

National Council for the Professional
Development of Nursing and Midwifery

Agenda for the Future Professional Development of Public Health Nursing

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*National Council for the
Professional Development
of Nursing and Midwifery*

*An Chomhairle Náisiúnta d'Fhorbairt
Ghairmiúil an Altranais agus
an Chnáimhseachais*

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Foreword

The National Council is pleased to publish this report, *Agenda for the Future Professional Development of Public Health Nursing*, subsequent to *Agenda for the Future Professional Development of Nursing and Midwifery*. The intention of the present report was to review the implications of health policy and to stimulate debate regarding the future professional development of nursing and midwifery and its implications for public health nursing.

The *Report of the Commission Nursing* was a landmark document for nurses and midwives in Ireland when it was published in 1998. We are still experiencing its many major and beneficial consequences to this day. The cumulative effects of the national health and primary care strategies dating from 2001, the major changes taking place in Irish health services, and the societal and demographic trends of the twenty-first century have changed the course of the development of nursing and midwifery envisaged by the Commission on Nursing.

Public health nurses are involved in the delivery of care to service users of all ages and form an important link between primary and secondary care settings, and between statutory, voluntary and private sectors. The integration of the public health nursing service with nursing and midwifery services in these other sectors and greater levels of intra- and inter-disciplinary working are the keys to the further strengthening of the health service as a whole and of the nursing and midwifery contribution in particular. This emphasis on interdisciplinary, integrated working reflects the direction for development signalled by the Primary Care Strategy, *Primary Care – A New Direction*, and more recently by the National Primary Care Steering Group. It is in order to support this integration that the National Council has prepared this report, which sets an agenda for debate on options, direction and action for the future.

The preparation of this report has been made possible by the unstinting participation of public health nurses of all grades throughout the country and other stakeholders. In addition, I extend my thanks to my colleagues at the National Council: Kathleen Mac Lellan, Head of Professional Development; and Georgina Farren, Mary Farrelly and Jenny Hogan, Professional Development Officers. Particular thanks are extended to Liz Early, who managed the initial phase of the study, and to Christine Hughes, who prepared the final report.

Yvonne O'Shea
Chief Executive Officer

Abbreviations

| | |
|--------|--|
| ANP | advanced nurse practitioner |
| CNS | clinical nurse specialist |
| CPD | continuing professional development |
| CSO | Central Statistics Office |
| DHSSPS | Department of Health, Social Services and Public Safety (Northern Ireland) |
| DoH | Department of Health |
| DoHC | Department of Health and Children |
| HSEA | Health Service Employers' Agency (now the Health Service Executive – Employers' Agency) |
| IHSMI | Irish Health Services Management Institute |
| LEO | Leading an Empowered Organisation |
| NAMIC | nursing and midwifery in the community |
| NCCRI | National Consultative Committee on Racism and Interculturalism |
| NCNM | National Council for the Professional Development of Nursing and Midwifery (National Council) |
| NMPDU | nursing and midwifery planning and development unit |
| OHM | Office for Health Management |
| PHAI | Public Health Alliance, Ireland |
| PHN | public health nurse |
| WHO | World Health Organisation |

Introduction & Methodology

1.1 Background to the project

In May 2003 the National Council for the Professional Development of Nursing and Midwifery published the *Agenda for the Future Professional Development of Nursing and Midwifery* (NCNM 2003a). This report aimed to assess progress made in the development of nursing and midwifery in Ireland following the publication of the *Report of the Commission on Nursing – Blueprint for the Future* (Government of Ireland 1998) and identified key issues and themes relevant to all branches of nursing and midwifery (the National Council gave an undertaking to review the implications for the professional development of public health nursing at a later date). In the *Agenda* report continuing professional development (CPD) emerged as the predominant issue of concern to nurses and midwives, particularly barriers to participation in formal CPD programmes and the limited range of such programmes. However, there were indications that steps were being taken to address these matters. The *Agenda* report also underlined the need to encourage and support an equitable geographic spread of courses and access to courses for those seeking to pursue education for practice.

The development of research competencies and capacity among nurses and midwives was recognised not only as enhancing the profession's ability to base its practice in evidence and facilitating a more flexible career pathway, but also as promoting nurses' and midwives' potential contribution to multidisciplinary and collaborative research and evidence-based decision-making. Demographic trends and epidemiological issues and their relevance to different types of nurses and midwives were identified, as were implications of a changing population for practice and professional development.

