Best Health for Children

Implementation in ERHA Region

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### Recommendation 5

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### Issue 6. Information Systems

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### Recommendation 6

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Terms of Reference

To review the recommendations made in Best Health for Children.

Document the progress to date in implementing the recommendations in the three health boards in the eastern region.

To document progress made in the other health boards.

To determine what is feasible in terms of implementation in the three eastern region area health boards and to propose an action plan for the Child Health Development Officers.

To develop ideas for demonstration projects using the experience of the other health boards, bearing in mind the goals for child health in the Department of Health and Children strategy documents.
Chapter 1  Best Health for Children Report

Background

The national health strategy document published in 1994, 'Shaping a Healthier Future' stated that a detailed review of the pre-school and child health services would be performed during 1994. [Department of Health, 1994 #1]

In 1996 the Chief Executives of the eight Health Boards commissioned a review of the screening and surveillance services for children in Ireland. Drs Seán Denyer, Lelia Thornton and Heidi Pelly performed this review, which was completed in 1998. The report 'Best Health for Children. Developing a Partnership with Parents' was released in 1999 and was launched in December 1999. [Denyer, 1999 #2] This report may be seen on the Best Health for Children website: www.besthealthforchildren.com

From this point on in this document the above report will be referred to as Best Health for Children.

The terms of reference of this group were:

To define a programme for child health surveillance in the pre-school and primary school age group, the content of which would be based on the best available evidence.

This review addressed the following areas:

- Content and timing of the programme
- Roles and responsibilities, including accountability
- Partnership with parents
- Training
- Information management
- Resources
- Opportunistic health promotion
- Quality assurance

The review employed the following methodology:
- Review of published and unpublished literature, both Irish and international. This focussed on the evidence for screening and surveillance and addressed issues of management, organisation and training.
- A broad consultation process involving interviews with professionals working with children, service managers and representatives of consumer groups.
- Qualitative research with consumer groups
- A multidisciplinary workshop
- A working group on parent held records.
- A working group on the birth notification system
- A workshop on parent support

The key themes of the Best Health for Children report are based on:
- Developing a child centred health promotion approach
- Creating partnership between professionals and parents
- Quality assurance systems and procedures that support screening
- Screening based on evidence
- Improved co-ordination for children with complex problems
- Improved management and increased accountability.
Recommendations were made on the following areas:

- Perinatal reporting system
- Behaviour problems and psychiatric disorders in childhood and adolescence.
- Promoting children's health through parent education
- Parent health child records
- Roles and responsibilities of professionals
- A national child health surveillance programme
- Newborn screening for metabolic disorders
- The six week examination
- Screening for hearing defects
- Screening for vision defects
- The school health service
- Idiopathic adolescent scoliosis
- Referral pathways and information feedback
- Monitoring child health surveillance: information and outcomes.

Following the publication of the *Best Health for Children* report structures were put in place to implement the recommendations therein. In the summer of 1999 two National Child Health Co-ordinators, Dr Ailis Quinlan and Ms Caroline Cullen, were appointed and were given the brief to implement the report.

All boards agreed to set up some form of steering committee to oversee implementation of the process and to establish which elements of the report
were being delivered and to identify elements, which were not. Priorities for service development and resources were then to be agreed locally. Each board was asked to choose one aspect of the Best Health for Children report as a topic for a demonstration project, the idea being that, once evaluated and refined, this action could be replicated throughout the other health boards.

A National Conjoint Child Health Committee was established in early 1999 to oversee the implementation of the Report's recommendations and to oversee further development and implementation of work on child health in Ireland. The committee includes representatives from each health board, the Department of Education and Science, the National Parents' Council, an observer from the Department of Health and Children and others with particular areas of expertise. The full membership may be seen in Appendix 1. This conjoint committee is advisory in nature and is composed of personnel who are experts in a wide range of fields but who may not necessarily be involved in the operational aspects of the health service. Various sub-committees of the National Conjoint Child Health Committee were established to address specific areas. To date, two major strategy documents have been published, namely an adolescent health strategy, 'Get Connected: Developing an Adolescent Friendly Health Service' and 'A Supporting Parents Strategy --- Investing in Parenthood to Achieve Best Health for Children'. A report addressing training for doctors and nurses in child health surveillance has been published, as has a document concerning the development of Child Health Indicators. Sub-committees are currently considering issues around the newborn metabolic screening programme, planning for the implementation of neo-natal Cystic Fibrosis screening, and planning the implementation of a quality assured universal neo-natal hearing screening programme.
Initially the National Health Board Child Health Steering Committee was established to draw up service plans and is involved in the operational aspects of the implementation of Best Health for Children and acts as a conduit for information between the committee and health board personnel. The membership of this committee may be seen in Appendix 2.

This committee dealt exclusively with children in the 0 to 12 year old age group. Subsequent to the publication of the adolescent health strategy, 'Get Connected: Developing an Adolescent Friendly Health Service', a national health board adolescent health steering committee was established. [National Conjoint Child Health Committee, 2001 #4] This committee has a brief for the 12-18 year old age group.

Both committees have similar objectives:
To share information re best practice and
To allow for a co-ordinated approach to child and adolescent service delivery.

Endorsement

The Best Health for Children initiative has been endorsed in a number of government publications. The National Health Strategy, Quality and Fairness: A Health System for You, endorsed the Best Health for Children's co-ordinated approach to the protection and promotion of children's health in partnership with parents and professionals. The document outlined a number of actions to improve children's health and child health services among which were the development of an integrated national programme for child health, the development of national minimum standards / targets for surveillance and screening. Such actions complement a number of the recommendations of the Best Health for Children for Children report.
The National Children's Strategy, 'Our Children - Their Lives' in 2000 set out a ten-year plan to improve the quality of all services to children through coordination and planning at local and national level. [ , 2000 #5] The strategy plans that all actions will be child centred, family oriented, equitable, inclusive, action orientated and integrated. The strategy seeks to establish the 'whole child' perspective at the centre of policy development and service delivery.
The National Health Promotion Strategy aims to raise public awareness of the numerous determinants of health through multi-sectoral action.

The Chief Medical Officer's Annual Report in 2000 reiterated the findings of the Best Health for Children review and referred to the need for wide-ranging reforms to develop health promotion and child-centred services. [Chief Medical Officer, 2000 #3]
Chapter 2  Progress in the eastern region

Introduction

A Regional Implementation Committee was established in 1999, in the former Eastern Health Board, with the following terms of reference.

- To identify the priorities for implementing the recommendations of *Best Health for Children*
- Devise a targeted action plan for two-year implementation
- Support the regional co-ordinator in carrying out their role
- Identify resource implications and make recommendations to the appropriate Chief Executive Officer, Area Health Board / ERHA
- Report as appropriate to the Chief Executive Officer, Area Health Board / ERHA

The membership of this committee may be seen in Appendix 3.

This following progress was made by the Regional Committee before it was disbanded:

- The committee identified the need for a project manager / Child Health Development Officer in each area health board. Funding was provided in 2001: Suzanne Kirwan to insert data here.
- A Regional demonstration project 'Developing Best Practice in Child Health Development Examination' was identified in which the three area boards would participate in a particular aspect:

  1. The SWAHB to focus on attendance rates for the developmental examinations, patterns of attendance, waiting time for
appointment, numbers referred for specialist opinions etc. A profile of non-attenders to be performed, to identify factors influencing attendance, which may thus in turn be addressed and monitored.

2. The ECAHB to address the screening processes with reference to screening for hearing defects.

3. The NAHB to focus on consumer and provider satisfaction with the developmental examination.

- Part time researchers to support the Child Health Development Officer in each area health board were also required.
- A Child Health Co-ordinator in the eight districts in the region.
- Estimated costs for the proposed three-year implementation were presented.
- The need for a comprehensive survey of health centre facilities was also identified in particular those facilities where vision and hearing screening is performed.
- The need for a comprehensive and effective information system to record and monitor surveillance data was identified and was under review in the region at this time. The Committee was keen to participate in and advise on the development of such an information system so as to ensure that the Best Health for Children programme may be effectively implemented.

The Eastern Regional Health Authority was established in 2000 and three area health boards were set up: the Northern Area Health Board (NAHB), the East Coast Area Health Board (ECAHB) and the South Western Area Health Board (SWAHB).

