Briefing paper: Health for all children (Hall 4)

Introduction

The CPHVA welcomes the recommendations of the 4th edition of *Health for all Children*. It gives the range of practitioners who work with children and families an opportunity to review how they can deliver preventive and health promotion services. The recommendations in Health for all Children 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 at families at risk. It highlights the need for an integrated, evidence based approach in the delivery of services and support for children and families: with greater partnership approaches between health practitioners and statutory and non-statutory agencies through education, working practices and organisational design. The delivery of Hall 4 is integrated with other policies, for example the National Service Frameworks, and other 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 most in need 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.

The focus on the requirements of children beyond early years and recognition of the contribution of school nursing in delivering health improvements is welcomed. This opens a raft of opportunities for the development of creative initiatives led and co-ordinated by school nurses, across health and education. However, this will require investment in the service.

Core Programme

There is wide variation about what the constituents of a core programme should be. This leads to a lack of consistency in the equity and quality of services. Anecdotal evidence suggests that many health visitors feel that a core service should consist of an antenatal contact with a minimum of five contacts within the first year, which may include 6/8 weeks, 3-4 months, 8 months; thereafter at 2 years and pre-school. 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. Opportunities to also work in a multi-skilled, multi-agency way with examples of this type of approach within Sure Start, for example, working within the local libraries, promoting early literacy through Book Start and fun activities, such as story times, alongside health input supporting families in their parenting and understanding of their child's development with perhaps input from speech and language therapy assistants (library staff, health visiting service, family support workers, speech and language workers). Clearly local circumstances will influence the components of a core programme, however guidelines that are developed at local level should reflect the needs of all children and families. Service planners must be able to demonstrate transparent processes in the development of guidance for practitioners adopting partnership approaches and exploring the use of robust assessment tools and criteria. Newly qualified staff in particular will need a straightforward pathway to follow.

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 Health Visitor, and not an Early Years Worker/ Nursery Nurse or Health Visiting Assistant, should conduct an assessment of need to negotiate a pattern of contact with the families.

Early years workers have a key role in the delivery of preventative and health promoting services. However a comprehensive approach cannot rely entirely on early years services making pre-school contacts, as there is no statutory obligation for children to attend nursery. There is a danger that some vulnerable families may be amongst those who are not seen regularly in a pre-school setting.

Attention also needs to be given to transition issues of pre-school children into primary school and again between primary six/seven and secondary school. A protocol-based approach may be reasonable to manage the transfer of information. Also it must be remembered that reviewing children in these settings provide limited opportunities to review family health needs or provide health education.

Needs assessment

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 as a result of reduced contact. A stable, apparently not vulnerable family at birth, could be in need of intensive support within a comparatively short time, adolescents can raise a myriad of complex issues that were not manifest earlier. It is because children are so vulnerable that systems must be in place to pick up and action support for all families, if required. Practitioners need to be systematic about the process around determining a contract of care with a family and be rigorous about maintaining accurate and informative 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. However, narrowly defined lists to target vulnerability and to identify need should be regarded with caution. Children and families can be vulnerable for a wide variety of reasons including the spectrum from a first time mother breastfeeding to a first time mother with a drug dependency and chaotic lifestyle. However, inn 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. Some examples of work in this area include the *Framework for the assessment of children in need and their families (Wales)*.

The Family Health Plan is one 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.

Communication, partnership and integration

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?

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. Points that practitioners should clarify 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 and issues relating to timing, the use of the tool and identification & allocation of resources. It is, however, acknowledged that there are currently 10 pilots within England using Passport for Services to consider all of these issues. This is on the back of the recommendations of *Every Child Matters* and will provide a child index for all workers across agencies to enter and retrieve information on a needs to know basis on children to support the identification of vulnerable children and clear auditable pathways of care.

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, though the imminent Children's Bill is expected to address this. More guidance is required across agencies on this. There are some issues relating to Personal Child Health Record; clarity is required regarding accountability for documentation within the Personal Child Health Record, inconsistencies exist throughout regions in its application and how it fits with other NHS documentation.

Leadership and team working is 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 a 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, children's centres, children's trusts, Starting Well, and extended and full service schools.

Skill Mix

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. Early Years Workers/ Nursery Nurses, Health Visitors Assistants, and registered nurses are valuable contributors to community child health teams. 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 Starting Well initiatives

Redesign of services to maximise the benefits that may be delivered as a consequence of skill mix must be thoughtfully considered with the child and family at the centre. The unique contribution of everyone within the team, including, for example, nursery nurses or early years workers and practice nurses, to deliver effective prevention and health promotion strategies must be considered and learning from the models of working within Sure Start. Health visitors have a unique position of leading such teams, as outlined in policies such as *Making a Difference*. and *Nursing for Health* . Training may be required, for example, around the 5 curriculum areas and some areas have developed standardised educational schemes for Health Visiting Assistants – immunisation clinics, support visits to non-complex visits, default appointments.

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. 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.

Cultural change across the health, social care and early education systems, including children's services within local authorities should remain a fundamental goal, particularly with the advent of Children's Centres and Children's Trusts. There needs to be greater collaboration and joint training is an obvious route to developing shared understanding of each other's 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. The recent *Chief Nursing Officer Report (England)* and the *National Service Framework for Children, Young People and Maternity Services* further endorse this way of working, with the promotion co-location working in teams. In some areas, multidisciplinary action learning sets have been employed with clinical supervision a component of this.

Policies relating to joint 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 will be 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 co-ordinated, 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 sustainable public health incorporating community development approaches with planning, implementing and evaluating services, with due consideration of facilities management to accommodate staff appropriately.

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

Community Development

The Child Health Promotion approach aims to support the local community in creating an environment at home and at school, in which a child can be safe to grow and thrive physically and emotionally. This increased emphasis towards health promotion and prevention with recognition of mental and social as well as physical health needs 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. Some practitioners perceive that 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.

Practitioners and planners need to develop a broader awareness of the role that all family members have in developing services for children. Too often the term 'family' is translated as mother and child (ren). The role that fathers and other extended family members have in promoting the health of children, given the diversity of families within today's society, should be reflected in practice. Identification of standards relating to the development of agreed training and competencies across disciplines would provide guidance to inform education and practice.

There is a challenge for professionals in modifying their approaches to empowering communities more fully. The school nurse and health visitor practice development resource toolkits may assist to this end. Consideration of training around legal issues may be useful to equip practitioners to understand what actions are deemed 'reasonable' and to articulate clinical judgements.

References

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Every Child Matters: www.dfes.gov.uk

Framework for the Assessment of Children in Need and their Families :
www.wales.gov.uk

Sure Start: www.surestart.gov.uk

Starting Well Health Demonstration Project :
www.gorbalslive.org.uk/data/community/cgroups/startingwell.htm