

Level 3 Cambridge Technical in Health and Social Care 05871

Unit 25: Research methods in health, social care and childcare

Pre-release material

Friday 22 June 2018 – Morning

First Name						Last Name				
Centre Number						Candidate Number				
Date of Birth	D	D	M	M	Y	Y	Y	Y		

GUIDANCE NOTES

- This pre-release material contains three research articles on three different themes.
- The question paper will require learners to respond to questions about research they have completed and questions which are associated with general research principles.
- Learners need to conduct research linked to the pre-release material in the five weeks they have access to the document.

INSTRUCTIONS FOR TEACHERS

- This material must be issued 6 weeks prior to the published examination date.
- This material must be printed on A4 only.
- Learners are permitted to summarise their research findings and record results/evidence/data gathered **in the notes pages at the back of this document only** (not in the margins or around the pre-release material itself or on additional sheets) and **must not exceed the 2 pages provided**.
- The notes section must **not** be used to produce a formal write-up of the research conducted.
- Teachers must collect in each learner's pre-release material and notes **one calendar week** prior to the exam date.
- Teachers must check that the notes made are appropriate and are the learners' own work in advance of the examination taking place.
- The pre-release and notes must then be returned to learners **immediately before the exam** commences.
- The pre-release and notes **must** be submitted along with the learners' Question Paper at the end of the examination.

INFORMATION FOR LEARNERS

- You **must** choose one of the research articles (source **A**, **B** or **C**).
- You **must** identify a specific focus from the article for further secondary research.
- You **must** then complete further secondary research related to your focus, using **at least two** sources.
- Your notes on the research **must not** exceed the pages provided in this document; no additional sheets may be taken into the examination.
- Your secondary sources **must be** recorded on page 9 of this document.
- Notes are only permitted on pages 10 and 11, not elsewhere within the pre-release material such as in the margins or around the sources themselves.
- You **must** hand in your pre-release material and notes with your question paper at the end of the examination.

SOURCE A

Extracts from and summary of:

Statham, J. (2011) Grandparents providing childcare. Briefing Paper. Childhood Wellbeing Research Centre.

Background

The Families and Early Years Analysis and Research Team at the Department for Education requested a brief review of research evidence and statistical data on grandparents providing childcare. This was carried out (over ten days) during July 2011. Initial discussions clarified that the focus should be on the provision of care while parents work/study, and also contact (i.e. the time grandparents spend with grandchildren more generally, and any trends in this). The review also addresses contact between grandparents and grandchildren after parental divorce or separation.

Aims

To understand further the role of grandparents in providing child care for grandchildren and the impact on wellbeing (child and adult).

Methods

A range of databases were searched for relevant publications between 2001 and 2011, using search terms such as 'grandparent', 'grandchildren', 'care', 'childcare', 'daycare' and 'contact'. Websites of key research centres known to undertake relevant research in other countries were also searched, in particular the Australian Institute of Family Studies, as well as websites of organisations such as Grandparents Plus in the UK. Additional material was identified through reference harvesting. Data on the extent and type of grandparent care in other countries was restricted to the UK, but particularly relevant studies from other countries on the impact of grandparental care were included. Key messages were extracted from the most relevant publications (identified from their abstracts) and the evidence collated to address the research questions.

How extensive is care by grandparents?

Grandparent care can take many forms, from occasional babysitting through regular help with child care to being the sole or main provider of childcare while parents work, or living with their grandchildren in multi-generation households. (Grandparents may also care for grandchildren whose parents are unable or unwilling to do so but these situations are not covered in this review).

Studies of the extent of grandparent care do not always specify the circumstances in which it occurs, its hours and frequency or the other care arrangements that parents may use alongside grandparent care, making it difficult to form a clear picture. The Childcare and Early Years Survey in 2009 carried out by NatCen for the Department for Education (Smith et al 2010) (based on just over 6,700 parents with children under age 14 randomly selected from Child Benefit records) found that around 26 per cent had received help with childcare from grandparents in the previous (term-time) week. Useful information on care by grandparents for children at different ages is provided by successive sweeps of the Millenium Cohort Study (MCS). When children were nine months old, grandparents provided at least some care for 42 per cent of families, rising to 71 per cent of families where the mother was in employment or studying. Grandparents were the main childcare arrangement for 35 per cent of families where the mother was working or studying when the child was nine months old, ahead of all other types of care (Dex and Joshi 2004).

Who uses grandparent care?

