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Model shown is All-New Renault KADJAR Signature Nav dCi 110.
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United against FGM
The International Day of Zero Tolerance for FGM conference brought together healthcare professionals, policy makers and the police in a bid to eradicate the practice.
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Standing with women

Welcome to the March issue of Community Practitioner.

Working on this issue of the journal, which marks both International Women’s Day (IWD) on 8 March and the second decade in our ‘Look back’ series charting the history of the CPHVA, has prompted me to think about women in society, how far equality has come and how far it has to go.

In 2016 it seems surreal to have a set date in the calendar when we celebrate the achievements of women across the world, particularly when the theme this year is ‘Pledge for Parity’. But, as the IWD website confirms, ‘progress towards gender parity has slowed in many places’, and so it seems that the event is still sadly necessary.

Barely a day goes by when gender equality, or should we say inequality, doesn’t make the headlines. A quick search of today’s papers threw up the news that women took 22 per cent of key roles in the top films of 2015 (though roles for women of colour have not increased), and that a scheme in rural South Africa is offering female students scholarships ‘if they can prove they are virgins’.

While such stories make for grim reading, it’s events like IWD that refresh the cause in people’s minds and ultimately help to narrow the gender parity gap. Turn to page 12 to find out more about the history of the annual event and how the CPHVA’s professional officers will be marking the day – I hope you’ll join them in their #PledgeforParity.

On a brighter note, you need look no further than the fantastic front cover of this issue to be reminded of the great strides that Emmeline Pankhurst and the suffragettes made for women in the early 1900s, which is also the period in the history of the CPHVA we’re looking back on this month (see page 18). In this instalment, we reach the point where the WSIA was able to expand its membership to include health visitors – a highly important point in its journey to become the diverse organisation it is today.

Let’s hope that great strides can continue to be made in women’s rights – we’re all responsible for accelerating the rate at which the gender gap closes.

I hope you enjoy this issue of Community Practitioner and don’t forget to contact me at helen.bird@tenalps.com or on Twitter at @HealthcareHelen with any comments, ideas or news from the frontline – I’d be happy to hear from you.
UK mothers 'let down' by lack of breastfeeding support

THE BREASTFEEDING CRISIS IN the UK represents 'a lack of support for those mothers who choose to breastfeed', professionals from across the healthcare sector have claimed.

In an open letter issued in February, health visitors, midwives, breastfeeding counsellors, charities and university researchers highlighted recent cuts to breastfeeding support services and infant feeding specialist posts, and called on government to safeguard the public health budget.

The letter follows recent research from the World Health Organisation (WHO) and UNICEF, which estimates that 800,000 child deaths per year would be prevented worldwide if breast milk were used universally to feed babies.

The researchers found that just 0.5 per cent of British children are breastfed for a year, compared to 92 per cent in India and 44 per cent in New Zealand.

Dr Nigel Rollins of WHO said: “The success or failure of breastfeeding should not be seen solely as the responsibility of the woman. Her ability to breastfeed is very much shaped by the support and the environment in which she lives.

“There is a broader responsibility of governments and society to support women through policies and programmes in the community.”

CPHVA lead professional officer Obi Amadi, one of the signatories of the open letter, said: “It is very clear that the government must commission the range of services that have been proven to support women to establish and sustain breastfeeding.

“The UK government needs to follow the lead of the Scottish and NI assemblies’ commitment to policy and structural support, including appointing a national infant feeding coordinator.”

Scotland could fortify flour

SCOTLAND IS CONSIDERING whether to add folic acid to flour amid ‘frustration’ at the delay in decision by the Westminster government.

It is thought that the move by Scotland would lead to folic acid being added to flour across the UK, since it would be the easiest option for commercial bakers.

According to reports, 85 per cent of women do not take enough folic acid. Government advisers have recommended adding it to flour for years but the Department of Health is still ‘considering the matter’.

Zika virus could infect up to four million, WHO predicts

THE FAST-SPREADING ZIKA virus could infect three to four million people in the Americas this year, according to predictions by the World Health Organization (WHO).

While most of those infected will not develop symptoms, the virus, which is spread by mosquitoes, has been linked to brain defects in babies.

The infection has been associated with cases of microcephaly, which causes babies to be born with underdeveloped brains.

WHO has said that the disease poses a global public health emergency, which requires a united response.

Director general Margaret Chan said Zika had escalated “from a mild threat to one of alarming proportions” and has set up an emergency team to deal with the “explosive” spread of the virus.

Dr Chan said the priorities were to protect pregnant women and their babies from harm and to control the mosquitoes that are spreading the virus.

She advised pregnant women to avoid travelling to areas affected by the Zika virus and for those living in areas affected by Zika to seek advice from their physician and to wear insect repellent to protect themselves from mosquito bites.

Brazil reported the first cases of Zika in South America in 2015. The virus has since spread to more than 20 countries in the region, according to WHO.
Mothers favour A&E over NHS 111, survey finds

**THE MAJORITY OF MOTHERS WOULD GO** straight to A&E rather than call the NHS 111 service if their child was unwell, a survey has found.

In a Netmums poll carried out in the wake of a report into the death of one-year-old William Mead, who died from blood poisoning in 2014 after neither GPs nor the 111 service identified the severity of his condition, it was revealed that 78 per cent of mothers would bypass 111.

More than 4,000 mothers participated in the survey.

NHS England said it was "entirely understandable" that parents wanted to be "safe rather than sorry", but asserted that more than 90 per cent of callers to NHS 111 come away satisfied with the advice they received.

Children increasingly using e-cigarettes, study shows

**ADVERTISEMENTS FOR** chocolate and bubble gum-flavoured e-cigarettes could attract children to try vaping, according to new research.

The research, carried out by the University of Cambridge for the Department of Health, examined concerns that the use of e-cigarettes among children and adolescents could lead to tobacco smoking.

The study found school children shown adverts for candy-flavoured e-cigarettes expressed greater interest in buying and trying them than their peers.

It is illegal to sell e-cigarettes and e-liquids to under-18s in the UK, but their use rose from five per cent in 2013 to eight per cent in 2014, researchers from the university’s Behaviour and Health Research Unit said.

**New mums ‘missing out’ on mental health care**

Perinatal mental health care is 'unacceptable' across large parts of the UK, according to a coalition of charities.

The Maternal Mental Health Alliance says a lack of mother and baby units (MBU) and specialist community health provisions mean some women who suffer with mental health issues during pregnancy and in the months after giving birth are not given the right standard of care.

There are 17 MBUs in the UK; however, Wales, Northern Ireland and parts of the North East, South and East of England do not have any.

Mothers who do not have access to MBUs are often admitted to adult wards, which mean they are separated from their babies.

One in 10 women develops a mental health illness during pregnancy or in the first year of motherhood.

**HEE seeks views on nursing support role**

**THE VIEWS OF HEALTHCARE** professionals, commissioners and other stakeholders are sought as part of a consultation on the design of a new nursing support role.

Health Education England (HEE) is keen to hear the sector’s views on the newly created role, which would fit alongside healthcare support workers and fully qualified registered nurses to deliver hands-on care to patients.

The role would also offer opportunities for healthcare assistants to progress into nursing roles.

The consultation, which closes on 11 March, invites the sector’s views on a range of issues, including principles for the new care role, whether or not it should be regulated and learning outcomes that will need to be assessed.

Professor Lisa Bayliss Pratt, HEE director of nursing, said: "We need a new type of care worker with a higher skill set who can deliver person-centred care in all health and social care settings."
United against FGM

Community Practitioner reports from the International Day of Zero Tolerance for FGM conference in London

THE INTERNATIONAL DAY OF ZERO
Tolerance for Female Genital Mutilation 2016 conference was held at the Royal College of Obstetricians and Gynaecologists on 8 February.

It brought together healthcare professionals, educators, policy makers and the police through one goal – to join forces and move faster and more effectively towards the ultimate goal of eradicating FGM in a generation.

Chaired by Susan Bookbinder, managing director of Zamala International, the conference saw speakers discussing the importance of mandatory reporting duty, multi-agency working, the role of the paediatrician and safeguarding and risk assessments.

Jane Ellison, parliamentary under-secretary of state for public health, gave the keynote address to a packed auditorium. Some of her most resonant comments are as follows:

“We’re marking the International Day of Zero Tolerance for FGM: the theme is achieving the new global goals through the elimination of female genital mutilation by 2030.”

“The continued dedication and commitment to ending FGM is evident when I look up at this room and see so many familiar faces – but the increased awareness in tackling FGM is also apparent when I see all the new faces here today.”

“The latest UNICEF report shows that although there are growing numbers of instances, the proportion of young girls between 15 and 19 with FGM has decreased and in some countries the drop is very significant indeed. In Liberia, for example, in 1983 some 72 per cent of girls aged 15-19 [were victims of] FGM. Now in that age range there is a prevalence of 31 per cent. So we’re seeing a really significant intergenerational change.”

“Don’t underestimate the power you have to change attitudes towards FGM. I urge you all to act as champions of change, no matter your profession.”

“Talking about it isn’t enough, we can’t stop there. Now we’ve agreed that FGM is child abuse, we have to start asking the key questions.”

“And you also come across excuses for the perpetuation of FGM and again I hope that we can answer strongly now with one voice that this is an outdated, unusual, and unnecessary practice”

“But in order to change attitudes we do need to understand the culture that FGM springs from. And we need to understand the fear and misunderstanding sometimes of what we’re doing but we need to be very clear about our mission to prevent it, protect, and to care for women. And when we leave here today we all need to know what we can all do to challenge these views and turn them around every time they are brought up.”

Top tweets

@lregan7
Key messages from speakers @RCObsGyn #tacklingFGM, partnership working and multifaceted approach crucial to end this abuse in a generation

@JMoses4NASUWT
Globally Millions of women & girls continue to be mutilated by FGM. Together we can stop this. #tacklingFGM #NASUWT @4RacialJustice

@GCampbellMPS
Key message from the #tacklingFGM conference keynote speakers ‘care, protect, prevent’... #EndFGM #AddYourVoice

@consideredview
It’s not an option to ignore #FGM #MandatoryReporting is an important tool to enable professionals to protect girls at risk. #tacklingFGM

@ObiCPHVA
#tacklingfgm just starting out zero tolerance day conference. @JaneEllison mp gives keynote address

@RCObsGyn
#tacklingFGM ‘Don’t underestimate your ability to change attitudes’ @JaneEllison #endFGM
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1 Contains 1.89g/100kcal of protein, including α-lactalbumin, making the protein level and quality closer to that found in breastmilk (1.7g/100kcal). Nommsen LA et al. Am J Clin Nutr 1991; 53: 457–465.


Important Notice: Breastfeeding is best for babies. Breastmilk provides babies with the best source of nourishment. Infant formula milks and follow on milks are intended to be used when babies cannot be breastfed. The decision to discontinue breastfeeding may be difficult to reverse and the introduction of partial bottle feeding may reduce breastmilk supply. The financial benefits of breastfeeding should be considered before bottle feeding is initiated. Failure to follow preparation instructions carefully may be harmful to a baby’s health. Infant formula and follow on milks should be used only on the advice of a healthcare professional.
There’s perhaps no prouder moment than receiving recognition from your peers, particularly when you least expect it. So learned Yvette Bynoe, winner of last year’s CPHVA Award for School Nurse of the Year. As the 2016 event approaches, the senior school nurse at Central London Community Healthcare NHS Trust tells Community Practitioner how it felt to be nominated.

“I’d been back a year from maternity leave as a senior school nurse and when the email came through saying I’d been nominated for School Nurse of the Year I thought it was a wind-up! Someone in my office had won the year before, so I thought they were just winding me up.

“I said ‘Who’s nominated me?’ because I didn’t believe I’d been nominated, and everyone stayed quiet, because some of my team members knew who it was but I didn’t. So I was a bit gobsmacked for the rest of the day.

“It turned out I was nominated by a colleague I’d been mentoring at the time – she’s since left the Trust and moved on to pastures new – and she nominated me for, I suppose, my patience. And for being me really – listening, giving advice when it was needed and stopping my work to lend an ear.”

A Rich Career
Yvette describes how, after many years of ward work, she found her niche in the community. She says: “I’ve been in school nursing for just over 10 years and I came into it having left the ward as clinical nurse specialist in allergy and immunology. I’d done all the shift patterns on the ward and I wanted to come out into the community.

