Member Focus
Research reflections

CPD
Meningitis B

Professional
Childhood bereavement

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Prescribing Information

Oilatum® Junior (light liquid paraffin 63.4%) Bath Additive and Oilatum® Junior Cream (light liquid paraffin 6%, white soft paraffin 15%) have been successfully used for over 50 years in the treatment of dry skin conditions.

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**Indications**

Contact dermatitis, atopic eczema, senile pruritus, ichthyosis and related dry skin conditions.

**Dosage and administration**

Use as often as necessary.

**Bath Additive:**

Apply to wet skin or add to water. Adult bath: 1-3 capfuls in an 8 inch bath of water, soak for 10-20 minutes, pat dry. Infant bath: ½-2 capfuls in a basin of water, apply gently over entire body with a sponge, pat dry.

**Cream:**

All ages:

Rub in well to affected area.

**Contraindications and Precautions**

Hypersensitivity to any ingredient.

**Side effects**

See SPC for full details. Application site reactions including erythema, rash, pruritus, dermatitis.

**Legal category**

GSL.

**Presentation and NHS cost**

**Bath Additive:**

- 150 ml £2.82, 250 ml £3.25, 300 ml £3.90, 600 ml £5.89, PL 00079/0708.

**Cream:**


**PL holder**

Stiefel, 980 Great West Road, Brentford, Middlesex, TW8 9GS.

Date of revision: May 2015.

**References:**

1. GSK Data on File (Product testing with 450 mums with children with dry skin aged 6–36 months. Product tested unbranded in 3 cells: cream emollient (n=150), bath emollient (n=149) and both products (n=151). 2015.


3. GSK Data on File (A cosmetic study to consider the effect of Oilatum emollient as a cleansing product on skin barrier function using a forearm-controlled application technique). 2014.

Date of preparation: August 2015. CHGB/CHOIL/0060/15

OILATUM is a registered trade mark of Stiefel Laboratories, Inc.

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**Have you considered prescribing Oilatum Junior Cream?**

(light liquid paraffin, white soft paraffin)

87% of mums agreed Oilatum Junior Cream soothed their child’s dry skin1 (product testing with 150 mums)

**Oilatum emollient creams:**

- Specifically formulated to restore the skin barrier and break the itch-scratch cycle
- 70% of mums agreed that Oilatum Junior Cream left their child’s dry skin less itchy1 (product testing with 150 mums)

Use with an Oilatum wash product – the No 1 prescribed emollient wash range2 – for complete emollient therapy in line with NICE guidance.3

**Oilatum bath emollients:**

- Proven to maintain the skin’s moisture barrier and significantly improve hydration in healthy, dry adult skin4
- Provide an active emollient benefit and an effective cleanser

Prescribe Oilatum Junior Cream in combination with Oilatum Junior bath additive for a complete emollient therapy solution for babies and children with eczema.
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November 2015 Community Practitioner 3
The smallest victories over eczema start with QV

For eczema and dry skin sufferers, simply stopping scratching is not an option. Food, perfume, clothes, temperature – anything can trigger a flare-up. An effective way to help manage the itch-scratch cycle is to encourage complete emollient therapy. And QV makes compliance easy.

QV has a range of cost-effective products that are free from colour, fragrance, lanolin, propylene glycol and sodium lauryl sulphate (SLS), which can irritate skin. It’s also one of the few brands to use glycerin, a naturally occurring humectant that helps skin to retain moisture, without blocking pores.

Because QV feels so light and comfortable on skin, patients are much more likely to keep on using it morning, noon and night. Which means they can enjoy their own personal victory over eczema, thanks to QV.
This month brings the CPHVA annual conference, which takes place on 17-18 November at the Manchester Central Convention Complex.

For those of you joining us at conference, it is a great way for you to network, share best practice and stay up-to-date with the latest policy and clinical updates. All the speakers and streams are targeted at your day-to-day practice as CPHVA members, and all the content is focused and streamlined to ensure it is appropriate and relevant to you.

And for those of you that can’t make it, Community Practitioner will make sure we bring you all of the action – stayed tuned to www.commprac.com and next month’s issue.

Attending conference is also a great way to pick up those CPD hours, especially now that the regulator, the Nursing and Midwifery Council (NMC), has approved the introduction of revalidation in 2016. Our special report on CPD access and quality shows that more than eight in 10 of you feel confident you will be able to complete the new requirements of 35 hours of continuing professional development (CPD) as set out in the NMC’s new Code of Conduct. See pages 20 – 25 for the results of our survey.

Along with CP’s professional editor Professor Jane Appleton, I will be hosting a morning session on day two of conference, entitled ‘Writing for the Community Practitioner journal’, where we will discuss how you can submit your professional research for publication, outline the Community Practitioner’s author guidelines, and explore the article submission process from beginning to end.

This is your journal and we want to support and help you publish your great research and work. We will be uploading the presentation to the www.commprac.com website so those of you who cannot attend can find out all the answers to your publishing questions.

We have a stand in the exhibition centre at conference where we will be canvassing nominations for the CPHVA 2016 Awards ceremony (see pages 16 – 19). Next year’s event promises to be bigger and grander than ever before. It has never been more important to recognise the hard work of your colleagues and reward those who go the extra mile. So make sure you get in early and register your nominations now. It couldn’t be easier, pop over to the stand and tell us who you want to nominate and why. We’ll do the rest!

Have a great conference.

Louise Naughton
Managing Editor
Breastfeeding may reduce the risk of autism in babies

Breastfeeding a baby may reduce its risk of developing autism, according to a study of almost 100 infants. Babies who were exclusively breastfed for longer were more likely to prefer looking at happy eyes and less likely to prefer looking at angry eyes. Although it is difficult to diagnose autism before the age of 24 months, children later diagnosed with the condition have been seen to pay less attention to people’s eyes between the ages of two and six months old.

Research finds flu jabs work in one out of three cases

Last winter’s flu jab worked in 34 per cent of cases, according to a final report by Public Health England. Researchers estimated that the vaccine prevented just three out of every 100 people immunised from developing symptoms during flu season. The report claimed there had been a ‘shift’ in the dominant circulating strains during the rest of the winter. Professor Paul Cosford from Public Health England said its effectiveness had been ‘slightly lower’ than usual.

NHS suffering ‘hardest decade’ since creation

The NHS is suffering its hardest decade since its creation, three leading think-tanks have said. They warned that current government spending pledges amount to the lowest 10-year growth rate the health service has ever seen.

Depression drugs linked to violence

Young people who take antidepressants are more likely to commit violent crimes, a major study by scientists from the University of Oxford has found.

The researchers found a 43 per cent increase in the risk of crimes such as rape, murder and assault in 15-24 year olds if they took selective serotonin reuptake inhibitors such as Prozac.

Portion size is key in tackling obesity

Reducing the portion sizes offered in supermarkets, restaurants and at home would help reverse the obesity epidemic, said researchers. Researchers from the University of Cambridge said their review of 61 studies provides the most conclusive evidence to date that portion size affects how much we unwittingly eat. They also said smaller plates, glasses and cutlery helped people eat less, with people being reluctant to leave a plate with food on it.

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Researches suggest more sleep could help teens

A LEADING UK SCIENTIST BELIEVES that starting school at 10:00am could have huge benefits for teenagers.

Sleep expert Dr Paul Kelley, an honorary clinical research fellow at Oxford University’s Sleep and Circadian Neuroscience Institute, said adolescents effectively lose two hours of sleep per day.

He believes the internal body clock shifts with age, delaying the phase at which sleep can be initiated.

He and colleagues are currently recruiting 100 schools from around the UK to take part in a project called Teensleep, due to commence in 2016. Teensleep will chart the impact of sleep patterns on pupil attainment.

Childhood stress has adverse affect on female fertility

RESEARCH HAS SHOWN THAT childhood stress can have a negative impact on female fertility.

The adverse childhood event experiences, fertility difficulties and menstrual cycle characteristics, a paper published in the Journal of Psychosomatic Obstetrics & Gynecology, examined data from 774 women of reproductive age, 195 of whom were pregnant.

They found that women who had experienced negative events at a young age – such as abuse, neglect, household dysfunction or parental substance abuse – were more likely to have faced fertility difficulties and abnormal absences of menstruation lasting three months or more.

Paediatricians warn of staff shortage

CHILDREN’S DOCTORS have raised fears over patient safety and the ability to deliver sustainable services due to a lack of permanent staff.

More than two-thirds of lead paediatricians said they were either ‘moderately’ or ‘very concerned’ about how middle grade consultant services would cope in the next six months, according to a report by the Royal College of Paediatrics and Child Health (RCPCH).

The Rota Vacancies and Compliance Survey found 47.3 per cent of junior (tier one) and middle grade (tier two) consultant vacancies were filled by locums. The vacancy rate was found to be highest in tier two rotas in Northern Ireland and Wales.

More than 20 per cent of vacancies were found on neonatal rotas.

NICE guidelines advise hand washing lessons

SCHOOL PUPILS SHOULD BE TAUGHT HOW TO wash their hands correctly by teachers, according to new guidance from the National Institute for Clinical Excellence (NICE).

The recommendations aim to tackle the growing problem of antimicrobial resistance (AMR).

Teachers should also provide appropriate lessons on when antibiotic drugs are required, says NICE.

Professor Gillian Leung, deputy chief executive and health and social care director at NICE, said: ‘The overuse of antibiotics in the past 30 years has led to microbial resistance, and with so few new antibiotics being developed, this could result in once-treatable infections becoming fatal in years to come.’

Probe launched as school child contracts e-coli

A health board has launched an investigation after a school pupil contracted e-coli O157.

The pupil at a South Ayrshire school is reportedly being treated for the bug in Glasgow, reports The Herald.

NHS Ayrshire and Arran has launched an investigation but said there was ‘no evidence to suggest this infection was contracted at the school’.

The public health department has now written to parents whose children attend the school, offering advice about the signs and symptoms of the bug, which include stomach cramps, diarrhoea (often bloody), nausea and fever.

290,000 used ChildLine services in 2015

CHILDLINE PROVIDED ALMOST 300,000 counselling sessions to children and young people in 2014-15.

The latest Always There When I Need You annual ChildLine review found the top three concerns facing children accessing Childline were family relationships, self-confidence and abuse.

The number of counselling sessions about low self-esteem increased by 9 per cent to 19,525 since 2013/2014, with demand for sexual abuse counselling increasing by 9 per cent to 8,285.
Can you reduce the risk of an infant developing eczema?

Tanya Wright BSc Honours MSc Allergy HCPC Registered Dietitian MBDA

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

Eczema is a growing modern epidemic

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

Its impact extends to the whole family

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

What are the options for feeding infants?

Breastfeeding is best for babies and should always be recommended as the first choice of feed. If exclusive breastfeeding is not possible however, reducing the impact of allergy (including eczema) in bottle-fed infants has been a major focus of research.

The independent prospective GINI study, for example, enrolled over 2000 infants. It found that certain formulas containing hydrolysed proteins reduced the risk of eczema by over 50% in babies with a family history of the condition (those with at least one parent or sibling with allergy).

What the guidelines recommend

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

Supporting you to support mums

Visit us: smahcp.co.uk or smahcp.ie

SMA H.A.® Infant Milk – designed to specifically reduce the risk of developing allergy (e.g. eczema) to cows’ milk proteins.

It is nutritionally complete and can be used from birth.

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

*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

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® Registered Trademark
Day in the life...
Michelle Thomas, senior lecturer, University of South Wales

‘MOST MORNINGS I GET UP AT
6am to walk the dog, and then I’m ready to leave the house by 7:40am for the drive to work, usually arriving around 8:10am.
The first thing I do is say hello to my colleagues. The offices for the public health team are close together, and it definitely helps with communication, planning and sharing ideas.

Between 8 and 9am I review my emails and also review published research commentaries and news articles to check for updates, particularly on topics I will be teaching that day. I may also use this time to provide supervision for students, either face-to-face or via electronic feedback.

I usually teach my first class at 10am, and from 9:30am onwards I prepare by checking that my materials and slides are ready. So, for example, I might be teaching student specialist community public health nurses (SCPHNs) (school nurses and health visitors) for two hours on topics relevant to the foundations of specialist community public health nursing.

From 12pm to 1pm on a typical day I sometimes teach first year Bachelor of Nursing students, in preparation for their community placement. I focus on the differences between primary and acute care, and encourage them to map their learning contracts to meet their clinical competencies so that they seek out learning opportunities on their placement. Students at this point have done six months in the acute sector and many will see nursing as ward based and focused on illness rather than a profession where you visit people in their own homes and enable them to participate in their own care.

Usually I finish about 12:45pm and I then have about 15 minutes to grab a cuppa and a bite to eat before teaching again. Sometimes I manage to have a quick walk with colleagues, and I feel that I am much more productive in the afternoon as a result.

My next two-hour class is at 1pm, with the student SCPHNs from the morning. These sessions may include facilitating a discussion with an external presenter on how to extrapolate population data from a database, and on other days it will be focused on areas relating to SCPHN practice.

At 3pm my teaching is generally done for the day. I then update the virtual learning environment with the day’s sessions, providing links to other health databases and useful additional reading or pre-reading for the next class. This takes about 30-40 minutes.

For the rest of the afternoon I undertake a variety of tasks depending on what is on my to-do list. For example, I may need to prepare material for teaching sessions and for a tripartite meeting with student health visitors in a practice setting. It is part of my role to visit students and their practice teacher three times during the programme.

I am also part of a study team involved in developing a family resilience assessment tool for health visiting practice with two colleagues, working under the umbrella of the Community Nursing Resilience Strategy. We meet once a quarter and whenever I can find time during the day I work on the tool. We have been asked to present a bite-size session at the CPHVA conference this month entitled ‘Family resilience assessment instrument, developing and testing a training package for health visitors across Wales’.

During the afternoon I check emails again. I try to limit it to three times a day – in the morning, at lunchtime, and in the evening, so that I can use my time to continue with teaching preparation and planning.

I usually leave the office between 5pm and 5:30pm. I often take work home with me, even if it is just some reading, although I do try to contain it and make sure I have got a good work-life balance.
Research reflections

Within this short reflection I describe a research internship programme made available through the North West Coast Collaborations for Leadership in Applied Health Research and Care (CLAHRC). In considering the experience afforded to myself I hope to encourage other community practitioners to seek out such opportunities to broaden their professional knowledge and practice

IN 2014, I WAS GIVEN AN INCREDIBLE opportunity to complete a Lancashire Internship for Nurturing Research Capability and Skills (LINCS) Clinical Academic Research Internship. The aim of this internship programme was to build research capacity and capability by creating and supporting research opportunities for nurses, midwives and allied health professionals (AHPs). This programme provided a one day per week backfilled secondment where I was able to carry out a small research project and attend research-based training workshops. Prior to this internship, I had studied academic research modules at post-graduate level but I felt I wanted to learn more about the real world implications of research and how research is conducted within the NHS.