The Regional Implementation Committee continued to meet and advised the early establishment of a Steering Committee for Best Health for Children in each area health board. In anticipation that these three committees would be
convened the Regional Committee did not arrange any further meetings but agreed to reconvene if necessary to provide support and advice.

While the new structures in the eastern region were being put in place little further progress was made in implementing Best Health for Children in the Area Health Boards.
The Northern Area Health Board delivers the health and personal social services to the families and individuals in Dublin City, north of the River Liffey and the community of Fingal County. It comprises the Community Care Areas 6, 7 and 8 of the former Eastern Health Board and has a population of 455,000 based on the 1996 census. It is anticipated that this population will increase when the results of the 2002 census are available in the latter half of 2002.

Implementation of Best Health for Children

A Steering / Implementation Committee has not as yet been convened. Since the board’s establishment in 2000, staff for many departments has been recruited on a continuing basis. The board has understandably been occupied with general strategic and service issues and Best Health for Children has to date not been considered a priority area. As a result appropriate structures are not yet in place to prioritise the Best Health for Children initiative.

A Director of Health Promotion was appointed in the latter half of 2001 and the staffing complement of this department is now just being attained. This department has a large number of staff, many of whom will have a significant role in both child and adolescent health issues. In this Board as in the other Area Boards the responsibility for the operational and planning of child health services crosses over two management lines resulting in no single person with responsibility for the implementation of Best Health for Children.

The post of Child Health Development Officer was advertised but not filled in early 2001. The reason this post was not filled is considered to be the fact that it was a Grade VI1 post and was advertised among a variety of other posts and therefore was not given due prominence and recognition.
Combining the Best Health for Children and Adolescent brief along with a general health promotion role is now under consideration and it is hoped to advertise this post in the near future at a Grade V111 level.

The board now appears to be in a position to consider the implementation of Best Health for Children and plans to proceed as follows:

- To convene a steering / implementation committee to plan progress. Membership of this committee will probably initially be just the key management personnel: Director of Services for Children and Families, Director of Health Promotion and Group Services Manager.
- Advertise the position of Child and Adolescent Health Development Officer.
- Commission a demonstration project.
- Make the Best Health for Children report available to all relevant staff and ensure that its content becomes familiar to all.

The board is keen to commence the implementation of the Best Health for Children recommendations, to learn from the experience of other boards and may commission a demonstration project while awaiting the appointment of a Development Officer. With regard to the demonstration project there are a number of areas in the board's service plan, which could be adopted and used in the context of a demonstration project.

The evaluation of health centre facilities with regard to suitability as venues for child health surveillance was suggested during the course of this review as a suitable topic. The Western Health Board considered a similar project, but the cost was in excess of available funds as other projects had been undertaken under the Best Health for Children initiative.

A survey of those (staff and clients) who use the health centres would be a valuable exercise in obtaining an overall view of the general suitability of
premises. Such a survey could look at access, noise levels, changing facilities, waiting areas, comfort, security etc. The planning phase of a number of new health centres built in the board’s area in recent years probably involved consideration of the above factors, making them a useful reference for review of the older centres.

Results of such a survey could be used alongside the technical aspects in the planning or refurbishment of health centres and would aid in ensuring that the facilities where child health surveillance (in particular vision and hearing) is carried out are appropriate in providing a child centred quality service.

A third topic, considered during discussions with the Board, is a parenting skills initiative. This could be also considered as a demonstration project under the auspices of developing a partnership with families.

Summary

While no concrete progress has been made in implementing Best Health for Children in the NAHB, a number of individuals are keen that the initiative progresses. However, without a dedicated person or persons to drive the initiative progress will be slow. The lack of profile of Best Health for Children has more than likely played a major role in this situation and the fact that those currently involved in the Best Health for Children initiative were unaware that a demonstration project had been identified for the three Area Boards.
The ECAHB provides health and personal social services in the former Community Care Areas 1, 2 and 10, but excluding west Wicklow. It has a population of 325,000 based on the 1996 census. This figure will no doubt increase when the results of the 2002 census are available.

**Implementation of Best Health for Children**

A Steering / Implementation Committee was convened and met on one occasion in early 2001. This committee was referred to as the 'Area Implementation Group Committee' and consisted of health board personnel, representing management, clinical services, public health nursing, social work, speech therapy, mental health and disability services. At this meeting a decision was made to advertise the position of the Child Health Development Officer. No further meetings of this group were subsequently held.

In August 2001, Ms Marian Quinn was appointed as Director of Children and Family Services. In this board Ms Cate Hartigan, A/CEO has responsibility for the operational aspect of services for children and families, except for the operational aspects of child health which is the remit of Mr Martin Gallagher, A/CEO. Therefore, the planning and development of child health services crosses over two management lines.

In October of 2001, it was decided that the board would convene a single committee to look at both adolescent and child health. The composition of the original committee referred to above was considered to be too health board orientated and a decision was made to convene a regional forum, to include managers, practitioners and health board personnel as well as representatives.
from external organisations. This composition probably reflects the background of the Director of Child and Family Services in youth work and education and was decided on to ensure that appropriate links and relationships are made with relevant agencies outside the board concerned with services which impact on both children and adolescents. This structure is similar to that recommended in the *Children First Report* published in 1999, i.e. co-operative interagency and multidisciplinary work.

The Implementation Committee was given the following terms of reference:

- To co-ordinate recommendations and implementation of the *Best Health for Children Report* and the *Get Connected Adolescent Health Report*.
- To inform the Community Care Groups and be guided by them
- To ensure appropriate links are made with relevant agencies and initiatives
- To oversee the development of a regional demonstration project
- To meet on a quarterly basis

In order to convene a committee representative of all stakeholders, a one-day conference was arranged with representatives from health board and external agencies. The aim of this conference was first of all provide an introduction to *Best Health for Children* policies, its key themes and recommendations, to establish working groups to consider these recommendations and then to establish an implementation committee to oversee the implementation of these recommendations. This committee has been given the title of 'Regional Implementation Committee', which may be confusing to the reader. In effect the committee is an area board committee.

A number of themes (13) were identified from the *Best Health for Children* report and from the *Get Connected* report on adolescent health. Participants were asked to consider these themes and to prioritise 8 for further action. Working groups would then be convened with representation of all relevant stakeholders.
The 13 themes were as follows:

- Child health surveillance services
- Child health surveillance training needs
- School health services
- Child health referral and information feedback mechanisms
- Partnership and communication with parents
- Roles, responsibilities and training needs
- Health services for children and adolescents
- Hospital services for children and adolescents
- Risky behaviours in relation to health
- Health needs of homeless young people
- Health needs of children and adolescents from minority groups
- Accidents and injuries
- Mental health issues

The 8 prioritised themes (in bold in the above list) were then considered by 8 working groups, with the following terms of reference:

- To identify what has already happened locally, regionally and nationally.
- To link and be informed by existing learning and knowledge
- To interpret policy, strategy and recommendations from the reports
- To make recommendations regarding local structures/initiatives which would enable the implementation of these recommendations.
- Feedback to and from the CCA care groups
- Feedback to the Best Health for Children Implementation Committee
- To meet four times in the coming year, (including a final feedback forum).

Participants were asked to either commit to being part of the working group or to seek the nomination of another representative of their relevant agency or organisation.
The new Implementation Committee will then consist of a representative from each working group, from the key care group in each CCA, the Best Health for Children, Child and Adolescent Health Co-ordinator (a.k.a. Child Health Development Officer), others co-opted for their expertise or experience and will be chaired by the Director of Child and Family Services.

A Child Health Development Officer has recently been appointed to the board (early April 2002) to progress the implementation of the recommendations of both the child and adolescent health initiatives.

**School Health Services**

In the area of school health during the one-day meeting mentioned above representatives from both the health services and the education field identified a major deficit in the awareness of each other's role and committed to undertake a base line audit of the general school health service. A second meeting of the group was held a number of weeks later. The group plans to first gather basic information to identify the key personnel with responsibility for the planning and delivery of the school health service, the school dental service and the school immunisation service. This information will then be used to perform an audit of services currently provided by the board to schools.

