CPHVA Position Statement: Hall 4

Caring for children is not only about finding out about things going wrong but also about promoting public health practice and developing the health promotion ethos. The recommendations in Hall 4 calls for a move away from a wholly medical model of screening for disorders towards a greater emphasis on health promotion, primary prevention and targeting effort families at risk and on active intervention for children (from birth to adolescence). These recommendations are firmly rooted in the need for an integrated, evidence based approach in the delivery of services and support for children and families, and they are aimed at all professional who work with children and families, including social work, family support workers, practitioners in schools and early years. The delivery of Hall 4 is integrated with other policy and legislative changes.

The principal of universal access, advocated in Hall 4, is supported if the ethos of health for ALL children is to be promoted. Universal access should not assume, however, that services have to be delivered in a uniform manner. Resources ought to be aimed at those who are most vulnerable within our society with due regard given to the wider determinants of health. There should be sufficient flexibility to allow service planners in partnership with practitioners and families to respond to local variations.

National agreement regarding the appropriate minimal number of contacts would be welcomed. This is not to uphold rigid delivery or prescriptive practice but would ensure consistency in the equity and quality of services. Local variations are beginning to manifest. Some practitioners have expressed concern about management pressure to push through protocols that do not support routine contact between the 10-day visit to the 6-week contact. This is felt to be too long a gap at a potentially vulnerable time. A comprehensive approach to health promotion in early years cannot rely entirely on early years services, although they do have a key role. There does appear to be significant emphasis on contacts being made at pre-school provision, when this is not universal and there is no statutory obligation for children to attend nursery. Therefore there is a danger that some vulnerable families may be amongst those who are not seen regularly in this setting.

There is wide variation about what the constituents of a core programme should be. A general view was upheld amongst health visitors that a core service should consist of an antenatal contact with a minimum of five contacts in the year including 6/8 weeks, ¾ months, 8 months, thereafter at 2 years and preschool. Rather than diminishing the contact it is suggested that the purpose of the contact could be reviewed, for example, using 8 month contact to formally discuss oral health & MMR discussion.

A systematic approach including an assessment at a primary visit during which a programme would be mutually agreed between the practitioner and the family is advocated. It is important that a qualified practitioner, e.g. health visitor, should conduct the first or primary assessment and not a Nursery nurse (NN's) or Health Visiting Assistant (HVA's) to conduct an assessment of need and to negotiate a pattern of contact with the families.

Leadership and team working are key to progressing integrated working with clear lines of responsibility within a framework of Clinical Governance. There must be clarity at all levels

within and across agencies regarding accountability and scope of professional practice. In areas where a health practitioner is employed by social services, clinical supervision, ongoing professional development and support mechanisms must be priority. Models of working employed where there is greater use of multi-skilled and multi-agency approaches should be explored, for example, within Sure Start and Starting Well.

Rationalisation of screening based on sound evidence is supported. As 'needs' are rarely static, there is some concern about who may be held liable if things are missed or an incident occurs with a 'hands off' approach. A stable family at birth could be in need of intensive support within a comparatively short time and because children are so vulnerable systems must be in place to pick up and action support for families if required. Consideration of training around legal issues may be useful to equip practitioners to understand what actions are deemed 'reasonable' and to articulate clinical judgements.

The Family Health Plan is a method towards more systemised working practices. However, detailed information is needed relating to clarify the nature, purpose, ownership and operation of the plans, and relationship of the Family Health Plan with other health records.

There is a growing focus on assessment of 'vulnerability' rather than 'need'. The rationale behind this being that if vulnerability is identified there is an opportunity to intervene before a need becomes manifest. In terms of assessing vulnerability the CPHVA would welcome a standardised approach that could be used by all agencies, with common understanding and agreed definitions. A standardised approach to assessment of vulnerability would be used in conjunction with clinical judgement. Such an approach would have application and be transferable across the spectrum of society. Points that require clarification include:

- Who should carry out the assessment
- Which other services should be involved
- Who should have overall responsibility
- Where and how should the assessment be documented
- How are specific aspects to be assessed
- Issues relating to timing, the use of the tool and identification & allocation of resources.

