Oil or nothing?

When it comes to skincare, ‘natural’ doesn’t always mean safe, indeed olive oil can be harmful

Parents put their baby’s health first and new parents, especially, look to you for advice. For baby skincare, parents and healthcare professionals often assume that ‘natural’ is best.

However, there is strong evidence to suggest that natural products are not necessarily better than carefully designed alternatives.

When it comes to oils, vegetable oils are often considered more wholesome than mineral oil; however, such oils are associated with a number of potential disadvantages. Depending on the type of oil, its composition and active ingredients, the biological activity and toxicology of vegetable oils can vary, and they are often sensitive to oxidation and/or light.1

Parents are often advised to use shop-bought olive oil for infant massage or to treat areas of dry skin. However, a recent study concluded that this practice should be discouraged: direct application of olive oil damaged the adult skin barrier and caused redness, likely as a result of the high levels of oleic acid present in the oil. It remains to be determined, with further research, the effect of other vegetable oils on the skin.2

By contrast, pharmaceutical-grade mineral oil is non-toxic and very stable, and has a long history of proven efficacy in skincare.1 In fact mineral oil used in cosmetic products is highly purified and certified to be free of impurities.

Delicate baby skin deserves mild products that help maintain and enhance skin barrier function. If you’d like to find out more about the use of oils on babies’ skin, please contact jhocpcontact@its.jnj.com.

The evidence is clear... it’s time for a change

Johnson’s baby

Committed to advancing an evidence-based approach to baby skincare

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Gypsy and Traveller communities
An account of how a specialist health visitor has attempted to reduce prejudice and discrimination experienced by Gypsies and Travellers living in the UK

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Unite/CPHVA is based at:
Transport House, 128 Theobald’s Road, London WC1X 8TN
Tel: 020 3371 2006

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95% of Paediatricians\(^1\) reported an improvement in common infant feeding problems with a formula like Cow & Gate Comfort\(^1\)

Evidence shows these partially-hydrolysed formula milks containing oligosaccharides (GOS/FOS) improve the symptoms of colic in bottle-fed babies.\(^2\) So if a bottle-fed baby’s colic is more than mum can manage with practical tips alone, put digestive care first with Cow & Gate Comfort.

Learn more about the evidence-based management of colic at in-practice.co.uk

\*Important Notice: Breastfeeding is best for babies. Breastmilk provides babies with the best source of nourishment. 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 bottlefeeding may reduce breastmilk supply. The financial benefits of breastfeeding should be considered before bottlefeeding is initiated. Failure to follow preparation instructions carefully may be harmful to a baby’s health. Infant formula and follow on milks should be used only on the advice of a healthcare professional.

Ring out the old, ring in the new

Here we are, starting another year and who knows what there is in store? I believe the year 2015 will be positive in many ways.

How did we do last year? It was a year filled with many highs, but also lows. We are on the last leg of the Health Visitor Implementation Plan in England – a major investment that should be continued. The new NHS Five Year Forward View document released at the end of 2014 contains some very positive messages that will support community and the shift to primary care we have been waiting for. There were new announcements from Scotland with their ambition to increase the health visitor workforce by 500; absolutely the right move and one we will be actively supporting to ensure success.

However, yet again we had to hear about how we failed to safeguard children. Why as a nation do we continue not to get this right? We cannot rest while school nursing services are so stretched, and we neglect being able to give adequate time and support to individual children, including those who attend school and those who do not. I hope you are signed up to the manifesto and are supporting our 121 School Nurse Campaign.

Community nursery nurses are still facing problems with down-banding and service cuts, and CPHVA is challenging this where we hear there are issues, so do let us know about the situation in your area.

The publication of Roger Kline’s Snowy White Peaks report and other research evidence has shown how racial bias still exists in the NHS, and how it, in turn, leads to poorer patient outcomes. The issue has the attention of many, including Simon Stevens, the new NHS Chief Executive in England. He has stated his commitment to change and we are starting to see evidence – but we will hold him to account on this. We have to stop talking about equality and start doing it.

There are never enough hours in the day for our team to meet and talk to you all, so I would like to send a big thank you for your hard work and commitment to doing what is right for children and families. They are the reason we come to work every day and why we must remain ‘radical, professional, caring’.

Obi Amadi
Lead Professional Officer, Unite CPHVA
E: obi.amadi@unitetheunion.org
A report, Young People into 2014, a ‘unique contemporary archive’ of young people, has been published by the Schools Health Education Unit (SHEU). Each year, since 1977, SHEU carries out healthy lifestyle surveys with young people and, in 2013, this involved over 58,000 young people.

This report contains over 100 health-related behaviour questions and answers from over 30,000 pupils between the ages of 10 and 15. The report reveals details about what they do at home, at school and with their friends.

The data were collected from primary and secondary schools across England. Under the heading food choices and weight control, the survey found that:

- Sixty-two per cent of 14–15 year old females, 53% of 12–13 year old females and 33% of 10–11-year-old females ‘would like to lose weight’. This compares with 27% of 14–15 year old males, 32% of 12–13 year old males and 27% of 10–11 year old males who ‘would like to lose weight’
- Fourteen per cent of Year 10 females have ‘nothing at all to eat or drink for breakfast this morning’ and 20% had nothing for lunch on the previous day
- Less fresh fruit and vegetables are eaten as pupils get older and up to 55% report eating one to three portions of fruit and vegetables
- Up to 78% of 12–15 year olds reported drinking less than a litre of water.

The survey also discovered pupils are suffering from lower levels of self-esteem than they were in 2008.

Angela Balding, Survey Manager at the Schools Health Education Unit, said, ‘The rising trend of self-esteem from 1997–2007 stopped in 2008, and the figures we are seeing for high self-esteem in 2013 are generally lower now. The 2008 date coincide with the economic recession, so that’s a plausible explanation of what we see – but we are also aware of new pressures about being online and of online bullying.

‘We can see among the pupils with low self-esteem that they are much more likely than their peers to have experienced bullying at or near school in the last year. We don’t know if that’s because bullying causes a drop in self-esteem, or if pupils with low self-esteem are more likely to be picked on, or both.’
Association between increased LARC use and reduction in abortion

NEW FINDINGS, PUBLISHED in the International Journal of Women’s Health, show increased long-acting reversible contraception (LARC) use in England was significantly associated with decreased teenage pregnancy rates (under 18 years) and abortion rates in women aged under 20 years.

The research found that:
• Under-18 conception rates decreased significantly between 1998 and 2011, from 46.6 to 30.7 per 1,000 women
• Abortion rates in younger women (under 20 years) decreased between 1998 and 2011 and their association with increased LARC use in this age group was statistically significant
• The trend of LARC use observed over the entire 1998–2011 study period was an 89.7% increase. It is thought that the government’s 1999 Teenage Pregnancy Strategy contributed to the reduction in teenage conceptions over the 13-year study period. The strategy aimed to reduce the rate of teenage conceptions with the specific aim of halving the rate of conceptions among under-18s, and to set a firmly established downward trend in the rate of conceptions among under-16s by 2010.

Lead author of the report, Dr Anne Connolly, GP/Clinical Lead for Maternity, Women’s and Sexual Health in Bradford and Chair of the Primary Care Women’s Health Forum, said: ‘These findings are interesting because they demonstrate that the use of LARC can make a significant impact to the rate of unplanned pregnancies.

‘There are also US data to show that when women have full information about available contraceptive methods, many will choose intrauterine devices or implants. LARC methods have proven efficacy, and there is strong evidence to demonstrate the economic benefits resulting from the use of these methods from both a health and social care point of view.

Midwife-led care ‘safest’ for low-risk second pregnancies

ACCORDING TO THE NATIONAL INSTITUTE FOR Health and Care Excellence (NICE), the evidence now shows midwife-led care to be safer than hospital for women having a straightforward (low-risk) pregnancy.

NICE updated its guidance in December 2014, which also confirms that home birth is equally as safe as a midwife-led unit and traditional labour ward for the babies of low risk pregnant women who have already had at least one child previously. The updated NICE guidance says that women should be given this information to help them think about where they would most like to give birth, but that the final decision should be made by them and supported by healthcare professionals.

Professor Mark Baker, NICE’s clinical practice director, said: ‘Most women are healthy and have straightforward pregnancies and births. Over the years, evidence has emerged which shows that, for this group of women, giving birth in a midwife-led unit instead of a traditional labour ward is a safe option. Research also shows that a home birth is generally safer than hospital for pregnant women at low risk of complications who have given birth before.

‘Where and how a woman gives birth to her baby can be hugely important to her. Although women with complicated pregnancies will still need a doctor, there is no reason why women at low risk of complications during labour should not have their baby in an environment in which they feel most comfortable.

‘Our updated guideline will encourage greater choice in these decisions and ensure the best outcomes for both mother and baby.’


UNIONS HAIL ‘GREAT VICTORY’ AS MPS VOTE ON NHS BILL

The decision of MPs on 21 November 2014 to vote in favour of the private member’s bill to roll back the privatisation of the NHS was hailed as ‘a great victory’ by unions and health campaigners.

MPs voted by 241 to 18 in favour of the National Health Services (Amended Duties and Powers) bill, promoted by Labour MP for Eltham, Clive Efford.

Clive Efford said: ‘I am delighted that my bill has been passed with the overwhelming support of Labour MPs.

‘The Labour Party created the NHS and today we were out in force to protect it from competition from private companies, to exempt it from any Transatlantic Trade Investment Partnership (TTIP) agreement and to ensure that we prioritise patients not profit. But our fight isn’t over. Now we need to pressure the government to make sure that they take the bill straight to the committee and do not use delay tactics to try to stall its passage through parliament.

‘It is simple, we will not stand for this and my bill just signals the start. A Labour government would repeal the toxic Health and Social Care Act and ensure that we put patients back where they belong – at the heart of our NHS.’

Activists from the health unions, Unite, Unison and the GMB staged a candle-lit vigil in support of the bill on 21 November at Old Palace Yard, Westminster until the vote by MPs on the bill.

Unite head of health Rachael Maskell said: ‘This is a great victory for public opinion and is the first step on the road to restore the NHS to a service free at the point of delivery for all those in need. We must redouble our efforts to achieve this goal as the bill goes through the committee stage.’

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Health visitors ‘not yet feeling benefit’ of increased numbers

The health visitor workforce in England increased from 9,092 in 2010 to 10,383 in March 2014, according to new figures published by the Department of Health (DH).

The statistics were released in 2014 as part of the Department’s Quarterly Progress Report, which summarises the progress of the Health Visitor Implementation Programme in the second half of 2013/14 (from October to the end of the financial year at 31 March 2014). The report was developed by the DH in conjunction with NHS England, Health Education England and Public Health England.

According to the report, in 2013/14 2,046 health visitors completed their training qualification and there were 2,743 new starters on health visitor training programmes during the same period. This has increased from under 500 in 2009/10 to 2,743 in 2013/14.

The DH has assured health visitors that they will be supported in service improvement, professional leadership programmes and resources ahead of the transfer to local authority commissioning in October 2015.

In a recent interview with Nursing Times, Health Minister Dan Poulter described the expansion of the health visiting workforce as ‘the single biggest programme to improve the health outcomes and life chances of children and families in a generation’.

Dr Poulter stated that he is ‘absolutely confident’ that local authorities are ready to take on the responsibility of commissioning public health services. He said, ‘Local authorities are very close to the communities they look after. It’s absolutely the right place for health visitors to be working.’

Despite this, there are some concerns about the target of 4,200 extra health visitors being reached. Dave Munday, Unite Professional Officer, said, ‘I’m pleased that Dr Poulter is confident that the health visitor plan target figure will be achieved. However, we will of course continue to monitor whether this is the case as we get to April 2015.

‘Members across England continue to report to CPHVA that they don’t often yet feel the benefit of the increased numbers of health visitors. During our #CPHVAtt Twitter debate on the subject we provided updated graphs, which highlighted that only this year have we wiped out the decline in health visitors that was felt between the years 2000 and 2010.

‘During this same period, the increasing birth rate has meant that, in fact, we have more children per health visitor. To achieve the plan, the increase between August 2014 and March 2015 needs to be 19.8%’.

FOR MORE INFORMATION VISIT: https://storify.com/Unite_CPHVA/cph-vatt-2014-02-12

External review of CAMHS to launch in Wales

An Inquiry into Specialist Child and Adolescent Mental Health Service (CAMHS) provision in Wales has found serious failings, a new report says.

The National Assembly for Wales Children, Young People and Education Committee, led by Welsh MP Ann Jones, recommended a review into CAMHS in the country after it found that there were issues of concern that needed addressing, and that the service does not have capacity to meet current demands placed upon it.

The inquiry report’s key recommendations include that children and young people should get access to appropriate mental health services in a timely way, with an emphasis on arrangements for access to CAMHS on an emergency basis and out of hours, and transition from child to adult services.

‘The report states, ‘We will take forward further scrutiny of [the Welsh government’s] specific concerns about service provision in two key areas – prescribing trends for young people with mental health problems and primary care provision. We will undertake short pieces of work on both areas in the next year.’
HEALTH SECRETARY, Jeremy Hunt has launched MyNHS, available as part of health advice site NHS Choices, where patients and professionals can compare the performance of their local hospital, care services and their local authority.

Data have been added to MyNHS since September 2014, and now patients and professionals will be able to search information as part of the government’s transparency drive. Currently, the site holds around 45,000 pieces of data on health and care in England.

The launch comes on the one-year anniversary of the government’s response to the Francis Inquiry on Mid Staffordshire and is the first time any major health economy has gathered such a wide range of critical performance indicators together and made them available to the public in this way.

MyNHS now includes searchable data on food quality, staffing, patient safety and mental health, along with many other areas of care. From early December patients were able to see the Care Quality Commission’s individual risk rating for GP practices on the site.

The Department of Health in England says that over time, the data will allow the NHS and patients to better see and measure progress in health outcomes and will become an increasingly More data will be added, including one year and five year cancer survival rates for NHS trusts.

In a speech at the Foundation Trust Network Conference, Jeremy Hunt announced that the government will consult on including explicit rights in the NHS Constitution for patients and the public to have clear and comparable data about the organisations providing their care.

MyNHS to let patients compare care in England

AN INVESTIGATION INTO THE EXTENT of child sexual abuse in Northern Ireland has published findings, which suggest that there is work to be done to tackle the problem, but that there is a need for balance in response.

The inquiry draws attention to the emergence of an increasingly sexualised culture with exposure to text and online messages and content that renders children vulnerable to grooming, and threats specific to Northern Ireland, posed by powerful individuals with links to paramilitary organisations, where communities are reluctant to report due to fear of reprisals, and lack of confidence in the ability of authorities to respond effectively.

The report says that the government’s existing commitment to early intervention and prevention should be strengthened and that schools are identified as having a key role in raising awareness, and preventing, identifying and reporting child sexual exploitation.

Its recommendations include that there is a need for balance in the response to the reality of the problem, so that it:

- Does not focus purely on children in the care system
- Does not lead to a panic response that scares children and parents
- Does not result in a sudden lurch towards child sexual exploitation as a stand alone priority.

There is also a need to promote confidence on the part of children, parents, workers, including education and training, developing clear pathways for reporting and promoting an effective response.

Child sexual exploitation in Northern Ireland: ‘balanced response needed’

TO READ THE REPORT IN FULL VISIT www.dhsspsni.gov.uk/csereport181114.pdf

TO READ THE REPORT IN FULL VISIT www.dhsspsni.gov.uk/csereport181114.pdf

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Welsh CNO Annual One Day Conference: call for papers

T HE CNO IN WALES holds an annual showcase conference for nurses and midwives to gather together to re-invigorate their enthusiasm and pride in their profession by:

• Sharing good practice that contributes to improving patient care and patient experience
• Debating new ideas
• Celebrating successes.

The conference is open to all nurses, midwives, specialist community public health nurses, students and healthcare support workers.