“Also, when I did my paediatric placement I did a placement in school nursing I couldn’t get a job at that point because you needed community experience and nobody was willing to give me community experience! So I went back to the ward.

“I think in total I’ve done about 14 years’ ward work and then I came out into the community, so I took a drop in salary. I’m now back on the patch where I started my career in school nursing, so I’ve gone full circle.”

A Proud Moment
On the arrival of the Awards, Yvette still didn’t believe that she’d be successful, so being called to the stage came as quite a shock, she tells us. “I really wasn’t expecting it. When they called my name out I just sat really still – I was pretty gobsmacked! I wasn’t expecting my name to be called at all.

“My family was really chuffed – my parents, my partner and my little boy – he said ‘My mummy’s won the best award’. So I’m very proud of it.”

Wider Recognition
The CPHVA Awards represent a valuable opportunity for the work of school nurses and other community practitioners to be celebrated, Yvette explains. She says: “We’re flying the flag and we’re flying it very well. Not many people know that we’re out here doing that job, very few people will say they know of their school nurse – some schools might even say: ‘Who is our school nurse?’

“So to get recognition, firstly for being a school nurse and secondly by a national award… I really wasn’t expecting that. Now people know that I’m one of those school nurses that will go the extra mile for you.

“It’s also about public recognition – letting people know that school nurses do exist. You may not know who that person is, but there is someone that champions the cause of school nursing and will do their best to get you through the academic years.”

Keeping the Flame Alight
Would Yvette encourage her peers to nominate for the CPHVA Awards? “Oh yes,” she says. “We’re actually in the process of nominating someone now!”

She adds: “I remain very honoured and humbled to win this national award for ‘being me’.”

The CPHVA Awards 2016 will take place on 8 April at Plaisterers’ Hall, London

A huge thanks to our supporters for the 2016 Awards
Nominations have now closed!

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8 April 2016,
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Two years later, in Copenhagen, during the International Conference of Working Women, a unanimous vote carried the decision to hold an annual day on which women would make their demands for gender equality, whether that be in the workplace, in education, in the home or in government, including voting rights for women around the world. It was no longer just a national day, now it was International Women’s Day (IWD).

The following year, IWD was celebrated in European countries, with rallies being held in Austria, Denmark, Germany and Switzerland. By 1913, Russian women were celebrating their first IWD and their famous four-day Bread and Peace protest in 1917 forced the Czar to abdicate and the Russian government to grant women the vote.

It wasn’t until 1928 that the right to vote was extended to all women in Britain over the age of 21, thanks to the activism of suffragettes Emmeline and Christabel Pankhurst. Indeed, the suffragette colours of violet, white and green still feature on the CPHVA logo to this day, in a nod to its foundation by a group of women who were refused entry to the male version of what was then the Sanitary Inspectors’ Association.

IWD was recognised by the United Nations in 1975 and in 1996 the UN proposed there be an annual theme, from ending world hunger to putting a stop to domestic violence. Roll on 2001, when the IWD website was launched in an effort to refocus the day’s energies and reignite the passion. And not a minute too soon. While great strides have been made since that march back in 1910, women are still under-represented in positions of power in commerce and governments and, worldwide, women are still not paid the same as men for the same jobs. They also suffer more violence, poorer health and have less access to education than men.

In short, IWD still has an important role to play in raising awareness of inequality while recognising and applauding the achievements of women around the globe.

Pledge for Parity
The World Economic Forum predicts that the gender pay gap won’t be entirely bridged until 2133. So, this year, everyone – men and women – is asked to pledge to do something to balance this inequality, whether it’s educating others about this situation or taking some kind of action to open the way for women to achieve their economic potential and redress this unfairness.

To find out more, visit: www.internationalwomensday.com

Opinions
We asked the CPHVA’s professional officers their thoughts on IWD by putting to them the following questions:

1. In your view, why is International Women’s Day important?
2. Will you be marking it this year and, if so, how?
3. What would you like to see members doing to mark it?
4. This year’s theme is Pledge for Parity. What does that mean to you?
5. Will you make this pledge and how will you implement it?
6. What theme would you like to see IWD take up next year?
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Obi Amadi

“There are two aspects to IWD that I feel are important. First, it is an opportunity to celebrate all that women have achieved globally in terms of recognition and equality. Second, we need to highlight that there are still so many aspects of life where women are not equally viewed or treated. That goes for this country and around the world.

“I mark the day every year in some way – getting together with other women I know and debating current issues or just doing something simple, such as reading a passage from a book by a female author who inspires me.

“I would like to see members just doing something simple to recognise what women who came before us have done in the struggle that has given us the status we have now and the motivation to keep pushing until we have equality with men.

“For me, Pledge for Parity is about commitment to creating the environment where women are given equal status to men.

“I will make this pledge. I have always campaigned for equality, as I see that our society is not, so my campaigning will continue.

“For next year’s theme, it would be nice to maybe see something concerning teenage girls – something around supporting their transition into womanhood.”

Jane Beach

“My late auntie, a nurse during and after the Second World War, was a strong, independent woman who was my role model. One of her many projects was to research her family tree and she discovered she was distantly related to the Pankhurs, a fact of which she was immensely proud. I think of her often, but she especially comes to mind on International Women’s Day, as she had to overcome a great deal to forge her way in life. It is important to have at least a day when we celebrate the many and great achievements of women across the globe in order to keep gender equality high on the agenda.

“I am working on IWD, but as I am attending the Regional Industrial Sector Committee meeting, this is an excellent opportunity to celebrate with colleagues and also to look at what more we need to do locally. I might even make some cakes!

“Our members protect and promote women’s rights on a daily basis. On this day I would like to see them focusing on their own achievements, of which they should be proud and celebrating.

“Parity to me is about women’s struggle for equality. Whilst much has been achieved, there is still much to do. Women are still disproportionately more likely to be subject to sexual or physical violence, more likely to be repressed and to be paid less than their male counterparts. It is time to move from talk to action and to work together to ensure progress towards parity.

“I will make the pledge to challenge conscious and unconscious bias. I will challenge organisations (and individuals) that do not enshrine cultures that value people and their contributions. On a practical level, together with colleagues, I will submit a response to the governments consultation on the abolition of student bursaries for health students. If these plans go ahead, they will disproportionately affect women and mean that many cannot ‘fully contribute according to their capabilities’.

“There are so many equally important issues still to tackle! For me, next year I would like to see a focus on putting an end to the oppression of women, so maybe ‘Freedom to make choices’!”

Gavin Fergie

“Personally, I think it’s poor that there is an International Women’s Day – not that the cause isn’t important: it’s poor because we still need it.

“One hundred and seventeen years, it’s been worked out, until we achieve global equity: 117 years. That is disgraceful.

“It’s a man’s world and it seems that we have 364 international men’s days.

“It’s an uphill struggle, but I’ll continue to do my bit to ensure everyone is treated fairly and equally.”
March 2016

Rosalind Godson

“IWD concentrates the mind on the issue worldwide.

“Our local Labour party always covers it and I would like to see members finding out about the health issues which affect women from different societies and cultures.

“Pledge for Parity means equal rights, equal outcomes, equal opportunities. I will make this pledge, but I’m not sure yet how. Locally, I think we could highlight issues, eg, are there more women going to foodbanks than men and, if so, why?

“For next year, I would like the theme to be that no woman should be afraid within her own home and community. That includes elderly women, unmarried women, disabled women, what women wear, what relationships and friendships they choose to have.”

Dave Munday

“I’ve always felt I was in a very interesting position in that, as a male, I’ve been in a very female-dominated profession. First in nursing and then even more so in health visiting, where the vast majority are women. I’ve also always felt very privileged to be in that position and it’s one that I’ve thoroughly enjoyed.

“Since having a daughter, it’s interesting to me that the day she was born she was inherently coming into a society where she’s at more of a disadvantage than her brother and the reality is, if we carry on the way we are at the moment, she’s likely to earn less than he will, even if she does at better at school. We should be moving toward the kind of society where we’re all much more equal, not just in terms of sex, but in terms of all the characteristics of equality. These are the things that come to mind when you talk about IWD.

“Internationally, it’s recognising that across the world there are some societies were women are treated very poorly and again we need to remember that and think about how we can further the cause for women across the world and in the UK.

“I write blogs for community practitioners so I might write a blog on IWD that focuses on some of the historical issues. For instance, when you look at the CPHVA’s 120th anniversary this year and then back at the 1920s, when the reason the CPHVA struck up was because women weren’t allowed access to the male version of our organisation. It shouldn’t be something we think about just on that day but on every day, although having a day does focus your mind on the issues.

“For next year, one of the things I would suggest, that’s UK focused, is how women have suffered the most under austerity. They face the harshest cuts. I’m not sure what the title of that theme would be, but something about women having to shoulder the greatest burden and how that shouldn’t be the case.”

To celebrate International Women’s Day, the weekly CPHVA Twitter Tuesday chat, #CPHVAtt, will focus on the topic on Tuesday 8 March between 7 and 8pm.

Make sure you join the conversation with your views on what makes women great, the importance of IWD and your hopes for future generations of women.
District nursing: a Cinderella service?

With healthcare cuts across the board, community practitioners are no stranger to shortages; perhaps none more so than district nurses. Helen Bird asks why the profession is becoming a precious commodity in public health services.

With so many healthcare services stretched to the limit, it's little wonder that qualified district nurses – whose role demands a highly specialist skill set – are a rare breed.

And the strain is showing: a 2014 survey by the Queen's Nursing Institute (QNI) revealed that 70 per cent of the 1,035 participating nurses said their team's morale was low, while 60 per cent reported not having enough staff to meet their current workload.

And in Community Practitioner's survey, published in the February edition of the journal, 67 per cent of respondents believed investment in the district nursing (DN) specialist qualification would increase the numbers joining the profession, while 94 per cent thought more opportunities should be provided for DNs to further their education.

For Sue Elvin, nurse consultant in district nursing and Queen's Nurse, the plight is all-too familiar. Luckily for the profession, and most importantly for patients, her commitment remains strong. "There's nobody more passionate about district nursing than me," she says.

Sue is one of only two district nurse consultants in the UK – the other residing in Scotland – which is a stark contrast to the dozens of consultants that are employed in various acute specialisms of nursing. This, she says, "is quite significant in terms of where we are as a profession and the understanding and respect for our role".

In Camden, where Sue is based (at Central and North West London NHS Foundation Trust), the national shortfall in district nurses, particularly those joining the profession, is exacerbated by the sky-high cost of living. For this reason, Sue explains, the Trust has "tried to be as innovative as possible" and is currently training five specialist practitioner DNs.

To put this figure into context, just a few years ago, says Sue, there were just five student DNs across London due to qualify.

"I think there's been quite a push [to promote
Due to the shortfall in qualified DN, the nature of nursing in the community has become more task-oriented, believes Sue. In effect, rather than the holistic assessment that DN are trained to carry out, practitioners working in the field without the specialist qualification are focusing purely on the patient’s immediate and obvious needs, such as wound care.

So what’s the solution? Part of Sue’s role as nurse consultant is to identify new ways of working that can optimise nurses’ time and skills. Her evaluation of a new wound care product to improve the management of venous leg ulcers, for example (a heavy aspect of community nurses’ work), has saved 42 hours per week in nursing time and £20,000 over six months on alternative products. Never has creative thinking been more crucial, she explains.

“We’re not magically going to get loads more nurses and we haven’t got enough nurses with the appropriate skills, so we have to look at doing things differently.”

A lack of public and government understanding as to the valuable role of the DN is also a matter of concern, it seems. Sue explains that, with palliative care for example, it’s the district nurses that visit patients daily to relieve pain and control symptoms, although that isn’t necessarily widely understood.

“I think that because we’re specialist generalists, some of the magic of what we do is lost,” she says.

“A lack of public and government understanding as to the valuable role of the DN is also a matter of concern, it seems. Sue explains that, with palliative care for example, it’s the district nurses that visit patients daily to relieve pain and control symptoms, although that isn’t necessarily widely understood.”

