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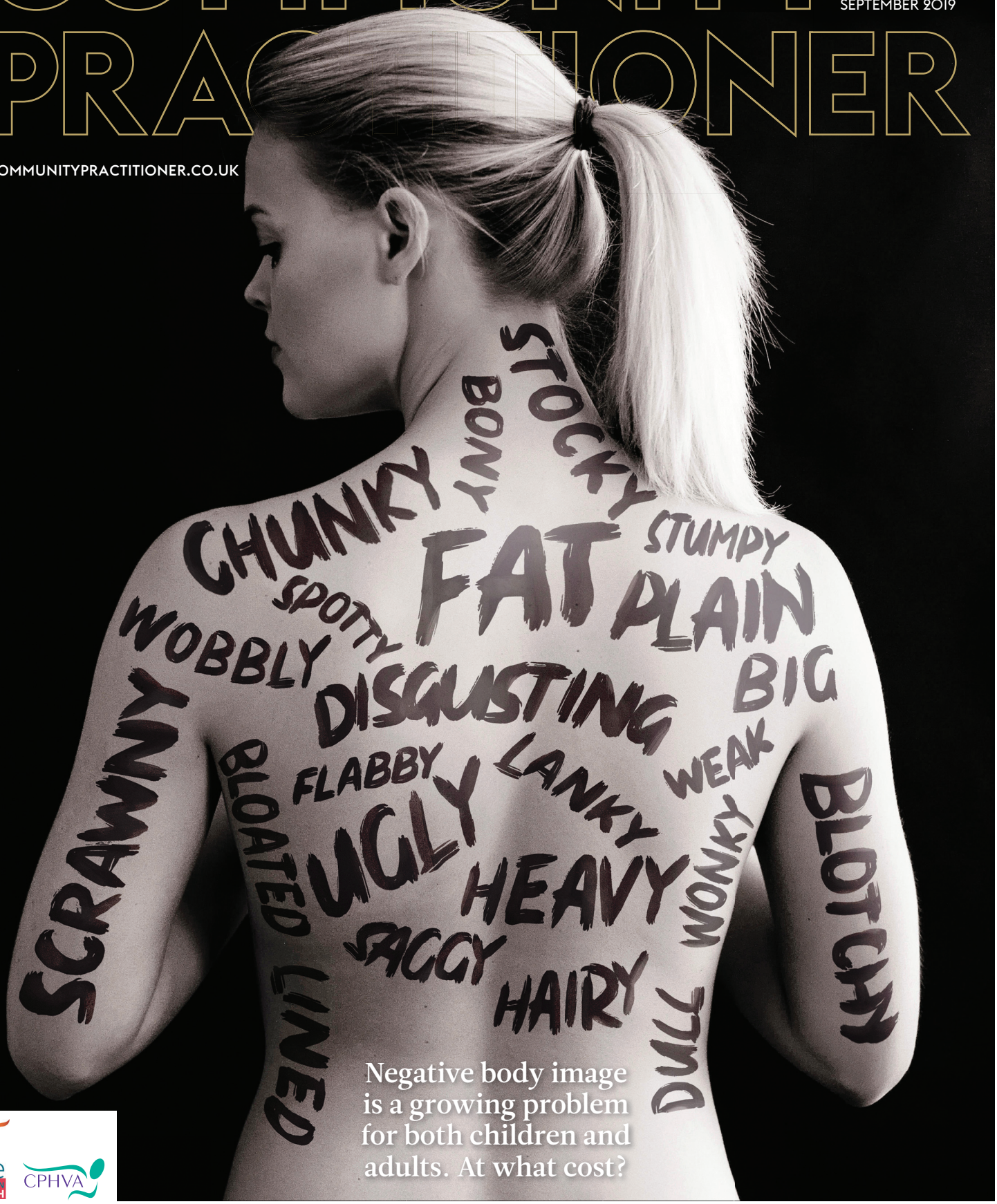

Negative body image is a growing problem for both children and adults. At what cost?

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FEATURES

RESEARCH

PROFESSIONAL PAUSE

WELCOME

from Aviva and Emma

If you've not long returned from your summer holiday, perhaps you're more aware of your body image than usual. Maybe you – or your family and friends – were one of the many gripped by ITV2's *Love Island* over the summer and gave more thought than usual to appearance and body shapes. Or maybe you or someone you know are part of a growing number of people in the UK who feel upset or ashamed by their body image. As explored in our cover story on page 32, the way we think and feel about our bodies can seriously impact wellbeing and mental health. Why is body image such an issue for so many of us, and how can CPs help?

Should you ever find yourself in practice, 'stuck' and not sure how to assist your clients, perhaps because of impossibly long waiting lists – what should you do? This situation is discussed on page 41. Let us know your thoughts, too.

In addition, discover all you need to know about this year's Unite-CPHVA Annual Professional Conference on page 30 and the invaluable benefits you can gain from attending (as well as the nitty-gritty of how to book).

In the meantime, one of this year's speakers shares his expertise on the latest *Health for all children* guidelines on page 48. We very much hope to see you at conference next month!

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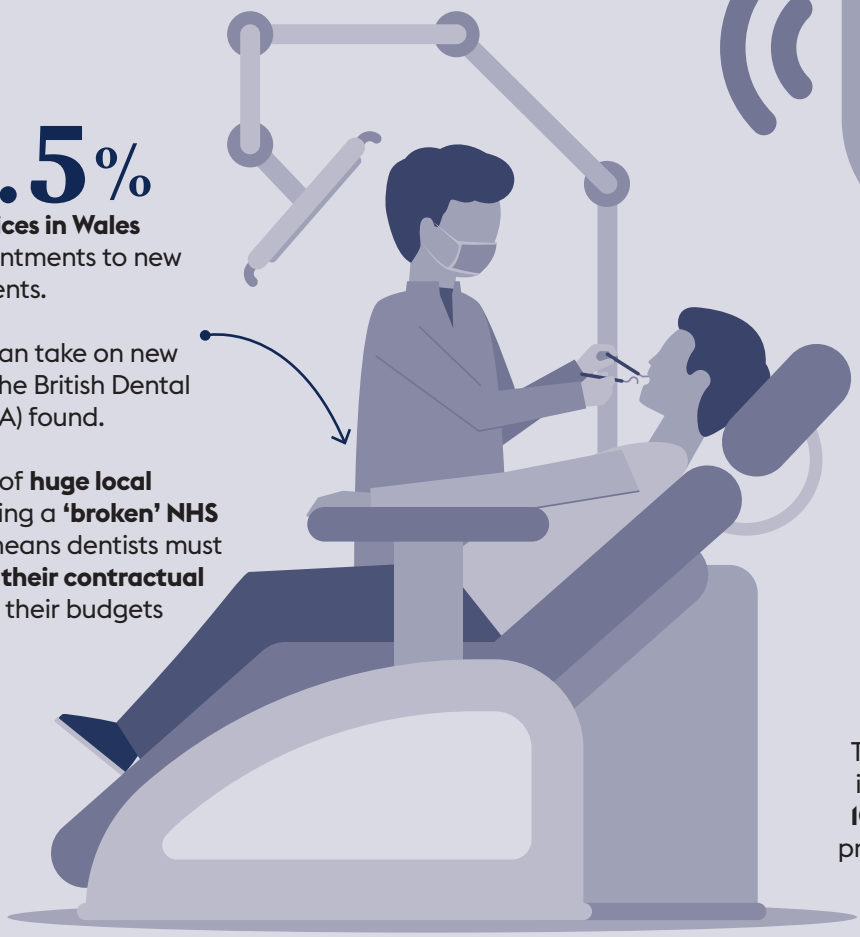
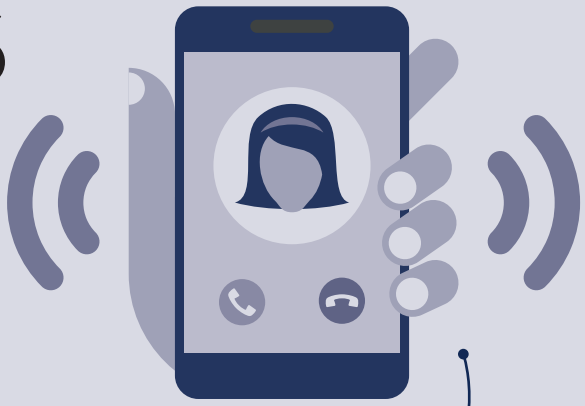
NEWS IN NUMBERS



Only **15.5%** of **dental practices in Wales** can offer appointments to new adult NHS patients.

And only **27%** can take on new child patients, the British Dental Association (BDA) found.

The BDA warns of **huge local variation**, blaming a **'broken' NHS contract** that means dentists must achieve **95% of their contractual target** or return their budgets



36%

The increase in calls to the **NSPCC FGM helpline** in **1 year**. The numbers rose from **476** in **2017-18** to **645** in **2018-19**

163

The number of **infant deaths** in Scotland in **2018** – **3.2 per 1000** infants – equalling the previous rate recorded in **2015**.

There were **190 stillbirths**, also an all-time low, at a rate of **3.7 per 1000**

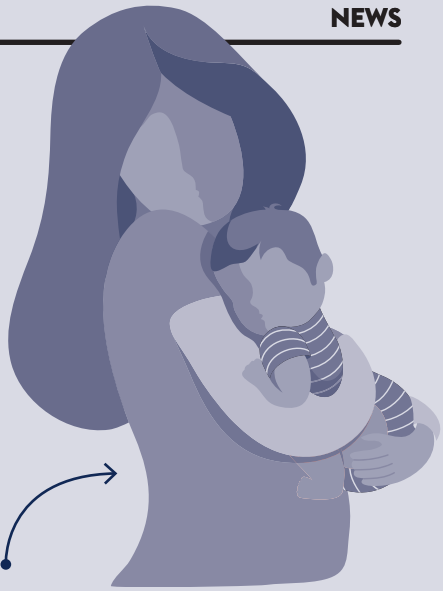
30.2

The number of **teen pregnancies** per **1000 women in Scotland** in 2017. The level has fallen for the **10th year in a row** and is now at its lowest level in **25 years**, down from **54.7 per 1000** in **1994**

3+

Teenagers who check social media more than **3 times a day** have **poorer mental health** than those who don't.

The study of **12,866 school children** found that **girls** who checked social media frequently had a **28%** increase in **anxiety** and **14%** decrease in **life satisfaction**



7000

The number of **young mothers and their newborns** who have received support from the **Family Nurse Partnership** in Scotland since its launch in **2010.**

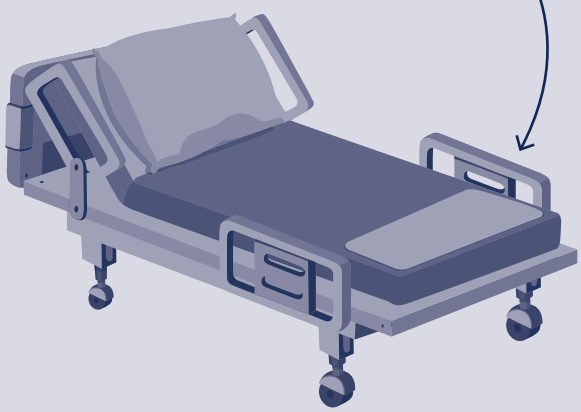
200 nurses across **11** health boards have delivered care to **82%** of eligible mothers

5830

The number of **hospital beds** available in Northern Ireland in **2018-19** – a drop of **3.4%** from the **6000** available in **2014-15**, according to the Department of Health

2–3x

The **daily rate of asthma consultations** in England was **3 times** higher for children aged **0 to 4**, and **2.5 times** higher for those aged **5 to 14** in the **back-to-school period in September** than at other times in the year



Find links to relevant reports and surveys highlighted in the news stories at **bit.ly/CP_news_in_numbers**

ISTOCK

PUBLIC HEALTH LATEST

KEY

Video

Report

Campaign

Poll

Website

Health programme

CHANGE4LIFE HIGHLIGHTS WELLBEING BOOST FROM EXERCISE

Change4Life, a campaign run by Public Health England (PHE), is highlighting the positive impact of exercise on wellbeing with the launch of Disney-inspired short bursts of activity.

A survey by Change4Life and Disney UK found that less than half of parents are aware that physical activity can build children's self-confidence (49%), reduce anxiety (47%) and improve their self-esteem (46%). Just 16% (one in six) think that physical activity can help children develop attributes which make it easier to cope with life's setbacks.

And the survey also found almost half of children think that they need to be 'fast' (49%) or 'strong' (41%) to be physically active and only a quarter see themselves as 'sporty'.

THE CAMPAIGN IS ENCOURAGING CHILDREN TO PLAY '10 MINUTE SHAKE UP' GAMES INSPIRED BY CHARACTERS FROM FILMS SUCH AS *TOY STORY 4*

The Change4Life campaign is encouraging children to play '10 Minute Shake Up' games inspired by favourite characters from films such as *Toy Story 4*, and has launched an online quiz to help them find activities and sports to suit them.

Eustace de Sousa, national lead for children, young people and families at PHE, said that children's physical activity levels were 'worryingly low'.

bit.ly/ENG_disney_PHE

HPV VACCINATION OF BOYS TO START

Boys in England are being offered the human papilloma virus (HPV) vaccine for the first time as research shows it could prevent more than 100,000 cancers by 2058.

Modelling by the University of Warwick estimates that by 2058 in the UK the HPV vaccine now being used may have prevented up to 64,138 HPV-related cervical cancers and 49,649 other HPV-related cancers.

As the HPV vaccine extension to boys in Year 8 in England is rolled out this September, Public Health England (PHE) shared evidence of the potential impact of the vaccine, which has been offered to girls since 2008.

PHE head of immunisation Dr Mary Ramsay said: 'This programme offers us the opportunity to make HPV-related diseases a thing of the past and build on the success of the girls' programme. Offering the vaccine to boys will not only protect them but will also prevent more cases in girls and reduce cancers in both men and women in the future.'

bit.ly/ENG_HPV_boys

GETTY / ISTOCK / SCIENCE PHOTO LIBRARY

INFANT MORTALITY RATES RISE FOR THIRD YEAR RUNNING IN ENGLAND AND WALES

The infant mortality rate increased to 3.9 deaths per 1000 live births in 2017 compared with 3.8 in 2016

Figures from the Office for National Statistics show infant mortality rates in England and Wales have risen for the third year running.

The report, covering 2017, says 'the infant mortality rate increased to 3.9 deaths per 1000 live births compared with 3.8 in 2016'.

Following steady improvement, the rate had been 3.6 deaths per 1000 in 2014, but then began to rise.

And in the most deprived areas of England, babies were almost twice as likely to die within the first year of life (5.2 deaths per 1000 live births) than those in the least deprived areas (2.7 deaths per 1000 live births).

Reacting to the figures, Professor Russell Viner, president of the Royal College of Paediatrics and Child Health, urged the government to 'take immediate steps to tackle social inequality and improve maternal and early years care', including 'reducing maternal deprivation and providing properly funded supportive services'.

He also called for 'a reversal of the cuts to public health budgets which have slashed health visitor numbers'.

bit.ly/ENGWAL_infant_mortality

GOVERNMENT TARGETS CHILD WEIGHT-MANAGEMENT INEQUALITY WITH £1.7M BOOST FOR HEALTH BOARDS

The Scottish Government is giving £1.7m to health boards as part of its push to reduce the number of overweight under-18s by half by 2030.

The money will go towards ensuring equal access to weight-management services across the country, in an attempt to tackle growing inequality in children's obesity levels between the wealthiest and poorest areas.

Scotland's public health minister Joe FitzPatrick said weight-management services would be a vital component of action to prevent and reduce childhood obesity, adding: 'We want children and families to have access to the appropriate support, no matter where they live.'

The investment follows the publication by NHS Health Scotland of standards for weight-management services for under-18s.

Senior health improvement officer at NHS Health Scotland Suzanne Connolly said the standards were 'designed to ensure all children and young people will receive the same weight-management support'.

bit.ly/SCT_obesity_funding

PREGNANT WOMEN URGED TO GET PERTUSSIS IMMUNISATION

Northern Ireland's Public Health Agency (PHA) has reminded pregnant women to get the whooping cough vaccine, with the latest figures revealing a rise in cases this year.

Up to 19 June this year, 44 confirmed cases of whooping cough were reported to the PHA, of which just over one-fifth were in infants aged under six months – too young to be protected by their routine childhood immunisations. During the equivalent period last year, there were just 16 cases.

Dr Jillian Johnston, PHA consultant in health protection, said: 'Whooping cough continues to circulate in Northern Ireland, and every three to four years it is normal to see increased activity.'

But she added that it was 'really important that women receive the pertussis vaccine during every pregnancy, so that their baby is protected against whooping cough in their first months of life'.

The best time to get the vaccine is between 16 and 32 weeks of pregnancy.

bit.ly/NI_pertussis_jab

PROFESSIONAL UPDATE

‘We want to see all frontline services become more informed and responsive to trauma’

NHS ADDRESSES ITS WORKFORCE ISSUES WITH INTERIM PLAN

The NHS must become a better place to work, according to the new *Interim NHS people plan*, which sets out actions to tackle workforce challenges.

It recommends NHS organisations pay greater attention to why staff leave the NHS, take action to retain existing staff and attract more people, as well as set out plans to make the NHS the best place to work.

Other themes include improving leadership culture and developing a workforce to offer 21st-century care.

The plan also prioritises action on nursing shortages, including commitments to boost nursing placements by 5700, working with the website Mumsnet on a ‘Return to the NHS’ campaign, and better coordination of overseas recruitment.