In the selection of abstracts the planning committee are looking for presentations that:

• Demonstrate innovation
• Identify how to get from ideas to action
• Inspire others to think about how they could improve the care they give.

Categories

You are invited to submit an abstract for either oral and/or poster presentation on one or more of the categories listed below (the bullet points are to give you ideas on subjects within each category and are not exhaustive):

1. Leadership
   Encouraging or promoting clinical research and its application to practice
   Promoting professionalism.

2. Service OR Educational Development
   Promoting better health
   Effective and efficient use of resources to improve quality.

3. Workforce Development
   Working across organisations and/or disciplines
   Enhancing or developing a role or team.

4. Patient and Public Involvement
   Improving patient safety and/or managing risks
   Putting patients at the centre of care delivery.

Your abstract should describe best practice or innovation in the delivery of care. We are interested in organisational approaches as well as individual schemes. You may be describing a true innovation, or more likely, the implementation of a tested system within a particular setting. Please show how you used evidence and accelerated the uptake of best practice.

You may wish to reference codes of conduct, standards, relevant strategies, or the Welsh government’s Nursing Principles if appropriate to your submission.

There is a specific workshop session for new presenters.

The authors of the best conference poster in each category will receive an award.

To submit an abstract please visit the conference website: www.eventsforce.net/CNO2015

All abstracts must be submitted using the abstract template which you can download from the conference website. Abstracts that do not use the template will not be accepted.

Further guidance and submission instructions can also be found on the website. The closing date for abstract submission is 6 February 2015.

Jane Beach, Unite Professional Officer, said, ‘There are numerous examples of innovative practice by our members in Wales so please use this excellent opportunity to showcase it!’

Dangers of button batteries to children highlighted

THE CHILD ACCIDENT PREVENTION TRUST (CAPT) has begun a campaign to raise awareness about the dangers to small children of button batteries. The warning was highlighted recently with the case of Jack Taylor who swallowed one of the batteries aged 13 months and has endured several years of operations since. The small, round batteries are found in toys and everyday appliances like calculators and remote controls. They can be extremely dangerous for children, and if swallowed, can kill within a matter of hours. The CAPT says, ‘The scary thing is that your child may seem fine at first. They may not show any signs of choking or poisoning. In some cases, they may develop cold or flu-like symptoms. Button batteries are also dangerous if children put them into their noses and ears.’

For more information about the campaign visit: http://capt.org.uk/safety-advice/keeping-children-safe-button-batteries
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Important Notice: Breastfeeding is best for babies. Breastmilk provides babies with the best source of nourishment. Infant formula milks and follow-on milks are intended to be used when breastfeeding cannot or is not being done. The decision to discontinue breastfeeding may be difficult to reverse and the introduction of solid/porridge foods and/or the introduction of bottle feeding may reduce breastmilk supply. The benefits of breastfeeding should 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 should be used only on the advice of a healthcare professional.
Unite in Health online training

WE KNOW HOW IMPORTANT IT is to members in the health sector that they have time to develop their skills and knowledge. We also know that in the current climate this has become increasingly difficult to achieve. That’s why we’ve launched Unite in Health Thinking Thursday (#UiHTT) Online Training. These sessions will cover topics that our members tell us are important. The modules are free to Unite Health Sector members. To book your place, please visit: http://tinyurl.com/UiHTTonlinetrainingsessions

@Unite_CPHVA #CPHVATT

#CPHVAtt: WAVE Trust

IN NOVEMBER 2014 CPHVA hosted a joint Twitter chat with WAVE Trust on child protection and the work the trust is doing with practitioners to help improve outcomes.

@RosGodson
Do you think safeguarding is everybody’s business?

@derlor1
Absolutely but not everybody thinks it is everybody’s business. That’s the problem.

@WAVE_Trust
Great questions so far with @Unite_CPHVA. HVs are essential 2 70/30. Early Years Champions, some info here: http://wavetrust.org/our-work/campaigns/7030-campaign

@theresaLBishop
Video interactive guidance a strength based ebp for HVs to use to prevent maltreatment.

@RosGodson
Scottish GIRFEC guidance says “what can I do to help this child?”. What can my agency do to help this child?

@DawnStorey68
It’s the borderline cases with ‘hunch’ something not quite right that fall through net.

Twitter Tuesdays take place every week from 7–8pm. To join in, use the hashtag #CPHVAtt

ON 19 NOVEMBER 2014 I SPENT A DAY IN LONDON with Dave Munday, Professional Officer from Unite/CPHVA. After listening to a talk given by Dave at university about how the principles of specialist community public health nursing should not stop at the front door, I was inspired to learn more. This opportunity was a chance to increase my scope of knowledge and to gain a better understanding of what is going on nationally with regards to health visiting. I felt that this would help to enhance my learning and development in both the short and in the long term, and hoped that it would increase my confidence to meet with my local MP to ask what they are doing for the health visiting profession. On the day I arrived with an open mind, but Dave provided numerous learning opportunities for me, including continuous reflection on what I had learned from each meeting. He also proved a good tour guide for my first time in London!

The day began with an early commute by train from Wigan to London, where I was met by Dave at Euston. We headed over to the Unite office where I was introduced to the lovely team and we discussed plans for the day and any objectives that I wanted to achieve. I had a brief chat with Unite Head of Health, Rachael Maskell, about the impending strike action and the role of the union and its reps.

Next we made our way to the Community Practitioner journal office to chat to Editor Polly Moffat. We discussed the content and layout of the journal, and Polly was keen on my input for future topics to cover and we spoke about the process of writing an article for publication. We also briefly discussed the new-look website and the value of the CPD modules available to subscribers.

Afterwards, it was back to the Unite office where I chatted with Professional Officer Rosalind Godson about many things, including the 25th anniversary of the UN Convention on the Rights of the Child. We also discussed some relevant and current documents pertinent to both health visiting and school nursing. Rosalind is an extremely knowledgeable and passionate advocate for children’s rights and this was clear through her fascinating discussion.

After lunch we headed over to Portcullis House to meet with Sharon Hodgson MP about her brief as shadow minister for women and equalities. We discussed several other topics, including the 1001 critical days document and the importance of the role of health visitors and school nurses in early intervention, improved life chances, support for new mums and safeguarding children and young people, especially around the topic of female genital mutilation.

It was fantastic to hear such strong support from Sharon for both the Health Visitor Implementation plan and the CPHVA 121 campaign for school nurses. Dave and I joined Sharon for a Labour Party photo opportunity for the Back the Bill campaign (pictured above). During this I was able to meet my own local MP, and shadow health minister, Andy Burnham, who expressed his strong support for increasing the numbers of health visitors and school nurses. Meeting with political figures, especially if they are local, is a good opportunity to find out what they are doing for the profession and keeps the importance of health visitors at the forefront of their minds.

After a busy day and a whistle-stop tour of London on foot, Dave dropped me back at Euston station for the commute back to Wigan. During the journey I reflected on my day and how this was an excellent time to be joining this profession. The Unite professional officers work hard to influence and improve current policies and practices for professionals at a national level.

I was encouraged to contact my local branch of CPHVA and local politicians to take a more active role in promoting our profession. Although much of health visiting practice adopts a bottom-up approach to change, sometimes a top-down approach is vital to make a real difference and to influence on policies affecting health.

#adaywithDave: Tracy Dearden, Student Health Visitor, Wigan

For information visit www.unitetheunion.org/pay

Tracy meets shadow Health Secretary, Andy Burnham
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Less is more: the UK’s first reduced protein infant milk, now with alpha-lactalbumin

High protein intake in the first two years of life has been linked with an increased long term risk of being overweight or obese. Our new infant milk with 1.89g protein/100kcal, and added alpha-lactalbumin, is the first formula in the UK to contain less than 2g protein/100kcal (Figure 1).

The BeMIM (Belgrade-Munich Infant Milk) study

Aim: to prove the safety and suitability of the reduced protein formula for healthy term babies aged 0-4 months and non-inferiority compared to a standard formula.

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- Adequate growth: no significant difference in weight gain between formula groups
- Good tolerance and acceptance: both formulas were well accepted and tolerated. No differences in stool consistency and colour, colic, flatulence, regurgitation or vomiting
- Protein intakes closer to that of breastfed babies for those on the reduced protein formula (Figure 2)
- Positive influence on satiety: no compensatory increases in formula intake for babies on the reduced protein formula. In fact, these babies consumed significantly less energy at 90 days and 120 days of age compared to the control-fed group. This was explained by lower meal frequency, which might indicate higher satiety
- Improved energetic efficiency: Weight gain per 100kcal and length gain per 100kcal were significantly higher in the 4th month for the intervention group compared with the control group. This could be due to the improved protein quality of the intervention formula.

To find out more, visit hipp4hcps.co.uk

References:

Important Notice: Breastfeeding is best for babies. Breastmilk provides babies with the best source of nutrition. Infant formula milks 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 infant feeding may reduce breastfeeding supply. The benefits of breastfeeding should be considered before infant feeding is initiated. Failure to follow preparation instructions carefully may be harmful to a baby’s health. Infant formula and follow on milks should be used only on the advice of a healthcare professional.
The fight for fair NHS pay continues ...

RACHEL MASKELL
Unite Head of Health

ON MONDAY 24 NOVEMBER 2014, THOUSANDS OF NHS workers took part in the second NHS pay strike of the year. Members joined picket lines between 7 and 11am, and workers stuck to their contracted hours and took their breaks, commencing eight weeks of working to rule.

Workers have always had to fight for their rights. If we think about the raft of terms and conditions like holidays, maternity leave, sick leave, the national minimum wage, anti-discrimination laws and more recently carers leave, generations before us have fought for these rights ad had to make sacrifices to achieve them. It is now on your watch and the issue is pay.

We have now had two morning strikes in England and Northern Ireland over pay. We have now settled pay in both Scotland and Wales. We are in our second tranche of working to rule.

Working to rule is a very effective form of industrial action. It simply means working the hours you are paid to – starting and finishing work on time and taking your breaks. It isn’t easy for staff to stick with it, but the feedback we are getting is that it is really having an impact. It is putting pressure on services – and managers, if overtime is essential, are having to pay for the time staff previously gave for free.

At my local hospital, we are hearing directly from managers about how they are having to make adjustments to workloads accordingly. The work to rule also applies to managers. Your Trust needs to understand that the good will has run out, and that you and your staff will no longer cover for staff shortages.

In a recent survey, it was shown that NHS employers are squeezing the service and the staff for more without paying them to. Nightingale House Hospice, Chester Road, Wrexham LL11 2SJ.

Those wishing to make donations in memory of Betty should send them to: Nightingale House Hospice, Chester Road, Wrexham LL11 2SJ.

Unite CPHVA briefings

UNITE CPHVA BRIEFINGS ARE PRODUCED BY THE PROFESSIONAL officer team to give members access to the most up-to-date information on issues relating to practice. The following summaries are three of the newest briefings that can be read in more detail at your convenience.

School readiness: the role of health visitors, community nursery nurses and school nurses in ‘supporting children into school’

A new descriptor of children’s development has entered professional conversations: ‘readiness for school’. However, there is no agreed definition of what this means or how we should measure it. CPHVA members, as child public health specialists, need to clearly understand what we do as practitioners must be in the best interests of the child, and must resist any ‘tick box’ procedure which could adversely affect the child.

Mobile working for community nurses

Mobile working is the ability to work anywhere and at any time to access and update information from a supported mobile device. Unite has a network of trained health and safety representatives, and members are advised to seek their support before any decisions are made to change working practices.

Supporting pupils at school with medical conditions: the role of the school nurse

New statutory guidance for supporting pupils at school with medical conditions was published in April 2014 and statutory from September 2014. The guidance replaces all previous English government guidance and focuses on three key points: pupils with medical conditions should be properly supported so they have full access to education; governing bodies are responsible for ensuring arrangements are in place to support those pupils; the needs of children with medical conditions are effectively supported through consultation with health and social care professionals, pupils and parents.

Obituary: Betty Raymond

Ex-students and colleagues of Betty Raymond will be saddened to learn of her death last November following a short and painful illness.

Betty taught the Principles and Practice of Health Visiting at London South Bank University from the early 1970s until 2005. She was an important member of the Health Visiting team, who brought rigorous academic expertise and creativity to the programme, and was always willing to support students and colleagues alike in their work.

Following retirement, Betty became involved in many activities, including working for the CAB, singing in a choir, travelling widely with her partner Rosemary and most significantly, joining the Quakers with whom she took on several positions of responsibility. Betty and Rosemary moved to Wales last May and Betty became ill in August and died in a hospice on 17 November. She was sustained during this time by her deep faith and the devoted support of Rosemary and other friends, to whom we offer kindest thoughts and condolences at this sad time.

For more information about participating in action for fair pay visit the website: www.unitetheunion.org/pay

For a full archive, please visit: www.unitetheunion.org

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Fatherhood Institute: supporting fathers to play their part

WHETHER ALIVE OR DEAD, GOOD, BAD or indifferent, highly involved or rarely in contact, dads matter enormously to children’s health and wellbeing.

Fathers’ characteristics; their attitudes and behaviours around smoking, drugs and alcohol, nutrition, breastfeeding and postnatal depression; the quality of their relationship with the mother and with the child; and the nature of their parenting all have a significant impact. Long term, children with positively involved fathers:

• Have higher self-esteem and life satisfaction.
• Have greater capacity for empathy.
• Are less likely to get involved in criminality.
• Get better results at school.
• Have fewer behaviour problems.
• Make better friendships with better-adjusted children.

Levels of ‘nurturing hormones’ are the same or indifferent, highly involved or rarely in contact, dads matter enormously to children’s health and wellbeing.

The government and professional bodies now see early engagement with fathers as core business for health visitors. For example:

• The Department of Health Healthy Child Programme: pregnancy and the first 5 years of life stresses the importance of engaging with fathers.
• National Institute for Health and Care Excellence (NICE) public health guidance, Social and emotional wellbeing: early years recommends that health visitors develop the father–child relationship as part of a whole family approach.
• NHS Choices (www.nhs.uk) engages with fathers in pregnancy, birth and beyond by providing a dedicated online pathway for dads to receive information.

Why support dads?

Contrary to popular belief, fathers are ‘hard-wired’ to care for infants. A substantial body of research finds no biologically based differences between mothers and fathers in sensitivity to infants, capacity to provide intimate care or acquisition of parenting skills.

Levels of nurturing hormones are the same in men and women exposed to ‘infant stimuli’ before their babies are born (watching a video of a baby, listening to an audio-tape of babies’ cries, holding a doll wrapped in a blanket recently worn by a newborn) and when interacting with them afterwards.

How the Institute can help

The Fatherhood Institute (FI) has been training practitioners to engage effectively with dads and support father–child relationships since 1999. Our well evaluated ‘Creating father-inclusive health and social services’ course (www.fatherhoodinstitute.org/2011/creating-father-inclusive-health-and-social-services-one-day-course) has been shown to significantly improve health visitors’ and community practitioners’ knowledge and attitudes, and inspire changes in practice.

Our new ‘Bringing Fathers In’ resources (www.fatherhoodinstitute.org/bringingfathersin) build on the IHV briefings listed above. They include tips on how to make the most of fathers to support maternal and child health; ideas for attracting fathers to programmes; and a range of research summaries, including ‘Dads and hormones,’ ‘Supportive fathers, healthy mothers,’ ‘Fathers and attachment’ and ‘Co-parenting and early child development.’

To find out more about the FI, visit the website: www.fatherhoodinstitute.org

Letters

Dear Editor,

I was pleased to see two articles on maternal mental health issues in the October issue of Community Practitioner, and the health visitor role in addressing this significant health need.

There are so many possible causes and remedies for these illnesses, and the HV role in identifying and referring on is coupled with the supportive role in managing family outcomes. The health visitor is continuously searching for health needs but the public health nurse role includes proactive preventative health care and health promotion.

There is much current research which shows increasingly the links between nutritional status (especially with regard to DHA omega three oils from fish and algal sources with vitamin D) and mental health/neurological development of both mother and child.

