Help parents teach healthy habits from the start

Cow & Gate Friends are designed to make vegetables an essential part of the weaning journey. This unique range of savoury food pouches helps parents start weaning with single vegetables and gradually introduce combinations of flavours, a process that helps create a love of vegetables for life.

Find out more about the ‘Start, Vary, Repeat’ approach to weaning at www.in-practice.co.uk/weaning.
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Wendy Nicholson
From the leading experts in organic infant nutrition, comes the UK’s lowest protein infant milk.

Ours is the first infant milk in the UK to contain less than 2g/100kcal protein, making the protein level and quality closer to that found in breastmilk. High protein intake in the first two years of life has been linked with an increased long term risk of being overweight or obese.

With prebiotic oligosaccharides (GOS) for healthy digestion, and Omega 3 & 6 LCPs for brain and tissue development, our formulas combine all the natural benefits of organic ingredients, with 50 years of breastmilk research.

Discover more at hipp4hcps.co.uk

@hipp_for_hcps

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 babies cannot be breastfed. The decision to discontinue breastfeeding may be difficult to reverse and the introduction of partial bottle feeding may reduce breastmilk supply. The financial 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.
It’s been another busy month here at Community Practitioner HQ. Way back in May I attended the Primary Care and Public Health conference in Birmingham. Unite/CPHVA professional officers Obi Amadi, Ros Godson and Ethel Rodrigues were also there; chairing, speaking and staffing the Unite stall. It was fantastic to hear about some of the initiatives from colleagues across different areas of health and how professionals are working together to reach their shared goals of better health for all.

I was fortunate to shadow Kerry Du Fraisse, a school nurse in Bedfordshire at the start of June. At one stage it didn’t look like the visit was going to happen, as the school required me to have disclosure and barring service (DBS) clearance and we didn’t think there would be enough time to get this and meet our print deadlines. Thankfully, in the end, we managed to push it through, and although it created a bit of a potential problem for a couple of days, it’s reassuring to know that checks on people who come into contact with children are so thorough, especially in a post-Saville era.

Speaking of eras, after its surprise majority victory in May, the new Conservative government have now had a couple of months to settle in and set out their plans for the forthcoming term. On page 10, the Unite in Health professional officer team respond to some of the proposals and explain what they think this will mean for children, families and the health service. Unfortunately, the outlook seems mostly quite bleak, so it’s more important than ever to fight for the services and rights you believe in.

Last month’s ‘breastfeeding special’ issue attracted lots of comments via email and social media. Although there was positive feedback, there was also considerable discussion, particularly about the evidence base of the article on lactation-related infections. International board certified lactation consultant and health visitor Carmen Pagor has written a response to the article on page 20 clarifying some of the myths and misconceptions presented. We welcome your views and responses to this, or any other article in Community Practitioner.

The third part of our caseloads special report culminated in a roundtable discussion on caseload sizes, weighting tools, and whether there should be a nationally mandated ratio. You can read a summary of the discussion on page 14. This issue is an ongoing project, and we’ll keep you updated in the journal and through the website www.communitypractitioner.com.

Amy Brewerton
@Amy_Brewerton
Acting Editor
SECRETARY OF STATE FOR HEALTH, Jeremy Hunt, has spoken for the first time since being reappointed as part of the new cabinet.

In a speech at the King’s Fund in London, he highlighted obesity and diabetes as being among the government’s top priorities for the health service.

‘One in five children leave primary school clinically obese,’ he said.

‘It is something that we cannot say that we accept. We absolutely need to do something.’

He claimed that the start of a new term in government would mean ‘a chance to put in place a national strategy for reducing diabetes and particularly child obesity.’

Hunt went on to describe the prevalence of weight problems in children as ‘a great scandal.’

The latest figures from the National Child Measurement Programme (NCMP) show that 19.1 per cent of Year 6 children are obese, with a further 14.4 per cent classified as overweight.

Hunt pledges ‘national strategy’ for child obesity

MORE THAN 23 PER CENT of British under-fives are an unhealthy weight, according to evidence presented at the European Congress on Obesity.

In Ireland, this figure rises to more than 27 per cent.

Researchers compared publicly available nutrition data from various countries from 1998 onwards. Adjustments were made for the various measurements and definitions of obesity across the different nations.

Kazakhstan had the lowest obesity rate of the 28 countries included in the study, with less than one child in 100 being overweight or obese.

Quarter of UK children overweight

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Mothers-to-be warned over paracetamol

RESEARCH HAS FOUND PROLONGED paracetamol use by pregnant women may reduce testosterone production in unborn baby boys.

Some male reproductive health problems could be affected by their mother’s use of the over-the-counter painkiller in the gestational period.

Reduced testosterone exposure in the womb can be linked to fertility problems, testicular cancer and undescended testicles.

Authors of the study suggest that paracetamol, the main pain reliever used during pregnancy, should be used at the lowest dose and for the shortest possible time.

This echoes existing guidance on the use of the pain-killing medicine.

Researchers at The University of Edinburgh studied the effect of paracetamol on testosterone production in mice.

Although they found there was no effect on testosterone production following 24 hours of paracetamol treatment, after seven days of exposure, the amount of testosterone was reduced by 45 per cent.

uk ranked 26th for maternal wellbeing

A REPORT BY SAVE THE Children has found UK mothers are worse off than those from countries including Slovenia, Israel and Singapore.

The annual Mothers’ Index assesses indicators of maternal wellbeing, such as mother and child health, education and economic status from 179 countries.

The UK ranked 26th, lagging behind Scandinavian countries such as Norway, Finland and Denmark, which dominate the top 10.

The under-5 mortality rate in the UK is 4.6 per 1,000 live births, among the lowest in the report. However, the lifetime risk of maternal death is one in 6,900. This is higher than countries such as Macedonia (one in 10,200), Poland (one in 19,800) and Slovakia (one in 10,200).

Hidden peanut allergy in asthmatic children

MORE THAN HALF OF children with asthma who tested positive for sensitivity to peanuts were unaware of their allergy in a recent study.

Preliminary findings from an ongoing study presented at the American Thoracic Society annual conference found, of 1,517 children with asthma, 22 per cent were also allergic to peanuts.

However, 53 per cent of these had absolutely no knowledge of their allergy to the legume.

Exposure to peanuts can cause anaphylactic shock in those who have the allergy, which in severe cases can be fatal.

It is therefore important important families are aware of the risks and moderate their diet to avoid the allergen.

The risk of peanut allergy is higher in children with asthma, or those who have other allergies such as egg allergy or eczema.

Cannabis use before puberty could stunt growth in teens

SMOKING MARIJUANA BEFORE puberty could cause boys to be up to four inches shorter than those who do not use the drug.

A study of more than 400 boys by scientists in Pakistan compared hormone levels of those who smoked cannabis with those who did not.

They found hormones that affect the onset of puberty, including testosterone and luteinising hormone, were far higher in boys that regularly took cannabis.

However, hormones responsible for growth were lower in the regular marijuana users.

By the age of 20, those who did not take the drug were an average of 4.6 inches taller than those who did.

They also weighed around four kilos more than the regular cannabis users.

It is estimated around 250,000 youngsters in England aged 11-15 took the drug in 2013.
ALISON SPIRO, a health visitor and Unite/CPHVA member from Harrow in North West London, has been awarded the Queen Elizabeth the Queen Mother Award for Outstanding Service by the Queen’s Nursing Institute.

Alison works as a specialist health visitor for breastfeeding in Harrow and is involved with direct patient care and service developments as well as teaching.

Harrow Community Services is only the second trust in London to achieve full Unicef Baby Friendly Accreditation.

As a result of Alison’s work to make Harrow breastfeeding friendly, businesses and cafes in the area now display ‘breastfeeding friendly’ stickers, with the local Starbucks even offering breastfeeding mothers a free cup of coffee.

One of only three nurses to receive this prestigious award, Alison received a certificate signed by HRH Her Majesty the Queen.

A MOBILE APP TO HELP PROMOTE active play in babies and young children has been designed by a health visitor in Kent.

Unite/CPHVA member Julia Haynes, who has been a health visitor for more than 28 years, had the idea for the Born to Move app after reading about findings that almost half of children start school without the necessary physical and social skills.

The app is being used by health visitors in Kent Community Health NHS Foundation Trust, where it has been piloted by a group of 100 parents.

It is intended to help parents and children to develop positive habits in active play, and deliver the best evidence-based information in an accessible format.
Meet your reps...
Kathy Walters is a Unite the Union rep for South East branch

TELL US A LITTLE BIT ABOUT YOURSELF
I qualified as a health visitor in 2003 having previously worked as a community midwife. My current role is as a seconded full-time convenor for the staff side at Kent Community Health NHS Foundation Trust, but my substantive post is in health visiting. I am a trustee for the McQueen Awards Charity within CPHVA, and this year we have awarded an unprecedented £15,250 in bursaries to five award winners who will be carrying out research and projects to further public health and our profession. In my personal time I am a volunteer youth worker and run a weekly group for teenagers, as well as two residential trips per year for 14-18 year olds. I am also an avid baker of cakes and maker of gemstone jewellery.

HOW LONG HAVE YOU BEEN A CPHVA REP?
I became a CPHVA rep in 2005 during the Agenda for Change (AfC) transition and have been branch chair or secretary (or sometimes both!) since 2007.

WHAT MADE YOU WANT TO BECOME A REP?
I have always been the one who speaks out and gets myself into trouble!

WHAT’S THE BEST THING ABOUT THE ROLE?
Being a rep is very much like being a health visitor in a number of ways. You have the skills and knowledge to help someone move forward in what they feel is a very difficult situation by listening and empowering them to make effective choices. You are able to unpick the complexity, reframe it and give them information and advice about potential ways to resolve the situation. It’s very rewarding.

WHAT’S THE BIGGEST CHALLENGE?
I suspect that any rep would agree with me that time is the biggest enemy. It’s important to get support from your colleagues who appreciate your role – one day it might be them needing your help. Another big challenge for a community trust is engaging your membership. In Kent we have run a series of really successful recruitment events, offering food and free goodies in their workplaces. Our branch meeting numbers are steadily increasing and we have nine accredited reps in our trust. Using branch funds for recruitment has been really successful and only last week we signed up 22 new members at an event.

WHAT WOULD YOU SAY TO ANYONE WHO IS THINKING OF BECOMING A REP?
Talk to your colleagues and get them on board. Meet up with an experienced rep and find out what it is all about. Get hold of the company facilities agreement to see what the organisation has committed to in terms of supporting reps in their role. Speak to your local full time officer to find out about local and regional support, training and contacts.

HOW CAN MEMBERS GET IN TOUCH WITH YOU?
The best way to contact me is via email at k.walters@nhs.net.

The app gives advice to parents at every stage of their child’s development, and can be personalised with the user’s own photos. Health visitor Julie says: ‘We all know that babies learn best if they “see it, hear it, and do it” through playtime and interacting with their parents, siblings and friends. ‘For example, awake tummy time helps your baby to learn to crawl, chatting and interacting with your baby increases their vocabulary, and reducing screen time and playing games encourages them to track objects and helps to strengthen eye muscles to learn to read.
‘Parents told me they wanted evidence-based, practical information to help them do what’s best for their child and to support brain development at each stage as, let’s face it, babies don’t come with instructions. ‘We know it’s ironic we’ve put this information into an app when we are encouraging parents to reduce screen time for babies. ‘But we can’t ignore the large part that technology plays in our lives, it’s the place we all turn to for information.’ The app can be downloaded from the App Store and Google Play.
A DAY IN THE LIFE OF A...
SCHOOL NURSE

WHEN I FIRST EXPRESSED AN INTEREST in shadowing a school nurse for the day, Unite/ CPHVA professional officer for school nursing, Ros Godson, put me in touch with Kerry Du Fraisse, a school nurse based in Bedfordshire. We emailed back and forth, and although Kerry and I were both desperately keen to go ahead with the visit, it quickly became apparent that it was going to be much more complicated than me just turning up for the day. Understandably, school security and checks are extremely tight, and the schools were reluctant to let a member of the press – even one from a professional journal – show up without the relevant checks and supervision.

After a lot of persuasion from Kerry, the schools agreed that provided I had disclosure and barring service (DBS) clearance, I would be able to accompany her on her visits to schools. I'm law-abiding to the letter and have a pretty boring past, but even so I was strangely nervous. Thankfully, and predictably, it was all fine, so we booked a date for early June.

Working in a team based in a local medical centre, Kerry begins her day at the office she shares with health visitors, community staff nurses and healthcare assistants. As I arrive, she explains that she has spent the last hour or so on the phone making sensitive calls regarding safeguarding, so my arrival was well-timed. Usually this time is spent on the phone or responding to a never-ending stream of emails, which Kerry likes to keep on top of as soon as she can. We move to a side room so that the rest of the team can continue with their confidential work, and Kerry explains a little more about how the service is structured. Bedfordshire, she tells me, has 20 qualified school nurses, who work closely with community staff nurses to deliver drop-in clinics and other services across the borough. She is clearly passionate about the school nursing service and about caring for young people.

Mid-morning, we head out to a local secondary school, an academy with around 500 pupils aged 11-18. Kerry had an appointment with a pupil who was currently undertaking their GCSEs so couldn't attend the usual drop-in, and had previously accessed the service. This was to be Kerry's final contact with the pupil, who would be leaving the school after the examination period, and she wanted to ensure the young person had the appropriate support in place and to say goodbye. When we arrived, the pupil was next door speaking to a professional from another service that Kerry had signposted the young person to, so once that had finished, I left the room to allow the session to take place. Afterwards, Kerry was pleased with how it had gone – the pupil was doing well and had agreed to share their exam results with Kerry later on in the Summer, although the pupil had become emotional knowing that this would be their last meeting.

We head back to the office and Kerry explains that although she is always there to give support to pupils, it's important they don't become too reliant on her and that they are referred and signposted to longer-term solutions. From their first contact, they are aware that pupils will have a maximum of five or six sessions with the school nurse. The majority of problems she encounters in young people are emotional or social – relationship issues, bullying, self-harm, problems at home, child exploitation, or pregnancy – and her role involves a lot of safeguarding work.

Knowing how to treading the line between...
confidentiality and disclosure is a particular skill that Kerry, and all school nurses, possess. At the start of a session, Kerry tells the student that everything they say will be confidential, but if they tell her something that causes her to be concerned for their safety, she will have to pass it on. Transparency and trust are key to building this relationship, and it’s important to make sure young people aren’t afraid to disclose private information. Kerry explains how sometimes the smallest things – the colour of her nails, her shoes or her handbag – can give students something to latch onto and begin to open up.

The next visit was a drop-in session at another nearby academy, which is currently transitioning from a middle school to a secondary school. Bedfordshire is one of only two local authorities in the UK where its state schools have historically been broken up into infant, junior, lower, middle and upper schools – however, these are slowly becoming single-site primary and secondary schools. We arrived at the school during lunchtime, by which point there were already two pupils waiting for the nurse to arrive. One of the students was very reluctant to go into the room and was starting to turn away, but her friend stood firm and encouraged her in. Both girls went into the room - Kerry later explains that friends are allowed in if they have permission, as often they will have told the friend their problem first and can be a useful prompt.