Chair of NHS Improvement Dido Harding said action had started, with NHS trusts identifying more than 5500 extra clinical placements for undergraduate nurses.

bit.ly/ENG_NHS_workplace

WELSH LEGISLATION FOCUSES ON QUALITY OF HEALTH AND SOCIAL CARE

A health and social care bill that would introduce an ‘organisational duty of candour’ to encourage openness and transparency in NHS organisations has been introduced to the National Assembly for Wales.

The Health and Social Care (Quality and Engagement) (Wales) Bill embeds a system-wide approach to improving quality and public engagement in health and social care.

The bill will help NHS organisations be open with patients and service users when things go wrong. It places a duty on Welsh ministers to consider if any decision secures improvement in quality and outcomes, and gives them the chance to appoint a vice-chair on NHS trust boards if necessary.

The bill will also see the creation of an independent ‘citizen voice’ body to replace community health councils.

If passed, the bill will become law next summer.

bit.ly/WAL_quality_health

STAFF TO RECEIVE PSYCHOLOGICAL TRAUMA TRAINING

More than 5000 workers are to be trained in recognising and dealing with psychological trauma, in a UK first.

The Scottish Psychological Trauma Training Plan announced by the Scottish Government will benefit staff including nurses, police and social workers.

Scotland’s cabinet secretary for health Jeane Freeman said abuse, neglect and other trauma ‘can have a devastating and long-lasting impact upon people’s lives’.

She added: ‘We want to see all frontline services become more informed and responsive to trauma – our plan looks to equip workers with the training to support people affected.’

The plan, developed by NHS Education for Scotland, follows the Scottish Government’s £1.35m National Trauma Training Programme, established last year.

bit.ly/SCT_trauma_training

ISTOCK / SHUTTERSTOCK

Applications to study nursing in England have increased

4%

from last year

STUDENT NURSING APPLICATIONS STILL DOWN IN ENGLAND

Student nursing applications in England are still 29% lower than three years ago before the removal of the bursary, the latest figures show.

Applications in England have increased 4% from last year, but remain down by more than 15,000 since the bursary was axed.

Figures from the Universities and Colleges Admissions Service show 36,810 signed up for a nursing degree in England by the June 2019 deadline, up from 35,260 in 2018. However, this remains far lower than the 51,840 signing up in 2016, the last year before the bursary was removed. The removal hit mature students the hardest.

In Wales, the student nursing bursary has been extended until 2021, while it has remained in Northern Ireland and Scotland. Scotland was the only nation to see applications increase between 2016 and 2019, with a rise of 10%.

bit.ly/ENG_nursing_overview

NEW PUBLIC HEALTH DUTY TO TACKLE SERIOUS VIOLENCE

Public bodies such as NHS trusts and schools are to be bound by a new legal duty to prevent and tackle serious violence.

The 'public health duty' will cover the police, local councils, local health bodies such as NHS trusts, education representatives and youth offending services in an attempt to improve collaborative working and intelligence-sharing, to tackle the root causes of serious violence including knife crime.

When the plans were first announced, then prime minister Theresa May made assurances that the duty will 'hold organisations to account as opposed to individual teachers, nurses or other frontline professionals'.

Home secretary Sajid Javid said: 'I'm confident that a public health approach and a legal requirement that make public agencies work together will create real long-term change.'

bit.ly/ENG_public_health_duty

WALES EXTENDS BURSARIES FOR ANOTHER YEAR

The NHS Wales bursary scheme has been extended for another year, and will be in place for students starting their courses in the 2020-21 academic year.

The bursary for eligible student nurses, midwives and allied health professionals will continue to be available for those who train in Wales and commit to working there for up to two years after qualifying, it has been confirmed.

Health minister Vaughan Gething said: 'We are committed to investing in the training of skilled professionals working in our NHS. By extending this support package, I want to demonstrate how much we value our healthcare workforce.

'We're also taking action to attract more health professionals from other parts of the UK and beyond through our This is Wales – Train, Work, Live marketing campaign, which sets out what Wales has to offer.'

bit.ly/WAL_bursary_extension

GLOBAL RESEARCH

▶ For more information on these studies, visit the **bit.ly** links

CANADA

ENERGETIC PLAY IN EARLY CHILDHOOD CAN KEEP HEART HEALTHY IN LATER LIFE

Physical activity in children as young as three can prevent early risk indicators that lead to adult heart disease, research has found.

Scientists at McMaster University followed the activity levels of more than 400 three- to five-year-olds over three years and measured key markers of heart health: cardiovascular fitness, arterial stiffness and blood pressure.

The findings, which appeared in *Pediatrics,* also showed more intense activity was more beneficial.

Professor Brian Timmons, who supervised the research, said: 'Children benefit the most from energetic play, which means getting out of breath by playing games such as tag. And the more, the better.'

▶ **bit.ly/P_active_childhood**

ENGLAND

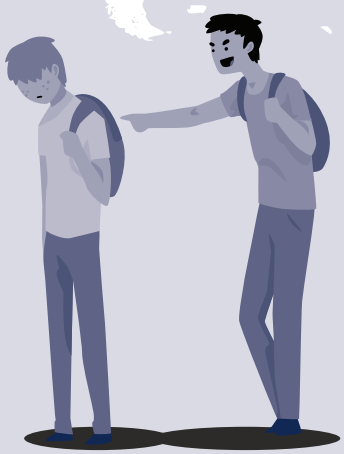
BULLIED CHILDREN ARE AT GREATER RISK OF DEPRESSION

A mix of genetic and environmental factors could put some people at greater risk of depression if they are bullied as children, says a study in *JAMA Network Open.*

Researchers from the University of Bristol, using information from 3525 teenagers who are part of Bristol's Children of the 90s study, looked at the factors that influenced depression in 10- to 24-year-olds. They found that childhood bullying was strongly associated with trajectories of depression that rise at an early age. Children who continued to show high depression into adulthood were also more likely to have genetic liability for depression and a mother with postnatal depression.

University of Bristol PhD student Alex Kwong said: 'It's important that we know if some children are more at risk of depression long after any childhood bullying has occurred.'

▶ **bit.ly/JAMA_child_depression**



WALES

SCIENTISTS SPOT EATING DISORDER EARLY WARNING SIGNS

Researchers have found a series of early warning signs that could herald the development of an eating disorder.

People with an eating disorder had higher rates of conditions such as personality disorders, alcohol issues or depression, and higher incidence of self-harm in the two years before their diagnosis.

Researchers from Swansea University analysed the health records of more than 15,500 people diagnosed as having eating disorders between 1990 and 2017. The results were published in *The British Journal of Psychiatry.*

The authors conclude that looking out for one or a combination of these factors could help GPs pick up eating disorders early.

▶ **bit.ly/BJP_eating_disorders**

ENGLAND

BMI IS HIGHER IN CHILDREN OF SEPARATED PARENTS

The body mass index (BMI) of children who have separated parents is significantly higher than that of children whose families have stayed intact.

There proved to be an especially strong association if the parents' divorce occurs before the children reach the age of six. The results, published in *Demography*, also showed that the effect of separation on a child's BMI tends to increase with time since separation.

Researchers from the London School of Economics (LSE) used data from the UK Millennium Cohort Study of more than 7500 children.

Dr Berkay Özcan, associate professor in LSE's Department of Social Policy, said: 'We show that the family context is crucially important for children's health, and we need policies that support children and families that are undergoing a break-up.'

▸ **bit.ly/D_weight_of_divorce**

FINLAND

COUNTRYSIDE CHILDREN HAVE BETTER MOTOR SKILLS THAN THOSE IN TOWNS

Children living in the country spend more time outdoors and have better motor skills than those in towns, says a study of almost 1000 three- to seven-year-olds published in the *International Journal of Environmental Research and Public Health*.

Researchers from the University of Jyväskylä found that children took the opportunity to play outdoors when they had more space or larger gardens, giving them more ability than their peers in metropolitan areas to challenge themselves, practise more frequently, and improve motor skills.

Donna Niemistö from the Faculty of Sport and Health Sciences at the university concluded: 'When planning the environment, one should take into consideration the safety, versatility and independency of the child's opportunity to move around in an age-appropriate way.'

▸ **bit.ly/IJERPH_motor_skills**

DENMARK

BABIES BORN TO POORLY EDUCATED WOMEN ARE MORE LIKELY TO DIE WITHIN THE FIRST YEAR

A study shows that women with less than nine years of education, or no education, have an increased risk of their child dying during the first year, with premature birth and low fetal weight explaining 55% to 60% of cases.

In Denmark, four out of every 1000 newborns die before reaching their first birthday, and socioeconomic inequality in infant mortality remains.

The findings, from researchers at Aarhus University in Denmark and published in *PLoS Medicine*, were based on a study of almost two million children born in Denmark between 1981 and 2015.

Co-author Yongfu Yu said: 'Even in a welfare society like Denmark, pregnant women with short-term education need more resources to address social challenges in order to improve the health of infants in general and reduce child mortality in particular.'

▸ **bit.ly/PM_infant_mortality**

ISTOCK

BIG STORY

THE HIDDEN HELPERS

As a report highlights how the needs of black, Asian and minority ethnic young carers are going unmet, journalist ***Juliette Astrup*** explores the issues facing this marginalised group within a group.

'I get myself and Dev up. Then we come down and give Mum and Dad their medication, check they are okay and we get breakfast and Dev ready for school. I walk Dev to school. I come home then and make breakfast for Mum and Dad and I look at any bills or other household things, then I wash up or do any washing or cleaning and do the other chores like shopping. If I have any time, I try and revise for a bit.

'I'd not heard of being a young carer. That is what is expected for Indian families.'

This is the voice of Neha Lathia, aged 19, who lives in Leicester and cares for her unwell parents and her two siblings, aged 14 and 10 (Barnardo's, 2019a).

A hidden army of children and young people are caring for sick and disabled relatives in homes up and down the UK. Children as young as five are taking on caring responsibilities, and one in 12 young carers in England is caring for more than 15 hours per week (Children's Society, 2013). Tasks range from cooking, cleaning and caring for siblings, to providing nursing care and emotional support.

WHO HELPS THE HELPERS?

While many feel proud of what they do (Carers Trust, 2015), caring responsibilities have an adverse impact on carers' health, future employment opportunities and social lives (ONS, 2013). Around one in 20 young carers in England missed school because of caring responsibilities, and young carers were less likely than the national average to be in

education, employment or training (Children's Society, 2013). Research in Scotland also found young carers were more at risk in terms of their mental health and wellbeing (Watt et al, 2017).

Yet despite all this, most are not receiving the support they need. A study of young carers in England reported nearly two-thirds (64%) were receiving no support, formal or informal (Department for Education, 2017).

Within this vulnerable group, black, Asian and minority ethnic (BAME) young carers fare even worse. They are likely to encounter the same barriers to access and engagement with services as their white counterparts, but compounded by racism, bullying, language barriers and a lack of understanding of the availability and nature of provision (Children's Society, 2016).

This is especially worrying given that young carers are also 1.5 times more likely to come from these communities, and twice as likely not to have English as their first language (Children's Society, 2013).

Furthermore, a report published earlier this year by Barnardo's – *Caring alone* – found that BAME young carers are more likely to be isolated from support services (Barnardo's, 2019b).

HIDDEN ISSUES

This report highlights a number of issues, says its author Emma James, senior policy and research officer for Barnardo's: 'Often these families simply don't know that the support is out there, or the term "young carer" is not something they are familiar with. Children and young people caring for older relatives is something expected within many communities, and the adverse effects on the young carer are not always realised.

'And there are a lot of issues with children interpreting sensitive information within medical appointments; a lot of families don't realise they are entitled to an interpreter.'

Asking for assistance is also an issue. 'There is a real fear in most of these communities of getting agencies involved and asking for help, and a stigma around issues such as mental health and autism.'

Vera Beining, children's services manager at Action for Children's Hackney Young Carers project – where at least 90% of the families are from BAME communities – knows the issues well.

'We worked with an Asian family where neither of the parents spoke English, both were elderly and disabled, and the 16-year-old daughter did absolutely everything in that home. They were worried that she wouldn't be there to help any more. We had to do quite a few home visits before they'd even consider allowing their daughter to have any kind of support from the project – we had to prove ourselves to them, to build a relationship.'

She adds: 'Practitioners really need to be persistent, and give people lots of opportunities to disclose – don't expect that if you ask them if their child is a young carer they'll say yes.

'And you can't assume that because a family is from a certain community the issues will be the same – there will be very specific barriers each family is facing and you need a tailor-made way of engaging with that family and that child.'

IMPROVING SUPPORT

Helen Leadbitter, national young carers lead at The Children's Society, says that Barnardo's findings reflect their own. 'We know it can be hard for young carers to identify themselves as carers and ask for help, particularly hidden groups such as those from BAME communities. Boys are less likely to ask for help, and young carers who care for their fathers too. Those young people affected by all those different issues can be particularly hidden.

Helen says: 'Health professionals are ideally placed to identify young carers. One thing to bear in mind when you are supporting a young person with their own health needs or mental health needs is to ask if there is anyone in their family affected by ill health and disability.'

The Barnardo's *Caring alone* report sets out nine recommendations, including access to a translator for all patients who don't speak English. It has also called for the NHS to work with BAME communities

HOW MANY YOUNG CARERS?

While census figures are thought to vastly underestimate the true number, they show:

177,918
young carers aged 5 to 17 in England and Wales in 2011

8480
carers aged under 18 in Northern Ireland – 820 of whom care for 50 hours or more a week

37,393
people aged 4 to 24 identified in Scotland as young carers

However there could be as many as

800,000
secondary school age children caring for sick and disabled relatives in England alone, according to research from the University of Nottingham

Northern Ireland Assembly, 2018; University of Nottingham, 2018; Scottish Government, 2017; ONS, 2013

ISTOCK

Young carers are

1.5 times

more likely than their peers to be from BAME communities

Children's Society, 2013

to reduce stigma around mental illness, special needs and disability and improve access to services, and for NHS services to employ community outreach workers to improve understanding and relationships in BAME communities.

'It is down to professional agencies to ensure they are getting into these communities and raising awareness of what a young carer is, the impact it can have on a child, the support and the services out there for them,' adds Emma.

'It means overcoming the language barrier and ensuring websites and materials are translated, and recognising cultural issues, such as by organising groups on days when the children don't need to go to mosque, or ensuring the food is halal. Getting in touch with religious leaders in communities and sharing that information can also help reduce stigma.'

And while the Barnardo's report is focused on England, its findings are applicable around the UK, says Emma. 'The demographics are different, but the issues and the recommendations are the same across the board.'

HOW YOU CAN HELP

When it comes to identifying young carers, community practitioners could have a 'crucial role to play', says Emma. 'These are the people that are in the communities, in the schools, in the family homes, and see these young people and the family situations first hand.

'Any practitioner can make a referral, and services will then make an assessment of what the families need. They can provide family support, one-to-one support, peer groups and respite, and can liaise with schools and other agencies. There is a lot that can be done. Just to realise that there are other children in the same situation, and that there is more to their lives than being a carer really makes a huge difference.'

For health visitors specifically, Emma says: 'If an HV sees a mother who is disabled or has mental health or substance addiction issues, think about children in the home, and what they are doing within that family.'

School nurses are, she says, 'in a prime position to support young carers. They could be proactive about awareness-raising, organising groups for young carers, or facilitating the introduction of young carers cards, which young carers can show to teachers when they are tired or feeling stressed with what's going on at home.'

Helen from The Children's Society adds: 'Early intervention for young carers is key. That is the best way to reduce the impact on their mental health and wellbeing.'

THE BIGGEST BARRIER?

While the detrimental impact of caring on a young person is understood, and the need to reach out to young carers, particularly those from BAME communities, is clear, perhaps the biggest barrier they're facing is not stigma, or even lack of awareness, but the current financial climate. Austerity and cuts have compounded the issues, creating more young carers, says Emma: 'The government is more aware, local authorities are more aware, but until there is more investment this situation will continue.'

This concern is reflected in the first recommendation in *Caring alone* - that the NHS long-term plan needs to 'allocate more resources and go much further in its proposals for improving support for young carers'.

'There is a lot more work to be done with these communities – we are seeing the tip of the iceberg,' agrees Vera. 'But as the Barnardo's report says, it's not enough to focus on identification, we need the resources to make meaningful interventions and offer meaningful support to families.'

The Children's Society is backing calls for an additional £3bn for children's services to plug the 'funding gap'.

However, without proper investment, the danger is that this hidden army of young carers, especially those from BAME communities, will continue to soldier on alone.

RESOURCES

- Carers Trust offers resources and information for anyone who works with carers **professionals.carers.org**
- The Young Carers e-learning module provides resources and support for schools working with young carers **bit.ly/carers_learning**
- This insight document from Glasgow charity Iriss focuses on improving support for BAME carers in Scotland **bit.ly/SCT_BAME**
- The Engage toolkit aims to help practitioners support BAME carers and their families **bit.ly/toolkit_BAME**

For references, visit **bit.ly/CP_news_big_story**

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RIGHTS AT WORK

INDUSTRIAL ACTION WHAT YOU NEED TO KNOW

Colenzo Jarrett-Thorpe, Unite national officer for health, examines your right to take industrial action as health visitors go out on strike in Lincolnshire.

For the first time ever, health visitors are on strike. HVs in Lincolnshire have been on picket lines throughout the summer over their pay, de-skilling and the undermining of the profession.

We salute them for this brave step in defending their service and profession. It was not a rash decision, and came at the end of months of talks with Lincolnshire County Council.