Through the internship I studied the experiences of health visitors carrying out listening visits for women with perinatal mental illness. Although a wealth of knowledge exists around therapeutic relationship building and use of listening skills, health visitor-led listening visits are poorly defined in the literature and very little evidence exists to support their efficacy. As a health visitor with experience as a mental health nurse, I felt that this was an essential area of practice that I could contribute to through the research internship. I devised a questionnaire that was emailed to all health visitors in my Trust asking open and closed questions around the intervention of listening visits. I asked health visitors about training, confidence levels and staff support/supervision. I also interviewed a small number of staff about their experiences.

During this time, I was able to engage with a number of processes that are essential when carrying out research within the NHS. With support from my local research and development team, I applied for NHS approval via The Integrated Research Application System (IRAS). I was also required to gain ethical approval from the host university and my local trust.

CLAHRC RESEARCH INTERNSHIPS 2015

Following on from my experience as a LINCS research intern, I now aim to develop my research skills through a PhD programme. In order to strengthen my doctoral application, I have been successful in securing a further secondment via CLAHRC NWC whereby I am gaining user feedback to develop a doctoral research proposal. This will ensure that I tailor my research question to reflect the needs of service users. The CLAHRC NWC internships are designed to support individuals to undertake a small research project under the supervision of experienced researchers. Interns may choose their own research idea, but it must align with
their organisation’s priorities, focus on addressing health inequality and fit within at least one of the NIHR CLAHRC NWC themes.

This internship is offering me the opportunity to prepare an application for a doctoral fellowship where I hope to undertake a piece of research to further explore the role of health visitors in supporting women suffering from perinatal mental illness. In order develop my research proposal, I feel it is imperative to gain the voice of the service user to ensure that my research methods are suitable for mothers who have experienced perinatal mental illness. I intend to run a discussion group with women from an existing perinatal mental health support group. The existing group is currently coordinated by the Improving Access to Psychological Therapies service who have offered their support in inviting women to the discussion group. I have secured some funding to enable me to provide refreshments and thank you vouchers for the discussion group members. In order to develop my proposal, I would like to ask the women questions that will help me to decide upon the methods that I will use if my fellowship application is successful.
WHAT WERE THE CHALLENGES?
Having a supportive team and line manager has been vital to my continued involvement with research. As a health visitor, my caseload has to take priority and although I have tried to keep my research day on the same day each week to fit in with the needs of the team, there are times where flexibility is required in order to meet the needs of clients. Being highly organised is essential as there are numerous forms to be completed and deadlines to meet. I found there were some weeks where fitting everything into my one research day was a real challenge.

WHAT HAVE I GAINED?
I have gained real life experience of research processes and have learned lots of valuable lessons along the way. I feel the support provided by experienced researchers and academics through the internship programmes has been extremely nurturing and has helped me to cultivate new skills and to feel more confident in my abilities. I now have experience and understanding of navigating research approval systems and the knowledge I have gained of data collection and analysis through hands on workshops has enabled me to put this into practice. As a result of my internship, I was nominated for a CHPVA Student of the Year Award and I was selected as a finalist; although I didn’t win, it was such an honour to have been selected. All of these experiences have motivated me to build upon my skills as a researcher and to hopefully further my studies through a PhD programme. I now feel committed to enhancing the evidence base for health visiting practice in order to improve patient care. I am currently preparing a paper based upon my LINCS research findings that I hope to have published in the near future and I have also had the opportunity to publish a journal article about perinatal mental health (Cummings and Whittaker, 2014).

I have shared my research findings at; The North of England Health Visitor Celebration Event (iHV, Leeds, October 2014); with health visitor students (UCLAN, October 2014) and with other health professionals at a research presentation day (Preston, October 2014). Through these events, I have been able to further explore the themes of my research findings with other health visitors. I have enjoyed sharing my experiences as a researcher and have hopefully inspired other health visitors to get involved with research.

I would definitely recommend the internship experience to other health visitors as a means to evidencing the impact of our practice on public health outcomes for children and families. Interns have access to support from experienced researchers and academics who guide them through the research process. Health visitors who are interested in carrying out a research project can contact their local Trust’s research and development team or access the National Institute for Health Research website http://www.nihr.ac.uk/ for details.

Contact: emma.cummings@lancashirecare.nhs.uk

References
19/10/2015 16:52
When parents turn to you for help,
there's one range specifically
designed for children that has over
45 years of expertise.

To treat all their coughs, colds
and stuffy noses this winter.

When it comes to kids, we understand.

Calpol Infant and Sugar-free Infant Suspension Product Information
Precautions: suspension containing 120mg Paracetamol per 5ml.
Treatment of mild to moderate pain and as an antipyretic. Can be used in many conditions
including headache, toothache, sore throat, joint pain, colds and flu.

Children: 6 months to 16 years: 2.5ml 3 times daily; Children 6 to 12 years: 5ml 3 times daily; Children 12 to 16 years: 10ml 3 times daily.

Uses:
- Treatment of mild to moderate pain and as an antipyretic. It can be used in
  many conditions including headache, toothache, earache, sore throat, colds and influenza.
- The product is also suitable for use in children with symptomatic upper respiratory tract infections.

Precautions:
- Caution in severe hepatic or renal impairment.
- Interactions with anticoagulants, colestyramine, anticonvulsants.
- Maltitol may have a mild laxative effect (Sugar-Free only).

Contraindications:
- Hypersensitivity to paracetamol or other ingredients.
- Children under 1 year: not recommended.

Side effects:
- Very rarely hypersensitivity and anaphylactic reactions.
- Blood dyscrasias, chronic hepatic necrosis and papillary necrosis have been reported.

Doseage:
- Children aged 1 - 5 years: 10ml 3 to 4 times daily; Children 5 to 10 years: 10ml 3 to 4 times daily; Children over 10 years: not recommended.
- Children with rare hereditary problems of glucose-galactose malabsorption, fructose intolerance.
- Due to the presence of sucrose, patients with glycosgen storage disease or rare hereditary problems of glucose-galactose malabsorption should not take this medicine. Maltitol may have a mild laxative effect (Sugar-Free only).
- Paracetamol hypersensitivity and anaphylaxis may cause allergic reactions.

To treat all their coughs, colds
and stuffy noses this winter.

When it comes to kids, we understand.

CalCough Children’s Soothing Syrup Product Information
Precautions: syrup containing glycerin 0.75ml and liquid sugar 1.93ml per 5ml. Use only as required.
- When treating dry, irritating, tickling dry coughs and sore throats.
- The syrup is also suitable for use in children with symptoms of upper respiratory tract infections.

Uses:
- For the relief of irritant, tickly dry coughs and sore throats.

Precautions:
- Caution in severe hepatic or renal impairment.
- Do not give more than 4 doses in 24 hours and leave at least 4 hours between doses.
- Do not give to children under 1 year.
- Do not use in children with rare hereditary problems of glucose-galactose malabsorption, fructose intolerance.

Contraindications:
- Hypersensitivity to ingredients.
- Do not use in children under 1 year.
- Do not use in children with rare hereditary problems of glucose-galactose malabsorption, fructose intolerance.

Side effects:
- Very rarely hypersensitivity and anaphylactic reactions.
- Blood dyscrasias, chronic hepatic necrosis and papillary necrosis have been reported.

Doseage:
- Children aged 1 - 5 years: 10ml 3 to 4 times daily; Children 5 to 10 years: 10ml 3 to 4 times daily; Children over 10 years: not recommended.
- Children with rare hereditary problems of glucose-galactose malabsorption, fructose intolerance.
- Due to the presence of sucrose, patients with glycosgen storage disease or rare hereditary problems of glucose-galactose malabsorption should not take this medicine. Maltitol may have a mild laxative effect (Sugar-Free only).
- Paracetamol hypersensitivity and anaphylaxis may cause allergic reactions.

To treat all their coughs, colds
and stuffy noses this winter.

When it comes to kids, we understand.

CalPol Six Plus Suspension and Calpol Six Plus Suspension Sugar Free Product Information
Precautions: Suspension containing 250mg paracetamol per 5ml; Use as treatment of mild to moderate pain in adults and as an antipyretic. It can be used in many conditions including headache, toothache, earache, sore throat, colds and influenza.

Uses:
- Treatment of mild to moderate pain and as an antipyretic. It can be used in many conditions including headache, toothache, earache, sore throat, colds and influenza. It can be used in conditions such as toothache, earache, sore throat, colds and influenza.

Precautions:
- Caution in severe hepatic or renal impairment.
- Interactions with anticoagulants, colestyramine, anticonvulsants. Sorbitol may have a mild laxative effect (sugar free). Pregancy and Lactation:
- Not applicable.

Contraindications:
- Hypersensitivity to ingredients; Not applicable.
- Do not use in children under 1 year.

Side effects:
- Very rarely hypersensitivity and anaphylactic reactions.
- Blood dyscrasias, chronic hepatic necrosis and papillary necrosis have been reported.

Doseage:
- Adults and children over 16 years: 10ml to 20ml daily; Children 8 to 16 years: 7.5ml daily; Children aged 6 to 15 years: 5ml; Children 10 to 12 years: 2.5ml ml; Children 0 to 9 years: 1.25ml daily; Children aged 4 to 6 years: 6.25ml; Children aged 2 to 4 years: 3.75ml.

CalPol Infant and Sugar-free Infant Suspension Product Information
Precautions: Suspension containing 120mg Paracetamol per 5ml.
Treatment of mild to moderate pain and as an antipyretic in infants weighing over 4kg and not recommended for children under 2 months.

Uses:
- Treatment of mild to moderate pain and as an antipyretic in infants weighing over 4kg and not recommended for children under 2 months.

Precautions:
- Caution in severe hepatic or renal impairment.
- Interactions with anticoagulants, colestyramine, anticonvulsants.
- Maltitol may have a mild laxative effect (Sugar-Free only).

Contraindications:
- Hypersensitivity to paracetamol or other ingredients.
- Children under 2 months: not recommended.

Side effects:
- Very rarely hypersensitivity and anaphylactic reactions.
- Blood dyscrasias, chronic hepatic necrosis and papillary necrosis have been reported.

Doseage:
- Children aged 2 - 3 months: 2.5ml, and a second dose, if necessary, 4 hours after dose one.
- Children 3 to 6 months: 2.5ml.
- Children 6 to 24 months: 5ml.
- Children over 24 months: 10ml.

CalCough Infant Syrup Product Information
Precautions: Syrup containing glycerin 0.75ml and liquid sugar 1.93ml per 5ml.
Treatment of irritant, tickly dry coughs and sore throats.

Uses:
- For the relief of irritant, tickly dry coughs and sore throats.

Precautions:
- Caution in severe hepatic or renal impairment.
- Interactions with anticoagulants, colestyramine, anticonvulsants.
- Sorbitol may have a mild laxative effect.
- Maltitol may have a mild laxative effect.

Contraindications:
- Hypersensitivity to ingredients; Not applicable.
- Do not use in children under 1 year.

Side effects:
- Very rarely hypersensitivity and anaphylactic reactions.
- Blood dyscrasias, chronic hepatic necrosis and papillary necrosis have been reported.

Doseage:
- Children aged 1 - 5 years: 10ml 3 to 4 times daily; Children 5 to 10 years: 10ml 3 to 4 times daily; Children over 10 years: not recommended.
- Children with rare hereditary problems of glucose-galactose malabsorption, fructose intolerance.
- Due to the presence of sucrose, patients with glycosgen storage disease or rare hereditary problems of glucose-galactose malabsorption should not take this medicine. Maltitol may have a mild laxative effect (Sugar-Free only).
- Paracetamol hypersensitivity and anaphylaxis may cause allergic reactions.

To treat all their coughs, colds
and stuffy noses this winter.

When it comes to kids, we understand.
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 moisturizer and quiet activities is a scientifically supported and simple behavioural intervention for improved quality and quantity of sleep in babies.5

When bath time is part of an everyday ritual, the benefits have been shown to help generate a predictable and less stressful environment for the baby and parents.5

**Bath time provides an ideal opportunity to create an enriched multisensory experience.**

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 jbhcpcontact@its.jnj.com

**Making Bath Time Part of a Ritual Improves Sleep**

![Graph showing improvements in sleep with and without a ritual]

<table>
<thead>
<tr>
<th>Improvement %</th>
<th>Week 2</th>
<th>Week 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control Group</td>
<td>0%</td>
<td>-1%</td>
</tr>
<tr>
<td>Product Group</td>
<td>3%</td>
<td>6.2%</td>
</tr>
</tbody>
</table>

Adapted from Mindell, et al. 2009

**References:**

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NMC registration rule change

FROM NOVEMBER 2015 NMC registrants who fail to submit their NMC registration on time will be taken off the register immediately. Readmission will take between two and six weeks and it will be illegal to practise during this time. Registrants should visit www.nmc.org.uk or call 0207 3339333 to check their annual payment dates and for information about the rule change.

UPDATE: ROS GODSON

PO ROS GODSON IS LOOKING forward to working with the new RISC (Regional Industrial Sector Committee) on professional issues in the South West and East Midlands regions.

‘My role is to promote all professional matters within the regions and to support regional officers and workplace reps when members are in difficulty regarding professional problems (safeguarding, confidentiality, record keeping, duty of care, accountability, etc). I am happy to facilitate branch meetings by attending, giving presentations, helping with the agenda, bringing cake or anything else that could be useful. I also sometimes get asked to speak on professional issues to university students, and feel this is an area where we could be more proactive.

‘Currently the Nursing and Midwifery Council is changing the way nurses are revalidated, and Unite’s professional officers took part in the pilot study. We are offering all nurse members the opportunity to attend a short presentation outlining the changes in groups of 10 or more. This will bring Unite Health Sector to a wider audience.’