I feel strongly that the SCPHN health visitor role would be better engaged in promoting better diet and nutritional status to reduce the incidence of postnatal depressive illness and other conditions than to spend large amounts of time offering CBT.

An important HV role is to recognise and refer to specialist services, and I hope that we might soon see an increase in funding and recognition for those mental health services, which can be difficult to access.

Midwives in our area are already routinely referring for antenatal assessment and care of women with a history of depressive illness. I hope, in time, postnatal depression may be reduced in incidence and effect.

Yours sincerely, Bernie Wood, Health Visitor

January 2015 Community Practitioner 13
Parental physical punishment and behavioural outcomes in preschool children

The aim of this study, carried out in Scotland, UK, was to determine whether there is an association between being smacked by your main caregiver in the first two years and emotional and behavioural problems at age four. The results showed that preschool children exposed to main caregiver smacking in the first two years were twice as likely to have emotional and behavioural problems as measured by parental assessment as children never smacked by their main caregiver. The authors conclude that parental use of physical punishment in the first two years may be a modifiable risk factor for emotional and behavioural difficulties in preschool children.

Child Care Health Dev 2014 40(3): 337–45

An alternative to calorie counting in obesity

Prevailing thinking about obesity and related diseases holds that quantifying calories should be a principal concern and target for intervention. This commentary discusses various problems with the idea that “a calorie is a calorie” and with a primarily quantitative focus on food calories. Instead, the authors argue for a greater qualitative focus on the sources of calories consumed (ie, a greater focus on types of foods) and on the metabolic changes that result from consuming foods of different types. The paper concludes that public health should work primarily to support the consumption of whole foods that help protect against obesity, promoting energy imbalance and metabolic dysfunction and not continue to promote calorie-directed messages that may create and blame victims and possibly exacerbate epidemics of obesity and related diseases.

Appetite 2014 doi: 10.1016/j.appet.2014.07.00

THE CPHVA PROFESSIONAL EXECUTIVE

Committee is the overarching strategic committee of the CPHVA, working alongside the professional, national and industrial officers of Unite to ensure that the professional needs of the membership are advanced through a work plan.

Issues of concern are identified from national policies, initiatives and targets; information gained from the Annual Professional Meeting held at CPHVA Conference, and views of members through Community Practitioner, social media and other communications, and the professional team.

The committee is made up of members who are professional activists within their region; some are also local accredited representatives and/or branch officials, while others are involved in the Unite industrial sectors, women’s or equality committees. None of these are pre-requirements to the position.

The committee meets four times a year, usually in London, with all travel and subsistence expenses paid. Committee membership supports attendance at CPHVA Annual Conference and attendance at any other meetings you may attend to represent CPHVA views. Facilitated time should be allowed from employers, and supporting documentation can be provided to assist you with this process.

In addition, there is an expectation that the member will set up a professional network (virtual or face-to-face) to allow two-way communication and a gathering of views from members in your region to feed into the committee.

If you would like to be a part of this vibrant committee and ensure that your region/professional group has a voice, we have vacancies in Wales, the North West and East Midlands areas. We would welcome any CV of approximately 250 words from interested members in these regions. The CV should include your job role, membership number, current job and roles within CPHVA/Unite, what you believe you can bring to the committee and why you would like to be considered.

Please email your CV to: healthsector@unitetheunion.org no later than 14 February 2015, as the first meeting will be held on 5 or 6 March.

CPHVA activists in Wales, North West and East Midlands, now is your chance to have a voice.

Calling all CPHVA activists in Wales, the North West and East Midlands!

Online child protection training

Safeguarding Children and Young People is an online training programme suitable for all health, social care and occupational health professionals who are working to protect children. The programme, developed by a consortium of professional bodies led by the Royal College of Paediatrics and Child Health, covers a broad range of issues such as the roles and responsibilities of staff, multi-agency working, what to do if a child discloses abuse, unexplained injuries, disability and neglect. Visit: www.eintegrity.org/e-learning-healthcare-course/safeguarding-children.html

All about eczema: an information pack for schools

The National Eczema Society has produced a new information pack on eczema. The pack provides an overview of the condition, with advice on how teachers can help a child with eczema to integrate into both their class and the school routine. Through a series of activities and lesson plan resources in different formats and for different suggested age groups, it equips teachers with tools to teach their class about eczema to encourage understanding and compassion among a child’s peers. See: www.eczema.org/new-eczema-information-pack-for-schools

ERIC to re-launch childhood continence awareness campaign

After a successful first phase of the ‘Let’s Talk About Poo’ campaign in 2013, during which 6,000 GP surgeries received information about children’s bowel problems, the campaign will be re-launched in April 2015 with a focus on raising awareness among parents, health professionals and early years’ education professionals of children’s bowel problems. The campaign will educate these target audiences about how to avoid problems, how to spot the early signs of a problem and how to intervene early. The goal is to ensure children get the support they need before they reach the age of four. Visit: www.eric.org.uk
LAST CHANCE
TO NOMINATE
CLOSING DATE
16TH JANUARY 2015

NOMINATING COULD NOT BE EASIER – SO MAKE YOURS NOW

You can nominate a colleague or team by visiting the Community Practitioner website (www.communitypractitioner.com/awards).

You can nominate any colleague or team demonstrating exceptional performance in their role, as long as they are a member of CPHVA.

Choose the appropriate category for your nomination and follow the simple entry instructions.

www.communitypractitioner.com/awards

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Getting published in
COMMUNITY PRACTITIONER

Polly Moffat
Editor

Jane Appleton
Professional Editor, Community Practitioner

Writing for publication is a good way of being part of a forum and a community where you can reach people you may not normally get the chance to speak to. Polly Moffat and Jane Appleton explain how to share your thoughts with colleagues in the form of a journal article, to inspire others and challenge them to learn from your experiences.

Should I write an article?

When you are thinking about writing an article and in the initial stages of planning a submission there are some key things you need to consider which will help you to format your article.

First, you need to think about what it is you want to say. What is the message you wish to communicate to readers? It could be a research project you have completed, a service you have set up and delivered or a strong opinion you have about a particular issue relevant to your work. It is vital to think about yourself as a reader. Put yourself in their shoes. What would you like to read? What would make you take 10 minutes out of your busy day to read an article in a journal?

This is the first battle – to encourage the reader to turn to your page and read what you have to say. What are the issues that affect you at work and what would you like to learn from an article?

Have you completed a project that might inspire others to do the same? What did you learn from the experience and what can others learn from your successes and your mistakes?

Finally, it is important to consider the type of article you feel you can write. Journals will expect you to submit your article in a suitable format tailored to that journal. An editor will not be happy to receive an article that is double the length specified in the author guidelines, with no recognisable structure, so plan ahead and make sure you know what format is expected of you.

You need to read the journal you are submitting to carefully, taking note of its content, word count and style or tone of voice of articles. Editorial teams work with a very specific brief and expect writers to follow their guidance so that copy fits in with what is usually found in that journal. If you are unsure speak to the editorial team, who will be happy to advise.

COMMON MYTHS ABOUT WRITING FOR PUBLICATION

There are some common myths that abound among potential writers. Editors often approach people to contribute to the journal and quite a common response is for people to say they wouldn’t know where to start.

I’m not a good enough writer

This lack of confidence is quite common among health professionals who aren’t used to writing articles for publication and who are unfamiliar with the publishing process. It can sometimes be a difficult task persuading someone who has carried out some interesting work that they should share it with colleagues in the form of a journal article.

Editors encourage submissions from any professional who has something to say, and part of the job of an editorial team is to take a piece of writing and help to make it suitable for publication. When a draft article is submitted, it needs to be of a suitable length depending on the type of article it is to become. Check with the editor or the author guidance as to how many words they would like you to write and stick to it. Cutting down a long research report or opinion piece is a key part of writing an article that is readable and can say what it needs to succinctly, without waffle or complicated, overly long sentences.

If readers are faced with a lot of text on a page they need to be taking in the key points as they read, or they will lose interest and flip to the next page. It’s your job to attract the reader to your article and to keep them there. Think about what you enjoy reading in a magazine or newspaper – is it a long, wordy page of text with no breaks or headings? Your attention is much more likely to be held on the article in front of you if the text is split into manageable paragraphs and sections, with a structure that flows and does not wander off at a tangent.

I don’t think my findings or experiences are interesting enough

There is always something interesting about the work you’re doing in practice and readers will usually learn something they can apply to their own work, no matter how unimportant you think it is. This may not be the case if the content doesn’t quite fit with the readership, but if the editor tells you this, don’t be put off – just try another journal that might be more suited to the subject matter. You can ask the editor if they could recommend an alternative journal as they will be aware of their competitors.
It depends on the publication, but a general rule is that if a subject has been covered in the last three or four months, the editor won’t be keen to cover it again. The most important thing to consider if you’re submitting an article on a topic that has been covered before is to say something new and add your own perspective or experiences. As long as you do not plagiarise others’ work a journal should be interested in your submission, even if it has been covered before.

‘Journals are inundated with so much good material that my article will not be able to compete’

Editors are always on the look-out for new submissions and ideas, and their work is made much easier if there is a steady flow of content to consider – the more the better. There is no single, consistently high standard of writing in submitted articles – it is very much a mixture of different types of writing by a range of professionals, from academics who have a catalogue of previously published work, to first-time writers who need a bit more guidance. Subject matter usually takes precedence over writing style or ability, and if an editor feels that the content is interesting enough they will help you to structure your article to make it readable, and will edit it for grammar and style.

ARTICLES IN COMMUNITY PRACTITIONER

Features
These are usually 750–2,000 words in length (one to two printed pages) and are written in an informal style, based on opinion and/or personal experience in your area of work. You can choose your own headings and structure your article as you wish, and any pictures or figures are welcomed to break up the text and help illustrate the points you are making.

Clinical updates/CPD articles
These are reviews of clinical management or case studies usually around 1,400–2,100 words in length (two to three printed pages) and should be fully referenced, as readers will want to use the article as an evidence base to inform their practice. They may also appear in the continuing professional development (CPD) section of the journal, which is also uploaded to the CP website as part of the resources offered for continuing professional development (www.communitypractitioner.com).

It is important that the references you use are as up to date as possible and refer to the current guidance so that practitioners are given the best available advice to inform their practice. Clinical updates are sent out for review to at least one person and the author may be asked to make amendments in light of the feedback received from the reviewers.

Professional and research papers
These are between 2,000 and 3,500 words in length (three to five printed pages) and, once submitted to the editor, are sent out for double-blind peer review. Professional papers usually require the most amount of work and need to be structured in a formal way.

Other contributions
Other types of contributions to journals can include profiles or noticeboard postings, where you may want to ask readers to contact you with advice about an area of practice, or a project you are setting up. Alternatively, you might want to write a letter on an issue you feel strongly about. This can be something you have read in the journal or a piece of news you would like to comment on – either way contact the editor if you would like to submit a letter. CP also covers industrial issues from your area so if you are a rep and have anything you would like to bring to the attention of readers you can write a short piece and submit for inclusion in a future issue.

RESEARCH PAPERS: GUIDANCE

Types of professional paper include: critical reflections on professional practice and experiences; project reports where the intention is to share good practice as well as the difficulties and challenges encountered; original research papers – both quantitative and qualitative; methodological papers; other kinds of academic paper such as concept, philosophical or ethical analyses; and critical and systematic reviews of the existing literature.

You should always say something new or bring a fresh perspective to the topic. Ensure that you make the paper a good read, with plenty to keep readers on the page and interested in what you are saying, and include full references in the correct house style (the set of rules on grammar and spelling that publishers will stick to so that their publication is consistent). Papers should build on, or add to, readers’ existing professional knowledge base. It’s not usually a good idea to assume that readers know nothing about your subject – they may have read around the topic before and have some idea of the existing literature, so there is no need to spell everything out as if you were talking to a layperson.

Professional papers should follow a specific structure. This is important because if you don’t do this, reviewers will pick you up on it and you will be asked to amend your article. Sorting the article into the correct headings with the correct sections in the right order will cut down review time and ensure that the paper is readable and recognisable to the reader as a piece of research. The format works, so don’t veer from it too much if you can.

You need to start with an abstract (these are around 150 to 200 words). The abstract should be a brief summary of your paper that serves as an enticement for readers to continue on and read the article in its entirety.

Start the main body of the article with an introduction and add some background – why did you decide to conduct the research? What was there a need for that you felt should
be addressed?

Next is the study aim and purpose – what were your intentions? What did you hope to achieve?

Your method is the next section, setting out exactly what you did in a logical order. It is important that this section is as detailed as possible so that readers can have confidence in your research and understand exactly how it was carried out, as this affects the outcomes.

The results section follows, where you explain what you found, and the next part is the discussion, which is your interpretation of the results and what they mean for practice.

Your recommendations should cover what you believe should be the outcome of the research – are there any changes that need making or is there a need for further research?

Most people find the conclusion of the article the most difficult part to write as it is easy to repeat what you have written in the main body of the article. This can be a way to approach a conclusion, but you’re not saying anything new. To some extent this is unavoidable, but try to come up with some solid conclusions – what were the main things you discovered once the project or research was completed?

Acknowledgement should be made of anyone who has contributed to your work and who isn’t included in the author list.

Finally, references appear in a list at the end and these should be clear, and most importantly, follow the style used by the journal. CP uses the Harvard style of referencing and if you are unsure about what this entails, check the author guidelines. Make sure you are as thorough as you can be with your referencing – it is often a good sign to a reviewer if you have your references in order so that they can understand where you are getting your information from. The article is more likely to pass peer review if the references are in the correct format.

PROJECT REPORTS: GUIDANCE

Make sure you have a clear introductory section. You then need some background to the project (idea, impetus, funding and relevant background/research literature, statistics, current government policy). Your next heading should be project context – who led the project, how it was conducted, any problems encountered. You should outline your experience of setting up the project and implementing the project; in other words, the project in practice (its impact, your findings). You can conclude the article with your future plans; for example, how will it continue or develop? And a summary/conclusion, including implications for practice.

PEER REVIEW PROCESS

For journals that publish academic papers, a rigorous peer review process is usually followed. This is also called double-blind peer review, which means that articles are sent out to at least one reviewer with all author details removed so there’s no chance of bias.

- Articles should be submitted directly to the editor by email. This is usually the case although some journals have an online submission system.
- Always include a title page, with all authors’ full qualifications, job title, place of work and contact address. These details are often missing from articles and you will need to include them so that editors can contact all authors involved if necessary and then send them copies once the issue is printed.
- Articles are sent out for double-blind peer review in anonymised format
- Articles are usually:
  - Accepted for publication
  - Accepted provisionally, subject to minor alterations by the authors
  - Recommended for revision and resubmission by the authors
  - Rejected (this is rare).

Authors are given a date by which to amend and resubmit their paper, and are generally required to include an anonymous sheet listing the changes that they have made to the paper. When a paper is accepted for publication, authors are requested to complete an ‘author’s consent form’ giving details of job titles, place of work and signature to agree that you work has not been published elsewhere.

Final proofs are sent to authors for checking shortly before the paper goes to press, and final queries may be sorted out at this stage. At proof stage there shouldn’t be too many changes – this is just a chance for the editor to show you the pages as they will appear in the journal and it is at this point that you can make any final corrections, check the correct figures or images are in place and that you are happy to proceed to print.

Once the issue featuring your article has been published, authors are sent complimentary copies of the issue in which their paper appears. This is the time to feel proud of the work you have done, particularly if it is your first article.

POINTS TO REMEMBER

There are some general points to remember when submitting any article for publication and the following are specific to CP but apply to most journals – it is always a good idea to check with the editor before you start if you are unsure.

Articles are subject to copyright and you should not formally submit an article to a journal that has been published elsewhere. Be aware that it is unethical to submit your article to more than one journal at a time. If you receive help from an editor to amend your article with a view to publication, it cannot then be considered by another journal. No journal wishes to reproduce material from another source so your work should always be original. It is important to acknowledge anyone who has contributed to your work in whatever way, not matter how small.