The Child Health Development Officer and the Senior Health Promotion Officer and the immunisation co-ordinator for schools will each have roles in progressing this audit. The information gleaned from this exercise will be used:

- To assist in the development of minimum standards and to work through the provider planning process to deliver these services.
- To develop minimum standards and protocols for service delivery.
- To provide a forum for sharing information and to identify how services to schools can be co-ordinated and communicated to schools.
• As an aid to developing a means of communication with schools and an information tool for parents with regard to the availability of the various elements of the school health services.
• To develop a partnership between the schools and the relevant health service.

This audit will commence in May and was considered as a possible demonstration project for the board.

The Child Health Development Officer has just recently taken up her post and will be the liaison person for the various sub-groups.

Following the appointment of the Child Health Development Officer progress has been made in formally identifying demonstration projects for both children and adolescents. The membership of some of the working groups has been altered as the initial composition was proving to be too diverse. The groups will now be made up of key players and will draw on the expertise of others as and when required.

The National Child Health Steering committee suggested guideline templates for funding submissions for demonstration projects. Each board has been advised to apply for the same level of funding (€200,000 per health board).

In 1999 the former Eastern Health Board Implementation Committee suggested a regional demonstration project in the area of child health developmental examinations. The committee suggested that the ECAHB should look at the screening processes with reference to hearing defects.

In the area of adolescent health a project 'looking at methods of empowering parents to provide an environment conducive to positive emotional development using an interagency approach', is being proposed. Another proposal is the compilation of an index of services for adolescents in the board's area.
Summary

While the East Coast Area Health Board (ECAHB) has developed a method for the implementation of the recommendations of both the Best Health for Children and adolescents reports, and is unique in having convened an implementation committee with an inter-agency and multidisciplinary membership, it appears to have taken on a task much greater than that recommended by the Best Health for Children authors and may be attempting to do much too quickly. This is reflected in the committee's terms of reference (see page 16) and in those of the working groups (see page 17). The latter have been set a task, which more or less amounts to a review of existing services and the drawing up of a service plan for the year ahead.

While acknowledging that the board is new and must naturally plan its services, using the Best Health for Children as a means to such an end makes no sense. The progress to date in the identification of themes relating to both child and adolescent health is laudable but it appears that the methods chosen are more appropriate to solving all problems in the child health service. Many of the issues considered by the working groups at their initial meetings are not the recommendations of Best Health for Children and should be addressed from a different perspective and funded through normal health board channels. The Best Health for Children budget is small on a board level as well as on a national level and funding requests for large-scale projects are unlikely to succeed.

However as the work to date has been carried out in the absence of a dedicated person to co-ordinate activities, i.e. the child health development officer, the above criticism may prove to be excessive. As the ECAHB is new and structures are still being put in place attempts to solve all problems under the auspices of Best Health for Children are perhaps ill-advised.
The present composition of the board’s Steering / Implementation Committee, with its eight subgroups, aims to look at various aspects of child and adolescent health, but it precludes some elements of the implementation of Best Health for Children, as for example there is no group looking specifically at training for doctors and nurses involved in child health surveillance.

Training issues have been identified by the group looking at the child health surveillance service, nonetheless similar issues are of relevance to the doctors and nurses involved in the school health service, usually the same group of professionals. Without a dedicated plan to provide improvements in training it will not be possible to deliver the core surveillance programme in an evidence-based manner.

From discussions with a number of personnel in the Board the lack of progress to date appears to be the result of a number of facts: firstly the lack of profile of Best Health for Children in the board and perhaps its confusion with other documents related to children, for example Children First, published the same year as Best Health for Children and which is concerned with guidelines for the protection and welfare of children; secondly many of those involved in the above sub-groups have never read the Best Health for Children report.
The South Western Area Health Board extends from Dublin inner city, south of the River Liffey, through South County Dublin, all of Co.Kildare and West Wicklow, (the Community Care Areas of 3, 4, 5 and 9 and parts of areas 2 and 10). The board provides health and social services for a population of over 500,000. As with the other Area Boards this figure will more than likely increase when the 2002 census data is available.

Implementation of Best Health for Children

The Board had initially committed to convening an Implementation Committee as soon as a Child Health Development Officer post was filled.

At present a number of events, detailed below, have prompted the board to decide to convene a committee as soon as possible and to advertise for a development officer. The committee will cover both child and adolescent health issues and will be drawn from health board personnel only. Sub-groups will be formed of personnel from relevant areas to look at specific issues.

One of the factors, which prompted the above decision, is that the Best Health for Adolescent - National Steering Group has called for proposals for pilot projects for consideration in the budgetary allocation for 2004.

A second factor is that the SWAHB has been requested by Best Health for Children to undertake a joint pilot project with the North Western Health Board on the feasibility of establishing a peer visiting support service for parents of young children. This service has some similarity with the Community Mothers' Programme. Two nominees from both health boards and a project
A third factor influencing this decision is that a new paediatric consultant post in Tallaght Hospital with a community component will be filled in October 2002 and it is hoped the appointee will be a valuable member of the implementation committee.

**Demonstration Project**

In order to fulfil its commitment to undertake a demonstration project the SWAHB is considering a number of areas relevant to the initial recommendations contained in *Best Health for Children*. While the peer visiting parent support pilot project is to be performed in the board, it comes under the remit of the Parenting Support sub-committee and obviously is funded through a different channel to the main *Best Health for Children* Report.

Aspects of the child health surveillance service, in both pre-school and school children are under consideration as suitable demonstration projects. However to date there has been no progress made in drafting a proposal as such.

Some work has already been carried out independently of *Best Health for Children* with regard to the methods and means by which information is gathered, collated and transmitted from the developmental health check. The quality of the data was found to be poor but with some extra training for the relevant administrative staff it is now possible, for example, to report on referrals from each health centre.

While acknowledging that the RICHS system is undergoing review by the SWAHB on behalf of ERHA it may be possible to use the current system to identify the non-attenders at developmental clinics and then to link this
information with the peer visiting scheme mentioned above. Obviously due regard must be given to client confidentiality before this idea could be progressed.

In the area of the school medical service, a suggestion has been made about the feasibility of piloting the core school surveillance programme as described in the Best Health for Children report in one or more schools in the area and then perhaps carrying out an 'activity based costing pilot'; this involves an assessment of a service led by a health service professional and assisted in the financial aspects by financial personnel. A new school in a relatively deprived area has been suggested as one possible school for inclusion in such a study.

In the area of adolescent health the board is planning to participate in a large youth project in Ballyfermot. The overall project involves the development of a large youth centre with sports and entertainment facilities, which will be financed under an Urban EU scheme (the EU provides €4 million and the Irish government matches this amount). A similar funding arrangement has been employed in the redevelopment of Ballymun.

The health board is planning a one-stop adolescent health shop for inclusion in this development. This will be staffed by a triage teen-nurse and trained reception staff who will provide health information; there will be facilities for group work and therapy in specially designed rooms. The health board had a large input into the design of this element of the facility. Five hundred thousand euro (€250,000 capital and €250,000 revenue) will be required to finance this development.

The board would like to pilot this venture as part of the adolescent Best Health for Children initiative.
RICHS

The child health information system, RICHS, in use in the eastern region since 1989 has proved to be inflexible, not user friendly, it contains a large amount of information which was difficult to access and does not support the delivery of a seamless child health service. These findings have been borne out by a number of reviews of the system. Its replacement is a priority issue for the board.

In April 2001 the SWAHB commenced a review of the system and to define the requirements of a new Child Health Information System (CHIS). At present structures are being put in place to commence EU tender processes for the development of a new child health information system (CHIS). The board has expressed an interest in using this as a demonstration project for Best Health for Children.

Summary

The SWAHB has, like the other boards in the eastern region, been slow to become involved in the implementation of Best Health for Children due mainly to the major re-organisational issues which have understandably been the focus of attention up to now. However, like the other boards the time now appears opportune to forge ahead. A number of key personnel are anxious not to let Best Health for Children be overshadowed by other issues and have taken the decision to convene a Steering / Implementation Committee for both child and adolescent health issues. This committee will consider how best to advance the possible demonstration projects mentioned above. When a designated key worker, i.e. a child health development officer, is appointed it will be possible for a number of these projects to commence.

The post of Child Health Development Project Officer was advertised on 28 April 2002, with a closing date of 10 May 2002. The advertisement stated that
the post holder will have a key role in developing local structures in order to implement the recommendations of the review.