Programma
Make sure you are part of one of the most prestigious events in the 2016 Healthcare calendar.
“A fantastic day. This comes at the end of a challenging year. I feel so privileged”
Student winner – 2015

“This recognises all the hard work and dedication of our team. It has been a brilliant day and we are so pleased we could be a part of it”
Team winner – 2015

“I’m honoured, overwhelmed, surprised and proud. Just great to share it with so many deserving colleagues”
Educator winner – 2015

“I really feel truly honoured to have received this award. It has really shown me how valued I am within my team”
School Nurse winner – 2015
REWARDING, CELEBRATING AND SHARING EXCEPTIONAL ACHIEVEMENTS IN PROFESSIONAL PRACTICE

This year we will hold the awards in a spectacular new venue – Plaisterers’ Hall – the largest livery hall in London

We have expanded the number of categories for entry, making them more diverse to recognise skills and roles across Professional practice in Community Care

- Practice teacher Award
- Lecturer Award
- Universal HV Award
- Specialist HV Award
- School Nurse Award
- Community Nursery Nurse Award
- Team Award
- Leader Award
- Student Award
- Family Nurse / Flying Start Practitioner Award
- Equality and Diversity Award
- Public Health Award
- Advocate Award
- Macqueen Award for Research
- MacQueen Award for Professional development x2
- MacQueen Award for Public Health project and overseas

Previous
We are delighted to have supported the HV Award, as they do such outstanding work in Community.
Sponsor – Pampers

We are delighted to have sponsored the CNN of the year, their work is essential within the HV team.
Sponsor – Mothercare

We will be opening our nomination process very soon, so look out for details in Community Practitioner and on our website www.commprac.com

We will also be at Unite-CPHVA Annual Professional Conference 2015 in Manchester – 17/18th November, so please come and nominate a colleague
MORE THAN EIGHT IN 10 UNITE/CPHVA MEMBERS feel confident they will be able to complete the new requirements of 35 hours of continuing professional development (CPD), as set out in the new Nursing and Midwifery Council’s (NMC) Code of Conduct.

In a survey by Community Practitioner, 91 per cent of respondents said they feel up-to-date with core training.

More than two-thirds of those polled described the quality of CPD modules and events as ‘average’ with 87 per cent saying they are ‘helpful to practice’.

However, more than a third of Unite/CPHVA members are currently working without a personal development and training plan.

On the whole it seems employers are supportive in helping members access CPD, with 66 per cent of respondents marking them a five and above (one being least supportive and 10 being very supportive).

Worryingly, five per cent marked their employers at a woeful one, and 34 per cent admitted ‘sometimes’ carrying out compulsory training in their own time, with 40 per cent paying for it out of their own pocket.

Staff shortages have also meant almost six in 10 members have missed out on CPD opportunities.
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).
SPECIAL REPORT

ARE YOU A NURSING AND MIDWIFERY COUNCIL (NMC) REGISTRANT?

99% YES
1% NO

WHAT IS YOUR ROLE?

Health Visitor 72%
Other 18%
School Nurse 8%
Community Nursery Nurse 1%

DO YOU CURRENTLY FEEL UP-TO-DATE WITH CORE TRAINING?

91% YES
9% NO

DO YOU FEEL CONFIDENT THAT YOU WILL BE ABLE TO COMPLETE THE NEW REQUIREMENTS OF 35 HOURS CPD AS SET OUT IN THE NEW NMC CODE OF CONDUCT?

82% YES
9% NO

DO YOU FIND THE CPD EVENTS/MODULES YOU UNDERTAKE HELPFUL TO PRACTICE?

87% YES
13% NO

DO YOU HAVE TO CARRY OUT ANY COMPULSORY TRAINING IN YOUR OWN TIME?

49% NEVER
34% SOMETIMES
11% REGULARLY
5% ALWAYS
**DO YOU HAVE A PERSONAL DEVELOPMENT AND TRAINING PLAN?**

- **Yes:** 64%
- **No:** 34%
- **Not Applicable:** 2%

**AVERAGE:** 64%

**Above Average:** 26%

**Below Average:** 7%

**HOW WOULD YOU DESCRIBE THE QUALITY OF CPD EVENTS/MODULES AVAILABLE?**

- Average: 64%
- Above Average: 26%
- Below Average: 7%

**ON A SCALE OF ONE TO TEN (ONE BEING THE LOWEST), HOW SUPPORTIVE IS YOUR EMPLOYER IN HELPING YOU ACCESS CPD?**

- 1: 5%
- 2: 2%
- 3: 4%
- 4: 6%
- 5: 13%
- 6: 10%
- 7: 16%
- 8: 20%
- 9: 11%
- 10: 13%

**DO YOU HAVE TO PAY FOR YOUR OWN CPD?**

- 35% Always
- 3% Sometimes
- 2% Regularly

**HAVE YOU EVER MISSED OUT ON CPD TRAINING DUE TO STAFF SHORTAGES?**

- **Yes:** 59%
- **No:** 41%
Question: Have your CPD opportunities improved or worsened over the past five years?

Answer:

- Apart from a period of staff shortage, I’ve never had a problem
- They are more limited now
- Very much the same, but money for external courses is probably less easy to access
- The resource of time is increasingly short as a result of performance targets and continual staff shortages that affect training time and opportunity
- Only those provided locally by the trust are funded. Limited opportunity on other courses without doing in own time/ at own expense
- They have improved in the past two years to comply with CQC requirements
- No difference. We always had to have updates
- The same, but due to current NHS employer changes anticipate that it will worsen
- More difficult to get the time off to attend due to work pressures
- Apart from a period of staff shortage, I’ve never had a problem
- Have improved with merger to larger organisation. Larger training budget
- Good opportunities when ticks trust’s box. Increasingly tight time restrictions
- Worsened - all down to manager preference as to who should go, not based on identified individual needs
- Very much the same, but money for external courses is probably less easy to access
- Worsened – my employer has a £46 million overspend to claw back
- Worsened, Difficult to access CPD that is not in-house
- It has become increasingly difficult to access Level 4 safeguarding training and anything external due to costs of travel
Question: What additional support do you need to successfully complete your CPD?

Answer:

- To take account of the needs of bank staff training
- Standards to employers especially in view of private providers
- Nil I think. However, the feedback from colleagues is a new component – other than the feedback via previous KSF review. The idea of getting feedback from a wider range of colleagues/clients will take thought and preparation
- More staff would allow more time. We seem to be covering for school nurses more and more!
- It would be helpful not to feel isolated and to have the time to process learning
- Employers to realise that in order to practice effectively and in an evidenced-based way, we need time and access to training outside of safeguarding and mandatory skills. It might also help raise morale
- More time – support from others to do work not done when undertaking CPD
- Better staffing to allow me time to attend/complete work required
- Guidance on how to create an e-portfolio
- Help with templates to make capturing what’s studied simple
- Defined training sessions around revalidation
- Paid time off or more in-house training
- Study time allowed. Reduction in caseload when studying
- It support as I have never had any training in this and always struggle when it comes to computer skills
- IT support as I have never had any training in this and always struggle when it comes to computer skills
- One-to-one chats
- Time and a quiet space to be able to absorb learning
- More – support from others to do work not done when undertaking CPD
- More staff would allow more time. We seem to be covering for school nurses more and more!
- It would be helpful not to feel isolated and to have the time to process learning
- A commitment that staff will not be prevented from accessing relevant training and that less time will be spent teaching community practitioners about blood transfusions etc
- More time – support from others to do work not done when undertaking CPD
- Employers to realise that in order to practice effectively and in an evidenced-based way, we need time and access to training outside of safeguarding and mandatory skills. It might also help raise morale
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Domestic abuse ongoing after separation

THE ISSUE OF CHILD CONTACT AND domestic abuse has gained significant attention in recent years. Research highlights that domestic abuse may not end at the point of separation and the presence of children has been found to be a risk factor for continued abuse. This raises questions about whether contact in the context of domestic abuse is safe for children and for women. The article ‘All Over Now?’ The Ongoing Relational Consequences of Domestic Abuse through Children’s Contact Arrangements presents findings from a qualitative study with 18 children aged eight to 14 years and 16 mothers who had experienced domestic abuse in Scotland. Participants were recruited from domestic abuse support services in both the voluntary and statutory sectors. The research found evidence that the continued abuse of women and children following parental separation was linked to contact arrangements. Children’s contact with their non-resident fathers often took place amid an absence of parental communication and cooperation, which was traced to domestic abuse. This left children responsible for navigating the complex and charged dynamic of their parents’ relationship. Children reported this negatively, especially in regard to their relationships with their parents. The findings highlight the importance of considering the impact of the on-going relational consequences of domestic abuse when considering children’s contact arrangements.

Fiona Morrison, Centre for Research on Families and Relationships, University of Edinburgh, UK


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Academic performance of poor children in London is improving

LESS THAN A QUARTER (22 PER CENT) of children on free school meals in inner London obtained five or more A*–C grades at GCSE, or their equivalent, (including English and Math) in 2002. In 2013, this had risen to almost half (48 per cent). Gains were much smaller among disadvantaged children outside London (from 17 per cent to 26 per cent).

A study published by researchers associated with the Centre for Analysis of Social Exclusion (CASE) at the London School of Economics (LSE) and the Institute for Fiscal Studies (IFS) concludes that the improved performance largely reflects gradual improvements in school quality over time. Improvements in primary schools played a major role in explaining later improvements in secondary schools. The researchers followed a group of children born around the year 2000 from preschool to age 11, and found that disadvantaged pupils in London are not ahead at age five, but instead make faster progress once they get to school compared with their peers outside the capital.

Understanding the improved performance of disadvantaged pupils in London Authors: Jo Blanden (School of Economics, University of Surrey), Ellen Greaves (Institute for Fiscal Studies), Paul Gregg (Department of Social Policy, Bath University), Lindsey Macmillan (Institute of Education, University College London), and Luke Sibieta (Institute for Fiscal Studies).

Contact: J.Blanden@surrey.ac.uk
Luke_S@ifs.org.uk

Dangers to children’s health from wi-fi radiation in schools

Many parents worry about the effects of wi-fi radiation on their children’s health in primary and secondary schools. If you share their concerns and live in Scotland we would like to hear from you. We intend to form a group to take strength from each other and raise awareness about the dangers.

Please respond to me at peter.limbrick@teamaroundthechild.com

World AIDS day

World AIDS Day is held on 1 December each year and is an opportunity for people worldwide to unite in the fight against HIV, show their support for people living with HIV and to commemorate people who have died. World AIDS Day was the first ever global health day, with the first one was held in 1988. Around 100,000 people are currently living with HIV in the UK, and globally an estimated 34 million people have HIV. More than 35 million people have died from the virus, making it one of the most destructive pandemics in history. Take the World AIDS day online quiz: Are you HIV aware? (http://www.hivawarequiz.org.uk/quiz-3/about-you) Test your knowledge and awareness by taking the quiz, and act aware by passing the quiz on and sharing it with your friends on Twitter and Facebook.

If you understand how HIV is transmitted, how it can be prevented, and the reality of living with HIV today, you can use this knowledge to take care of your own health and the health of others, and ensure you treat everyone living with HIV fairly, and with respect and understanding. You can also show your support for people living with HIV on World AIDS Day by wearing a red ribbon, the international symbol of HIV awareness and support. World AIDS Day is also a great opportunity to raise money for the National AIDS Trust and to show your support for people living with HIV. If you feel inspired you might like to hold an event, bake sale or simply sell red ribbons. If you’d like to see what other events are taking place, go to http://www.worldaidsday.org/
Breastfeeding is best for babies*

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,1 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.1 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.2,3,4 In one study, 86% of infants with GOR who were fed anti-regurgitation formula pre-thickened with cornstarch demonstrated an improved reflux index — 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.6

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.7,8

SMA Staydown Formula is designed for the dietary management of babies with significant reflux. It is nutritionally complete and can be used from birth.

- Clinically proven to reduce reflux in infants with GOR*
- Thickened with easily digestible cornstarch
- Omega 3 and 6 LCPs
- Halal approved and suitable for vegetarians

SMA Staydown is a special formula intended for the dietary management of bottle-fed babies when significant reflux (regurgitation) is a problem. It is suitable as the sole source of nutrition up to 6 months of age, and in conjunction with solid food up to 12 months of age. If the baby’s reflux does not improve within 2 weeks of starting SMA Staydown, or if the baby fails to thrive, the GP, Health Visitor or other healthcare professional should be consulted.

*IMPORTANT NOTICE: Breastfeeding is best for babies. Breast milk provides babies with the best source of nourishment. Infant formula milk and follow-on milks are intended to be used when babies cannot be breast fed. The decision to discontinue 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 babies health. Infant formula and follow-on milk should be used only on the advice of a healthcare professional. This product must be used under medical supervision. SMA Staydown is a special formula intended for the dietary management of bottle-fed babies when significant reflux (regurgitation) is a problem. It is suitable as the sole source of nutrition up to 6 months of age, and in conjunction with solid food up to 12 months of age. If the baby’s reflux does not improve within 2 weeks of starting SMA Staydown, or if the baby fails to thrive, the GP, Health Visitor or other healthcare professional should be consulted.

Registered Trademark

Visit us: smahcp.co.uk or smahcp.ie

New meningococcal vaccines in the UK

KATHERINE ELIZABETH LLOYD, fourth year medical student, University of Bristol
DR SIBA PROSAD PAUL, specialty trainee year 8 in Paediatrics, Yeovil District Hospital, Yeovil
DR ANIL KUMAR GARO, consultant paediatrician, Worthing Hospital, Worthing

Two new vaccines to target invasive meningococcal disease (IMD) were introduced into the UK immunisation schedule in September 2015 (PHE, 2015). IMD has an average incidence of 2/100,000 per year in the UK (Ladhani et al, 2012). Since the introduction of the Meningococcal C (MenC) vaccine in the UK in 1999, IMD due to MenC has significantly decreased in children. Neisseria meningitidis serogroup B – MenB – now accounts for 87 per cent of all cases of IMD (Ladhani et al, 2012) making it the most common cause of meningitis in children aged three months and over (NICE, 2010).

In 2013-14 there were 636 reported cases of IMD in the UK, with MenB being responsible for 85 per cent and 92 per cent respectively in infants (<1 year) and toddlers (1-4 years) (PHE, 2015). The disease carries a significant mortality rate of 6 per cent, attributed to its rapid onset and progression (PHE, 2015), with MenB being responsible for 45 per cent of all deaths from meningitis (PHE, 2015). One-third of sufferers are left with defects in physical, cognitive or psychological functioning (Viner et al, 2012).