Amy Mack, student district nurse, CNWL NHS Foundation Trust

“I fell in love with district nursing as a student nurse – I think we can really make a difference to people’s quality of life by understanding everything that has an impact on their health, including things like housing and social isolation. The DN course is helping me to understand the wider context of our role, while developing specialist skills in clinical assessment and prescribing so I can practise more holistically.

“I think some people don’t realise that the DN is often the coordinator for someone’s care in the community. Generally our clients can’t get out of the house and other services rarely have the resources to do home visits, so we tend to do quite a lot of assessment and liaising with their social workers and carers. People who work in community nursing are very aware of that, but I’m not sure that’s always recognised outside of the profession.

“When I did my management placement as a student nurse I was quite unusual in wanting to work in the community. Because of the shortage of qualified DN, many trusts changed their job descriptions so people who hadn’t done the district nursing course were promoted to senior roles. I think this changed the way people view the DN course – it’s no longer a necessity to progress. So I think at least part of the overall trend is the fewer people you have with the specialist qualification, the less it’s known about and respected.

“It’s interesting because health visitors can’t do their job without having completed this training and so when there’s a shortage of health visitors to fill those posts, the obvious thing to do is to invest in their training. The impact of funding fewer places on the SCPHN course for health visiting is immediately obvious, whereas district nursing is a bit different.

“It takes quite engaged commissioners to realise the benefits of having qualified district nurses. It works both ways – we as students and then as qualified district nurses need to show what we’re doing and what the benefits are. I think sometimes in nursing we’re not quite as good at being able to show our results and quantify what we’re doing. But it’s obvious that if you want to work with commissioners you need to be able to present a business case for your own service – that’s the kind of world we’re working in.

“Part of doing this course is being able to understand how you measure quality and how you show that you’re making improvements, so in a way that means you can be part of how commissioning works rather than just hoping it will be obvious to other people. That’s something I’m aware of trying to improve – making sure we’re measuring things that are meaningful and genuinely reflect the quality of patients’ experiences.

“It’s really part of being an advocate for your patient, which is what we learn from the first day of training. Part of that is being able to promote what you’re doing and make sure that you continue to have enough resources to look after your patients, so I think it is truly part of our role.”

“You need to present a business case for your own service”
Continuing our journey through the history of the CPHVA, we track the period from 1906 to 1916, when healthcare started to become more regulated and membership of the WSIA was extended to include health visitors.

**1907**

The Notification of Births Act became compulsory so that a local medical officer of health could send a trained health visitor to the mother’s home. This promoted the Women Sanitary Inspectors’ Association (WSIA), thus attracting more members.

The 1907 Education (Administrative Provisions) Act was an act of parliament passed by the Liberal government as part of its package of welfare reforms. The act set up school medical services run by local government.

**1908**

The Royal Sanitary Institute began to set examinations in health visiting, which extended to school nursing after medical examination of school children became mandatory in the same year.

**1909**

WSIA represented a total of 96 women sanitary inspectors and health visitors.
Health visitors were allowed to join WSIA as associate members. A special order in London stated that health visitors should possess either a medical degree, a Central Midwives Board certificate or general nursing training and a health visitor’s certificate so all members were qualified enough to know what they were doing.

WSIA was renamed to become the Women Sanitary Inspectors’ and Health Visitors’ Association (WSIHVA). This was to reflect how the organisation had expanded its membership to include more and more health visitors.

The College of Nursing was established.

The Royal Sanitary Institute (now the Royal Society of Public Health) began overseeing qualifying courses for health visitors, with the first statutory qualification for health visiting established by the Ministry of Health in 1919.

Training was divided equally between theoretical and practical training. It was proposed to include: Elementary physiology; methods of artisan cookery and household management; hygiene, infectious and communicable diseases; maternity and infant and child welfare; and elementary economics and social problems.
Commissioning guidance: your reactions

On the release of Public Health England’s new commissioning guidance, CPHVA members took to Twitter with their questions and comments during the weekly #CPHVAtt. We look at just some of your reactions.

On 20 January Public Health England (PHE) published extensive guidance documents around the commissioning of public health services. The guidance is aimed at local authorities commissioning health visitors and school nurses ‘to lead and co-ordinate delivery of public health for children aged 0-19’ and takes the form of four downloadable documents, which are available at: http://bit.ly/1PyBnAP

@RosGodson
@CommPrac OK; my initial thoughts are: PHE has done a comprehensive job, but will LAs read it? #cphvatt

@busygirllizzie
@davidamunday #cphvatt what I see is the left hand not knowing what the right hand is doing(re:prioritising) with HVs #piginthemiddle

@NoolaMary
#cphvatt all Hvs in my base very worried whether we will still have jobs in 5 years, unsettling and bad for morale

@HelenRaywood
@Unite_CPHVA HV contact essentially ends at 2 now. Fewer problems identified early eg: speech so not school ready. #CPHVAtt

@Turner23Jo
#cphvatt The 5 reviews for SNs is interesting as we are not currently doing health reviews at all those stages would need SNs
<table>
<thead>
<tr>
<th>Username</th>
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<tr>
<td>@libbywilcock</td>
<td>@RosGodson @CommPrac @davidamunday I have a genuine sympathy for LAs currently. The country and the govt want something for nothing #cphvatt</td>
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<td>@libbywilcock @davidamunday @RosGodson @CommPrac agree they are facing impossible choices huge responsibility #CPHVAtt</td>
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<td>@CharWSmith</td>
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<td>@libbywilcock @Turner23Jo @CharWSmith @CommPrac @RosGodson How many people know full extent of any health professionals job? #CPHVAtt</td>
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<td>@Unite_CPHVA</td>
<td>should we have more mandatory contacts in 0-19s? There is only NCMP for 5-19s. Scotland has 12 contacts #cphvatt</td>
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<tr>
<td>@davidamunday</td>
<td>@RosGodson @libbywilcock @Unite_CPHVA Mandation should be minimum. Our argument always that would become maximum! #CPHVAtt</td>
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<tr>
<td>@NickyHields</td>
<td>@davidamunday @RosGodson @libbywilcock @Unite_CPHVA Data collection doesn’t address quality. We need to be better at self promotion #cphvatt</td>
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Join #CPHVAtt every Tuesday from 7-8pm. Further guidance and advice around commissioning will be published in future issues of *Community Practitioner*. 

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Viral infection during pregnancy ‘causes autism-like behaviours’ in mice

Activation in pregnant mice of a particular immune response, similar to what may occur with certain viral infections during pregnancy, alters the brain structure of the offspring and causes behavioural changes reminiscent of those observed in humans with autism spectrum disorder (ASD), according to a new study from the US.

Researchers from the University of Massachusetts medical school said that while several past human studies have suggested a correlative link between maternal viral infection during pregnancy and risk of autism spectrum disorder, the mechanism underlying this was not known until now.

The study, published in the journal Science, shows that increased production of a cytokine by a subset of helper T cells (Th17) was the mechanism by which the inflammatory response in the mother led to mouse versions of ASD symptoms in the offspring: deficits in social approach behaviour, abnormal communication and increases in repetitive behaviour.

Researcher Jun R Huh said: “We don’t know yet how these findings are correlated in humans. We need to find out, for example, whether Th17 cells have the same key function in human mothers as in mice.’

Huh added that a human study was needed next to monitor levels of the cytokine in a large number of women, including those infected with viruses or have autoimmune conditions, and correlate the levels with the diagnosis of ASD in children over several years.

PHE clarifies guidance around children’s flu vaccine

PUBLIC HEALTH ENGLAND (PHE) HAS reissued information around children’s flu vaccine following ‘a number of instances’ involving parents who have not given their consent for the vaccine keeping their children out of school.

According to PHE, parents’ concerns over the live attenuated influenza vaccine (LAIV or children’s flu vaccine nasal spray) relate to two misunderstandings: that the fine mist of the vaccine that is squirted out of the applicator could infect others; and that children who receive the vaccine will ‘shed’ live flu virus for several days or weeks after vaccination, thus putting others at risk of infection.

The information is designed to assure head teachers and healthcare professionals that the vaccine ‘has a good safety record’ and that unvaccinated contacts ‘are not at risk of becoming seriously ill with the flu vaccine virus, either through being in the same room where flu vaccine has been given or by being in contact with a recently vaccinated individual’.

PHE adds that excluding children from school during the period when LAIV is being offered or in the following weeks ‘is therefore not considered necessary’.

Supporting homeless and inclusion healthcare

A LEARNING RESOURCE TO SUPPORT nurses who are new to working in the field of homeless and inclusion health is to become available.

The Queen’s Nursing Institute (QNI) has confirmed that over the next six months it will develop the online resource, which will cover professional and practical issues for inclusion health nurses.

Inclusion health covers the healthcare needs of people who face some of the poorest health outcomes. They may be homeless, seeking asylum or have refugee status, from a gypsy or traveller ethnicity, experiencing drug and alcohol problems or sex working.

The resource would suit nurses considering a career in inclusion health, the QNI says, by providing them with information to understand the different skill set and knowledge required to care for people in this setting.

Those wishing to become involved should contact rosalind.godson@unitetheunion.org

Text messages ‘could help reduce blood pressure’

TEXT MESSAGE REMINDERS CAN HELP reduce people’s blood pressure, according to the findings of new research in South Africa.

The study, led by the University of Oxford in conjunction with the University of Cape Town, compared text message reminders and interactive text messaging to a control group receiving standard care.

Professor Andrew Farmer from Oxford University’s department of primary health care sciences, said: “Two common issues are not turning up to collect medicine, so running out or forgetting to take tablets.

“We knew that text messages had worked to support people with HIV/Aids to stick to their treatment and improve their health as a result. We wanted to see whether the messages could work for blood pressure treatment in a deprived community.”

Patients for the study were randomly split into three groups: the first received weekly text messages and extra reminders to collect medicine or attend appointments; the second received the same messages but were able to interact by calling to change or cancel appointments; and the third received standard care.

After 12 months, all three groups had reduced blood pressure; however, those who had received text messages had a slightly greater reduction in their blood pressure and were more likely to have achieved a controlled blood pressure.

Professor Lionel Tarassenko from Oxford University’s Institute of Biomedical Engineering said: “There is a great potential for mobile phone technology to help with the management of chronic diseases worldwide through automated messaging to the right person at the right time.”

The results appear online in Circulation.
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- Strict sugar targets for new products

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Recognising and responding to domestic violence and abuse: the role of public health nurses

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Domestic violence and abuse (DVA) is defined by the UK Home Office (2013a) as ‘Any incident or pattern of incidents of controlling, coercive behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members, regardless of gender or sexuality. The abuse can encompass, but is not limited to, the following types of abuse: psychological, physical, sexual, financial [or] emotional.’ The broad nature of the UK government definition provides scope for other forms of DVA to be included, such as harmful traditional practices, including female genital mutilation and forced marriage, teen dating violence and child (or adolescent) to parent violence (Home Office, 2013b).

The World Health Organization (WHO) (2013) describes it as the infliction of physical, sexual or mental harm, including coercion or arbitrary deprivation of liberty. In contrast to the broad definition used in the UK, the WHO differentiates between abuse perpetrated by current or former spouses and partners and other household members by specifically referring to it as ‘intimate partner violence’ (IPV), arguing that DVA can include other forms of violence in the home, such as child abuse and elder abuse. Both these definitions highlight some important points. Domestic violence and abuse involves a range of behaviours and the word ‘violence’ can sometimes be misleading because of its physical connotations. DVA is often characterised by controlling, coercive behaviours and emotional abuse that do not involve physical violence (see for example, Stark, 2007; Katz, 2016). In recognition of the seriousness of control and coercion, such behaviours are now considered an offence in the UK under the Serious Crime Act (Home Office, 2015). It is important to note that almost all physical violence is accompanied by emotional abuse, coercion and control.

Public health nurses, and in particular health visitors and school nurses, have a crucial role to play in recognising and responding to women who have experienced DVA (Department of Health, 2013). The purpose of this CPD article is to discuss the issue of DVA, with specific emphasis on public health nurses’ role in relation to recognition and response. The importance of supervision, support and training are also highlighted.