The intention to support parents and children through multi-agency work must remain the end goal. There is some concern, however, that even in areas where IM&T systems have been developed and improved that there are still significant gaps in communication infrastructures with incompatible systems remaining within health. This is even more evident between health and local authority partner agencies. This is particularly key as circumstances can often change within families following the initial assessment, e.g. change of partner, domestic violence, redundancy. Reduced contacts may mean that changes may not be so readily identified. Clearly, if all agencies that come into contact with a child and family share agreed protocols, agreed referral systems, common language/ terminology, risk will be minimised. Initiatives, such as, the Identification, Referral and Tracking (IRT) pilots are considering approaches to develop and test new ways of information sharing and multi-agency working to establish effective identification, referral and tracking systems for all children at risk from the autumn of 2003. However, currently the reality on the ground does not reflect the aspiration and this is a source of concern to practitioners. Practitioners must find out who

their local IM&T lead is now and engage in discussions around the development of local IM&T systems so that they are 'user friendly' and 'fit for purpose'. Planners and Trusts must recognise their obligation in this also.

The development of clinical networks would support more integrated working practices. Detailed and agreed pathways would provide an opportunity to undertake audit. However, clearly pathologies are not often linear and the development of networks to manage multiple pathologies and the complex situations that can arise within the community setting should be considered.

Increasingly, practitioners are relying upon information systems to support redesigned working approaches and it is essential that these systems are rigorous. Practitioners reported that the Child Health Computer system is potentially a useful resource but the system is often not up to date. In other instances this information is not integrated or compatible with other systems community practitioners may be using and therefore does not enable practitioners to have accessible data when they need it to inform their practice.

The development of a rigorous infrastructure is fundamental to the success of integrated working and safe practice. Health information leads locally must actively engage with practitioners across agencies, and vice versa, to ensure that 'grass roots' opinion is factored into planning and implementation. Consistent mechanisms to identify 'risk' incidents must be transferable and linked, e.g. an incident seen in isolation may not raise concern but several incidents on separate systems (NHS Direct, NHS24, A&E, GP, Education, police & justice) may merit a review. The issue of domestic violence should be considered as an integral component of community child health services. How too would information from Partnership and Private nurseries be fed into the system?

Ambiguity and uncertainty continues to surround the issue of data sharing and confidentiality. Recommendations following the death of Victoria Climbie highlighted this as an issue and it is evident that current legislation relating to this is not protecting some of the most vulnerable within our society. More guidance is required across agencies on this. There are some issues relating to parent held records and practitioners would seek clarity surrounding the Red Book and potential inconsistencies through regions and accountability for documentation within the Parent Held Record.

Redesign of services to maximise the benefits that may be delivered as a consequence of skill mix must be thoughtfully considered with the patient at the centre. For example, practice nurses may do immunisations but this contact must now also have a significant health promotion component. One may argue that practice nurses may not currently have the specific skills to deliver child health promotion (on top of their already broad clinical agenda) as well as the administration of the immunisation. Also the ability of parents to retain information at the time of immunisation administration is questionable. The opportunity to redesign these sessions using the unique skills of the practice nurses and those of the health visitor/ public health nurse should be explored.

Often the term 'family' can be translated as mother and child/ren. There is a role that fathers have in promoting the health of children, in particular given the diversity of families

within today's society. Practitioners and planners need to develop an increased awareness of the role and responsibilities of men in developing services

Cultural change across the health, social care and early education systems, including children's services within local authorities should remain a fundamental goal. There needs to be greater collaboration and joint training is an obvious route to developing shared understanding of each others role and to consider the unique contribution of each profession in the child's well being. This may be labour intensive to initiate but will be less so when this becomes the norm. Common systems for communicating standard information across agencies may be useful. In some areas, multidisciplinary action learning sets have been employed with clinical supervision a component of this. Self-selection of a clinical supervisor may mean poor practice may be less likely to be challenged.