Above four years of age, the incidence of IMD due to MenB falls and the incidence of the other strains such as A, C, W and Y begins to increase. After the age of 25 years, the meningococcal strains most responsible for IMD are Y (80 per cent), C (59 per cent) and W (57 per cent) (PHE 2015). A dramatic change has been noticed in the incidence of the MenW strain in recent years with a year-on-year increase since 2009–10 (Campbell et al, 2015) – 42 cases in 2012, 76 in 2013, and 117 in 2014 (PHE, 2015). Although initially detected only in adults, MenW cases are now being seen in children of all ages and adolescents, with university students living in crowded conditions such as halls of residence at increased risk (PHE, 2015). Carriage of the strain is highest among young adults who are thought to transmit to other age groups, causing 13 per cent of deaths in recent years from IMD (PHE, 2015).

This article largely discusses the two new meningococcal vaccines and common challenges that community practitioners may face with the introduction of new vaccines. It provides strategies as to how they can enhance uptake of immunisation in the community. Table 1 highlights the revised immunisation schedule to be followed in the UK from September 2015.

MENINGOCOCCAL B VACCINE

The Meningococcal B vaccine, known as 4CMenB, was introduced into the NHS vaccination schedule in September 2015. This inactivated combination vaccine is made up of three N. meningitidis proteins and N. meningitidis capsular group B outer membrane vesicles (PHE, 2015). It is licensed for use from two months of age in the UK and is marketed under the brand name Bexsero®. Administration is via intramuscular injection into the upper arm or anterolateral thigh (PHE, 2015). Doses will be given at two, four and 12 months of age (PHE, 2015). Research suggests that 4CMenB may protect against 88 per cent of meningococcal strains in circulation (Frosi et al, 2013) and that five years after the vaccine was administered 79 per cent of cases still have immunity to C, W and Y serotypes (Baxter et al, 2015), although there was found to be a resultant fever in 77 per cent of infants of more than ≥38 °C following administration of the vaccine (Vesikari et al, 2013; PHE 2015). The fever generally peaks at six hours post-immunisation and normally resolves by 48 hours. This is compared to an incidence of 45 per cent of febrile events noted after administration of other routine vaccines in childhood (Vesikari et al, 2013). The Joint Committee on Vaccination and Immunisation (JCVI) has therefore recommended that paracetamol be given to infants under the age of one year after administering the 4CMenB vaccine to reduce fever and other symptoms associated with immunisation, such as pain at the injection site (PHE 2015). Parents should be advised to seek medical advice if the child is advised to seek medical advice if the child is

MENINGOCOCCAL ACWY VACCINE

The MenACWY vaccine is made from capsular polysaccharides of N. meningitidis serogroups A, C, W and Y. The vaccine is marketed under two brand names: Menveo® and Nimenrix®. It will be offered to school children around the age of 14 years with the aim that everyone is vaccinated by the time they reach year 13 (PHE, 2015). This has replaced the MenC booster vaccine previously given at this age. There is also a catch-up regimen for first-time university students. Administration is by intramuscular injection in the upper arm. Research suggests MenACWY induced a “robust immune response” against all four serogroups of Meningococcus (Lalwani et al, 2015) and that five years after the vaccine was administered 79 per cent of cases still have immunity to C, W and Y serotypes (Baxter et al, 2015).
unwell with a high fever or continues to need multiple doses of antipyretics 48 hours after immunisation (PHE, 2015). The Department of Health guidelines suggest the use of antipyretics on an as-required basis if a fever develops post-immunisation.

The MenACWY vaccine also has a good safety profile. Research performed in Russia in 2014 tested on 197 adolescents (Ilyina et al, 2014). Some common reactions to the vaccine include pain and swelling at the injection site as well as headache, nausea and malaise (PHE, 2015).

### CONTRAINDICATIONS

It is important for community healthcare professionals to be aware of contraindications to available vaccines. Neither vaccine should be given to a patient with a confirmed anaphylactic reaction to a previous dose or a constituent of the vaccine. Specialists with an interest in immunisation, such as paediatricians and immunologists, should be contacted if there is any doubt about whether to administer the vaccine or not. Precautions should also be taken in infants born before or at 28 weeks gestation, as apnoea is more

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Table 1: The routine immunisation schedule from Summer 2015

<table>
<thead>
<tr>
<th>Age due</th>
<th>Diseases protected against</th>
<th>Vaccine given and trade name</th>
<th>Usual site1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two months old</td>
<td>Diphtheria, tetanus, pertussis (whooping cough), polio Haemophilus influenzae type b (Hib)</td>
<td>DTaP/IPV/Hib Pediacel or infanrix IPV Hib</td>
<td>Thigh</td>
</tr>
<tr>
<td></td>
<td>Pneumococcal [13 serotypes]</td>
<td>Pneumococcal conjugate vaccine [PCV] Prevenar 13</td>
<td>Thigh</td>
</tr>
<tr>
<td></td>
<td>Meningococcal group B [MenB]2</td>
<td>MenB Bexsero</td>
<td>Left thigh</td>
</tr>
<tr>
<td></td>
<td>Rotavirus gastroenteritis</td>
<td>Rotavirus Rotarix</td>
<td>By mouth</td>
</tr>
<tr>
<td>Three months old</td>
<td>Diphtheria, tetanus, pertussis, polio and Hib</td>
<td>DTaP/IPV/Hib Pediacel or infanrix IPV Hib</td>
<td>Thigh</td>
</tr>
<tr>
<td></td>
<td>Meningococcal group C [MenC]</td>
<td>MenC Nimenrix or Menveo</td>
<td>Thigh</td>
</tr>
<tr>
<td></td>
<td>Rotavirus</td>
<td>Rotarix Rotarix</td>
<td>By mouth</td>
</tr>
<tr>
<td>Four months old</td>
<td>MenB2</td>
<td>MenB Bexsero</td>
<td>Left thigh</td>
</tr>
<tr>
<td></td>
<td>Pneumococcal [13 serotypes]</td>
<td>PCV Prevenar 13</td>
<td>Thigh</td>
</tr>
<tr>
<td>12 months old</td>
<td>Hib and MenC</td>
<td>Hib/MenC booster Menitorix</td>
<td>Upper arm/thigh</td>
</tr>
<tr>
<td></td>
<td>Pneumococcal [13 serotypes]</td>
<td>PCV booster Prevenar 13</td>
<td>Upper arm/thigh</td>
</tr>
<tr>
<td></td>
<td>Measles, mumps and rubella [German measles]</td>
<td>MMR Priorix or MMR VaxPro</td>
<td>Upper arm/thigh</td>
</tr>
<tr>
<td></td>
<td>MenB2</td>
<td>MenB booster Bexsero</td>
<td>Left thigh</td>
</tr>
<tr>
<td>Two to six years old [including children in school years 1 and 2]</td>
<td>Influenza [each year from September]</td>
<td>Live influenza vaccine Fluency Tetra3,4</td>
<td>Both nostrils</td>
</tr>
<tr>
<td>Three years, four months old</td>
<td>Diphtheria, tetanus, pertussis and polio</td>
<td>DTaP/IPV Infanrix IPV or Repevax</td>
<td>Upper arm</td>
</tr>
<tr>
<td></td>
<td>Measles, mumps and rubella</td>
<td>MMR [check first dose given] MMRVaxPRO4 or Priorix</td>
<td>Upper arm</td>
</tr>
<tr>
<td>Girls aged 12 to 13 years</td>
<td>Cervical cancer caused by human papillomavirus (HPV) types 16 and 18 (and genital warts caused by types 6 and 11)</td>
<td>HPV [two doses 6-12 months apart] Gardasil</td>
<td>Upper arm</td>
</tr>
<tr>
<td>14 years old [school year 9]</td>
<td>Tetanus, diphtheria and polio</td>
<td>Td/IPV (check MMR status) Revaxis</td>
<td>Upper arm</td>
</tr>
<tr>
<td></td>
<td>Meningococcal groups A, C, W and Y disease</td>
<td>MenACWY Nimenrix or Menveo</td>
<td>Upper arm</td>
</tr>
</tbody>
</table>

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1. Where two or more injections are required at once, these should ideally be given in different limbs. Where this is not possible, injections in the same limb should be given 2.5cm apart.
2. Only for infants born on or after 1 May 2015
3. If Fluency is contraindicated and child is in clinical risk group, use inactivated flu vaccine
4. Contains porcine gelatine
common in this group. However, as the 4CMenB vaccine is of particular benefit to premature infants, immunisation should not be delayed but preferably be performed in the hospital setting (PHE, 2015). Patients who are immunocompromised should also be given meningococcal vaccines in line with the normal schedule.

**COST-EFFECTIVENESS OF NEW VACCINES**

The UK is the first country to introduce the 4CMenB vaccine to their nationwide immunisation programme. Economic models from multiple countries initially indicated that the vaccine was unlikely to be cost-effective (Christensen et al, 2014). However, after further consideration the JCVI in the UK decided that the vaccine is cost-effective and recommended its use in the vaccination schedule (JCVI 2014; Sarfatti et al 2015). It is predicted that this introduction will reduce the cases of MenB by 26.3 per cent in the first five years (Christensen et al, 2014). Over 30 years, the impact of preventing transmission to other groups will result in a 51.8 per cent decrease in cases of Men B (Christensen et al, 2014). One of the vaccine components used in New Zealand during an outbreak of MenB demonstrated an efficacy of 73 per cent (Kelly et al, 2007). Data on the MenZB vaccine showed it to be effective and provided good insight into further vaccine development (Holst et al, 2013).

The ACWY vaccine was also found to reduce carriage of meningococcal strains in a study of 2,954 university students across England in 2010-11. Serogroup Y carriage in adolescents was decreased by 39 per cent and serogroups CWY by 36.2 per cent (Read et al, 2014). Based on the high prevalence of carriage within the target age group, this is likely to be cost-effective in the long term. As well as reducing carriage, the vaccine given to adolescents is expected to have the greatest impact on IMD incidence, with a 74 per cent reduction over 40 years. (Vickers et al, 2015).

**BENEFICIAL EFFECTS EXTEND TO THE COMMUNITY**

As well as protecting individuals directly, vaccines have the ability to protect others by interrupting transmission of the organism through a phenomenon known as herd immunity. The same study carried out on 2,954 university students in England in 2010-11 showed that the MenB vaccine reduces carriage of the bacteria after 12 months compared to a control, thus decreasing carriage frequencies across the population (Read et al, 2014). This provides protection to those who haven’t been immunised, including those in whom the vaccine is contraindicated. For effective herd immunity a high uptake of the vaccines in the normal population is necessary.

Herd immunity is of particular relevance with the ACWY vaccine. Follow up of 129 cases from the UK from 2010-13 showed that 81 per cent of cases of MenW had been previously healthy and had not travelled before illness (Campbell et al 2015). This highlights that the strain is “endemic and already established in carriage” (Campbell et al, 2015). The vaccines will target adolescents (13-18 years old) as this group shows the highest rate of carriage as well as the greatest increase in incidence of IMD (Campbell et al, 2015). The programme intends to respond to the rapid increase nationally and provide both direct immunity to the patients receiving vaccines, and indirect immunity to the rest of the population.

**NO RISK OF VACCINE OVERLOAD**

A common concern many parents have is that too many vaccines may result in “antigenic overload”, with the immune system unable to respond safely to multiple vaccines at once. Others believe that the immune system of infants is too immature to respond to vaccines and they should be administered when it has had time to mature (Poland and Jacobson 2012). In fact, infants encounter more antigens than the number presented to them in vaccines. Therefore there is no risk of vaccine overload (Poland and Jacobson 2012). Previous reports have highlighted that even if 11 vaccines were administered at one time to an infant, it would involve less than 0.1 per cent of the immune system (Hilton et al, 2006). Other reasons that parents may cite as to why their children can’t receive immunisations include “because Dad is epileptic”, or “I hate injections” (Paul et al, 2011). However, providing reassurance and information on the safety of vaccines can reduce anxiety and improve uptake of immunisation.

**ROLE OF COMMUNITY PRACTITIONERS**

Although vaccines are generally administered by practice nurses in GP surgeries and in schools, health visitors and community nurses have an important role to play in enhancing uptake through providing evidence-based and accurate information, providing reassurance and dispelling myths. From our clinical experience in dealing with families and the available literature, the following strategies are suggested, which may be useful to community practitioners (Sarfatti et al 2015; Paul et al, 2011; PHE 2015; JCVI 2014; Poland and Jacobson 2012).

- Provide relevant, up-to-date, evidence-based and non-biased information to parents regarding the new meningococcal vaccines.
- Explain that the vaccines have been introduced in light of the increasing prevalence and associated morbidity and mortality from other strains of Meningococcus such as MenB, MenW.
- Highlight the favourable safety profiles of both vaccines and the successful use of these vaccines in other countries around the world and in pilot studies in the UK.
- Explain the benefits of the vaccines in reducing the incidence of IMD and the long-lasting effects of vaccination.
- Explain the concept of herd immunity and the impact the new programme will have on reducing the incidence of IMD in other vulnerable groups in the community who have not received the vaccination – in the elderly population or those who are immunosuppressed or have had a previous anaphylactic reaction to immunisation and therefore cannot receive the vaccine.
- Reassure that the new meningococcal vaccines will not overload the immune system and that vaccination only involves a very small proportion of the immune system following administration.
- Explain that even in cases where a child has had a confirmed case of IMD due to a particular strain of Meningococcus they must still have all the vaccines as per the existing immunisation schedule to protect against the multiple other strains capable of causing further illness in the child.