The room in this school was chosen because it enables pupils to come along without others seeing them – there is direct access from the playground, but it is also hidden from view. At one stage, a group of boys were messing around at the window, at which point Kerry and the student moved round into a more private area to maintain confidentiality.

During the visit, the school safeguarding lead helps Kerry to track down a pupil she had previously spoken to who she wanted to follow up with. Kerry works closely with the pastoral team, with whom she shares information when necessary. They are holding a training event where teachers and other school staff will be able to meet the school nurse team and learn more about their role as multi-skilled professionals, and how they can work together to deliver better outcomes for children.

As the drop-in session came to an end, Kerry heads off to a local primary school to do some safeguarding work. This school hadn’t given their permission for me to attend, so at this point we said goodbye and I made my way back to London. I was left with an overwhelming feeling that the school nursing service is extremely valued by pupils themselves, as well as by the multidisciplinary team that work so hard to keep the students safe, happy and protected.

I was impressed at how comfortable pupils were with approaching Kerry, remembering the times of the drop-in sessions, giving up their lunch breaks to speak to her, and understanding the role of school nurse. This is largely down to the promotion that Kerry is able to do, working with schools to take assemblies, provide posters and leaflets, and educate other staff so that everyone knows how they can access the service.

One young person summed up their experience with Kerry: ‘I feel that having a nurse who does drop-ins into school is very beneficial. This is because it is an extra person who you can speak to, knowing that everything you say is confidential.

‘Having the extra person to talk to helps to get things off your chest without being judged. After having experienced meetings with a school nurse, I can very easily say they help a lot! I am massively grateful of my school nurse talking with me and helping me through the tough situations.’
Educational Roadshow 2015

As part of the build-up to this year's Annual Professional Conference, Unite/CPHVA will be holding a series of free one-day educational roadshows across the UK. Each roadshow will complement the Annual Professional Conference programme, covering topics such as behaviour management, children's eczema and childhood obesity.

The Unite/CPHVA Educational Roadshow will be visiting the following cities:
- Liverpool – 2nd July
- Brighton – 6th July
- Southampton – 7th July
- Slough – 9th July
- Cardiff – 14th July
- Exeter – 16th July
- Nottingham – 15th September
- Carlisle – 17th September

For more information and to register your place, visit www.cphvaroadshow.co.uk.

#CPHVAttCPD

IT’S NOW EASIER THAN EVER for members to gain continuing professional development (CPD) hours as #CPHVAtTwitter discussions now count as CPD. During each chat session, which run on Twitter every Tuesday at 7-8pm, participants will be invited to complete a short survey. They will then receive a certificate via email, which can be printed out and included in their professional portfolio. This evidence of CPD participation can be used as part of registrants' Nursing and Midwifery Council (NMC) revalidation. As part of the requirements coming into force from next year, all registered nurses will be required to demonstrate they have undertaken 40 hours of CPD over the previous three years, at least half of which need to be participatory. Twitter Tuesday chats can count towards the participatory element of the CPD requirements.

Campaign for compulsory PSHE in schools

UNITE/CPHVA HAS SIGNED A LETTER TO THE NEW SECRETARY of state for education, Nicky Morgan, urging the government to make personal, social and health education (PSHE) compulsory in schools.

A recent independent survey of 1,000 12 to 15-year-olds found that, of those taught PSHE education in England, 92 per cent agreed that all young people should receive these lessons.

The government's education committee recommended in February 2015 that PSHE should be given statutory status, and Unite/CPHVA are among the bodies to urge the government to implement the committee's recommendations.

PO top tips: revalidation

DAVE MUNDAY, PROFESSIONAL OFFICER at Unite/CPHVA, gives his top tips for successful Nursing and Midwifery Council (NMC) revalidation:

- If you don't understand the basics of the process, get to know what you’ll need to do after April 2016 soon.
- Start recording now! This includes your 40 hours of CPD, your five bits of feedback, your five reflections on the Code and your hours worked.
- Think about how you can do some simple things to get your CPD hours. For example, read your Community Practitioner, complete the online CPD, join in #CPHVAtTwitter (which now includes #CPHVAttCPD) and join us at both your regional CPHVA Roadshow and CPHVA Annual Conference.
- Keep an eye on Community Practitioner where our revalidation expert, Jane Beach will be providing more info.

Read more about Dave and the other professional officers’ experiences as part of the revalidation pilot at www.communitypractitioner.com.

Our Voice, Our Direction: Annual Professional Conference

THE UNITE/CPHVA ANNUAL Professional Conference is coming to Manchester in 2015. Join us on the 17-18 November at the leading event for community practitioners in the UK. Bringing together colleagues from around the country, this is a unique opportunity for you to hear the latest professional and strategic changes that will affect your day-to-day practice while developing core skills to ensure you are remaining at the forefront of public health.

The 2015 conference features a brand new programme of inspirational and incisive talks. This year’s theme is ‘Our Voice, Our Direction’ and gives you the chance to hear about the latest examples of implementation, integration and inspiration in community practice.

Over the two days you will gain practical advice and guidance from professional experts, and the chance to share best practice with your peers and colleagues.

Reasons why you should attend:
- Access to a dedicated conference programme that will give you practical insights to take away and reflect on in your role.
- Opportunities to network and share experiences with community practitioners and leading healthcare organisations around the UK.
- A tailored programme to meet your professional needs with a choice of break-out sessions and masterclasses.
- Hear inspirational success stories from your colleagues and the pioneering work they are doing in their regions.
- The opportunity to develop your skills and share experiences.

For more information on the programme and confirmed speakers go to http://cphvacconference.co.uk.
HER MAJESTY THE QUEEN OUTLINED
the priorities for the new government at the
state opening of parliament.
Addressing the House of Lords and the
House of Commons, Her Majesty laid out
plans put forward by the Conservative Party
for their forthcoming term in office.
However, the plans have attracted
criticism from senior figures in Unite/CPHVA,
who explained their fears to Community
Practitioner.

FAMILIES AND CHILDREN
One of the priorities of the new government
includes the expansion of the Troubled
Families programme, and benefit cuts to
encourage young people to 'earn or learn.'
Responding to this announcement, Unite/
CPHVA professional officer Rosalind Godson
says: 'The Troubled families programme is
good, but expensive, so it will be interesting
to see where the funding is coming from.
The legislation being suggested around
welfare reform is reducing young people's
entitlement to housing benefit before age 25.
'Young people without the support of
loving families have been treated very badly
by this government: if you have nowhere to
live, how are you meant to get up, wash and
dress and get ready for work or training?
The previous government removed
the education maintenance grant which
meant that young people couldn’t afford to
catch the bus to college so missed out on
acquiring skills for work.'
Plans for more academy schools have
also been put forward, with the intention of
improving ‘failing and coasting’ schools to
give every child the best start in life.'
Godson continues: ‘At the same time
government is legislating for local authorities to influence the public health of
school-aged children, and in particular to
finance school nurses in these schools.
‘Local authorities are commissioners of
school health services and have a duty to
promote co-operation between relevant
partners to improve the physical and mental
health of school-aged children.
‘School governing bodies are legally
responsible for fulfilling their statutory duties,
but there is only guidance that says they
should establish relationships with relevant
local health services to help them and to take
advice from healthcare officials.
‘State-funded academies do not have
to follow the national curriculum for PHSE
[personal, health and social education] and the
local authority has no oversight as to how each school is delivering
 equitable public health outcomes.'

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curriculum for PHSE [personal, health and social education] and the
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equitable public health outcomes.

Ros Godson, professional officer for school nursing

‘My main question is how are these measures to be funded, on the
back of a less than robust recovery, with no tax, VAT or National
Insurance increases? The Conservatives now claim to be the party of
the working people but with the other hand will attack your human
rights and working rights.'

Gavin Fergie, professional officer for Scotland and Northern Ireland

‘Another problem is that it’s not just about
time, but about quality of childcare as well.
Governments are interested in the first but
not the latter.'

INDUSTRIAL ACTION AND
PROFESSIONAL ISSUES
Her Majesty explained how the new
government intend to ‘bring forward
legislation to reform trade unions and to
protect essential public services against
strikes.’
Commenting on this proposal, Barrie
Brown, acting head of health at Unite, said:
‘Our members in the NHS have never taken
industrial action that creates a risk to patients.
‘This proposed legislation is intended
to make any challenge to attacks on our
members pay and benefits more difficult at
a time when Agenda for Change is under
review.’

Unite/CPHVA professional officer in
charge of regulation, Jane Beach, expressed
disappointment that calls for the inclusion
of the legislation resulting from the Law
Commission recommendations went
unheard.
‘These changes to the regulators’ legislation
would have streamlined fitness to practice
processes leading to improved patient safety and reduced costs for registrants,” she said.

**NHS and Health**
The speech touched on the government’s plans to secure the future of the NHS by implementing NHS England chief executive Simon Stevens’s Five-Year Forward View, and ‘by increasing the health budget, integrating healthcare and social care, and ensuring the NHS works on a seven-day basis.’

Commenting on these plans, Brown continues: ‘Our members across the NHS have always provided a seven-day service.

‘The issue will be how staff in the NHS are paid when working unsociable hours to deliver seven-day services, and whether the increased health budget will recognise the contribution health professionals make to patient care.

‘For the past five years, when their pay has reduced in real terms while senior NHS managers have had significant pay increases’

Munday added: ‘The £8 billion promised before the election was an pledge that many believe the Conservatives knew they would never need to implement.

‘It will be the poorest who shoulder this burden through their regressive policies.

‘It’s important to remember however that this £8 billion will only allow the NHS to mark time, delivering no new investment in the service, for example to pay for the seven-day service that David Cameron promises.’

Gavin Fergie, professional officer at Unite/ CPHVA, questioned the practicalities of the proposals: ‘My main question is how are these measures to be funded, on the back of a less than robust recovery, with no tax, VAT or National Insurance increases?

‘The Conservatives now claim to be the party of the working people but with the other hand it will attack your human rights and working rights.’

The Queen also announced that legislation will be introduced to ban the ‘new generation’ of psychoactive drugs.

Acting national officer for Unite in Health, Kevin McAdam, welcomes this move, but highlights other concerns. “Undoubtedly we would welcome the banning of psychometric drugs and hope that this government intends to remain proactive in countering this scourge on society,” he says.

‘There is much in the speech which refers to the health service and Unite would have concerns about the detail of seven day services while our members are already engaged in seven-day provision of many services we feel that an open all hours solution, unless adequately funded and resourced, will dilute health provision rather than improve it.

‘Without considerable direct investment there will be the potential for the poor outcomes experienced currently at weekends to be spread over the rest of the week rather than bringing the weekend up to weekday standards.

‘Unite, as with other trade unions, remain committed to engage with the department and employers on this subject.

‘The issue of integrated care across England has the potential to drive the NHS through another major change which may take years of implementation with the ensuing chaos that bedevils any change to the NHS.

‘At this time, what patients/clients and workers in the service need is a period of stability and investment in services to secure the NHS into the future.’

What do you think about the government’s plans for families, children, the NHS and health? Do you agree with the professional officers? Tweet us your thoughts @CommPrac

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**What does the election result mean for NHS staff?**

**By James Lazou, Research Officer, Unite in Health**

**THE DUST IS SETTLING ON MAY’S general election but the future looks no less bleak. After the shock result of a Conservative majority it is likely to be a tough few years for NHS staff.

After this year’s bitter pay dispute, the government is yet to announce next year’s pay policy but the Chancellor has made it abundantly clear that cuts to departmental budgets are set to continue. Privatisation is expected to rocket in the NHS as the breaks put on by the uncertain election result have been lifted.

The renewed drive for devolution and integration with social care also carries risks as the Tories have said there will be no new money to bring the services together.

Cameron’s government has not wasted any time with their other pet political projects. One of the first policy initiatives announced has been the renewed attacks on trade unions and trade unionism, particularly in the public sector.

There has been a ratcheting up of initiatives designed to target working people’s ability to speak out and resist bad policy. This has included attacks on trade union political funds, a proposal wholly absent from the Tory manifesto.

They have announced plans to introduce 50 per cent turnout of all eligible trade union members balloting for strike action and insist that at least 40 per cent of workers vote for strikes in essential public services, instead of the straight majority now required. They have also announced plans to allow employers to use agency staff to cover striking workers.

The reality is these proposals are designed to outlaw the right to strike in the UK public sector in all but name, especially given the arcane laws requiring postal ballots for industrial action. These changes will put the UK out on the far extremes of Europe in our industrial relations policy and bring us in line with more authoritarian regimes.

The proposals are totally hypocritical as they will not apply to other votes in the UK, such as the general election where for example the new Tory administration only received 36.9 per cent of the vote.

Unite has been calling for reform of industrial action ballots to bring them up to date with modern technology. This includes requests to be able to use electronic balloting methods that would help raise turnouts. So far, government has refused to support these proposals, putting pay to the lie that their proposals are about increasing workplace democracy.

One thing is for sure Unite will not give up your workplace rights easily, even if this is the fight of our lives.”
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Amy: What have people found that is the situation in caseload numbers? Are they high, is it variable, are there a lot of discrepancies around the country?

Obi: I would say in terms of the experiences that I have and the people that I speak to, there is a wide variation. I think that there’s probably a bigger problem with high caseloads in the urban areas like London, Manchester, Birmingham, whereas in some of the more rural areas it’s less of a problem.

Christine: And the whole implementation plan with the pressure on practice teachers that students experience, I mean the fall out from all of that is all very obvious.

Julie: It takes a long time just to settle. It’s great that we’ve got the new staff in, I know that Birmingham managed to hit our target, but it’s still the new staff settling down, I want to say it’s like passing a driving test isn’t it? You’re not confident until at least a year, two years down the line. So there’s a lot of pressure on the teams.

Amy: I think one of the things that stood out when we were doing our research and were speaking to health visitors was that they were saying it’s like a knife edge, and things are working in a lot of teams at the moment, but as soon as something else changes, that’s what tips it from manageable to completely unmanageable.

Christine: I think another one of the elements is because it’s more than just numbers; it is also something about the support that the practitioners get as well. Because if there is a reasonable amount of support and supervision, it’s not quite so overwhelming.

Julie: It’s retaining the staff as well, once you’ve recruited isn’t it? Mentoring within the teams to help support the newly qualified.

Christine: I’m not in practice at the moment, but the recommendation of the one to 300, or one health visitor to 250. That seems to be okay for delivering the universal service and the five contacts that are stipulated, but if you’re going to have universal plus and universal partnership plus, you actually need to increase the amount of staff you have. It’s a case of trying to find a formula that actually weights those caseloads so the right number of staff are there to meet the needs of the
population because that’s how it should be defined, not just about numbers.

Julie: We’re still in a situation in Birmingham where it is higher than that target; we have around 330 I think whole time equivalent. Some teams might be lower than that and some teams might be higher, so there’s a lot of remodelling going on. We do have a caseload monitoring tool, the allocation tool that I use, which feeds into the Benson dependency tool to help feedback into that.