Policies relating to point planning and delivery of services appear to provide a sensible mechanism to draw many of the disparate strands that deliver children's health services together. However, ultimate accountability must lie jointly with Chief Executives within respective agencies to ensure the agenda is delivered otherwise there is a risk that this responsibility may be discharged without real authority.

The philosophy of partnership working approaches is applauded but there remains a sense that partnership working is still not palpable to 'grass roots' practitioners. Chief Executives must be constantly vigilant that partnership approaches across agencies ad at all levels must be actively worked upon. Mechanisms to bring services working with children together must be part of the integration process. A failure to develop systems to protect the most vulnerable within society cannot be tolerated.

In practice real partnership approaches are inhibited where practitioners are not working within a defined area or population with caseloads that are dictated by GP registered lists. These caseloads are often so dispersed that practitioners are working into several areas/communities. The way some are organised does not promote a coordinated, partnership approach with common objectives and targets across both health and other agencies where trust might be built and a strong network of workers can jointly identify the local needs, with local families/ communities and consequently define local priorities to influence service provision. Greater emphasis needs to bear on the development of a sustainable public health incorporating community development approaches when planning, implementing and evaluating services.

The joint working agenda drives the need for service planners to be attentive at the onset of issues relating to professional accountability, role clarity and employment issues across agency 'boundaries'. This may mean that mangers of children's services may be required to undertake training to more fully understand the complexities of employment law and/ or encourage partnership working with staff side representatives.

The increased emphasis towards health promotion and prevention is one that the CPHVA strongly advocates. However, at present community based approaches are often shoe- horned

into traditional working practices. The significance of this approach is not often acknowledged and historical views/ practices, which are entrenched within general practice, mean that health promotion and prevention activities are often marginilised. Practitioners felt that often the relevance and intricacies of public health was poorly understood within health agencies far less across other agencies in the face of perceived 'quick wins', e.g. waiting times. The government must also recognise this.

There is a challenge for professionals in modifying their approaches to empowering communities more fully. The DOH 'Toolkit for health visitors and school nurses' identified that practitioner's skills were often weaker in Community Development techniques and in being Political/ lobbying.

A period of consolidation or a supported mentoring period following qualification is seen as a positive step to allow newly qualified practitioners to attend additional training on specific practice/ clinical sessions that relate to community child health services. Such sessions may also serve as an update for established practitioners as part of a systematic continuous development programme further enhancing quality. Practitioner's felts that practical training, for examples, in identifying squint and hearing anomalies should continue despite orthoptic screening, distraction testing, etc should continue to maintain skills. Funding and protected learning time (with relevant backfill) across agencies must be visible if shared learning and continuous improvement is to be seen as a legitimate activity.

The concept of skill mix is viewed as a sensible step forward on the condition that it is done to further compliment the existing skills within the team and in response to population and local resource profiles. Nursery Nurses (NN's) and Health Visitors Assistants (HVA's) are valuable contributors to community child health teams. Training may be required around the 5 curriculum areas. Some areas have developed standardised training schemes for HVA's – immunisation clinics, support visits to non-complex visits, default appointments. Remember that skill mix may not be confined to health but include, for example, family support workers perhaps employed by Social services or voluntary organisations, as in Sure Start and Staring Well initiatives.

The increased focus on the continuing requirements of children beyond early years and into early adulthood which recognises the complexity of needs that within this age group is welcomed. This opens a raft of opportunities for the development of creative working across agencies, for example through community schools and with a firm commitment in the investment in school nursing.

Reference

'Health for all Children' 4th edition, edited by David M.B. Hall & David Elliman
Health for all children website www.health-for-all-children.co.uk

Anna Daley
Professional Officer CPHVA, Scotland

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