As they too reach the end of their tether, others may decide to follow Lincolnshire's example. Here, we answer some commonly asked questions about strikes and industrial action.

What is industrial action?

Industrial action is usually split into two categories: strike action, which is any concerted stoppage of work; and action short of strike action such as 'go-slows' or 'working to rule'.

What is lawful industrial action?

In the UK, there is no positive right to strike. Industrial action organised by a trade union is lawful as long as a number of conditions are met:

- The action has to be about a trade dispute between the union and employers as defined by section 244 of the Trade Union and Labour Relations (Consolidation) Act 1992.
- The trade union must call a lawful ballot of all members of the union who they believe are part of the dispute. This means the trade union must ensure that members' details such as job role, location and contact information are up to date.
- The general secretary of the union must authorise the industrial action before it can lawfully take place.
- There are very strict rules about the information the union must give to the employer when giving notice of an industrial action ballot, providing the results of the ballot and calling for the industrial action to take place.

Am I breaking professional codes by taking industrial action?

No. In 2014, the NMC said: 'The code does not prevent nurses and midwives from taking part in lawful industrial action but we remind them of their duty to uphold their professional standards at all times. The code will continue to apply in the event of industrial action.'

Will an employer deduct my pay if I take industrial action?

An employer can deduct your pay for taking part in strike action, but the deduction cannot be more than one-fifth of your weekly pay. The union tries to ameliorate the effect of a deduction of pay for strike action by offering strike pay of up to £50 per day, each day of strike action.

Do I have to be a Unite-CPHVA member to take industrial action?

Yes, lawful industrial action is organised by trade unions.

Will I be dismissed for industrial action?

It is illegal to dismiss someone who's taken part in any lawful industrial action within 12 weeks of the action.

Taking industrial action is always a last resort, but it is always an option should trade unions and employers enter into a dispute. It shows how serious the issues are, and that members are united to bring about the best results from collective bargaining.

FURTHER INFORMATION

Contact us at **cphva@unitetheunion.org** if you have any queries on industrial action – or visit the following links:

- Government advice on taking part in industrial action **gov.uk/industrial-action-strikes**
- TUC workplace guidance **tuc.org.uk/workplace-guidance/industrial-action**
- Thompsons Solicitors on the Trade Union Act 2016 **bit.ly/Thompsons_industrial_action**

FEEDBACK

YOUR THOUGHTS

It's time to get nominating for the CPHVA Executive Committee, and as always don't forget to send in your thoughts on the journal.

ELECTION TIME

The CPHVA Executive Committee elections opened on 17 July in order for the newly elected Executive Committee to start its work in December 2019.

The CPHVA seeks to elect a new Executive Committee with member representation from the 12 CPHVA Executive Committee constituencies.

Each constituency will be analogous with Unite the Union regions and nations.

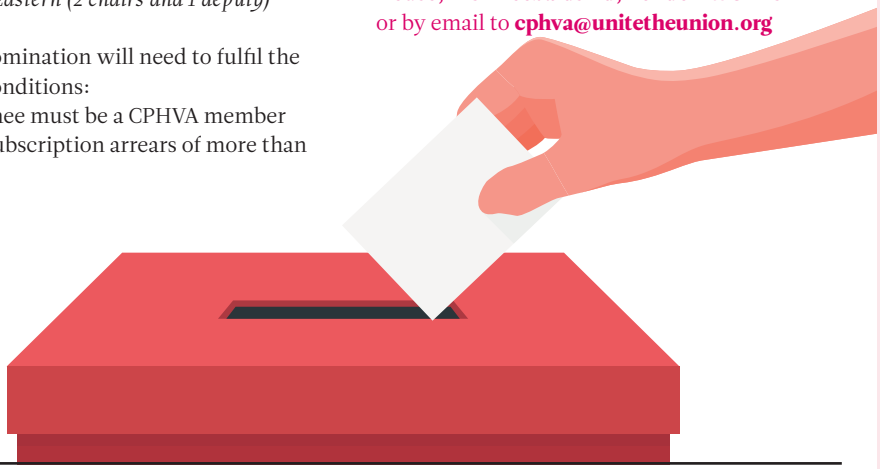
The elections will be for a chair and deputy for each constituency as described below:

Northern Ireland
East Midlands
Scotland
West Midlands
Wales
South West
North East, Yorkshire and Humberside (2 chairs and 1 deputy)
South East
North West
London and Eastern (2 chairs and 1 deputy)

A valid nomination will need to fulfil the following conditions:

- The nominee must be a CPHVA member without subscription arrears of more than 13 weeks.
- They must be proposed and seconded by two CPHVA members without subscription arrears of more than 13 weeks from two different employers from a different branch of the constituency the nominee seeks to represent and a different employer to the nominee.
- The nominee should indicate which one of the 12 constituencies they seek to be elected to.
- The nominee must complete all sections of the nomination form, including the personal statement (500 words maximum). The statement will be published in the October 2019 issue of *Community Practitioner* should it be necessary to hold an election.
- All nominees must be employed in order to be a representative of working people.

Completed nomination forms (if you haven't received one, please email Irene below) should be returned by **23:59 on Monday 9 September 2019** to **Irene Fynch, Unite in Health, Unite House, 128 Theobalds Rd, London WC1X 8TN** or by email to **cphva@unitetheunion.org**



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To give any feedback on the journal, or to talk about your work projects or achievements, email **aviva@communitypractitioner.co.uk**, tweet us **@CommPrac**, or reach us on **facebook.com/CommPrac**

Dear Community Practitioner Editorial Team...

Regarding: Why are they waiting? Community Practitioner, June 2019

First, many thanks for your recent coverage of tongue-tie.

Within the Association of Tongue-tie Practitioners (ATP) we understand the challenges for parents whose babies may be affected by tongue-tie, including their feeding issues and potential barriers in the recognition of the problem, and the importance of ongoing feeding support. We were pleased to read that you involved two of our members as contributors to your article, with the ATP listed as a reputable information resource.

Second, we recognise the paucity of recent tongue-tie studies: we feel that the 2014 study quoted is rather outdated, but that is because currently there is not enough up-to-date research. It's why the ATP is keen to investigate further.

One of the objectives of the ATP for the forthcoming year is to audit the current services, both NHS and private, to identify the current situation for mothers and their infants. It would therefore be very helpful if you could encourage your readers to actively participate and respond to our request for information on tongue-tie services.

We would also like to request that you will be receptive to printing our updated information in future.

Sarah Oakley, health visitor, ATP founding member, former ATP chair and current events coordinator

Lynn Timms, health visitor, ATP founding member and sales officer

Deb Wilson, current ATP chair

tongue-tie.org.uk
chair@tongue-tie.org.uk

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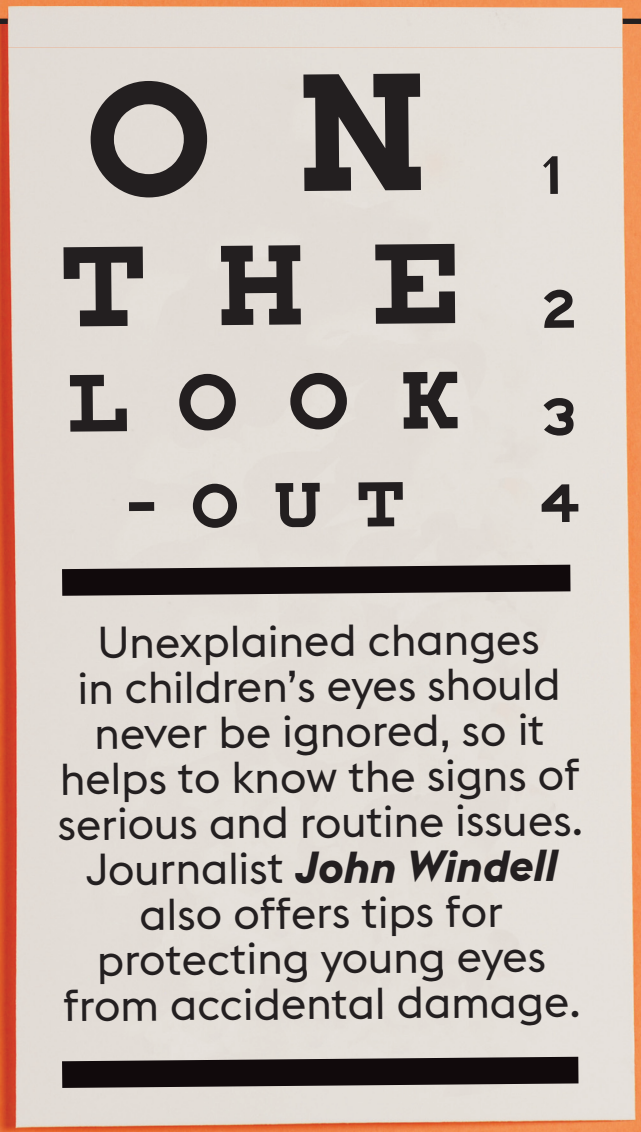


Unexplained changes in children's eyes should never be ignored, so it helps to know the signs of serious and routine issues. Journalist ***John Windell*** also offers tips for protecting young eyes from accidental damage.

The eyes are delicate and complex organs, so it comes as little surprise that parents often express worry about the healthy development of their children's eyesight. An online survey carried out earlier this year for UK charity the Childhood Eye Cancer Trust (CHECT) found that among just over 1000 parents – all of them with at least one child aged six or under – 26% feel their child's eye health is one of their greatest concerns, and 35% have asked their health visitor to check their child's eyes in the past year (CHECT, 2019).

Around 25,000 children under the age of 16 in the UK are blind or partially sighted, and half of them have other disabilities too (RNIB, 2018). In the context of a population of around 12 million under-16s (ONS, 2018), these severe cases are a small fraction. But alongside the dedicated care needed for these profoundly affected children, community practitioners should be vigilant for other – more minor but still worrying – issues that can affect a child's eyesight as they are growing up.

THE GROWING EYE

What does normal eye development look like? Newborns have trouble focusing or seeing colour until they are around six months old. Daniel Hardiman-McCartney, clinical adviser for the College of Optometrists, says: '[At six months] they should be able to see in three dimensions and to follow objects with ease.'

However, it's not always easy to spot problems with young babies. 'It can take children about three months to develop eye coordination,' says Melanie Hingorani, consultant ophthalmologist at Moorfields Eye Hospital in London. 'So they can see fine but a little bit of eye wandering is common. But if by six to eight weeks they don't seem to be looking at you, or making eye contact with mum and dad, if the eyes are wandering uncontrollably, you ought to get help. That's one of the things GPs look for at the six-week check.'

By the age of four, any issues with normal eyesight function should be clear. 'Most at this age are a little bit long-sighted, though it's not usually a problem,'

'IF BY SIX TO EIGHT WEEKS THE BABY DOESN'T SEEM TO BE LOOKING AT YOU, OR MAKING EYE CONTACT, YOU OUGHT TO GET HELP'

EARLY WARNING SIGNS FOR EYE PROBLEMS IN CHILDREN

Rubbing their eyes a lot (except when tired, which is normal)

Excessively watery eyes

Sitting close to the TV, holding books/objects close to their face

Clumsiness, poor hand/eye coordination

Blurred or double vision, or headaches that are unexplained

Screwing their eyes up, closing one eye when reading or watching TV

College of Optometrists, 2019a

SHUTTERSTOCK

COMMON CHILDHOOD EYE CONDITIONS

Short-sightedness (myopia)

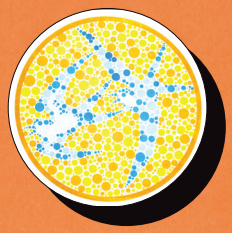
Difficulty seeing things far away, such as the TV or the board at school. Children whose parents are short-sighted are more at risk of developing the condition.

Long-sightedness (hyperopia)

Needing to work harder to focus close-up. A degree of long sight is normal in children, but they have strong focus so can still see well and often do not need glasses.

Astigmatism

The eye is shaped like a rugby ball rather than a football, making vision blurred or distorted. It is common, not serious, and is easily corrected with glasses or contact lenses.



Colour blindness (colour vision deficiency)

Around one in eight boys and one in 250 girls perceive colours differently and may confuse certain colours, such as red and green.

Lazy eye (amblyopia)

One eye that is weaker than the other. Glasses can correct the vision in the weaker eye, or a patch can be worn over the good eye to force the weaker eye to work.

Squint (strabismus)

The eyes look in different directions. Around 2% to 3% of children have a squint, which can run in families. Long-sighted children may squint without their glasses.

College of Optometrists, 2019b

says Daniel. 'But if there is any laziness in the eye or a squint, that will also be apparent.'

It's around the age of four and five that all children in England should be screened. The screening is normally run in schools by a specialist orthoptist, although in some cases it might be an optometrist or even a trained health visitor or school nurse. Testing does not look at long- or short-sightedness or colour vision problems. 'It is purely about pulling out children who clearly have a squint or lazy eye and need further investigation,' says Daniel. 'We think the majority of children are screened, but only just.'

'THERE IS SOMETHING ABOUT CHILDREN GOING OUTSIDE AND PLAYING A LOT THAT SEEMS TO PROTECT THEM AGAINST SHORT-SIGHTEDNESS'

All children in Scotland, Wales and Northern Ireland are also meant to be screened, though in practice it varies from area to area – only 60% of schools now supply eye tests (Vision Express, 2019).

STAYING VIGILANT WITH YOUNG EYES

Short-sightedness, or myopia, is most likely to appear in children between the ages of six and 13 and is increasingly common – it is twice as prevalent among UK children now than in the 1960s (McCullough et al, 2016). School children seem to struggle to focus in the classroom, and teachers and school nurses can be the first adults to notice.

HVs should also be on the lookout for more serious conditions, such as retinoblastoma, a rare form of cancer mainly affecting babies and children under five. 'The first thing parents notice is that one of the child's pupils looks white,' says Daniel. 'That's a red flag and requires an urgent referral to an optometrist or a GP' (see panel, right: *Checking for cancer*).

Other symptoms that may be warning signs of something serious include persistent headaches, double-vision and nausea. Melanie

A BRIGHT IDEA FOR SUNNY DAYS

There is evidence that children who spend time outdoors are less likely to be short-sighted (Tideman et al, 2018). But it's not just their skin that needs protecting from harmful UV radiation while enjoying the sun – children's eyes also need looking after. 'We don't recommend children should wear sunglasses all the time,' says Daniel Hardiman-McCartney, 'but if they are all day on the beach with a very high UV index, sunglasses will protect their eyes from UV light and from the glare and dazzle. If the glasses don't have a CE mark, don't buy them.'

ISTOCK / SCIENCE PHOTO LIBRARY

says that any abnormalities are a cause for concern. 'If anything makes you think it's not right, then it's always better to get it looked at.'

Can parents do anything to help the normal development of their children's eyesight? 'There is nothing specific except to let children run around and give them a healthy diet,' says Melanie. 'There is no evidence that screens damage the eyes or make children more short-sighted.'

Daniel agrees: 'Computers, phones and tablets are not directly harmful to the eye, All the same, our advice for children is the same as for adults – take regular breaks, every 20 minutes or so, to look away into the far distance and blink a few times. Children aren't very good at self-regulating, so parents have a role to play there.'

Both feel that the real problem with screens for children is that they aren't spending enough time outdoors. 'I think screens are harmful to the general health because they mean children are indoors and not running around [outside],' says Melanie. 'The only thing we can say with any certainty is that there is something about children going outside and playing a lot that seems to protect them against short-sightedness. Could it be because they are not looking at a lot of stuff close-up? That's the unanswered question.'

WHAT CAN HVs DO?

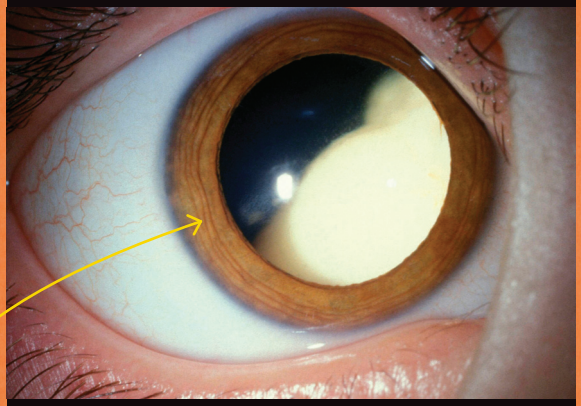
Health visitors have a key role to play in understanding not just the symptoms of eye problems but also the local protocols and what referrals to make. Daniel says: 'Normally, for all children over three that will be the local optometrist, while for those under three it may be hospital or a community service.' Speed is a factor, too. 'Act on those warning signs, because there is a critical period. Under the age of seven, the eye and the brain are still developing, so if we catch a problem like a squint or lazy eye we can correct it. But after that, the child may have the problem for the rest of their lives.'

Accidents and injuries also remain a threat that health visitors can show parents how to avoid. 'Here at Moorfields we still see a lot of incidents with children's eyes, particularly when they are toddlers,' says Melanie.

A persistent problem is laundry-liquid capsules, she says. 'Children see these squishy, coloured things, get their hands on them, squeeze them and they splat into their face. The chemicals can be damaging. Lock them away, out of reach.

'Also be wary of laser toys and laser pens. Small children can easily shine them in their own eyes and burn the retina. If you get a burn, it's completely irreversible. They look like toys, but don't trust them.'

CHECKING FOR CANCER



Retinoblastoma is a rare and aggressive form of eye cancer that affects babies and young children, mainly under the age of five (NHS, 2018). Around 50 to 60 cases are diagnosed a year in the UK (CHECT, 2018).

