also
postnatal depression (PND): CP 2.38, 10.4, 4.32
poverty
disabled children: CP 6.40
wellfare reforms: NF 8.10, 9.7, 11.7
Welsh children: NF 6.6
primary care trusts (PCTs)
prison, familial impact: PP 10.21
primary health care
public health
Welsh children: NF 6.6
welfare reforms: NF 8.10, 9.7, CP 2.38, 10.40 L 4.32
swine flu risks: CP 7.39 NF 11.8
smoking status: CP 10.41 NF 8.6
gestational diabetes: CP 4.41, PP 2.23
Early Explorer clinics: PP 11.33
pay: YR 6.42
training for non-SCPHN:
swine flu cuts: NF 6.8
social enterprise protests: NF 7.8, 9.7
safeguarding: NF 11.4
Mid-Staffs inquiry: YR 4.44
integration: NF 6.6
Bassetlaw children’s services: PP 2.23
new government: NF 6.4
charities: NF 3.6
Agenda for Change: YR 8.43
White Paper: NF 12.4, 12.7
sustainability: NF 11.16, 12.11
see also
community
see also
school meals: NF 2.8, 8.7, 9.6
schoolchildren
rubella
Royal Society for the Prevention of Respiratory illness: CP 9.40
research
reality TV shows: NF 2.8, 5.8
racial equality: NF 5.10, 12.22
professionals’ resource list: CP 2.39
Munro Review: NF 9.8, 11.5
domestic abuse: NF 8.10 R 4.42
children: FL 3.16 NF 8.12, 9.8, 10.6, 11.4, 11.5 PP 5.16
socio-economic status (SES) effects:
NF 8.10
Munro Review: NF 9.8, 11.5