Reform of the health services in Ireland was initiated shortly after publication of the *Agenda* report, and a decision was taken by the National Council in 2004 to undertake the promised review of the professional development needs of public health nursing. The review process, which commenced in November 2004, was similar to that used for the *Agenda* report and has coincided with major changes in the structures of the health service. For example, in January 2005 the ten former Health Boards were replaced by the Health Service Executive and implementation of the *Primary Health Care Strategy* (DoHC 2001a) is on-going at a number of pilot sites (see the website of the Primary Care Strategy for updates on the Action Plan and its implementation: www.primarycare.ie).

1.2 Consultation process

From November 2004 to February 2005 the National

Council undertook a major nation-wide consultation process with public health nurses in order to identify their views on their professional development needs. Twelve workshops were held with a total attendance of 218 directors of public health nursing, assistant directors of public health nursing and public health nurses engaged in clinical practice. A further eight meetings were held with key stakeholders such as representatives from relevant third-level schools of nursing and the Institute of Community Health Nursing. Eighteen submissions were received from interested parties (see Appendix 1).

As with the original *Agenda* report, an extensive literature review was undertaken in relation to public health nursing and health policy in order to provide an understanding of the contexts, both past and present, within which the service has evolved. This report places a particular emphasis on events and developments that have occurred in healthcare policy, service provision and society, as well as in nursing since the publication of the *Final Report of the Commission on Nursing* (Government of Ireland 1998).

Participants in this consultation process were asked to consider:

- current issues impacting on public health nursing
- opportunities and challenges for future developments in public health nursing
- professional development needs to meet the opportunities and challenges
- structures and supports necessary for professional development.

1.3 Health policy

Current health policy reports and other relevant documents were considered in light of their implications for nursing and midwifery. An index of these is contained in Appendix 2.

1.4 Structure of the report

The report reviews the development of public health and community nursing to date and the policy context of this development (Section 2). Demographic and epidemiological issues affecting public health are outlined in Section 3. Section 4 provides an overview of the current position of public health nursing in a changing healthcare environment. The opportunities and challenges facing public health nursing are considered in relation to professional development needs in Section 5, with an agenda for moving forward on these issues set out in Section 6.

Public Health Nursing in Ireland

2.1 Historical perspective

Public health nursing was first included in 1960 on the register maintained by An Bord Altranais, marking the beginning of a period of amalgamation of domiciliary nursing and midwifery services and district nursing services provided by local authorities and voluntary organisations respectively (Scanlan 1991; Leahy-Warren 1998). The current public health nursing service derives from a Department of Health Circular No. 27/66 of 1966 (DoH 1966) concerning the "District Nursing Service" (see Box 2.1). This circular outlined a concept of public health nursing as encompassing a broad range of preventive and caring functions and over thirty years later was observed by the Commission on Nursing to have remained the basis of that nursing service (Government of Ireland 1998). In the light of changes in the organisation and delivery of health services and the impact of technological, social and epidemiological changes on the role of the PHN, the Commission recommended that the DoHC issue a revised strategy statement on the role of public health nursing. Much work and effort has been put into the completion of this strategy under the direction of the Chief Nursing Officer at the Nursing Policy Division of the DoHC. In the interim, the job description for PHNs has been revised (DoHC Circular No. 41/2000), which firmly places public health nursing in the broader context of primary care.

The role of the PHN has undergone considerable change in the last forty years in response to demographic, social and epidemiological changes in community health needs, and has outstripped the expectations of the 1966 circular (see Box 1), which "greatly underestimated the diversity and range of activities of [the PHN's] multifaceted role" (Begley et al 2004 p3).

The majority of PHNs offer a generalist nursing service to all client groups in a defined geographical area. Public health nurses are unique among community health care providers in offering an area-based service with a remit to "encompass families, communities and population groups under the philosophy of primary health care and health promotion" (Leahy-Warren 1998). The aim of public health nursing was described as being "to contribute to health care in the community and for the community" (Chavasse 1995) and the role of the PHN was described as "manager, clinician and health promoter" providing "primary, secondary and tertiary care" (Hanafin 1997). The Commission on Nursing (1998) recognised the generalist role of the PHN as a strength and recommended the continuation of the present area-based model of public health nursing to ensure a public health focus.