Chapter 3 Health Boards outside the ERHA

The Western Health Board provides health, welfare, personal and social services to the residents of counties Galway, Mayo and Roscommon. The region is predominantly rural with a number of urban areas and seven inhabited offshore islands. In 1996, the Board's population was 351,874, which is an increase of 3% since 1991. The board's web site may be accessed on www.whb.ie.

Over the last 25 years the population increased by 13% compared to 22% for Ireland as a whole. There has been a trend towards people moving from rural to urban areas. Population growth has been most obvious within Galway County Borough, which increased by 12% between 1991 and 1996 (compared to 3% for Ireland as a whole).

Implementation of Best Health for Children

Following the publication of the Best Health for Children report a Regional Implementation Committee was established, chaired by Dr Marita Glacken, Specialist in Public Health Medicine. Its members include representatives from all the disciplines involved in the delivery of child health services: medical, public health nursing, school nursing service, management, community ophthalmology, audiological services, health promotion, paediatrics, general practice and a nominee from the National Parents' Council (unable to attend any meetings to date).
During 2001 a project manager, Ms Frances Neilan was appointed with the initial brief of co-ordinating the implementation of Best Health for Children in the region. This brief was subsequently expanded to include adolescent health and parent support. This post is at a Grade V11 level.

A number of sub-committees have looked at a number of aspects of the child health service.

- Performance indicators: discussed below.
- Development of a model for the delivery of a community service with a community paediatrician: development of job description for a community paediatrician, (currently with the director of human resources).
- Adolescent health services: audit, gap analysis and identification of priority areas
- Review of health centres: No capital money currently available to upgrade health centres, however newly developed centres have 'sound treated' rooms included in the specifications. The technical services department priced a review of health centres at €80,000 +.
- Audiological services review: development of 2nd tier clinics (one per county), training for AMOs and PHNs.
- Training: audiology and vision; ENT surgeon in University College Hospital Galway to run training workshops where a number of AMOs will be trained to a level of diagnostic training to work in 2nd tier clinics.

**Demonstration Project**

A demonstration project was identified and has just recently been piloted. A report on it is currently at a final drafting stage. A public health nurse and an area medical officer were seconded for a six-month period to work on this project. Plans are now underway to proceed to the next phase. The continued
secondment of staff and the provision of dedicated clerical support is being sought.

A review of the birth notification system employed throughout the country was performed and a template was developed for the standardised collection of a core data set. The WHB itself has a paper-based system, without dedicated clerical staff to maintain it. The possibility of using such a form on a national basis will be put to the National Conjoint Child Health Committee.

This project was performed at the same time as two other pieces of work, for which the standardisation of the birth notification form will be essential for these to move beyond this initial stage.

Research was carried out into the feasibility of collecting the five child health performance indicators identified by the Child Health Indicators Subcommittee: this was followed by the development and piloting of a form to accurately collect such data. Currently methods by which quarterly reporting of these indicators will be possible are being investigated.

A method for the collection of data on performance indicators at developmental screening examinations is being investigated by means of a gap analysis. As mentioned above there is no centralised process by which children from a particular birth cohort are identified and called for developmental screening. Clinic appointments are sent by clerical staff in one of the board's three community care areas. In the other two community care areas infants for screening are identified by the relevant public health nurse and a clinic is convened in consultation with an area medical officer.
Summary

The implementation of Best Health for Children has progressed well to date in the Western Health Board. The demonstration project has been piloted and will now progress to the main study phase. A number of points arose in review of the WHB initiatives.

As funding for the post of Child Health Co-ordinator is not available plans to establish county teams have been put on hold. These teams were to perform needs assessments in their counties with appropriate training provided for relevant members.

The absence of a computerised child health information system, and dedicated clerical support prevents the timely collection of core data essential for basic child health surveillance and the measurement of performance indicators.

The cost of assessing the health centre facilities precluded such a survey being performed.
The Southern Health Board provides health and personal social services to a population of 546,640 residents of the counties of Cork and Kerry. Its population accounts for 15% of the national population. Information on the board may be obtained on its website: www.shb.ie

Implementation of Best Health for Children

The Regional Child Health Implementation Committee has taken on board the combined child and adolescent health brief. Membership of the committee will include: general managers, SAMOs, director of public health nursing, principal community worker, health promotion officer, children’s ward manager from Cork University Hospital, child care manager and an asylum seekers project manager. At present speech and language therapy, physiotherapy and occupational therapy are not represented on the committee.

Sub-committees will be drawn from the above disciplines and the expertise of others will be added as necessary. Ms Majella Doherty was appointed as the Child Health Development Officer in December 2001.

The priorities for Best Health for Children in the SHB region are firstly the implementation of the core programme for child health surveillance as outlined in the recommendations of the Best Health for Children report. This involves the secondment of an area medical officer and a public health nurse to train as trainers for other AMOs and PHNs in the board’s region. To date there has been considerable interest from the public health nurses but little interest from the area medical officers. This probably reflects the relative larger complement of nurses in the board and also the difficulties in recruiting area medical officers to fill posts vacant as a result of secondment.
Preliminary discussions have however taken place with neighbouring health boards (MWHB and SEHB) with regard to combining the training programmes. The committee appreciates the importance of initiating some form of training and may proceed initially with training in audiology.

**Demonstration Project**

The regional committee is looking at referral pathways and information feedback. It is planned to develop a protocol for the relevant disciplines, such as speech and language therapy, ophthalmology and occupational therapy. It is hoped to develop protocols initially for three or four disciplines. At present initial meetings are being convened to develop relationships with key players.

A subcommittee from the steering committee (membership 5) will be responsible for this project, which will be managed by the Child Health Development Officer.

Two other subcommittees will be convened: one will look at the training requirements while the other will be involved in a demonstration project for the adolescent age group.

**Summary**

The implementation of Best Health for Children is progressing well in the Southern Health Board, but it is still at an early stage. Links with neighbouring health boards with regard to training is a good initiative as the problems with funding to date have perhaps discouraged other boards from persevering in the light of budgetary constraints.
The North-Eastern Health Board provides health and social services for the residents of the counties Meath, Monaghan, Cavan and Louth. It covers an area of 6,498 square kilometres and has a population of 306,155. Information on the board may be found on its website: www.nehb.ie

Implementation of Best Health for Children

A Steering Committee was convened following the publication of the Best Health for Children report and met on a number of occasions but has not met for over a year. This committee identified a number of areas for prioritisation:

- A consumer satisfaction survey of community clinic based services, which has been used as a demonstration project and is now nearing completion. Staff perception of services will be surveyed later in 2002.
- Feasibility of the PHN visiting new mothers within 24 hours of discharge from hospital to be investigated. Faults in the birth notification system at present prevent such timely visiting.
- Prioritisation of the seven to nine month developmental examination.
- Physical environment of health centres to be reviewed; this involves the drawing-up of lists of gold standards against which the centres will be assessed.
- Qualitative and quantitative assessment of the information and educational needs of expectant mothers in order to develop practice guidelines as a model of good practice.

A Child Health Development Officer has recently been recruited and will soon be in post. The Steering Committee will convene once this post is filled and will address both child and adolescent health issues. The Development Officer will
have the task of progressing the areas already prioritised by the committee and those applicable to the adolescent health brief.

**Summary**

Quite an amount of progress has been made in implementing the recommendations of Best Health for Children. Areas for prioritisation have been identified, a demonstration project is nearing completion and a Child Health Development Officer has been recruited.
The Mid-Western Health Board (MWHB) delivers health and personal social services to a population of 317,069 in the counties of Limerick, Clare and North Tipperary. The region comprises about 10% of the national land area and extends over 3,000 square miles, forming a 100 km arc around Limerick. Information on the board may be found on its web site: www.mwhb.ie

Implementation of Best Health for Children

A Regional Implementation Committee has been established in the MWHB, the membership of which represents management, public health medicine, nursing and dental and primary care. The committee is chaired by a Senior Area Medical Officer and by a director of Public Health Nursing as a deputy chair.

The post of Child Health Development Officer is to be advertised soon and it is hoped to have someone in post by 1 July 2002.