January 2011 Volume 84 Number 1 Community Practitioner 45
Author index

Adams, C 2.16
Adams, E 7.18
Adams, R 2.27
Ahmed, A 1.3
Ahmed, A 12.17
Amin, M 3.25
Ansell, P 2.18
Appleton, J 11.14, 12.7
Baggaley, S 7.24, 9.24
Bailey, S 12.26
Bantry-White, E 9.29
Barlow, J 11.33
Beddows, S 7.34
Bhrada, R 2.40
Bloomfield, L 1.26
Bolgar, R 4.29
Brewer, S 9.41, 10.42
Brimley, T 11.18
Brown, B 3.42, 5.4, 8.3, 11.44, 11.45, 12.45
Burton, L 3.16
Bussell, F 2.27
Caldwell, M 6.36
Cameron, S 2.23
Carson, M 7.24
Cartledge, P 5.40
Cassidy, C 5.32
Chetcuti, P 5.40
Chilvers, R 8.38
Chowdhury, U 5, 8.38
Clarke, A 10.16
Coe, C 11.33
Coleman, L 2.36
Condon, L 4.29
Cook, F 5.36
Court, C 7.36
Cowley, S 1.10, 11.21
Day, M 10.25
Devereaux, G 3.3
Dhir, S 1.32
Dickson, C 2.23
Douglas, H 8.22
Elliott, R 11.42
Errington, S 6.42, 8.43, 12.44
Fergie, G 3.41, 4.3, 10.14, 12.15
Fisher, M 2.35
Ford, K 8.40
Forge, F 1.16
Frampton, I 8.27
Francis, A 9.36
Frankland, S 12.34
Fraser, DM 9.19
Gilbberg, C 5.32
Gilmore, G 8.27
Glue, E 10.18
Glavin, P 9.29
Glen, F 2.36
Godson, R 2.32, 6.34, 7.3, 8.34
Gray, D 2.34
Greatax-White, S 9.19
Gregory, S 5.23
Hales, L 12.24
Hanley, V 3.38
Hanson, S 4.36
Hardy, S 6.26
Hardy, T 10.21
Haycock-Stuart, E 7.24, 9.24
Heywood, J 4.19
Hodge, D 5.40
Holden, C 5.22
Huc, S 6.30
Hughs, M 7.30
Hugues, R 12.18
Ilot, I 6.22
James, S 5.31
Jefferson, A 7.36
Jones, W 9.41, 10.42
Kamir, K 4.24
Kean, S 7.24, 9.24
Kelly, A 2.11
Kendall, S 1.26
Kennedy, K 11.38
Kraus, M 11.42
Lekka, C 6.22
Lewis, A 6.22
Lightfoot, T 2.18
Linnell, S 5.31
Low, E 6.26
Ly, K 1.12, 2.10, 3.10, 4.10, 5.10, 6.14, 7.12, 9.12, 10.10, 11.16, 12.15, 12.7, 12.22
Lyons, M 3.31
MacGregor, E 7.30
Maconochie, H 8.17
Mansfield, H 12.40
Martin, S 7.30
McComnachie, A 5.22
McDowell, L 5.40
McNeill, F 8.17
Micheson, J 2.36
Morris, D 8.27
Mountain, K 2.23
Munday, D 1.38, 2.4, 4.44, 5.3, 7.43, 10.44, 12.3
Neale, S 4.27
Norfolk, S 12.37
Oates, K 6.30
O’Donnell, A 3.25
Oluboyede, Y 6.22
O’Reilly, M 4.24
Osborne, S 3.31
Oxltram, K 9.43
Paul, SP 2.40
Paul, Ebhohimhen, V 6.30
Payne: 4.16
Pickering, N 10.27
Potter, J 11.40
Puckering, C 5.22
Ratnaite, D 11.10, 12.7, 12.14
Reay, K 9.9
Regan, P 10.38
Reynolds, B 3.30
Roberts, A 10.3, 10.14, 12.4
Roberts, D 10.27
Rollings, R 2.13
Rountree, J 2.34
Ryan, F 1.32
Scott, V 3.36
Sethi, S 7.16
Shain, N 2.30
Shore, S 2.18
Short, A 6.38
Smith, AM 2.27, 10.34
Smith, C 12.42
Smith, L 12.40
Snowden, M 10.21
Spencer R 9.19
Stark, C 6.30
Stein, S 8.38
Streeting, J 4.38
Symes, N 4.29
Taylor, C 7.34
Thompson J 1.36, 2.38, 3.38, 4.40, 5.42, 6.40, 7.38, 8.36, 9.93, 10.40
Tither, V 6.26
Tuffy, C 4.29
Tissington, H 10.30
Trivedi, S 12.40
Turney, N 3.25
Ullman, R 12.18
Unadkat, A 6.26
Upton, D 7.34
Van Hout, MC 5.27
Vice-Cain, S 7.36
Waring, M 5.36
Watson, L 7.40
White, M 3.20
Wilby, N 8.32
Wilson, K 5.40
Wilson, L 5.20
Wilson, P 5.22
Wootton, J 12.37
Woods, T 7.34
Yadav, V 4.24

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Cambridgeshire Health Visiting Service
Recruitment Day

Exciting Opportunities for Clinical Practice Tutors/Practice Educators (CPT's), Health Visitors, Staff Nurses and Nursery Nurses

Full/Part-time/Job Share opportunities available

Due to Service Transformation new vacancies have arisen throughout Cambridgeshire. We have exciting opportunities for Clinical Practice Tutors/Practice Educators (CPT's), Health Visitors, Staff Nurses and Nursery Nurses within the Cambridgeshire Health Visiting Service.

Our services are bordered by Lincolnshire, Bedfordshire, Norfolk, Suffolk and Northamptonshire. The population of Cambridgeshire is diverse covering rural and urban areas. This provides vast opportunities for professional development, up-skilling and the opportunity to specialise in particular areas.

CCS NHS Trust is committed to improving the outcomes for children and families, our teams benefit from support and supervision, training and career development opportunities are highly valued with staff progressing into specialist roles.

We have a flexible working policy in place to support work life balance, and relocation packages may be considered.