References

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

1. Invasive meningococcal disease can manifest as:
   a) Meningitis
   b) Septicaemia
   c) Pneumonia
   d) All of the above

2. Which strain of N. meningitidis is the leading cause of IMD?
   a) Men A
   b) Men B
   c) Men C
   d) Men W
   e) Men Y

3. How should the 4CMenB vaccine be administered?
   a) Subcutaneous injection
   b) Intravenous injection
   c) Intramuscular injection
   d) Orally

4. In addition to school children aged 14, the MenACWY vaccine will also be provided in a catch-up regimen to which of the following groups?
   a) Children who have previously suffered from IMD
   b) First time university students
   c) Health care professionals
   d) All university students

5. Fever is a known adverse effect from the 4CMenB vaccine. Which of the following statements is true about the associated fever?
   a) Peaks at six hours
   b) Suggest treatment with paracetamol
   c) Resolves by 48 hours
   d) All of the above

6. Both meningococcal vaccines have a poor safety profile.
   a) True
   b) False

7. Herd immunity describes the protection of the non-vaccinated population by preventing infectious disease transmission.
   a) True
   b) False

8. Which of the following statements about vaccine overload is true?
   a) It is better to wait for children's immune systems to develop before administering vaccines at once can override a child's immune system
   b) Too many vaccines at once can override a child's immune system
   c) It can be unsafe to give more than one vaccine at a time
   d) None of the above, it is a mythical concept

9. Immunisation should not be given to infants born at or before 28 weeks gestation.
   a) True
   b) False

10. The role of community health practitioners is to:
    a) Provide up-to-date and evidence-based information to parents about meningococcal vaccines
    b) Highlight the positive safety profiles of both vaccines
    c) Explain the benefits of the vaccine
    d) All of the above
Outcomes for children with bladder and bowel problems nationwide are being adversely affected by the transfer of commissioning responsibilities for school nursing services from central to local government. These changes, introduced in April 2015, saw many local authorities withdraw continence from their core offer, thereby reducing capacity for early intervention and placing greater pressure on both primary and tertiary care. This has also meant job losses for community practitioners and a rise in inappropriate treatment for children with continence issues. Well-publicised budgetary pressures will prevent local authorities from reversing these decisions, leaving the community to look elsewhere to fill the void. Our first step should be to encourage clinical commissioning groups (CCGs) to commission integrated, joined-up, community-based paediatric continence services. This will improve outcomes for children, deliver NHS savings, and ensure that community practitioners who specialise in paediatric continence are able to use their skills. A better focus on improving school readiness through training and education will also be necessary.

This is not as big a task as it seems. The CPHVA, along with the Royal College of Nursing and the Royal College of Paediatrics and Child Health, has already endorsed guidance for commissioners on how to commission such a service: The Paediatric Continence Commissioning Guide. This was produced by the Paediatric Continence Forum (PCF), a national group of healthcare experts, and has also been accredited by the National Institute for Health and Care Excellence (NICE). The challenge for community practitioners will be to ensure its widespread use and adoption.

CHANGING ROLE

School nursing services are a vital Tier 1 pre-service element of a paediatric continence service. Along with health visitors, community nursery nurses, other community nurses and GPs, school nurses identify and provide advice and information to children, young people and their families on nocturnal enuresis (bedwetting), constipation, soiling and toilet training problems, and initiate first-line treatments. Through early intervention, school nurses can identify and manage problems before they become serious. They also refer children with complex conditions to specialist clinicians to ensure serious conditions are not missed and are treated accordingly (DH 2012, Tappin et al, 2013).

The full commissioning responsibility for school nursing was transferred from Public Health England to local authorities in April 2015 as part of a two-year process initiated

Encourage CCGs to commission integrated, joined-up, community based paediatric continence services to improve outcomes for children
in 2013. This process also saw the transfer of health visiting services in October 2015, with many local authorities choosing to integrate the two services to create a single Healthy Child Programme Service (HCPS). This has resulted in a withdrawal of the Tier 1 continence clinics currently being provided by many school nursing services, raising concerns over the future of paediatric continence services nationally and what this will mean for both children and community practitioners.

DECISION FOR CHANGE
The transfer of responsibilities should have presented new opportunities for a robust approach to improving overall outcomes for children and young people, but the opposite has proven to be the case. The PCF learnt in July 2015 that a mixture of budgetary pressures and an increasingly limited list of public health priorities has led many local authorities nationwide to remove continence from school nurses’ core offer. The primary motivation for the local authorities’ decision is financial. In June 2015, Chancellor George Osborne unveiled plans to cut the local authority public health budget by £200 million nationally – the equivalent of a 6.2 per cent reduction across all local authorities. This has caused directors of public health to re-evaluate how much they are spending and what they are spending it on. As continence is not considered a public health issue, like obesity, diabetes and smoking, but a clinical need, it was determined that continence should no longer be considered a priority. The fact that education is part of the universal-plus service may also have contributed to this decision.

In addition, local authorities have very little scope to make up the shortfall through cuts to other services. A survey conducted by the Local Government Association (LGA) before the recent general election found that 75 per cent of MPs believed adult social care should be ringfenced in the same way that NHS funding is, compared with 15 per cent of MPs who disagreed and 4 per cent who strongly disagreed. Local authority attempts to make cuts in these areas would prove to be extremely unpopular, and public health budgets provide a softer target.

IMPACT ON CHILDREN, FAMILIES AND THE NHS
The impact of the withdrawal of Tier 1 on continence services has already led to an overwhelming increase in the number of inappropriate referrals to emergency departments, outpatient clinics and waiting lists in tertiary care, and ultimately poorer long-term health outcomes for children and young people (DH 2012, 2011).

Many children with continence problems who would ordinarily be dealt with in a cost-effective manner in the community setting are now being transferred to tertiary units by their GP. These referrals are expensive. Staff are struggling to cope with the quantity of referrals, and lack the capacity to follow up on a regular basis to ensure patients receive the quality of care they deserve. Withdrawal of Tier 1 continence services is a retrograde step both in terms of its financial impact on the NHS and on the health and wellbeing of children and young people and their families. Continence problems can have a significant emotional impact. They increase the risk of bullying and behavioural problems in children and young people, and may affect their education and learning. Managing the problem can also cause additional financial stress in a family, with extra laundering and bedding protection costs (NICE 2010a, b).

The change has already impacted on many community health practitioners, particularly those whose primary role is health education, offering advice, support, robust assessment and first line treatment and referral to Tier 2 continence services. This has left many community practitioners feeling frustrated that incontinence is not considered a priority, or seen as a public health issue.

Key outcome indicators
- Rates of A&E attendance and unplanned hospitalisation for constipation and urinary tract infection.
- Percentage of children and young people with bladder and bowel dysfunction successfully treated within the service or post discharge.
- PROMS (Patient Reported Outcome Measures)/FROMS (Family Reported Outcome Measures) from the perspective of the child, young person and family.
The Paediatric Continence Commissioning Guide is a resource designed to assist commissioners, clinicians and managers to deliver integrated and evidence-based community paediatric continence services that meet the needs of children and young people with continence difficulties (bladder and bowel dysfunction) across England.

The aim is to improve outcomes for these children and young people through supporting local service redesign that is high quality and cost effective, takes into account the patient experience, the “Voice of the Child”, meets Domain 2 of the NHS Outcomes Framework Enhancing quality of life for people with long-term conditions, and reduces health inequalities (DH 2014).

Continence problems should be prioritised in partnership with Local Joint Strategic Needs Assessment (JCSNA) teams as highlighted in the NHS Outcomes Framework 2015/6 (DH 2014) to review local health needs. This is essential to ensure the right services are in place to achieve better health outcomes and reduce long-term conditions for children and young people. Assessing the impact of withdrawal of paediatric continence services on the quality of life of children and young people, regardless of their ability, is their entitlement and access to care is key (United Nations Convention for the rights of all children and young people).

Gaps in services remain despite clear recommendations by the Department of Health (2006) to bring care closer to home. Large numbers of children with constipation are being seen at secondary or tertiary level, which is costly to the NHS. All children and young people from birth to 19 years with bladder and bowel dysfunction (continence problems), including children with learning and/or physical disabilities, should have access to an integrated, community paediatric continence service (CPCS). If the CPCS model were to be implemented nationally, it would improve the quality of care in helping children and young people to achieve complete continence, or to manage the condition discreetly and effectively in cases where full control was not clinically possible. It would also create significant cost savings (PCF 2014).

Improving school readiness

Increasingly many children entering school (4.5-5 year olds) are not toilet trained and are still wearing nappies. This presents a range of issues both for the child and the school – for staff who have to assist with nappy changes, and for children through the impact of learning interruptions to lessons, as well as the emotional upset of not being able to be independent and the risk of teasing and bullying.

A new approach to delivering Tier 1 services could be achieved through training and education of other health professionals and partner agencies including parents and carers, to help promote and manage incontinence issues as early as possible. Once a child has reached the age of 2.5 years the health visiting team have no further input before it starts school, unless additional or more complex health needs have been identified. Following the final health check at 2.5 years, health visitors and/or community nursery nurses are ideally placed to offer early intervention support to help the child and family establish good toilet training routines and to encourage independence on transition to school. This will make every contact count and reduce the pressures placed upon early years settings and school entry (NHS Future Forum). Improving outcomes for children requires senior managers to view school readiness as a priority and to ensure relevant practitioners undertake this essential work before school entry.

Despite the financial climate affecting the NHS, social care and education services, it is imperative that further action is taken to raise awareness of the impact that withdrawal of Tier 1 continence services will have on children, their families, and their schools as well as on school nursing and community health practitioners.

If you would like to get involved please visit the PCF website www.paediatriccontinenceforum.org. It includes further background on the situation, actions that you can take and template letters to your local MP, CCG and Healthwatch organisation. Contact details are listed on the website should you wish to receive further information.

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www.gov.uk


What is lactose intolerance and how can it be managed?

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

**Common symptoms**

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

**Primary lactase deficiency**

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

**Secondary lactase deficiency**

A common, but temporary, cause of diarrhoea, it often occurs because of damage to the intestinal brush border, where lactase production takes place. It is brought about by untreated coeliac disease, Crohn’s disease and severe gastroenteritis caused by infections, such as rotavirus.¹ ²

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

Studies have shown that infants with diarrhoea fed on lactose free formula milk recovered in significantly less time than those fed on a lactose containing formula.¹ ³ ⁴

**Lactose free vs. lactose containing formula**

Lactose free formula has been shown to provide comparable growth and key nutrient absorption; when tested it showed no significant differences for magnesium, phosphorus, calcium and nitrogen.⁵

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

**”IMPORTANT NOTICE: Breastfeeding is best for babies. Breast milk provides babies with the best source of nourishment. Infant formula milk and follow-on milks are intended to be used when babies cannot be breast fed. The decision to discontinue 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 babies health. Infant formula and follow-on milks should be used only on the advice of a healthcare professional. This product must be used under medical supervision. SMA LF is a lactose-free milk based formula for the dietary management of babies and young children who are intolerant to lactose or sucrose, or who are suffering from symptoms such as diarrhoea, abdominal discomfort or wind caused by temporary lactose intolerance. It is suitable as the sole source of nutrition up to 6 months of age, and in conjunction with solid food up to 18 months of age. SMA LF is not suitable for those who are allergic to cows’ milk protein, or who suffer from galactosaemia or require a galactose free diet.**

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⁶As of November 2014, as checked via company carelines

Child neglect identification: The health visitor’s role

INTRODUCTION
HM Government (2015:93) describes child neglect as the persistent failure to meet physical and psychological needs, including:
- Inadequate nutrition, clothing and shelter
- Inadequate protection from harm or danger
- Impassiveness to a child’s emotional needs
- Poor or no access to health care.

Although this definition encompasses the spectrum of neglectful behaviours, criticism may arise at the use of the word ‘persistent’, since neglect can also involve one-off incidents (NICE, 2009). For example, parental supervision may usually be very good but may falter for short periods during a family crisis. Such incidents can have a damaging impact and should not be disregarded.

Impairment of the developing infantile brain occurs when caregivers are not responsive to a child’s physical and emotional needs (NICE, 2012). Not only does this lead to poor outcomes during childhood, it may lead to low educational attainment, mental health issues and a higher prevalence of risk-taking behaviours (drug/alcohol usage, risky sexual practices, self-harm and suicide) during adolescence/adulthood (NICE, 2009). However, neglect is not easily identified and often concealed - leading to chronic maltreatment over many years (Dubowitz, 2013). Therefore, the aim of this paper is to ascertain strategies for more effectively identifying neglect.

LIMITATIONS
This paper centres upon child neglect. The intention is not to isolate neglect from other forms of abuse, nor undermine the severity and impact of physical, emotional and sexual abuse; merely to act as a focus so that sufficient depth is given. Additionally, while prevention and early response is of paramount importance surrounding neglect, this is not the paper’s focus.

METHODOLOGY
The methodology was a library based literature review, undertaken during February-April 2014, as part of an MSc study programme at the University of Bolton.

A brief literature search of the online database CINAHL was conducted initially, as recommended by Aveyard (2010). This developed understanding of basic theories and concepts. Following this, a broader search of several online databases was conducted, focusing on the key terms and synonyms of the paper’s title. Table 1 details the findings.

Online and hand searches of relevant professional journals were also conducted including the Journal of Advanced Nursing, British Journal of Social Work, Community Health Visitor, Bridgewater Community Healthcare, Ashton, Leigh and Wigan Division

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ABSTRACT
Child neglect is a significant public health issue, with impact often persisting into adulthood. However, neglect is not easily identifiable and may go undetected for many years. This library-based literature review critically analyses the research to uncover effective practices to aid neglect identification. The literature identifies that professionals may observe particular risk factors in a child’s life that make neglect more probable. Additionally, children who suffer neglect, and parents who neglect their children, may display signs that practitioners can be alert to. However, a number of barriers exist that make identification difficult. The literature highlights that health visitors have a significant role to play in identifying neglect. Final conclusions relate to the need for professional supervision, use of assessment tools and frameworks, multi-agency training, and timely interventions to safeguard children.

KEYWORDS
Health visitor, child neglect, graded care profile

Table 1: Literature searches using online databases

<table>
<thead>
<tr>
<th>Online Database</th>
<th>Search Term Combinations</th>
<th>“Hits”</th>
<th>Potential Papers</th>
</tr>
</thead>
<tbody>
<tr>
<td>CINAHL</td>
<td>(Child neglect) AND (identify OR identification OR assess OR recognise) OR Child neglect AND health visitor</td>
<td>144</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td></td>
<td>36</td>
<td>6</td>
</tr>
<tr>
<td>Proquest Central</td>
<td>Child neglect AND identification AND health visitor</td>
<td>156</td>
<td>13</td>
</tr>
<tr>
<td>Science Direct</td>
<td>Child neglect AND identification AND health visitor</td>
<td>456</td>
<td>32</td>
</tr>
<tr>
<td>PubMed Central</td>
<td>Child neglect AND identification AND health visitor</td>
<td>345</td>
<td>24</td>
</tr>
</tbody>
</table>
Practitioner, Child Abuse Review and Child and Family Social Work, as well as professional and organisational websites – such as NSPCC, UNICEF, DH, DfE and Action for Children. Finally, relevant books were searched online and by hand using the university library catalogue. The search ended when articles and authors reoccurred.

For all search methods, the inclusion criteria permitted only full-text articles, written in the English language, and published within the last 10 years. This enabled papers to be comprehensively analysed, and ensured the review was based upon the most up-to-date literature available.