THE EXTENT OF THE PROBLEM

The prevalence of DVA is difficult to assess because it is likely to be under-reported. It is estimated that almost one third (30 per cent) of all women who have been in a relationship have experienced physical and/or sexual violence by their intimate partner (WHO, 2013). The UK Office for National Statistics (ONS, 2015) reports on data from the 2013/2014 Crime Survey for England and Wales (CSEW, previously known as the British Crime Survey), that 8.5 per cent of women and 4.5 per cent of men experienced abuse in the last year, equating to an estimated 1.4 million female victims and 700,000 male victims. This means that women are almost twice as likely as men to experience DVA. Women do abuse men (Flinck and Paavilainen, 2010) but DVA perpetrated by men against women forms the most violent and the most repeated form of DVA.

As reflected in the earlier definition, DVA occurs in different relationships, irrespective of gender or sexuality (Home Office, 2012). ‘Lesbian and bisexual women experience IPV at a similar rate to women in general (one in four) although a third of this is associated with male perpetrators (Hunt and Fish, 2008). Compared with 17 per cent of men in general, 49 per cent of gay and bisexual men have experienced at least one incident of DVA since the age of 16’ (NICE, 2014, p27). Overall, DVA can be expressed as a gendered issue due to the significance of DVA perpetrated by men against women. This is why this article tends to focus on women. Although it is important to recognise that the configuration of a relationship is not in itself a risk factor, there are other associated risks.

RISK FACTORS

There are no straightforward linear causes of DVA, but there are a number of well documented risk factors and associations. Mental health problems and drug and alcohol misuse are closely related to DVA and their combined relationship is sometimes – somewhat contentiously – referred to as the Toxic Trio. In their investigation of the effect of DVA on children, Co-ordinated Action Against Domestic Abuse (CAADA) (2014) reported a clear co-occurrence of the toxic trio risk factors, with nearly a third of mothers and fathers in families experiencing DVA, disclosing either mental health problems, substance misuse, or both. It should also be remembered that children living in such home circumstances are vulnerable to abuse and neglect, a recurrent theme highlighted...
in a number of serious case reviews (Brandon et al, 2008). This does not imply an inevitable association between these three elements, but it is helpful to be aware of their tendency to co-existence in many cases of DVA.

Pregnancy is a risky time for DVA and Van Parys and colleagues (2014) reported that one fifth (20.4 per cent) of the women who took part in their study in Belgium experienced some form of DVA in the 12 months before and/or during pregnancy. Pregnant women experience a range of abuse and violence, such as the behaviours described in the introduction and DVA is linked to maternal morbidity, for example maternal depression (Woolhouse et al, 2014) and mortality (CEMACH, 2007; Campbell et al, 2004). Perhaps the most shameful assault is that directed at the foetus; kicks to the abdomen are not uncommon. Unsurprisingly, DVA is linked to adverse outcomes in pregnancy, including premature birth, low birthweight, stillbirth, perinatal foetal injury and death (O’Reilly et al, 2010). Disability is also a risk factor for all types of abuse, including child abuse. More than half of disabled women have experienced some form of DVA and they are at particular risk of severe physical violence (Brownridge, 2006). Disabled women can face particular forms of impairment-related abuse, such as partners withholding assistive devices or refusing to provide basic care (Breckenridge et al, 2014).

Age is an interesting issue in relation to DVA. The Home Office definition presented earlier refers to people aged over 16. The age limit was lowered from previous definitions in recognition that young people are at relatively high risk of DVA. There are no upper limits and on the other end of the age spectrum; older people experience DVA too (McCarron et al, 2011; Stockl and Penhale, 2015). It can be useful to conceptualise DVA as something that can happen to anyone irrespective of age, gender, socioeconomic status, nationality or ethnicity. That said, there are certain circumstances and contexts that place a person temporarily or permanently at risk. So the endemic issue of violence against women across the world means that in comparison to men, womanhood is an inherent risk factor. The relatively transient state of pregnancy might render a woman susceptible to certain types of abusive behaviour at that time, particularly directed at the unborn child. Overall it is important to remain alert to prejudgements that might lead us to believe that DVA only happens to certain people. It doesn’t. But levels of risk and manifestations of DVA vary considerably.

CONSEQUENCES FOR WOMEN AND CHILDREN

The relationship between DVA and poor health is well recognised and it is known to result in compromised health over the life-course (Symes et al, 2014). Its negative impact on health is greater than other more obvious threats, such as smoking or diabetes and it now ranks as a major public health problem (Bacchus et al, 2012). The negative health effects can be linked back to the risk factors described in the previous section: DVA is a cause of physical injury (Campbell, 2002), complications of pregnancy (Bacchus et al, 2004), mental health and addiction problems (Lazenbatt et al, 2009) and maternal mortality (CEMACH, 2007). Some women who experience DVA end their own lives (Campbell, 2004; Devries et al, 2011), and each year more than 100,000 people in the UK are at high risk of being murdered or seriously injured as a result of DVA (SafeLives, 2015).

Many children live in a home where DVA is an issue and it is recognised that living in such an environment is harmful to children’s social, emotional and physical development (Buckley et al, 2007). In their investigation, CAADA (2014) found that two-thirds (62 per cent) of the children exposed to DVA were directly harmed (most often physically) or emotionally abused or neglected. They reported that children living with DVA suffered multiple physical and mental health consequences as a result: more than half (52 per cent) had behavioural problems, over a third (39 per cent) had difficulties adjusting at school and nearly two-thirds (60 per cent) felt responsible or to blame for negative events. A study in the US involving 300 abused women and their children reported that children who live in homes where DVA is occurring grow up learning that violence is an acceptable way of resolving conflict (Blair et al, 2015). The findings showed that the effects of exposure to DVA were not the same between girls and boys. Boys were significantly more likely to display externalising behaviour, such as aggression and hostility, with potential influence on their own future intimate relationships. The Royal College of Psychiatrists has produced a helpful factsheet for parents, teachers and anyone who works with young people. It sets out the effects that DVA can have on children and offers advice about how to avoid these problems. See: http://www.chimat.org.uk/resource/view.aspx?RID=223567&src=pimh

In this section the consequences of DVA for women and children have been discussed. However, it is important to keep in mind the issue of resilience. There is a whole body of literature on resilience, with theories and empirical evidence explaining and reporting how many individuals overcome the harm caused by being abused. In the context of DVA, a balanced perspective is helpful. This means acknowledging the negative and often long-term effects on women and children on one hand, while avoiding determinism (harm is not inevitable). Early intervention is key, however, if long-term effects of DVA are to be ameliorated – this is where the role of public health nurses is key (DH, 2013).

ROLE OF PUBLIC HEALTH NURSES

There are many strategies that can be adopted to address risk factors for DVA and “promote protective factors across the life course” (DH, 2013, p3). The primary prevention of DVA is of key importance and Dennis (2014) has described ways in which health visitors may get involved in primary prevention activities. School nurses are well placed to educate and support young people in developing positive relationships (DH, 2013b). Public health nurses have a key role in recognising and responding to women who have experienced DVA (Dennis, 2014) and while many are competent and confident to do so, some are less so (Bradbury-Jones et al, 2014). There is an increasing amount of research that seeks to understand why this is the case, but the underlying reason seems to be fear of having what has been termed ‘difficult conversations’ about DVA (Bradbury-Jones, 2015). The fearful element is based on concerns about causing offence by broaching such an emotive subject. However, most women (whether experiencing DVA or not) are not offended when asked about DVA and in fact, most want to be asked (Taylor et al, 2013). It might seem a little contradictory that while many women want the issue of DVA to be discussed, abused women tend to deny their experiences when asked. It often takes a number of times of being asked before a
woman has the confidence to disclose. This can be a little confusing. The main reason is that DVA is surrounded by secrecy, stigma and shame (Ahmad et al, 2009). The impact of DVA on children has already been explored and women are concerned about having their children removed from them (Peckover, 2003). Also, fear of further abuse prevents many women from disclosing (Robinson and Spilsbury, 2008).

However, it is still important for public health nurses to be prepared to ask about DVA and this ought not to be a mere one-off event. Where possible, raising the issue sensitively on a number of occasions is helpful. NICE (2014) describes this as being ‘a routine part of good clinical practice’ (p12). The DH (2013) advises on the importance of ensuring it is safe to ask, noting:

- Consider the environment:
  - Is it appropriate to ask?
  - Is it safe to ask?
- Never ask in the presence of another family member, friend, or child over the age of two years
- Create the opportunity to ask about DVA
- Where required use an appropriate professional interpreter (never a family member).

Talking openly (but safely) about DVA provides an indication that it is an issue to be discussed. Many women experience coercive, controlling and emotional forms of abuse that they do not readily identify as being DVA – they deal with it as part of their life – so discussing the issue may raise their awareness of DVA in relation to their own experiences. Dennis (2014) provides some helpful suggestions for questions that might be asked, including the simple, open question: “Is everything alright at home?” Although there is no evidence to support the effectiveness of routine screening (Feder et al, 2009) it has been highlighted that healthcare professionals should enquire about DVA when managing adverse health conditions that are associated with DVA (Sohal and James-Hanman, 2013). The four HARK questions have been validated for use in general practice in the UK setting to support women in disclosing DVA (Sohal et al, 2007). In a randomised controlled trial these four questions were successfully incorporated into general practice consultations to selectively ask women about DVA (Feder et al, 2011) and may have potential for selective enquiry by public health nurses. Overall there are multiple benefits to health visitors and school nurses talking safely about DVA: it creates an environment in which women and young people can begin to see the abusive nature of their relationships; it makes it less of a taboo subject and it opens opportunities for disclosure, risk assessment and safety planning.

RESPONDING TO DISCLOSURE

Understanding the processes for responding to the disclosure of DVA is crucial. A helpful starting point is acknowledgement that disclosure in itself does not necessarily equate to a woman leaving the abusive relationship. In the same way as it takes most women several times of being asked about DVA before disclosure takes place, leaving the relationship often takes multiple attempts. Even when women leave, many return. There is not a straightforward link between asking-disclosing-leaveing. “Why doesn’t she just leave?” is over-simplification and there are multiple, complex reasons why the only choice for a woman is to stay (Bradbury-Jones, 2015). Homelessness and refuge are not appealing options. Most women know that abuse does not end on exiting a relationship – post-separation is an extremely high-risk time for women and children (Nikupeteri et al, 2015). So remaining in an abusive relationship is not an irrational decision. The role of public health nurses in this context is to respect women’s choices and work with her in safety planning for herself and her children. However, this can cause a dilemma for public health nurses when there are concerns for the safety and wellbeing of children and young people. In recognition of this complexity public health nurses should feel confident in accessing support and advice from named nurses and local DVA leads.

Public health nurses may become aware of DVA via third party disclosures made by friends and relatives outside the immediate family or other colleagues, such as teachers and GPs. All such disclosures must be taken seriously and public health nurses should not assume that others will deal with the issue and they need to ensure a coordinated response to the disclosure is undertaken. Eventually, many women do make the
One way to achieve this is through access to frustration (Taylor et al., 2013). It is important health nurses, including fear, distress and with a range of emotions among public discussed in this article. Dealing with the emotive element of DVA has been imperative whatever the context and public health nurses must be aware of local and Safeguarding duties and responsibilities are when documenting in personal records. This is a general practice-based DVA training support and referral programme with an enhanced referral pathway to specialist DVA services. IRIS is a collaboration between primary care and third sector organisations specialising in DVA, such as Women’s Aid. It arises from the research undertaken by Feder and colleagues (2011).

Referral processes will be determined by local policy. As with all referrals, information sharing and documentation are important, but there needs to be careful consideration of both safety and confidentiality, especially when documenting in personal records. Safeguarding duties and responsibilities are imperative whatever the context and public health nurses must be aware of local and national information sharing protocols (HM Government, 2015b).

SUPERVISION, SUPPORT AND TRAINING

The emotive element of DVA has been discussed in this article. Dealing with the issue has been shown to be associated with a range of emotions among public health nurses, including fear, distress and frustration (Taylor et al., 2013). It is important therefore that public health nurses take care of themselves and each other emotionally. One way to achieve this is through access to robust systems of supervision. This needs to offer support to health visitors and school nurses in dealing with DVA among children, young people, clients and families. But it also needs to take into account that many nurses are themselves living with DVA. Sensitivity, compassion and protection of each other are as important for public health nurses as they are for the children, young people and women with whom they work.