The current job description is outlined in the DoHC's Circular No 41/2000, which was circulated to the chief executive officers of the health boards, and states that the PHN:

"will focus 'on a district or area meeting the curative and preventative nursing needs of the population within the area.' The [PHN] will be expected to provide a broad based integrated prevention, education and health promotion service and to act as co-ordinator in the delivery of a range of services in the community.

The [PHN] in exercising his/her professional autonomy will be expected to maintain a high standard of nursing care, to share responsibility with the community nursing team for the management of nursing care and the patients' environment and to maintain a high standard of professional and ethical responsibility." (DoHC 2000)

Box 2.1. The Role of Public Health Nurse, 1966

The broad aim of what was termed "the district nursing service" was to make PHNs "available to individuals and to families in each area throughout the country, more specifically, ... to provide such domiciliary midwifery services as may be necessary; general domiciliary nursing, particularly for the aged; and at least equally important, to attend to the public health care of children from infancy to the end of the school going period" (DoH Circular 27/66, para 7).

It was also envisaged that PHNs would "provide health education in the home, and assist local medical practitioners in the care of patients who need nursing care but who do not require treatment in an institution." A further aim of this nursing service was "to integrate [it] with the general practitioner, hospital in-patient and out-patient services, so that the nurse [would] be able to fulfil the important function of an essential member of the community health team, and carry out her duties in association with the hospital staffs and others doctors in her district."

The service was to be provided initially to "persons in the lower income group in respect of all domiciliary nursing duties"; "persons in the middle income group in respect of domiciliary midwifery care, care of the aged, nursing of the chronic sick, domiciliary aftercare of patients discharged from mental hospitals, and the care of mentally handicapped children maintained at home"; and "persons in the higher income group in respect of the domiciliary aftercare of patients discharged from mental hospitals and the care of mentally handicapped children at home" and to "the aged in this group" (DoH Circular 27/66, para 15).

The main duties and responsibilities of PHNs and their specific patient/client groups include:

- Delivery of nursing care and provision of professional advice and support, including health education and health promotion
- Provision of support to persons with a disability
- Provision of support to families following bereavement, family disharmony or break-up
- Liaison with hospitals on discharge planning and performance of home assessments prior to discharge
- Provision of home nursing, including ante-natal care, where appropriate
- Promotion of and participation in primary and booster immunisation programmes, as required
- On-going child, maternal and family health monitoring, including liaising and advising parents or guardians on child health and participation in developmental screening/examination
- Participation in the school health service
- Working in partnership with colleagues in the area of child care and protection
- Provision of preventive services for older people, including maintaining independence at home
- Identification and assessment of the need for the home help service
- Provision of guidance and preceptorship to student PHNs and other student nurses during community placements.

The above appears to support the view of public health nursing as a generalist nursing service.

2.2 Policy Context

Public health in Ireland has developed over the last forty years and is concerned with all the factors which shape and influence the health of individuals, communities and society. According to the Public Health Alliance, Ireland (PHAI 2004), public health is concerned with creating the conditions in society, which enable people to be well and healthy, and with promoting, protecting and improving the public's health within the overall social, economic and political context. Solutions are sought in environmental and social action, individual empowerment and community development, as well as in clinical interventions, therefore requiring a multidisciplinary, multi-sectoral, partnership approach to improve health and to narrow the health gap between different sections of the population.

The primary care strategy, *Primary Care: A New Direction* (DoHC 2001a), acknowledged the central role of primary care in the future development of Irish health services and proposed the introduction of an interdisciplinary team-based approach which was to be introduced on a phased basis using existing infrastructure and encouraging the use of public-private partnerships where practical. Particular aims of the primary care strategy included:

- improved access to primary care services, especially out of hours,
- improved links between primary and secondary care,
- an emphasis on the importance of prevention of disease and health promotion, and
- making primary care a more satisfying and rewarding career for individuals and professions.