Dave: I think thinking back to where we were in 2009 and before, there was often the discussion about whether we need a maximum number. And one of the problems with that was you couldn’t take everything into account, so you couldn’t take in skill, you couldn’t take in deprivation. In terms of the Family Nurse Partnership, there’s a clear maximum there of 25 families for a full-time equivalent. There needs to be a maximum so that then you can work back. Scotland has come out to say something different in terms of using a tool to tell us how many health visitors we need, but the proof will be in the pudding in terms of how they manage that when it comes out.

Christine: ACRA is talking about using the child poverty as an indicator rather than the Index of Multiple Deprivation (IMD). The IMD and child poverty are fairly closely correlated, so I think it doesn’t really matter which one we use. Obviously not all people in poverty need extra services, and not all vulnerable families will be in particular areas.

Dave: The Health visitors - an endangered species paper did really well in terms of getting a ratio, but the problem was that we knew there were outliers where organisations were using corporate caseloads, whether they’re using a named health visitor caseload or what they’re doing.

Dave: So irrespective of how the caseloads have settled, you could say, well on average we’ve got this. The problem is that what organisations do is to say, ‘Well actually, we know our figures would be terrible, so we’re only going to talk about nought to twos, or nought to threes’ and try and massage the figures that way.’

Christine: And of course caseloads vary tremendously, like you said. But it depends doesn’t it, whether people are using corporate caseloads, whether they’re using a named health visitor caseload or what they’re doing.

Amy: Are we going round in circles?

Christine: A full circle. But in terms of the health visitor’s motivation and general feelings of well-being and being able to manage, it was certainly much better than the corporate approach. But this is just one area; they’re just looking at it to see how it goes.

Dave: I think that, going back to what I said before that I think whatever system you use, if people do it well it will be good, and if people do it badly it will be bad.

Amy: So in terms of the implementation plan, has that affected caseload numbers?

Julie: Massively so. My team’s gone from the equivalent of about 3.75 full timers to about 11. So yes, it’s had a huge impact.

Christine: This minimum floor of 300 to one health visitor has been put forward, and the fact that there needs to be weighting for deprivation has been acknowledged, but how much should the weighting be? How much more time is needed? And I think as a profession we need to be saying what we need. The ACRA said that with the mandated visits, it thought an end review would take an hour, a new baby review two hours, six to eight check one hour, a one year review one

‘It’s like a knife edge, and things are working in a lot of teams at the moment, but as soon as something else changes, that’s what tips it from manageable to completely unmanageable’
Dave: I don’t think anyone will have more money, I think everyone will have less. In some areas it could be really damaging I’m sure and I suppose in some respects that’s what it was before 2010. It’s not about who’s got the purse strings, it’s more about whether the person making the decision interested in what you do. The danger that we face after the implementation plan is that health visitors will be told, well you’re a resourced professional now, you’ve had all the days of training, you can go out there and convince everyone.

Julie: But this is like your point about we’ve got to get in there now to try and show evidence so that we have a say in how it’s continued.

Dave: When you talk to the people that have been part of the implementation plan nationally, they’re really keen to make sure the health visitor doesn’t fall off the edge of a cliff.

Amy: So what should health visitors be doing? What is the most effective thing for them to do?

Dave: The easiest thing is for something to be set nationally that’s good. We’ve had the great example of the implementation plan, before the implementation plan we had lots of areas fighting to get more health visitors, and maybe one in 20 managed to achieve something, 19 in 20 failed. So you see that situation now, health visitors will be going individually to local commissioners and trying to argue for a better situation but actually, will their influence ever make a big enough difference?

Julie: The mandated thing isn’t every part of our role isn’t it? It’s a very small part of the whole picture. The tool that we introduced in Greet, the whole idea was that it was about transparency within the team. It came from having the staff there and having the work, and sharing equitably but putting the report together, it actually reflected on information that we hadn’t got before, which hopefully will have some impact so the commissioners are aware that this is the extra work that’s coming through on a weekly basis and that wasn’t being picked up in our caseload figures that we submit monthly, because that’s all around the actives but it wasn’t actually looking at other stuff that we do on a weekly basis.

Dave: If you don’t have the mandation, then there’s nothing set in stone, but having it means that there’s only five things you have to do and why (would commissioners) do anything else?

Julie: Yes, and there’s lots of other stuff that we know that we do and wonder if it’s still going to be our place.

Dave: Well it puts health visitors in the situation that they argued the implementation plan should’ve solved. That we’d have people that could put a case together, argue the case, get the funding and go off and do it because it make a difference to communities, but it doesn’t work like that always.

Amy: So what kind of advice would you give to anyone who’s worried? What should they be doing?

Dave: The best thing to do is to have a national standard, and why isn’t there one? And like you say the ACRA stuff in terms of funding might mean that something is brought forward and made sense, but what’s the argument against it? Will they say it’s all down to local areas?

Christine: They are looking for tools, they’re looking for people to put forward the weighting tools, and I think if you’ve got experience of using something that’s worked, then we need to share that because again, it’s in our hands.

Amy: So do you feel that there is space for a national level weighting tool, or do local influences still need to be taken into account?

Christine: I think you could say that there’s a national minimum floor of one health visitor to 300. But then, you’ve got to add in a weighting tool for deprivation. I think that, I don’t know, what do other people think? I mean we said 250 originally, 250, 300, I think well 300 possibly if you’ve got a universal five mandated visits?

Amy: With the research we did in Community Practitioner, only around half of the people we spoke to even used any kind of caseload weighting tool. I don’t know if that’s a worry, if people should be aiming to at least try and use something, even if it’s not nationally mandated?

Christine: Way back in the early 1990s when I was working in a village in Hertfordshire, I remember complaining that actually the caseloads were too large, and it wasn’t equally distributed amongst the team, and
working out how many children per hour a health visitor had on the caseload. I remember trying to get some equity across what we were doing. I wasn't popular for trying to do that, but that was the nearest we got. It wasn't about client need actually, in this case it was about health visitor need to have something that was actually manageable.

Dave: When I was in practice, one of the things that we developed was really basic red, amber and green system where we looked across all the families in a caseload, if you were red you got three points, if you were amber you got two points, if you were green you got one point, you then added that up at the end, you then divided that by the staff. It can create a lot of problems in itself because actually you find that the areas where people want to work have too many health visitors, and the areas that people don't want to work have too few health visitors. So then you have to move some of those health visitors and they say, 'well actually, I don't want to move, if you move me I'll leave,' and they leave and that causes problems. So there's that kind of reality to it.

Christine: Yes, that was going on where I worked in Edmonton, because Edmonton was a very deprived area, we didn't have enough health visitors, but some of the surrounding areas where there was a much nicer clientele if you like. The health visitors out there didn't want to move into the area.

Dave: And that's a problem in itself. What you may find is those easier areas are actually at the right level, they've got the right number of staff for families, so you actually feel like you can do a decent job and you can deliver a service, so why would you want to move to an area that's poorly served, if you'll go home every night feeling like you've not done your job?

Julie: Health visitors need job satisfaction, we need to be able to do what we can, and we need not to go home stressed at the end of the day and tearing our hair out.

Christine: In thinking about weighting for deprivation too, that the other thing that needs to be taken into account is not just the visit with the family or the extra visits, but the extra meetings. There does seem to be an amazing amount of meetings that health visitors have to attend on behalf of children who had development problems, or behaviour problems in addition to just the safeguarding case conferences.

Obi: With the implementation plan, with all these extra health visitors and all the additional things they're doing, there's an additional need for supervision and support that's not necessarily factored in. The number of safeguarding nurses hasn't grown particularly in any significant way, when really if you think about the support that people should need because of the additional what they're doing, are they getting it?

Amy: What is the best way to get commissioners to listen?

Christine: They need a taste of it on the ground. It's definitely the consensus that we do need to put our case forward and try and have something that reflects what that is.

Obi: Another thing that is not directly linked to caseloads, but it has implications on the caseload is it's a whole generation since the whole downsizing, rationalisation of the health visiting service. The client group that we have now, many of them haven't seen what good looks like and don't necessarily have an awareness of what the whole potential offer could be. They appear to accept the service offered. Imagine what the demand would be if people understood and demanded the whole service, rather than what has been commissioned or prioritised. We have evidence that when the service is explained to parents, they want to receive it.

Julie: And I think that's where health visiting has always been, that's been the sticking point hasn't it really? Now there's more evidence. I think that's got to help.

ROUNDTABLE REFLECTION

Unite/CPHVA considers that the following principles are essential:

- The maximum caseload size for a full time health visitor must be 250 children. The level of deprivation will influence this figure downwards. This is irrespective of skill mix.

- Following the progress made under the health visitor implementation plan, the number of health visitors needs to continue to increase to achieve the new model of service demanded.

- Every child must have an individual named as their health visitor, ensuring continuity for the child and their family. Teams should be organised in such a way as to ensure allocation of a named health visitor to all children is maintained particularly in the event of absence through illness or vacancy for example.

- Health visitors must be supported by their employer professionally in respect of access to preceptorship, clinical supervision, (not limited to child protection supervision) and the requirements necessary for NMC revalidation.

- Health visitors lead on co-ordination and delivery of the health child program. Qualified community nursery nurses and other members of the team support them.
ADHD linked to eating disorders

CHILDREN WITH ATTENTION DEFICIT hyperactivity disorder (ADHD) are at an increased risk of developing an eating disorder, according to a study published in the International Journal of Eating Disorders.

A common biological mechanism was found between ADHD and loss of control eating syndrome (LOC-ES), which is similar to binge eating disorder.

The study involved 79 children aged between 8-14, and found that the children with a diagnosis of ADHD were 12 times more likely to also have LOC-ES.

Overweight or obese children with LOC-ES were also seven times more likely to have ADHD than overweight or obese children who do not have LOC-ES.

Researchers suggested that children with both conditions may suffer with a greater level of impulsivity as part of their ADHD that influences eating patterns. There also may be a common risk factor, such as genetics.

Further research is needed to establish the reasons for the link, but the authors hope there will be scope for strategies to help children with both conditions.


High altitudes increase SIDS risk

A study by researchers from the University of Colorado School of Medicine has found that children living at high altitudes are at increased risk of sudden infant death syndrome (SIDS).

Oxygen levels at high altitudes are lower than those of low altitudes, which may contribute to hypoxia in infants.

Analysing data from local birth and death registries and looking at the areas in which the parents live, scientists found that 79.6 per cent of infants in the Colorado sample lived at below 6,000 feet, 18.5 per cent at 6,000 to 8,000 feet, and 1.9 per cent at more than 8,000 feet.

It was found babies under one year old who live 8,000 feet or higher above sea level are 2.3 times more likely to become victims of SIDS than those living at less than 6,000 feet.

The results were unaffected by other determinants such as parental age, age of infant, race, education, breastfeeding status, maternal smoking or socioeconomic group.

Altitudes in some parts of Colorado, a popular ski destination, can top 14,000 feet. However, the highest point in the UK is the summit of Ben Nevis, at around 4,400 feet.


Dog bites in children on increase

The number of children being admitted to hospital as a result of dog bites has risen in the past year, according to statistics from the Health and Social Care Information Centre (HSCIC).

More than 1,500 children in England aged nine or under were hospitalised due to dog bites or strikes between March 2014 and February 2015.

This is a 10 per cent increase on the previous year’s statistics.

The most common injuries sustained from dogs during this period were bites to the head or arms, with children more likely to sustain injuries to the head than adults.

Other mammals that were responsible for bite injuries included rats, farm animals, horses, foxes and cats.

Merseyside has the highest rate of animal-bite related hospitalisations in England, with Kent and Medway reporting the lowest.

Eight out of ten overall admissions were in urban areas, and the rate of admissions for dog bites were between two and three times as high for the 10 per cent most deprived areas.

To prevent dog bites from occurring, NHS Choices advises never leaving a child unsupervised with a dog, regardless of the breed or its previous behaviour.

The risk of bites can also be reduced by not approaching unfamiliar animals, in case they react aggressively.

The complete data can be downloaded from the HSCIC website: www.hscic.gov.uk/pubs/hesapr14feb15
EXPLORING THE SCIENCE OF THE SENSES™ IN HEALTHY BABY DEVELOPMENT

A strong body of existing and emerging research suggests that multisensory stimulation—or the concurrent stimulation of tactile, olfactory, auditory, and/or visual stimuli—benefits the social, emotional, cognitive, and physical development of babies.

A baby’s brain creates up to 1.8 million new synaptic connections per second, and a baby’s experiences will determine which synapses will be preserved.1 Stimulation is essential early in development; within the first 3 years of life, there is rapid development of most of the brain’s neural pathways supporting communication, understanding, social development, and emotional well-being.2

Stimulating multiple senses sends signals to the brain that strengthen the neural processes for learning. Through consistent multisensory experiences, research shows that babies gain healthy developmental benefits, such as reduced stress in healthy and preterm infants3,4 and better quality and quantity of sleep in healthy babies,5 as well as improved weight gain which led to earlier hospital discharge in preterm infants.6

Everyday experiences in a baby’s life can develop and stimulate his or her senses and provide parents an opportunity to nurture their baby’s ability to learn, think, love, and grow. A simple ritual of bath time and massage is an ideal opportunity to create a multisensory experience. Bath time provides an opportunity for increased skin-to-skin contact (touch stimulation)7 and direct eye contact,8 as well as the introduction of new textures, sights, sounds, and smells that can stimulate a baby’s tactile, visual, olfactory, and auditory senses. The sense of smell, in particular, is directly linked to emotional memory,9 a mother’s scent can help soothe a crying baby,10 while a pleasant scent during bath time is shown to promote relaxation in both baby and parent.7

A ritual that includes a warm bath followed by massage with a gentle skin moisturiser can be created that can contribute to a lifetime of healthy development.

Multisensory stimulation—what a baby feels, smells, hears, and sees at every moment—helps promote the long-term survival of synaptic connections during brain development.1

Making Bath Time Part of a Ritual Improves Sleep5

Although science has made advances in understanding the long-term benefits of multisensory stimulation, there is more to be done to translate this research into everyday practice. By encouraging parents to view everyday rituals, such as bath time and massage, as opportunities for multisensory stimulation, experiences can be created that can contribute to a lifetime of healthy development.

For more advice and information, please contact jbhcppcontact@its.jnj.com

EXPLORING THE SCIENCE OF THE SENSES™

This promotional advertorial was developed in collaboration with Dr Charles Spence, Head of Crossmodal Research Laboratory at the University of Oxford and sponsored by JOHNSON & JOHNSON. Prof Spence received a fee for participation in this initiative.

References:

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Breastfeeding: myths and misconceptions

MYTH: ‘If the breasts are not producing sufficient milk to satisfy the newborn, there should be no hesitation in offering some additional bottle feeding. Babies do not get ‘confused’ and will happily take to bottle and breast - that is, to whatever satisfies their appetite. By 48 hours, most breasts will be producing sufficient milk and supplementary bottle feeding can be stopped or used intermittently as needed.