The search identified 44 potentially relevant papers for review. This was further refined by reading each paper’s title and abstract thoroughly, and ‘scan reading’ the entire paper, as recommended by Aveyard (2010). Papers were omitted if deemed irrelevant to the research question. ‘What evidence-based strategies can be used within health visiting practice to more effectively identify child neglect?’ The remaining papers were comprehensively read and, again, omitted if considered unrelated to the research question. The final selection of articles included those that were the most up-to-date and pertinent to the research question. The process located 26 relevant literature pieces of qualitative and quantitative research, SCR evidence, policy documentation and theoretical literature written by academic experts.

A grid reference system was produced to highlight similarities and differences between papers’ findings (Burns and Grove, 2011). This enabled themes to be generated, upon which this review is structured.

**RISK FACTORS**

In an attempt to predict and identify neglect, literature highlights risk factors that practitioners can be alert to (Daniel et al, 2011; Brandon et al, 2014). The aim is to identify concerns earlier and provide targeted and intensive support to ‘higher risk’ children (Munro, 2011). Risk factors are identified at various ecological levels: child, family and societal.

‘Child-related’ risk factors that render children more vulnerable to neglect are:

- Younger age – especially those less than one year.
- Low birth weight and prematurity - imposes heightened emotional stressors upon parents.
- Child disability – by imposing additional pressures (financial, practical and emotional), and in terms of disabled children not always fulfilling parental expectations.

(Rose and Barnes, 2008; Brandon et al, 2013).

Health visitors can be alert to families where these characteristics exist, and consider the heightened potential for neglect.

Extensive research has also been conducted into ‘parent-related’ factors, in particular the presence of domestic abuse - perpetuated through undermining the carer’s parenting capacity, and when physical assaults leave them unable to nurture and protect children (Davies and Ward, 2012). In a UK study, Dixon et al (2007) found that domestic abuse and child neglect coincided in 40 per cent of cases. Interestingly, the adult victim was more likely to neglect the child, while physical child abuse was perpetrated by the abusive partner (Dixon et al, 2007). Therefore, children can suffer neglect and physical abuse simultaneously when domestic abuse exists.

Literature indicates that poor parental emotional well-being renders children vulnerable to neglect (Kohl et al, 2011; Long et al, 2012; NICE, 2012). This occurs in a variety of ways: parental preoccupation with their own needs, insensitivity to children’s emotional and physical needs, and unrealistic expectations (Daniel et al, 2011; Kohl et al, 2011).

Furthermore, findings from a large-scale study (Marquis et al, 2008) and a longitudinal study (Forrester and Harwin, 2008) found significant correlations between neglectful parenting and substance misuse (illicit substances and hazardous alcohol consumption), with these children more likely to be removed into foster care placements. The impact is felt in several ways: antenatal use of illicit substances or alcohol impairs foetal growth, reduces parental cognitive ability, causes financial constraints, and children’s safety is compromised if drugs or needles are improperly discarded (Davies and Ward, 2012). Moreover, the partner of a drug or alcohol abuser may emotionally neglect the child through a preoccupation with the substance misuser (Horwath, 2007).

These risk factors are significant for health visitors who have identification and supportive roles to play in domestic abuse, mental health and substance misuse (DH, 2009; Cowley et al, 2013). Therefore, health visitors have a key role to play and are ideally placed to identify children at increased risk.

At societal level, literature identifies poverty as a risk factor, including: unemployment, low income, poor community resources and social support, inadequate or overcrowded housing and health inequalities (Daniel et al, 2011; Brandon et al, 2014). The link between poverty and child neglect is complex. It is suggested that financial constraints act as ‘stressors’ leading to harsh, inconsistent or passive parenting, reduced happiness and morale, and a sense of hopelessness (NSPCC, 2008). Furthermore, poverty is associated with substance misuse and poor mental health (NSPCC, 2008), creating an intricate network of factors. Indeed, the phrase ‘toxic trio’ is used to describe the co-existence of domestic abuse, substance misuse and mental ill-health, which Brandon et al (2012) found to co-exist in 86 per cent of serious neglect cases.

But caution must be exercised, as the presence of risk factors does not demonstrate causality and absence of risk factors does not exclude neglect. Indeed, Browne and Hamilton-Giachritsis (2007) warn that practitioners who hold stereotypical viewpoints of the circumstances in which neglect occurs, may fail to recognise vulnerable situations where there are no apparent risk factors. Powell (2007) advises that practitioners should acknowledge the correlations between circumstances and neglect, but appreciate that children may remain vulnerable where there are no apparent risk factors. Therefore, it is recommended that risk factors be used as pointers to the increased potential for neglect (Powell, 2007). Similarly, Brandon et al (2014) differentiate between risk factors for possible neglect, and signs of actual neglect, as discussed next.

**SIGNS AND INDICATORS**

Table 2 displays the numerous signs that neglect might be occurring, with some discussed below in more detail.

Research indicates that neglectful...
environments (inadequate play space and materials, limited opportunities for play, and impassiveness to a child’s play needs) impair children’s fine and gross motor skills, communication and cognitive development (NSPCC, 2008; Long et al, 2012). Therefore, in some cases developmental delay may signal neglect. As developmental assessment is a significant role of health visitors, they are in a key position to recognise concerns and consider neglect as a possible cause (DH, 2009). However, practitioners must consider other causes, and be mindful that children are unique in their developmental trajectories.

NICE (2009) identifies that faltering growth may be a signal of neglect. However, there is a dearth of up-to-date research to support this. Although a UK study (Wright et al, 2000) highlighted that neglected children are five times more likely to experience faltering weight, the study is more than a decade old, which may affect the finding’s transferability to contemporary practice. Evidently there is a need for further research surrounding faltering weight as a sign of neglect.

Birth to five years is considered the most critical growth period and thus a very vulnerable stage (Daniel et al, 2011). Health visitors are recognised as especially skilled in the assessment of weight and growth in this population (Hall and Elliman, 2008; Hall and Elliman 2008) recommend the use of centile charts on all children to identify faltering growth. However, in the Serious Case Review [SCR] of Peter Connelly, his weight deteriorated from the 75th centile to the 9th and was noted by the health visitor but not acted upon promptly (Haringey LCSB, 2010). This indicates the absolute necessity of timely and appropriate professional intervention, when concerns arise. Indeed, HM Government (2015) recognises that delaying action when abuse/neglect is suspected significantly impinges children’s welfare. This highlights that it is not enough to just observe for signs of neglect.

Family behaviours may also signal neglect, for example failed attendance at appointments, delays in seeking medical attention (NICE, 2009; Brandon et al, 2013). Indeed, one third of children subject to a neglect SCR, has a history of poor health appointment attendance (Brandon et al, 2013). Furthermore, a large-scale UK-based study of paediatric burns attendees found that among cases attributed to neglect, medical aid was sought 24 hours or more after the incident (Chester et al, 2006). However, this study involved children aged up to 16 years. Since it includes children of extremely different supervisory requirements, the results must be viewed with caution.

Dubowitz (2013) advises that although occasional missed appointments are unlikely to cause harm, it could be argued that failure to attend for a single appointment may have devastating effects, for example following a serious accident. Indeed, Powell and Appleton (2012) have stressed the importance of following up children who are ‘not brought’ to their appointments. In practice, the significance of a missed appointment needs to be established through further searching for health needs; focused on the presence or absence of other signs or risk factors. Health visitors, particularly, can be alert to children’s health appointment attendances since they receive correspondence from allied health professionals and are in a position to accumulate a fuller picture of the frequency and nature of missed appointments and A&E attendances. This also highlights the necessity of multi-agency information-sharing.

Cowley et al (2013) recognise that health visitors have comprehensive and specialist knowledge of neglect signs and risk factors; meaning that neglect can be identified more promptly. Furthermore, a health visitor’s unique position within the community – having universal contact with children and their families, often within the home – means that they can generate knowledge of family circumstances over time, observe for deteriorations in home conditions, and observe parenting within a more ‘natural’ environment (Laming, 2009; Cowley et al, 2013).

### BARRIERS TO IDENTIFICATION

The negative consequences of neglect upon child development, and the subsequent behaviours that practitioners can be alert to, have already been discussed. However, literature also describes those children who flourish despite adverse circumstances and show minimal (if any) signs of their circumstances – a concept known as resilience (Brandon et al, 2014). Generally, resilience is regarded positively; denoting adaptability and resistance to adversity.

**Table 2: Signs of neglect in pre-school children**

<table>
<thead>
<tr>
<th>Child Physical</th>
<th>Dental decay/pain.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Swellings/burns/Lacerations/fractures.</td>
</tr>
<tr>
<td></td>
<td>Faltering weight.</td>
</tr>
<tr>
<td></td>
<td>Developmental delay.</td>
</tr>
<tr>
<td></td>
<td>Poor hygiene, chronic nappy rash, severe and persistent infestations (such as scabies, head lice).</td>
</tr>
<tr>
<td></td>
<td>Non- or delayed immunisations (with no evidence of parental informed choice).</td>
</tr>
<tr>
<td>Child Emotional</td>
<td>Withdrawn, unresponsive or passive infant (aged 0-18 months), developing more aggression and extreme attention-seeking behaviours towards two years.</td>
</tr>
<tr>
<td></td>
<td>Poor play/imaginative skills.</td>
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<tr>
<td></td>
<td>Begging for, and stealing or hoarding food.</td>
</tr>
<tr>
<td></td>
<td>Self-comfort - rocking, head banging, “masturbation”.</td>
</tr>
<tr>
<td>Parent Behaviours</td>
<td>Limited parent-child interaction; criticism, aggression, indifference; little affection/love.</td>
</tr>
<tr>
<td></td>
<td>Repeated failed attendance for child’s appointments and non- or poor engagement with services.</td>
</tr>
<tr>
<td>Environmental</td>
<td>Overcrowding, unsanitary, hazardous housing.</td>
</tr>
<tr>
<td></td>
<td>Poor food provision.</td>
</tr>
<tr>
<td></td>
<td>Limited (if any) age-appropriate toys.</td>
</tr>
</tbody>
</table>

(NICE, 2009; Brandon et al, 2014)
However, another perspective is that this 'false resilience' masks poor parenting, with children minimising their distress (Brandon et al, 2014) and ultimately leads to professional oversight of neglect. Indeed, Rose and Barnes' analysis of SCR's (2008) found that children presenting as bright, intelligent and alert remained susceptible - if not more so – to harm.

Parental non-engagement and/or hostility also presents a barrier (Munro, 2011; Brandon et al, 2013). Neglectful parents are more likely to disengage with professionals, leaving children invisible and vulnerable (Powell, 2007). Indeed, Brandon el al’s (2013) analysis of SCR's indicates that health visitors often had a number of ‘no access' visits. Additionally, practitioners may deliberately avoid contact with, or fail to challenge families, who are aggressive out of fear of reprisal. Indeed, Baby Peter's mother was noted to be extremely volatile which prevented professionals from challenging her (Haringey LSCB, 2010).

Compounding this is the notion of 'disguised compliance', whereby neglectful families mislead services into believing they are co-operative and engaging (Brandon et al, 2014). In practice, disguised compliance might be seen through short-term improvements in home conditions or sporadic attendances at school/nursery/appointments. Disguised compliance can be extremely damaging to a child's welfare since it delays identification of neglect and disguises the reality of the child's life (NSPCC, 2014).

The very nature of neglect also inhibits identification. The 'threshold of significant harm' (HM Government, 2015) is the legal definition of abuse or neglect and the point at which state intervention is compulsory. However, Brandon et al (2013) recognise that individual instances of neglect (surrounding the same child) rarely reach this threshold. As a result, practitioners may fail to share minor incidents with one another, so that the cumulative impact is unknown (Davies and Ward, 2012).

Brandon et al (2013) also describe the practice of ‘start again syndrome’, whereby practitioners feel so overwhelmed by complex cases that they cast aside historical information as a professional coping mechanism. However, this practice loses information surrounding patterns of past behaviours that prove vital in cases of enduring neglect. Laming (2009) discusses professionals having unfounded empathy for parents undergoing difficult circumstances, meaning that they lose focus on the child. Munro (2011), cites Dingwall et al (1983), and describes the ‘rule of optimism’ whereby professionals perceive parents as caring and nurturing of their children, and take at face value parents’ explanations and views of home circumstances. This can be seen in the case of Daniel Pelka whose mother was often seen as the victim within the home.

USE OF ASSESSMENT TOOLS/FRAMEWORKS
To counteract these barriers, literature recommends 'significant event' front summary sheets, for all families, to generate a cumulative chronology (Munro, 2011). Joint professional visiting might help reduce the ‘threat’ of parental hostility, while reflective practice, professional supervision and multi-agency training are recommended to gain clearer perspectives on family circumstances when working with complex families (Munro, 2011; Davies and Ward, 2012; Brandon et al, 2013 and 2014).

Assessment tools and frameworks are also helpful in identifying neglect. The Graded Care Profile (GCP) provides a specific tool for assessing neglect (Srivastava et al, 2005). Based upon Maslow’s Hierarchy of Needs, it assesses parental care on a continuum from one (all areas of the child’s needs met) to five (needs grossly unmet/not considered).
As a result, the tool is considered more objective and acknowledges the grey area between 'acceptable' and 'unacceptable' care or parenting – often present in cases of neglect (Horwath, 2007). The GCP therefore supports referrals to social care through the implementation of an approved 'upper limit' for intervention, thus minimising the issue of thresholds previously discussed (Horwath, 2007). Interestingly, health visitors use this tool more than any other professional (Srivastava et al, 2005). Additionally, the Assessment Framework (DH, 2000) offers practitioners an ‘open ended’ method of assessing children’s health/development, parenting capacity, and family/environmental factors. It is considered pertinent to neglect identification as it identifies factors at various levels that enhance and detract from care (Daniel et al, 2011). Also, the sub-component ‘Family History and Functioning’ allows for consideration of current and previous circumstances – potentially avoiding ‘start again syndrome’. Using these frameworks, professionals can accumulate information about children’s needs, plan their interventions, be alert for the need for ‘Early Help’ (formerly a Common Assessment Framework) if family circumstances present challenges for the child, and make onward referrals to other agencies/services as required.

CONCLUSION

Childhood neglect can have a considerable detrimental impact upon physical, emotional and social health, with impact often persisting into adulthood. But neglect is not easily identifiable – leading to chronic maltreatment over many years. This paper seeks to review the evidence regarding effective measures for identifying neglect.