Primary care is described as "the appropriate setting to meet 90-95 per cent of all health and personal social service needs" on the basis that the services and resources available within the primary care setting have the potential to prevent the development of conditions which might later require hospitalisation and to facilitate earlier hospital discharge (DoHC 2001a p7). More recently primary health care has been deemed to mean "all the supports and health and personal social services required to promote health, prevent, diagnose and treat illness. It includes general practice and public health nursing services at its core, and a range of other services, including physiotherapy, occupational therapy, speech and language therapy, psychology, counselling, social work, community pharmacy, drug treatment services, community drug workers, community welfare officers, health promotion officers and community development workers. Primary health care also includes dental, aural and ophthalmic services" (National Primary Care Steering Group 2004 p8). Although more nurses and midwives now work in the community in specialised roles and with specialised client groups, it is as yet unclear how they will be integrated within the proposed primary care structures and services, and to what extent such integration will take place.

Departments of Public Health were established in each of the former health board areas during the 1990s. Led by directors of public health, these departments have a major role in health service planning, the introduction of best practice protocols and monitoring of services already in place. Other recent relevant developments include the establishment of health promotion units at a regional level, and the availability of undergraduate and multidisciplinary postgraduate courses concerned with public health and health promotion.

The last decade has witnessed various national public health and health promotion campaigns relating, inter alia, to obesity, cardiovascular health, breastfeeding, alcohol awareness, smoking, sexual health, Travellers' health and the health of other specific population groups (see Appendix 2). Many pertinent strategy documents and reports refer either directly to the actual or potential contribution of the PHN to their respective aims and activities; in some instances this contribution can be inferred. Furthermore, these documents may provide indicators for the development of specialised, advanced and other public health nursing practice.

Demographic & Epidemiological Issues

The population of the Republic of Ireland in 2002 was 3,917,203 (CSO 2005), having risen from an historical low of 2,800,000 in 1961. There have been many fluctuations in the population since the 1960s due to outward migration and rising and declining birth rates (CSO 2004a). In the early 1990s, there was a small net increase in the population due to increased economic activity and employment growth. This increase continued in the late 1990s and, coupled with historically high net inward migration, has led to an average annual population increase of about 1.6 per cent. The Central Statistics Office (CSO) has also identified certain population trends over the last forty years.

One such trend is the doubling of the number of women aged 20 to 39, but a halving of the average number of children per woman in the same period, leading to an overall decline in fertility rates. The CSO has also assumed that fertility rates will continue to decline while remaining higher than in some other European countries and that rates of childlessness will increase (CSO 2004a). Another trend is the improvement in life expectancy, with improvements in infant mortality rates in the 1960s attributed to improvements in maternity services and medical treatments, particularly immunisation. The influence of decreased infant mortality rates on life expectancy at birth diminished but the situation has improved again in recent years, with the CSO reporting that life expectancy at birth increased in 1986 and 2002. The improvements have been most notable in the older age groups and have also been very marked in the period 1996 to 2002, with a gain of 2.1 years in life expectancy at birth for males and a corresponding gain for females of 1.7 years. Improved living conditions coupled with further developments in medical care are considered to be the main contributing factors (CSO 2004a). Overall mortality rates are assumed to decrease resulting in gains in life expectancy at birth, with women's life expectancy being greater than men's. Older people will form an increasingly high proportion of the overall population.

Historically, Ireland has had high rates of emigration in the twentieth century, with an annual "outflow" of over 40,000 in the 1950s now changed to an average annual "inflow" of 26,000 in the period 1996-2002 (CSO 2004a). This high rate of immigration is expected to continue until the middle of the next decade. Approximately one third of those migrating to Ireland are returning Irish nationals (34%), while a further 30 per cent originate from outside of the European Union and the United States of America (CSO 2004b), thus contributing to a more heterogeneous and culturally diverse population in Ireland. The need to ensure that services are accessible, user-friendly and equitable to

people from minority ethnic backgrounds seeking to avail of healthcare services has been noted (NCCRI & IHSMI 2002).

While Ireland has become increasingly prosperous in recent years, the PHAI (2004) has documented a baseline of health inequality. Identified health inequalities include higher death rates in the lowest occupational class than in the highest due to all cancers, strokes and accidents. Perinatal mortality is three times higher in poorer families than in richer families, while women in the unemployed socio-economic group are more than twice as likely to give birth to low birth weight children as women in the higher professional group. The National Health and Lifestyle Surveys (Friel, Nic Gabhainn and Kelleher 1999; Kelleher et al 2003) found that poorer people are more likely to smoke cigarettes, drink alcohol excessively, take less exercise and eat less healthily than richer people. Population groups which experience health inequality in particular include Travellers and homeless people (PHAI 2004), as do people with different types of disability (Lollar 2001; Walsh, Kerr & Valk 2003).