Prior to the publication of Best Health for Children a working group was established in the MWHB in 1997 to review the child health record system. The Department of Health and Children provided funding for this project in 1999. The MWHB did not receive funding from the DoH&C for the implementation of Best Health for Children until 2002. The PHR project went through an extensive development phase from June 2000 until May 2001 when the implementation phase commenced. This latter phase of this project is funded until December 2002.
Ms Breda Ryan, previously a deputy director of public health nursing in the board, has managed the project for the PHR. A multidisciplinary working group was established to look at child health recording systems in use in other countries and to develop a system for use in the MWHB. A consultative steering group was established with a large cross section of professionals and parents. Training for public health nurses and area medical officers in the use of the PHR took place in 2000. This involved the development of 'train the trainers' programme. In May 2001 the system was introduced on a phased basis in the Limerick community care area for infants born on or after 1 May 2001. In September 2001 the remaining community care areas (Clare, East Limerick and North Tipperary) were included.

This record is held by parents and inputted by both parents and professionals during the child health screening programme and also following consultation with any professional.

The Department of Epidemiology and Public Health in University College Cork has been commissioned to evaluate the use of the record system since its introduction in May 2001.

The PHR has been generally accepted by the nursing profession in the area, despite some early reluctance to accept change in practice. As the initial cohort of infants are only now reaching the age for developmental examination its acceptance by area medical officers has not as yet been tested. As the training of this latter group in the use of the PHR was over a year ago there may be initial difficulties in its adoption.

In developing the PHR it was necessary to develop a database of infants born in the region. Like other boards the birth notification system was flawed. Births in the board take place in a total of 16 individual sites many of which are located outside the board (40%).
The first visit by the public health nurses during which the mother is presented with the PHR, the child’s first name is recorded, traveller status is determined and the address is given a DED code has resulted in a more accurate database.

The PHR provides a large amount of information for the parents on child development, surveillance, immunisation and health promotion. Parents are encouraged to bring the book when they consult any health professional and hospital emergency or out-patient department. Information on core service contacts and developmental data provides a facility for the collection and reporting on performance indicators for the pre-school child health service and information for the planning and management of services.

The only real weakness in the operation of the PHR is the fact that GPs have refused to participate in updating the record when an infant attends for a consultation. This refusal is now part of an IMO negotiating / bargaining debate. A video for parents is currently being produced by Windmill Lane productions as a support for parents with low literacy levels.

To address deficits in the board’s child health information system specification for a replacement system is currently being considered. An outside consultancy firm has been commissioned to initiate a review of requirements. The future plans in relation to the PHR include the development of a school health module, the attainment of a quality award and the securing of funding for an on-going evaluation programme.

**Summary**

The MWHB has established an implementation committee but has not as yet appointed a child health development officer. A Regional Co-ordinator for Planning and Development in Child and Adolescent Health has recently been appointed.
The PHR has been designed based on the recommendations of Best Health for Children, and, with the introduction of the PHR (i.e. for all children born from 01/05/01 in Limerick, and all children born from 01/09/01 in Clare and Tipp NR/E Limerick), Child Health Surveillance for 0-5 year olds in the MWHB region is in line with the recommendations of Best Health for Children. This project has enjoyed tremendous success to date.

While the general recommendations of Best Health have not been formally implemented the introduction of a standardised recording system has facilitated standardisation of Child Health Surveillance for preschool children across the 3 Community Care Areas in the Board's region. The PHR project has resulted in a number of improvements in the delivery of the pre-school health service in the board and therefore by default many recommendations are now in place.

For example, the standardisation of recording of information, the uniformity of equipment and training of nurses and doctors in recording methods have allowed the comparison of service delivery in the different community care areas.

The board is now planning to extend the PHR to the school aged children.
The North Western Health Board provides health and social services to the residents of counties Sligo, Donegal and Leitrim. The NWHB is a mainly rural region covering 2,600 square miles with only 2 sizeable urban populations - Sligo (pop. 17,000) and Letterkenny (pop. 7,000). Information on the NWHB may be accessed on the board's website: www.nwhb.ie

Implementation of Best Health for Children

A steering committee is currently being convened which will cover both child and adolescent health and care issues. The committee structure is being modelled on the structure employed by the Western Health and Social Services Board in Northern Ireland, which has a committee called the Western Area Children and Young People's Committee. The NWHB committee will have its first meeting at the end of summer 2002 and will convene a number of sub-groups to address the various issues of relevance to its remit. Dr Christine McMaster, has been recently appointed as Child and Adolescent Health Development Officer, but has not as yet taken up this position. She is currently a senior area medical officer in the board.

Demonstration Project

A project plan has been drawn up for a demonstration project to develop a modern look at the school health service in accordance with Best Health for Children recommendations. It is planned to recruit a project officer, an AMO
health promotion and PHN staff with dedicated clerical support to work on the pilot phase of the project but as yet these posts have not been filled. This project will draw on the expertise of a number of other disciplines, including public health medicine, psychiatry, psychology and paediatrics. The Child and Adolescent Health Development Officer will manage the project. It is anticipated that this project will run for three years.

Other areas of priority in the coming year for the committee will be child health surveillance and the training requirements of personnel involved in the process. Non-governmental organisations involved in adolescent issues will be asked to identify priority areas in for inclusion in an adolescent health service. It is hoped to develop parent support services in accordance with the Best Health for Children recommendations.

Summary

The North Western Health Board has convened a steering / implementation committee to oversee child and adolescent health and care issues. A Child Health Development Officer has been recently appointed. A demonstration project to look at the school health service is proposed and will have a lifespan of three years.
The Midland Health Board provides health and personal social services to the population of the counties of Westmeath, Laois, Offaly and Longford. The board has a population of 205,542 and has a higher dependency ratio than the national average. In 2001 3,217 births were registered in the board. Further information on the MHB may be found on its website: www.mhb.ie.

Implementation of Best Health for Children

A Regional Implementation Committee has not to date been established in the board. However a project team to oversee a demonstration project has been convened; this is made up of nursing, research and public health personnel as well as health board management.

A Child Health Development Officer has not been appointed to date, but recruitment will take place in the latter half of 2002. The funding provided in addition to supporting the planning and piloting of the demonstration project in two sites, has been also used to improve the clerical support for AMOs, to assist the development of systems of data collection and in supporting the provision of Performance Indicator data. In Addition it has been possible with some funding to review the role of the physiotherapy service in the child health area and arising from this review to provide for an additional child health physiotherapy post.

In implementing the breastfeeding policy developed by the Board, a Steering and Implementation Group has been established and a range of initiatives are underway in partnership with key stakeholders.

The board has worked on seeking to implement the developmental examinations in accordance with the best practice recommendations, however this
development has been severely restricted due to the recruitment/retention of Area Medical Officer staff - a difficulty experienced nationally.

A protocol has been developed in line with Best Health for Children by the Community Ophthalmic physicians in conjunction with the Area medical Officer and Public health Nursing service for referral of patients to the service from the 7-9 month developmental screening.

Reorientation of the hearing and vision screening in primary schools in accordance with Best Health for Children is at an advanced stage and it is expected that this will be completed by year end.

A project team was established with all relevant stakeholders and representatives from Acute services, Disabilities, Child health and Older persons to advise the Board in relation to Audiology services. The project team have prepared a draft report.

**Demonstration Project**

The MHB has undertaken a demonstration project on a dedicated child health nursing service. This project is based on a partnership approach with parents and families in order to provide a holistic service for children. It seeks to enhance linkages with GPs and with community support organisations etc. This project has been piloted in two centres: Tullamore and Athlone and involves a cohort of 100 families in Athlone and 50 families in Tullamore. In Athlone a PHN is working full-time on the project while in Tullamore a PHN is working part-time.

Each nurse is assigned to the families in the cohort (new born child and other pre-school children). The nurses will initially collect baseline information of both a quantitative and qualitative nature and will implement the recommendations of Best Health for Children in relation to screening and surveillance, in addition to adopting a 'whole child perspective'. This pilot phase will be evaluated in late 2002 or early 2003.
Another project related to child health is use of the Edinburgh Depression Score in monitoring post-natal depression. This has been piloted in two areas and is currently being evaluated.