Conflicts of interest should be declared from the start as it is important for readers to know if there is any hint at all of possible bias. You may not think that anything has impacted on your writing but conflicts of interest should always be declared in the interests of ethics. If your article is a feature or clinical update, any pictures you can provide to illustrate it will be welcomed. Publishers usually rely on commercial picture libraries to provide visuals for articles, but it is vastly preferable to use author’s own images from practice.

Of course, you will need to get permission from the owner or subject of the photo, and images should be supplied to the editor as separate files (not pasted into word documents). Images should be print quality (a minimum of 300 dpi) or the quality you get from most good digital cameras. As long as they are the original files this should be fine, it’s usually copies that are lower resolution and are unusable because they will appear blurred in print.

FURTHER INFORMATION

The writing process can be time consuming but it’s extremely rewarding and seeing your work in print will make it all worth it.

To discuss submitting an article to CP for consideration, you can contact the Editor, Polly Moffat (polly.moffat@tenalps.com) or the Professional Editor of the journal, Jane Appleton (jappleton@brookes.ac.uk).

More details, including author guidance for download, can be found on the CP website at: www.communitypractitioner.com
Can you reduce the risk of an infant developing eczema?

Tanya Wright BSc Honours MSc Allergy HCPC Registered Dietitian MBDA

Breastfeeding has many benefits for both the mother and infant and should always be recommended as the first choice of feed.

Eczema is a growing modern epidemic

The occurrence of eczema is greatest in young children, but the prevalence of allergic diseases worldwide is rising dramatically in both developed and developing countries. Eczema can occur from birth, on introduction to formula milk, or when weaning commences.

Its impact extends to the whole family

Apart from the visible effects on the baby, eczema can also affect the whole family socially, psychologically, and financially. Sleep deprivation, low self-esteem, exclusion from activities, along with inconvenient time schedules for treatments, are often the reality faced by these families.

"It is important to understand there are things we can do to help babies at risk of eczema and reduce the burden of this condition.”

What are the options for feeding infants?

Breastfeeding is best for babies and should always be recommended as the first choice of feed. If exclusive breastfeeding is not possible however, reducing the impact of allergy (including eczema) in bottle-fed infants has been a major focus of research. The independent prospective GINI study, for example, enrolled over 2000 infants. It found that certain formulas containing hydrolysed proteins reduced the risk of eczema by over 50% in babies with a family medical history of the condition (those with at least one parent or sibling with allergy).

What the guidelines recommend

Not all hydrolysed formulas have been found to reduce the risk of developing eczema. Therefore clinical guidelines, such as the European Academy for Allergy and Clinical Immunology (EAACI), suggest choosing a formula that has been clinically proven.

New SMA H.A. Infant Milk - designed to specifically reduce the risk of developing allergy (e.g. eczema) to cows' milk proteins.

It is nutritionally complete and can be used from birth.

- Clinically proven to reduce the risk of eczema by over 50% in ‘at risk’ infants
- Use from first formula feed
- Omega 3 and 6 LCPs
- Easy to digest

Supporting you to support mums

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IMPORTANT

SMA H.A. Infant Milk should NOT be used if a baby has already been diagnosed with allergy to cows’ milk proteins or is suspected of already having an allergy to cows’ milk protein. SMA H.A. Infant Milk should be used as the first formula feed, before babies have been exposed to intact cows’ milk proteins.

*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.

1. Asher MI et al. Lancet 2006; 368: 733–43
6. EAACI Food Allergy and Anaphylaxis Guidelines 2013.
School Nurse 121 Campaign

School Nurse Campaign

PUBLIC HEALTH HAS ‘LOST ITS WAY’
according to writer and commentator Roy Lilley. He uses the English government’s recently published Five Year Forward View report to support this (NHS England, 2014). His argument is that we haven’t managed to ‘design out’ ill health from our lives; it is still far too easy to lead an unhealthy lifestyle, and being healthy should be made a lot easier so that ‘choosing health’ becomes a feasible reality. The plan talks of responsibility for improvements in public health in future being held by local government and elected mayors. So are school nurses part of the problem – or part of the solution? How much of what they do is around system change and how much is concerned with encouraging individual behaviour change within the existing system?

HEALTH PROMOTING SCHOOLS
The World Health Organization’s (WHO) ‘Health Promoting Schools’ initiative (WHO, 2014) was taken up by the UK government in 1999 to make schools an integrated environment covering physical, emotional and environmental health.

The programme was funded so that one teacher in each school could devote a little dedicated time to planning and organisation, and so that teachers and school nurses could participate in bespoke joint training in order to be more effective when working together. How many school nurses out there still have their personal, social, health and economic (PSHE) education certificate? The beauty of such enterprises is that everyone becomes involved, including school governors, teaching and peripatetic staff, clerical and catering staff, parent-teacher associations, and extending into the community via the police, the local authority and voluntary groups. Everyone in the neighbourhood has their part to play to support health promoting schools and, ideally, this should become amalgamated into mainstream working.

All such projects are often enthusiastically taken up at first, and then gradually fade as keen staff move on, resources get squeezed and benchmarking becomes a tick-box exercise. Unfortunately, after the change of government in 2010, the programme ceased to be encouraged by the Department for Education and was left to local decision making. Some places, such as London and Leeds, are beginning to make a comeback (albeit on a limited scale) and you are left to imagine how much more could have been achieved in changing children and young people’s health outcomes if we had continued as we started, and consolidated schools as a genuine hub for holistic public health innovation.

Public Health England has been doing some work with stakeholders, including Unite/CPHVA, to develop seven priorities where it is suggested we can achieve results if all parties concerned (public, private and voluntary) focus upon the same issues. There is an understanding that improvements need multi-agency support; but, as always, who is to pay? The topics identified are:

- Tackling obesity
- Reducing smoking
- Reducing harmful drinking
- Ensuring every child has the best start in life
- Reducing dementia risk
- Tackling microbial resistance
- Reducing tuberculosis

You will notice the absence of priority to improve mental and emotional health, but that does not mean it has been shelved; rather that these are considered the most urgent.

SCHOOL NURSE ROLE
The topics mentioned above come high on the possible list of interventions and there is no reason to think that school nurses should deliver on all. However, we need to think about what these look like from a public health point of view. Let’s take the first one – obesity.

We know that the obesity rate in childhood is too high and is not improving, and we know that the rate increases steadily during the 12...
There remains the problem that packed lunches need to be supervised and audited by the dietician and the school nurse. Local takeaway shops often serve food high in fat and sugar, which is unsustainable if we really want to improve health. These shops will need to serve healthy products if families are to support them, and this will require a concerted approach from parents and schools. Where children need to pay for fares or food, cash-free alternatives must be put into place so that there is no money for shopping.

Going home from school needs similar conditions to the morning, and partnership work needs to be put in place to educate children, young people and families about what to eat when they get home. School cookery lessons should teach children how to make a cheap healthy snack so that growing children do not resort to junk food when they are ‘starving’.

School nurses need to make sure that the whole school food policy is up to date and understood, and work with the PE department, clearly a hugely important element in tackling obesity. Science, mathematics, English and home economics departments would all need to work together, and this would need to be sustainable and not seen as ‘just another project’.

GP’s, dentists, grandparents and churches should be seen as part of the solution over the weekend, and school nurses would need to be on hand on Monday morning to help deal with problems. This may all sound to you like a ‘nanny state’, but it is not a particularly new concept. We have seen several initiatives both in the UK and other countries, such as Birmingham’s ‘Healthy villages’ and Canada’s ‘Village on a diet’ programmes. School nurses are curtailed by their paucity in numbers and their contracts from embracing this kind of working, but the future might be entirely different from the past, and it will need to be, as the systems we have at the moment are simply not working. For a new year’s resolution, can I suggest you inspire your managers and commissioners with your ‘blue sky thinking’? They might even be excited to try it.

**REFERENCES**


Health visitors’ perceptions of barriers to health and wellbeing in European migrant families

HAYLEY TESHOME TESFAYE BSc MA Dip
Specialty Registrar Public Health
Health Education North West

JENNIFER DAY PhD MSc MPH BSc
Director of Studies Master of Public Health, University of Liverpool

ABSTRACT
Since 2004 the population of European migrant workers and their families living in the UK has increased. In 2012 a small qualitative pilot study was conducted involving interviews with eight health visiting professionals working in a Merseyside borough in the north west of England. Health visitors were asked about their perceptions of barriers to health and wellbeing faced by European migrant families and common challenges experienced in practice. Interviews were analysed thematically and interpreted using a constructivist approach. Multiple perceptions emerged regarding migrant families’ barriers to health and wellbeing, housing, language, and health service access, knowledge and attitudes. Health visitors provided confirmation of their important role within the public health agenda, identifying vulnerability and challenging inequalities particularly among minority ethnic and lower socio-economic groups. This study highlights areas for future consideration by European migrant families. However, further quantitative and qualitative research is needed to investigate the needs, inequalities, service use and barriers to health and wellbeing experienced by European migrants.

INTRODUCTION
In 2004 the EU expanded to include EU8 countries (Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia), plus two Mediterranean countries, Cyprus and Malta. Between 2004 and 2007, there was a significant increase in the number of migrants from the EU8 countries coming to the UK for work purposes.

Historically, European health policy has been considered inadequate in addressing the health needs of migrant populations (Davies et al, 2006), but in 2008 the World Health Organization (WHO, 2008) emphasised the need for public health strategies to safeguard migrants’ health. There is a dearth of literature available regarding migrants’ health, health needs and the wider determinants of these when living in Europe and the UK (WHO, 2010). Migrant health is not a prominent feature of public health strategies. Measurement of international migrant populations’ health is complex due to technical and political reasons, wide diversity of migrant categories, immigration status, and definitions of ethnicity or country of birth (Mladovsky, 2007). In the UK, there is a lack of accurate, valid and reliable quantitative research and data available to quantify the number of European migrants living in the UK, their health status, health needs and utilisation of health services available to develop policies for addressing these issues (Jayaweera, 2010).

Migrants’ health and wellbeing needs are similar to those of the general population where they settle, influenced by age, gender, ethnicity, and socio-economic circumstances (Health Protection Agency (HPA), 2012; Ingleby, 2009). However, some specific needs may arise depending on ethnicity or country of origin and reasons for migration. It has been suggested that barriers to and inequalities in migrants’ health and wellbeing are similar to those experienced by other black and minority ethnic (BME) groups in the UK and are related to poverty, housing, transport, culture, access and knowledge (Jayaweera, 2010; WHO, 2010).

Many migrants arrive in the UK with relatively good health, which tends to deteriorate over time due to the impact of wider determinants of health (housing, employment) or acculturation following migration (Kelly et al, 2005). Acculturation (adopting new customs and behaviours in the host country) has been documented in several UK and international studies (Jayaweera, 2010). Davies et al (2010) consider that, for migrants, the wider determinants of health following settlement results in a negative health impact.

Estimating the number of migrants is challenging as it involves numerous data sources. In a Merseyside borough during 2005/6 there was a peak of 1,470 National Insurance number registrations of foreign nationals issued to migrants. Between 2003 and 2011 there had been 5,610 new non-British registrations to GP surgeries, peaking in 2009. The majority of these non-British patients were born in Poland, Latvia, Portugal and Lithuania. Each individual data set has its own limitations regarding validity and reliability.

Births within the borough to non-British mothers have nearly doubled since 2004. In 2010 they accounted for 9.4% of all births. The majority of births to non-British mothers tend to be in the north of the borough. In the two most deprived wards there were 39% and 38% of births to non-British mothers, respectively.

Health visitors reported increased contact with European migrant families to their team leaders. At the time of this study in 2012, there was no published research specifically investigating health visitors’ perceptions of the health of European migrants.

This research aimed to explore the perceptions of health visiting professionals regarding barriers to health and wellbeing faced by European migrant families in the borough, employing a qualitative methodology.

METHODOLOGY
This was a qualitative study using semi-structured interviews with health visiting professionals. Participants were required to have a health visiting qualification and to have clinical or non-clinical experience associated with European migrant families. There were no restrictions on age, gender, length of work experience or area of specialty.
Eight health visiting professionals chose to participate in the study following briefings to their teams and general invitation letters. Participants were provided with written information about the study and consent was obtained before interview. Anonymity of participants taking part in the research was ensured throughout.

The development of a flexible interview schedule, informed by a comprehensive literature search, was structured to discover potential barriers to health and wellbeing, exploring emerging themes and issues. Data were collected by one researcher using face-to-face semi-structured interviews held at several NHS office locations and recorded on a digital device.

The interviews were transcribed verbatim and thematic analysis was undertaken (Creswell, 2003). Transcripts were read and re-read, informing the development of codes for analysis, and identifying emerging themes and areas for further exploration. Lists of themes were compiled and tables were created for each theme and data compiled from transcripts. The research supervisor independently and concurrently reviewed the transcripts, identifying similar themes, verifying findings. Thematic tables were analysed, comparing and contrasting the participants’ shared and conflicting perspectives.

Analysis was undertaken using a theoretical constructivist approach, applying principles that consider the existence of multiple realities, not aiming to prove causality and conclude generalisability (Guba and Lincoln, 1989; Creswell, 2003). The multiple perspectives of all individuals are considered to be meaningful (Guba and Lincoln, 1989). Expeditied ethical approval was granted by the university and approved by NHS Merseyside.

**FININDS**

Multiple perceptions of eight health visiting professionals regarding barriers to health and wellbeing faced by European migrant families emerged from the interview data. The four most dominant themes will be reported in this paper: perceptions of migrant families’ health and wellbeing; housing, language and health service access; and knowledge and attitudes.

**Perceptions of migrant families’ health and wellbeing**

Most health visitors perceived migrant families’ health and wellbeing positively, comparable to or better than the general population in the borough, with the same or similar health needs. European migrants were described as fit, active, young people whose purpose of coming to the UK was to work.

One health visitor perceived the different health needs of different migrant groups, unravelling some of the heterogeneity of this group.

“You’ve got your young lads who are coming over for short periods of work and probably don’t go down to the GP surgery, or likely to access out-of-hours. But then you’ve got your young migrant families … who are more likely wanting to stay and have different needs again.” (HV5)

Several health visitors reported a higher incidence of breastfeeding and immunisation among European migrant mothers compared to mothers born in the UK. They perceived the health of children in migrant families as better as a consequence. However, they also expressed the impact of acculturation on mothers’ breastfeeding:

“I worry sometimes that if they weren’t here they’d do it longer. Of course, here they are bombarded with all this stuff on the shelves and all these baby follow-on milks.” (HV6)

One health visitor said that the family support mothers normally receive when breastfeeding in their home country is absent once they settle in the UK, impacting on a mother’s capacity to breastfeed. This health visitor believed that there was a danger in UK health professionals assuming that mothers will breastfeed because they are from an eastern European country and not provide additional breastfeeding support. Several health visitors expressed concern about migrants’ physical and mental health ‘dropping off’ or ‘deteriorating’ after arriving and spending time living in the UK.

All health visitors emphasised the importance of the impact of wider determinants of health on the health and wellbeing of migrant families and this was expressed fervently by some of the participants as they bore witness to poor environments to which they felt some families were exposed.

**Housing**

Four health visitors based in the north of the borough saw housing and accommodation as the most significant threat to health and wellbeing of migrant families. Housing in the borough’s north town area was described as large houses or hotels converted into multiple flats and bedsits. Some landlords were described as unscrupulous and perceived to be charging high rents for poor-quality housing. Overcrowding was reported by most health visitors working in the north as a significant issue.

“They are overcrowded ... it can always be a little bit blurred ... I don’t know if it is bigger numbers because that’s how they can afford the rent.” (HV3)

Most expressed that it was not clear how many adults and children would be living in the accommodation, and this fluctuated as families arrived, saved for a deposit and then moved on to another place.