Current Developments

4.1 Introduction

Ireland has changed in many ways since public health nursing was originally established as a division of the register, in terms of population and population health trends. Health and primary health care provision and services have also changed during the last forty years, as have reporting relationships within regional structures (see Figure 4.1). In each region a programme manager has responsibility for a specialist service provided by a number of community care areas, and a general manager has responsibility for a particular community care area within the region.

These changes and the aims for future public health, health promotion and primary health care services are more closely reflected in the current job description for PHNs (DoHC Circular No 41/2000) than in the original. At the same time there are more nurses working in the community and in primary care settings: these include practice nurses, school nurses, community-based mental health and intellectual disability nurses (including clinical nurse specialists), palliative care nurses and domiciliary midwives. It has been noted that in some community areas, community mental health and intellectual disability nurses and practice nurses, in particular, work "in isolation" from the public health nursing service (ie, within other systems), although the

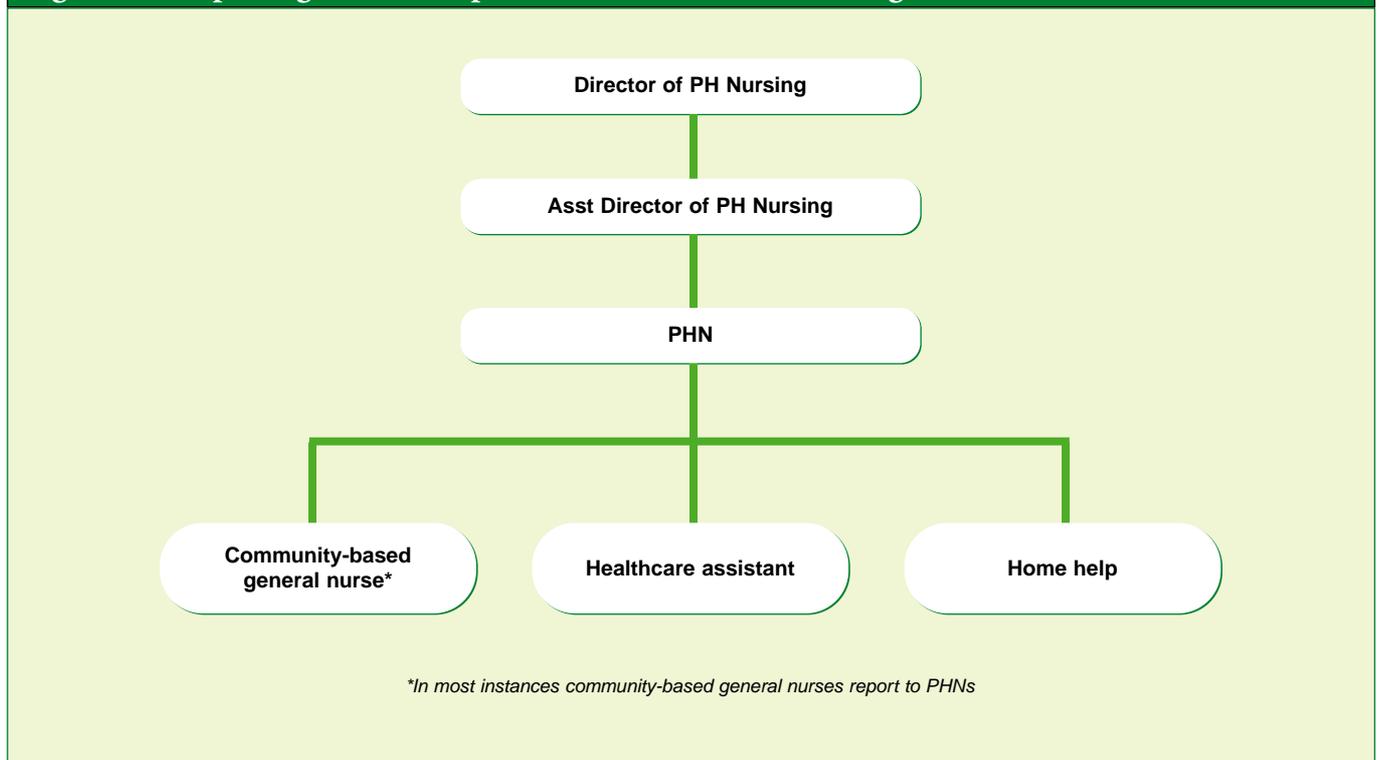
interdependence of this service with other service providers is "considerable and often determines both the components and level of public health nursing service provision" (Hanafin et al 2002 p 70).