The main signs of retinoblastoma are:

- White glow in the pupil, or a white reflection in the pupil in flash photographs
- New squint
- Change in the colour of the iris
- Red or inflamed eye
- Deterioration in vision.

Patrick Tonks, chief executive of CHECT, says: *'Health visitors are a key source of information and support for parents of this age group, so we are asking them to take five minutes to familiarise themselves with the common signs and symptoms. Over 90% of children diagnosed with retinoblastoma will survive, but more than half will lose an eye in order to save their life, so urgent referral and early diagnosis is vital.'*

RESOURCES

- The College of Optometrists has a range of useful information about children's eyes at **college-optometrists.org**
- Consumer-focused help and advice from the College of Optometrists at **lookafteryoureyes.org**
- The Moorfields website has an area dedicated to children's eyesight at **moorfields.nhs.uk/childrens-eye-health**
- National Eye Health Week takes place from 23 to 29 September, promoting the importance of good eye health and regular eye tests for all
- Vision Matters is an industry-wide website that supports National Eye Health Week. Visit **visionmatters.org.uk**

For references, visit **bit.ly/CP_P_features**

PUTTING CHILDREN AT THE HEART OF POLICY

Sally Star explores the emergence of ground-breaking Welsh legislation and public health strategies on keeping the nation's children safe.

ISTOCK

In recent years, Welsh policy-makers have responded to the increasing child safeguarding concerns in Wales, including the highest-ever rates of children subject to child protection procedures, neglect, homicide, sexual offences and being looked after in care (NSPCC, 2016).

THE PICTURE IN WALES

Research into adverse childhood experiences (ACEs) by Public Health Wales (PHW) suggests that children who suffer physical or sexual abuse or are exposed to domestic violence, drug or alcohol abuse at home have a significant predisposition to risky health and social behaviours over their life course (PHW, 2015).

Throughout the past 15 years, Welsh poverty rates have routinely outstripped the rest of the UK, and proportionally there are more children living in deprivation than any other section of the population in Wales (Welsh Government (WG), 2014a). According to Public Health Network Cymru (2018): 'Childhood inequalities in physical, mental and emotional health are strongly associated with increased lifetime risk of poor physical and mental health.' Safeguarding children is most effective through promoting welfare and protecting from significant harm through systemic protective processes (NSPCC, 2018). Recent changes in Welsh legislation have put children at the heart of co-produced, sustainable policy-making through two recent ground-breaking acts: the Wellbeing of Future Generations (Wales) Act (WBFGA) (WG, 2015), and the Social Services and Wellbeing (Wales) Act (SSWBA) (WG, 2014b).

This article will explore the developmental methods used to create the acts and how the best interests of children are addressed by the public health agenda, whose aim is to work nationally across all sectors to 'achieve a thriving society and optimum health and wellbeing for the present and future generations' (PHW, 2016). Further investigation will outline common principles of wellbeing, prevention, people's involvement and partnership-working, which are fundamental to both acts, and the PHW strategies that impact on the practice of health visitors and school nurses.

POLICY DEVELOPMENT

The Welsh child-centric safeguarding and child protection legislative landscape has evolved during the last 15 years from primarily reactive referral responses to proactive outcome-focused

systems (Rowlands, 2011). Traditionally, policy changes are driven by tragic events. The death of Victoria Climbié led to the Laming inquiry (2003), which contributed to the revised 2004 Children Act. However, since 2014 the WG has significantly reformed its statutory guidance for public bodies. There is now greater advocacy of transparent, accessible, evidence-based practices and citizen participation with the embedding of the 2011 Rights of Children and Young Persons (Wales) Measure at the core of all practice (Children's Commissioner for Wales, 2017).

The SSWBA began through reviewing social services, using nationwide individual and organisational consultations (Welsh Assembly Government, 2011; Independent Commission on Social Services, 2010). These consultations drew on wider expertise than the relatively small Welsh legislation chamber with limited resources could usually muster, and highlighted changing demography and its associated opportunities and challenges (Kaehne and Taylor, 2016). The resulting SSWBA was the first policy passed since Welsh devolution in 2011, and it unified and simplified the many previous care-based regulations. However, recent consultation discovered that most young carers in Wales had little knowledge of the act and that it had made no difference to their lives (National Assembly for Wales, 2018). The scope and depth of engagements and lack of children's participation had affected the legislation's success.

Conversely, the WBFGA was founded on a population-wide longitudinal consultation exercise including children. It laid out children's happiness, health and connectivity to their community as the best indicators for quality of life (WG, 2015).

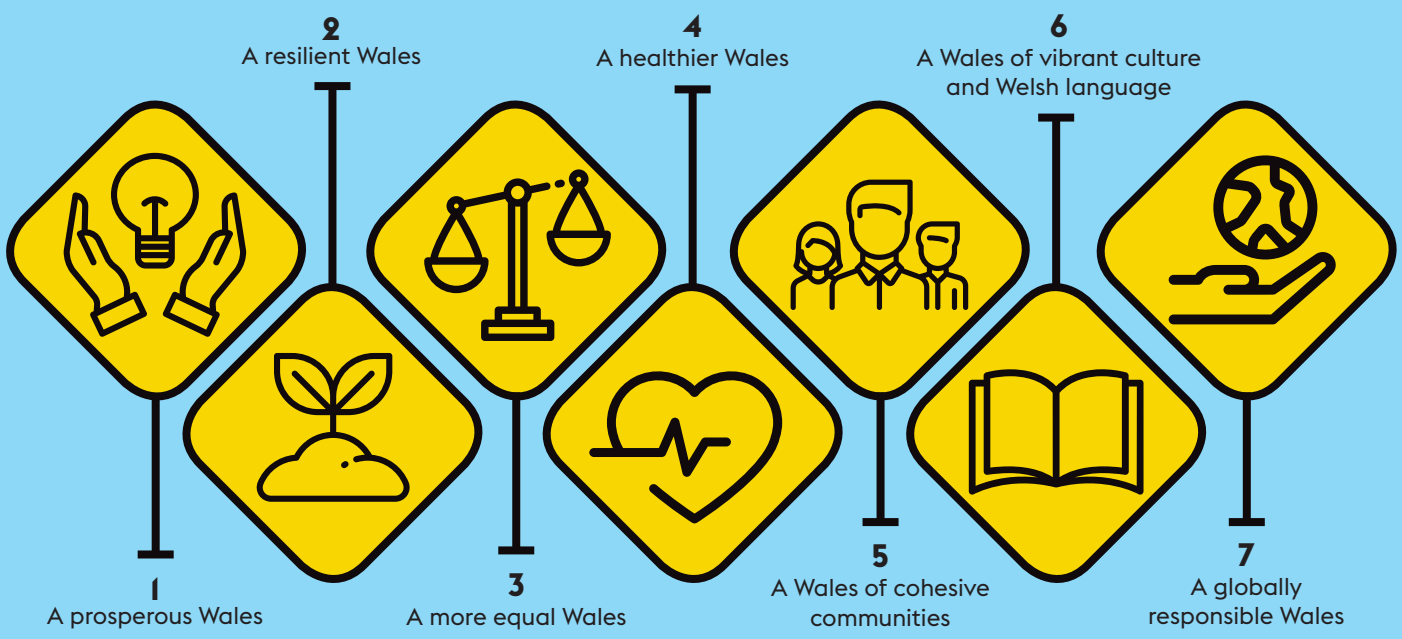
PHW underpins both pieces of legislation with a radical long-term strategy for health and wellbeing to achieve equitable, resilient communities (PHW, 2018). This strategy supports the evidence-based outcomes of 'prudent healthcare' principles (PHW, 2014), the Healthy Child (Wales) Programme (WG, 2016a) and used ACE studies, now recognised across many agencies as best practice (Social Care Wales, 2017). The SSWBA and WBFGA are indicative of shifts in political viewpoints from authoritarian protection – in which children are considered 'saplings' – to a nurturing 'caterpillar' approach, empowering individual wellbeing (Tomlin, 2018).

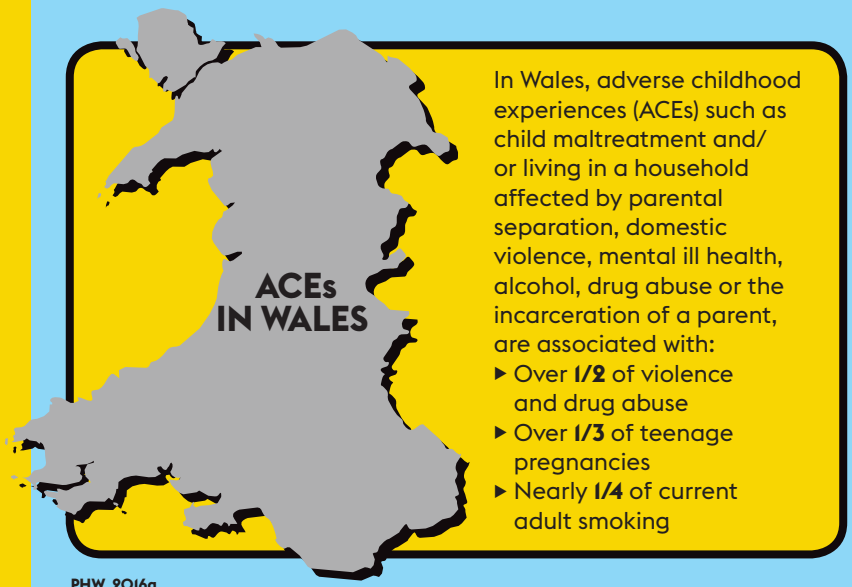
THE ACTS ARE INDICATIVE OF SHIFTS IN POLITICAL VIEWPOINTS FROM AUTHORITARIAN PROTECTION TO A NURTURING APPROACH

WHAT ABOUT WELLBEING?

Since 2004, the language surrounding child-centred legislation has evolved to increasingly include 'wellbeing', meaning 'physical, psychological, cognitive, social and economic' domains (Rowlands, 2011). The Marmot review of health inequalities (2010) stated that people from lower socioeconomic positions experience poorer health and life opportunities. Childhood poverty and deprivation have repercussions in adult life, and wider determinants of

SEVEN WELLBEING GOALS IN WALES





PHW, 2016a

health must be addressed at policy level (Modi, 2018).

With these two acts, the WG has taken the internationally unprecedented step to safeguard the best interests of children by measuring and monitoring wellbeing, familiar territory for health visitors and school nurses. The SSWBA emphasises individuals' accountability for health and resilience, alongside the shared responsibility of public bodies to provide appropriate services. The act strengthened child protection frameworks, emphasising professionals' duty to report any 'child at risk', replacing the old indistinct term of 'child in need'. Legislating safeguarding is the most powerful way to positively protect society and is evident through public body achievement of the seven WBFGA wellbeing goals (see *Seven wellbeing goals in Wales* on page 23).

Successive PHW wellbeing plans endorse children's 'best start' in life by directly tackling cross-generational causes of harm – violence, abuse, alcohol misuse – reducing exposure to ACEs and preventing early death (PHW, 2016a). ACE research used a random sample population between 18 and 69 years, which constituted only 0.06% of the Welsh population (PHW, 2015). Nevertheless, outcomes are reflective of the Welsh population as overall processes followed recognised international ACEs methodology (Ashton et al, 2016). Furthermore, PHW's holistic plans under the WBFGA acknowledge Wales's ground-breaking wellbeing contribution to the global Agenda for Sustainable Development (United Nations, 2015) to eradicate poverty and fight inequalities to protect and promote children's wellbeing worldwide.

THE VOICE OF THE CHILD HAS BEEN HIGHLIGHTED AS A MAJOR FACTOR IN KEEPING CHILDREN SAFE FROM ABUSE AND NEGLECT

EMBEDDING PREVENTION

Growing global and national fiscal difficulties are evident in the joint preventative ethos of the two acts, reflecting the period of austerity at their creation. The acts' prevention requirement is embedded into all services, particularly early years, to avoid expensive long-term and crisis situations (Edwards and Lloyd-Williams, 2016). The SSWBA stipulates that public bodies undertake an interagency population assessment of care, with children as a core theme. Social Care Wales (2017) found the assessments, along with ACE information, focused regional priorities and ensured that subsequent plans prevented long-term poor health and wellbeing.

The same organisations also conducted their WBFGA 'wellbeing assessment' to ascertain local population economic, environmental, cultural and social wellbeing. Successive inter-agency plans committed to 're-orientate the focus on the wider determinants of health and to challenge public sector partners to see their contribution to prevention, health improvement and health protection' (NHS Wales, 2016).

According to Kiran and Pinto (2016), this 'upstream' public health approach, which equitably tackles the social determinants of health, is most effective through direct engagement of Bronfenbrenner's (1979) ecological systems theory. Here, the individual can influence through the 'microsystem' proactive organisational 'macrosystem' governance. PHW partnership prevention structures are seen in their evidence-based sustainable health and wellbeing initiatives (PHW, 2016a) and dedication to the Healthy Child (Wales) Programme. They invest in early years (0 to seven) through progressive universalism, offering individual and population-level early interventions to promote lifelong wellbeing via co-production and collaboration.

INVOLVING PEOPLE

Unlike preceding didactic child protection legislation, the SSWBA recognises the value of participation from people to encourage inclusion, acceptance and adherence. The SSWBA enables approximately 700,000 children living in Wales to live healthily, happily and safely, inspiring reciprocal societal contribution (PHW, 2013). Gal (2017) suggests Bronfenbrenner's (1979) model aids professionals as gatekeepers to each ecological layer, encouraging innovative techniques to nurture characteristics and capture the voices of children. The Children and Young People's National Participation Standards confirm that 'children are active citizens with an important contribution to make to their families, schools, communities and nation' (WG, 2016b); reinforcing the WBFGA 'involvement' principle. The WBFGA supports

public bodies to view children as equal partners, benefiting their own physical and mental wellbeing. The voice of the child has been repeatedly highlighted in child protection reviews as a major factor in keeping children safe from abuse and neglect (Department for Education, 2016; Munro, 2011; Laming, 2003).

The first PHW (2017) National Safeguarding Team report of Welsh child practice reviews identified that professionals must advocate for non-verbal children and work in the best interests of those who lack capacity by ethically promoting their autonomy with beneficent actions. Since 2015, prioritisation of listening to children has been reflected in PHW's *Young person's annual quality statement* (2016b), derived from an interactive event for 13- to 22-year-olds. This engagement influenced PHW practices, including development of their wellbeing goals, 10-year strategy and website reviews. However, it is unclear how these young people were selected, and the views of younger children were not sought. This compromises article 12 of the United Nations Convention on the Rights of the Child (Unicef, 2018), which states that every child has a right to be heard.

Throughout the last 15 years, the rights of Welsh children have been promoted by the Children's Commissioner, providing a mechanism for independent feedback to policy-makers. Such practices strive to achieve Sherry Arnstein's 1969 idea of democratic participation via citizen control, rather than adult-manipulated agency-driven outcomes (Alderson, 2008). However, engagement is an expensive commodity that can become tokenistic under economic organisational priorities.

PARTNERSHIP-WORKING

The SSWBA and WBFGA significantly altered the footprint of partnership-working. These changes forged equal roles and responsibilities across multi-agency public body boards to deliver united wellbeing aspirations for the best interests of the Welsh population (Greenwell and Antebi, 2017).

The SSWBA requires cooperative focus on localised areas of high need, such as children with complex needs, disabilities and young carers (NHS Wales, 2016). The SSWBA also amalgamated the children's and adults' national independent safeguarding boards. These provide collaborative, protective governance including joint cross-sector professionals training, regular supervision and implementation of the All Wales Child Protection Procedures and additional protocols (WG, 2008). A child practice review found that this improved multi-agency communication and information-sharing, making safeguarding more efficient and effective (PHW, 2017). The WBFGA recommends collaboration and integration by partners to potentially reverse increasing child-specific safeguarding concerns. Furthermore, the Future Generations Commissioner for Wales (2018) upholds children's best interests by advising multi-agency boards on how to fulfil the WBFGA. PHW acknowledges a purposeful shared-system approach is vital to attain commitment to safe societies and sustainable wellbeing. Public body partnership-working also supports shrinking budgets; however, barriers include poor joint vision and differences in language, thresholds for concern and overall safeguarding agendas (Davies et al, 2016).

THE ACTS SHIFTED THE CARE-TAKING NARRATIVE TOWARDS A MORE LIBERAL APPROACH TO CHILDREN'S RIGHTS

CONCLUSION

Economic challenges, changing demography and exponential growth in children's safeguarding and child protection have been reflected in post-devolution Welsh legislation (Social Care Wales, 2017). By regulating children's wellbeing as a best-interest intervention, the WG has empowered collaborative, cross-sector solutions, enhancing partnership capacity, culture and quality of services.

The national safeguarding process strengthens autonomous health visitors' and school nurses' knowledge, skills and confidence. This results in individual resilience and workforces that strive to be cognisant and timely (PHW, 2017).

The two acts shifted the national care-taking narrative, traditionally centred around negative rights, towards a more liberal approach to positive children's rights. The legislation aims to reduce detrimental tokenistic child participation, ensuring optimum life-long resilience through equal partner status, and enabling trusted relationships with professionals to enhance communication and safety.

Sharing dialogue, responsibility and actions between individuals, professionals and decision-makers is fundamental to all PHW policies. This investment in early years pays dividends to the long-term public health agenda. These ground-breaking acts have identified Wales as a leader in holistic safeguarding legislation to nurture and protect the current generation and the next.

Sally Star is a SCPHN school nurse at the Hywel Dda University Health Board.