In the north, all health visitors said that many migrant families would move from one accommodation to the next, slowly upgrading the standard of housing.

“Initially, they may be in a very grubby flat and then they’ll move to slightly a better one and then they’ll move again. It’s quite transient. We’ve got families that have been in five or six different addresses in the same amount of months.” (HV3)

Multiple accommodation moves were reported by three health visitors as a challenge when tracing migrant families.

“One of the problems we find is keeping track of families because they are always moving ... they don’t always think to tell us where they’ve gone.” (HV6)

One health visitor linked poor housing as a determinant of a family’s health and wellbeing.

“If people have poor housing then they are more likely, the children are more likely to be ill.” (HV2)

The impact of housing conditions was highlighted by a health visitor reporting children requiring A&E attendance due to recurrent chest infections, parents attributing this to damp housing.

One health visitor pointed out that her expertise was not housing but signposting and supporting families to services that could assist. Several health visitors described dilemmas in reporting housing conditions to environmental health officers. One health visitor explained:

“A whole houseful of migrant families in lots and lots of flats. If you call in environmental health, they will close the whole building down. Then they’ve got nowhere else.” (HV2)

Another health visitor emphasised the impact on the migrant families if environmental health do close down a property:

“Where do they go? You’re causing people to be homeless.” (HV5)

In the south of the borough, where more social housing was reportedly available, health visitors mentioned problems with damp, poor maintenance and repairs. They felt that migrant families would not complain as they were grateful to have been provided with accommodation.

**Language**

All health visitors reported language as a
Professional and research

barrier for some migrant families. 'Obviously they've got the same health needs as we have, but there are so many of them that haven't got English ... so they can't access all the services that we know about. So it's all the time a language barrier for the families.' (HV3)

Health visitors said telephone and interpreting services were used when working with migrant families. Health visitors based in the north of the borough used interpreting services more often due to greater numbers of non-English speaking families. Health visitors strongly believed in the use of interpreters within their work for their own professional responsibility, ensuring clear health messages (for example, regarding reducing the risk of cot death) were explained and enabling clients to disclose sensitive information, such as domestic violence.

Several health visitors said that some migrant families would refuse an interpreter. One health visitor believed that this may be because the interpreter is known to them through their community, and prefer a family member or friend to translate. Another health visitor described a mother refusing, stating that her partner would translate. Both of these health visitors expressed the clash of these situations with their knowledge of interpreting guidelines.

One health visitor managed the situation by documenting the families' refusal. However, another believed that refusal to have an interpreter was due to the way the subject is broached.

A perception among the health visitors was that barriers to health and wellbeing existed because other services and agencies did not provide interpreting services.

'I can't understand why other people, other agencies don't seem to take using an interpreter as seriously as we do.' (HV2)

Services and agencies reported as not using interpreting services included midwives, breastfeeding support, children's centres, housing providers, Citizens Advice, benefits, other hospital and community health services, all of which could have an impact on health and wellbeing. Health visitors were able to forward information to the specialist health visitor for migrant health when other agencies and services were not providing interpreting services to attempt to address the situation. Most health visitors based in the north reported that language barriers in GP services had been minimised through one of the surgeries employing staff who speak several European languages.

All health visitors described the significant difference that translation services and translated resources made to their practice, reducing barriers to health and wellbeing. The development of policies, guidelines and training was considered positively. However, they suggested there was a lack of resources in appropriate language formats for distributing to migrant families.

One health visitor saw the lack of information and booklets in particular languages on weaning and nutrition as a barrier to promoting healthy lifestyles for migrant families. All health visitors said that the lack of resources in appropriate language formats related to funding. However, there was a strong sense of inequity expressed by several health visitors.

'Whatever we are giving in English we should be able to give in any language ... How can you possibly give the same information that you are giving to an English-speaking person to if you haven't got the right tools?' (HV3)

All health visitors had raised these issues with managers, the specialist health visitor for migrant health and the public health development team.

Health access, knowledge and attitudes

Perceptions of migrant families' ability to access GP services varied between health visitors. Health visitors working with migrant families who had recently arrived in the UK reported that many register with the GP through word of mouth. Health visitors based in the north, where GP practices have multilingual staff, believed that GP registration had improved because of this. However, several health visitors pointed out they would only be able to provide services to a family who was registered with a GP already.

'As a health visitor you'll never get to see that family if they can't register in the first place, because you'll never be aware of them.' (HV3)

Two health visitors believed that a barrier to accessing GP services was migrant families being requested to produce documentation for registration and a lack of knowledge at the GP surgery regarding entitlements.

'They [GPs] said, "We won't take them unless they can show us a tenancy agreement". So if they [the family] have come in here and are bed-hopping around other people's flats, then they are unable to register with the GP.' (HV2)

Health visitors perceived that migrant families, who were registered with a GP, inappropriately used A&E services.

'A&E, it's really badly used. Even though you try and explain what the system is, it seems that after 5 o'clock or at the weekend they'll use A&E ... We'll get a lot of receipts back from A&E with a cold.' (HV3)

Several health visitors said that they thought UK families used A&E as often as migrant families, but acknowledged a lack of data to quantify the use of A&E by migrant families. There were mixed opinions regarding reasons for attendance of migrant families at A&E, including lack of awareness of the health system, dissatisfaction with GP diagnosis and failure to prescribe antibiotics, concern about an ill child, language barriers, GP interaction, education of patients, and transportation to GP out-of-hours services.

The perception of migrant families' knowledge, desire for and use of antibiotics featured strongly within many of the interviews as a cause for A&E attendance.

'They go to the GP and the GP says, “It's a virus, you don't need antibiotics”. We are told that if they aren't satisfied with that diagnosis they will go to the walk-in centre or the A&E department. Whether the outcome is that they are prescribed or not prescribed, I don't know.' (HV4)

Two health visitors believed that there was a need for education for the patient through interpreters and resources in appropriate languages. Both expressed the need for GPs, walk-in-centres and A&E to ensure a uniform approach across the whole health system to the prescription of antibiotics. Most health visitors perceived their role in educating families about how to choose well and to use NHS services appropriately and effectively. Health visitors' perceptions of migrant families' knowledge, access and attitudes towards health services varied. Several health visitors suggested that some migrant families considered the NHS negatively, preferring to return to their home country for medical care.

'Quite a few of the migrant workers don't like it at all, I've had lots of families who quite frequently go back to Poland and to Latvia for ... medical treatments.' (HV2)

Two health visitors described the challenges of children receiving medical treatment or undergoing investigations in their home country, and returning to the UK for follow-up treatment, with UK health professionals unaware of the clinical rationale or treatments given. Most of the health visitors said that migrant families used and valued their services, with high attendance at child health clinics.

**DISCUSSION**

This study has highlighted implications for public health in the area of preventing ill health among European migrant families due to acculturation, wider determinants of health...
and barriers to health, public and community services. The health visitors interviewed provided confirmation of their important role within the public health agenda, identifying vulnerability and challenging inequalities particularly among minority ethnic and lower socio-economic groups (DH, 2007, 2009, 2011; Marmot, 2010). Research evidence regarding health visitors’ ability to identify and address inequalities has been difficult to quantify (NiCE, 2004). Most research regarding the effectiveness of health visiting programmes has been undertaken outside the UK, within different health systems and cultural settings (NiCE, 2004).

Health visitors have been recognised as an interface between vulnerable clients and services, signposting such groups to housing, environmental health and community services (Office of Deputy Prime Minister, 2004; Shelter, 2010). This study demonstrates that health visitors have a unique public health role, identifying and tackling the wider determinants and barriers to health and wellbeing that they perceive are impacting on children and families.

The need for further research to explore the impact of health visitors on reducing health inequalities and improving public health has already been established as a priority by the CPHVAs Action on Health Visiting research group (CPHA, 2009). However, health visiting in isolation is not sufficient to radically alter health and social outcomes, multi-agencies and a ‘top down’ public health approach is required as well as political will at all levels (Elkan et al, 2010).

Ideally, it would have been preferable to interview European migrant families to ascertain their own perceptions and experiences of barriers to health and wellbeing. However, due to the time and resource constraints of a Master’s in public health dissertation, this was not possible. Stigma and discrimination were not highlighted by health visitors, although inequalities were. It is possible that European migrant families would have experienced discrimination or other issues that were not raised by health visitors.

**STUDY LIMITATIONS**

A limitation of the study is the small sample size. However, this area of study is a neglected research area and the authors believed they had interviewed the majority of health visiting professionals delivering services to European migrant families. The issues raised by health visitors indicate that there are very serious issues affecting the health and wellbeing of young families of European migrants and this needs highlighting to alert health workers and researchers to the need for further work.

Another limitation is the element of self-selection by health visitors in participating within the study. Self-selection introduces the potential of bias within the findings. It is important to acknowledge that the subject area is highly political, emotive and therefore self-selection bias may possibly occur.

The findings may have limited relevance to health visitors working in other regions of the UK with more diverse or non-European migrant populations. However, recently published research with 11 health visitors, community midwives and specialist voluntary workers in Bradford also highlighted wider determinants of health as an issue for Eastern European migrants (Richards et al, 2014). The findings of this study may be useful for informing future public health strategic planning, resource allocation and interventions for improving the health and wellbeing of European migrant families, informing the direction of future research.

**CONCLUSION**

This study identified that there are significant barriers to the health and wellbeing of European migrant families. The barriers included wider determinants of health and barriers in accessing health, public and community services. Further research is needed to investigate, triangulate and validate the findings, preferably with a cross-section of European migrant families living in the borough to ascertain their needs and their perceived barriers to health and wellbeing.

Current local and national intelligence systems are not able to quantify needs, inequalities and service use by migrants and their families. Comprehensive data systems, combined with rigorous quantitative and qualitative research, are required to improve understanding of the health needs of migrant families.

Health visitors participating in the study confirmed their public health role. Upstream, multisectoral, collaborative approaches are required to be effective at addressing the health and wellbeing needs of this population, the impact of wider determinants of health and the needs of multidisciplinary professionals.

**REFERENCES**


The positive impact of structured surfing courses on the wellbeing of vulnerable young people

INTRODUCTION
One in 10 young people aged five to 15 suffer from a mental health problem (Mental Health Foundation, 2013). Recognition of preventive initiatives for mental ill health is recommended to reduce the cost of mental health services for these young people (King's Fund, 2008). The average cost of mental health service for young people is £265 per person, per year and prevention savings for school-based emotional learning programmes are calculated at £3,206 per child over a 10-year period (Knapp et al, 2011).

The Wave Project is a surfing intervention that promotes ‘confidence through surfing and the sea’. It provides a six-week course of one-to-one surfing support for clients aged eight to 21, in a group setting. A follow-on surf club enables clients to continue their surfing and progress to becoming volunteer helpers and surf-mentors. Specific targets for achievement are not set and it is a chance to forget rather than focus on problems. The ethos and course delivery are constructed to provide fun, friendship and positive challenge with implicit objectives around developing the core life skills of confidence, self-reliance, self-management and social skills.

Demonstrating the value of this intervention through evaluation is important for service users, practitioners and commissioners, all of whom share an interest in promoting the wellbeing of young people. The Wave Project is rapidly expanding. It started in 2010 as a project for 20 young people run by volunteers. Now it is implemented in 20 locations across eight counties in the UK, each run by a local co-ordinator using teams of local volunteers.

Funding for these projects has come from grant funders such as the Big Lottery Fund and the BBC’s Children In Need, along with the NHS and local authorities. Since the project began, over 400 young people have benefited, some of whom have become trained as session volunteers. Parents and referrers noticed an increase in positive attitude and better communication, as well as improved self-management and behaviour at both home and school. It is concluded that the Wave Project provides a demonstrable and cost-effective way to deliver wellbeing and self-management and behaviour at both home and school. It is a chance to forget rather than focus on problems. The ethos and course delivery are constructed to provide fun, friendship and positive challenge with implicit objectives around developing the core life skills of confidence, self-reliance, self-management and social skills.

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To evaluate The Wave Project we used the SCWBS, along with single items from other validated scales, notably to measure self-esteem, social wellbeing and physical health. Finally, overall evaluation design included feedback from three sources (clients, parents and referrers) and used four points in time to help paint the picture of outcomes without disturbing the flow of the project.

**AIMS OF THE STUDY**

- To evaluate the wellbeing outcomes and impact of the Wave Project
- To highlight any issues around delivery and follow-up
- To use validated measures that were practical for data collection and robust enough to provide useful evidence for commissioners and practitioners.

**INTERVENTION**

Clients attended a free course of six weekly surfing sessions, usually for 10 clients and led by paid surf instructors and enough volunteers to provide one-to-one support. Courses were carefully constructed to bring clients out of their comfort zone and get them focused on positive experiences. Wetsuits and transport were provided if needed. Sessions ran at the weekends in spring or autumn.

**PARTICIPANTS**

A total of 121 young people aged eight to 18 facing mental health issues or social exclusion were referred by health, education and social services. Approximately 30% of referrals were from schools; 30% from NHS healthcare providers (GPs, nurses, psychologists); 20% from council-run social and family services; and 20% from other child support agencies (Action for Children, Young Carers).

The majority of clients were socially isolated and did not attend clubs and activities regularly. Most had not surfed before. Many were anxious before starting the Wave Project and some had sensory issues that made them reluctant to visit the beach or go into the sea. Thirty-nine parents and 13 referrers provided feedback as to satisfaction and effects on the children.

**EVALUATION DESIGN**

Data were collected on subjective outcomes (client perspective), impact (parent and referrer perspective), sustainability of impact (long-term attendance at surf club) and process delivery (satisfaction and improvements, results of which could then be used towards regular staff training and quality control).

After referral a questionnaire was posted to clients along with information and consent forms. At the end of the six-week surf course, a repeat measure plus satisfaction/experience questionnaire was administered. Parents and referrers completed feedback questionnaires (both closed and open questions) up to three months later. Further follow-up data were available for most clients through a log book and attendance records for the ongoing regular surf club, also run by the Wave Project.

### Table 1. Repeat pre- and post-intervention measures of wellbeing

<table>
<thead>
<tr>
<th>Wellbeing aspect indicated</th>
<th>Validated items: ask ‘How I’ve been feeling over the past couple of weeks’ on 5-point Likert scale from ‘none of the time’ to ‘all of the time’</th>
<th>Original measurement instrument/source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive functioning/outlook</td>
<td>I think good things will happen in my life ‘I’ve been able to make choices easily ‘I can find lots of fun things to do’ ‘I feel I am good at some things’ ‘I think lots of people care about me’ ‘I think there are things I can be proud of’</td>
<td>Stirling Children’s Wellbeing Scale (SCWBS) (the 6 items form a component of positive outlook on a single dimension)*</td>
</tr>
<tr>
<td>Resilience/self-esteem</td>
<td>‘I’ve been feeling good about myself ‘I’m good at managing my daily responsibilities’</td>
<td>Validated item for 13-16 year olds on Warwick-Edinburgh Mental Wellbeing Scale Validated item on Rosenberg Self Esteem Scale</td>
</tr>
<tr>
<td>Emotional wellbeing</td>
<td>‘I’ve been feeling calm’</td>
<td>SCWBS validated as a single item on the scale’s Positive Affect component</td>
</tr>
<tr>
<td>Vitality</td>
<td>‘I’ve been having fun’</td>
<td>Own item</td>
</tr>
<tr>
<td>Social wellbeing</td>
<td>‘I feel safe with my friends’</td>
<td>Children’s Society validated item in draft Children’s Wellbeing Scale</td>
</tr>
<tr>
<td>Social trust</td>
<td>‘I think other people are basically good’</td>
<td>Recommended as a question by NEF, but no validated item available</td>
</tr>
<tr>
<td>Physical health</td>
<td>‘I like being active’ ‘I feel fit and healthy’ ‘I enjoy being outside’</td>
<td>National Obesity Observatory Standard Evaluation Framework suggest these items for determinants of activity behaviours, such as attitude to physical activity Own item</td>
</tr>
</tbody>
</table>

*These items formed a reliable ‘positive functioning’ scale pre- (T1) and post- (T2) intervention, with T1 alpha .781 (6 items) and T2 alpha .766 (6 items)
• Satisfaction ratings around feeling safe, overall experience, improvements needed and follow-on attendance at regular surf club.