Another recent development has been the amendment to An Bord Altranais' rules concerning entry to pre-registration public health nursing education programmes. The Nurses Rules, 2004, were signed into effect by the Tánaiste and Minister for Health and Children in December 2004 and now extend entry to these programmes to "persons holding a registration in any Division of the Register" (An Bord Altranais 2004)¹. The effect of this change, when fully implemented, will mean that registration as a general nurse and as a midwife will no longer be prerequisites for public health nursing. The removal of midwifery as a prerequisite was originally proposed by An Bord Altranais in 1994 and re-encountered by the Commission on Nursing during its consultation process (Government of Ireland 1998, par 8.22).

Given the developments outlined above, it is not surprising that the participants in the consultation process spoke of a need for role clarity and expressed concern about the demands of their workload.

Other developments that have occurred since the mid-1990s for the benefit of professional development include funding

Figure 4.1. Reporting Relationships within Public Health Nursing



¹ This rule change occurred after most of the consultations undertaken for this document had taken place.

of nurses and midwives working in the public sector to undertake primary degrees and an increasing range of specialised postgraduate courses, the establishment of nursing practice development co-ordinator posts, funding of continuing education programmes for nurses and midwives by the National Council, and the establishment of the nursing and midwifery planning and development units and the centres of nurse education.

At a global level, health policy has actively promoted public health practice in nursing (World Health Organisation 2000 & 2002). On the island of Ireland the chief nursing officers of both jurisdictions have made a commitment to building a sustainable, creative and effective nursing contribution to public health practice (Mason & Clarke 2001; DHSSPS & DoHC 2003, 2005). The authors of the report *Nursing for Public Health: Realising the Vision* (DHSSPS & DoHC 2005) outline a model for embedding public health into education and practice "across the range of clinical areas and community settings in which nurses work" (p16), and reiterate the principle that public health is "a multi-professional, multi-agency activity [requiring] effective collaboration and communication between all sectors, including users groups, [in order to fulfil] public health targets" (p26).

4.2 Workload of public health nurses

The workload of public health nurses has been a cause of concern for PHNs for many years and has been the subject of a small number of reports (DoH 1975; Burke 1986; O'Sullivan 1995; DoH 1997; Begley et al 2004). During its consultative process the Commission on Nursing noted the concerns of PHNs regarding their "increasing workload and increasingly complex range of social and health issues related to substance abuse and child care protection" (p153). In addition, the various strategy and other documents that allude to the actual and potential contribution of PHNs present other challenges and opportunities that affect both their workload and role.

4.3 Clinical career pathway

The clinical career pathway was established and developed by the National Council (NCNM 2001a, 2001b, 2004a, 2004b, 2004c) in accordance with the recommendations of the Commission on Nursing. A wide range of clinical nurse and midwife specialist posts have been approved since 2000 under the immediate and intermediate career pathways, and at the time of writing twenty-nine advanced nurse practitioner posts had been established in general nursing. The *Agenda* report (NCNM 2003a) noted the lack of clarity around the term *generalist* nursing practice. The Commission on Nursing was of the view that in the longer term community nursing services would become more integrated and that nurses "might then progress by specialising in the care of particular client groups in the community" (p160).

Key Issues

During the consultation process, PHNs highlighted a number of issues currently impacting on their work and role, such as role clarity, caseload/workload and the clinical career pathway.

5.1 Role clarity and caseload/workload issues

As the consultation process advanced, it became apparent that role clarity and caseload/workload issues were inextricably linked. The role of the PHN encompasses that of manager, clinician and health promoter (Hanafin 1997), but many of those participating in the consultation process stated that the clinical aspect of their work, with its increasing complexity and volume, currently subsumes the managerial and health promoting aspects of their role. Another criticism of their large caseload was that the volume of work made it difficult to provide primary as well as secondary nursing care (Chavasse 1998), and many participants expressed frustration at not being able to meet their role expectations.