On day one the newborn has a stomach capacity of 6ml, increasing to 12ml on day two (Wilson-Clay and Hoover, 2013; La Leche League, 2013). The drops of colostrum a mother feeds her newborn are physiologically normal and meet the needs of the healthy infant. A newborn’s swallow is approximately 0.6ml; an effective feed on day one being around eight to 10 swallows (Lawrence, 2011). The onset of copious milk production typically happens around day three.

Unnecessary early supplementation with formula has been shown to significantly reduce the duration of breastfeeding (Ekstrom, 2003).
Supplementing without medical indication is undermining for the mother and can damage her confidence in her body and the process of lactation. Day three and days 10-14 have been shown to be pivotal or ‘crisis points’ in cessation of breastfeeding (UNICEF, 2012), demonstrating how vital evidence-based practice and sensitive input is in the early days. The UNICEF Ten Steps of the Baby Friendly Hospital Initiative suggests giving newborns time to learn to breastfeed without interference or unnecessary interventions, especially bottles (UNICEF, 1998).

The notion that a mother can just stop bottles is unrealistic when her confidence may have been shattered by being told she was not able to satisfy her baby’s hunger from birth. The action of drinking from a bottle is completely different to breastfeeding, which can alter the suck pattern for a newborn making them reluctant to return to the breast (La Leche League 2013, 2014). Interfering with the breastfeeding dyad by supplementing with artificial baby milk can lead to engorgement; this milk stasis can lead to blocked milk ducts and potentially mastitis. Aside from the risk of these breastfeeding complications, supplementation can have a negative impact on the milk supply. Once the placenta has been delivered, lactation depends on a supply and demand system. The more supplementation, the less time spent stimulating milk supply, therefore the less milk is made (Hoover and Wilson-Clay, 2013).

For the baby, disruption of exclusive breastfeeding alters gut flora, increases risk of cow’s milk protein allergy, insulin-dependent diabetes and the risk of infection (Riordan and Wambach, 2010). The human immune system is immature at birth. Breastfeeding is a dynamic process that allows the mother to effectively share her well-developed immune system with her baby. Breastmilk is a living food, which cannot be replicated by any artificial baby milk. The secretory immunoglobulins (SIgA) in colostrum coat the gut offering protection from pathogens. Exposure to foreign proteins interrupts this process and damages the permeable gut (Hoover & Wilson-Clay, 2013). In the case of low income families a mother’s milk has been shown to have up to three times the levels of SIgA’s than a higher income mother. It is as though breastfeeding can also assist in protecting against the harmful impacts of poverty (Best Beginnings, 2015; Riordan & Wambach, 2010).

Myth: In cases of early breast infections… ‘For women who want to continue to breastfeed but don’t want to feed from the affected side, the short-term solution is to express and discard from the affected side’. In the management of breast abscesses… ‘The majority of women will be advised to stop breastfeeding’. Lactation may need to be suppressed to enable healing to take place, ‘the majority of women will be advised to stop breastfeeding to minimise ongoing complications’.

It is rarely necessary to avoid feeding from the affected side in the case of mastitis. Current research supports the continuation of breastfeeding where possible, offering affected side first to ensure milk flow (Riordan and Wambach, 2010; Hoover & Wilson-Clay, 2013; Mohrbacher and Stock, 2003). If the mother is too uncomfortable to feed from the affected side support with expressing should be offered to protect supply and avoid inflammation and infection from worsening. The milk is safe to be fed to the baby (Hoover and Wilson-Clay, 2013; Riordan and Wilson-Clay, 2010). It may be necessary to discard milk in the case of a breast abscess if the breast is still draining pus and the baby is unwell or premature. This is due to the high number of pathogens (AAP, 2012). Leaking milk in a wound may be beneficial due to the immune factors, anti-inflammatory properties and human growth factors (Hoover and Wilson-Clay, 2013). Therefore milk suppression should not be advised without careful consideration.

Becoming a mother is a monumental life event that can bring an increased vulnerability. It is the role of the healthcare professional to share evidence-based information and sensitive input to encourage the mother to have faith in her body and ability to nourish her baby. Without interference, the mother is physiologically programmed to care for and feed her baby (Best Beginnings, 2015). The release of oxytocin during breastfeeding promotes early attachment behaviours as well as facilitating the milk let down reflex. Oxytocin is impacted negatively by stress, thus demonstrating importance of sensitive input at this stage.

References

July 2015 Community Practitioner 21
95% of Paediatricians* reported an improvement in common infant feeding problems with a formula like Cow & Gate Comfort

Evidence shows these partially-hydrolysed formula milks containing oligosaccharides (GOS/FOS) improve the symptoms of colic in bottle-fed babies.1,2 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

*Out of 96 paediatricians


Comfort for babies, relief for mums
Skin cancer is now the most common form of cancer in the UK. At least 250,000 people in the UK are diagnosed with skin cancer each year, of these over 13,000 are melanoma - the most deadly form of skin cancer. On average, seven people in Britain die each day from the disease.

Since the 1970s, skin cancer rates in the British public have increased at alarming rates. A number of reasons are to blame for this, such as cheaper holidays abroad, the continuing desire to have a tan and poor sun protection habits. We also often hear from people who do not consider skin cancer to be a serious disease, and therefore they don’t take the appropriate measures to protect themselves. In addition, many think that the sun in the UK is not strong enough to give rise to skin cancer.

Sadly, these misconceptions are leading people to expose their skin to the sun without protection. As outlined above, this has led the UK to a skin cancer crisis.

Caused by ultraviolet radiation from the sun, skin cancer can develop from either short intense exposures or damage that has accumulated over the years. While skin cancers can affect any age group or skin type, most commonly they appear in the over 65 demographic and in fairer toned skins. Having said this, skin cancer is disproportionately represented in the 16-24 age group. Likewise,

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British Association of Dermatologists

Sun exposure: know the risks

SIX STEPS TO PROTECT CHILDREN

1. USE WATERPROOF SUNSCREEN WHEN SWIMMING, AND REAPPLY AFTER DRYING
2. BABIES under six months should always be kept out of direct sunlight
3. USE A HIGH FACTOR SUNSCREEN AND REAPPLY OFTEN REMEMBERING TO APPLY TO ALL EXPOSED AREAS
4. DRESS children in loose, cool clothing that covers their back, shoulders and tops of arms and legs
5. A FLOPPY HAT WITH A WIDE BRIM WILL HELP TO PROTECT A CHILD’S FACE AND NECK
6. BETWEEN 11am and 3pm, children should be kept out of the sun
while skin cancers can appear anywhere on the body, the most common place for them to occur in men is on the back and on the legs in women.

A recent study conducted by the British Association of Dermatologists, surveyed over 1000 people in regard to their sun protection habits and knowledge. 77 per cent of people acknowledged that they would not recognise the signs of skin cancer, and a further 72 per cent admitted to having been sun burnt in the past 12 months (Reference, year).

If we are to see a decrease in the number of individuals developing skin cancer within the UK, then the British public must start taking sun protection seriously. On sunny days, it is recommend that a sunscreen with a sun protection factor (SPF) of at least 30 is applied half an hour before going outside, again shortly after going in the sun, and then reapplied liberally every two hours. It also important to reapply after any activities which might accidentally remove the sunscreen, such as swimming or towel drying. You must ensure that your chosen sunscreen provides a good level of ultraviolet A (UVA) protection, which will block out the sun’s harmful UVA rays associated with ageing. European Union (EU) regulations state that the UVA protection offered by each sunscreen should be a third of its SPF. Products that meet this criteria are stamped with the letters UVA surrounded by a circle. Sunscreens that offer SPF 30 and possess a UVA rating of four or five stars are generally considered high quality protection, it is not the first line of defence.

It was a new strange little pink spot on my leg - which looked a bit like a mole - and itched, that caused me to go straight to my GP in June 2013. I was told that the spot did not look like something to worry about (and that it was likely a venous haemangioma which would fade). I was told to monitor it for any changes, and return if it changed in any way. I monitored the spot regularly by examining my skin and using my camera phone to keep a visual record. Six months later, it suddenly changed when I was shaving my legs and caught it with the blade. It bled profusely and then scabbed over. I went straight back to the GP and was immediately referred to a dermatology specialist for a biopsy. A week later, I was called in for the results – and the bomb was dropped. Malignant melanoma, of unknown depth. Everything from then until now seems to have blurred into a series of appointments, scans, and surgeries.

Following my diagnosis, I was rushed straight into hospital for an operation in which the surgeon removed an extensive amount of tissue surrounding the melanoma. For the sake of a tiny spot, I was left with a 10cm scar down my thigh. But that wasn’t the end of it. I underwent blood tests, full-body scans, and a brain scan since it was unclear whether the melanoma had already metastasized around my body. Although the first round of tests were negative, follow up scans a few months later detected melanoma in a lymph node in my groin. I underwent a second surgery in September 2014. This was a groin dissection, a four-hour operation in which a cluster of lymph nodes are removed and then analysed for melanoma. Of the 13 lymph nodes removed during that surgery, one showed the presence of melanoma. With a new diagnosis of stage 3b melanoma and a scarily poor survival statistic at five years, I began to consider myself officially a cancer patient.

Although my latest full body computed tomography (CT) scan in May 2015 was stable, I am currently exploring all further treatment options, including the option of joining a clinical drug trial. Over the past few years there have, fortunately, been some exciting developments in the field of immunotherapy drugs used to treat advanced melanoma, and potentially decrease the chance of melanoma recurring.

During the past 12 months I have learned that, unfortunately, my story is not an unusual one. Skin cancer is rapidly becoming one of the most common cancers among young people, and if not caught early it can be deadly.

My melanoma diagnosis has completely turned my life upside down. As a result of having the lymph nodes in my right groin removed, I now have to wear a support stocking on that leg most days. If I don’t am at risk of getting lymphoedema in that leg. A chunky thick leg stocking is not the summer accessory that most 30 year olds would choose, plus it affects what I can and can’t wear. Luckily I’m not too affected by my scars, but again, as a young woman, I’d obviously prefer if my leg hadn’t been turned into a patchwork quilt. However, if a few scars are all I have to pay for having my life saved, I’m OK with that. Beyond the physical issues that I have with my leg, it’s the psychological impact of melanoma that I struggle with most. Dealing with the worry that the cancer will return can be exhausting, and it’s only in the last few months that I’ve felt more accepting of my uncertain future.

As a result of my experience, I am now working with the charity Trekstock on their THRIVE initiative, helping young people thrive in the face of cancer.

Lauren McDonald, 30, is a doctor from Brighton

Until last year I was a fit and healthy 29-year-old. Despite my medical training, I still considered skin cancer a relatively rare disease that happened after decades of excessive tanning, and certainly not something that I would find myself up against while still so young. Raised in North Devon, I have always had plenty of outdoor hobbies and lived an active lifestyle, often involving spending time in the sunshine.

However, during my 20s I spent less time in the sun, and became much more vigilant, making sure to apply high factor sunscreen regularly if spending time outdoors. However, looking back at my teenage years there were a few occasions where I can remember accidentally burning.

Case Study

‘Skin cancer is disproportionately represented in the 16-24 age group’

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All skin types can enjoy the sun...

with the UK’s most prescribed sunscreen

Some people are more susceptible to developing conditions such as sunburn, pigmentation, skin ageing and even skin cancers. But these people can still enjoy the sun, with your help.

SunSense is the highest factor sunscreen available for all ages and skin types (SPF 50/50+). Formulated to meet the Australian standard – the most stringent in the world – it contains high-quality ingredients that help protect against UVA and UVB radiation and is dermatologically tested, making it suitable for sensitive skin. Plus, the range comes with a suite of educational materials for healthcare professionals, parents and teachers, on the importance of sun safety.

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Our range of SPF 50/50+ sunscreens has been formulated for every skin type. It’s free from paraaminobenzoic acid derivatives and lanolin, and uses physical blocker and a variety of chemical UV absorbers to provide very high levels of sun protection. Plus, we’ve now introduced SunSense Kids (previously Toddler Milk) for children aged 6 months and above; SunSense Sport Gel and SunSense Sport Mist for active bodies; and SunSense Sensitive Mattè.

The UK’s No.1 prescribed sunscreen

Sunscreens are often prescribed to people with skin photosensitivity problems, either as a result of cancer or genetic conditions. In the UK, British dermatology nurses prescribe more SunSense products than any other brand due to its high efficacy and superior skin feel.

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References:
1. NHS BSA prescription services, prescription cost analysis England 2014 data.
Five simple steps: #CPHVAtt Twitter Tuesdays

Every Tuesday from 7-8pm, Community Practitioner (@CommPrac) and Unite/CPHVA (@Unite_CPHVA) join forces on Twitter to host a live chat on issues affecting young people and healthcare professionals.

Below are five simple steps to help get you started with Twitter Tuesdays:

1. **Sign up for Twitter!**
   Simply go to www.twitter.com and follow the instructions to sign up for an account. You only need to supply the minimum required information if you’re worried about online security. You can use Twitter through the web or via an app.

2. **Follow people**
   You can see what people are saying on Twitter by ‘following’ them. Try searching for and following @Unite_CPHVA and @CommPrac as a starting point. People can also ‘follow’ you, which means they get to see what you post.

3. **Write a tweet**
   Messages on Twitter are called ‘tweets’. When you post a tweet, it is potentially visible to everyone, and will show up on the home page of anyone who follows you. Tweets have to be 140 characters or less, so use them wisely.

4. **Use hashtags**
   Hashtags are words that start with the ‘hash’ (#) symbol. They are used on Twitter to link similar content together. For example, the Twitter Tuesday hashtag is #CPHVAtt. Anyone who searches or clicks on this hashtag will see all the tweets related to the chat. You can use popular hashtags or even make up your own.

5. **Join our chat**
   Log into Twitter from 7-8pm on a Tuesday and make sure you’re following @Unite_CPHVA to find out the theme for this week’s discussion. Any tweets you send during this time that include #CPHVAtt will form part of the chat. Click or search #CPHVAtt to view all the tweets in the chat.

**And finally...**

Don’t forget that everything on Twitter is public, so be mindful of this when sending tweets. The Nursing and Midwifery Council (NMC) and Unite/CPHVA both provide guidance on the responsible use of social media. Other than that, get stuck in and don’t be shy - everyone is helpful and friendly! Twitter Tuesday chats are fun, informative and can even count as self-directed continuing professional development (CPD).
Salmonella in pets: the risk to children

INTRODUCTION
You visit a baby boy at home following a handover from the community midwife. His parents are keen to meet you and chat about their first-born son. You notice a large tank in the living room and on questioning, his parents explain that they keep iguanas, which live in the tank but are able to roam freely around the house. They ask if this poses any risk to their baby and, not knowing the answer to their question, you say you will endeavour to find out.

In 2013 it was estimated that 13 million (45 per cent) households in the UK had pets (Pet Food Manufacturers Association, 2013). Although dogs and cats are the most popular types of pet, there has been an increase in the number of people owning exotic pets in recent years. This may be due, in part, to the 2007 modification of the Dangerous Wild Animal Act (1976), which removed some exotic animals from the list of animals requiring a license if kept as a pet (Dangerous Wild Animals Act 1976 Modification, 2007).