Summary

The Midland Health Board has not convened an implementation committee. The appointment of a Child Health Development Officer will occur later in 2002. A project team has been convened in relation to the planning, implementation and evaluation of the demonstration project on the piloting of a dedicated child health nursing service in two areas. A range of developments/enhancements to the child health service are underway and include implementation of the breast feeding policy developed by the Board, reorientation of vision and hearing screening service in accordance with best practice recommendation, a review of audiology services in the Boards area, development of referral protocol to Ophthalmic physicians, some structural supports including staff, IT and improvements to some health centres towards 'a family friendly environment'.
The South Eastern Health Board provides health and personal social services to a population of 391,046 living in the counties of Kilkenny, Waterford, Wexford, Carlow and South Tipperary. Information on the services and structure may be found on the board’s website: www.sehb.ie

Implementation of Best Health for Children

A Child Health Implementation Committee was established in 2000 with the remit to look at the existing services, to identify gaps and to recommend priority areas for further development and to present a report to the board. The Committee, chaired by a community care general manager, was multidisciplinary but had no representation from the GP Unit, health promotion or parents. An AMO was seconded to carry out this work on behalf of the committee. The work was completed in April / May 2001 and the committee then proceeded to recruit a Child Health Development Officer. While interviews were held in May / June the position was only filled in May 2002. The Committee was disbanded in mid 2001.

The report from the Implementation Committee was not completed as planned and work is now underway to bring it to fruition.

Due to structural and managerial changes in the SEHB no decision has yet been made as to whether or not to combine the child and adolescent health brief. Dr Julie Heslin, Specialist in Public Health Medicine, who is a member of the National Conjoint Child Health Committee, recommends that the Board would be wise to keep the two topics separate.

Demonstration project
A demonstration project has been identified and plans are underway to establish a steering committee to oversee it. A public health nurse has been appointed as a project manager and she will work closely with the Child Health Development Officer.

The project is concerned with the provision of information to parents: information on health and health promotion, health service availability and how to identify health problems. At present the appropriate means to communicate information are being explored. Following this a framework will be developed to look at resources and quality standards. Focus group work with parents and health service providers will be part of this overall needs assessment.

Summary

While the early establishment of an Implementation Committee and its work on the identification of priorities promised early implementation of the recommendations of Best Health for Children, the reality was that until the appointment in the middle of May of a Child Health Development Officer no further progress was made.

Plans are now underway to reconvene an Implementation Committee and to build on the enthusiasm generated by the appointment of the Child Health Development Officer and the initiation of a demonstration project.
Chapter 4  Discussion and Recommendations

In the process of reviewing the implementation of *Best Health for Children* in the eastern region and with reference to developments in other health boards a number of issues have arisen which will need to be addressed in order that the recommendations of the *Best Health for Children* report may be implemented. These will be discussed below with their relevance to the ERHA boards. As the National Conjoint Child Health Committee is the body overseeing the implementation of *Best Health for Children* a number of issues below may be of relevance to it. Also the committee may have made decisions, which may negate some of the following comments and suggestions. As this report was being finalised the three area health boards have been submitting funding requests to Best Health for next year. 

As I have no knowledge of these proposals I am not in a position to comment on them. Suzanne Kirwan to give details of these proposals.

The following issues / topics are discussed below and each is followed by a recommendation:

- Availability of the *Best Health for Children* Report.
- Implementation / steering committees
- Demonstration project
- Child health development officer
- Role of *Best Health for Children* within the health service
- Information systems

**Issue 1. Availability of the *Best Health for Children* Report**

While there is a tremendous level of interest and enthusiasm by those who have had long-term involvement in *Best Health for Children* and in its implementation,
for those who have only recently become involved the lack of profile of Best Health for Children is proving somewhat of a hindrance.

The long interval between the launch of the report and putting structures in place has resulted in much of the significance of the report's recommendations being lost in both time and context.

Many of those who now have responsibility for the implementation of Best Health for Children have as a result only limited knowledge of the entire Best Health for Children initiative. The fact that the report is no longer available in its original format means that many have if they are lucky, access only to poorly reproduced copies of the original document and indeed many others have never read the report. While the report is now only relatively recently available on the Best Health for Children website, this information has not percolated down to grassroots level.

(www.besthealthforchildren.com)

The launch of the adolescent health report 'Get Connected' last year and the Parent Support initiative earlier this year have to some extent overshadowed the Best Health for Children initiatives.

The recommendations of Best Health for Children and their implementation are the remit of the regional implementation committees. Priorities for service development and resources required need to be established according to the needs of individual boards.

There appears to be some confusion around the whole area of recommendations and demonstration projects. The demonstration project is just one aspect of the Best Health initiative and in fact by devoting too much emphasis to the project the general recommendations fail to be prioritised. This is compounded
by the lack of knowledge and understanding of the Best Health for Children initiative.

**Recommendation 1**

A re-launch of the Best Health for Children initiative should be considered with an information day / seminar organised to present and discuss the findings and recommendations of the Best Health for Children report. This could be facilitated by the Best Health for Children office.

The Best Health for Children report should be made available to all relevant personnel.

**Issue 2. Implementation / Steering Committees**

The strategy for the implementation of Best Health for Children included the establishment of sub-committees of the National Conjoint Child Health Committee to address certain aspects of the report. The health boards were requested to convene child health steering /implementation committees to oversee the implementation of the Best Health for Children recommendations and to identify demonstration projects. For various reasons some committees have either not been established or have not been in a position to meet on a regular basis. A major reason has been the difficulties encountered throughout the country in recruiting Child Health Development Officers. Without such a person in post there was a very valid perception that there was not much point in planning implementation strategies in the absence of a dedicated person to drive projects ahead.
The composition of the regional committees varies throughout the country. In a number of the boards the committees are entirely composed of health board personnel, while in at least two boards the membership has been expanded to include not only health board personnel but also personnel from other agencies and bodies involved in services for children and young families.

Such a composition has the benefit of learning from the experience of groups outside the board, for example in the education sector, and involving the many disciplines involved in the holistic approach to both child and adolescent health. However, as the recommendations of the Best Health for Children report are predominantly concerned with health service issues the presence of outside agencies may detract from the basic recommendations and there is a danger that a perception may arise that this is the means to sort out all problems with the child health service. However, such a multi-sectoral approach would be more appropriate in the area of adolescent health.

While outside agencies have a role in ensuring that child health is given prominence on a wide range of agendas, to ensure that the recommendations of Best Health for Children are implemented, a committee dedicated to child health issues is essential.

**Recommendation 2**

An ERHA Steering Committee is urgently required to set a regional agenda, to place the Best Health brief at a management level, to recommend on necessary structures, to provide support to the Area Board committees and to assess the strengths and weaknesses of the different committee structures.
This committee should have a role in co-ordinating the implementation in the ERHA area boards of the recommendations of Best Health for Children in line with the National Conjoint Child Health Committee’s advice.

A dedicated committee to look solely at child health issues is essential in each area board. Without such a committee the recommendations of Best Health for Children will fail to be prioritised and will be in danger of being used as a means of solving problems and issues associated with a multitude of aspects of child health and child care services.

### Issue 3: Demonstration Projects

Best Health for Children is a national initiative and its recommendations were made on the basis of a number of key themes:

- Developing a child centred health promotion approach
- Creating a partnership between professionals and parents
- Quality assurance systems and procedures that support screening
- Screening based on evidence
- Improved co-ordination for children with complex problems

These themes are very specific and the recommendations made and the means to implement them were made in a national context. Each health board agreed to perform a demonstration project on a topic identified in the report - the idea being that once evaluated and refined it could be replicated throughout the other health boards.

From discussions with personnel in the three Area Boards it is clear that the recommended regional demonstration projects identified in 1999 did not
progress and in fact information regarding them had not been communicated to the relevant personnel. These projects were to focus on the development of best practice in the child health developmental examination with each board addressing a specific aspect.

As it stands attempts to identify demonstration projects are being made in a vacuum and in a somewhat haphazard way and confusion may exist between putting the recommendations of Best Health for Children into practice and addressing the issue of a demonstration project. The lack of profile of the Best Health for Children initiative has been a major influence on this situation.

As the eastern region lags behind some other health boards it now makes sense to progress with the project suggested back in 1999 so as not to fall even further behind. This project is still relevant and progress in the implementation of the Best Health for Children report is possible if agreement were reached to forge ahead with the demonstration project. This project has not been considered elsewhere and the large population in the eastern region would facilitate a worthwhile exercise.

At the same time energy and interest may be channelled into the actual implementation of the Best Health for Children recommendations; this can involve topics such as those raised in the ECAHB where eight themes were identified for attention.

Failure to detect children with treatable or remediable defects due to the lack of staff training, failure to screen at correct times or the absence of 'best practice and evidence-based' screening service may leave the boards vulnerable to litigation.