The paper identifies multiple risk factors for neglect. However, it acknowledges that risk factors do not diagnose neglect. Likewise, absence of risk factors does not eliminate neglect. Instead, they act as pointers to an increased potential, which professionals can be alert to. Signs and indicators were also examined. Evidence indicates that these may demonstrate more substantial verification of neglect. However, the paper also highlighted a number of barriers that may occlude professional’s judgement. To overcome these, evidence highlights the importance of multi-agency training and information-sharing, professional supervision and reflection, joint visiting and the use of chronologies and assessment tools/frameworks.

This paper examined the health visitor’s role, and highlights the significance of this profession in terms of their universal contact with families within the home, and their specialist knowledge of the family, and risk factors and signs of neglect. This paper may go some way to remind health visitors of their crucial importance in protecting children from neglect.

In conclusion, early identification, and subsequent timely intervention and support are essential for the short- and long-term welfare of children in cases of neglect, with SCR evidence highlighting the devastating consequences of delayed action.

References

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Initial analysis of a community-based bereavement programme

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ABSTRACT
It is well evidenced that childhood bereavement has a negative impact upon a range of psychological and educational outcomes. This article describes a service evaluation of the national child bereavement charity, Winston’s Wish SWITCH programme. SWITCH is a community outreach bereavement programme targeted at children that are at risk of antisocial and self-destructive behaviour. A preliminary evaluation of baseline to follow up of parent (n=31) and young person (n=96) Strength and Difficulties (SDQ) data suggests that the programme contributes to a positive impact upon emotional distress, relationships, and concentration. Further, more robust evaluation needs to be conducted to understand the long-term implications of the programme on vulnerable young people.

KEY WORDS
Child bereavement, community intervention, risk, attachment, group work

INTRODUCTION
The leading child bereavement charity, Winston’s Wish aims to support children who have suffered a significant bereavement, to help them make sense of the death, to rebuild their lives and to develop resilience for their future. Winston’s Wish SWITCH programme is a community outreach service that targets children aged 8-14 years who are at an increased risk of antisocial and self-destructive behaviour following bereavement, and may be on a pathway to youth offending. They may be experiencing difficulties in one of the following areas – truancy, exclusion and risk of expulsion from school, relationship breakdown with peers or family, difficulties with managing emotions or behaviours, and social isolation. These have all been highlighted as risk factors for difficulties with the criminal justice system. The SWITCH project is supported by the Big Lottery and is part of a wider project entitled Realising Ambition, which is managed by Catch 22. This is a social business that provides support to services, such as Winston’s Wish. The project works in partnership with the Social Research Unit, Young Foundation and Substance. This article describes a service evaluation that was undertaken to understand the impact of the SWITCH programme on young people. The evaluation helps us to understand some of the limitations and benefits of the programme and informs future improvements.

A bereavement in childhood from a significant attachment figure can have a detrimental impact upon a range of developmental and life issues (Aynsley-Green et al, 2012; Ribbens McCarthy & Jessop, 2005). The Child Bereavement Network has suggested that 5 per cent of children within the UK are bereaved of a parent or sibling before the age of 16 (Parsons, 2011). Akerman & Statham (2014) suggest that a bereavement in childhood impacts upon a child’s wellbeing, short term and long term, specifically in areas of psychological health and educational attainment. It is typical, following a significant bereavement for a child to display a range of emotional and behavioural responses to their grief. These can be displayed in a variety of different ways. Dyregrov (2008) has outlined some of the more common reactions to grief which include – but are not limited to – anxieties, vivid memories and sleep difficulties. The complex responses of bereaved children can often be “forgotten” (Smith, 1999) by adults and their needs unheeded. It is important that child bereavement services, and indeed the wider network such as schools, are aware of the different ways a child can react to bereavement, in order to be able to support the child in the best way possible.

Theoretical grounding for child bereavement
There are a range of different bereavement theories that have been adapted and used across children’s services. Three models in particular are the Dual Process Model (Stroebe & Schut, 1999), Continuing Bonds (Klass et al, 1996) and the Growing around Grief Model (Tonkin, 1996). When working with a child that has suffered a significant bereavement, it is important to keep in mind these theories, and to be able to apply them succinctly to appropriate situations.

What happens if childhood bereavement is unsupported?
It has been demonstrated that a significant bereavement in childhood can cause long-term risks to health and wellbeing, and if left untreated these can increase a young person’s vulnerability to a range of behavioural, social and psychological difficulties (Ribbens McCarthy & Jessop, 2005, Penny & Stubbs, 2014). The likelihood of vulnerabilities to additional difficulties following a bereavement is increased if the young person is already experiencing difficulties within family and social relationships (Ribbens McCarthy & Jessop, 2005) or faces further changes and losses (Christ, 2005). A significant bereavement can increase a child or young person’s vulnerabilities and can lead to behaviour that is difficult to manage, for example
agression, and result in destructive coping mechanisms such as criminal behaviour. These coping behaviours, coupled with a significant bereavement, can impact on a young person facing the difficulties of balancing school, home life and peer relationships and possibly facing a pathway into the criminal justice system (Vaswani, 2008).

The following subsections outline some of the key areas that may be affected by unsupported childhood bereavement:

a) Educational attainment
Following a bereavement, children may face difficulties with underachieving (Abdelnoor & Hollins 2004b), truancies, difficulties with concentration (Dyregov, 2004), and attentional problems (Haine et al, 2008, Akerman & Statham, 2014). The research has also demonstrated that they are more at risk of future unemployment in adulthood (Parsons, 2011).

b) Mental health difficulties
A significant bereavement in childhood can result in several difficulties, in particular anxiety (Fauth et al, 2009), depression (Brent et al, 2009), conduct disorder (Fauth et al, 2009), and in some cases post-traumatic stress disorder (PTSD) (Melhelm et al, 2008).

It is estimated that approximately 50-60 per cent of all children and young people who are bereaved of a parent show distress and depressive symptoms which persist over time (Parsons, 2011).

c) Risk of youth offending
It has been reported that a bereavement experienced by a youth offender is typically more traumatic and violent (Vaswani, 2008).

Approximately 13 per cent of young people under the supervision of Youth Offending Teams (Youth Justice Trust, 2003), 17 per cent of persistent young offenders (Vaswani, 2008), and 10 per cent of prisoners (Boswell, 1996) had suffered a significant childhood bereavement.

METHOD

Description of the SWITCH intervention

The SWITCH programme includes up to four family meetings, four group sessions for children and young people (after school, two hours), and one celebration day. The groups and family meetings are delivered by senior practitioners, who are trained in working in bereavement, family therapy and counselling and they are supervised by a qualified psychologist.

Referral information

Figure 1 illustrates the referral criteria used for the SWITCH programme. The referrer is typically a social worker, teacher or parent.

Family meetings

During the intervention the practitioners aim to support the children and young people to understand the finality of death, to create an attachment to the person who has died by retaining a continuing bond, to have a final goodbye, and to provide a visual representation of the sequence of events that preceded the death and events at the time. The child is supported to express difficult emotions, and given permission, within a safe environment, to explore all feelings and memories whether positive or negative. The development of coping skills will be individual to each child and family, but it is crucial that children develop the skills to identify and manage arousal to high emotions, and give them permission to seek help from others to regulate their behaviour.

Group work

All the children and young people are invited to take part in four group sessions, held over a two-week period. The aim is to share the grief experiences with others, to reduce the sense of ‘aloneness’ and feeling different from their peers. An important element of the group work is the permission given to be a child and have fun without feeling guilty or anxious. The group is designed for a maximum of six children with a shared age and level of maturity. Group work involves the use of creative activities, talking together, and thinking and sharing, which allows the child to continue the bond with the person that has died (Rothaupt & Becker, 2007). Additionally memory activities are completed within the group. Sometimes, there are no

Figure 1: Referral criteria for the SWITCH programme
children and adolescent mental health services and children's charities, as well as other child bereavement services. The SDQ measures children and young people's behaviours, emotions and relationships through 25 items across five subscales – emotional distress, hyperactivity and attention difficulties, behavioural difficulties, peer problems and pro-social behaviours. The first four areas can be summed for an overall stress score. The SDQ scoring range for the overall stress score is between 0-40. A score of less than 13 is normal, and more than 17 is cause for concern.

For children below the age of 11 years, we asked parents or carers to complete this on their behalf. For children over the age of 11, we asked children to complete a self-report version. The SDQ is a standardised measure that has been thoroughly researched in child and adolescent services. It has a strong test-retest reliability of 0.62 and the criterion validity is judged to be adequate (Goodman, 1997).

RESULTS

Initial results of the SWITCH programme

As a part of the regular service outcome monitoring, all children and young people who are involved in the SWITCH programme, complete a Strength and Difficulties Questionnaire (SDQ) pre and six months following the completion of the intervention. The mean age of participants was 12.27 (SD=2.03, range: 8-14 years); 52 per cent were male and 48 per cent were female; 37 per cent had experienced death of a father, 34 per cent a grandparent, 15 per cent a mother; 97 per cent of deaths were accidents or an illness, and 3 per cent were suicide bereavements.

As can be observed in the table we noticed a decrease in the overall stress scores from baseline to follow up. There is a slight difference between baseline (mean=16.83, SD=7.09) and follow up (mean=16.24, SD=5.62) on the parent reporting SDQ (n=31). Furthermore Cohen’s effect size (d=0.046) for these results suggests they are statistically insignificant. However, in the young person self-reported SDQ results (n=96), there is a larger difference between baseline (mean=18.56, SD=6.33) to follow up (mean=15.62, SD=6.57). A Cohen’s effect size (d=0.22) for these results suggests a low clinical significance.

The table illustrates the differences between parent and child reporting on the breakdown of the different SDQ domains. It is notable that there is a decrease from baseline to follow up in emotional distress, behavioural difficulties, and hyperactivity and peer problems. These results suggest a small clinical significance in the reduction across the domains. There is a slight increase in pro-social behaviour, which again suggests a small clinical significance from the impact of the SWITCH programme.

DISCUSSION

These preliminary results are promising and suggest that from baseline to follow up the SWITCH programme may contribute to a reduction in the impact of difficulties on a child’s life. The results suggest that this is across several domains, including emotional distress, behavioural difficulties, hyperactivity and peer problems. It could be suggested that the SWITCH programme supports a reduction in areas that should impact upon a child’s ability to concentrate in school, and to develop and maintain appropriate peer and family relationships, and thus could lead to a reduction in the likelihood of developing further risk factors of progressing into the...
criminal justice system. It is important to note that although the initial results of the SWITCH programme are promising, there are a variety of confounding factors that can impact upon these results, such as improvement in home life, parent more able to parent as their acute grief lessens, changes in school, general adolescent transitions and development of emotional maturity. Additionally due to the nature of childhood bereavement, it is highly likely that the feelings of anxiety and other grief symptoms would have decreased after a period of time. Therefore it is impossible to attribute the improvements in the SDQ purely to the SWITCH programme.

Limitations with the evaluation
One of the main limitations of the evaluation was that it only used the SDQ, thus the data gathered was purely based on self-reporting and was not objective. The evaluation did not gather any background information on the children's levels of educational attainment and pre-existing mental health disorders that may have impacted upon their involvement with the group. Additionally data were just gathered from a specific sample, from the two sites in West Sussex and Gloucestershire. For the purpose of the evaluation, children were only included that had completed the SWITCH evaluation and the post intervention SDQ. Despite having no drop out, once children are signed up to SWITCH, data from a group of children could not be included as they did not complete the SDQ pre and post measures. The reasons for children and young people not completing the post SDQ were mainly due to lack of resources, changes in children’s situation, or difficulties with engagement. Further evaluation is currently being undertaken to understand the reasons for these children dropping out of the programme, as this information could help to guide future developments and make it more accessible.

Implications for clinical practice
The SWITCH programme was developed to support children and young people who are more at risk of becoming youth offenders. The practitioners that work with these families have observed that the children and young people often report that they are better able to cope and feel that they are a different person after engaging with a SWITCH programme. One of the main implications of the intervention is the benefits of successful engagement with difficult or hard-to-reach families. The team have suggested a number of reasons for this, which include a 'fun' approach, being outside of school, and the fact that practitioners are ‘persistent’ with the children. Also, group sizes are small and sessions are of a short duration.

Limitations of the SWITCH programme
However, there are some limitations to the programme. It is a challenge to run the group work with a range of different ages, background, types of death and time frame since the person has died. The aim of a broad referral criteria is to capture a wide range of children, but it often means that there are a number of conflicting variables within a group. There can often be a range of different capacities, ages, personalities and behavioural difficulties within a group. These can all impact upon the smooth running of the group. Additionally, the significance that each child places on the death can be an issue. The programme is delivered across a wide geographical area, which has implications for the amount of travelling the team has to undertake. There have been practical challenges, including engaging parents in the group work, travel difficulties with getting children to the groups, and the challenges of the programme being held across two hubs in West Sussex and Gloucestershire affecting successful joined up working. Winston’s Wish started in 1992, and has established itself as one of the leading child bereavement charities. SWITCH was a new, funded programme set up within Winston's Wish. There have been challenges setting up the programme within an existing service, but these have been minimal. We have in place a specific manual, with peer-peer observation, supervision and ongoing team meetings for all staff involved in the programme to maximise standardisation across teams.

CONCLUSION
Overall, the initial results from SWITCH are promising. However there are several areas that require further attention. In particular, the service is interested in conducting research to understand the long-term effect of the SWITCH programme, to explore whether there has been a significant impact of the bereavement intervention upon children and young people’s behaviour, relationships and educational attainment. It would also be interesting to compare this data to a

<table>
<thead>
<tr>
<th>Informant Group</th>
<th>SDQ Emotional Distress M (SD)</th>
<th>SDQ Behavioural Difficulties M (SD)</th>
<th>SDQ Hyperactivity M (SD)</th>
<th>SDQ Peer Problems M (SD)</th>
<th>SDQ Pro-social M (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent (n=31)</td>
<td>Baseline 5.4 (2.7)</td>
<td>4.0 (2.0)</td>
<td>6.5 (2.45)</td>
<td>3.0 (2.0)</td>
<td>7.3 (2.0)</td>
</tr>
<tr>
<td></td>
<td>Follow up 4.6 (2.8)</td>
<td>3.4 (2.0)</td>
<td>5.5 (2.6)</td>
<td>2.3 (2.0)</td>
<td>7.5 (2.0)</td>
</tr>
<tr>
<td>Child (n=96)</td>
<td>Baseline 5.1 (2.3)</td>
<td>4.2 (2.1)</td>
<td>5.9 (2.0)</td>
<td>3.2 (2.4)</td>
<td>7.3 (2.0)</td>
</tr>
<tr>
<td></td>
<td>Follow up 4.1 (2.3)</td>
<td>3.9 (2.2)</td>
<td>6.7 (1.9)</td>
<td>2.1 (1.4)</td>
<td>7.8 (1.8)</td>
</tr>
</tbody>
</table>

Table 2. Breakdown of SDQ results across the different domains

Key points
- SWITCH is a community-based bereavement intervention, targeted at children who have suffered a significant bereavement and are at risk of antisocial and self-destructive behaviour in areas of school, home life and relationships.
- The intervention includes four family meetings, four group sessions for children and young people (after school, two hours), and one celebration day.
- The service evaluation studied a sample (n=127) of pre- to six months post-intervention completion scores on the Strength and Difficulty Questionnaires (SDQ).
- Overall, the initial evaluation results are promising, but more robust research needs to be undertaken to understand the full impact of the SWITCH programme.
sample of typically developing children to further understand the impact that the programme is having. It would be useful to interview parents and children to understand individual perspectives of the programme. And it is important to gather information on educational attainment, as this is an area that has been highlighted in research as affected by childhood bereavement. There are several limitations with this service evaluation, but the initial results suggest that the SWITCH programme may have an impact on a sample of vulnerable, difficult-to-engage children and young people.