Education and training are vital in promoting public health nurses’ confidence in recognising and responding to DVA. Many health trusts and boards in the UK have lead health professionals that provide guidance and training around DVA issues. However, although some public health nurses have access to regular, high-quality DVA training, provision is patchy. A message for managers of public health nursing services is in the significant benefit of such training. For public health nurses who do not have access to formal DVA training programmes (or to supplement the learning of those who do), further information about DVA can be found at: https://www.gov.uk/guidance/domestic-violence-and-abuse

CONCLUSION

There are three key messages for public health nurses in this article and recommendations for practice. Firstly, in relation to recognition, do not be afraid to discuss the issue of DVA. It is unlikely to cause offence if undertaken sensitively and safely and it will demonstrate confidence in addressing the issue in which women will trust. Secondly, regarding response, sometimes the only helpful response to disclosure of DVA is acceptance that for now that is all that a woman can deal with. But the act of disclosure can begin a pathway of safety planning for both the woman and her child(ren). Lastly, there is nothing mystical about recognising and responding to DVA, although it can be extremely complex. It requires sound clinical judgements, communication competences and referral knowhow. These are at the heart of public health nursing practice.

References

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NICE (2014). Domestic violence and abuse: How services, social care and the organisations they work with can respond effectively. London: NICE.


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**CPD questions**

**Visit www.communitypractitioner.com/CPD to submit your answers**

1. Domestic violence and abuse encompasses a range of behaviours which include including:
   a) Physical and sexual abuse
   b) Psychological abuse
   c) Controlling, coercive and emotional abuse
   d) All of the above.

2. What is the prevalence of DVA for women and men according to the 2013/2014 Crime Survey for England Wales?
   a) 11.5 per cent of women and 7 per cent of men
   b) 8.5 per cent of women and 4.5 per cent of men
   c) 7 per cent of women and 3 per cent of men
   d) 6 per cent of women and 3.5 per cent of men.

3. Which negative health outcomes are associated with DVA?
   a) Physical injury
   b) Complications of pregnancy
   c) Mental health and addiction problems
   d) All of the above.

4. DVA is something that can happen to anyone irrespective of age, gender, socioeconomic status, nationality or ethnicity.
   a) True
   b) False

5. What age group of young people is referred to in the Home Office (2013) definition of DVA?
   a) 16 years
   b) 17 years
   c) 18 years
   d) 21 years.

6. Which of the following statements is incorrect when responding to disclosure about DVA?
   a) Ensure the safety needs of the woman and child(ren)
   b) Be kind, sensitive and non-judgemental
   c) Do not validate what is happening to the individual
   d) Ensure that all safeguarding obligations are met.

7. Is the following statement true or false: ‘Lesbian and bisexual women experience IPV at a similar rate to women in general’ although a third of this is associated with male perpetrators.’
   a) True
   b) False

8. Which of the following relating to DVA is false?
   a) The relationship between DVA and poor health may result in compromised health outcomes over the life-course.
   b) Some women who experience DVA and their own lives.
   c) The severity of DVA is not linked to health outcomes.
   d) Leaving an abusive partner is an extremely high-risk time.

9. Which of the following relating to DVA and pregnancy is false?
   a) DVA may start or intensify during pregnancy
   b) DVA is linked to poor foetal outcomes including premature birth, low birthweight and perinatal foetal injury
   c) DVA can result in stillbirth and death
   d) Pregnancy-related violence is rarely directed at the unborn child.

10. Which of the following statements relating to the public health nurse role in relation to responding to DVA is false?
    a) A safety assessment should consider both risk and protective factors
    b) Training is unlikely to impact positively on their confidence in dealing with DVA
    c) Education and training are vital in promoting their confidence in recognising and responding to DVA
    d) Risk factors may be assessed using the CAADA-DASH Risk Identification Checklist.
Which First Infant Milk is most in line with expert opinion on growth?

The Department of Health recommends exclusive breastfeeding for the first six months of life.1

Protein and the importance of slower growth rates

Because the protein in breast milk is adapted to a baby’s needs,2 a breastfed baby tends to grow more slowly than a formula fed baby.3 This slower growth rate has shown to have significant long-term health benefits, including a lower risk of obesity, cardiovascular disease and diabetes.4

We’ve responded to expert opinion about proteins in SMA® PRO First Infant Milk

“Protein intakes of infants are generally well above the requirements, so protein content of Infant Formula and Follow-on Formula could be reduced”

European Food Safety Authority 20145

“The breast milk content of amino acids is the best estimate of infant amino acid requirements”

WHO/FAO/UNU 20146

Of the essential amino acids, four have been shown, when supplied in excess, to be associated with increased release of insulin. This may trigger a cascade of reactions in the body which may result in faster growth.7

European Childhood Obesity Trial Study Group 20158

Getting the right quantity and quality of protein in infant and toddler diets has lifelong health benefits.

With SMA PRO First Infant Milk, you can help build a nutritional foundation for life in the first 1000 days.

IMPORTANT NOTICE: Breast milk is best for babies and breastfeeding should continue for as long as possible. Good maternal nutrition is important for the preparation and maintenance of breastfeeding. Introducing partial bottle-feeding may have a negative effect on breastfeeding and reversing a decision not to breastfeed is difficult. A caregiver should always seek the advice of a doctor, midwife, health visitor, public health nurse, dietitian or pharmacist on the need for and proper method of use of infant formulae and on all matters of infant feeding. Social and financial implications should be considered when selecting a method of infant feeding. Infant formulae should always be prepared and used as directed. Inappropriate foods or feeding methods, or improper use of infant formula, may present a health hazard.


ZTC1238/12/15
The Surviving Crying study: progress report for the first stage of research

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ABSTRACT
The term ‘infant colic’ has been used to refer both to ‘prolonged’ infant crying (a measure of crying) and to parents’ concern that ‘excessive’ crying is a sign that something is wrong with their baby. There is growing evidence that the terms need to be distinguished, so that the traditional focus on the crying is balanced by an equal focus on the impact of the crying on parents. The Surviving Crying study is a first step towards developing and evaluating routine NHS services to support parents who are worried about their baby’s excessive crying. The study is based at De Montfort University, Leicester and funded by the NIHR HTA Programme. It involves a collaboration with Leicestershire Partnership NHS Trust (LP Trust), University College London, Leicester and Middlesex Universities and the charities National Childbirth Trust (NCT) and Cry-Sis.

Surveys in the UK and other countries have found that around 20 per cent of one- to four-month-old infants cry for long periods without apparent reason (Alvarez, 2004; St James-Roberts and Halil, 1991). Traditionally, this crying was attributed to gastro-intestinal disorder and pain and known as ‘infant colic’ (Illingworth, 1954; Wessel et al, 1954). More recently, evidence has accumulated that most such infants are healthy and grow and develop normally (Lehtonen, 2001; Stifer and Braungart, 1992). Many normal babies have a crying ‘peak’ at around one to two months of age (Barr, 1991; St James-Roberts and Halil, 1991). In most cases, this peak and the ‘unsoothable’ crying bouts that alarm parents resolve spontaneously by five months of age and appear to be linked to normal development (Barr, et al, 2005; Barr and Gunnar, 2000). More detailed review of this evidence is available elsewhere (St James-Roberts et al, 2013).

Alongside these findings, the term ‘infant colic’ has been criticised for being confused and confusing (St James-Roberts, 2012). In particular, this term has been used to refer both to ‘prolonged’ infant crying (a measure of crying amount) and to parents’ concern that the ‘excessive’ crying is a sign that something is wrong with their baby. Although prolonged and excessive crying are related, there is growing awareness that they need to be distinguished, so that the traditional focus on the crying is balanced by an equal focus on the impact of the crying on parents.

KEYWORDS
Infant crying, colic, excessive crying, prolonged crying, parental support

INTRODUCTION
The Surviving Crying study is a first step towards developing and evaluating routine NHS services to support parents who are worried about their baby’s excessive crying. The study is based at De Montfort University, Leicester and funded by the NIHR HTA Programme. It involves a collaboration with Leicestershire Partnership NHS Trust (LP Trust), University College London, Leicester and Middlesex Universities and the charities National Childbirth Trust (NCT) and Cry-Sis.

This is a two-year study. Stage one (development and evaluation of the intervention package) began in November 2014 and lasted a year. Aims at this stage were to identify existing support materials for parents of excessively crying babies and to develop a new, evidence-based support package for this purpose that is suitable for NHS use. The aims, methods and outcomes of this stage of the research are described in more detail below.

Stage two of the study (feasibility study of package implementation in the NHS) runs for 12 months from November 2015. This stage of the research will provide provisional data on the effectiveness and cost of the package, find out whether parents and health visitors consider it worthwhile and make recommendations about its inclusion and further evaluation in the NHS.

INTRODUCTION
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KEYWORDS
Infant crying, colic, excessive crying, prolonged crying, parental support
Following this initial contact, the researchers explained the study in full and obtained parents’ written informed consent to take part. They invited them to return in five months to discuss and screen for distress due to excessive infant crying.

Step two involved updating a systematic review of the evidence (Douglas and Hill, 2011) to identify the best available evidence about infant crying and its management by parents. The researchers identified eight sets of example materials and permission to use them in stage one of the study. These included websites, information booklets and training for practitioners to allow them to deliver support sessions directly to parents.

Procedure

With support from LP Trust managers who are partners in the study, the first step was to establish collaborative arrangements with health visitors and other professionals working in the Trust. Briefing workshops were held with five health visitor teams working in the city or county. As a result, 55 health visitors gave written informed consent to take part by referring parents who had previously been distressed due to their baby’s excessive crying to the study team. Following this initial contact, the researchers explained the study in full and obtained parents’ written informed consent to take part.

The researchers identified four sets of example materials and permission to use them in stage one of the study. These included websites, information booklets and training for practitioners to allow them to deliver support sessions directly to parents. Evidence also noted that in related areas practitioner-provided interventions, particularly based on cognitive behavioural therapy (CBT) rationales, can help vulnerable parents and reduce depression (Stevenson et al, 2010). CBT treatments for acute/moderate adult emotional distress are supported by NICE (2009) and the use of groups may improve service access and limit costs (Stevenson et al, 2010).

Recent reviews highlight parental acceptance and take-up of intervention components as crucial for intervention effectiveness (Moore et al, 2012; Olds et al, 2007). Accordingly, in step three the researchers ran focus groups with 20 of the parents who had previously sought NHS help for distress due to excessive infant crying. Both mothers and fathers were invited to take part and two fathers participated. They were asked what they had found challenging, what had helped, and about family, community and health service supports. In addition, they were asked to evaluate the shortlisted example materials and to advise on how to adapt them for NHS use. They also identified the methods they currently used to access health information and the methods of delivering information that parents in their position would find most suitable. The resulting data was collected for analysis using NVivo 10 for the qualitative data and statistical analysis of the rating data.

Based on the parental views and preferences, the final step involved working with a commercial website company, Consider Creative, to develop a website and other materials for delivering the support package.

OUTCOMES FROM STAGE ONE

The main outcome of the study so far is a package of materials to support parents who are worried about their baby’s excessive crying, comprising a Surviving Crying website, printed materials for parents who do not use the internet, and a CBT-based programme manual for delivering direct one-to-one or small-group support sessions to parents. The website includes evidence about crying, guidance for parents, stories and videos from parents who have survived their baby’s crying and access to other sources of support. It can be accessed by mobile phone or tablet, as well as on a computer. The package components have received feedback from NHS and parent collaborators and the presentation and reading level of the materials has been checked to ensure they are suitable for use in the general community.

Secondly, together with the LP Trust safeguarding officers and clinical staff, the study’s paediatrician has developed safeguarding protocols to ensure the safety of parents and babies involved in stage two of the study.

Thirdly, methods for collecting the stage two data have been finalised in collaboration with Leicester Clinical Trials Unit, which will be responsible for data entry and analysis.

The researchers intend to recruit two groups of parents. To enrol a referred group, around 60 LP Trust health visitors will invite parents who approach them during a six-month period with concerns over excessive infant crying to participate. Where initial written informed consent is given, they will be interviewed by researchers, offered the package components, and followed up. Estimates are that around 20 per cent of parents judge their baby cries to be excessive (St James-Roberts and Hall, 1991; Douglas and Hill, 2011). The LP Trust areas targeted for the study see more than 1,000 births annually, thus allowing the target 30 cases for a six-month period.