Parent/referrer
• Behaviour, self-management, progress at school
• Communication, empathy, making new friends
• Self-confidence, positive attitude, happiness, having fun
• Satisfaction, fun in sessions, and progress with surfing
• Activity, healthier lifestyle
• Referrer satisfaction: would recommend, refer others, waiting times, outcome expectations.

RESULTS
A total of 114 young people attended some or all surf sessions and 84 completed a valid pre- and post-intervention questionnaire. Just over half (n=45, 53.6%) attended all six sessions. A further third (n=27, 32.1%) attended five sessions, with 12 children (14.3%) attending four or less. Seventy per cent (n=59) of referrals were boys and 30% (n=25) were girls. Thirty-three per cent were aged eight to nine, 49% aged 10–14, and 10% aged 15–18. Frequency scores and percentages (%) were calculated for all items. Where items had categorical responses (yes/no) a chi2 indicated how much responses varied from chance; for example, were the number of females and males across the six locations significantly different?

Difference pre- and post-intervention for scaled items was calculated using a paired sample t-test. This calculated whether the difference in mean score across the whole sample at time 1 (T1) was significantly different from the mean score at time 2 (T2). Qualitative data were analysed thematically (Braun, 2006) by coding statements into categories and assigning thematic descriptors to each category.

OUTCOMES
In terms of direct effects, categorical data showed clients felt better (96%), happier (98%), had fun (99%), made friends (89%) and felt fitter (87%). All wellbeing measures showed statistically significant change after the intervention and the effects were very robust. Location, gender and attendance were unrelated (chi2) to any variable.

The only significant effect of gender was in terms of partial or full attendance on the course, with females significantly less likely than males to complete the full course (chi2=6.659, p=.01). The reasons for females’ less than full attendance are not clear from the quantitative data but were followed up on an individual basis by Wave staff and included being unwell and losing interest, transport difficulties and holidays.

QUALITATIVE AND CATEGORICAL DATA
Post-intervention comments were collected by asking clients what made them feel different. A summary of results is presented in Table 4.

PARENT AND REFERRER FEEDBACK
Data collected from 39 parents and 13 referers showed the Wave Project was extremely positive for family life, behaviour and achievement at school.

Positivity and a more confident outlook
Parents saw their children as having fun during the sessions. They reported that children were more positive, happier and more self-confident after the Wave Project.

Behaviour change
Seventy-nine per cent of parents reported a more positive attitude and 62% reported better communication skills. Self-management, empathy and improved behaviour were identified in around half the cases.

Activity and achievement
Sixty-two per cent of parents reported children being more active and 82% saw their progress with surfing. Fifty-six per cent thought they showed a healthier lifestyle after participation and 46% knew of progress in education since the course. The Wave Project experience was a ‘touchstone’ for some children.

We have been able to use the Wave Project to boost his low self-esteem and low self-worth. When

Table 2. Effects of Wave Project (client perspective)

<table>
<thead>
<tr>
<th>Client perspective (sample 103 children)</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘I feel better than before’</td>
<td>79</td>
<td>96</td>
</tr>
<tr>
<td>‘I feel more happy’</td>
<td>79</td>
<td>98</td>
</tr>
<tr>
<td>‘I feel fitter than before’</td>
<td>69</td>
<td>87</td>
</tr>
<tr>
<td>‘I made new friends’</td>
<td>71</td>
<td>89</td>
</tr>
<tr>
<td>‘I had fun’</td>
<td>80</td>
<td>99</td>
</tr>
</tbody>
</table>

Table 3. Statistically significant change on all wellbeing areas using paired sample t-tests

<table>
<thead>
<tr>
<th>Wellbeing aspect</th>
<th>Significant change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive functioning: 6-item scale</td>
<td>t (82)=−6.42***</td>
</tr>
<tr>
<td>Resilience/self-esteem: feeling good about myself, managing my responsibilities</td>
<td>t (81)=−3.87***</td>
</tr>
<tr>
<td>Emotional wellbeing: feeling calm</td>
<td>t (76)=−3.20**</td>
</tr>
<tr>
<td>Vitality: having fun</td>
<td>t (79)=−5.26***</td>
</tr>
<tr>
<td>Friendship: feeling safe with friends</td>
<td>t (78)=−2.87**</td>
</tr>
<tr>
<td>Social Trust: people are basically good</td>
<td>t (78)=−2.48**</td>
</tr>
<tr>
<td>Physical health: feeling fit</td>
<td></td>
</tr>
<tr>
<td>Physical health: being active</td>
<td></td>
</tr>
<tr>
<td>Enjoying outside</td>
<td></td>
</tr>
</tbody>
</table>

Key: *** p<.000 ** p<.00 * p<.0

Table 4. ‘Things that made me feel different’ (client comments)

<table>
<thead>
<tr>
<th>Theme</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resilience and achievement</td>
<td>I now give things a try even if I feel nervous’</td>
</tr>
<tr>
<td></td>
<td>‘I thought I wouldn’t do well when I have’</td>
</tr>
<tr>
<td></td>
<td>‘Boosted my confidence’</td>
</tr>
<tr>
<td></td>
<td>‘I am happier, and happier about life and living it’</td>
</tr>
<tr>
<td></td>
<td>‘It makes me feel safer and a lot more happy’</td>
</tr>
<tr>
<td></td>
<td>‘Having someone helping me’</td>
</tr>
<tr>
<td></td>
<td>‘Working in a group’</td>
</tr>
<tr>
<td></td>
<td>‘Slightly more confident at talking to new people’</td>
</tr>
<tr>
<td></td>
<td>‘That there is a sport that I actually like’</td>
</tr>
<tr>
<td></td>
<td>‘It gave me confidence to learn a new hobby’</td>
</tr>
</tbody>
</table>

* 'Touchstone’ for some children:

Community Practitioner January 2015
The comments made by parents and clients reflected these wellbeing measures and lent more detail to the real experience of any changes. Positive functioning, resilience, self-esteem and confidence, happiness, fun, friendship and experiencing (and achieving) a new, active hobby were strongly represented in comments and parents reported a positive impact on family life. Parents valued the opportunity for their children to start a hobby, take part in local culture, have an antidote to problems, socialise better and achieve by completing an activity (that many had not done before). Children were able to talk about the course with their family, be more resilient and calm, to complete chores at home and to ‘feel comfortable in their own skin’. Clients with anxiety and sensory difficulties, such as autism, did not experience these as barriers to participation and this is a strength of the project. Access for a wide range of young people was encouraged and issues addressed early. There were slightly lower referral rates for girls and slightly lower attendance, and the project has been addressing this in the promotion of the service and course induction. As a result, female and male attendance is now equal. Although the intervention is located at the coast, this did not seem to limit access as many participants came from inland Cornwall and some may have travelled over an hour to attend.

In addition to the significant immediate improvements after a course, over 70% of clients carried on surfing, joined and still regularly attend a surf club up to a year later. Engaging in an active hobby in group settings and in their local communities is a notable impact of the Wave Project. All the findings taken together suggest that the cost per client of around £50 per session offers good value for money as an intervention.

LIMITATIONS

The evaluation sample was limited and provides limited evidence, so more ongoing data, particularly from parents and referrers, would give an even clearer picture. Response–bias effects may have been present in that the most enthusiastic parents and referrers were more likely to respond. Evaluation would be stronger if continued over a longer follow-up period and if school feedback could corroborate self-reports from clients and parents. Although in the Wave Project referrals and attendance included those from inland as well as coastal areas, access to coastal locations may be seen as a difficulty to overcome.

CONCLUSION

Wellbeing was promoted by participation in surfing, a physically challenging outdoor activity experienced with other people in a friendly, supported and fun way. These findings demonstrate a valuable and cost-effective way to deliver mental health care, mentoring and to encourage social integration of young people. Clients progressed, formed a new hobby and were interested in volunteering. Going forward, it might also be interesting to plot the wider value of such interventions (or ‘social return on investment’) in terms of family wellbeing and wider benefits to communities as well as individuals.

ACKNOWLEDGEMENTS

The authors would like to thank Joe Taylor, all the Wave Project staff, volunteers and participants at the Wave Project for contribution and data collection.

REFERENCES


The Wave Project builds skills and social capital through increasing volunteering and mentoring.

Key points

- Commissioners and practitioners should consider the Wave Project as an intervention to promote wellbeing and specific outcomes; notably, social interaction and engagement among young people.
- The Wave Project model (surf, challenge, fun and support) plus a follow-on club enables progression from participant to proponent
- The Wave Project builds skills and social capital through increasing volunteering and mentoring.
- Evaluations that incorporate wellbeing measures alongside other (follow-up) impact indicators can be used in a wide range of situations, including interventions with different activities or different target groups such as young or older people.

The Wave Project model (surf, challenge, fun and support) plus a follow-on club enables progression from participant to proponent.
Gypsies and Travellers: their history, culture and traditions

INTRODUCTION
Travellers can be divided into two groups: ethnic Travellers, such as Romany Gypsies, Scottish Gypsy Travellers and Irish Travellers; and those who live on the road for economic reasons, such as New Travellers and Showmen (Bowers, 2013).

It is estimated that there are between 200,000 and 300,000 Gypsies and Travellers living in the UK (Friends, Families, and Travellers (FFT), 2011). However, during the 2011 Census, which for the first time included a tick-box for the ethnic group ‘Gypsy or Irish Traveller’, only 58,000 identified themselves as being part of this group (Office for National Statistics (ONS), 2014). Issues such as mistrust of official data collections and fear of discrimination make it likely that many Gypsies and Irish Travellers chose not to self-identify as belonging to these groups. According to FFT, an estimated 25,000 ‘Roadsiders’ or Gypsies and Travellers have nowhere legal to stop and end up by the roadside or living on unauthorised encampments (FFT, 2011). Thus, the numbers presented by ONS (2014) are likely to be underestimated, although they go some way to providing much-needed up-to-date information on the Gypsy and Traveller community to aid planning of services.

This article will outline how a specialist health visitor working in the south Gloucestershire area has attempted to reduce prejudice and discrimination experienced by Gypsies and Travellers by raising awareness of their cultural issues. It will also focus on how to ensure services take into account the needs of Gypsies and Travellers.

KEY WORDS
Gypsies, Travellers, prejudice, discrimination, history, culture, traditions, minorities

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No conflict of interest declared
Although there is a large established Irish Traveller community living permanently in the UK, some travel from or back to Ireland for part of the year (Travellers Aid Trust, 2014). As well as sharing traditions of ‘nomadism’ and living in caravans or trailers, and an oral tradition of passing on knowledge, Bowers (2013) also suggests that they share other cultural values as Romany Gypsies, in that they have a preference for self-employment. 

Scottish Gypsy Travellers
Scottish Gypsy Travellers were only recognised as an ethnic minority community in 2008; they are believed to go back to the 12th century and are made up of a range of different groups. They may refer to themselves as Scottish Travellers, Scottish Gypsies or as Nawkens or Nachins. Like Irish Travellers, many also speak Cant/Gammon (Travellers Aid Trust, 2009).

Box 1. Traveller ‘norms’ (Travellers Aid Trust, 2009)
- Nomadism, whether past or present
- Self-reliance, self-employment and independence
- Shared culture and strong oral traditions
- Strict rituals around birth, death and cleanliness
- The importance of children, family and the extended family
- Annual and seasonal social gatherings, fairs or festivals

Box 2. Summary of Census Analysis 2011 (Office for National Statistics, 2014)
- 58,000 people identified themselves as Gypsy or Irish Travellers in the 2011 Census (0.1% of the usual resident population of England and Wales)
- People identifying as Gypsy or Irish Traveller had a high proportion of residents under the age of 20 at 39%. This compares to 24% of the overall England and Wales population who were under 20
- Gypsy or Irish Travellers born in non-UK countries was double the proportion for England and Wales as a whole – 8% compared to 4%
- The majority of people who identified as Gypsy or Irish Travellers identified with an English only identity (66%) and were Christian (64%)
- Gypsy or Irish Travellers had the highest proportion with no qualifications for any ethnic group (60%) – almost three times higher than for England and Wales as a whole (23%)
- Gypsy or Irish Travellers was the ethnic group with the lowest proportion of respondents who were economically active at 47%, compared to 63% for England and Wales as a whole
- Over half of those who were economically active were employed (51% compared to 75% for the total of England and Wales). Gypsy or Irish Traveller had the highest proportion of self-employed out of the ethnic groups at 26% compared to 14% for England and Wales
- Elementary occupations (such as sales, service or construction) were the most common type of employment at 22% for Gypsy or Irish Travellers [11% for England and Wales as a whole]
- Just under half of Gypsy or Irish Traveller households had dependant children [45%] – above the average for the whole of England and Wales (29%)
- Whole house or bungalow was the most common type of accommodation for respondents who identified as Gypsy or Irish Traveller, at 61% (84% for England and Wales as a whole)
- Gypsy or Irish Travellers were more than twice as likely to live in social housing than the overall population of England and Wales [41% compared to 16%] and less likely to own their accommodation outright [21% compared to 26%]
- Gypsy or Irish Traveller had the lowest proportion of any ethnic group rating their general health as ‘good’ or ‘very good’ at 70% compared to 81% overall of the overall population of England and Wales
- Gypsy or Irish Traveller ethnic group was among the highest providers of unpaid care in England and Wales at 11% (10% for England and Wales as a whole) and provided the highest proportion of people providing 50 hours or more of unpaid care at 4% (compared to 2% for England and Wales as a whole)

NON-ETHNIC TRAVELLERS
There are other groups and individuals who call themselves Travellers. They may be people who have chosen, or been forced into, a life on the road; or they may be part of larger cultural groups who are not recognised as an ethnic minority but who share a common culture.

New Travellers
New Travellers originated out of the Peace Convoy of the 1960s; and although very diverse, this community was primarily driven by those wishing to live an alternative travelling lifestyle. New Travellers are predominantly people who have chosen to live on the road in their lifetime, but many will claim to have second and third generations on the road. Members of this community tend to call themselves simply Travellers and may find the terms ‘New Age’ or ‘New’ offensive (Travellers Aid Trust, 2009).

Occupational Travellers
Occupational Travellers include showmen or fairground and circus people who have a long history of travelling for a living. They are culturally similar to Romany Gypsies but their identity is connected to their family businesses. They travel mainly in the summer months to fun fairs and usually have a winter base where the family will settle and prepare for the next summer’s travelling season. This group also includes ‘bargees’ or boat dwellers living primarily on narrow boats.

ISSUES FACING GYPSIES AND TRAVELLERS IN THE UK TODAY
From the 16th century to the present day, no other ethnic group in Britain has aroused as much curiosity, romance, hatred and fear as Gypsies and Travellers (Bowers, 2013). Gypsy and Traveller communities in the UK face wide-ranging inequalities (Cemlyn et al, 2009).

The reality for Gypsies and Traveller families is that they belong to a community that is the most excluded in the UK. The health status for this community is considerably poorer than other English speaking ethnic minority groups and Brown (2010) proposes that Gypsies and Travellers suffer third-world levels of health quality. This disparity is generally attributed to poor accommodation, poor access to health services and education, and discrimination. According to Marmot (2010), there is a social gradient in health – the lower
Gypsies and Travellers report the poorest health of any ethnic group living in England and Wales. The ONS analysis poses challenges for health, education, housing and employment services. The Public Sector Equality Duty (Equality Act, 2010) applies to all organisations carrying out public functions and states that they are to have ‘due regard’ to the need to eliminate unlawful discrimination, harassment and victimisation. It is the duty of all public sector organisations to promote equality of opportunity between different groups, and foster good relations between people from different groups. This goes some way to addressing prejudice and discrimination by ensuring policies and procedures are inclusive and take into account the needs of all groups including Gypsies and Travellers.