Analysis of data from the Avon Longitudinal Study of Parents and Children (ALSPAC) showed that grandparents are more likely to be involved with first-born children, when mothers are younger (especially with teenage mothers), and where mothers work on a part-time basis. Levels of grandparent involvement were highest for those mothers who returned to work before the child was six months old.

Grandparent involvement was also greater in single parent families and in families where mothers' marital status changed in the first two years of the child's life, but was lower in step-families (Fergusson, Maughan, and Golding 2008).

Families with no financial problems are the least likely to report grandparent care (Fergusson, Maughan, and Golding 2008).

Just under a quarter of parents in the Millenium Cohort Study (MCS) who were educated to degree level used grandparent care compared to 30-36 per cent of less educated parents (Dex and Joshi 2004).

What is the impact of grandparent care on children's wellbeing?

In England, analysis of longitudinal data showed a positive association between grandparental closeness and child adjustment when children were on average nine years old, but by age 14 that link had disappeared (Bridges et al 2007).

Another UK study funded by the ESRC, on grandparenting and child wellbeing as seen through the eyes of young people, surveyed 1596 children aged 11 to 16 and conducted interviews with 40 young people. Greater reported grandparental involvement was significantly associated with fewer emotional problems and with more pro-social behaviour, especially when grandparents were involved in the child's hobbies and interests; their schooling and education; and talking about future plans. A range of factors predicted the level of grandparental involvement including the child's age (greater involvement with younger children), living in a less deprived area, frequent contact, good grandparental health and grandparent-grandchild closeness. Geographical proximity was less important as new technology overcame some of the barriers created by distance (Griggs et al 2010).

What is the impact of grandparent care on children's cognitive attainment and behaviour?

Analysis of MCS data showed that children who had been looked after by grandparents at the age of nine months while their mothers worked had, on average, similar vocabulary scores at age three to those who had attended formal group care (nurseries, crèches, nursery schools and playgroups) and were ahead of those who had been involved in other informal care arrangements. But they were behind on assessments of their school readiness (understanding of colours, letters, numbers etc.). The researchers suggest this may be due to grandparents having less access to settings where children can interact with their peers, such as toddler groups and children's centres (Hansen and Hawkes 2009).

SOURCE B

Extracts from and summary of:

Capstick, A., Ludwin, K. (2015) Place memory and dementia: Findings from participatory film making in long term social care. *Health & Place*.

Introduction

Activities provided for people with dementia in care homes often fail to take account of their individual abilities, interests or choices. Group activities may be based on the assumption that all participants will enjoy the same things and benefit equally from them. The researchers' previous observations showed that during such activities people taking part were often disengaged or bored and/or frustrated. Claims by staff about the success of activities were often based on enthusiastic responses from a small number of participants, while the voices of those who were not able to take part, or did not want to, were less often heard. This study explored the potential for a personalised film-making approach called Participatory Video (PV) to enhance well-being and social participation for people with dementia. PV has been developed for use with people who are prone to social exclusion as a way of facilitating their voices to be heard.