To recruit a community group, health visitors will invite 15 families per week to enter the study at the statutory home visit in postnatal days 10 to 14. It is expected that 10 per week will give informed consent to be followed up and screened for distress due to excessive infant crying giving a total of 150 families in 15 weeks. This will ensure a sufficient number of participants and should identify 30 cases offered the package. The longitudinal community approach will also indicate differences between these parents and those who approach health visitors for help. The two recruitment methods should indicate
95% of Paediatricians\textsuperscript{†} reported an improvement in common infant feeding problems with a formula like Cow & Gate Comfort\textsuperscript{1}

Evidence shows these partially-hydrolysed formula milks containing oligosaccharides (GOS/FOS) improve the symptoms of colic in bottle-fed babies.\textsuperscript{1,2} So if a bottle-fed baby’s colic is more than mum can manage with practical tips alone, put digestive care first with Cow & Gate Comfort.

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

*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.

The primary outcome measures will be:
1. Demographic data for the parents and infants
2. Figures for parents’ take-up of the package components and persistence in the study
3. Parents’ rating-scale measures of the effectiveness of the package components in providing support

The secondary outcome measures will be:
1. Parents’ scores on depression, anxiety, quality of life and coping measures and changes in those scores
2. Parental reports of the duration of full and partial breastfeeding
3. Whether parents have gained knowledge about infant crying as a result of participating in the study, using methods developed by Barr et al (2006)
4. Figures for the cost of NHS services involved in supporting parents of excessively crying infants, and for each support package component provided by the study. The health economic data will be analysed to assess the amount of staff-parent contact time and associated potential costs to the NHS. Methods will be developed to allow cost-effectiveness analyses. A study co-applicant and expert in health economic analyses will supervise the data collection and analysis involved.
5. Parents’ willingness to accept randomisation to treatment or control conditions in a future randomised controlled trial designed to evaluate the package more thoroughly.

Dispersion of the findings from the study will continue over the next 12 months and involve workshops for NHS professionals as well as further publications. Those wishing to be added to the mailing list and receive further information as it appears should email the researchers at: survivingcrying@dmu.ac.uk

ACKNOWLEDGEMENTS

This study is supported by a grant from the National Institute for Health Research HTA Programme (HTA 12/150/04). I would like to acknowledge the major contribution to this research made by Surviving Crying study research team (Rosemary Garratt, Charlotte Powell, Deborah Bamber, Jaqi Long, Sue Dyson), WP Trust staff, the study management and steering groups, and the health visitors and parents who have taken part.

Key points

- This report describes the first stage of the Surviving Crying study, which is designed to develop an information and support package for parents who are worried about their baby’s excessive crying
- The first stage of the study has employed focus group methods with parents of previously crying babies to identify the types of support materials and methods of delivering them that are suitable for parents in this position
- The support package developed includes a website, printed materials and support sessions delivered directly to parents by a practitioner qualified in cognitive behavioural therapy (CBT) methods
- The report also introduces stage two of the study, which is designed to provide a provisional evaluation of the package, its costs, and its suitability for use in the NHS. This is underway.

References


March 2016 Community Practitioner 33
New dietary recommendations for carbohydrate have focused public attention on reducing sugar intakes. Breakfast cereals have been cited in the media, and by some influential individuals, as a significant contributor to sugar in the UK diet. However, the UK National Dietary Survey shows that breakfast cereals in fact contribute just 7% of extrinsic dietary sugars (6-8% children and 6% adults). Despite this, Kellogg’s is continually seeking ways to improve the nutrition profile of our foods – including lowering sugar content – without compromising on taste or quality.

Since 2010, in the UK and across Europe we have started to reduce the sugar content in our foods. Specific examples in the UK include Bran Flakes (30% reduction); Special K flakes (10% reduction); and Coco Pops Rocks (16% reduction). As part of the on-going Kellogg’s commitment to sugar reduction, more reductions are already planned for 2016.

Challenges of Sugar Reduction?
Reducing sugar takes time from both a technical and consumer perspective. The impact on food safety must be considered whilst maintaining the physical and functional properties of the food. One example is the effect on texture, such as maintaining crunchiness in milk. Reducing sugar with stealth allows consumer taste buds to adapt to lower sugar recipes with no preconceived impact on taste.

Lowering sugar starts with evaluating the functional role of sugar in the food. In cereal, sugar’s physical and functional role is to team with other ingredients, such as starch, to create the desired texture, aroma, flavour, colour and overall appearance of the food. Reducing sugar may also require introduction of new technologies or equipment into our manufacturing plants. The effect of sugar reduction on the foods physical properties, nutrition profile and taste must all be carefully monitored. Our experience globally shows us that consumers are more willing to accept our foods when the sugar is reduced gradually over time.

Myth: less sugar = lower calories
Reducing the sugar content of breakfast cereals in fact has little impact on the energy that they provide. This is because sugar and starch contain weight for weight the same number of calories. A 30g bowl of a low sugar cereal, will have a similar carbohydrate content as a higher sugar cereal. As the sugar is replaced by starch the calorie content will remain similar. This is demonstrated in the product panels below.

Achievements since 2010
• 60% of cereals in the Kellogg portfolio are low or medium sugar
• 20% of snack foods are low or medium sugar
• 70% of Kellogg new products launched since 2013 have been low or medium sugar

For more information go to: www.kelloggsnutrition.com/en_UK/ahome.html
Why reformulate by stealth?

Stealth = surreptitious or difficult to detect.

The “stealth” approach to product reformulation has been used in the food industry for the past two decades. Consumers want healthier products and yet are usually unwilling to compromise on taste or texture. Reformulation will have little impact on nutrient intake if consumers switch to another product. When carrying out a reformulation companies have to make a choice – either to market the improved nutrition credentials, or to reformulate by stealth, giving the consumer nutritional benefits while they remain unaware and allowing taste to slowly adapt. There are pros and cons to both approaches.

In terms of sugar, consumers often associate low sugar with low taste and will decide against a product even when the change is almost undetectable. For this reason, Kellogg’s has carried out reformulation in the past, without communication to the consumer.

Case Study: Assertive Sugar Reduction

In 2004, Kellogg’s introduced Frosties Reduced Sugar into the UK which contained one third less sugar compared to standard Frosties. Consumers failed to make the transition to a lower sugar version and the product was discontinued from the UK market.

It’s not just about sugar

Sugar is currently in the spotlight, however Kellogg’s R&D (research and development) attention includes sugar, salt, fibre and continued provision of a range of nutrients in response to identified dietary needs. Since 1998, Kellogg’s has achieved a 57% reduction in the amount of salt in our cereals through innovation and reformulation.

Sugar reduced by...

↓ 71%
↓ 16%
↓ 10%
↓ 30%

"We are a company of dedicated people making quality products for a healthier world"

WK Kellogg

No Kellogg cereal is high in salt and we are fully compliant with 2012 government salt targets. Identification of a public need for increased vitamin D intakes led to the addition of vitamin D to Kellogg family cereals during 2010. And, 94% of our breakfast cereals are now at least a source of fibre (3g or more fibre per 100g).

Research supports the benefits of cereal for breakfast, with experts agreeing worldwide that breakfast is the most important meal of the day. There is an accumulating body of evidence that shows that a cereal breakfast enhances physical and mental performance, promotes general well-being, can help reduce disease risk factors, and offers variety for diverse consumer tastes.

For both children and adults in the UK, fortified breakfast cereals provide a major source of iron, thiamin, riboflavin, niacin, B6, and folate. Most bowls of Kellogg’s breakfast cereal* provide at least 25% of recommended intake of 6 B-group vitamins (thiamin (B1), riboflavin (B2), niacin, Vitamin B6, Vitamin B12, folic acid), Vitamin D (in kids and family cereals) and at least 15% of the recommended intake for iron.

We believe that enjoyment and appeal of our products are essential if they are to make a nutritional contribution to the diets of consumers. The challenge for all manufacturers is therefore to meet health expectations in terms of formulation without compromising product quality, taste or price.

References:
The health risks of incense use in the home: an underestimated source of indoor air pollution?

INTRODUCTION
Clean air is a basic requirement of life and hazardous substances produced from human activities indoors, such as tobacco smoking, cooking or burning incense, can lead to a broad range of health problems (WHO, 2010). It is estimated that people spend up to 90 per cent of their time indoors, particularly young children, women and elders (Al-Rawas et al, 2009.) This makes indoor air pollution an important issue for public health workers.

Children’s vulnerability to tobacco smoke in the home has been well documented, and the UK government continues to promote rigorous measures to protect children from second-hand smoke (NICE, 2013). Burning incense in the home is common among many cultures, but the health effects have received little attention in Western literature. Many UK families burn incense regularly for religious or cultural reasons, particularly those from Asian, North African or Arabic backgrounds. A number of studies link incense burning to a variety of health conditions, ranging from cardiopulmonary problems, headaches, forgetfulness and allergies, to neoplasms (Huang et al, 2014; Al-Rawas, 2009).

This paper explores the practice of incense burning in the UK among ethnic minority communities, the chemical composition of the smoke and its potential effects on human health. It focuses on the health visitor’s role in promoting health and reducing health risks for children and families, while recognising the value of clients’ traditional practices and beliefs.

BACKGROUND
Modifiable environmental factors account for approximately 25 per cent of the global disease burden, and more than 33 per cent of the burden among children (Prüss and Corvalen, 2006). Public health strategies that consider environmental health interventions contribute to the overall wellbeing of communities and are often cost-effective. In recent years there has been considerable public interest in understanding the health impacts of outdoor pollution, but less recognition of the importance of the indoor environment, and in particular indoor air quality, on health (WHO, 2010). According to the Global Burden of Disease 2010 study, particulate matter air pollution is responsible for 3.2 million premature deaths globally, making it the second biggest environmental and the ninth most important overall risk factor (Lozano et al, 2012). In contrast to the outdoor environment, people have a greater potential to modify their exposure to indoor environmental pollution, making indoor air pollution an appropriate target for health promotion and disease prevention.

Incense burning inside the home is a common practice in China, Taiwan, Singapore, India, North Africa and Middle Eastern nations (Tse et al, 2011; Wahab and Mostaña, 2007). Incense may be used as a traditional perfume or air freshener as part of religious rituals or to repel mosquitoes. When incense burns it emits smoke containing particulate matter, gas products such as carbon monoxide, sulphur dioxide, formaldehyde and other...
organic compounds. Incense burning is recognised as a source of indoor air pollution that can be modified (Wang et al, 2011); however, it is difficult to evaluate the evidence and draw out practice implications because of the variety of types of incense, the methods of burning and variation in research study designs.

**TYPES OF INCENSE**

Incense can be burnt in two ways: directly, e.g. incense (joss) sticks, or indirectly using charcoal or another combustion source. Using Chinese incense typically involves lighting a flame on a cored incense stick, which is then fanned out. The glowing ember smoulders and burns away the rest of the incense. In contrast, the most frequently used Arabian incense is resin-based. These include oud, bakhour and frankincense, which are derived from aromatic trees. Charcoal is typically used to help burn the blocks, or granules of resin.

**ETHNIC MINORITIES IN THE UK**

Data from the most recent census suggests that 7.5 per cent of the UK population self-identifies as Asian or Asian-British (including Chinese), 1.8 per cent as African and 0.4 per cent as Arabic (ONS, 2012). Many health visitors, particularly in urban areas, are likely to be working with diverse populations and may come across families who regularly burn incense in the home. Cultural sensitivity and appropriate responses to cultural issues are important aspects of health visiting work (Cowley et al, 2013).

**AIM**

This literature review identifies and critiques the available evidence about potential health risks of incense use in the home and draws out implications for HV practice.

**METHOD**

A range of electronic databases, Google Scholar and the Cochrane database were searched using the search terms in Table 1. Reference lists of relevant studies were manually searched to capture all relevant literature sources on this topic. Relevant papers were then accessed. Inclusion/exclusion criteria are outlined in Table 2. CASP UK (2013) critical appraisal tools were used to identify study validity, reliability and generalisability.

**RESULTS**

Eleven studies met the eligibility criteria – these included two case control studies, four surveys, three cohort studies and two cross-sectional studies. The evidence was analysed using the headings of a number of potential health effects of incense burning (see Table 3), and the reliability, validity and generalisability of the studies was evaluated. The studies are summarised in an annotated bibliography in Table 4. No systematic reviews relevant to the research question were found.