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For references, visit **bit.ly/CP_P_features**

PLUG IN – AND LEARN SOMETHING NEW

Podcasts are a brilliant bite-size way to deliver information to an audience. Health visitor ***Amy Dobson*** reveals how you can benefit from podcasting, as a listener or contributor.

I am a health visitor in practice in Warwick and together with Jenny Harmer, an HV friend, we run the *I am a health visitor* podcast. We are a free, evidence-based resource for HVs to use to help them keep on top of current studies, new guidance or professional issues. We do the background reading, then chat about it over a cup of tea so that you can listen in at a time convenient to you. We hope our episodes help inform your practice and share our learning, as well as celebrating everything about health visiting.

WHAT IS A PODCAST?

For the uninitiated, podcasts are audio files that can be downloaded, usually for free, to your phone or other digital device. You can listen to podcasts on any number of topics, all in an instant. There are lots of documentary and learning podcasts, as well as drama and comedy ones.

To listen while out and about, iPhones already have an app installed called Podcasts, or on other smartphones, you can download any free podcast app. You can then search for *I am a health visitor* and start listening for free straightaway. If you click 'subscribe', the episodes will automatically appear in the app every time we release one. There are also free online streaming services such as SoundCloud, where all you need to do is press play on your chosen podcast. There are other health podcasts, such as those from the *BMJ* and the Cochrane Library as well as BBC Radio 4's *Inside health*, *All in the mind* and *More or less: behind the stats*, which all release some relevant episodes for HVs. If in doubt, just search for your chosen podcast online.

OUR STORY

I am a health visitor started as an initial idea around two years ago. I was only six months into my first post as a newly qualified HV and feeling that I still had so much to learn. Part of that was finding a way to stay up to date with evidence, as evidence-based practice is of course a fundamental cornerstone of healthcare in today's NHS. In fact, in HV contracts, it is commonly mandated. It is fundamental to the work we do for good reason: parents don't come to us for opinions – they often have too many people sharing unsolicited personal advice on their parenting choices already. From us professionals they want and need advice based on the best scientific knowledge currently available.

However, being six months down the road from my SCPHN qualification, I was aware that my knowledge was already getting out of date. Research was being published all the time and I was struggling to stay on top of it. I started asking myself how I could ever manage a full caseload effectively and feel confident that the advice I was giving was current.

We feel it is unfair to expect overloaded HVs to independently scour the Cochrane Library at the weekends. Yet there is no fail-safe

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national mechanism for ensuring HVs are aware when a major change is made to policy or when an important piece of research is released (for instance: Hilton, Bedford, Calnan, Hunt, 2009). There is a piecemeal approach nationally to updating and training staff with different trusts taking different approaches.

In some areas, there are regular staff update days that include presentations from local specialist practitioners. Some trusts have team meetings with an evidence-based discussion section, while others rely on practice educators to update the staff. In my personal experience, these methods, while they can be effective, are often reliant on already overstretched staff making time for researching and digesting the evolving evidence base, in addition to their day-to-day workload.

WE ARE SO PROUD AND THRILLED THAT HVs ARE FINDING OUR EPISODES HELPFUL AND WOULD LOVE MORE TO JOIN US

Furthermore, I was becoming aware that so few people in my personal and professional life actually knew and understood my job role. The breadth of the issues we cover and the tailored care we offer means that no individual family could ever get a full picture of our service. In addition, the hidden nature of our work focusing on prevention and inequality can mean that the families we spend the most time with are often not the families with the loudest voices or highest profiles. As a result, vital work being done up and down the country can easily be lost or misunderstood. I found it was difficult to describe my role to people and slipped quickly into describing myself as a nurse and not giving the full picture. In the current climate, with public HV budget cuts in many areas of the UK, I feel our role needs to be fully understood and properly valued to protect the future of health visiting so we can continue to be advocates for society's most vulnerable groups and complex families. We need to be able to proudly declare: 'I am a health visitor.'

WHAT TO EXPECT

I knew my colleague and friend Jenny Harmer was equally passionate about the need to protect and promote the health visiting service and reached out to her for help. Now partners in crime on the podcast, we bring different things to the table. With a

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fantastic career in paediatric A&E nursing as well as lots of practical, hands-on experience and areas of specialism in breastfeeding, Jen can supplement my research-based approach and ensure the episodes have a balance of practical and academic content. We also have such a laugh every time we record – so hopefully the episodes are fun to listen to as well.

I am a health visitor now releases regular 30 to 60 minute episodes on a topic we feel will be relevant and timely for HVs in practice. Some episodes cover clinical themes, such as infant measurements, reflux, bronchiolitis, umbilical granulomas and birthmarks. Other episodes cover a change in practice, such as the introduction of a new vaccine to the immunisation schedule, the removal of teething gels from UK supermarkets, new guidance from the First Steps Nutrition Trust or law changes around child contact in domestic abuse cases. Finally,we also discuss professional issues, such as caseload numbers, workplace stress and national service delivery data. Some of my favourites have been our interviews with expert speakers on topics such as supporting adoptive families or paternal mental health.

We currently have a library of 36 episodes and have hit over 19,000 downloads. We are so proud and thrilled that HVs are finding our episodes helpful and we would love more HVs to listen in and join us. We feel we are the perfect complement to the *Community Practitioner* journal [which of course serves HVs, school nurses, community nursery nurses and all CPs]: while we operate on a smaller scale, we both seek to keep professionals up to date with a range of recent research and changes to practice.

LEARNING MORE EVERY EPISODE

Personally, I have learned a huge amount from my podcasting journey. With every episode we do, I gain knowledge to inform my practice, helping me to feel more confident in the advice I am giving. It keeps my research skills fresh, helping me stay engaged and interested in our varied role as I am always on the lookout for new topics to cover. We have discovered that even seemingly simple topics turn out to be much more complex when you begin to dig. The old adage really is true: the more you know, the more you realise you don't know.

If you are wondering about getting involved in podcasting for HVs yourself, then we would love to hear from you. It would be fabulous to have more professionals contributing and helping us to share learning and good practice and it really isn't as time-consuming as you might expect (See *Top 5 tips for podcasting*, left, for more advice). Everyone has something fantastic to offer.

Amy Dobson is a Warwick-based children's nurse and health visitor who is passionate about infant mental health and early intervention.

TOP 5 TIPS FOR PODCASTING

Fancy having a go at creating your own podcast? Read this first:

1. Sort out the recording equipment (microphone and headphones) and recording and editing software you'll need for your podcast ahead of time and practise using it – Audacity is free, GarageBand comes with Mac computers, Adobe Audition has a monthly cost.
2. Try to find somewhere quiet to record – background noise can be so annoying and hard to remove!
3. Make a rough plan beforehand of what you want to include, especially if you're recording with another person.
4. Keep a running note of episode ideas that occur to you at any point, to save you searching for inspiration later on.
5. Have fun! The more you enjoy recording, the more others will enjoy listening to your podcast and choose to continue listening.

▸ For more tips on the basics of podcasting, visit **bit.ly/podcast_basics**

I AM A HEALTH VISITOR PODCAST

iamahealthvisitor@gmail.com

@IamaHV

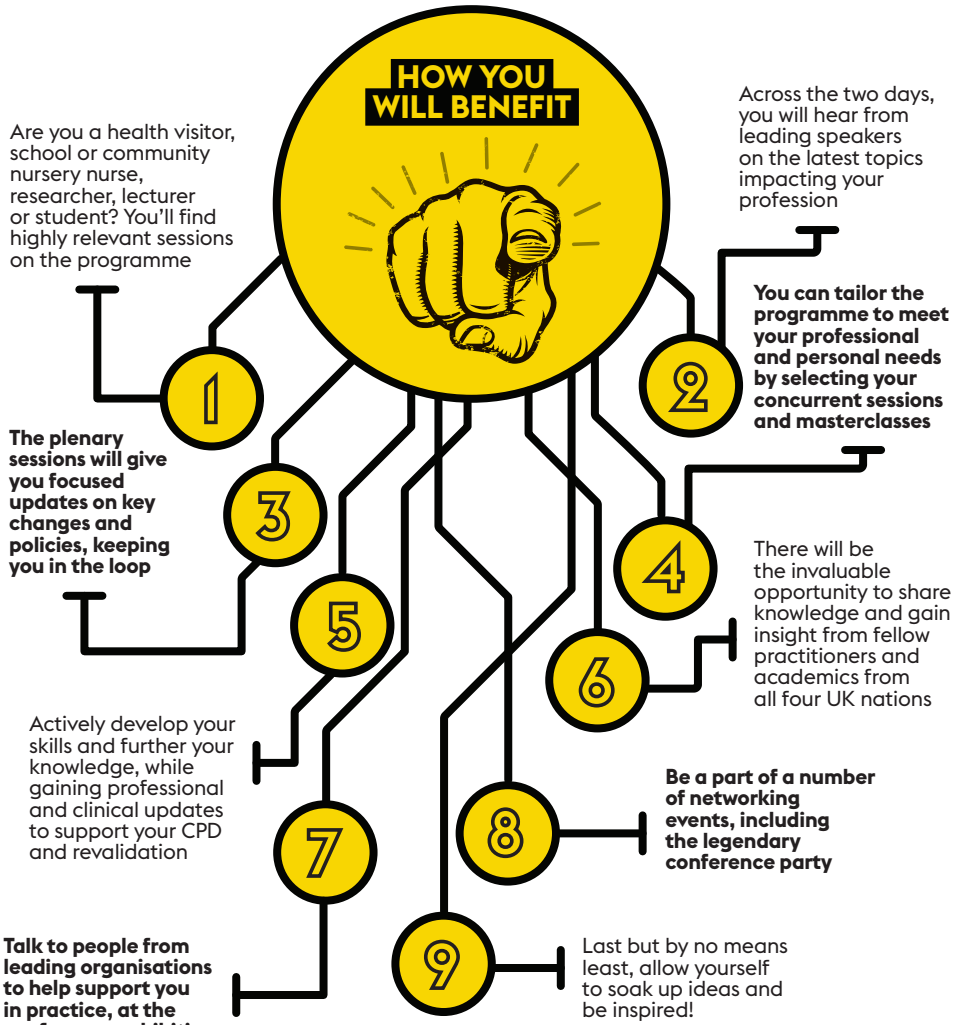
I am a Health Visitor

For references, visit **bit.ly/CP_P_features**

ARE YOU IN?

Discover all you need to know about this year's Unite-CPHVA Annual Professional Conference.

Have you got your tickets to this year's Unite-CPHVA Annual Professional Conference? If not, there is still time! Whether or not you've booked yet, here's all you need to know about what's happening this year – on 16 and 17 October 2019 at the Harrogate Convention Centre, King's Road, Harrogate, HG1 5LA. Want to know what you'll learn, who'll you hear, and the many ways you can benefit, both professionally and personally? We've got that covered. Plus, find out how to get there, the important details of how much it will cost and how you may be able to get support in funding your attendance. Not forgetting your invite to the infamous conference party...



THE SPEAKERS

Len McCluskey, general secretary of Unite will be opening the conference. After which, you'll find a packed programme which you can tailor to your needs. Leading speakers will include: Professor Alan Emond, emeritus professor of child health at the University of Bristol and senior editor of the latest *Health for all children*; Yvonne Coghill OBE, director of WRES implementation in NHS England; and Professor Jane Barlow, professor of evidence-based intervention and policy evaluation at the University of Oxford. Topics to be covered will include the future of community practice and public health nursing; equality; mental health at work; and supporting victims of abuse. **Find more details at bit.ly/C_programme**

ALAMY / ISTOCK

Harrogate has lots to offer if you have time...

THIS WAY...

Conference this year is being held in the Victorian spa town of Harrogate. The Harrogate Convention Centre has been hosting events for almost 200 years and is in the heart of the North Yorkshire town. If you are able to extend your stay just before or after conference, you'll find a long list of places to enjoy. On the food front, as well as restaurants, bars and pubs, it's home to the well-known Bettys – a 100-year-old and popular tea room. To relax in spectacular style, there is the impressive Turkish Baths Harrogate – the UK's most fully restored Victorian Turkish Baths which also offers spa treatments. There's a wide range of shops from independent boutiques and antique shops to high-street favourites, too. All of this is just a short walk from the convention centre.

See visitharrogate.co.uk for more information.

GET THERE AND STAY

To make your visit as smooth as possible, Redactive events has arranged special rates at two hotels near to the convention centre: Crowne Plaza Harrogate and The Majestic Hotel. Be sure to indicate your chosen hotel and dates when booking for conference.
Find more at bit.ly/conference_stay

The train from London is around 3 hours, and less than 2 hours from Manchester and Sheffield. Leeds Bradford Airport is approximately 20 minutes from the convention centre. If driving, there are a number of car parks nearby.
See bit.ly/get_to_conference

FIND FUNDING

You may be able to get help with funding your place at conference, so explore what's possible: there are numerous options, from either a Unite branch or your employer.

If asking for funding from your employer, give them concrete reasons for doing so, as this can help to gain managerial approval. For example, say:
- 'It will support revalidation, with best-practice workshops, plenary sessions and masterclasses.'
- 'I'll hear policy updates on the latest regulatory challenges.'
- 'I'll bring back useful insights to share.'

Financial support from your Unite branch might also be possible, especially if you attend their meetings. Each branch has funds that can be used where considered appropriate, and that might include supporting members to attend conference. Try:
- Asking for items that can be evidenced with a receipt – such as the cost of a ticket or travel. The branch can then keep a record of money spent
- Aim to make the request in writing to the branch secretary
- Ideally attend the next branch meeting.

TICKET PRICING

	TWO DAY	SINGLE DAY
CNN/STUDENT/ SCHOOL NURSE	£144	£94
UNITE-CPHVA MEMBER	£244	£159
NON-MEMBER	£314	£189

- All bookings must be paid for before the conference
- Group discounts are available for multiple bookings
- Prices exclude VAT

For further information, see bit.ly/get_to_conference

WHAT DO YOU SEE?

Negative body image is an issue for children and adults alike. What's the impact, and how can you help? Journalist ***Anna Scott*** reports.

The subject of body image (how we think and feel about our bodies) reached the House of Lords just before members went on their summer recess in July. Crossbench peer Baroness Bull, a former ballet dancer, asked the parliamentary under-secretary of state for health and social care, Baroness Blackwood, if she was confident that adequate social policies were in place to address and reduce the incidence of weight bias (TheyWorkForYou, 2019).

'Weight-related teasing is a form of weight bias, the consequences of which can include depression, anxiety, low self-esteem, substance abuse, eating disorders, obesity and suicidality,' she said. 'Research shows that even health professionals are not immune to negative stereotypes that connect character and capability with weight.'

It's not surprising that politicians are beginning to discuss physical appearance in this way, given the prevalence of negative body image among the UK population: one in five adults felt shame, just over a third felt down or low, and 19% felt disgusted because of their body image in the last year (Mental Health Foundation, 2019a). In the UK, 37% of 13- to 19-year olds felt upset in relation to their body image, and 31% felt ashamed (Mental Health Foundation, 2019a). These were some of the findings of a large survey by the charity Mental Health Foundation (MHF) earlier this year, comprising 4505 adults and 1118 teenagers. Around the same time, another survey of young people found that 67% of 2189 11- to 24-year olds said they regularly worry about the way they look (YMCA, 2019).

These are stark figures showing body image issues among multiple age groups. And these figures matter. '[While] body image concerns are not a mental health problem in themselves, they can make a person more likely to have mental health problems,' explains Dr Antonis Kousoulis, director of England and Wales at the MHF. 'At a time when the mental health of young people especially seems to be under unprecedented strain, we cannot dismiss body image as a trivial or frivolous subject.'

With the MHF report also revealing that one in eight adults have experienced suicidal thoughts or feelings because of concerns about their body image (2019a), it's clear just how important the perceptions we hold about our bodies are.

GETTY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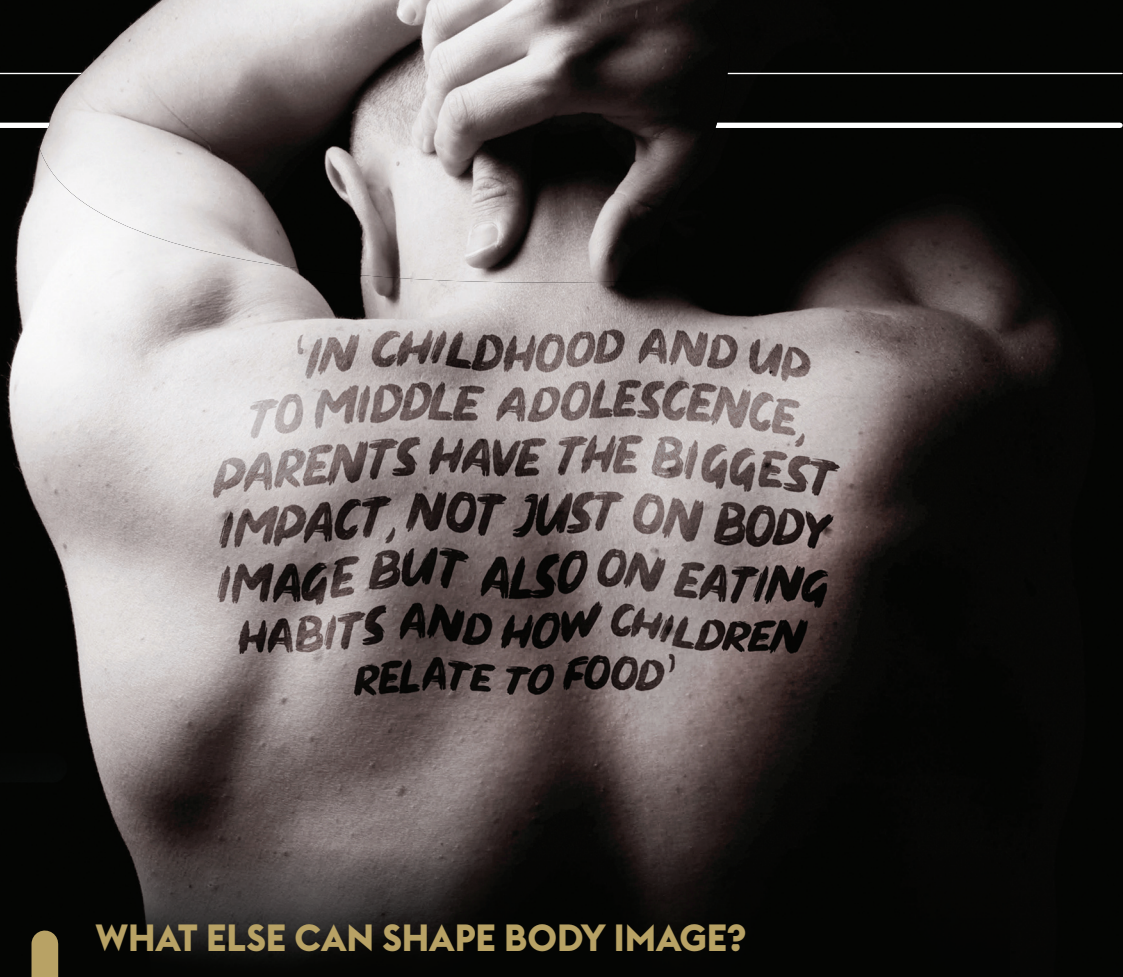

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WHY IS OUR BODY IMAGE SO NEGATIVE?