However, the biggest challenge is raising awareness and getting such organisations to recognise the needs of Gypsies and Travellers, and ensure service design and delivery is accessible and culturally appropriate.

**THE ROLE OF THE SPECIALIST HEALTH VISITOR**

In the south west of England, two part-time specialist health visitors are employed by North Bristol Trust (NBT) working in the Bristol area and the South Gloucestershire area (Bristol being one unitary local authority and South Gloucestershire being the other). The main focus for the work of the specialist health visitor is to reduce health inequalities experienced by Gypsy and Traveller families (see Box 3). Health inequalities result from social inequalities (Marmot, 2010). Ignorance and prejudice can lead to discrimination which, in turn, leads to social inequality. According to Thornicroft et al (2007), ‘stigma’ and ‘stereotyping’ refer to problems with knowledge (ignorance). ‘Prejudice’ is a negative attitude attributed to the stigmatised/negative stereotyped group, and discrimination is the resulting behaviour. Therefore, any intervention that aims to increase knowledge, and works to reduce negative attitudes and affects behaviour change will reduce discrimination.

**RAISING AWARENESS**

A large part of the role of the specialist health visitor for Gypsy and Travellers (Box 3) is providing cultural awareness training within the health service and within other agencies. Members of the Traveller community were consulted in the design of the training and were also included in its delivery, where possible. The training provides an overview of Gypsy and Traveller history and culture, prejudice and discrimination and the impact this has on outcomes for the Gypsy and Traveller community.

The training has been given to GP receptionist staff, practice nurses, health visitors and midwives working in the South Gloucestershire area. It has also been provided for student nurses and student health visitors on placement, as well as for nursing and health visitor students attending the University of the West of England.

The experience of the specialist health visitor during training sessions is of participants being openly hostile, and demonstrating discriminatory attitudes towards the Gypsy and Traveller community. This supports the findings within the literature and demonstrates a need for cultural awareness training (National Centre for Social Research, 2003; Valentine and McDonald, 2004; Richardson and Ryder, 2012).

The specialist health visitor also provides information and resources for nurses and health workers to assist them to work effectively with Gypsies and Travellers. According to Van Cleemput (2010), nurses have an important role in challenging the prejudice faced by the Gypsy and Traveller community. The month of June each year is Gypsy, Roma and Traveller History Month, the purpose of which is to raise awareness of the rich Gypsy, Roma, Traveller culture...
and heritage, and to challenge negative stereotyping.

In South Gloucestershire the specialist health visitor planned events to raise awareness and celebrate Gypsy/Traveller culture as the area has very few Roma. Local libraries were used as venues to host ‘Story time’ events for pre-school children and their parents raising awareness of history month and its purpose, and using stories and books to tackle negative stereotyping by using positive images of Gypsy and Travellers.

At the events, books were given to the children that included positive stories about Gypsy and Traveller children, provided by Ethnic Minorities and Traveller Achievement Services (EMTAS), an organisation providing educational support to schools and Gypsy and Travellers families in South Gloucestershire. The event was well supported by libraries in the area and well attended by pre-school children and their parents.

Another very successful event was a performance of Crystal’s Vardo by FFT. The play focuses on Crystal, a young Gypsy girl who has been bullied at school. Desperate to escape, she runs away from home with her Grandfather’s ‘vardo’ (a traditional wooden Gypsy caravan) and pony to find herself lost and miles from anywhere familiar. She has no choice but to put her trust in the audience to help her find her way back. As she begins to tell the story of her ancestors, Crystal and her companions find themselves far back in time, when the first Gypsies migrated from northern India. By piecing together the shards of her ancestry, Crystal regains a new identity and celebrates her Traveller heritage.

The key principle of raising awareness can be applied to ethnic minority groups in other areas across the country and by other health visitors and health workers. Actions to reduce social inequalities will contribute to reducing health inequalities, as a matter of fairness and social justice (Marmot, 2010).

REFERENCES


January 2015 Community Practitioner 33
Health Visitor Debbie Prigg reports from the Marcé Society Biennial Scientific Conference 2014 at Swansea University

Founded in 1980, the Marcé Society is an international organisation made up of scientists, clinicians and practitioners who wish to understand, prevent and treat mental illness in the perinatal period. The Society’s scientific conference’s range of speakers addressed issues and concerns around perinatal mental health.

DAY 1

The conference welcome address was delivered by the outgoing society President, Dr Jane Hanley. As the president and a former health visitor, Jane has championed maternal mental health in Wales, and alongside Professor Davies was delighted to be hosting this prestigious event. The conference lasted three days, consisting of 11 plenary speakers, symposia, poster presentations, book signings, focus groups and workshops. The depth of knowledge and experience was humbling, and the enthusiasm and commitment to bring about change by working together across disciplines was palpable.

Parent–infant attachment

In the first of the plenary sessions, Professor Steve Suomi discussed his work with rhesus monkeys in a naturalistic setting. He looked at imitation in a three-day-old monkey and found the traits used by the animal lasted only about a week – monkeys are known to mature four times faster than the human baby. They found that in later life baby monkeys who didn’t imitate played less and were not as socially sophisticated. During the project, scientists were able to observe the effects of good parent–baby attachment vs baby monkeys that had developed attachments to peers. Monkeys of the same age had been raised in a nursery-like environment due to being orphaned, and scientists observed how the baby monkeys compared when placed in stressful situations. They also recorded the effect of introducing foster parents and felt that studying these monkeys may have some real opportunities for evaluation practice in longitudinal studies as monkeys mature so much quicker than human babies. Further work is being done to explore if this, in the future the research may prove to be significant for identifying signs of early autism.

Following the observations, Professor Jane Barlow discussed intergenerational psychopathology resulting in insecure and disorganised attachment between mothers and their children. This is often as a result of unresolved maternal trauma. She outlined the intervention landscape available for improving outcomes for infants of parents with mental health problems. Describing them as non-dyadic (focusing on parent) eg, home visiting, counselling, social support and dyadic (focusing on parent and infant interaction) parent infant psychotherapy and infant massage. The message of her address centred on how important it is to focus on needs of the parents to develop an appropriate therapeutic response.

The choice of symposia and presentations throughout the three days was overwhelming. Chris Bingley’s documentation of his wife Jo’s postnatal depression (PND) proved to be particularly poignant. Jo was a community nurse, and after having her baby girl she became very unwell. Ten weeks postpartum she took her own life. Her husband Chris is now calling for a Parliamentary Commission into perinatal mental health care in the UK. He strongly believes that the importance of the father’s role in PND is often ignored and has created a foundation (www.joebingleymemorialfoundation.org.uk) dedicated to his wife highlighting the devastating effects of postnatal illness. He asked the question: ‘If 5% of dads are thought to experience postnatal illness, how is this being addressed?’ Chris’ local health board has now accepted there were mistakes made in Joe’s case, but it has taken four years for this to happen – meanwhile the provision of specialist services in many areas across Britain remain staggeringly poor.

Lunchtime was spent viewing the wealth of poster presentations from all over the globe. It was pleasing to see a poster from colleagues in Monmouthshire, Dr Aideen Naughton and Julie Wallace, outlining the ‘Watch, Wait and Wonder’ parent/infant psychotherapy, a project that we are very lucky to be able to access in our area.

Social contact

Professor Graham Thornicroft from South London and Maudsley NHS Trust opened the afternoon with a skilled and engaging presentation on stigma, and discrimination and mental health using poetry, advertising and visual images of some of our most famous musicians, sports personalities and comedians who have fallen victim to mental health problems. He talked of mental illness and its effect on life expectancy, and how fear, above all...
Help parents teach healthy habits from the start

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else, leads to discrimination. The ‘Time to Change’ campaign by charities Mind and Rethink Mental Illness has led to England’s biggest initiative to challenge stigma and discrimination. Professor Thornicroft noted that if you only remember two words from this conference, they should be ‘social contact’ – as it is this that leads to disclosure, which, in turn, leads to change. He spoke of his mother’s battle with mental illness and the book they are writing together from their differing perspectives of the same journey. Professor Thornicroft reminded his audience that there is ‘no health without mental health’ and how UN development grants have funded work on equity between physical and mental health.

DAY 2
Professor Lynne Murray was the first of the plenary speakers and is no stranger to those who work with babies and their families. Through the Cambridge Longitudinal Study and her other many other works she has been able to look at the effects of PND on the developing child. She has recently published her second book, The Psychology of Babies. The book charts the four key areas of early child development: social understanding; developing attachments; emotional self-regulation; and cognitive skills. She emphasised the importance of analysing parenting to identify individual relationships, and feels that only then can tailored interventions be provided in the form of parenting support and infant cognitive development.

Professor Vikram Patel from the London School of Hygiene and Tropical Medicine was the second plenary speaker of the day, presenting a global view of mental health and the need for improving access to mental health care. In the Channi Kumar Lecture, he outlined the four key areas of early child development: social understanding; developing attachments; emotional self-regulation; and cognitive skills. He emphasised the importance of analysing parenting to identify individual relationships, and feels that only then can tailored interventions be provided in the form of parenting support and infant cognitive development.

Empathy through music
The next speaker took a different approach. Jennie Muskett is a composer for film and television, and throughout her career she had explored her fascination with creating empathy through music and has recently developed an interest in the benefits of music for babies and mothers during the perinatal period. She noticed how her daughter had calmed postnatally when hearing the cello music she had played whilst pregnant. Jenny has since gone on to produce a series of lullabies, which she hopes mothers will listen to as part of their babies and mothers during the perinatal period. She noticed how her daughter had calmed postnatally when hearing the cello music she had played whilst pregnant. Jenny has since gone on to produce a series of lullabies, which she hopes mothers will listen to as part of their antenatal care. To conclude, Jenny played a little of one of her pieces.

Professor Louise Howard was the recipient of the prestigious Marcé medal. Professor Howard outlined her own experience of postnatal illness following both of her pregnancies, the differing pathology each time that no one around her recognised and how this influenced her desire to examine ‘What is Evidence Based Perinatal Mental Health Care and is it achievable?’ Alongside an eminent research career she chairs the NICE Guideline Development Group on Antenatal and Post Natal Mental Health and has been part of the WHO working group developing guidance on domestic abuse.

DAY 3
Dr Hamish McAllister-Williams from Newcastle University took the stage on the third day addressing the need to balance risk with efficacy when treating women with bipolar disorder in the antenatal period. He feels the risks of not treating women with mental illness with the correct pharmacological interventions far outweigh the risks of treatment itself in many situations. He explained how research had revealed that in women with anxiety issues, certain atypical anti-psychotic medications, such as quetiapine, had been much more successful than the use of SSRIs.

Marcé Award
Jane Hanley took to the stage to present a new award from the Marcé Society, making Professor John Cox its first recipient. Professor Cox has an established international reputation in the fields of perinatal mental disorder, international public health and transcultural psychiatry. He has been a Marcé Society member since its launch 35 years ago. Professor Cox spoke highly of the health visiting profession, mentioning Jeni Holden, Jane Hanley, Cheryll Adams and Aysha Day for their contributions through science and leadership in this field. He spoke of the Francis inquiry and the tragedy of lost lives through failures of the system. He feels that perinatal psychiatry may have the key in quality standards for the provision of humanistic and person-centred medicine. He went on to emphasise the need for good role models and development of standards in organisations surrounding plans to support staff through supervision.

Professor Marie-Paul Austin spoke of the importance surrounding the link between screening and care pathways and the need for appropriate staff training. She addressed the challenges associated with mental health screening and the importance of embedding screening into practice at a local level.

Former government policy maker Chris Cuthbert (NSPCC) spoke of the recent changes in the UK that aim to influence mental health outcomes for families in the form of the Family Nurse Partnership, CPHVA, health visiting, mental health champions, the ‘1,001 Critical Days’ campaign and the formation of the Maternal Mental Health Alliance (MMHA). All of these are the agents of change to raise awareness of mental health and bring about equity of service delivery. He called on the audience to harness their collective talents and use alliances such as the Marcé and MMHA to present a united front that cannot be ignored.

Alain Gregoire continued on this theme with his session, ‘Perinatal Mental Health: Golden Opportunity for Equity, Parity, Priority and Investment’. He discussed the need to address generational trauma coupled with mental health, and said that the implementation message should be:
- Simple and consistent
- Frequent and ubiquitous
- Convincing and memorable
- Personal and attractive.

Dr Alain Gregoire is keen to promote the Every Body’s Business’ mental health campaign. The project, funded by Comic Relief, encourages the public to think differently and innovatively about mental health in order for it be considered as important as physical health.

Challenging and informative
The Marcé conference was a wonderfully intellectually challenging and informative three days. I came away inspired by all the work going on in the field of perinatal mental health, and felt privileged to have been invited to attend by the CPHVA. There were many eminent academic and scientific speakers, and I am proud that the health visiting profession was so well represented and highly regarded among the other professions working in this arena. I have already made a few changes to my practice, and with the help of senior staff hope to implement several more in the form of being the first health board in Wales to introduce mental health champions.
What is lactose intolerance and how can it be managed?

Lactose is a sugar found in milk and dairy. A deficiency in the enzyme lactase stops the body breaking down the lactose sugar.¹

Common symptoms
Undigested lactose remains in the intestine and can cause diarrhea, abdominal distension, nausea, flatulence and bloating.¹,²

Primary lactase deficiency
Lactose intolerance can affect any infant but primary lactase deficiency is genetic and more common in Hispanic, Asian and black populations, with around 20% of children under 5 affected.²

Although temporary, it may take weeks rather than days for lactase secretion to be adequately re-established. Formula fed infants may require a lactose free formula as a temporary substitute for standard cows’ milk formula.¹

Primary lactase deficiency
Lactose intolerance can occur because of damage to the intestinal brush border, where lactose production takes place. It is brought about by untreated coeliac disease, Crohn’s disease and severe gastroenteritis caused by infections, such as rotavirus.¹,²

Secondary lactase deficiency
A common, but temporary, cause of diarrhea, it often occurs because of damage to the intestinal brush border, where lactase production takes place.

Lactose free formula has been shown to provide comparable growth and key nutrient absorption; when tested it showed no significant differences for magnesium, phosphorus, calcium and nitrogen.³

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“Lactose free formula is well accepted and tolerated and maintained growth at a comparable level to that in infants receiving lactose containing formula.”⁶

SMA LF Lactose Free Formula
is designed specifically for the dietary management of primary and secondary lactose intolerance. It is nutritionally complete and can be used from birth.

The only whey dominant LF formula available in the UK and Ireland³

Omaga 3 and 6 LCPs

Fortified with iron to help support normal cognitive development³

Halal approved and suitable for vegetarians

Available on prescription or to buy at Boots and other pharmacies

*As of March 2014, as checked via company carreines

A health visiting sabbatical in South Sudan

Candy Barrett, Health Visitor, Sussex

In a remote corner of South Sudan known as Upper Nile State, Médecins Sans Frontières (MSF) (www.msf.org.uk) has constructed a hospital and staff accommodation out of tents and breeze blocks in an area that was previously covered in acacia trees and scrub. Over 100,000 refugees have migrated there, fleeing from aerial bombing in the north and now living in a series of camps with their goats, dogs and camels and large numbers of small children. Outbreaks of diseases such as hepatitis E, especially dangerous for pregnant women and young children, had led MSF to set up a project. There are many challenges: security, waste management, energy supply, language and HR issues to name a few, and all in extreme heat.

**HEALTH EDUCATION**

A few months earlier I had applied to take a sabbatical from my job as a health visitor working with Travellers and migrants in Sussex. Soon, I found myself sleeping in a tent, attached to an international team of 12 and over 100 Sudanese staff. Unexpectedly, aspects of my new role as Outreach Nurse Supervisor had similarities to my job in the UK. I had a team of 16 Sudanese staff, many of whom were living in the camp themselves and they were trained to do active case finding and health education.