A wide range of infections can be associated with pets, including parasitic, bacterial, fungal and viral diseases. Human salmonellosis attributable to reptile exposure was first documented in the 1940s, and a large number of case reports have since described zoonotic transmissions of salmonella from reptiles to humans (Hoelzer, 2011). The exact number of reptile-associated salmonellosis cases among humans is difficult to determine, but one study estimated that in the USA reptile exposure is associated with approximately 74,000 human cases annually (Mermin, 2004).

Although the primary source of salmonella infection in humans is contaminated food, it has been estimated that 3–5 per cent of all cases of salmonellosis in humans are associated with exposure to exotic pets, including iguanas, turtles, sugar gliders and hedgehogs (Woodward, 1997). An estimated 90 per cent of all reptiles carry salmonella in their gastrointestinal tract and shed salmonella in their faeces, and around the world a large number of serotypes have been isolated from feral and captive reptiles as well as their eggs. Reptiles carrying salmonella are generally asymptomatic, and clinical salmonellosis is rare.

Treating reptiles with antibiotics to eliminate salmonella from their intestinal tract has not proven to be effective. Doing so increases the risk of emergence of antimicrobial-resistant salmonella strains, and attempts to raise ‘salmonella-free’ reptiles have been unsuccessful (Bradley, 2013).

REPTILE-ASSOCIATED SALMONELLA
Reptile-associated salmonella infection in humans is more likely to present with systemic disease than food-borne infections. After an incubation period of around 12–24 hours, salmonella produces symptoms of headache, fever, malaise, nausea, vomiting, abdominal pain and diarrhoea, which may contain blood. A study by Meyer Sauteur (2013) found that, although reptile-associated salmonella manifested mainly with gastrointestinal disease, 15 per cent presented with invasive disease, 15 per cent presented with invasive disease, including septicaemia, meningitis, arthritis, osteomyelitis and joint disease, and children with invasive disease were significantly younger than those with non-invasive disease.

To determine the association between reptile ownership and salmonellosis, Ackman...
(1995) reviewed New York State salmonella case reports and conducted a matched case control study. The authors contacted 24 people with selected salmonella serotypes and found that 12 out of 24 case patients owned reptiles compared to two out of 28 controls (matched odds ratio, 6.6; 95 per cent confidence interval, 1.4 to 31.0). Ten of the case patients (but no controls) owned iguanas, and 10 of the 12 case patients were aged six months or under. The reasons for the high prevalence of salmonella among infants and children are not clear but may include biological, immunological and behavioural determinants (Olsson, 2001).

Mermin and colleagues looked specifically at Salmonella marina infection in children in a 12-month period (Mermin, 1997). Of the 32 children infected, 26 (81 per cent) were infants (less than one year of age), compared to children with other salmonella isolates of which only 14 per cent were infants. Of the study group 34 per cent were hospitalised and one died and 28 (88 per cent) of the study group reported iguana exposure, although only four (14 per cent) reported touching an iguana. A number of human salmonella outbreaks have been attributed to indirect reptile contact. Reptile-associated salmonellosis occurs frequently in small children, who are rarely allowed direct contact with reptiles, suggesting indirect exposure routes. A case control study found presence of reptiles in the home to be a highly significant risk factor for salmonellosis in infants <1 year of age, strongly suggesting a predominant role of indirect transmission (Mermin, 1997). Given the large number of indirect transmissions, the USA Centers for Disease Control and Prevention (CDC) recommends that households with young children (under five years of age) do not own reptiles and that reptiles are not introduced into school settings.

**PUBLIC AWARENESS OF SALMONELLA**

Few reptile owners are aware of the risk of disease. In Mermin’s study (Mermin, 1997) only 12 families (43 per cent) realised that the iguana may have been the source of infection, and in another study from USA only 20 per cent of case patients were aware of the association between reptiles and salmonella infection (CDC, 2008). If individuals are unaware of the risk, good hand hygiene, which has been shown to be highly protective in preventing infection, may not be strictly enforced (Friedman, 1998). There is a zoonosis risk from contact with animals in pet shops. Some families visit pet shops as a leisure activity, where children can see and handle animals, potentially exposing them to disease, even though they do not own a pet. Halaby and colleagues performed a systematic review of the literature and found 57 cases of disease or incidents associated with pet shops or other facilities (e.g. animal shelter, educational organisation) distributing companion animals. The infection described most often was psittacosis followed by salmonellosis (Halaby, 2014).

Evidence suggests that many pet shop employees do not fully understand or control the risks imposed by their pets. Ipsos MORI conducted a poll in 2003 for the RSPCA contacting 300 pet shops selling exotic pets. When asked whether any illnesses may be passed on from the pets to other animals or humans, 48 per cent replied ‘No’ - if take precautions, e.g. hand washing; 36 percent replied ‘No’ – not at all and 11 per cent said ‘Don’t know’ (MORI, 2003).

It has been shown public education campaigns do work. In USA the Association of Reptilian and Amphibian Veterinarians (ARAV) produces a client education handout with basic facts on how to avoid transmission of Salmonella from reptiles to humans, and in Sweden following the distribution of information based on that produced by ARAV, the number of reported cases of reptile associated salmonellosis decreased significantly (de Jong, 2005).

**CONCLUSION**

Reptiles are becoming increasingly common as household pets, and with them comes the risk of reptile-associated salmonella infections, with infants and young children particularly at risk. Frequently, only a single person in the household is affected and severe clinical manifestations may occur even as a result of indirect contact. Recommendations for reducing the risk of Salmonella to humans from exotic pets (including turtles and tortoises) include:

- **Those handling exotic pets should wash their hands thoroughly after both direct and indirect contact**
- **Aquariums and cages for exotic pets should not be cleaned in kitchen sinks**
- **Exotic pets should be confined to aquariums or cages and should not be allowed to roam freely in areas occupied by children**
- **Veterinary surgeons and pet shop owners should give information to potential purchasers and owners about the increased risk of acquiring salmonellosis from exotic pets**
- **Health professionals should be aware of the risks and when seeing families with small children they should enquire about family pets.**

**References**


28 Community Practitioner July 2015
How common are infant feeding problems and how can they be managed?

The first few months of an infant’s life can be a stressful time for their small bodies as they adapt to digesting a range of nutrients and they will often experience mild gastrointestinal (GI) disturbances. In fact, up to 55% of babies will experience symptoms such as mild constipation, colic and wind in the first 6 months of life.

Modifying standard infant formula to help digestion

Adaptations can be made to standard first infant formula which may help alleviate the challenges faced by an immature GI tract.

**Partially hydrolysed whey protein**

Breast milk provides a very fast gastric emptying time that reduces the risk of digestive disturbances. For formula fed infants, partially hydrolysing the proteins to form smaller peptides makes the formula easier to digest.

**Reduced lactose**

In the immediate weeks after birth a young baby’s body is often unable to efficiently digest lactose, and this can cause discomfort due to wind. The symptoms of colic; fussing, crying and wind, can be difficult for both baby and mother. Reducing the levels of lactose is one potential strategy to help reduce the amount of wind babies produce. For some colicky babies, decreasing the concentration of lactose in formula has been found to result in an improvement in crying and wind.

**SN-2 enriched fat blend**

An SN-2 enriched fat blend structurally resembles that found in breast milk and is well absorbed by infants. As the fats are more easily absorbed, formula using an SN-2 enriched fat blend is proven to reduce soap formation in stools and help make stools softer. A recent study has also found that infants fed formula with an SN-2 enriched fat blend spent significantly less time crying than babies whose formula did not contain the same fat blend.

**Practicalities of preparation and feeding**

Some comfort formulas contain thickeners which require the use of a fast flowing teat. They have a thicker texture which can become more viscous as the liquid cools and have the potential to block normal flow teats. SMA Comfort milk has been designed to be easily digested and therefore there is no need for a thickener.

*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 breastfed. The decision to discontinue breastfeeding may be difficult to reverse and the introduction of partial bottle-feeding may reduce breast milk supply. The financial benefits of breastfeeding should be considered before bottle-feeding is initiated. Failure to follow preparation instructions carefully may be harmful to baby’s health. Infant formula and follow-on milks should be used only on the advice of a healthcare professional. ©Registered Trademark

SMA Comfort is an easy to digest infant milk. It is designed specifically to care for healthy babies who are experiencing stomach troubles. It is nutritionally complete and can be used from birth.

- The only comfort milk without a thickener (no need to use a fast flow teat)
- Halal approved and suitable for vegetarians
- Available on the Healthy Start scheme
Diabetes in children

INTRODUCTION
Diabetes mellitus (DM) is a chronic medical condition resulting in high levels of blood glucose. DM is caused by insufficient insulin production or insufficient sensitivity to insulin, or a mixture of both. Type 1 DM develops if the body cannot produce insulin. Insulin is a hormone that helps the glucose to enter the cells where it is used as fuel by the body. Type 1 DM is the most common type of diabetes seen in children but overall accounts for only 10 per cent of all people (i.e. children and adults) with DM (Diabetes UK, 2011). Type 2 DM develops when the insulin produced by the body is not working properly (insulin resistance) or not enough is being made. Type 2 DM is associated with factors such as obesity, South Asian ethnicity and family history (Haines et al, 2007). Type 2 DM is thought to affect older people. However, type 2 DM is becoming increasingly common in children due to increasing obesity in children. This article will discuss Type 1 DM, the most common types seen in children and is referred to as diabetes in the rest of the article.

EPIDEMIOLOGY
Type 1 diabetes is one of the most common endocrine diseases in children. Worldwide, an estimated 65,000 children under 15 years old develop the disease each year, and the global incidence in children continues to increase at a rate of three per cent a year. There are about 29,000 children and young people with diabetes in the UK (Ali et al, 2009), out of which about 26,500 have Type 1 DM (Diabetes UK, 2011). The current incidence in the UK is around 26 in 100,000 per year. In a large UK general practice, a child with new diabetes will be seen about every two years (Ali et al, 2011).

CHILDREN WHO ARE AT INCREASED RISK OF DIABETES
Diabetes is a common health condition. The chances of developing it may depend on a mixture of factors – genetic, lifestyle and environmental factors. Type 1 diabetes develops when the insulin-producing cells in the pancreas have been destroyed. No one knows for certain why these cells get damaged, but the most likely cause is the body having an abnormal reaction to the cells (an autoimmune condition). This may be triggered by viral or other infections (Craig et al, 2014). Children with some other autoimmune conditions such as coeliac disease and autoimmune hypothyroidism are also at higher risk of developing diabetes (NICE, 2004).

Genetics play a major risk for developing diabetes in children. The risk among children with type 1 DM in first-degree relatives is about 15 times higher than in the general population. The risk of developing diabetes in a child where a first-degree relative has type 1 DM is highlighted below (Diabetes UK, 2011).

- Mother: 2-4 per cent
- Father: 6-9 per cent
- Both parents: 30 per cent
- Sibling: 10 per cent
- Non-identical twin: 10-19 per cent
- Identical twin: 30-70 per cent.

DIAGNOSTIC DILEMMA IN DIABETES IN CHILDREN
The classic symptoms of diabetes may not be evident in children under two years and subtle and non-specific symptoms such as headache, constipation, oral and vulval thrush, abdominal pain, vomiting may be the presenting feature (Diabetes UK, 2012). It can be difficult to distinguish from other acute illnesses at the initial stages in younger children and therefore a high index of suspicion among health professionals is important. In older children and adolescents, polyuria and polydipsia are the main symptoms of diabetes in all age groups, occurring in up to three-quarters of school-aged children (Roche et al, 2005). However, these symptoms are not always mentioned initially and must be elicited by a proper history-taking. Nocturnal enuresis in a previously dry child is the earliest symptom of diabetes in 89 per cent of children over the age of four years (Roche et al, 2005). Weight loss occurs in 50 per cent of those aged 10-14 years, but in only five per cent of children under two years (Williams et al, 2012). Lethargy occurs in 10-20 per cent of children of all ages. Constipation is an important symptom in the under-fives, occurring in around 10 per cent, secondary to chronic dehydration (Roche et al, 2005). Recurrent infections are uncommon as a presentation, occurring in only two per cent, although oral and vulval thrush has been reported more commonly (Diabetes UK, 2012).

CLINICAL PRESENTATION
Diabetes UK has launched the ‘4Ts’ campaign which largely summarises the clinical symptoms of diabetes (Diabetes UK, 2015):

- **Toilet:** going to the toilet a lot, bed wetting by a previously dry child or heavier nappies in babies
- **Thirsty:** being really thirsty and not being able to quench the thirst
- **Tired:** feeling more tired than usual
- **Thinner:** losing weight or looking thinner than usual.

Polyuria and polydipsia are the main symptoms of diabetes in all age groups, occurring in up to three-quarters of school-aged children (Roche et al, 2005). However, these symptoms are not always mentioned initially and must be elicited by a proper history-taking. Nocturnal enuresis in a previously dry child is the earliest symptom of diabetes in 89 per cent of children over the age of four years (Roche et al, 2005). Weight loss occurs in 50 per cent of those aged 10-14 years, but in only five per cent of children under two years (Williams et al, 2012). Lethargy occurs in 10-20 per cent of children of all ages. Constipation is an important symptom in the under-fives, occurring in around 10 per cent, secondary to chronic dehydration (Roche et al, 2005). Recurrent infections are uncommon as a presentation, occurring in only two per cent, although oral and vulval thrush has been reported more commonly (Diabetes UK, 2012).
as polyuria misdiagnosed as urinary tract infection), exclusively focusing on one or more symptoms (such as oral candidiasis), and not performing appropriate investigations (such as blood glucose or urine tests) (Pawłowicz et al, 2008).

Between 10 and 70 per cent of these diagnosed children present in DKA, a metabolic derangement characterised by the triad of hyperglycaemia, acidosis, and ketonuria. In a Canadian study of 3,947 children with newly-diagnosed diabetes, 735 (18.6 per cent) presented with DKA, and this rate was highest among children aged ≤3 years; 39.7 per cent in comparison to 16.3 percent for children >3 years of age (Bui et al, 2010). Another study from the UK with 99 children, 27 out of 99 (27.2 per cent) presented in diabetic ketoacidosis (DKA) (Sundaram et al, 2009). The same UK study recorded a delay in diagnosis in 21 out of 99 (21.2 per cent) cases by >24 hours due to missed diagnosis at the local hospital (n=4) or by the general practitioner (n=7), arranging a fasting blood glucose test (n=9) and outpatient appointment requested via fax (n=1). Children presenting with DKA had symptoms for a mean of two weeks, up to a third had at least one medical consultation in the week before diagnosis, and misdiagnosis was associated with a threefold increase in DKA (Usher-Smith et al, 2011).

If ketoacidosis has already supervened, then the symptoms can include vomiting, deep sighing respiration, reduced conscious level, and abdominal pain. Because of these, DKA can be misdiagnosed as acute abdomen, possible severe gastroenteritis, acute asthma, or pneumonia if the parents are not asked about a history of polyuria and polydipsia. (Ali et al, 2011).