The MHF's research highlights four areas that affect how we see our bodies: our relationships with our family and friends, how our families and peers feel and speak about bodies and appearance, exposure to images of idealised or unrealistic bodies through the media or social media, and pressure to look a certain way or to match an 'ideal' body type (MHF, 2019a). 'What this ideal looks like will shift across cultures and can vary between genders,' the report reads.

'In the West, for most women that's a desire to be thinner,' says Viren Swami, professor of social psychology at Anglia Ruskin (AR) University. 'For a lot of men that is a desire to be taller and more muscular.'

The MHF report also shows that consistently speaking about our bodies or others' bodies in ways that imply weight or youth are central to attractiveness and value shows how many people feel about body image. For example: 'I feel fat today' and 'Ugh, look at my wrinkles' (MHF, 2019a).

Society does seem to be increasingly focused on self-image and self-awareness, says Sally Star, a SCPHN school nurse at the Hywel Dda University Health Board (see her safeguarding piece on page 22). 'Young people are undoubtedly more media savvy and peer-aware than in previous generations and that does introduce health and emotional wellbeing risks to susceptible individuals,' she says.

Indeed, 24% of 18- to 24-year-olds say reality TV makes them worry about their body image, reveals MHF research (2019b). The charity has concerns over the ITV2 reality show *Love Island*, with Antonis saying it displays body images that are 'not diverse, largely unrealistic and presented as aspirational'.

Watching *Love Island* won't automatically lead to a negative body image, says Viren, who is also an associate editor of journal *Body Image*. 'Viewers are both clued-up and active users of these kinds of programmes,' he says. 'Most are probably actively negotiating with appearance ideals and talking about it with their friends or parents thinking, "I don't want to look like that."

'But people who have pre-existing conditions such as eating disorders or body dysmorphia or a personality framework that predisposes them to such conditions may experience a negative outcome from watching these kinds of programmes. For example, people who score highly in the personality trait of narcissism are likely to view *Love Island* and come away with worse body image.'

Sally adds that if people have a healthy body image through 'robust inner resource pools, the impact of current virtual and media worlds would not have such a detrimental impact'.

It's a similar story with social media. Research from the Be Real campaign – a movement to change

WHAT ELSE CAN SHAPE BODY IMAGE?

'There are lots of complicating factors that affect body image, such as ethnicity, social background, gender and sexuality,' says Viren Swami. 'Ethnic minorities tend to be buffered against negative body image as they are not represented on TV primarily. Migrant populations tend to develop a more negative body image because of the stress of migration and trying to live up to host cultural ideals.'

Gay men often have a negative body image compared to heterosexual men because of subcultural rules about acceptable and normative body shapes and sizes, Viren explains. 'Conversely, lesbian women tend to have a more positive body image compared to heterosexual women because there is more variance and acceptance of different body shapes and sizes,' he adds. The MHF notes that research is mixed on this point (MHF, 2019a).

Sally Star adds: 'The likelihood is increased in those with a diagnosed or existing mental health condition, chronic health disorder or disability, looked after children or those who have had adverse childhood experiences.'

'Sexual harassment, rape and trauma are big triggers for negative body image and could lead to a clinical diagnosis,' says Viren.

attitudes towards body image coordinated by the YMCA – reveals that 61% of 11- to 24-year-olds feel pressure to look their best online, and 67% edit photos of themselves before posting them on social media (YMCA, 2019).

'Social media continues to present a multitude of dangers for young people, which they have been left to navigate using their own devices,' says Denise Hatton, chief executive for YMCA England and Wales. 'These dangers are not just limited to the content they see, but also the pressure to emulate them. [We all] need to be conscious about the content they are posting online.'

LIFE INFLUENCES

Similarly to the MHF report, Viren says: 'There are three primary factors that tell us about standards of appearance in society: the media, parents and peers. [For instance] research shows parents who have negative body image are much more likely to pass on negative outcomes to their children.'

This issue is not often picked up by healthcare professionals, adds Saskia Waage Townsend, a health visitor at Leicestershire Partnership NHS Trust. 'The intergenerational transmission of eating problems and the psychological meaning of eating and body difficulties is often overlooked.'

Viren also explains that influences on body image change during the course of life. 'In childhood and up to middle adolescence, parents have the biggest impact, not just on body image but also on eating habits and how children relate to food. From middle adolescence and onwards, peers will have the biggest impact on body image. And there are many other triggers of negative body image – clothes, exercising, socialisation, teasing or bullying.'

Moving through adulthood, particular events can play a role, including pregnancy, the menopause and ageing in general. 'The perinatal period for women tends to cause negative body image, primarily because of weight gain,' says Viren. 'Although during the same period women often develop a different attitude to their body and focus on what it is able to do to feed their baby, for example. So there is a tension between wanting to encapsulate this thin ideal and having respect for their bodies.'

Unaddressed issues carried over from childhood can also play a role in adults having a negative body image, says Viren. 'Most studies suggest that negative body image becomes gendered at quite a high level at a relatively young age. Boys tend to develop negative body image slightly later in life compared to girls, but it generally exists.'

Body image issues don't just disappear as we age either. 'Body image in people in later life is informed by a lifetime of experiences throughout childhood, young adulthood and middle age,' explains the MHF report (2019a) and so elements that can play a role in body image throughout life 'will all have played a role in shaping how people in later life understand and experience their bodies'.

While men tend to have a more positive body image than women, just§ 23% feel satisfied with their body image (19% for women) (MHF, 2019a).

AT WHAT COST?

As we have already seen, poor body image can be a serious issue, and can affect behaviour, health and quality of life. 'Body image is associated with a desire to change physical appearance and it may also affect relationships and sexual wellbeing,' states the MHF report (2019a). 'Increased body dissatisfaction has been linked to increased likelihood of depressive symptoms, psychological distress, disordered eating and eating disorders.'

But it's not necessarily straightforward causation: 'Many people with eating disorders do suffer from body image problems, and body dissatisfaction can be one of the risk factors for an eating disorder, but they are separate issues,' says Jamie Osborn from the eating disorders charity Beat.

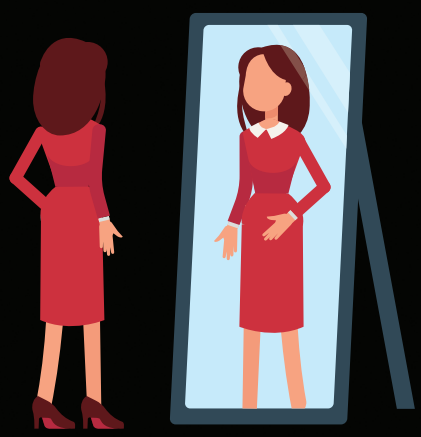
In the same way, body dysmorphic disorder is a mental health problem closely linked to poor body image, but they are distinct from each other.

Sally agrees there is a strong correlation between a negative body image and poor emotional and mental health, but 'not all young people who experience poor mental and emotional health will have issues with their body image'. When young people are unable to see themselves as others can see them, it can affect their perception of their own weight, body shape and skin colour. 'This can lead to behaviours such as self-harm and substance misuse,' she says. 'It can exacerbate mental and emotional health conditions such as anxiety and depression and make suicidal thoughts more likely.'

Poor body image can affect the way people behave too. 'It can potentially affect social factors, such as increasing isolation and reducing friendships,' says Sally.

Viren adds: 'In women, negative body image is associated with social exclusion – they are less likely to go out with friends, and they might make poor sexual health decisions, and have poor breast care, especially when they have a negative image regarding breast size,' he says. 'Use of anabolic steroids by men is another example.'

Antonis says: 'People may try to hide certain parts of their body, bringing their shoulders forward instead of having a confident body posture. They may avoid wearing certain clothes.'



1 in 8

adults in the UK have experienced suicidal thoughts or feelings because of concerns about their body image *MHF, 2019a*

RECOMMENDATIONS FOR PUBLIC HEALTH

- Frontline health practitioners should receive training which includes information about how parents and carers can, from a very early age, positively influence their children's feelings about their bodies through their behaviours and attitudes.
- Children and adults in distress should receive fast and empathetic support when they need it, regardless of where they live in the country.
- Public campaigns on nutrition and obesity should avoid the potential to create stigma and indirectly contribute to appearance-based bullying. They should focus on healthy eating and exercise for all members of the population, regardless of weight.
- A co-produced body image and media literacy toolkit (by the government with input from young people) should be a compulsory element in schools. This should include the development of a charter for achieving a healthy and positive body image. MHF, 2019a.

YOUR ROLE

The likelihood that community practitioners (CPs) will come into contact with someone with a poor body image is extremely high, given its prevalence, says Viren. 'Certain groups might need additional care – mums in the postnatal period, for example. HVs might need to have conversations about looking after the body by shifting the focus away from aesthetics onto body functionality.'

Saskia adds that early intervention is key with pregnant women to minimise the impact on both parent and baby. 'If midwives and HVs could routinely talk with pregnant women about these issues, it would help to identify causes of distress and unease and legitimise asking for help if parents feel they want and need it,' she adds.

'For CPs, the most important thing is to be able to engage with people,' says Antonis. 'A question such as "Obviously your body is changing [pregnancy or adolescence, for example], how do you feel about that?" can be invaluable. It's also important to normalise it – millions of people have gone through and are going through this.'

Poor posture is one of the signs you can look out for if you suspect someone has negative body image, says Antonis. 'Some people might joke about their bodies, especially pregnant women and teenagers. Is this a self-defence mechanism? On the other hand, people may also never talk about their body image, which could be a sign.'

Viren has advice for when it comes to school children: 'It's important to look out for things like bullying, or "fat talk" – when young girls in particular talk to each other about their body fat – and working out what interventions might be needed. The other thing to think about is media literacy interventions in schools – to give children the tools to critically appraise what they are watching on TV – because that doesn't come naturally.'

Sally believes that children are not provided with enough opportunity to develop good health and emotional literacy. 'If we don't teach children about positive healthy emotions, self-worth and relationships, then the adult that they become won't have a healthy self-image.'

As a school nurse, Sally is often called upon to address established problems with young people. 'Our intention is to help the development of emotional literacy and positive associations with the triggers, such as food and physical fitness,' she says. 'Ideally, we work with partners in the primary mental health team, healthy schools practitioners and education staff to provide a whole-school approach, promoting positive body image across the curriculum, throughout the school and beyond.

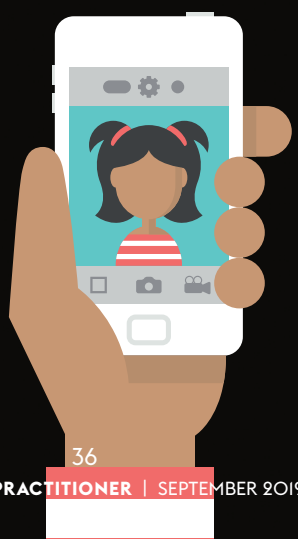
'Collaborating with parents/carers is vital and we will meet individually with young people and families if it's needed, either at home or in school.

'Depending on the specific needs we can signpost them to resources, provide interactive programmes for home, prescribe recommended reading or refer to specialist services if intensive intervention is required to safeguard the young person.'

67%

of 11- to 24-year-olds regularly worry about the way they look

YMCA, 2019



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STAYING POSITIVE

Of his work, Viren says: 'We [AR University] have been developing interventions focused on things like spending time in nature, which is good for mental health in general and helps to promote a positive body image.' Interestingly, he says, it's been shown that activities such as life drawing can be particularly effective among teenage children. 'It can help expose them to the idea that people come in all different shapes and sizes, and we can be happy irrespective of what we look like.'

But, as is often the case, resources are an issue for CPs. 'We don't have the opportunity for formal supervision regarding general emotional and mental health concerns,' says Sally. 'Some of the team, like myself, share an office with other SNs who will provide informal support and share resources. However, due to the rural locality [in Wales], some SNs are quite isolated and don't have that instant support, although they can obviously phone the team leader and others.'

Increasing training and resources will, according to Saskia, give CPs the confidence and knowledge to discuss body image and its impact on wellbeing with their clients.

ADDRESSING THE ISSUES

The government's *Online harms* white paper sets out its plans for online safety legislative and non-legislative measures to make companies more responsible for users' safety online, especially children and other vulnerable groups (HM Government, 2019).

As mentioned in the May issue of *Community Practitioner* (Fuller, 2019), the white paper (the consultation closed in July) proposes establishing a new duty of care towards users, to be overseen by an independent regulator. It also wants companies to be held to account for tackling behaviours including harmful body image representations (HM Government, 2019).

'The white paper should address harms relating to the promotion of unhelpful or idealised body image online,' says the MHF report. It also recommends: 'Social media companies should sign the Be Real campaign's body image pledge and investigate new ways of using their platforms to promote positive body image and to ensure that a diversity of body types is presented positively to users' (MHF, 2019a).

The MHF is also calling on greater guidance and training for healthcare professionals (see *Recommendations for public health*, opposite page), along with effective regulation of how body image is portrayed, and has specific recommendations for the national governments (MHF, 2019a).

For example, the NHS, governments and public health bodies across the UK should actively consider the effects of the increased attention paid to people's weight and size when developing messaging on obesity (MHF, 2019a).

As can often be the case when changes in attitude are required, collective responsibility is needed, says Viren. The MHF report (2019a) shares this conclusion, stating that instead of striving towards a single body ideal, we should all, in our different and complementary ways – individually, professionally and corporately – strive to shape a society that embraces and champions the diversity of the human race'.

For CPs, particularly SNs seeing body image issues in children, more time, resources and training are needed, says Sally. 'We should be part of a multi-agency team delivering research-based culturally and gender sensitive interventions using differentiated methods and quality resources within an alternative curriculum.

Viren says: 'There are difficult conversations to be had about the nature of beauty structures and societies that tell both women and men that they are not good enough in terms of their appearance. We need a broader societal shift in terms of how we relate to people and how we talk about appearance.'

Better body image, it seems, is on all of us.

RESOURCES

- The MHF *Body image* report, including advice for children, adults and professionals **bit.ly/MHF_body_image**
- The Be Real campaign has a pledge with businesses, charities and experts, showing how everyone can bring about responsible change **bit.ly/be_real**
- *Body Image* is an international, peer-reviewed journal **bit.ly/BI_journal**
- Advice for children and young people struggling with a poor body image **bit.ly/YM_BI_advice**
- Guidance from the Personal, Social, Health and Economic Association for teaching children **bit.ly/PSHE_body_image**
- A toolkit by Beat and KCL's Institute of Psychiatry for those working with young people **bit.ly/beat_KCL_body_image**

For references, visit **bit.ly/CP_features**

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Whether you are a health visitor, community nursery nurse, or school nurse, or you are an educationalist, researcher or student, there is something of interest for everyone on the programme.

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SPEAKER
Yvonne Coghill CBE, FRCN, Fellow KCL (Hon),
Director - WRES Implementation Team,
NHS England

EQUALITY – WHY ARE WE STILL TALKING ABOUT THIS?

Equality issues have come a long way but there is still more work to be done. Why is inequality still so prevalent and what can you do to influence a more equal and positive future. Whether you feel discriminated against or work with colleagues who may feel this way, you will hear how you can receive and provide support.

SPEAKER
Gabby Edlin, CEO and Founder,
The Bloody Good Period Charity

PERIOD EQUALITY – WHY HASN'T IT HAPPENED YET?

Gabby started the charity Bloody Good Period to do something to provide menstrual products for those who can't afford to buy them. What started as a whip-round on Facebook is now a growing enterprise with a vision to end period poverty.

The session will cover the stigma of periods and period poverty – the stats, the impact and what has been promised in UK schools. We will hear what Gabby would like to see happen to reach period equality and how community practitioners can help.

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Are you an experienced community practitioner with a broad knowledge base? Maybe you work in academia, or perhaps you've worked in practice and are regularly published.