In the SWAHB the new child health information system (CHIS) has been suggested as a demonstration project which while fitting extremely well into the Best Health for Children initiative is on the one hand a much bigger project than
the Best Health for Children authors and the National Conjoint Child Health Committee had possibly anticipated and is a project which to date has been planned, initiated and funded from sources other than Best Health for Children.

The original regional implementation committee had expressed an interest in participating in the review of the information system and in advising on its development but had not proposed using it as a demonstration project.

The ECAHB is considering a school health service audit as a demonstration project. This is also being considered by the NWHB and it has come up also in discussions with the SWAHB.

Recommendation 3

As Best Health for Children has in essence been without an agenda or structure within the Area Boards for the last few years it is vital at this stage to identify and put in place necessary structures and to revitalise the Best Health for Children initiative before decisions are made as to demonstration projects or indeed to drawing up an action plan for the Child Health Development Officer. This recommendation in conjunction with the recommendations 1 and 2 above should be looked on as the way forward for Best Health for Children in the Eastern Regional Health Authority.

Recommendations 1 and 2 above will assist in setting Best Health for Children on the regional agenda. This should be quickly followed by the creation of three implementation committees whose main aim will be implement the recommendations of Best Health for Children, to appoint Child Health
Development Officers, to initiate a demonstration project and to implement the main recommendations of Best Health for Children.

It seems logical that the demonstration project identified in 1999 should now be initiated in the three area boards. This would allow the boards' implementation committees to focus on the general recommendations of the Best Health for Children report and to put structures in place to ensure that progress is made in implementing them.

As one Area Board (ECAHB) now has a child Health Development Officer in post, work on the project should ideally commence in that board. While project officers are being recruited in the other boards the implementation committees should consider how to proceed with their element of the project and should link up with the ECAHB in developing an action plan.

**Issue 4  Child Health Development Officer**

A number of issues arose in the filling of these posts throughout the country. Firstly the level at which the post was initially graded seems to have reduced interest: posts were initially advertised as Grade V11, but have now been generally pitched at a Grade V111 level. This change in grading in itself may be of concern as those already in post as a Grade V11 have the same job specification as those now being recruited at a higher grade.

When the nature of these posts was first described the implementation of Best Health for Children was the core task. However, as many if not most of the Regional Implementation Committees decided to combine Best Health for Children with the recommendations from the Adolescent Health Strategy, Get
Connected, in its brief, it was considered a logical step to include this brief also in that of the Child Health Development Officers.

At this point it is worth considering that while there is a well established child health service in all health boards and that the recommendations of the Best Health for Children report are aimed at its improvement, the area of adolescent health is much more complex and the skills required to implement the recommendations for this age group are very different. Combining the two roles in the one post may result in neither age group being given the attention it warrants.

In the Area Boards a Child and Adolescent Health Development officer has to date been appointed in only one board, the ECAHB, and this is a very recent appointment. One other board has recently advertised a post and the third board is planning to advertise again.

In the absence of a dedicated person to co-ordinate the Best Health for Children initiative progress will be limited.

**Recommendation 4**

Efforts should be made to appoint Child Health Development Officers in the area boards so that each board may undertake a demonstration project. However failure to fill these posts should not deter the implementation committees from progressing with the recommendations of Best Health for Children. Separation of the child and adolescent briefs is essential.

Each board will have its own ideas on how this post will function but it is vital that there is some uniformity in the duties and responsibilities of the posts. A
job description for this post was drawn up by the Regional Implementation Committee in the former Eastern Health Board and was circulated to the National Child Health Conjoint Committee. It may be seen in Appendix 4. The experiences of the development officers in some of the regional health boards would be valuable in formulating action plans for the ERHA area boards' posts.

**Issue 5: The role of Best Health for Children within the health services**

The implementation of Best Health for Children is in danger of being subsumed in the overall planning and delivery of child health services and of being confused with child-care and protection issues. While this prospect is not without merit and in the future the model proposed by the authors should indeed underline the planning and delivery processes of all child health and social services, the three area health boards have differing demographic and socio-economic profiles and deliver health services appropriate for these populations. Therefore the planning and delivery of services will vary from board to board and services must continue to be delivered in tandem with the implementation of Best Health for Children.

Child health services in the past as outlined in the Best Health for Children report have been bureaucratic, service centred, static and based on orthodoxy. The proposed new model is to be flexible, child centred, dynamic and based on evidence.

As the area boards have developed their own strategic units it would appear that the implementation of Best Health for Children has less profile than originally anticipated.
To ensure the standardisation of service delivery on a national level the information obtained from demonstration projects is a vital element in ensuring that the aims and objectives are achieved.

Failure to both distance the Best Health for Children implementation from the planning and delivery function of the health boards and to keep the above themes to the fore may result in the Best Health for Children initiative failing to progress as a national initiative.

The area boards in the eastern region have the largest population of the country's health boards and as such are in the position of making a major contribution to the future of Best Health for Children. Therefore it appears logical that the demonstration projects for each board should be related to each other.

Best Health for Children urgently requires a regional agenda and a profile to match. While the National Conjoint Child Health Committee has the task of overseeing the implementation of the Best Health for Children recommendations and to oversee further development and implementation of work on child health throughout the country, to date it has perhaps lacked the power to achieve meaningful results.

The recently established Health Boards Executive (HeBE) has the remit of ensuring that the health boards work effectively to achieve improvements in health and in the health service, to modernise the Irish health service and to enable joint working between boards.

The chief executives of the then eight health boards, who are now members of the HeBE, commissioned the Best Health for Children review and have identified the Best Health for Children initiative as one of its work priorities. When the time is right the National Conjoint Child Health Committee will also need to
ensure that the recommended new model is the cornerstone of future planning and development of services.

(The HeBE board comprises the chief executives of the seven health boards, the Eastern Regional Health Authority and its three area boards).
information systems to record and monitor surveillance data. The peri-natal reporting system which is the basic data set employed in the development of such an information system was recommended by Best Health for Children for review with regard to its content, its transmission and dissemination. The birth notification system is pivotal to the smooth operation of the child health service.

While a standard birth notification form is used throughout the country, problems with its content and transmission inhibit the standardisation of surveillance and immunisation programmes in both the pre-school and school age children. A number of boards are independently considering reviewing their health information systems (many of which are paper-based), which may result in a number of different systems operating for what is essentially a relatively small population.

As mentioned in the introduction, in 2000 the Eastern Region Implementation Committee strongly supported the need for a comprehensive and effective information system to record and monitor surveillance data. The Committee was keen to participate and advise on the development of such a system to ensure that the Best Health for Children programme would be effectively implemented and a member of this Committee, Dr Lelia Thornton is a member of the SWAHB Project Team, which is currently developing a new child health information system (CHIS), discussed above.

**Recommendation 6**

A Child Health Information System should be developed which will facilitate the timely collection and transmission of data required for child health surveillance. Any ERHA recommendations on child health information systems
should take account of the Best Health for Children recommendation of need for a standard national approach to the recording and monitoring of surveillance data and of other Best Health initiatives.

With a population of only 3.5 million ten distinct child health information systems is not only unworkable but makes the development of a service based on evidence very difficult to achieve.

The Health Information and Quality Authority (HIQA) proposed in the recent health strategy, Quality and Fairness: A Health System for You, will have responsibility for the development of health information systems and will provide the lead on information development in line with the forthcoming National Health Information Strategy. This Strategy Report will no doubt recommend processes and procedures to ensure easier access and best available use of health information, including the exploitation of modern information and communications technology.

Linkage with the HIQA through the HeBE appears to be the means by which the Best Health for Children recommendations on information and peri-natal reporting may be best achieved.

The work being undertaken by the SWAHB on behalf of ERHA is concerned with the information system for a substantial proportion of the country’s population and may have a role as a model for a national system. In the event that the SWAHB employs the new CHIS as a demonstration project, its potential role in a national context would suggest that the three Area Boards might work jointly on this project.
Chapter 5. Action Plan for Child Health Development Officer

Introduction

One of the objectives of this review is to propose an action plan for the Child Health Development Officers in the area boards. As discussed in the previous chapter the actual progress made to date in the three area boards has been such that in only one board has a child health development officer actually been appointed. The appointment of development officers has encountered some problems with regard to grading of the post and it has proved difficult throughout the country to recruit for these posts.