Clinical Practice Tutors/Practice Educators (CPT's)

Band 7: £30,460 - £40,157 p.a.
Ref: CCSP1370

Health Visitors

Band 6: £25,472 - £34,189 p.a.
Ref: CCSP1371

We have a number of vacancies throughout Cambridgeshire offering diverse opportunities.

Staff Nurses

Ref: CCSP1372

We offer unique opportunities for Band 5 staff nurse development. CCS have invested in specific training modules via local universities designed to prepare staff for Health Visitor training.

Nursery Nurses

Band 4: £18,152 - £21,798 p.a.
Ref: CCSP1373

CCS Health Visiting service are keen to develop the role of the nursery nurse. We have invested in a new Nursery Nurse professional lead post who will lead these clinical changes.

For full details on these vacancies and to apply online, please go to www.jobs.nhs.uk

Should you not have access to the internet please call 01480 398652 (24hr answerphone).

If you would like to speak to someone on an informal basis please contact Stephanie Dean, Team Manager for East Cambs & Fenland on 07900 264697 or Helen Greathead, Team Manager for South Cambridge on 07909 967154.

Closing date: 21st January 2011.

Interview/Recruitment date: 4th February 2011.

Should you be shortlisted for interview you will be required to attend the whole recruitment day.

We are an equal opportunities employer.
Certificated teacher training courses in developmental baby massage with Peter Walker

Two-day certificated teacher training courses in developmental baby massage with Peter Walker.
- Non-residential course on 2 to 3 April 2011 at Viveka, St John’s Wood, London
- Residential and non-residential course on 26 to 27 March 2011 at Emmaus House, Clifton Hill, Bristol.

For more details and ‘in-house’ teacher training in your area, email: walker@thebabieswebsite.com

Touch-Learn International Infant Massage Teacher Training Programme

Venues across the UK, plus in-house

An accredited five-day comprehensive infant massage programme for health and parenting practitioners, provided by Touch-Learn, the exemplary international training provider. This dynamic course includes simple massage techniques coupled with in-depth knowledge to practice safely and professionally, so practitioners feel confident to teach parents in a variety of settings. Also included:
- Research-based evidence
- Relevant anatomy and physiology
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- Free membership to the Guild of Infant and Child Massage
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Touch-Learn International Ltd
Tel: 01889 566222 or email: mail@touchlearn.co.uk
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Rhythm Kids

One-day, fun-filled workshop for baby massage teachers. Enhances child’s language, muscle, cognitive and vestibular development, as well as their social skills.
email: rk@touchlearn.co.uk

On-going, across the UK
Tel: 01889 566222 or see: www.touchlearn.co.uk

Baby Yoga

Two-day workshop for qualified baby massage teachers to enhance teaching skills. Supports bonding, attachment, parenting skills, physical development, relaxation.
email: yoga@touchlearn.co.uk

Access the online journal archive

All Unite/CPHVA members should be able to access the online journal archive:
- Select ‘Journal archive’ at www.commprac.com and log in using your Unite membership number
- You should then be able to search for articles on particular subjects or by specific authors, then select ‘Advanced search’ (toward the top of the page, on the right-hand side of the main search box) – remember to type ‘Community Practitioner’ in the publication box.

Are colleagues receiving their journal?

If any colleagues who are Unite/CPHVA members have not been getting their journal, ask them to email their name, membership number, postal address and telephone number to: danny.ratnaike@tenalps.com

NHS pension retrospective rule change

I am a health visitor who retired at 55 (under the special classes rule). I chose to commute the maximum amount of my pension into a larger lump sum. I returned to work on reduced hours, and have made every attempt to keep to the rule that my pension and my earnings must not exceed my salary pre-retirement.

After two years, NHS Pensions have made a new rule that the larger lump sum should be taken into account and now want to claim over £2000 back for each year. I can accept that they can apply this rule from now on but cannot accept it retrospectively. There must be other people affected in a similar way.

If so, I would be very keen to hear from them.