In particular, we were looking for cases of malnutrition, acute watery diarrhoea (cholera) and yellow eye (hepatitis E). In small teams they would cover assigned areas of the camp, going from tent to tent seeking out sick people and referring them to either the local primary care clinic or if more serious to the MSF emergency room for admission. Arabic was the most commonly spoken language among the staff and refugees but some of the older camp residents only spoke their tribal language of In Jessana or Jumjum, increasing the chances of miscommunication.

As the rainy season came to an end and the temperature increased, the morbidities changed – chest infections and malaria cases replaced gastrointestinal diseases and there was a rise in the number of scorpion and snake bites. Small children would be brought, often at night, with pneumonia requiring oxygen, IV antibiotics and hydration, all of which were administered under canvas. In addition, there was a constant stream of children presenting with burns from falling or walking into the open fires, the families used for cooking in the camp. Issues of child supervision were difficult to address effectively when a woman was on her own with six or eight children, having been either widowed or abandoned.

**TRAINING NEEDS**

Only a very small percentage of South Sudanese people have had the opportunity to complete primary education and this meant that the training needs of the staff were great. Some of the outreach team could write their names but were unable to record any information. Hence, the education messages around hand hygiene and malaria prevention were very simplistic and relied on pictures rather than words.

Every month the World Food Programme did a general food distribution to camp residents, giving out quantities of sorghum, oil, sugar, salt and lentils to a representative of each household. Non-food items such as blankets, bed nets and soap were supplied by another non-government organisation (NGO). Hundreds of people would wait in line patiently, making an ideal audience for health education. New mothers would arrive carrying their babies in baskets on their heads. Camels were used by some to transport the goods back to the camp. Lactating and pregnant women received increased food rations – formula feeding was not an option. There was very little interest in MSF’s contraception options as the will of God was thought to be of more importance.

To encourage attendance at the Emergency Room of acutely sick people three donkey cart drivers were recruited to bring those who were too ill to walk. These men were living in the camp and were strategically located to provide maximum cover. Their MSF T-shirts meant they were very visible to others and immediately the attendance rates increased. Each child admitted had to have a carer with them, which was a challenge for single-parent households.

Now back in the UK, I have very fond memories of this time. It was a humbling and enriching experience. However, there has been extensive inter-tribal fighting leading to over a million people being displaced, as well as severe flooding, malnutrition and outbreaks of cholera. MSF is one of many NGOs that continues to work there.
under-18 rates: NF 4.5, 10.8, 12.8
whooping cough vaccination: NF 9.4
wired radiation: R 8.13
premature births
antibiotics: NF 3.8
emotional reactions: RE 10.12
false take: RE 12.12
pre-school children see also early years
asthma inhaler use: PR 12.44
dental care: PP 4.32
digital technology use: RE 7.13
measurement: NF 11.14
school starting age: NF 5.5
where: PR 4.45
prescribing
nurses cautious: NF 9.8
student concerns: NF 4.4
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conference: NF 3.49, 4.0, 12.50
dementia: RE 12.12
Ebolavirus guidance: NF 11.16
primary schoolchildren see also schoolchildren
obesity: NF 27.3, 6.7, 10.8
sex attacks: NF 3.8
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NHS services: E 8.3
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probiotics, no colic effects: NF 6.7
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R
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NHS staff: E 7.3
Welsh schoolchildren: NF 4.8
reading, Book Bus project: E 8.7
record keeping see also health records
HV standards: L 7.12
information governance: PP 2.43
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Recognising meningitis in children

EMMA NEWTON PhD
Clinical Scientist, Vaccine Evaluation Unit,
Public Health England

INTRODUCTION
Meningococcal disease (MD) encompasses meningitis and septicaemia, and is caused by the organism Neisseria meningitidis. The organism may either cause meningococcal meningitis alone, together with meningococcal septicaemia or meningococcal septicaemia alone. Meningitis is inflammation of the meninges. Septicaemia, also known as sepsis/blood poisoning, is infection in which large amounts of bacteria are present in the blood. Usually, septicaemia arises as a result of localised infection in the body, commonly meningococcal infection. When meningococcal infection occurs, first at a primary site (within the nasopharynx), the bacteria can enter the blood and are carried throughout the body, spreading infection to various systems of the body.

MD has a rapid onset with sometimes devastating consequences. It is most common in young children and teenagers, and as such is a highly feared disease, particularly as symptoms can be difficult to spot.

In the absence of appropriate treatment, the mortality rate as a result of meningococcal meningitis can exceed 50%. Even when diagnosis and treatment are applied appropriately, at least 10% of patients die, typically within 24–48 hours of the onset of symptoms. Approximately 10–20% of survivors are left with permanent sequelae such as mental retardation, deafness, epilepsy or other neurological disorders (Borrow, 2012).

DIAGNOSING MENINGITIS/SEPTICAEMIA
Generally, the first symptoms are fever, vomiting, headache and malaise. Some symptoms are more commonly associated with meningitis, while others are specific to septicaemia. It is important to recognise that some children may present with almost entirely non-specific symptoms/signs, which makes it especially difficult to diagnose ahead of other less serious infection, such as a viral infection (Tables 1 and 2). Table 3 shows some specific signs of the disease.

A rash that does not fade under pressure is a sign of meningococcal meningitis and/or septicaemia. This can be determined by performing the glass test as follows:
- Press the side of a clear glass firmly against the skin
- Spots/rash may fade at first

Table 1. Common non-specific symptoms and signs of meningitis and septicaemia (not necessarily present, especially in neonates)

<table>
<thead>
<tr>
<th>Symptom/sign</th>
<th>Meningitis</th>
<th>Meningitis and/or septicaemia</th>
<th>Septicaemia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Vomiting/nausea</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Lethargy</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Irritable/unsettled</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Ill appearance</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Refusal of food/drink</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Headache</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Muscle ache/joint pain</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Breathing difficulties</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

Table 2. Less common non-specific symptoms and signs

<table>
<thead>
<tr>
<th>Symptom/sign</th>
<th>Meningitis</th>
<th>Meningitis and/or septicaemia</th>
<th>Septicaemia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chills/shivering</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Diarrhoea, abdominal pain/distension</td>
<td>Y</td>
<td>Y</td>
<td>NK</td>
</tr>
<tr>
<td>Sore throat/coryza or other ear, nose and throat symptoms</td>
<td>Y</td>
<td>Y</td>
<td>NK</td>
</tr>
</tbody>
</table>

Y: symptom or sign present; N: symptom or sign not present; NK: not known if present (not reported)
Practice: CPD

• Keep checking
• Fever with spots/rash that do not fade under pressure is a medical emergency
• Do not wait for a rash. If someone is ill and getting worse, get medical help immediately.

MENINGOCOCAL VACCINATION

*Neisseria meningitidis* can be classified into 12 serogroups, although the vast majority of infections are caused by just six of these: A, B, C, W, X and Y (Harrison et al, 2009).

Various vaccines have been developed and trialled over the years, most using the polysaccharide ‘coat’ or capsule of the bacteria to generate an immune response. These polysaccharide vaccines can be used to combat meningococcal disease caused by serogroups A, C, W and Y but are poorly immunogenic in children under two years of age. For this reason, development of ‘conjugate’ vaccines arose where the polysaccharide capsule of the bacteria has a protein component attached and these vaccines induce good immune responses in all age groups.

The introduction of group C conjugate vaccines (MCC) into the UK schedule in 1999 has successfully achieved group C (MenC) disease control (Campbell et al, 2009).

The majority of meningococcal infections in the UK are now caused by serogroup B organisms. Although polysaccharide and conjugate vaccines against serogroups A, C, W and Y have been available for years, no serogroup B polysaccharide-based vaccine is licensed. This is because of the poor immunogenicity in humans and concerns over safety owing to the possible induction of auto-antibodies (Wyle et al, 1972; Finne et al, 1983). The polysaccharide capsule of serogroup B bacteria is similar to human fetal neural cell adhesion molecule (Bai et al, 2011).

For these reasons, other options have been explored regarding serogroup B vaccination, which has mainly focused on non-capsular vaccine candidates. Non-capsular antigens are antigens beneath the outer coat of the bacteria but which are accessible to immune responses which can be targeted by the vaccine (Findlow, 2013). The development of group B meningococcal vaccines has thus been based on the prediction of antigens (in silico ie, via computer software) with DNA sequence data.

Using this method, a four-component vaccine to combat group B meningococcal

<table>
<thead>
<tr>
<th>Table 3. Specific symptoms and signs</th>
<th>Meningitis</th>
<th>Meningitis and/or sepsicaemia</th>
<th>Septicaemia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-blanching rash$^a$</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Stiff neck</td>
<td>Y</td>
<td>Y</td>
<td>NK</td>
</tr>
<tr>
<td>Altered mental state$^b$</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Capillary refill time more than two seconds</td>
<td>NK</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Unusual skin colour</td>
<td>NK</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Shock</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Hypotension</td>
<td>NK</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Leg pain</td>
<td>NK</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Cold hands/feet</td>
<td>NK</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Back rigidity</td>
<td>Y</td>
<td>Y</td>
<td>NK</td>
</tr>
<tr>
<td>Bulging fontanelle$^c$</td>
<td>Y</td>
<td>Y</td>
<td>NK</td>
</tr>
<tr>
<td>Photophobia</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Kernig’s sign$^d$</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Brudzinski’s sign$^d$</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Unconsciousness</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Toxic/moribund state</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Paresis</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Focal neurological deficit including cranial nerve involvement and abnormal pupils</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Seizures</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

a) Rashes may be less obvious in darker skin tones – check soles of feet, palms or hands and conjunctivae
b) Include confusion, delirium and drowsiness, impaired consciousness
c) Relevant for children under two years of age. Other possible signs in babies include:
   • Refusing to feed
   • Irritable when picked up with a high-pitched or moaning cry
   • Stiff body with jerky movements OR floppy/lifeless
   • Absence of fever with babies under three months of age
d) One of the physically demonstrable symptoms of meningitis is Kernig’s sign. Severe stiffness of the hamstrings causes an inability to straighten the leg when the hip is flexed to 90°
e) A second physically demonstrable symptom of meningitis is Brudzinski’s sign. Severe neck stiffness causes a patient’s hips and knees to flex when the neck is flexed

Y: symptom or sign present; N: symptom or sign not present; NK: not known if present (not reported)

(Information in Tables 1–3 is taken from National Institute for Health and Care Excellence [NICE] guidelines, 2013)
disease has recently been licensed for use in the UK (Bexsero®; Novartis, was licensed from two months of age in Europe in 2013).

Bexsero® contains four immunodominant antigens: fHbp, PorA, NadA and neisserial heparin binding antigen (NHBA) (Bai et al, 2011). Invasive meningococcal strains may contain one or more of the vaccine antigens or variants, which may be expressed in different quantities (Vogel et al, 2013).

RECOMMENDATIONS FOR THE USE OF BEXSERO®

Children and adults with asplenia or splenic dysfunction may be at increased risk of invasive meningococcal disease. Given the increased risk, additional vaccinations against meningococcal disease are advised for individuals with asplenia or splenic dysfunction or when complement deficiency is diagnosed depending on age and vaccination history.

In the UK the Joint Committee on Vaccination and Immunisation (JCVI) has recommended the incorporation of Bexsero® into the infant immunisation schedule in a 2-, 4- and 12-month schedule, assuming it can be procured at a cost-effective price (JCVI, 2014).

**IMPORTANT POINTS TO CONSIDER**
- Presentation of meningococcal disease is often with non-specific symptoms (particularly in young children and babies) and is hard to distinguish from viral infection.
- If in any doubt seek further medical intervention as soon as possible.
- Do not wait for a rash to appear or for there to be photophobia/neck stiffness as these signs and symptoms, although perhaps the best known, are not necessarily present.
- The current UK infant immunisation schedule includes vaccination against meningococcal disease caused by group C but does not routinely vaccinate against group B, so vigilance is still paramount.
- Bexsero® is licensed in the UK and is available for particularly vulnerable groups but is not used routinely yet.

**REFERENCES**

**CPD questions (please visit www.communitypractitioner.com/CPD to submit your answers)**

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. In the absence of appropriate treatment, the mortality rate for meningococcal disease as a result of meningococcal meningitis can exceed what percentage?</td>
<td>A. 20% B. 30% C. 40% D. 50%</td>
</tr>
<tr>
<td>2. Approximately what percentage of survivors are left with permanent sequelae, such as mental retardation, deafness, epilepsy or other neurological disorders?</td>
<td>A. 5–10% B. 10–20% C. 20–30% D. 40–50%</td>
</tr>
<tr>
<td>3. Neisseria meningitidis can be classified into 12 serogroups, although the vast majority of infections are caused by how many serogroups?</td>
<td>A. 6 B. 5 C. 4 D. 3</td>
</tr>
<tr>
<td>4. In what year were the group C conjugate vaccines (MCC) introduced into the UK schedule?</td>
<td>A. 1989 B. 1999 C. 2000 D. 2004</td>
</tr>
<tr>
<td>5. The majority of meningococcal infections in the UK are now caused by organisms belonging to which serogroup?</td>
<td>A. A B. B C. C D. D</td>
</tr>
<tr>
<td>6. The current UK infant immunisation schedule includes vaccination against meningococcal disease caused by group C but does not routinely vaccinate against group B. True or false?</td>
<td>A. True B. False</td>
</tr>
<tr>
<td>8. How many immunodominant antigens does Bexsero contain?</td>
<td>A. 1 B. 2 C. 3 D. 4</td>
</tr>
<tr>
<td>9. Children and adults with asplenia or splenic dysfunction may be at increased risk of invasive meningococcal disease. True or false?</td>
<td>A. True B. False</td>
</tr>
<tr>
<td>10. Which of the following is a specific sign of meningococcal disease?</td>
<td>A. Fever B. Breathing difficulties C. Sore throat D. Non-blanching rash</td>
</tr>
</tbody>
</table>
Courses & Recruitment

COMMUNITY PRACTITIONER

www.communitypractitioner.com | www.unitetheunion.org/cphva

CONTACT: Claire Barber dl 020 7878 2319 e claire.barber@tenalps.com

The Brazelton Centre UK

Registered charity number 1158765
Telephone: 01223-314429

info@brazelton.co.uk www.brazelton.co.uk

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(Brazelton NBAS and NBO are recommended in the Healthy Child Programme, 2009, DOH and the New Health Visiting Specification, 2014/2015 and 15/16)

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Fee including book, kit, handouts and third day for certification: £695.00 (incl lunch, refreshments)

Newborn Behavioural Observations (NBO)
Systems Training
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Fee including book, kit, handouts, lunch and refreshments: £395-00

Please contact Tiffany Kerr: info@brazelton.co.uk
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For further details please visit www.iam.org.uk. In-house trainings are available on request.

IAMI UK Chapter
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info@iam.org.uk
www.iam.org.uk

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All our seminars and webinars are free to attend for those who are registered with the Hipp Hub healthcare professional website. Places are limited so register early to avoid disappointment.

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Wednesday 4th February online at 6pm
Register at www.hipphub.co.uk

Fetal Alcohol Syndrome – with Susan Fleisher (NODAS-UK)
Tuesday 17th February at Woodlands Hotel, Leeds at 6pm
Register at www.hipphub.co.uk

Child development – with Juliette Francis
Tuesday 24th February at Hilton St. Anne’s Manor, Wokingham at 6pm
Register at www.hipphub.co.uk

An introduction to autism – with Lorraine MacAlister
Wednesday 18th March online at 6pm
Register at www.hipphub.co.uk

Feeding infants – is less more? – with Professor Atul Singhal
Tuesday 21st April at the Royal College of Surgeons of England, London at 6pm
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www.touchlearn.co.uk

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Sarah Forster RGN HV Cert. Ed.
Professional Officer (Education)
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