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Capacity building deconstructed

SALLY SMITH SCPHN, Bsc (Hons) Nursing Studies, health visitor and BCC lead for Mid Yorkshire NHS Trust

ABSTRACT
Community engagement and seeking out health needs are core principles of the Specialist Community Public Health Nurse’s (SCPHN) role. In view of the changes to health service provision, the ability to work with the community in a positive manner and facilitate a Community to help themselves, and enable good health outcomes, is the essence of Building Community Capacity (BCC). However, the challenges faced by SCPHNs in the often long and complex processes involved with BCC projects highlights the intensive nature of this work and how disparity in provision of BCC remains an issue. This article strives to define and discuss BCC, the positives to staff, communities and individuals involved and debates the role of BCC in the future of Health Visiting.

KEY WORDS
Community, building community capacity, community development, engagement, health needs

INTRODUCTION
Building Community Capacity (BCC) appears to be the new ‘buzz-word’ within health visiting today. Government literature is littered with references to the concept (NICE, 2008, Department of Health, 2011, 2013). Kenyon (2015) highlights this as an integral aspect of the specialist community public health nurse (SCPHN) role, and social media is alive with blogs, hash-tags, and threads detailing the positive impact this method of integrated working can bring (Crees, 2015).

But practically speaking, how do most health visitors feel about engaging in this activity as part of their everyday role? This article aims to discuss the essence of BCC, the impact of the changes within health visiting in relation to BCC, and the challenges faced by practitioners working on the ground.

DEFINING BCC
As most SCPHNs will testify, BCC helps communities and individuals to help each other to help themselves, reducing health inequalities and improving health outcomes (Kenyon, 2015). Although this may appear simple on the surface, when we delve deeper into BCC it becomes apparent that this is a concept whose roots are firmly fixed in public health (Smith & Horne, 2012) and whose key characteristics call on the full range of the SCPHNs role. Locally, the changes in Sure Start services and reduction in Children’s Centres have called for a new way of working and community level support. Furthermore, the role of capacity building is intrinsic to the SCPHN role and a requirement of continued registration and revalidation (NMC, 2015).

Reflecting on Skinner’s (2006) definition of community development, the concept of empowerment and professional support is highlighted to enable the community to take a lead role in changing their social circumstance to improve their lives – the very essence of BCC. With this in mind, BCC appears to fit intrinsically within the health visiting principles of seeking out health needs and encouraging health enhancing behaviours (Council for the Education and Training of Health Visitors, 1977). Experienced health visitors know that BCC is not a new concept but appears to have re-emerged in the specialist community public health nurse role with the increase in staffing levels associated with the Health Visiting Implementation Plan. Historical pressures of caseload management, changing skill mix, safeguarding responsibilities or low staffing levels (Royal College of Nursing 2011, UNITE 2015) have not, in the past, been conducive to a capacity building environment.

Even when the climate is good and intentions are well meant, Pearson (2013) identifies how stringent time constraints on BCC projects often limit the choices practitioners can make in the changes they wish to achieve. Supporting a community to reduce health inequalities takes time. In the face of growing pressure to deliver on the Commissioning for Quality and Innovation (CQUIN) targets (by which many of us are bound), a particular BCC project – for example dental health interventions in Mid Yorkshire NHS Trust in 2015 – is unlikely to deliver the outcomes based results that are desired, such as a reduction in tooth decay rates in the under 5’s, in such a short time scale. Health visitors are then left to look for a simpler option to meet CQUIN targets, to build the capacity of their professional colleagues rather than that of the families within their caseload community. An example of this could be the development of a tool to ensure all nursery nurse staff provide uniformity in speech reviews, rather than the longer process of creating a community group to enable parents to improve speech and communication at home. This method of...
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There are easier ways to help with the itch

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delivering BCC enables practitioners to fulfil the criteria of BCC but appears to fall short of Skinner’s (2006) vision of empowerment and improved social capital. There is a case to be argued therefore that this is building capacity for capacity building’s sake.

THE VALUE OF BCC
The benefits of community engagement and the positives this can bring locally and nationally are overwhelmingly recognised throughout the literature (NICE 2008, Cowley, et al 2013, RCN 2011a, South 2015). The increase in health visitor numbers over the past four years should allow BCC projects to become a priority for teams nationwide. However, research reveals that the number of children being born each year is rising (UNITE, 2015) and to ensure that health visitor numbers rise proportionately will continue to be a challenge. This needs particular focus with the transfer of the service to local authority commissioning last month (Bhardwa, 2015). Members of the CPHVA report that they do not yet feel the benefit of the increased numbers of health visitors (UNITE 2015). Furthermore, as the Health Visitor Implementation Plan comes to a close, some trusts, such as those in central London, are still struggling with caseloads where Partnership Plus families outweigh those on Universal pathways of care (Davis, 2014).

How, in BCC terms, will this reflect the holistic wellbeing of the communities they serve?

THE CHALLENGES OF CAPACITY BUILDING
It is the author’s experience that despite working within a pro-active, forward-thinking team with a manageable caseload, once an area of the community that needs support has been identified, many colleagues lack the confidence, knowledge or skills to take a pro-active stance and begin to take steps to support the community to help themselves. Although excellent training tools are readily available (Kenyon, 2015) many health visitors report that the processes involved, such as audit, bid planning, funding application and report writing are still a challenge. Many trusts have taken a pro-active approach and designated health visitors to lead on projects and support staff in achieving their aims and meeting their BCC objectives (Appleyard 2015, Leeds Community Healthcare Trust, 2015, and Health Education East of England, 2013). The benefits are three-fold. Firstly, the communities profit from the service in place. Secondly, one could argue these expert teams have been created with the image of the trust in mind, making the successes of the trusts in question appear a prize acquisition for a new commissioning service, and thirdly, the staff involved benefit. These health visitors have been exposed to experiences which will enrich their professional abilities, assisting them in the process of revalidation by continuing their professional development, which can only be seen as a positive for all parties involved.

The skill and effort required when involved in a BCC project calls for a greater sense of collaborative working. Optimistically speaking, the advent of local authority commissioning should create a solidified workforce with colleagues in public health and community development making BCC projects appear more manageable to a health visitor who has ideas to implement, but little time to spare. However in these times of austerity, perhaps roles may be merged to make deeper financial savings to local government departments. Following takeover in October 2015, local authorities across England have to ensure that The Healthy Child Programme is adhered to for the first 18 months after the handover of the service (National Children’s Bureau, 2015). But when this time period has elapsed, what of the role of health visiting, and what of the BCC groups or projects that have been established? When there is uncertainty about how long health visitors will be able to support communities in their new-found emancipation, is it right to promise a service that cannot be guaranteed for the longer term? The discussion then becomes an ethical debate rather than an analysis of current trends.
The BBC (2015) reported on the ‘shocking post-code lottery’ of child health in a recent publication which highlights further health inequalities and a continued north-south divide in relation to health and wellbeing (National Children’s Bureau, 2015). To most health visitors this is not news. There continues to be clear variation in positive life outcomes in the under 5’s when differing sections of society are closely compared. More worryingly, these differences can be seen within the same locality. When further comparisons are made it becomes apparent that in areas where poor health outcomes are expected, lower levels of health visitors have been identified (Royal College of Nursing, 2011b). In BCC terms the areas that need capacity building the most are least likely to receive it.

**COMMUNITY CHANGE**

But there is a third challenge here. How easy is it to empower a community? Whether affluent or deprived, rural or industrial, encouraging families within communities to have the vision, to concentrate on the positives, and to improve their own life chances can often be an arduous struggle. Health inequalities breed disempowerment among those who are entrenched within generations of poor access to education, healthcare and housing or employment. This will undoubtedly lead to a lack of social capital to lift themselves out of the cycle of deprivation they find themselves in. Kenyon (2015) asserts that health visitors must understand the culture of a community before capacity can be built – calling again on the core competencies of health needs assessment to allow an intrinsic vision of a community’s needs and not just those perceived by the professionals to which it is served (Bryan & Orr, 2012).

**CONCLUSION**

It has been recognised that BCC and The Health Visitor Implementation Plan (DoH, 2011) have unified the health visiting service and helped communities and individuals to help themselves. It has created a freedom for some professionals, allowing new and exciting methods of working to deliver key public health messages to be imagined. But for others the challenges that a varied caseload brings, and areas of priority working, make BCC brilliant in theory but not as alluring in practice. Whatever one’s opinion on building the capacity of a local community, it appears it is here to stay. As with professional changes in the past, the top-down approach has often led health visitors to feel powerless, and their professional integrity to be lost. Therefore, it appears imperative that health visitors design and shape their new role within public health, and carve a place for themselves in community capacity building before the profession is once again redefined by inevitable change.

**Key points**

- Building Community Capacity (BCC) fits intrinsically to the principles of health visiting
- BCC arises from theories of community development, but community-based initiatives are not new ideas of working for the SCPHN
- BCC takes time and is a complex process – often becoming the target rather than being community driven
- The benefits of community engagement and the positive impact of these initiatives on health outcomes are well documented
- The role of BCC SCPHN leads for trusts are key to supporting colleagues and staff to succeed with their BCC ideas and to providing training and help as required.

**References**


Updated guidelines for authors and contributors to *Community Practitioner*

Articles are considered for publication on the understanding that they are not being offered to any other journal and have not been published or accepted elsewhere. Manuscripts should be submitted with full author contact details to the editor via email to: katie.osborne@tenalps.com and authors should keep a copy of the material they submit.

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Articles should be written with our readers in mind – health visitors, school nurses and community nursery nurses, and others working in primary care and community settings. We welcome the inclusion of relevant figures, tables and images, though original work on paper is submitted at the owner’s risk. Electronic images should be at least 300dpi resolution and in tif, jpg or eps format.

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Either 1400 or 2100 words in length, these should review clinical management, present case studies etc.

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have always had a passion for research and for asking questions about professional practice. Working as a health visitor, my interest in research was first stimulated when I undertook a part-time MSc in Nursing at King’s College, London and I carried out an empirical study on health visitors’ work with vulnerable families. I was really inspired by my course leaders, people whose research I’d read when I was a student.

This started me on my current career path. During my MSc I transitioned to the position of community nurse tutor, a job that involved preparing and supporting student nurses in their primary care placements, and it was also around this time that I started disseminating my research work by publishing and speaking at professional conferences.

I started out by applying for lots of small research grants and these have got bigger over time. My current research programme on child protection developed from my health visiting PhD study, when I was awarded a Smith and Nephew Nursing Research Fellowship. Later I sought postdoctoral research funding, and in 2007 I completed a study on Safeguarding children: The management and organisation of child protection responsibilities in primary care, funded by the Health Foundation Consortium.

Over the years I’ve been a lecturer, senior lecturer in community nursing, principal lecturer in research education, Reader and now a Professor. I’ve always been interested in looking for new opportunities and if things have come my way I’ve tended to say “yes” and worried about how I would find the time to do them afterwards.

Throughout my career I have been extremely fortunate to have worked with some amazing role models who have been inspirational and generous in their support.

Now at Oxford Brookes University, I run a distance learning Masters in Child Welfare and Wellbeing, as well as a module on child protection for SCPHN students. I lead the Children and Families Research Group, which is part of the new Oxford Institute of Nursing & Allied Health Research (OxNAHR). Some of our recent research has focused on the child sexual exploitation knowledge and training needs of health care staff, children who miss healthcare appointments and Think Baby. I work with a small group of researchers and supervise some fantastic PhD students. I also love talking to would-be researchers, working with professionals to change practice, and supervising research students. Three of my PhD students have won major national awards, one of them winning The RCN Akinsanya Award for the most Innovative Doctoral Study in Nursing in 2008.

What drives me forward is continuing to make a distinctive contribution to the health visiting service. I enjoy working nationally to influence policy, such as when I was an expert health visitor member of the NICE Guideline Development Group on ‘When to Suspect Child Maltreatment’. I believe the most important part of doing research is to make a difference in practice with children and families. It’s always incredibly rewarding when professionals say they have read my work and found it helpful. My advice to those who want to follow a similar career path is:

• Grasp the opportunities that come your way
• Start by applying for small research grants
• Find a mentor or a champion of your work
• Persevere
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Essential Information: Diprobase Lotion
MDS Consumer Care, Inc., 3000 Jackson Avenue, Memphis, TN 38112, USA.
N.V. Organon, Molenstr. 110, 5342 CC, Oss, The Netherlands.

Active Ingredients: None. Legal Category: Medical device.
Uses: Diprobase Lotion is an emollient with moisturising and protective properties, recommended for the management of eczema and other dry skin conditions. Relieves and soothes dry or eczematous skin. Side effects: No skin reactions have been reported with product use.

Contra-indications: Hypersensitivity to any of the ingredients. Dosage: Apply to affected area as often as required.

Package Quantities: 300ml pump pack, 50ml tubes.
NHS Price: 300ml £3.49, 50ml £1.28. Recommended Retail Price: 300ml £7.00, 50ml £3.99.
Date of preparation: December 2014. For further information contact Bayer plc, Consumer Care Division, Bayer House, Strawberry Hill, Newbury, Berkshire, RG14 1JA, U.K.

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Spread Calm
Soothing, calming and protecting, Diprobase has been helping people with eczema to hydrate their skin, relieve symptoms and live more peaceful lives for over 30 years.

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