WHY DOES THIS MATTER?

Some children can develop dehydration and acidosis within 24 hours of first presentation of diabetes, and children under two years of age are at most risk. In a recent UK study, a higher proportion of children with delayed diagnosis presented with DKA in comparison to those with no delay in diagnosis (52 per cent compared to 21 per cent) (Sundaram et al, 2009). DKA is the leading cause of mortality and morbidity in children with Type 1 diabetes, 10 children a year die from DKA in the UK. Most diabetes-related deaths are due to cerebral oedema, which is more common when DKA occurs at the onset of diabetes (Edge et al, 2009).

History and observation (weight loss, unexplained infections, thirst, etc) both play an important role in raising suspicion about diabetes in children. In cases where a health visitor or school nurse considers diabetes as a strong possibility, they need to inform the parents of the child and suggest immediate referral via their GP to be seen straight away in hospital by a paediatrician. This is to confirm the diagnosis of diabetes, make sure that they are not in DKA and to start treatment with insulin to prevent this serious complication.

DIAGNOSTIC CRITERIA FORDIABETES IN CHILDHOOD AND ADOLESCENCE

Diagnostic criteria for diabetes are based on blood glucose measurements and the presence or absence of symptoms. Different methods can be used to diagnose diabetes and in the absence of unequivocal hyperglycaemia, blood glucose level must be confirmed by repeat testing.

The current criteria for diagnosis recommended by The American Diabetes Association (2014) and World Health Organization (2006) is either:

- A random (i.e. any time of day without regard to time since last meal) blood glucose level of >11 mmol/L, OR
- Fasting (i.e. no calorie intake for at least eight hours) plasma glucose >7.0 mmol/L.

If symptoms are present, urinary ‘dipstick’ testing for glycosuria and ketonuria, or measurement of glucose and ketones using a glucometer, provides a simple and sensitive screening tool. If the blood glucose level is elevated, then prompt referral to a centre with experience in managing children with diabetes is essential. Waiting another day specifically to confirm the hyperglycaemia in a fasting state is unnecessary, and if ketones are present in blood or urine, treatment needs to be urgently initiated as otherwise DKA can evolve rapidly (Craig et al, 2014; Diabetes UK, 2012). Finger prick blood glucose level (BGL) testing should not be used to diagnose diabetes and a confirmation through a laboratory BGL is essential (Craig et al, 2014).

Any child found to have high BGL by non-specialist staff or community health professionals should be assumed to have Type 1 diabetes and be referred to a multidisciplinary specialist paediatric diabetes team that has competencies needed to confirm diagnosis and to provide immediate care on the same day. The team consists of a paediatrician with interest in diabetes, paediatric diabetic specialist nurses (PDSN), dietitians, general practitioners and also, ideally, a psychologist (Husband, 2005; Diabetes UK, 2012). Specialist paediatric diabetes teams may consider other forms of diabetes where the diagnosis of diabetes remains unclear. If there is any doubt at all about the type of diabetes, the child should be presumed to have Type 1 diabetes and insulin therapy should be commenced (Diabetes UK, 2012).

MANAGEMENT

The medical treatment for type 1 DM is by subcutaneous insulin injections. There are different types of insulin commercially available with different onsets and durations of action. There are three main regimes for insulin treatment used in diabetes; however, regular BGL monitoring is required at home irrespective of the regime followed (NICE, 2004).

1. One, two or three insulin injections per day at fixed times: this regime relies on consistent meal habits but can be useful for children who will have problems injecting insulin at school lunchtime or if compliance is an issue.
2. Multiple daily injections: the patient has one or more injection per day of long-acting insulin but also injects short/rapid-acting insulin just before meals. This regime offers more flexibility with meal times but relies on good patient education and carbohydrate counting.
3. Continuous subcutaneous insulin infusion (also known as insulin pump therapy): Rapid/short-acting insulin is continuously infused and extra boluses can be given at mealtimes by pressing a button. This regime most closely mimics normal process by which insulin is secreted by the pancreas. Different rates can be set for different times of the day and even for different activities. However accurate carbohydrate counting and calculation of correction insulin doses is important. Insulin pump has shown to improve quality of life and improve glycaemic control. The pump has its own problems like rapid onset
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of diabetic ketoacidosis in case of pump failure. Therefore children and family should be assessed for motivation and education before a pump is recommended.

It is important to support the family not only in managing the medical aspects of diabetes, but to provide education and advice regarding diet, school meals, school trips, holidays, etc. (Sparud-Lundin et al, 2013). A written plan should be given outlining the management of diabetes at home and what to do when the child is unwell, misses a dose of insulin, or has been given an extra dose by mistake. Children and young people with type 1 DM should also be offered (NICE, 2004):

- Appropriate advice on diet, alcohol, smoking and exercise
- Influenza and pneumococcal immunisations
- Screening for coeliac disease, thyroid disease, retinopathy, microalbuminuria and blood pressure
- Annual foot care reviews.

**COMMON MEDICAL PROBLEMS ASSOCIATED WITH DIABETES Hypoglycaemia**

Hypoglycaemia is the most common acute problem with diabetes. In a child with diabetes, hypoglycaemia is defined as a BSL of <4mmol/l. The risk of recurrent and severe hypoglycaemia causes significant anxiety and emotional morbidity for patients and families and is a limiting factor in achieving optimal glycaemic control.

Symptoms of hypoglycaemia include shakiness, pounding heart, and sweating, headache, drowsiness and difficulty in concentrating. In young children, behavioural changes such as irritability, agitation, quietness, and tantrums may be prominent. Common clinical precipitants for hypoglycaemia include: excessive insulin dosing, missed meals, exercise, sleep and alcohol ingestion in adolescents (Ly et al, 2014). Risk factors include young age, previous severe hypoglycaemic events, accidental insulin overdoses and reduced hypoglycaemia awareness (Ly et al, 2014). Most children and their families should be given a clear plan of how to manage any episode of hypoglycaemia.

Children, parents, schoolteachers, and other caregivers should be trained to recognise the early warning signs of hypoglycaemia and treat low blood glucose immediately and appropriately. Children and adolescents with diabetes should wear some form of identification or medic alert bracelet about their diabetes (Ly et al, 2014).

**Diabetic ketoacidosis**

DKA is a critical, life-threatening condition caused by prolonged raised blood glucose levels that requires immediate medical attention. DKA results from critical relative or absolute deficit of insulin, resulting in breakdown of fats as a fuel source and build-up of acid and ketones (breakdown product of fats) in the blood. Children can develop this condition at diagnosis, from long-term mismanagement of their diabetes or acutely during an inter-current illness. Recurrent DKA (high risk groups) may be seen in children with poor blood glucose control (due to missing doses of insulin), previous episodes of DKA, female gender (peri-pubertal or adolescent), psychiatric disorders including eating disorders, difficult or unstable family circumstances, limited access to medical services, and insulin pump therapy (chances of malfunctioning). A suspicion of DKA warrants urgent referral and management in the hospital (Wolfsdorf et al, 2014).

**COMPLICATIONS OF DIABETES**

Complications of diabetes tend to develop in older age groups but NICE recommends that children and young people with type 1 DM are offered screening for coeliac disease, thyroid disease, retinopathy and microalbuminuria (protein loss in urine) (NICE 2004). Persistently high blood sugar levels can lead to serious problems, including heart disease and kidney disorders. The complications of DM seen in young diabetics are usually related to poor compliance, issues with injections, weight issues and bullying or peer pressure (NICE 2004).

The Royal College of Paediatrics and Child Health (RCPCH) looked at figures from young people’s diabetes units across England and Wales in 2013-14. Just 16 per cent underwent all seven annual health checks that are recommended to monitor their blood sugar control and any complications. The figures suggest (RCPCH, 2015):

- More than 27 per cent of young people had high blood pressure – putting them at risk of heart disease
- Some 7 per cent had markers of future kidney disease
- Over 14 per cent had early signs of eye disease - putting them at risk of blindness in later years
- More than 25 per cent were classed as obese.

**SICK DAY RULES**

The diabetes care team should provide clear guidance to patients and their families on how to manage diabetes during inter-current illnesses with vomiting or fever and such education should be repeated periodically to avoid the complications of – ketoacidosis, dehydration, uncontrolled or symptomatic hyperglycaemia, and hypoglycaemia.

The Five General Sick Day Diabetes Management Principles (Brink et al, 2014) are:

- More frequent blood glucose and ketone (urine or blood) monitoring
- Do NOT stop insulin
- Monitor and maintain salt and water balance
- Treat the underlying precipitating illness
- Sick day guidelines including insulin adjustment should be taught soon after diagnosis and reviewed at least annually with patients and family members with a goal of minimising and/or avoiding DKA and similarly minimising and/or avoiding illness associated hypoglycaemia.

**HOW CAN COMMUNITY PRACTITIONERS SUPPORT CHILDREN WITH DIABETES?**

Diabetes is a life-long medical condition with potential for serious complications. Community practitioners play an important role in helping to identify children who may have diabetes and prompting rapid blood glucose testing and referral. Community practitioners also have an important role in the paediatric diabetes care team, in helping ensure continuity of care for these children and appropriate support and education. We have outlined a few suggestions as to how community practitioners can help children with diabetes, drawn up from the available literature and our experience in managing children with diabetes (Ali et al, 2011; Williams et al, 2012; Sparud-Lundin et al, 2013; NICE, 2004, Diabetes UK, 2012):

1. Use the 4T’s to help recognise children early with common features of diabetes
2. High level of suspicion in young children...
7. General Sick Day Diabetes Management Principles include
A. More frequent blood glucose and ketone (urine or blood) monitoring.
B. Do not stop insulin.
C. Monitor and maintain salt and water balance.
D. All of the above.

8. Complications of long-standing diabetes include
A. High blood pressure with risk of heart disease.
B. Kidney disease.
C. Retinopathy and blindness.
D. All of the above.

9. The role of the school in managing children with diabetes is mainly to
A. Ensure availability of suitable meals.
B. Suitable place to inject insulin injections for diabetic children.
C. Recognise signs of hypoglycaemia and treat it.
D. All of the above.

10. Community practitioners can play an important role for children with diabetes...
A. By diagnosing diabetes in children and making a referral to specialist services on the same day.
B. Supporting children in the community post diagnosis.
C. Help local schools support children with diabetes and educate the staff about how to manage emergences.
D. All of the above.
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\(^1,2\)

The occurrence of eczema is greatest in young children,\(^1\) but the prevalence of allergic diseases worldwide is rising dramatically in both developed and developing countries.\(^2\) Eczema can occur from birth, an introduction to formula milk, or when weaning commences.

Its impact extends to the whole family\(^3\)

Apart from the visible effects on the baby, eczema can also affect the whole family socially, psychologically, and financially.\(^3\) 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.\(^6\) The independent prospective GINI study, for example, enrolled over 2000 infants.\(^5\) It found that certain formulas containing hydrolysed proteins reduced the risk of eczema by over 50% in babies with a family history of the condition (those with at least one parent or sibling with allergy).\(^4,5\)

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.\(^6\)

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\(^6\)
- Use from first formula feed
- Omega 3 and 6 LCPs
- Easy to digest

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

\(^6\)Registered Trademark

6. EAACI Food Allergy and Anaphylaxis Guidelines 2013.
Antenatal young parents: introducing a pathway to enhance health visiting practice

LISA JENNISON RGN, RM, RHV, BSc (Hons.), PG Cert.(PT).
Health Visitor, Practice Teacher, Humber Foundation NHS Trust

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ABSTRACT
Although their numbers have declined over the last 10 years, younger (teenage) parents are still one of the most disadvantaged client groups and have significantly poorer health outcomes for both themselves and their children. This article describes the author’s creation of a Health Visiting practice pathway for this specific client group. The pathway was planned to promote a standardisation of service from all the health visiting teams across the Humber Foundation Trust area, aiming towards equity of service for all clients in this group. This is particularly important in a Trust which has a very diverse client population covering approximately 930 square miles. The article explores young parents’ health issues and summaries why we should invest health visitor resources in this small but very specific client group. As a result of the project work, challenges and opportunities for health visiting practice were identified. Recommendations for both current and future practice are discussed.

KEY WORDS
Health visitors, young parents, practice development, change management

No conflict of interest declared.

INTRODUCTION
Many young parents will encounter positive experiences in pregnancy and require little additional support from professionals. However, some young parents have additional unmet health needs and are known to experience more social, educational and economic difficulties. The evidence is clear that teenage parenthood can often result in poor health, under-achievement and low earnings for both the mother and her baby (TPIAG, 2010).

In 1999 the National Teenage Pregnancy Strategy (SEU, 1999) was launched. It was a multifaceted strategy that included an action plan to halve the under-18 conception rate by 2010 and provide support to teenage parents to reduce the long-term risk of social exclusion, by increasing the proportion in education, training and employment. Some local areas failed to implement the strategy effectively and as a consequence their teenage pregnancy rate stayed high or increased.

The national teenage pregnancy rate is currently at its lowest level for almost 30 years, having fallen 18 per cent since 1998 (NHS England, 2014). Recent figures from the Office of National Statistics (ONS, 2015) show that conceptions among under-18s in England are continuing to fall. Pregnancies in this group have reduced by almost 50 per cent across the whole of England since 1998.

However, the UK still has one of the highest rates of teenage pregnancy in Western Europe. In England in 2010 over 32,500 women under the age of 18 became pregnant, approximately 6,000 of whom are under the age of 16. (UNICEF, 2001; NHS England, 2014).

Teenage pregnancy is a significant public health issue in England. Younger parents are more prone to poor antenatal health and lower birth weight babies. Infant mortality is 60 per cent higher for those babies born to mothers aged under age 20 years (DCSF, 2010).

The prevalence of domestic violence is greater among young women under 24 years (ONS, 2015). Many young people view violence as a normal aspect of intimate relationships and 30 per cent of domestic violence starts in pregnancy (Moffit, 2002; NHS 2013). It has also been postulated that as many as 40 per cent of teenage relationships are abusive ones (Home Office, 2010). These statistics show that young parents have additional risk factors both during and after pregnancy.

Teenage mothers are less likely to finish their education or find employment, more likely to be single parents, and 63 per cent more likely to bring their children up in poverty. The children themselves run a much greater risk of poor health, and have a much higher chance of becoming teenage mothers themselves (HDA, 2004; DCSF, 2010).

Research also suggests that the children of teenage parents may have poorer outcomes in terms of educational attainment, emotional and behavioural problems, and higher rates of illness, accidents and injuries (HAD, 2004). Some studies point to a higher risk of child maltreatment among younger parents (Bucholz 1993; Wakschlag 2000), although it is recognised that this risk is compounded by the environmental factors experienced by many younger parents, including socio-economic deprivation, lack of social support, depression, low self-esteem and emotional stress (Utting 1993).

Lifestyle choices of this group influence quality of health outcomes. Young parents are 50 per cent less likely to initiate breastfeeding and three times more likely to...
smoke throughout pregnancy and less likely to stop (in comparison with older mothers) (DCSF, 2007).