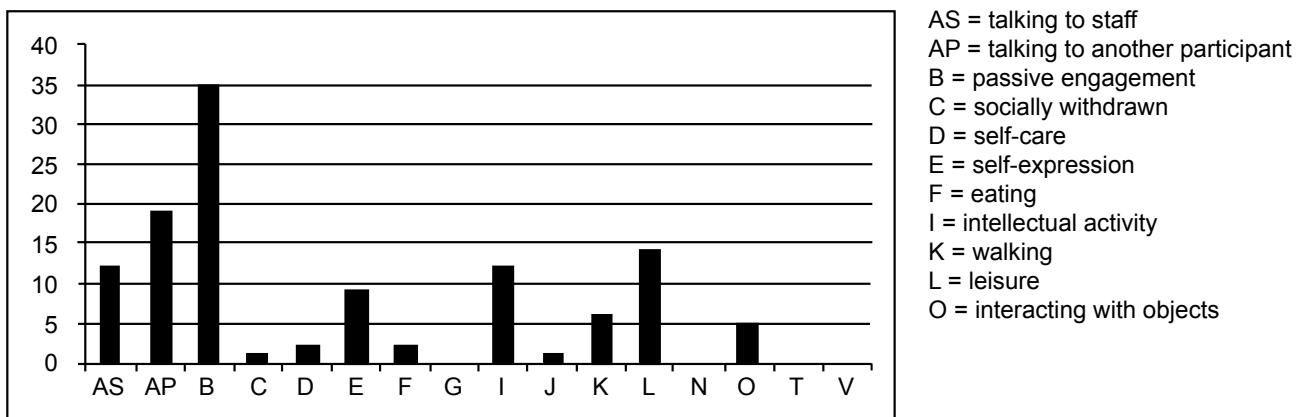
Sample

Fifteen eligible participants were identified. These were people living in long-term social care who were over 65, had a confirmed diagnosis of dementia, and whose current levels of well-being or social involvement gave staff members cause for concern. Of the 15, two died during the study, and it was not possible to proceed with three others for practical or ethical reasons unconnected with the film-making process itself. The remaining ten (two men, eight women) participated in all stages of the study. Their age range was 76 to 99 years (average 87). In accordance with the Mental Capacity Act (2005) personal or nominated consultees were appointed for the seven participants who did not have capacity to consent for themselves.

Baseline measurements

Profile of existing activities in the care environment. At the beginning of the study the researchers observed each participant for one hour when he or she was taking part in an activity already provided by the care environment, for example, a music or art group. The Behaviour Category Coding frame from Dementia Care Mapping (University of Bradford, 2008) was used for this baseline measure of activity. A letter code is used to represent different types of activity. Some codes, e.g. G = going back, or reminiscence, did not feature at all in the baseline observation period. In Figure 1 the vertical axis shows the percentage of time spent in each kind of activity.

Figure 1: Baseline activities



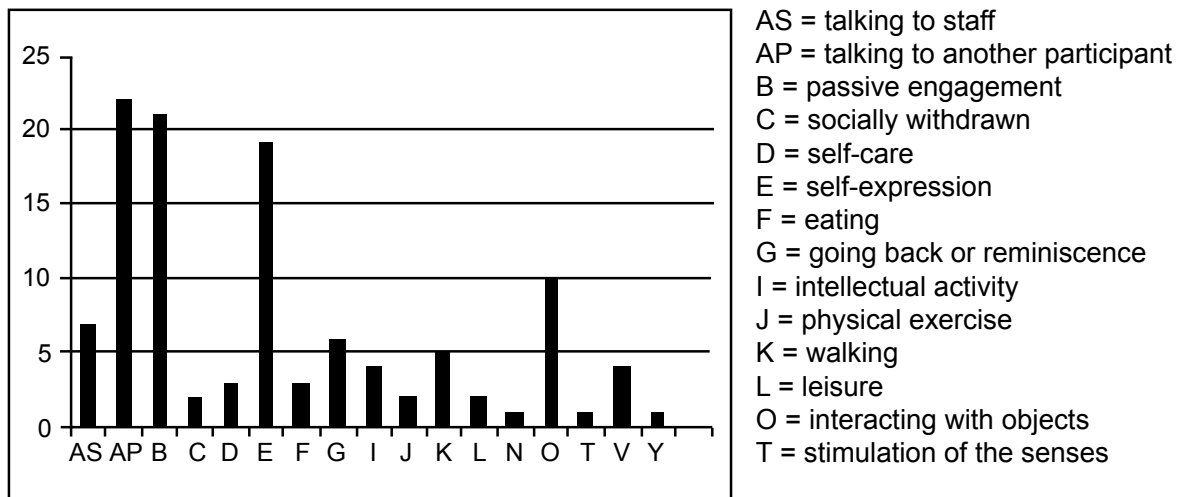
Intervention

Impact of participatory video on meaningful activity and well-being. Each participant had six one-hour sessions with the researchers to choose a subject for their films, identify images, develop a storyboard, create a slideshow and add sound tracks. Subjects chosen included: childhood evacuation from London to the Fens, growing up by the sea, moving from a slum clearance area to new social housing, and joining a cycling club. All themes related to early personal life history, and the majority focused on a specific geographical place. Meaningful activity and well-being mid-way through the participatory video activity were compared with baseline. The predominant activity codes during the film-making process were G (Going back or reminiscence) 59%, AP (Articulation/talking to another participant) 29% and E (Creative expression) 9%. There was an increase in the number of positive indicators of well-being on our measure and a decrease in indicators of ill-being during the film-making process.

Changes in the activity programme at the care environment

After the six-week intervention the researchers observed each participant again for one-hour using the same measure as at baseline. This was to find out whether there had been any changes in the kinds of activity staff of the home were now providing as a result of the study (see Figure 2).