Either way, if you would like to use your expertise to help inform and maintain the high editorial and clinical standards of *Community Practitioner* – now's your chance! The pivotal role of professional editor will be available from October 2019, and the editorial team is looking for a new candidate to take the reins.

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- Reviewing research submissions as part of the peer-review process
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- Regular contact with the editorial team.

The position will therefore involve a regular time commitment, which would vary week to week depending on the journal's press schedule.

If you are interested in the role of professional editor, which will receive an honorarium, please get in touch as soon as possible. Simply send **your CV** and **cover letter** (ideally by the end of **September 2019**) to the journal's managing editor **Emma Godfrey at emma@communitypractitioner.co.uk**

Thank you and good luck!

THE STICKING POINT

An action plan to help your client when the odds are stacked against you is more important than ever, writes journalist ***Erin Dean***, especially with harder-to-access services and CP staffing issues.

Earlier this year, eight out of 10 child and adolescent mental health services (CAMHS) providers in the community said they were unable to meet current demand in England (NHS Providers, 2019). Almost 30% of in-patient CAMHS services told the survey they couldn't provide all the care needed.

These are not the first figures to show the strain on children's mental health services, and the problem is not just limited to England, as hundreds sit on waiting lists for specialist support across the UK (ISD Scotland, 2019; BBC, 2019).

Meanwhile, in March, a coalition of more than 60 organisations wrote to the government calling for action to end the 'postcode lottery' of access to speech and language services for the 1.4 million UK children who need support (I CAN, 2019). And in Northern Ireland, children with heart conditions, allergies and skin conditions are waiting as long as four years for a hospital appointment (Smyth, 2019).

As community practitioners, accessing the services and support needed by your clients in a timely manner is of course essential. But how can you help when services are full and busy and thresholds to access services get higher and higher? This is not the only scenario that leaves CPs, for want of a better word, 'stuck' and unsure of where to turn.

THE CRITICAL PERIOD

John McLaren, senior representative for Unite-CPHVA at NHS Borders, has

ISTOCK

seen it get harder for community staff when it comes to accessing CAMHS as well as social services support across Scotland.

More than 10,600 children and young people were waiting to be seen by CAMHS in Scotland in March, more than 400 of whom had been waiting for more than a year (ISD Scotland, 2019). In Northern Ireland, figures from the Health and Social Care (HSC) Board show 487 patients missed the CAMHS target of waiting no longer than nine weeks in March (BBC, 2019).

These long waits can be critical, as a survey of parents by mental health charity YoungMinds (2018) said that around three-quarters of young people waiting for CAMHS become more unwell before they can access treatment.

HIGH CASELOADS

'Families are sometimes waiting up to a year for an assessment with CAMHS, and health visitors will still be expected to support these families on an ongoing basis, without the support they need,' John says.

'We also hear time and time again about the threshold rising for social service referrals, and while referrals are being considered, or have been rejected, HVs are carrying much more complex, difficult cases, with families who are just a hair away from falling apart. This is very difficult for HVs, and I can remember the sleepless nights I had when I was practising, worrying about some of the families on my caseload.'

Another concern for many of you is how to find the time to do the work required. One issue is caseloads for HVs and district nurses. These are particularly bad in England where district nurse numbers have also fallen sharply, dropping by almost 43% over the past decade (QNI, 2019).

Unite-CPHVA recommends a ratio of one HV to every 250 clients. But the union has heard reports of HVs in England with more than 800 clients, says Colenzo Jarrett-Thorpe, Unite national officer for health.

'Across England, HV caseloads appear to be above the CPHVA recommended limit,' says Colenzo. 'With high caseloads it is impossible to provide the service HVs want to. Cuts to budgets need to be reversed in order to protect services for children and families or the damage will be felt for a generation.'

Recent Public Health England (PHE) 2018-19 preliminary figures revealed that only 77% of children received the 12-month HV review in England by the age of one (PHE, 2019), with the number at 75% for the previous year (PHE, 2018).

Health visitor numbers have dropped by 30% in England since 2015

NHS Digital, 2019

STAFFING SHORTFALL

But staffing is a countrywide lottery. The number of HVs in England has fallen by 30% since 2015 (NHS Digital, 2019). But HV numbers have been fairly stable in Wales (Welsh Government, 2019) and Northern Ireland (NI HSC, 2018; 2017) between 2015 and 2018.

In Scotland, however, there has been governmental investment to meet the pledge to increase the number of health visitors by 500 (Scottish Government, 2018).

As *Community Practitioner* reported in February this year (Scott, 2019), Northern Ireland, Scotland and Wales all had some issues with workforce capacity, and of course there's still deadlock in the government in Northern Ireland.

On a more positive note, Annie Hair, senior nurse and chair of the CPHVA occupational and professional committee, says that in Glasgow, where she works, from September all HV posts will be fully staffed with lower caseloads designed to reflect the level of need in a community.

There has also been a significant investment that has created four new school nursing posts, with at least four more training posts planned this year.

'The number of HVs has increased dramatically and we are in a positive place at the moment, but this needs to be sustained,' she says.

WHEN YOU DON'T KNOW WHERE TO TURN... A SUMMARY OF ACTION POINTS

- **Keep good records and escalate concerns to managers as they arise**
- **Continue to risk-assess clients and discuss the outcome with managers**
- **Contact Unite-CPHVA representatives for support and advice. Seeking early support can avoid more serious problems**
- **Give families on waiting lists coping tips and strategies, such as behaviour management advice, for the issues they face**
- **Get to know communities well and tap into local support such as parenting groups.**

YOU ARE URGED TO KEEP YOUR PAPERWORK UP TO DATE, AND RAISE CONCERNS SWIFTLY AND REPEATEDLY WITH MANAGERS

ISD Scotland, 2019

A FINE LINE

Another issue that can complicate matters for HVs and other CPs is when clients reject services that are offered.

If a family or other client comes below a threshold where services would automatically get involved but a professional feels they need that support, the parent can choose to reject it.

'If there is a concern about child neglect that doesn't meet the threshold for non-consent, a parent can say no to involving any other supportive service, such as social work,' says Annette Holliday, health visiting team leader at Glasgow City Health and Social Care Partnership.

'The HV is still holding the concern but has not got anywhere to go unless the situation gets worse and meets the level where you don't need consent. There is nothing to do but keep working with parents to manage the risk and maintain the relationship. Continue to risk-assess and analyse the situation so that the reasons for your decisions can be identified and recorded.'

But these situations have an impact on the professional involved. 'Ultimately it often makes you very worried,' says Annette.

YOUR ACTION STEPS

When you're unsure about what steps to take next, you are first urged to keep your paperwork up to date. You should then raise concerns swiftly and repeatedly with managers. As John explains: 'While paperwork can be one of the first things to slip when people are overworked, it is essential it is completed.

'Staff should also escalate concerns through their risk register systems, so that managers can be held to account. This should include issues caused by a lack of support from other services and the problems this causes for clients.'

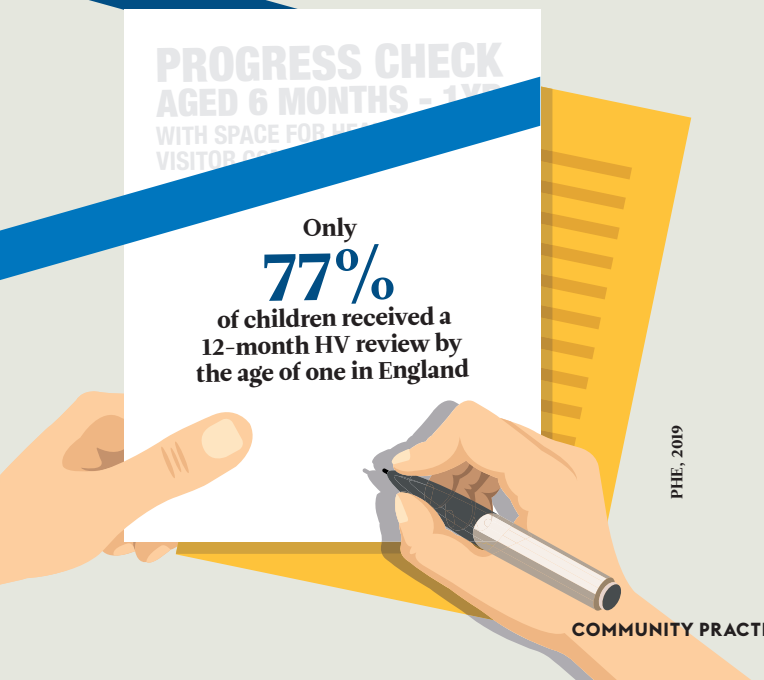
Practitioners should also approach Unite-CPHVA representatives for advice early on to avoid later problems, advises John.

For clients stuck on waiting lists, professionals should give advice to help them while they wait. Janet Taylor, chair of the CPHVA executive, says giving practical pointers such as behaviour management or speech development to families waiting for referral can make a vital difference.

'The reality is that parents may be waiting for an assessment to find out if their child has autism or ADHD, but it is really important that an HV gives the family coping strategies for before and after the assessment,' she says.

It is also essential that you know well the area you work in. Signposting an isolated new mother to a local mother and baby group can be as important as a referral, says Janet.

'CPs are the glue in the system, and we refer people to other services as we should, but we can also give parents tools to empower them in the meantime,' Janet adds.



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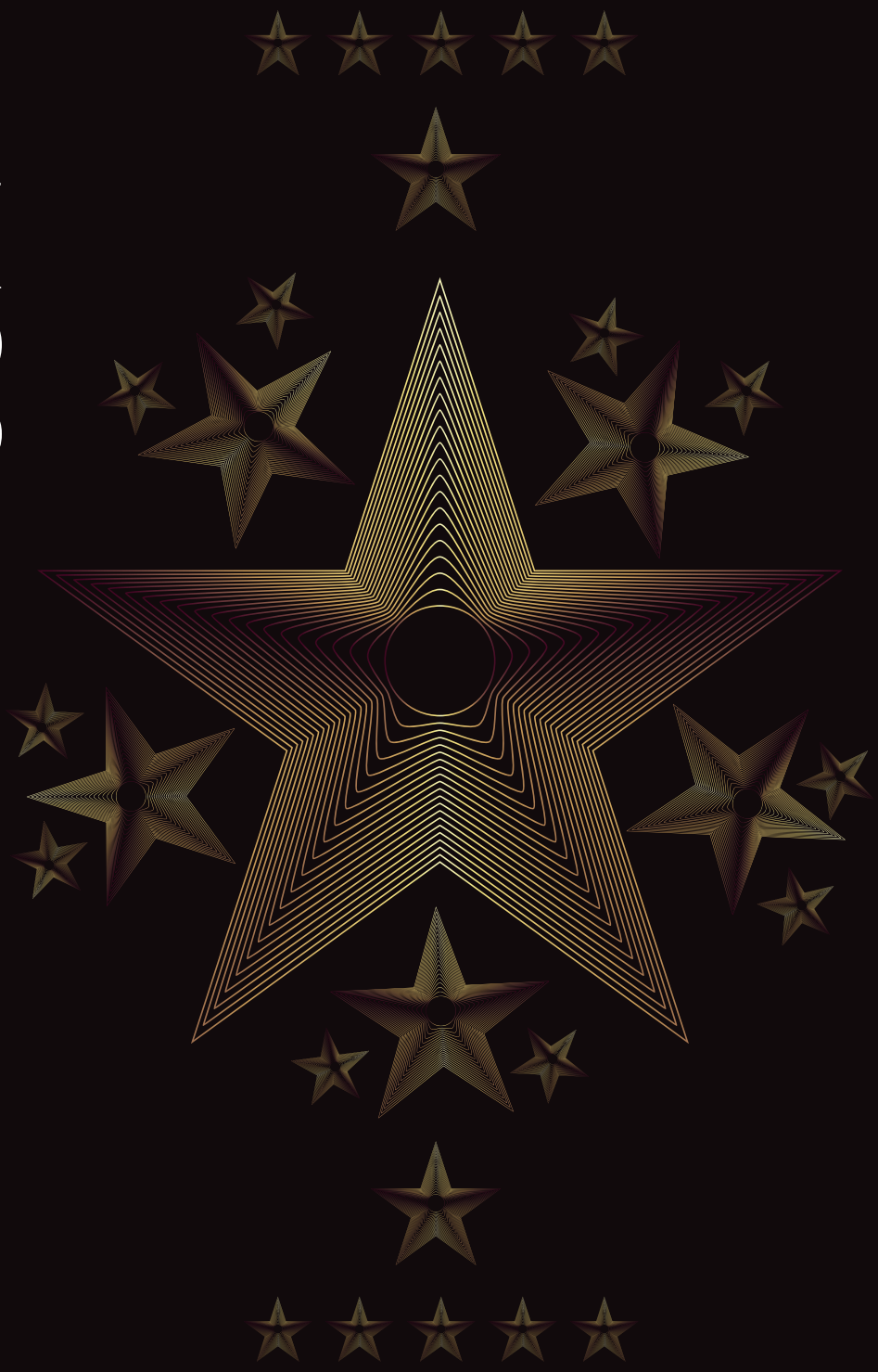

Do you know a Local Accredited Representative who deserves special recognition for their hard work and commitment?

If someone stands out for their exceptional work, nominate them today for the LAR of the Year Award 2019.

The award will be presented at the Unite-CPHVA Annual Professional Conference 2019 in Harrogate on 16 and 17 October.

Nominate a candidate by sending an email with the nominee's name, job title and place of work, the names of the two people nominating and a 500-word supporting statement.

We look forward to receiving your nominations!

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ABRIDGED VERSION

THE SOLIHULL APPROACH 10-WEEK PROGRAMME: A RANDOMISED CONTROLLED TRIAL

RESEARCH SUMMARY

- Researchers evaluated the manualised Solihull Approach group 'Understanding your child's behaviour' (UYCB), a 10-week course available universally to a population of parents/carers of children aged 0 to 19 years.
- This was a parallel-group, non-matched samples, randomised controlled trial where participants were allocated to an intervention or wait-list control group. The absence of a control group and small sample size had been weaknesses in methodology in previous studies (Baladi et al, 2018).
- Data was collected from 249 participants from Wrexham in Wales and Solihull in England between April 2013 and September 2017, with 223 in the experimental group and 26 in the control group.
- All eligible prospective attendees (those who booked a place on a course) of UYCB were invited to participate in the study.
- The majority were female (92.4%), with an ethnic mix consistent with the Office for National Statistics estimates for the UK population.
- Three self-report measures were used at two time-points – pre- and post-intervention – measuring child behaviour, parental emotional health and child-parent relationship.
- Participants' responses in the intervention group were compared with waiting-list controls, after controlling for pre-test scores, by analysis of covariance, as per protocol.

Hazel Douglas and ***Rebecca Johnson***

assess the impact of a parenting programme based on the Solihull Approach on child behaviour, parental emotional health and child-parent relationships, which addresses previous studies' methodological weaknesses.

Parenting programmes are group-based interventions aimed at helping parents develop skills for working positively with their children to reduce or prevent the development of behavioural difficulties (Lindsay, 2019). They have been shown by many studies to benefit individuals (Barlow and Coren, 2017; Furlong et al, 2013), with positive impact on parental psychosocial health (Barlow et al, 2014); parents' sense of competence (Lindsay and Totsika, 2017) and satisfaction (Löfgren et al, 2017); and to benefit society (Bonin et al, 2011; Scott et al, 2001).

The Solihull Approach model was collaboratively developed in the late 1990s by Solihull health visitors and the local NHS child psychology service. The emerging model (Douglas, 1999) integrates psychoanalytic theory (containment) with child development research (reciprocity) and learning theory (behaviour management). The aim is to increase the emotional health and wellbeing of children and parents by emphasising the links between behaviour and emotions, focusing on parental as well as child emotional regulation, and enhancing practitioner-parent and parent-child relationships.

More attuned parenting, with better child-parent relationships, should contribute to a reduction in what are now widely known as adverse childhood experiences (ACEs), a term originally coined by Felitti et al (1998), as well as increase the ability to process the experience of trauma and adversity, thereby decreasing the wide-ranging impact of ACEs across a lifespan (Crouch et al, 2019).

In 2006, the Solihull Approach model was introduced directly to parents as a weekly two-hour group for 10 weeks, with set topics and activities each week as described in a facilitators' manual.

ENABLING PARENT-CHILD RELATIONSHIPS

'Understanding your child's behaviour' (UYCB) was designed to encourage a move away from a 'command and control' way of parenting, with the primary objective of enabling good-quality parent-child relationships. This is not to throw out behaviour management but customise it within a wider understanding of behaviour as communication and the ways in which relationships help children learn to regulate themselves.

Previous quantitative and qualitative research into UYCB has shown positive

ANOVA RESULTS COMPARING GROUPS AT POST-CONDITION WITH PRE-CONDITION SCORES AS A COVARIATE

VARIABLE	*F*		*P*	*Partial* η^2
SDQ Total difficulties	(1, 184)	1.745	.188	.009
SDQ Emotional problems	(1, 185)	2.870	.092	.015
SDQ Conduct problems	(1, 185)	5.441	.021*	.029
SDQ Hyperactivity and inattention	(1, 185)	2.614	.108	.014
SDQ Peer relationship problems	(1, 184)	0.025	.873	.000
SDQ Prosocial behaviour scale	(1, 184)	5.297	.022*	.028
DASS-21 Depression	(1, 223)	3.584	.06	.016
DASS-21 Anxiety	(1, 223)	6.182	.014*	.027
DASS-21 Stress	(1, 223)	8.018	.005**	.035
CPRS Closeness	(1, 218)	9.919	.002**	.044
CPRS Conflicts	(1, 218)	4.096	.044*	.02

*** = SIGNIFICANT AT P = < .05, ** = SIGNIFICANT AT P = ≤ .005**

outcomes for parents, child behaviour (Cabral, 2013; Bateson et al, 2008) and the child-parent relationship (Baladi et al, 2018), which were maintained at follow-up (Baladi et al, 2018). It also has high satisfaction ratings for helping parents understand their child and make changes to their parenting (Appleton et al, 2016; Vella et al, 2015; Johnson and Wilson, 2012).