Teenage pregnancy has an economic impact. There is a strong economic argument for preventing teenage pregnancy. For every £1 the NHS spends on contraception, £1.1 is saved in maternity costs. Teenage pregnancy also costs the taxpayer in terms of benefits and income support. They may get help with parenting, budgeting on a low income and support to get back into education, employment or training (FPA, 2011).

Young parenthood is often viewed as reinforcing social disadvantage because of the perceived consequences in terms of the teenage mother’s life chances (Duncan, 2007) and also because of the estimated cost to society. In the UK, the annual cost to the NHS of pregnancy in women under 18 years of age was over £63 million (HAD, 2004).

Other economic factors include the cost of domestic violence and of perinatal maternal mental illness (as both are additional potential risk factors for this client group).

It should be noted that the statistics for young parents are difficult to aggregate due to the differences in definitions for this client group. Health, education, local authority and welfare organisations have their own distinct criteria when describing ‘young’ or ‘teenage’ parent groups.

BACKGROUND

Local picture

The North East region recorded the greatest number of teenage parent deliveries by population size, at 21.0 per 1,000 (for mothers aged 19 and under) - 7.7 per cent of all deliveries in this region were to mothers of this age, the highest percentage of any region in the UK (Health and Social Care Information Centre, 2012).

A scoping exercise identified that although generally the Trust had a low proportion of young parents (under age 19), there were two distinct areas where the figures were disproportionately higher than the UK average.

Both of these areas had been given support from the Family Nurse Partnership (FNP) scheme, however not all the resident young parents received FNP services, due to the strict referral criteria and caseload limitations. At the time of the project, it was uncertain as to whether funding for the FNP scheme would be continued. Having no FNP support would impact greatly on the local health visiting service, particularly in the identified areas of greatest need. This provided impetus and rationale to drive the pathway forwards. The pathway project identified a potential gap in local services, and scope to improve health outcomes for this specific client group.

Evidence base

The health visiting service is currently commissioned by NHS England. This includes the delivery of the Healthy Child Programme (DOH, 2009).

Before the introduction of the Healthy Child Programme (HCP), the Social Exclusion Task Force (2007) recommended that the HCP look beyond the child to their family context, reviewing family health as a whole, working in partnership with adult services and building family strengths and resources.

This view was echoed by the Teenage Pregnancy Independent Advisory Group (TPIAG) (2010). They recommended that Local areas should work in partnership to ensure teenage pregnancy prevention and support for young parents is integrated into locally-decided plans and implemented effectively.

The 2015-16 National Health Visiting Core Service Specification (NHSS England, 2014) details the core elements for the commissioning of health visiting services. This includes ongoing work with families who have complex needs, in partnership with other key services such as early years and children’s primary and social care. Other areas include safeguarding children and working to promote the health and development within the six ‘high impact areas’ (DOH, 2014).

The development of a pathway specific to young parents is highlighted in the Core Service Specification and therefore provided some impetus for this project.

PROJECT CONTEXT

Aims and purpose

The overall aim of the antenatal young parents pathway is to improve the quality and level of the health visiting service offered for this client group, in order to achieve better health outcomes. This will include the outlining of a standard service pathway to be adopted by all health visitors working in the Trust. The purpose of this will be to support staff to manage the potential risks associated with this client group, to address health needs using a co-ordinated, multi-agency approach and to build on the evidence base of the HCP (DOH, 2009).

The project was limited to a three-month timeframe for the production of a first draft, therefore the methods used to establish it initially were chosen to fit this short timeframe. A ‘rag rated’ action plan and timelines were established from the outset, using a Project Initiation Document Checklist (Mindtools, 2014) for guidance. Local health visitor resources were reviewed, and a literature search was conducted to identify current health issues related to this specific client group. Relevant stakeholders were identified and consulted. A change management model was used to approach the development of the pathway, using the ‘RAPSIES’ change model of Johnson and Scholes (2001).

Monitoring and evaluation

The pathway is still a work in progress and therefore evaluation will be ongoing. It is expected that when the pathway is launched, the local ‘Patient Experience Survey - Friends and Family Survey Test’ (Humber Foundation Trust, 2014) data can be used to assess user experience and quality of service inputs. It is hoped that this will provide feedback on which to inform and improve the service for users. Regular reviews of client feedback will be essential to inform and update the pathway. The author expects to hold regular meetings with relevant stakeholders and service managers to facilitate this and to explore any difficulties resulting from the transference of the pathway directly to practice.

A bi-annual newsletter was devised and launched on the Trust intranet to enable staff to follow events related specifically to the pathway. This is accessible to all staff who work in the Trust.

Electronic client records can be used to specifically measure client’s health and wellbeing outcomes (such as data on smoking, breastfeeding uptake and prevalence, or maternal mental health),
With so many other agencies and partners, opportunities are perceived. Some clients felt that health visitors were closely aligned to social workers (Cooper, 2012). These are issues to consider and require health visitors to build positive relationship with their young parent client group but also to realise how we as a profession are perceived.

**PROJECT IMPACT AND FINDINGS**

Potential challenges identified

Engaging with fathers and partners

Health visitors should always ask about the father and involve them at contacts. Fathers are clearly involved with their children, as four out of five teenage mothers register their babies’ births jointly with their baby’s father (DCSF, 2009). When fathers do more baby care and housework, mothers experience less stress and depression, fathers are happier and adjust better to fatherhood, and babies do better (HIV, 2014). Health visitors should observe and discuss fathers’ needs, experiences and behaviour and make referrals where necessary. When their behaviour is challenging (e.g. in cases of domestic violence, substance misuse) mother-child attachment is less secure (and of course father-child attachment is less secure, too) (Kernan and Smith, 2003), therefore health visitors must be mindful of the influence of fathers and include them in contacts where possible.

Client views of the health visiting service. A study by Kate Cooper, on the Surrey antenatal young parent pathway project (Cooper, 2012) suggested some common themes of young parent’s perceptions of health visitors. They reported that they feel there is an assumption from professionals that their age means they won’t parent well. They feel there is an over-reliance on handing out leaflets without relaying the information in a meaningful way. Communication methods for this client group are therefore important. The inventive use of social media, tailored to young parents’ needs, could provide a way forward.

Some clients felt that health visitors were potentially involved with this client group (for example, youth and education services, midwifery and children’s centre staff, looked-after children’s team, sexual health services, social care team, etc.) it can be difficult to co-ordinate care around the client. As health visitors are able to work with young parents, until their child is aged at least four years old, they are ideally placed to build positive relationships with this client group and can foster partnership working, using their inherent health needs assessment and leadership skills. Early intervention can help teenage mothers avoid getting pregnant again too quickly. One fifth of births conceived to under-18 conceptions are second or subsequent births (ONS, 2013). If young parents are offered the right support at the right time – for example supported housing – it can increase their rates of participation in society and improve the long-term outlook of both parent and baby (FPA, 2011). Planned partnership working can positively improve health and wellbeing outcomes for young parents and their children (DSCF, 2008).

**IMPLICATIONS FOR CURRENT PRACTICE**

- To offer this client group an additional early health visitor antenatal contact, jointly with children centre staff at around 24-26 weeks of pregnancy (to promote a skilled and comprehensive Family Health Needs Assessment). This contact can be either in the home or other venue suitable for the client.
- This 24-26 week antenatal contact to be offered to partner as well as the mother to promote involvement of partners.
- Partners to be included in every health visitor letter correspondence where appropriate.
- A second health visitor antenatal contact to be offered at the end of pregnancy (between 32-39 weeks). One of the two health visitor antenatal contacts is to be conducted in the home, to assess home circumstances, discuss concerns in private (routine enquiry question can be asked if client is alone).
- Utilise new technologies for young parents to access ‘up-to-date’, ‘real-time’ health information, when they need it. For example, use of appropriate smartphone ‘apps’ and text message services.
- Changes to the local electronic records system (to enhance data collection and benchmarking, and demonstrate improved client outcomes). For example, ‘routine enquiry’ question to be included and recorded in the antenatal electronic records.
- Antenatal caseloads on electronic records should be separated into three groups of ‘universal,’ ‘universal partnership’ and ‘universal partnership plus’ to reflect the level of health visitor service required following health needs assessment.
- Data performance to show specifics of smoking, breastfeeding, domestic violence and safeguarding data outcomes for young parents, gathered from electronic records.
- Service managers need to consider the potential resource issues for the areas where numbers of young parents are highest. Yearly figures (collated from electronic records data) would give a more accurate picture of where the young parents are living within the Trust. This would enable appropriate allocation of resources.

**RECOMMENDATIONS FOR FUTURE PRACTICE**

- Health visitors need to explore the scope and content of parent education class provision for young parents, particularly in those areas of high need.
- Auditing local service user views of the health visiting service could inform future planning and development of care, and help market the current role of health visitors to service users.
- Profiling is required on the scoping of the ethnicity and diversity of culture in the Humber NHS Trust area, in order to build a picture of the needs of the local population. Are there any implications for health visiting practice? The 2001 census shows significantly higher rates of motherhood for those of ‘Mixed White and Black Caribbean’, ‘Other Black’ and ‘Black Caribbean’ ethnicity (ONS, 2015). This is a factor which would need consideration, depending upon the local profile.
- Explore other areas where improved health outcomes can be benchmarked
and demonstrated from system one records (for example, statistics on accident prevention, mental health outcomes for young parents).

- A Quality Impact Assessment tool (Portsmouth Hospitals NHS Trust, 2014) could be used to assess the impact of the pathway in more detail and depth.

CONCLUSION

Young parents are a client group who can have complex health needs, sometimes requiring specialist and additional support. This group are worth the health visitor service investment, as their potential poor health outcomes can be the most positively affected, with professional input. The evidence base for improved health, social and educational outcomes from a systematic approach to early child development has never been stronger and has been described as a powerful equaliser which merits investment (Irwin et al., 2007; Marmot, 2010; Shonkoff, J.L., The Wave Trust, 2013). Health visitors can influence this crucial time by providing their services early and in an engaging way, tailored to young parent's specific needs. Although evidence shows that teenage pregnancy rates are currently on a long-term downward decline, that trend is not guaranteed and rates could start to rise again if this group is not prioritised. Local investment in the specific health needs of young parents needs to continue. Health visitors can use their established skills in early intervention and health needs assessment, communication and relationship building to ensure better outcomes for young parents. Developing a young parents’ pathway could facilitate the development of measurable values and outcomes of health visiting contacts to this client group.

In following the pathway project recommendations, it is hoped that health visitors will be able to positively improve health outcomes for clients, service commissioners and, in the long term, society as a whole.

REFERENCES


Cooper (2012) Surrey antenatal pathway project. Available from: https://www.gov.uk/.../516_Antenatal_Pathway_Surrey...


Key points

- Teenage parenthood remains a significant public health issue in England.
- This client group can have complex health needs which can be positively affected with appropriate intervention.
- Health visitors can use their specific skills of early intervention and partnership working to positively improve health and wellbeing outcomes for this group.
- Development of a local pathway for this client group can facilitate this process and make outcomes measurable.


When is infant regurgitation a cause for concern and how can it be managed?

Uncomplicated regurgitation is a developmental issue, but it is normally nothing to worry about.1

Virtually all infants will experience some symptoms of gastroesophageal reflux.1

Gastroesophageal reflux (GOR) is the effortless passage of gastric contents into the oesophagus, with or without regurgitation and vomiting.2

Symptoms peak at 3 months of age,3 usually resolve between 12 and 14 months of age, and do not require further assessment by a specialist.2

Gastroesophageal reflux disease (GORD) occurs when reflux leads to complications and/or troublesome symptoms.2

Guidelines recommend considering pre-thickened formula to reduce GOR.2

The European Society of Pediatric Gastroenterology, Hepatology and Nutrition recommend parental reassurance and education when trying to help resolve reflux. They also recommend considering anti-regurgitation formula for uncomplicated GOR in formula fed infants.2 These formulas help to minimise regurgitation by thickening on contact with the stomach acid.4

The benefits of thickening with cornstarch

Since children under 6 months of age can digest cornstarch, it is an appropriate carbohydrate to use as a thickening agent in formula.2 Cornstarch provides a valuable source of calories and, importantly, it does not interfere with the absorption of other nutrients.3

Several studies have demonstrated the advantages of using cornstarch as a thickener.3–5 In one study, 86% of infants with GOR who were fed anti-regurgitation formula pre-thickened with cornstarch demonstrated an improved reflux index6 – this is a measure of how long oesophageal pH was most acidic (pH4).5

As a result of this improved reflux index, formulas thickened with cornstarch may also help to reduce silent reflux. Pre-thickening with cornstarch also led to significantly fewer daily episodes of regurgitation and vomiting compared with infants fed on regular formula.4

The effects of using non-digestible thickeners in infants is unclear

Carob bean gum is one such thickener. It passes undigested into the colon which may impact on the digestion and absorption of certain nutrients such as calcium, iron and zinc. Further studies are required to evaluate the effects of such thickeners in regurgitating infants.7,4

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- Thickened with easily digestible cornstarch
- Omega 3 and 6 LCPs
- Halal approved and suitable for vegetarians

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1. Jung AD. Am Fam Physician 2001; 64: 1853–60

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A community practitioner abroad: listening to women in Dailekh, Nepal

BACKGROUND
Nepal lies on the north-eastern border of India and lies between India and China. It is one of the poorest countries in the world (United Nations Development Project (UNDP), 2013). The country has a population of approximately 26.5 million and has over 125 different ethnic groups (Central Bureau of Statistics (CBS, 2011)). Despite positive rhetoric for gender equality, legislation to facilitate this (Local Self-Governance Act, (Government of Nepal (GON), 1999), Interim Constitution of Nepal (GON, 2007)) and affirmative action, the deeply engrained cultural norms that exist within patriarchal structures in the country still cause discrimination against women (Nath, 2013). Although a caste system was abolished in 1963, this too is still deeply engrained in the culture today (UNDP, 2009) and within all caste and ethnic groups women and girls are the most marginalised.

Dailekh, in mid-west Nepal, is one of the ten poorest districts in Nepal, (UNDP, 2004). Life expectancy is 56 years compared to 61 in Nepal as a whole with literacy rates are 62 per cent, compared to 86.3 per cent in Kathmandu (CBS, 2011). Although women exceed men in numbers, they hold the least power. In Dailekh none of the senior health posts are held by women (Women’s Empowerment Action Forum (WEAF), 2014), there are only seven female police officers in the district compared to 283 males (United Nations Field Coordination Office (UNFCO, 2013) and in the Bindabasini area of Dailekh, for example, research has found that 50 per cent of boards did not meet the legal quota for the number of women sitting on influential boards (WEAF 2014). Both caste and gender discrimination is prevalent in Dailekh (UNFCO, 2013). Dalit women often suffer from multi layered discrimination for being women, being poor and being bottom of the caste system. Thus, although change in the law has been made, cultural practices and social norms hinder real progress.