**POTENTIAL HEALTH EFFECTS**

**Respiratory effects**

When incense burns it releases particulates, gas products and other organic compounds. The adverse effects on health of particulates are well documented and there is no evidence of a safe level of exposure (WHO, 2013). Four of the studies found a link between frequency of incense burning and childhood asthma. Wahab and Mostafa (2007) carried out a case control study of 100 asthmatic children in Qatar and found there was statistically significantly higher exposure to Arabian incense.

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<table>
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<tr>
<th>Table 1: Study search terms (* = truncation)</th>
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<tr>
<td>Incense AND child*</td>
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<td>Incense AND health</td>
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<td>Incense AND particulate matter</td>
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<td>Incense AND asthma</td>
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<td>Indoor air pollution AND child*</td>
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<th>Table 2: Inclusion/exclusion criteria</th>
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<td>Studies under 10 years old</td>
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<td>Studies with human subjects</td>
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<td>Studies of the health effects of burning</td>
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<td>incense in the home</td>
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<td>Studies of the health effects of a variety</td>
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<td>of indoor air pollutants including</td>
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<th>Table 3: Potential health effects of home incense use</th>
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<td>Lung cancer</td>
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<td>Carcinomas of the respiratory tract</td>
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<td><strong>Cardiovascular effects</strong></td>
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<td>Stroke</td>
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<td>Reduced cardiac function</td>
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<td>Difficulty concentrating</td>
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<td>Forgetfulness</td>
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<td>Itchy eyes and rhinitis</td>
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<td>Accidental burns</td>
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<td>Author and year of publication</td>
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<tr>
<td>Wahab and Mostafa (2007)</td>
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<td>Liu et al (2013)</td>
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<td>Yeatts et al (2012)</td>
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Table 4: Annotated bibliography (cont.)

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<th>Sample Size</th>
<th>Methodology</th>
<th>Findings</th>
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<td>Pan et al (2014)</td>
<td>Singapore</td>
<td>Cohort study</td>
<td>63,257 Singapore Chinese 45- to 74-year-olds</td>
<td>Questionnaire as part of the Singapore Chinese Health Study</td>
<td>Long-term exposure to incense burning in the home environment was associated with an increased risk of cardiovascular mortality in the study population. Relative to non-current users, current users had a 12 per cent increased risk of cardiovascular mortality.</td>
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<td>Friborg et al (2008)</td>
<td>Singapore</td>
<td>Cohort study</td>
<td>63,257 Singapore Chinese 45- to 74-year-olds</td>
<td>Questionnaire as part of the Singapore Chinese Health Study</td>
<td>The use of incense increased the risk of squamous cell carcinomas of the respiratory tract in a dose-dependent manner. The influence was most pronounced for carcinomas of the upper respiratory tract.</td>
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<tr>
<td>Hsu et al (2012)</td>
<td>Taiwan</td>
<td>Cohort study</td>
<td>257 mothers</td>
<td>Telephone questionnaire</td>
<td>Regular incense burning and water damage at home were found to be the most significant risk factors for childhood respiratory allergy and allergic morbidities at three to five years. A more than nine-fold increase of risk was identified for children with concurrent paternal history of allergies and exposure to the above housing factors.</td>
</tr>
<tr>
<td>Wang et al (2011)</td>
<td>Taiwan</td>
<td></td>
<td>Frequency of incense burning at home</td>
<td></td>
<td>Surveyed Taiwanese school children and found that the frequency of incense burning at home was associated with an increased risk of asthma and increased medication use. Furthermore, a Taiwanese cohort study examining the impact of genetic and environmental factors on childhood respiratory allergy found that regular incense burning alongside water damage in the house led to more than a nine-fold increase in symptoms in children with a paternal history of asthma (Hsu et al, 2012). This demonstrates that when a number of risk factors coexist the individual may be more susceptible. Alternatively, three studies noted a negative correlation between incense use and respiratory symptoms. Their authors suggest that the presence of a person within the household with respiratory problems was associated with an avoidance of incense burning; however, more study is needed to evaluate this hypothesis (Liu et al, 2013; Yeatts et al, 2012; Lee et al, 2005). The association between burning incense and lung cancer is uncertain, and epidemiological evidence is limited. Tse et al (2011) conducted a case control study of male lung cancer sufferers in China and found that exposure to incense smoke in the home may increase the risk of lung cancer among smokers. The Singapore Chinese Health Study, a large cohort study of adults aged 45 to 75 years, noted that the use of incense in the home seemed to increase the risk of squamous cell carcinomas of the respiratory tract in a dose-dependent manner (Friborg et al, 2008). Cardiovascular effects</td>
</tr>
</tbody>
</table>

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included both stroke and coronary heart disease, and the association was particularly strong in never-smokers and those without a history of cardiovascular disease at baseline (Pan et al, 2014).

Other health effects
Two of the studies identified additional health outcomes of burning incense. A cross-sectional study in the United Arab Emirates found that burning incense daily was associated with increased headaches, difficulty concentrating and forgetfulness (Yeatts et al, 2012). Hsu et al (2012) carried out a cohort study of paternal heredity and household characteristics and found that burning incense was associated with asthma and other allergic symptoms, such as itchy eyes and rhinitis in children with a family history of allergy. Finally, the fire risk from burning incense is not explored by any of the studies identified. This is an important consideration for families and the HVs who work with them.

DISCUSSION
Respiratory effects
The review evidence suggests that burning incense in the home presents a risk factor for asthma and possibly respiratory tract carcinomas; however, the evidence is equivocal. Families with members susceptible to respiratory symptoms may avoid or limit burning incense in their presence, making the evidence difficult to evaluate. Nevertheless, in vitro experiments have identified incense burning as a source of air pollution, releasing a range of compounds including known carcinogens, irritants and toxins (Elsayed et al, 2014). Some authors argue that burning incense can lead to higher levels of indoor pollution than tobacco smoking (Liu et al, 2013). The exact mechanism by which incense provokes respiratory symptoms is not fully understood. The complex mixture of gas, particulate and other organic compounds inhaled by people exposed to the smoke varies depending on the type of incense used, the combustion source (if any) and room ventilation.

Cardiovascular effects
There is growing evidence of the adverse cardiovascular effects of ambient air pollution, including premature mortality (WHO, 2013). Ultra-fine particulate from sources such as incense burning may translocate from the lungs into the blood causing vascular inflammation, clotting and the risk of myocardial infarction. Two studies that link cardiac outcomes to incense use were identified. Huang et al (2014) carried out a small, non-randomised survey with limited generalisability. The authors concede that medication use, comorbidities and other unmeasured indoor air pollutants may have confounded their findings. Nevertheless it is the first study to evaluate the impact of personal exposure to household particulate on acute changes in heart rate variability indices.

The Singapore Chinese Health Study is the second study and it suggests that incense users had a 1.2 per cent higher risk of cardiovascular mortality relative to non-users. It has a number of strengths – a population-based design, a large number of participants sharing a number of characteristics and detailed information collected on lifestyle factors. Alternative sources of air pollution were negligible as other levels of air pollution in Singapore were low, and solid fuel use was rare. This provided a good opportunity to evaluate the association between incense use and cardiovascular mortality in this population. Nevertheless caution should be used when inferring causality because the study did not collect information on the type of incense used, or other practices such as room ventilation during burning (Pan et al, 2014).

Other health effects
Studies of other health effects of burning incense are limited: only two meet the eligibility criteria of this review. Yeatts et al (2012) used a cross-sectional design with a nationally representative sample of 628 households to look at the neurological effects of using incense in the home. Further study is needed to better understand both the constituents of incense and their possible neurological effects.

The cohort study by Hsu et al (2012) was the only one identified to explore the outcome of childhood asthma and childhood allergy more generally. The prospective design meant that parental history was collected from pregnant women and would not have been influenced by the children’s later health status. However, only mothers completed the telephone questionnaires and they may not have had precise knowledge about their husband's allergic history. Furthermore, a link between incense burning and childhood allergy and asthma was only found to be significant in the presence of a paternal history of allergy.

Implications for further research
There are limitations to these studies, which may influence the interpretation of results and limit their generalisability. Some of the surveys rely on responder recall and do not record, for example, the degree of room ventilation where the incense was burnt. Some respondents may also have had additional incense exposure, for example in the temple, which the survey does not record and different types of incense may be used outside the home from those recorded in the questionnaires. Since incense is used widely in the communities studied, it is probable that non-incense users had contact with incense, either in places of worship or when visiting other people’s homes. Nevertheless, the robustness of the evidence presented is increased by the large numbers of subjects in the majority of the studies, and the variety of geographical locations.

No randomised control trials (RCTs) were identified in this review. This study design may be unethical when researching the effects of incense burning on human health. Nevertheless, a number of animal subject RCTs noted adverse metabolic changes, weight loss and pulmonary changes in rats exposed to daily incense smoke (Alokail et al, 2011).

Finally, incense does not refer to simply one product. It can have a variety of ingredients and be burnt in a number of different ways. See and Balasubramanian (2010) found that emissions varied among the six different
Incense burning in the home is common in a number of cultures; however, it has received little attention in Western literature.

**Key points**

- Incense burning in the home is common in a number of cultures; however, it has received little attention in Western literature.
- Home incense use can have significant adverse health effects; particularly on cardiopulmonary morbidity and mortality.
- Young children, the elderly and those with pre-existing health conditions may be particularly at risk.
- Health visitors can help families to limit their exposure to incense in the home.

**CONCLUSION**

The findings from this literature review have important public health implications for HVs. Current evidence confirms that HVs should raise family awareness of the potential harmful effects of incense burning to respiratory and cardiovascular health. HVs should support families to take steps to manage their exposure to incense in the home. These may include reducing the frequency and duration of incense burning and avoiding burning incense in the presence of children and susceptible individuals. Further studies are needed to profile the chemical components in a variety of incense preparations. This could help manufacturers take steps to use alternative, less hazardous ingredients and make this traditional practice safer to human health and the environment.

**References**


Common sense suggests that increasing home ventilation during incense burning will minimise its effects. Unfortunately, none of the studies reviewed actually explored this and further research is required to establish the role of home ventilation in reducing the health impacts of incense burning before firm recommendations can be made. Finally, a systematic review is needed on interventions to reduce ambient particulate air pollution and their effect on health (Burns et al, 2014).
ABSTRACT
The purpose of this study was to establish what is important to pre-school children as service users of a children's centre. This research was conducted as part of a range of service user's perspectives in one inner city children's centre. This study shows that young children as service users are capable of contributing their views. The participants enjoyed private spaces. Nature and the environment were important to these children, as was watching their friends playing happily. A mosaic approach was used in this qualitative study of five children aged three to four years. The mosaic approach uses observation and interviewing with participatory use of cameras by the children. It is a strengths-based approach, which extends to all children irrespective of ability and background. If adults are to understand children they need to look for opportunities for their voices to be heard.

KEYWORDS
Children's voice, children's rights, mosaic approach, children as service users, children's centre

INTRODUCTION
Clark and Moss (2011) have done much to address ways of listening to young children and thus their mosaic approach was the inspiration for accessing the views of children as part of this research project. Since completing the research the literature on children's perspectives or children's voice has been revisited and updated. While there is a great deal of literature on childhood studies, research that specifically seeks the views of young children appears to be limited (McTavish et al, 2012). This research with young children did not set out to prove a hypothesis. The aim was simply to find out what was important to children in their everyday setting. The overarching research was to seek the views of users of a children's centre on partnership working. Young children are also users and central to the core purpose of children's centres.

“The UN Convention on the Rights of the Child Article 12 states that children not only have a right to articulate their opinions with regards to issues that affect them but they also have a right to have these opinions heard (UNCRC, 1991). Anecdotal evidence suggests that seeking the voice of the child is routine as part of a child's pre-education. Children's social workers also utilise age-appropriate tools, such as drawings, to elicit children's views. Section 3 of the Children Act (2006) requires local authorities to have "regard to any information about the views of children.”

Pascal and Bertram (2009) argue that if the rights of the child enshrined in the UNCRC are to be enjoyed by children then research and practice in the UK needs to become much more inclusive and participatory. The authors assert that many English children are not listened to and where young children are concerned there is a tendency to assume they are too young to express their views and adults need to act on their behalf. Bertram and Pascal (2006) found that children from diverse communities and backgrounds, asylum seekers, travelling families, refugees and migrant families are even less likely to be heard.