In the absence of many of the structures recommended above it is difficult to formulate a definitive action plan for this post. However, a number of suggestions follow which may be used in due course to finalise an action plan.

Action Plan

The objectives, roles and responsibilities of the Child Health Development Officer / Project Manager were drawn up by the former Eastern Health Board Implementation Committee at a time when it was anticipated that appointments would be made quickly and when the post was concerned solely with the child health brief. (See Appendix 4) However in the intervening years a number of events have resulted in the need to amend and refine this job description. The most important event has been the decision to combine both child and adolescent health in the one brief. While a number of health boards throughout the country have recruited people for the post with just the child health brief and then subsequently expanded the brief to that of adolescent health, it is perhaps too early to gauge the success of this combination of roles. It would
appear that the roles and responsibilities of each brief are so extensive that they are in excess of what one individual could feasibly deliver in a quality manner.

As discussed above in Discussion and Recommendation 3, it must be borne in mind that while there is a well-established child health service in all the health boards and the implementation of the recommendations of Best Health for Children is aimed at its improvement, the area of adolescent health is very different. The issues are more complex and prior to the publication of the Best Health for Adolescents, 'Get Connected' report very little attention had been given to the subject. The report set an agenda for the health services and for other agencies that have an influence on the health and well being of young people. The authors intended that the report 'would be used in service planning, alongside processes of consultation with adolescents, parents and service providers (voluntary and statutory) to ensure the agenda for adolescent health is as full and vibrant as adolescence itself.' The skills required to achieve this differ greatly from that of the child health brief and while individuals may possess many skills common to both, the wisdom of the decision to combine both these roles in the one position must now be questioned. A Regional Implementation Committee is the forum for addressing this issue and perhaps one of its initial tasks should be to advise on the matter, with due regard for the national dimension of Best Health for Children.

Whether or not a decision is made to separate the two briefs or to retain the combination, the original description should now perhaps be amended and refined to reflect the status of Best Health in the eastern region.

A two-phased approach to this post would appear to be the logical format.
Phase 1

The initial phase will be concerned with raising the profile of Best Health for Children. He/she should be given the task of identifying key personnel in the health board and ensuring that they are fully informed of the rationale and recommendations of Best Health for Children. This may involve for example, the presentation of information to multidisciplinary groups, the convening of seminars/study days, the creation of a newsletter, or the use of the board's electronic communication systems to maximise the dissemination of information. This first phase should take place over a reasonably short period of time to ensure maximum impact.

Phase 2

While the second phase could follow that outlined in the original description in Appendix 4, some modifications may be necessary if the adolescent health brief is combined with that of child health.
Appendices

Appendix 1  Membership of the National Child Health Conjoint Committee

Ms Emer Brady, Department of Health and Children
Mr John Collins, National Children's Office
Ms Caroline Cullen, National Child Health Co-ordinator, Best Health for Children
Dr Antoinette Dalton, Consultant Child Psychiatrist, Midland Health Board
Dr Sean Denyer, Director of Public Health, North Western Health Board
Dr Nazin Eldin, Regional Health Promotion Officer, North Eastern Health Board
Dr Mary Favier, General Practitioner, Cork
Ms Patricia Forde-Brennan, National Parent's Council
Dr Tessa Graelly, Specialist in Public Health Medicine, Mid Western Health Board
Dr Hilary Greany, Consultant Paediatrician, Sligo General Hospital
Dr Julie Heslin, Specialist in Public Health Medicine, South Eastern Health Board
Ms Margaret Horgan, National Parents Council - Post Primary
Dr Phil Jennings, Specialist in Public Health Medicine, Midland Health Board
Ms Mary Liston, Director of Public Health Nursing, Mid Western Health Board
Mr Séamus Mannion, Regional Manager, Western Health Board
Ms Mary Martin, Director of Public Health Nursing, ERHA
Dr Catherine Murphy, Senior Area Medical Officer, Southern Health Board
Dr Alf Nicholson, Consultant Paediatrician, Our Lady of Lourdes Hospital, Drogheda
Dr Ailis Ni Riain, General Practitioner, Irish College of General Practitioners
Dr Clodagh O'Reilly, Consultant Paediatrician, South Eastern Health Board
Appendix 2  Membership of the Child Health Steering Committee

Mr Martin Gallagher, East Coast Area Health Board  
Mr Michael Walsh / Gerry Hanley, Northern Area Health Board  
Ms Carol Cuffe, South Western Area Health Board  
Ms Eileen O'Neill, Midland Health Board  
Dr Ann Hogan, Mid Western Health Board  
Dr Fenton Howell, North Eastern Health Board  
Dr Christina McMaster, North Western Health Board  
Mr Dermot Halpin, South Eastern Health Board  
Ms Mary Murphy, Southern Health Board  
Dr Marita Glacken, Western Health Board

Appendix 3  Membership of the EHB/ERHA Implementation Committee

Dr Brian Redehan, General Manager  
Dr Leila Thornton, Specialist in Public Health Medicine  
Ms Sheila Armstrong, Director of Public Health Nursing  
Ms Olga Garland, Child Care Manager  
Dr Roslaee Waters, Senior Area Medical Officer
Background

At the request of the Chief Executive Officers of the Health Boards, a review was carried out of the screening and surveillance services for children in Ireland. The Review Group reported in 1998. A revised evidence-based programme for child health surveillance was defined. The Review Group recommended the development of quality-assured child health services with an emphasis on health promotion and partnership with parents. A National Child Health Committee has been established to oversee the implementation of the recommendations of the report. A National Child Health Development Project Manager has been appointed with responsibility for co-ordinating the development of child health surveillance services in Ireland. A Regional Child Health Project Manager is now being sought to develop local structures in order to implement the recommendations of the review and ongoing development of the service in the context of national development in child health.

Main Duties

Objectives of Post: to work towards the implementation, at Regional level of the recommendations of the Review Group.

To promote the role of parents as partners in overseeing the health of children
To facilitate the delivery of the service by consultation and dissemination of information both internally and externally
To facilitate the monitoring of services through the continued development of a programme of multi-disciplinary audit
To facilitate quality improvement in services by the application of qualitative and quantitative methods
Co-ordinate consultation with consumers
To liaise with the national group as appropriate
In conjunction with the national group, evaluate on an on-going basis relevant new evidence as it comes to light and to review existing evidence as necessitated by changing circumstances.
To make recommendations for future restructuring of the services on the basis of review of the evidence.
To support those involved in the delivery of the services by identifying and addressing training and educational needs.
To support the development of computerised child health systems, capable of integration nationally, to support audit and performance management
To liaise with the Regional Implementation Group and prepare regular progress reports
To collate an annual report of the child health services for the region.

Working relationships

The Regional Child Health Project Manager will report directly to the Assistant Chief Executive Officer. He / she will have close working relationships with the Area Public Health Nursing and Medical Staff, Director of Public Health, Paediatricians, the Eastern Regional Health Authority, the Department of Education, National Child Health Co-ordinator, Regional Implementation Group and other agencies with a role in promoting the health of children.
Qualifications and Experience

Essential:
A primary degree
A higher degree or evidence of higher professional training
A clean current driving license
At least three years experience working at management level in a health or social care related organisation.

Desirable:
Experience of co-ordinating large, multidisciplinary projects
Experience of managing change in a complex environment
Experience of child health services or promoting children's health
Experience of undertaking research or getting research into practice

Key Skills

Management
Ability to initiate projects and be a self-starter
Ability to work with minimal supervision but to know when to seek advice
Ability to undertake several projects at the same time and keep to tight deadlines
Ability to influence and persuade others
Ability to write clear and concise reports

Interpersonal
Excellent communication skills and an ability to address different audiences appropriately
Ability gain confidence of and credibility with professionals
Ability to cope with uncertainty and change

Information
An understanding of the relevance and place of information systems to support child health
Good computer literacy
Research
Ability to interpret and disseminate in appropriate ways

Terms and Conditions

This is a two year fixed term contract post. Secondment form an existing post will be accommodated where possible. The salary of the post will be determined on the basis of the experience and background of the successful candidate, but will reflect the challenges of the role. The location of the post will be discussed with the successful candidate but the post will by necessity involve a degree of travelling.

The work of the post holder will be steered the Regional Child Health Committee, but line managed by the Assistant Chief Executive Officer.