Figure 2: End-point activities



Stakeholder feedback

Two end-of-study film screening events were followed by a discussion group with four of the participants, four relatives, and four staff members. A chaplain and a regional manager from the host organisation, and a commissioner of adult social care services were also consulted. Staff members who had identified concerns about the participants' well-being and participation commented on the value of handing over decision-making to the participants, and also thought the films had an important social history function.

A variety of ways of using PV were suggested: inducting new staff; inclusion in care planning; showing to schoolchildren; and filming activities and outings to watch later on TV. One participant moved to nursing care during the study and staff of the new home found her film useful during this transition. The main concern identified was the time required to sustain the activity. It was suggested that this would stem from more efficient use of staff time, since at present one-to-one time is not always used effectively due to lack of staff confidence. Family members, volunteers and students on work experience could also be taught to use PV. The step-by-step guide currently in production will provide a structured format for doing so. The process itself, carried out entirely using free software, is inexpensive and requires only an Internet-connected PC.

SOURCE C

Extracts from and summary of:

Oyebode O, Gordon-Dseagu V, Walker A, *et al*, Fruit and vegetable consumption and all-cause, cancer and CVD mortality: analysis of Health Survey for England data *J Epidemiol Community Health* 2014;68:856-862.

Introduction

In 1990, the WHO issued recommendations for a minimum daily intake of 400g of fruit and vegetables, based on evidence that higher levels were protective against cardiovascular disease (CVD) and some cancers.(WHO 1990). This led to the launch of the '5-a-day' fruit and vegetable campaign in the UK in 2003, which has shown some limited success in increasing fruit and vegetable consumption in England.

In recent years, there has been some controversy about the relationship between fruit and vegetables and mortality, with implications for health policy. A limitation of much of the previous data is that they come from studies of cohorts defined through occupation particularly physicians and nurses who are likely to be health conscious.

Participants and data

Study participants were adults aged 35 years or over within the Health Survey for England (HSE) who gave permission for their data to be linked to mortality outcome data. The HSE is an annual survey which uses a multistage stratified design to sample a new, nationally representative random cross section of the free-living population of England each year. Participants are visited by an interviewer who collects demographic and socioeconomic data; collects information on health and health-related behaviours; measures height and weight; and requests consent for data linkage. A nurse then visits participants who agree, to take additional measurements (e.g., waist circumference, blood pressure), collect biological samples (e.g. blood) and record information on medication use.

Research ethics approval was obtained from the relevant committees prior to each survey. Participants gave informed consent before taking part.

Response rates varied by year from 72–74% of eligible households participating in 2001–2006 to 64% in 2007 and 2008.

Date of death was known to the nearest quarter and entry into the study to the nearest month. Two thousand six hundred and eighty-two cases (4%) were excluded from this study due to missing information on fruit and vegetable consumption. A further 13 cases (0.02%) were dropped due to errors in the dates, leaving a total of 65 226 participants.

Results

Characteristics of the study cohort

Median follow-up was 92 months (7.7 years); 4399 deaths were recorded within the study population, 6.7% of the sample. Of these deaths, 1398 were due to cancer and 1554 to CVD. At baseline, participants' mean age was 56.6 (SD±14.3) years. Of the sample population 55.6% were female; 20.61% were current smokers; 48.4% had never smoked cigarettes regularly. Mean daily portions of fruit and vegetables consumed by participants in the study were 3.8 (SD 2.6): 2.3 portions of fruit (SD 2.0) and 1.5 portions of vegetables (SD 1.2).

Total portions of fruit and vegetables and all-cause mortality

Fruit and vegetable consumption was associated with decreased all-cause mortality. Fruit and vegetable consumption was associated with reduced cancer and cardiovascular mortality. Vegetables may have a stronger association with mortality than fruit. Consumption of vegetables or salad were most protective, while frozen/canned fruit consumption was apparently associated with increased mortality per portion.

Those who consumed more fruit and vegetables were generally older, less likely to smoke and more likely to be women, in a non-manual household, with degree level education. The proportion of study participants who were vigorously active in the last 4 weeks increased as more portions of fruit and vegetables were consumed. BMI as a categorical variable was significantly associated with portions of fruit and vegetable consumed ($p < 0.001$).

Conclusions

A robust inverse association exists between fruit and vegetable consumption and mortality, with benefits seen in up to 7+ portions daily. Further investigations into the effects of different types of fruit and vegetables are warranted.

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Notes Page

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