Annie Land
Tel: 01438 715166
email: anne.land2@nhs.net

Student Weekend

5 to 6 March, All Saints Pastoral Centre, St Albans
Are you a postgraduate research student (full or part time)? Studying for a master’s by research, or a doctorate? Why not join a group of like minded individuals studying topics around community practice for our CPHVA Research Student Weekend?

This will be held from lunchtime on 5 March to lunchtime on 6 March at All Saints Pastoral Centre, St Albans, with 24 hours’ full board, and expert facilitation from Professor Sally Kendall and Professor Pauline Pearson (Unite/CPHVA Research Forum).
- The cost with all meals included is £110, and feedback from previous weekends has been very positive.
- For further details and to book, email: s.kendall@herts.ac.uk or pauline.pearson@northumbria.ac.uk

Noticeboard listings

For a free posting, email: danny.ratnaike@tenalps.com

Noticeboard

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Diary listings

Tel: 020 7657 1804 or email: james.priest@tenalps.com

Noticeboard listings

For a free posting, email: danny.ratnaike@tenalps.com
Date for your diary:
Wednesday 19th and Thursday 20th October 2011

Venue:
The Brighton Centre, Brighton BN1

To receive regular updates please email:
info@neilstewartassociates.co.uk

Quotes from the 2010 conference:

Interesting, topical and supportive in helping form a vision for the future of health visiting – inspiring!
W Atkinson, SSAFA

Very informative and motivational
N Douglas, Community Health Oxfordshire

Morale boosting and a wonderful reminder why HVs are essential
V Lockyer, HMR PCT

Informative, enjoyable, topical and well organised, thoroughly worth attending
J Watt, Wolverhampton PCT

Well organised, interesting speakers, venue appropriate to our needs. Look forward to Brighton next year
E-A Strange, Aneurin Bevan Health Board

Really enjoyed this event – busy – good networking opportunities, discussion of our poster presentation and main themes
L Timms, Solent Healthcare
My baby brother would cry all night long! Mum said
“He’s got cowlick’
so she gave him Infacol.
Even though he stopped crying,
I gave him my moo-moo
just to be sure.

Anna, aged 8

suitable to use from birth onwards
- Effectively relieves wind, infant colic
  and gripping pain
- Clinically proven to reduce the frequency
  and severity of crying attacks associated
  with infant colic

Two thirds of healthcare professionals have consistently chosen Infacol® as their
preferred colic treatment since 2008

Infacol® is viewed as effective
and well-priced and achieves top
scores among colic treatments

British families’ No. 1 infant colic remedy

For further information, visit our website at www.infacol.co.uk

Infacol Prescribing Information
Please refer to Summary of Product Characteristics below prescribing

Presentation: An orange-flavoured, colourless, translucent suspension. Each ml contains 40mg
simethicone. Indications: An antiflatulent for the relief of gripping pain, colic, or wind due to
swallowed air. Dosage: Infants—one dropper full (2ml) in 5 ml of milk administered before each feed.
If necessary this may be increased to two droppers full (4ml) (max). Treatment with Infacol may
provide a progressive improvement in symptoms over several days. Contra-indications: None
stated. Warnings and Precautions: If symptoms persist, seek medical advice. Side Effects: None
stated. Legal Category: CII. Package Quantities: 50ml plastic bottle fitted with a plastic dropper
and exocone lid. Basic NHS Cost: £2.55. Marketing Authorisation Holder and Number: Forest
Laboratories UK Limited, Roorbridge House, Anchor Boulevard, Crossways Business Park,

For further information, or to request a copy of the Summary of Product Characteristics (SPC), please contact Forest Laboratories
UK Ltd, Roorbridge House, Anchor Boulevard, Crossways Business Park, Dartford, Kent, DA2 6SL. UK. Tel: +44 (0) 1322 421800.

Information about adverse event reporting can be found at
www.yellowcard.gov.uk. Adverse events should also be reported to
Forest Laboratories UK Ltd. Tel: +44 (0) 1322 421800.

References:
Colic Drops and Nurse Harvey’s Gripe Water.
3. IP Value and Volume Sales 52 week to 10 July 2010.