The primary hypothesis of this study was that UYCB would result in improved closeness subscale scores on the Child-Parent Relationship Scale (CPRS) and decreased conflict subscale scores and, consistent with previous studies (Alexandris et al, 2013; Cabral, 2013), an increase in prosocial behaviours and reduction in conduct problems displayed by the child, as measured by the 'prosocial' and 'conduct problems' subscales of the Strengths and Difficulties Questionnaire (SDQ).

The secondary hypothesis was that attendance at UYCB would also result in improvements in parental wellbeing (Depression Anxiety Stress Scale (DASS-21) scores) and overall child behaviour (SDQ scores).

INTERVENTION

UYCB introduces parents to the underpinning theoretical model of containment, reciprocity and behaviour management, with an emphasis on the links between behaviour and emotions, and parental as well as child emotional regulation. It explores issues such as 'tuning in' to children, exploring feelings, parenting styles, what is being communicated through behaviour, temper tantrums and what might be meant by them, sleep patterns and behavioural difficulties.

Participants attended 96 groups between April 2013 and July 2017, each facilitated by two appropriately-trained community practitioners following a manual outlining the content and delivery methods for each week, with a maximum cohort of 12 parents with similar aged children, for example 0 to 4, 5 to 11, or 11 to 18 years. The core content of the course remained the same across all the age groups, with practical, age-appropriate examples illustrating key principles in action.

FINDINGS

SDQ (Goodman, 1997)

After adjustment for pre-test scores, there were statistically significant differences between the experimental and control groups' post-test scores on the 'prosocial behaviour' subscale of the SDQ and the conduct problems subscale. However, neither the 'total difficulties' scores nor any other subscale of the SDQ showed statistically significant differences (see table, left).

DASS-21 (Lovibond and Lovibond, 1995)

Statistically significant differences were found between the experimental and control groups for the 'stress' and 'anxiety' subscales of the DASS-21, after adjustment for pre-test scores. Differences for 'depression' fell just short of significance.

CPRS – Short Form (Pianta, 1992)

There was a statistically significant difference between the groups on both the closeness and conflict subscales.

DISCUSSION

The results show that, compared with not attending, attendance at the Solihull Approach group resulted in improvements in child prosocial behaviour and conduct problems, parental anxiety and stress, and the parent-child relationship (increase in closeness, decrease in conflict), in a cohort that can be considered characteristic of the UK population in terms of ethnicity and those typically attending such groups (majority female).

Furthermore, the impact on closeness in the parent-child relationship and parental stress showed highly statistically significant results, with a 99.995% probability that these could not have occurred by chance (see table, above left).

These findings are consistent with previous research (Baladi et al, 2018; Vella et al, 2015; Alexandris et al, 2013;

Cabral, 2013; Bateson et al, 2008), and confirm that UYCB is likely to benefit the general population.

The vast majority of participants in this study were mothers, typical of those attending most parenting groups in the UK (Cullen et al, 2014). Further research is suggested to examine the ratio of men to women accessing the online course versus the face-to-face course, and comparing CPRS scores between genders.

A limitation of this study is the potential bias introduced by the drop-out of participants in the control group (the majority of those assigned to the control group declined to take part in the research study), and the ratio of participants in the experimental and control groups.

Further weaknesses include the reliance on self-report measures, and the absence of a follow-up measurement point, meaning it is not possible to draw conclusions about the longer-term impact of UYCB. A more robust design would include observational or third-party reporting, requiring practitioners trained in observations of parent-child interactions and coordination of, for example, teacher reports. This was beyond the scope of the present study and owing to the increased resources required would inevitably result in smaller samples.

THERE IS A BIG MOUNTAIN TO CLIMB TO DESTIGMATISE PARENTING PROGRAMMES SO THEY ARE SEEN AS WORTHWHILE IN THEIR OWN RIGHT

Evidence for the efficacy of parenting groups has built over the last two decades (Lindsay, 2019; Lindsay and Totsika, 2017). Now more research is required into what influences parents to take up face-to-face and/or online programmes.

One hypothesis is that while no stigma is attached to antenatal or postnatal classes, it is with other parenting classes. This may be because over the last two or more decades, programmes have been targeted at particular parents so that parents perceive that to attend classes implies there is something 'wrong' with their parenting. In some areas, parenting groups are offered universally, but there is a big mountain to climb to destigmatise them so that parents see them as interesting and worthwhile in their own right. This could usefully be informed by further research into attitudes of those who do and do not take them up. After all, as this study and others have shown, these programmes contribute to better regulated, prosocial children and less stressed and anxious adults, and therefore – it can be argued – better life chances for children. What's not to like?

Hazel Douglas and Rebecca Johnson are both consultant clinical psychologists at University Hospitals Birmingham NHS Foundation Trust.

REFERENCES

Alexandris M, Hammond S, McKay M. (2013) Children's emotional and behavioural problems and carer-child relationships in permanent care. *Children Australia* **38(1)**: 22-7.

Appleton R, Douglas H, Rheeston M. (2016) Taking part in 'Understanding your child's behaviour' and positive changes for parents. *Community Practitioner* **89(2)**: 42-8.

Baladi R, Johnson R, Law GU. (2018). Strengthening child-parent relationships. *Community Practitioner* **91(9)**: 45-7.

Barlow J, Coren E. (2017) The effectiveness of parenting programmes: a review of Campbell reviews. *Research on Social Work Practice* **28(1)**: 99-102.

Barlow J, Smailagic N, Huband N, Roloff V, Bennett C. (2014) Group-based parent training programmes for improving parental psychosocial health. *Cochrane Database of Systematic Reviews* **5**: CD002020.

Bateson K, Delaney J, Pybus R. (2008) Meeting expectations: the pilot evaluation of the Solihull Approach Parenting Group. *Community Practitioner* **81(5)**: 28-31.

Bonin E-M, Stevens M, Beecham J, Byford S, Parsonage M. (2011) Costs and longer-term savings of parenting programmes for the prevention of persistent conduct disorder: a modelling study. *BMC Public Health* **11**: 803.

Cabral J. (2013) The value of evaluating parenting groups: a new researcher's perspective on methods and results. *Community Practitioner* **86(6)**: 30-3.

Crouch E, Radcliff E, Strompolis M, Srivastav A. (2019) Safe, stable, and nurtured: protective factors against poor physical and mental health outcomes following exposure to adverse childhood experiences (ACEs). *Journal of Child & Adolescent Trauma* **12(2)**: 165-73.

Cullen MA, Strand S, Cullen S, Lindsay G. (2014) *CANparent trial evaluation: second interim report.* Department for Education: London.

Douglas H. (1999) The Solihull Approach: helping health visitors to help families with young children. *Young Minds* **40**: 19-20.

Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS. (1998) Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventative Medicine* **14(4)**: 245-58.

Furlong M, McGilloway S, Bywater T, Hutchings J, Smith SM, Donnelly M. (2013) Cochrane review: behavioural and cognitive-behavioural group-based parenting programmes for early-onset conduct problems in children aged 3 to 12 years (review). *Evidence-Based Child Health: A Cochrane Review Journal* **8(2)**: 318-692.

Goodman R. (1997) The strengths and difficulties questionnaire: a research note. *Journal of Child Psychology and Psychiatry* **38(5)**: 581-6.

Johnson R, Wilson H. (2012) Parents' evaluation of 'Understanding your child's behaviour', a parenting group based on the Solihull Approach. *Community Practitioner* **85(5)**: 29-33.

Lindsay G. (2019) Parenting programmes for parents of children and young people with behavioural difficulties. *Counselling and Psychotherapy Research* **19(1)**: 3-7.

Lindsay G, Totsika V. (2017) The effectiveness of universal parenting programmes: the CANparent trial. *BMC Psychology* **5(1)**: 35.

Löfgren HO, Petersen S, Nilsson K, Ghazinour M, Hägglöf B. (2017) Effects of parent training programmes on parents' sense of competence in a general population sample. *Global Journal of Health Science* **9(7)**: 24-34.

Lovibond SH, Lovibond PF. (1995) *Manual for the depression anxiety stress scales (2nd edition).* Psychology Foundation: Sydney.

Pianta RC. (1992) *Child-parent relationship scale.* University of Virginia: Charlottesville.

Scott S, Spender Q, Doolan M, Jacobs B, Aspland H. (2001) Multicentre controlled trial of parenting groups for childhood antisocial behaviour in clinical practice. *BMJ* **323(7306)**: 194.

Vella L, Butterworth R, Johnson R, Law GU. (2015) Parents' experiences of being in the Solihull Approach parenting group, 'Understanding your child's behaviour': an interpretative phenomenological analysis. *Child: Care, Health and Development* **41(6)**: 882-94.

To view references and the full version of this paper, *A randomised controlled trial of the Solihull Approach 10-week group for parents: UYCB,* go to **bit.ly/CP_research_hazel_douglas**

HEALTH FOR ALL CHILDREN

Alan Emond, senior editor of this vital child health reference book, reveals what's new in the fifth edition.

Health for all children was originally published in 1989 as the report of a multidisciplinary working party chaired by Professor David Hall, and the book subsequently became known as the 'Hall report'. The original report reviewed the evidence for screening and health surveillance of children and made evidence-based recommendations for a universal child health surveillance programme.

Subsequent editions in 1992, 1996 and 2003 expanded the evidence base and shifted emphasis onto health promotion and primary prevention. The revised fourth edition, published in 2006, had a significant influence on child health policy across the UK, informing the design of the National Service Framework for Children in 2007, and the child health programmes in the four devolved nations – the Healthy Child Programme in England (NHS England, 2009), Healthy Child, Healthy Future in Northern Ireland (Department of Health NI, 2010), the Scottish Child Health Programme (NHS Scotland, 2012) and Healthy Child Wales (Welsh Government, 2016).

WHY IS A NEW EDITION NEEDED?

An update of this important reference book is now overdue. In the past 13 years, the evidence base to support clinical practice in child health surveillance and health promotion has expanded, and the range of professionals engaged in delivering care to young children has widened. The commissioning of services for children outside hospital has changed, especially in England, and in the past decade child health services have been competing with other priority groups for resources in times of austerity. The world is now digital, and evidence-based recommendations for practice need to be web-based and linked to e-learning.

WHAT'S NEW?

In the latest edition, the review of evidence starts in pregnancy and runs until age seven. The book takes account of different government policies and different models of delivery of the child health programme in the different UK administrations. Evidence from all over the world is critically appraised, but referenced to UK policy and practice, using an approach based on 'proportionate universalism'. The fifth edition of *Health for all children* is available as an interactive online book as well as an e-book and a paperback.

The foundations of health and wellbeing are laid down in pregnancy and the early years. The fifth edition takes a life course approach to child health, starting in pregnancy and extending to the age of seven years, to include transition into school and to cover the early years in education. The scope of the book is to summarise evidence supporting preventive healthcare, health promotion and an effective community-based response to the needs of families and children. The book contains 35 chapters divided into five sections (see panel, *Health for all children sections*, right). Each chapter summarises evidence of effectiveness in the topic area, in health promotion and in universal and selective interventions.

It includes new chapters on, for example, safeguarding, gypsy/traveller health, migrant and refugee children, and school readiness and transition into school.

LEARNING LINKS AND RECOMMENDATIONS

The book summarises evidence about 'why' and 'what works' in health promotion and health surveillance with children and families. Where possible it gives guidance on 'how' to implement and quality-assure a programme and the competencies needed – but does not conclude 'who' should provide the service. Each chapter includes 'learning links' to online training materials and e-learning for health, or to resources freely available to practitioners.

Recommendations are made for commissioners of child health services, provider organisations and trusts, and practitioners. Each recommendation is made on the basis of evidence, and a weighting of the strength of that evidence is attached to

CONFERENCE ALERT

Alan will be delivering a plenary session at the **Unite-CPHVA Annual Professional Conference on 17 October**, entitled *What's new in the fifth edition of Health for all children.*

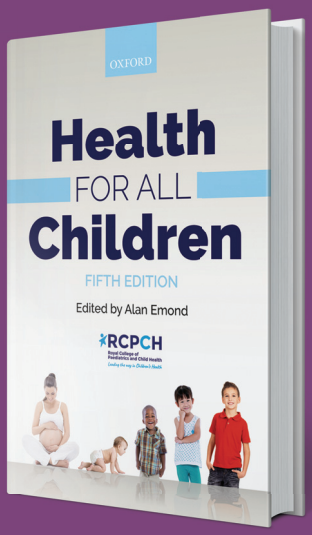
each recommendation. The strength of recommendations is determined by the balance between the quality of evidence, variability in values and preferences, desirable and undesirable consequences of alternative strategies, and resource use.

KEY MESSAGES FOR COMMUNITY PRACTITIONERS

The review and its recommendations will be of special interest to community practitioners. It will also be relevant to managers of child health programmes, and trainees and students from a range of professional backgrounds.

Here are some highlights:

- The evidence base is getting stronger supporting the importance of pregnancy and the first 1000 days in shaping health, psychological and developmental trajectories through childhood into adulthood.
- The strong evidence for the impact of the mental health of the parents in pregnancy and infancy on the developing child requires all practitioners to take action in families with depression, anxiety and inter-personal violence. A perinatal mental health coordinator is recommended for all trusts to develop care pathways and ensure that action is taken on practitioners' concerns.
- Antenatal care is now focused on mothers' health in pregnancy and on the safe delivery of a healthy baby. 'Preparation for parenthood' needs to be reinvigorated, especially for first-time parents.
- To reduce inequalities in health and life chances, a child health programme based on proportionate universalism requires both targeted and enhanced services in addition to universal provision. Targeted services can be commissioned for special groups, but enhanced services require comprehensive holistic assessment of families by skilled community practitioners – in the home as well as in clinic and in children's centres.
- No new universal contacts are recommended, but a flexible approach to the opportunistic identification of growth, developmental and behaviour problems is emphasised.
- Practitioners need to be trained and supported in distinguishing delayed from atypical development, with a clear pathway for referral to a single point of entry for further assessment.



HEALTH FOR ALL CHILDREN SECTIONS

1. Introduction: philosophy and principles
2. Pregnancy, perinatal period and preparation for parenthood
3. Primary prevention and health promotion in childhood
4. Secondary prevention – screening and identification of impairments
5. Children with additional needs and children in special circumstances
6. Components of a child health programme
7. Implementation of a child health programme

- For children in nursery settings, a joint health/nursery assessment with the parents at 27 to 30 months is endorsed.
- The aim of the child health programme should be to promote children 'ready to learn by two, ready for school at five' and school readiness is strongly supported as the outcome of the programme.
- Enhancements to the child health programme, such as Flying Start, A Better Start, Family Nurse Partnership and MECSH are critically reviewed.

The editors and authors of the new edition are not receiving fees – all royalties will go to the Royal College of Paediatrics and Child Health to be invested in future updates of the book.

Alan Emond is a clinical academic paediatrician with more than 40 years' experience of community paediatrics, and emeritus professor of child health at the University of Bristol.

RESOURCES

- The fifth edition of *Health for all children* is published by Oxford University Press and available as a paperback, online book and e-book in Kindle. Order the paperback at **bit.ly/Emond_OUP** and enter **AMPROMD9 to save 30%.** Or talk to your manager or librarian about online access for your team.
- An Early Intervention Foundation report looks at programmes for 0 to 5-year-olds and their families **bit.ly/EIF_start**
- Harvard University offers a resource library **bit.ly/Harvard_library**

TIME TO REFLECT

How might you use the latest review of the evidence to improve your practice with children aged under seven and their families? Share any insights and join the conversation on Twitter **@CommPrac #Health4all**

For references, visit **bit.ly/CP_features**

COMMUNITY PRACTITIONER COURSES

TOUCH-LEARN INTERNATIONAL BABY MASSAGE TEACHER TRAINING COURSE

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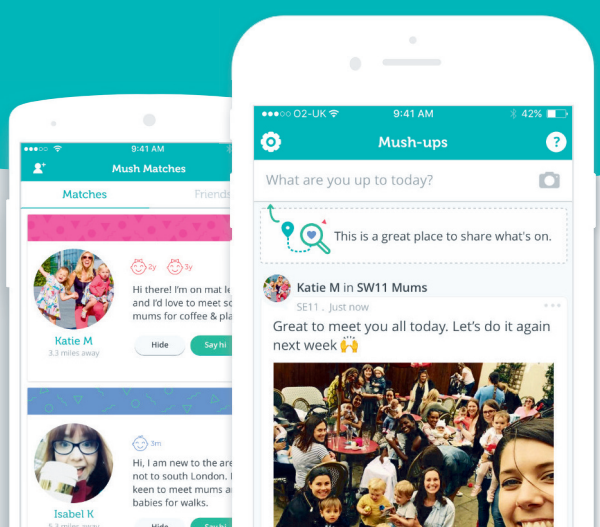

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To find out more about British Lion eggs visit egginfo.co.uk

*Gray, J. Egg consumption in pregnancy and infancy: Advice has changed, Journal of Health Visiting, February 2019, Volume 7, issue 2