Kellett (2011) suggests age should not be a barrier to involving very young children in research. Kellett differentiates that while participation is the act of being involved and doing, voice is the right to free expression. Lundy (2007, p933) asserts that voice is composed by four parts:

• Space: Children must be given the opportunity to express a view
• Voice: Children must be facilitated to express their views
• Audience: The view must be listened to
• Influence: The view must be acted upon as appropriate.

Children as service users have the same rights as other users of the children's centre to express their views and need to be facilitated to do so.

In his book The Little Prince (1945), Antoine de Saint-Exupery writes that grown-ups cannot on their own understand the world from the child's point of view and therefore they need children to explain it to them” (Christensen and James, 2008, p.9). These words are wise because actual experiences as perceived by children cannot be presumed by adults.

Christensen and James (2008) assert that only by actively listening to children and the ways they communicate with us will progress be made in researching with, rather than on, children.

The purpose of this study was to establish what is important to pre-school children as service users of a children’s centre. This research was conducted as part of a range of service users’ perspectives in one inner city children’s centre.

**METHOD**

The mosaic approach is a participatory research method that promotes tools such as cameras, bookmaking, tours and map-making, which play to the strengths of young children. In addition to observation and talking to children, this forms part of the listening framework (Clark and Moss, 2011).

Gatekeepers, such as the cluster manager and the nursery teachers in the children’s centre, were approached for permission to undertake the research for this part of the study. The next step was to see parents.

Parents who were waiting to collect their children from nursery were asked if they thought their child might be interested in taking part in the study. They were informed that ideally three boys and three girls would be needed to participate. The process was explained, that the children would be requested to take photographs of the things they liked in the children’s centre using disposable cameras. The children would then be invited to discuss their photographs with the researcher, who would take notes of the conversation. Parents were assured that having read the information sheet and signed the consent form they or their children could withdraw from the process at any time. This information was also stated in the participant information sheet. Children could say no or show no by raising the palm of their hand.

**PARTICIPANT SELECTION**

Written consent was obtained from the parents of the six children who agreed to their participation in the research. The children were aged three to four years. On the agreed date the keyworkers and researcher asked the children if they were happy to take part in taking photographs of the things they liked in the nursery. Since a couple of the children were known to the researcher in her role as health visitor it was important that the researcher did not influence participant choice. Five agreed and one child refused to take part.

There were three boys and two girls. These were children of mixed abilities, included children of black and minority ethnic groups and were representative of the children attending the children’s centre. They were of the age group that the researcher was comfortable to work with based on clinical experience as a health visitor. Children of this age group are generally more advanced developmentally in terms of dexterity and verbal skills compared to younger children.

An example would be that a child of three has good pencil control, can carry out a simple conversation and is able to describe present activities and past experiences. A four-year-old’s speech is generally grammatically correct and intelligible (Sheridan, 2009). The Ages and Stages Questionnaire developmental tool supports this (Squires et al, 2009). The researcher therefore felt that this age group were more likely to be able to use disposable cameras and be more articulate in discussing their photographs. Children under three years were therefore excluded from this study. Silverman (2013) claims it is important to state what types of people were excluded from the research and why.

The children’s keyworkers were present throughout. The photographs were taken on a clear, sunny day and children had lots of activities in the playground. Four of the five children focused on the outdoors.

The children were not used to using disposable cameras so it took a little time initially to get used to using them; however, some did very well. The number of shots varied from two to 24 per camera. Some were taken too close to the object so could not be seen, while one child took 10 photographs of his friends. These photos had to be destroyed since the researcher did not have parental consent for other children to be photographed. A sample of the remaining photographs was gathered to make a collage and photographed by the researcher (see Figure 1). These were then given to the nursery staff to give to the parents.

**ETHICAL CONSIDERATIONS**

Ethical approval was granted following a revised application on the 15/07/2014 reference number FBL/14/06/02 from the
University Research Ethics Committee at University of the West of England. The study involved young children, therefore the ethics committee needed assurance that the study would not cause any harm or discomfort to the participants. Photographs were taken by children using a disposable camera. Parents were given the opportunity to stay with their child while they took photographs if they wished but none chose to.

Nutbrown (2010) suggests the need for guardians of child participants rather than gatekeepers, asserting that it is the researcher’s responsibility to ensure that guardians have the information necessary to act in the interest of their children. The keyworkers in the nursery were present at all times. Clark et al (2014) highlight the importance of informing children about the purpose of the research and the means in which their views are to be sought and offering participation as optional.

The collage in Figure 1 is a representative picture of the things in the nursery that are important to this group of three- to four-year-old children within the children’s centre. The children in the study (three boys and two girls) chose to take the majority of the photographs outdoors. Photographs of other children were excluded as mentioned in the methodology. The children were generally excited to be participating in this activity and appeared to enjoy the task. The most popular items photographed were the grass, play tunnel, flour and dough play tray, egg timer, keyworker and sand. Some children embraced the activity and took some very good photographs. This was evident by the children’s enthusiasm. Sometimes they reported what they were photographing.

The researcher met with the children and keyworker in the nursery setting the following morning to discuss their photographs. One child was absent for the feedback and despite a written invitation to the parent to meet at the beginning of term there was no response. Some of the children were eager to get back to their activities so their descriptions of their photographs and why they took those particular photographs were brief.

**ANALYSIS AND DISCUSSION**

Photographs were grouped by category and in order of popularity based on the number of photographs of each category. There were 12 photographs of the grass followed by 10 of the tunnel. This was carried out following discussions with the children to clarify why the photographs they took were important to them.

What was apparent was the grass was important to this group of children. It was unclear to the researcher whether the photographs of the grass were due to user error. In the discussion with the children it became apparent that the children had deliberately photographed the grass since it was important to them, therefore this was not user error. Similarities between this finding and that of Clark and Moss (2011), who describe a three-year-old child photographing a piece of wasteland/grassy area by a tree were observed.

On reflection the researcher realised that many children do not have access to grass apart from at the children’s centre or if they are taken to the park.

Gill (2008) asserts that environmental and social change in the UK, including decreasing local green spaces, the fragmentation of communities and increased car ownership, provides limited opportunities for children of all social classes to participate in outdoor play. Several playgrounds now use artificial surfaces rather than grass so this may be something for planners to consider in the future.
One child told the researcher he had tried to photograph the sun in the sky as it was a nice day. Friends were clearly important and some children commented that they preferred to see their friend happily playing with their chosen activity. The researcher had assumed the children were photographing the activity itself.

The tunnel was also popular with one child reporting that you can ‘hide in there or look through and see your friend or the keyworker on the other side’.

One of the girls said she ‘loved the grass and playing outside but also liked the play tunnel and sandpit’.

The other girls preferred the indoors, the kitchen and toys, such as puzzles.

Another boy clearly loved the tunnel – a place where he could have the egg timer all to himself. The researcher observed this boy in the play tunnel clearly very happy in his own private space. One of the other participants happened to take a photograph of this, which can be seen in the collage.

It seems children also like their private spaces. Research by Shortt and Warren (2012) demonstrated through visual methodology that private spaces were important to the people in their study. There was also evidence of small separated spaces around the sandpit and a fenced, contained space leading to the garden was popular with participants in the current study.

Children are fascinated by spaces that contain and envelop (Athey, 2007). Play tunnels are such places.

The children were clearly happy in their surroundings and demonstrated that friends, space, the outdoors and those who cared for them were important within the setting. In the current study with children the researcher felt it was important to hear their voices.

While children may not understand a lot about partnership working the researcher believes it is important to work in partnership with children just as it is with parents. To that end what is important to children as service users within the children’s centre contributes to the research.

**IMPACT ON PRACTICE**

Pascal and Bertram in Clark et al (2014) argue the importance of going beyond listening to children. Participation in empowering children as learners enables them to make choices express opinions and develop self-esteem (Clark et al, 2014). Pascal and Bertram (2009) also assert that listening well to children can help researchers understand children’s priorities, challenge assumptions and provide unexpected insights into how practice might be improved.

This small study demonstrates that young children can articulate what is important to them. The insights revealed can be used in planning activities and improving the environment for pre-school children. In this children’s centre the focus on outdoor activities continues as much as possible and recording the voice of the child is used by the nursery teachers.

**LIMITATIONS**

This study with five children was too small to be generalised beyond the study context. However, it has value in that it highlights that children are also service users and are capable of giving their opinions. The timing of the study at the end of term was not ideal. Note-taking was manageable with the group due to its small size and the supervision of the keyworker. Best practice would be to record the conversation as it happened; however, it felt intrusive at the time to do so.

**CONCLUSION**

The study demonstrates that young children are capable of providing useful information about their environment. Clark and Moss (2011) describe using tools that play to the strength of young children and are not reliant on the spoken word. Clark and Moss’s (2011) mosaic approach was the approach utilised in the current study, combining visual and discussion methods to form a living picture of the environment for pre-school children. In this children’s centre the focus on outdoor activities continues as much as possible and recording the voice of the child is used by the nursery teachers.

**REFERENCES**


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The Lullaby Trust is a charity that provides specialist support for bereaved families, promotes expert advice on safer baby sleep and raises awareness of Sudden Infant Death Syndrome (SIDS). We are delighted to be chosen as the CPHVA’s Charity of the Month. This coincides with our second Safer Sleep Week, which begins on 14 March and we hope CPHVA members will actively support.

Since we launched in 1971 as the Foundation for the Study of Infant Deaths (FSID), The Lullaby Trust has invested over £11.6 million in research and produced evidence-based advice for all parents. This has resulted in a dramatic drop in SIDS over the last 20 years.

We calculate that the active promotion of our advice, notably the ‘Back to Sleep’ campaign, has saved the lives of more than 20,000 babies.

However, SIDS is not a thing of the past. Five babies die each week in the UK for no obvious reason, leaving bereaved parents heartbroken and with no explanation why their baby died. Last year, the Office for National Statistics’ data showed that in 2013 the number of unexplained infant deaths increased for the first time in five years, from 270 to 290.

While the increase is a small one (from 0.32 deaths per 1,000 live births in 2012 to 0.36 in 2013), it is worrying, and shows how important it is to continue raising awareness of SIDS and the safer sleep practices that reduce the risk.

This year, our annual national awareness campaign, Safer Sleep Week, aims to address this troubling rise in SIDS cases, particularly among young parents who are four times more likely to lose their baby to SIDS, compared to mothers aged 20 and over.

We would greatly encourage members of the CPHVA to get involved with Safer Sleep Week 2016, to help us reach all parents across the country. To spread the word, members can order a Safer Sleep Week display pack containing our advice cards, a guide for parents, posters and other useful materials.

Why not organise a local Safer Sleep talk for your colleagues or simply send a tweet using the official hashtag #SaferSleepWeek? Thanks to CPHVA members, last year #SaferSleepWeek reached 1.2 million unique users on Twitter alone! We achieved this thanks to a live ‘ask the expert’ session hosted by the CPHVA, which prompted a lively discussion around guidance on dummy usage, co-sleeping and the importance of our Care of Next Infant (CONI) programme. This year we will take part in another ‘ask the expert’ session so keep an eye on the @LullabyTrust and @Unite_CPHVA Twitter accounts for more information.

There is one other way that CPHVA members can help The Lullaby Trust, which is to help us raise much-needed funds for our research programme and bereavement support services.

For more information please visit: www.lullabytrust.org.uk or contact our fundraising team on 020 7802 3201.

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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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- Percent should be written as %
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**ARTICLE CONTENT AND LENGTH**

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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  Papers should be between 2000 and 3500 words in length (including references), and are subject to double-blind peer review following submission. Papers should begin with an unstructured abstract of 150 to 200 words, and up to five key words or terms that reflect the article’s subject and focus accurately. Research articles should be arranged in the usual order of introduction, background, study aim/purpose, method including confirmation of ethical approval, results, discussion, implications and recommendations, conclusion, acknowledgments and references.

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

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  The content of first-person articles (700 words) and general features (1400 words) should be discussed with the editor prior to submission.

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For further details please visit www.iaim.org.uk. In-house trainings are available on request.

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