This study explores some of the barriers and challenges that women face in participating in public and private decision making spheres and explores ways identified by the participants in which these may be overcome.

The aim of the study was to increase the capacity of women to participate meaningfully in decision-making roles in a village in Dailekh. WEAF chose to set the action research project up with funding from VSO Nepal to engage women in decision making roles and increase women’s ability to have a say in decisions that affect their lives. The objectives were to explore the barriers and challenges that prevent women from participating meaningfully in decision making roles.

Table 1: Focus Group Participants

<table>
<thead>
<tr>
<th>Focus Group</th>
<th>Formal quota</th>
<th>Female structures</th>
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<td>Political party</td>
</tr>
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CATHERINE NIXON
Health Visitor, Pennine Care

ABSTRACT
Nepal is one of the poorest countries in the world, and has a strongly patriarchal culture. This study reports on methods used to explore women’s opportunities in decision-making roles in Dailekh, Nepal. Action-based research was used to support women to identify barriers and to enable them to find solutions which could increase meaningful, practical and genuine representation. Participants were women in nominal positions of leadership in the community and subsequently also men in leadership roles. Focus groups and interviews enabled data to be collected and analysed using participatory and rich picture tools. A five-stage framework approach was used to analyse data. A major theme of ‘power’ emerged comprised of supporting themes; ‘place in society’, ‘formal power’, ‘informal power’, and ‘voice’. These outcomes formed the basis for identifying viable action plans generated by the participants of both genders to promote meaningful involvement of women in community decision making. Women were clear that involving men and women in the actions was key to increasing success.

KEY WORDS
Gender, community engagement, participation and leadership, power, Nepal
A four phase participatory learning and action cycle was used. This paper presents findings from the exploratory stage of this cycle. This involved exploring, identifying and prioritising problems that prevent women participating meaningfully. The action research method acted as a tool in providing women with a platform to voice their opinions and share them with the community. Prior to the study, women had identified that although they were titled with positions of power often they were unable to have a meaningful voice on boards. As this method is focussed around ‘action’, it not only captured the problems but also sought to address them.

A convenience and purposive sample was used from women already in positions of power. Women sitting on government boards (School Management Committee, Health Management Committee, Forestry boards (School Management Committee, Village Development Committee), political leaders and women’s activists (women’s network, mother groups, women’s reproductive health rights committee) were invited and agreed to participate making up the Action Inquiry Group. As the study progressed, the group was extended by the women to include men in positions of power. They felt that change was not possible without including men who held power in the area. Over the period of the study there were a total of 61 participants (45 women and 16 men), representing a range of castes and organisations (see Table 1 and 2).

### Table 2: Focus Group Participants Demographics

<table>
<thead>
<tr>
<th>No of groups attended</th>
<th>Caste</th>
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<th>Formal quota</th>
<th>Female structures</th>
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<td>Janjati</td>
<td>Dalit</td>
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**METHOD**

Exploratory meetings took place with the action inquiry group. This enabled initial relevant issues to emerge (Burns, 2007). Only following this was action planned. Data were generated with the use of participatory (Voluntary Services Overseas (VSO), 2004) and ‘rich picture’ tools (Checkland, 2000). Rich pictures are a form of Soft Systems Methodology that can be used to gather information about complex systems (Checkland, 2000). It is useful for finding out about a problem situation and apt in a situation where people are attempting to act to address the identified problems (Checkland, 2000). As people can see the same concept from different angles, drawing pictures allowed participants to explore these angles and develop a shared understanding. Focus groups, informal conversations, and semi-structured interviews were all used in data collection. The group reconvened every four weeks. The groups followed a cumulative approach where one focus group informed the questions for the next. After the second focus group, men were invited to contribute (see Figure 1).

**ANALYSIS**

A triangulation approach was employed to amalgamate data together forming common themes. A five-stage framework approach was used to analyse data (Pope et al, 2005), this being familiarisation with the range of raw data; identifying the thematic framework; indexing; charting and mapping; and interpretation. Figure 2 gives an example of the materials for analysis.

**ETHICS**

Ethical approval was gained from the author’s University Ethics Committee. Consent and information sheets were written and explained in Nepali. As not all participants were literate, the researcher and interpreter ensured participants fully understood the consent form before they signed and all participants consented to being involved. Data and quotes used were anonymised. The issue of confidentiality was stressed by the researcher as the cooperative responsibility of all participants in the focus groups.

**RESULTS**

Themes developed over the period of the study as this was a cumulative process, however the final themes are presented here. ‘Power’ emerged as the major theme throughout the research. Subthemes included ‘place in society’, ‘informal power’, ‘formal power’, and ‘voice’.

**PLACE IN SOCIETY**

Women felt that their place in society is seen as at home, completing domestic and agricultural duties. In ‘rich pictures’ one woman expressed this through an image of being ‘caged’ within the home. Women stated they have no financial resources and would require permission to leave the home. Household chores also prevented women attending decision making meetings. Women felt that their autonomy was further undermined by being treated as ‘entertainers for men’ as well as a ‘servant’ within the home. Furthermore, perceptions of women as ‘baby making machines’ limited their engagement in wider activities. There was enormous pressure put on married women not only to produce a child but particularly a son. This pressure did not just come from the husband but from themselves and their extended family too.

‘If we have 4 daughters, they will say give me a son. We sometimes have 7 or 8 daughters just to try for a son.’ (Female Participant)

Women discussed how their status was raised within the family once a son had arrived. In the community, women who
cannot have children become outcast. For women who either can’t have children or can’t produce a son there was also the threat that their husband would find a second wife in the form of polygamy. Women believed that men were viewed by the community in a much more positive light. One drew a man with many arms like a Hindu god. Above his head was the title ‘Bhagwan’ (God) and he had a light bulb to symbolise his intelligence. Women saw men as ‘natural leaders’, ‘decision makers’ and ‘politicians’ whom they looked up to for protection and guidance. Conversely, men were made to feel emasculated by community members if they completed housework. This discouraged them from helping out around the home.

‘If the husband sometimes works in the home the neighbours and father-in-law will tease the husband that he is the servant of the wife…’ (Female participant)

Thus, whereas women’s places were seen in the home, men earned money so that:

“They are the owner of everything. The house, the wealth, the property, everything.” (Female board member)

INFORMAL POWER
Men’s use of alcohol was one particular area where they demonstrated that they have the power to exercise their informal power. Men drink alcohol in tea shops at the same time as having informal meetings where decisions are made. Women are excluded from this decision-making arena thus reducing their ability to participate. Alcohol was an issue that women tried to speak up about but individually had little success. There was, however, also a divide in the group. Some women made alcohol and as this was one of their few sources of income, they were less willing to see it as a cause of problems than did the others.

Other informal power was exercised by both husbands and in-laws in the form of restrictions on activity in general, and violence in the home in particular. Women drew pictures of themselves being attacked with knives and sticks and reported physical abuse as a commonplace experience.

FORMAL POWER
Women spoke of feeling helpless about some issues identified, as these included men in positions of formal authority. Even those meant to be enforcing the law were sometimes breaking it. Women felt responsible towards the community and did not want to inform higher authorities when the repercussions may mean the perpetrator losing their job, which would affect the entire family. Thus men believed they would not be held to account.

‘Even when the police come they are drinking. So to whom do we believe and trust in.’ (Female Mother’s Group Member)

‘There are lots of men in positions of authority that still beat their wives, police, politicians, and teachers… They know there is a law, but no one to challenge it.’ (Female board member)

There was a notable difference to how women said they were viewed in female (women’s network and mother’s groups) compared to male dominant structures (government boards and political parties). Within female dominant structures women were viewed as very ‘active’ and engaged, ‘participating’ to make positive changes, using the power of women ‘standing together’. In describing one Rich Picture, a participant said:

‘In the women’s group, we view everyone in the community as equal (across caste, gender).’ (Female participant)

In male dominant structures women said women’s participation was always behind. They felt that even the 33 per cent legal requirement had not helped increase women’s meaningful participation, as
women were often placed on the board by a male. ‘No one will listen to the women when they raise their voice.’ (Female Political party/govt board members)

Despite, or possibly because of the cultural mores, female dominant structures viewed men in a positive light and believed that men’s participation was needed to make things equal, as was indicated by their inviting men to participate in this research. There was recognition that a man’s voice had power, and more likely to lead to success.

‘We would like men to take part in our mothers group. …..Men are most welcome in our groups.’ (Female mothers group member)

The members of male dominant structures viewed men as being respected, power holders, and providers. The 33 per cent quota had not dissolved any of this power.

‘One man, many women, but man still holds all the power.’ (Female government board member)

As men were seen as providers, it appeared participants believed this gave them the right to be listened to. Female and male perceptions of men as powerful decision makers underlined the weight of influence a man has within a patriarchal dominated society.

VOICE

Women reported that within their own home they had no voice. Situations often reached crisis point before being addressed. Similarly, alone they were not able to change things in their community. During the inquiry stage, women reported on heir experiences within the home or community as opposed to within positions of power in formal structures. They discussed lack of solidarity as a reason for why issues are not challenged. However, together they felt they had a strong voice and gave examples of how they had been able to make changes in their community. Being active in the community could give women respect they do not get in the home.

DISCUSSION

The results highlighted long term and deep-seated gender imbalances across all aspects of life in Nepal. How women and men are viewed by the community and in male dominated structures highlighted some of their starkly contrasting roles. The characteristics of what makes a good leader were not envisaged within women. From the beginning, the odds are stacked against them and in the favour of men. In addition, factors raised as problematic are tied into the gender roles. Women felt pressured to have multiple children until they have a son, highlighting that discrimination against girls starts from before they are even born. Alcohol consumption, violence, financial independence and child and home care are all gender specific roles and these roles are deeply embedded in the cultural understanding of both men and women (Ramdam, 2009).

The data identified that when women come together and they are given ownership over an issue, their confidence increases and they are able to have meaningful participation. When structures are female friendly, women had opportunity to achieve. However, in government and political boards that have a history of male dominated power, formalising a female quota alone may not increase women’s meaningful participation. Quotas may have opened up opportunities for women to participate, but they have not changed stereotypes of women.

Women spoke about the power of solidarity as women’s groups were able to make significant changes in their communities for example mothers’ group members in Nepal, made up of a high percentage of illiterate women, have significantly helped to improve maternal health (Morrison et al, 2010).

Women’s groups create spaces where women can gain power and make changes. Women in positions of power in women’s groups were more
confident in their ability to make change. Female-dominated structures saw men and women in a positive light. It was recognized that in the wider sphere of their community, men were the power holders, but participants felt that women have vital things to contribute and when given the chance can make changes. However, they recognized that with a male voice, these changes may be more successful, as men dominated formal and informal hierarchies of power.

This study had limitations. Women were busy with child and home care and thus could not always attend meetings. The translator spoke Nepali and English, but had no formal training as an interpreter and so found it hard to maintain a distance, initially wanting to lead the focus groups, although this did improve as the research progressed.

The approach of the researcher, as an obvious outsider with different cultural traits, may also have affected the dynamics of the group. This was counter-balanced by having a co-researcher from the local area.

### IMPLICATIONS AND RECOMMENDATIONS

As a result of the research, focus has been drawn towards women’s participation in decision making roles. In opening up discussions of the underlying issues that prevent women from having a voice, some of the stereotypes and cultural norms were challenged.

This project was only able to touch the surface of many deep seated issues, due to the limited time frame. However small changes have been possible and these encouraged participants to want to respond to the issues.

Creating female friendly spaces allowed women to participate meaningfully in decision making roles. Subsequently including men led to their awareness being increased and this in turn led to positive ongoing outcomes for the community, for example reducing violence against women and girls, improving sexual health provisions, and educational opportunities for all.

The study aspired to create role models for other women within the community to engage in community decisions.

### Key points

- Women’s place in society is seen as at home completing domestic and agricultural duties.
- Violence against women and girls (VAWG) is prevalent and used as a way of exerting power over women.
- Decisions were often made in male dominated informal arenas involving alcohol where women felt excluded from.
- Although quotas are in place for women’s participation in Nepal. Women feel that they do not have a voice in decision making roles. Although women were filled with positions of power often they were unable to have a meaningful voice on boards.
- Solidarity gained in women dominated forums gave women a strong voice leading to changes, such as reducing VAWG, improving sexual health provisions and educational opportunity for all.

Through increasing meaningful female participation, women’s needs may also be placed on the agenda, leading to the overall development of the area.

The study identified the need to move beyond quotas and address the social norms that hold women back from having a meaningful voice in decision making roles. As a result of the project, WEAF gained funding to continue to work in women’s political participation.

### CONCLUSION

This study highlights some of the challenges and barriers that women face in participating in decision making roles. Although the past decade has seen significant progress in gender equality within the Nepali law, deep seated gender stereotypes and social norms still prevent women from having a voice in decision making roles. This research hopes to provide an entry point for further exploration into developing women’s ability to have a voice in the decisions that affect their lives.

### ACKNOWLEDGEMENTS

We thank the individuals in Bindabasini who gave their time generously, the field staff from WEAF, and to VSO Nepal for funding the project.

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Supporting the health and wellbeing of children, young people and families has always been my passion. Through the twists and turns of my career I’ve always been totally immersed in roles related to children and young people. In April this year, I joined Public Health England (PHE) as lead nurse for children, young people and families after four years of leading school and community nursing at the Department of Health.

My new role in the national PHE team, led by chief nurse Viv Bennett, offers huge potential to build on the high-profile of health visitors and school nurses and to shine a spotlight on their contribution to the health and wellbeing of children.

Children, young people and families are a key priority for PHE – we know that 80 per cent of child brain development happens within their first three years of life. What’s more pressing is the fact that only 36 per cent of children from disadvantaged homes reach a good level of development by the end of their reception year, compared with 52 per cent of their more prosperous peers. That’s why ensuring every child has the best start in life is one of PHE’s seven priorities, published in Evidence into Action: Opportunities to Protect and Improve the Nation’s Health.

Public health nurses have a central role to play in achieving that goal, with their ability to improve health outcomes for this group. Working in PHE provides a fantastic opportunity to influence new developments and to contribute the evidence base which will support local delivery and improve on health outcomes across the life course. Working closely with the other directorates gives us an opportunity to share expertise and work closely to tackle PHE’s other priorities.

As part of raising the profile of public health nurses, I want to hear from you. Tell me how you and your colleagues are supporting children and families and what innovative approaches you’re adopting locally – so we share it with others and learn!

As a small team we will be working with regions to support the development and sustainability of networks for public health nurses and to raise the profile regionally and nationally.

I am looking forward to continuing to work with the professional organisations representing public health nurses and to forging new relationships with partners and wider stakeholders to ensure children, young people and families are supported to get the best start in life.

Over the last four years I established strong networks with school nursing colleagues which I hope will continue and be strengthened by remit of this role and greatly look forward to also working with health visitors and their colleagues.

Public Health England’s seven priorities
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2. Reducing smoking
3. Reducing harmful drinking
4. Ensuring every child has the best start in life
5. Reducing dementia risk
6. Tackling antimicrobial resistance
7. Reducing tuberculosis
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