In 2003 a total of 2,427 public health nurses were registered with An Bord Altranais, of whom 1,987 (82%) had their names entered in the active file. It is recommended that one PHN serves a population of 2,500, but the population may vary from 1:2,500 to 1:5,099 (DoHC 2002a), with PHN:client ratios being higher in urban than in rural locations (Begley et al 2004). PHNs' efforts to provide the "largely demand led" service requires them to "juggle the frequency and duration of visits depending on caseload and levels of patient dependency" (Begley et al 2004, p20) on the underlying assumption that everyone has equal need of the service (Hanafin et al 2002). However, a sounder way of assessing the number of posts should take account of local demography, population density, socio-economic conditions, the terrain to be covered, and community and social supports available at a local level (Begley et al 2004).

Within their caseloads the services and nursing practices may vary between individual practitioners (there may also be regional variation in service provision and delivery). A recurrent theme at the focus group discussions was the lack of standardisation of some core aspects of the service. For example, participants spoke of a dearth of policies, procedures or standards in relation to service delivery, and were keen for these to be developed and implemented. Variations in service delivery are evident within local areas, regionally and nationally. Some participant managers expressed the belief that they do not have the authority to challenge or manage PHN practice while others stated that they do not have time or the skills to monitor services.

5.2 Generalist, specialist and advanced practice

There has been on-going debate about whether or not the PHN operates as a generalist or specialist, and while Begley et

al (2004) refer to the role as having been "traditionally ... a generalist one" (p15) some ambiguity remains. The current job description (DoHC Circular 41/2000) depicts a generalist nursing role. Some participants indicated that they wished to continue to provide a generalist, area-based service as a basis for providing a comprehensive community nursing service. However, others referred to a lack of recognition for their "expertise" and the "uniqueness of public health nursing," claiming that recognition as specialists would enhance their confidence in their role.

It was apparent that large caseloads made it difficult for PHNs to retain a generalist community focus and many participants recognised the need for the development of some distinct specialist roles in areas such as tissue viability or child health. Others stated that even where they had a specialised interest or skill, the demands of their caseload hindered them developing this into a distinct role.

The absence of distinct clinical career pathways was raised by most groups throughout the consultation process and there was much discussion about clinical nurse specialist (CNS) status. The absence of CNS status and the extent of the clinical experience required for advanced nurse practitioner posts (NCNM 2001b, 2004b) were perceived by some participants as impeding the development of advanced nurse practitioner posts.

5.3 Leadership and management in public health nursing and primary care

A key theme of the consultation process was the need for enhanced leadership and management at a number of levels and both within nursing and health service structures. The breadth of the range of services they offer is such that "the public and other health care providers may not even be aware of those services to which they are not exposed" (Begley et al p15). PHNs described their work as "*unseen*" and "*unquantifiable*" and expressed their belief that the lack of appreciation by managers and policy makers for their role will continue unless they can make it more visible. Management structures and processes were generally experienced as hierarchal, conservative and in need of development. Positive leadership is experienced in some areas while in others the perceived absence of leadership results in "*apathy*" and a sense of being "*all over the place*". In relation to PHNs' health promotion contribution, reference was made to "*service gaps*" and "*the lost opportunity to engage with and influence the community on serious and current issues like childhood obesity and substance abuse.*" They also expressed a willingness to be actively involved in identifying population needs and liaising with voluntary and statutory sectors in the co-ordination of community care.

Assistant directors reported having responsibility for approximately ten PHNs as well as managing community-based general nurses, health care assistants and, in some areas, home helps. Some participants described the role of the assistant director as being concerned primarily with management rather than with leadership and mixed views were expressed on PHN managers' level of decision-making authority. Some believed they were working as managers within effective management structures while for others the role and its responsibilities were unclear. Concerned about what might happen to the assistant director grade following full implementation of the Primary Care Strategy (DoHC 2001a), assistant directors believed that, like the PHN grade, their role was ill-defined, overly focused on administration and varied from area to area. Some responsibilities were allocated in response to gaps in other services, for example, the lack of a home help supervisor. All expressed a desire to see a clearly defined management role in line with the recommendations of the Commission on Nursing. They also wanted to develop their role in evaluation and monitoring of services, as well as developing skills in caseload analysis, service planning, management and leadership, research and audit.

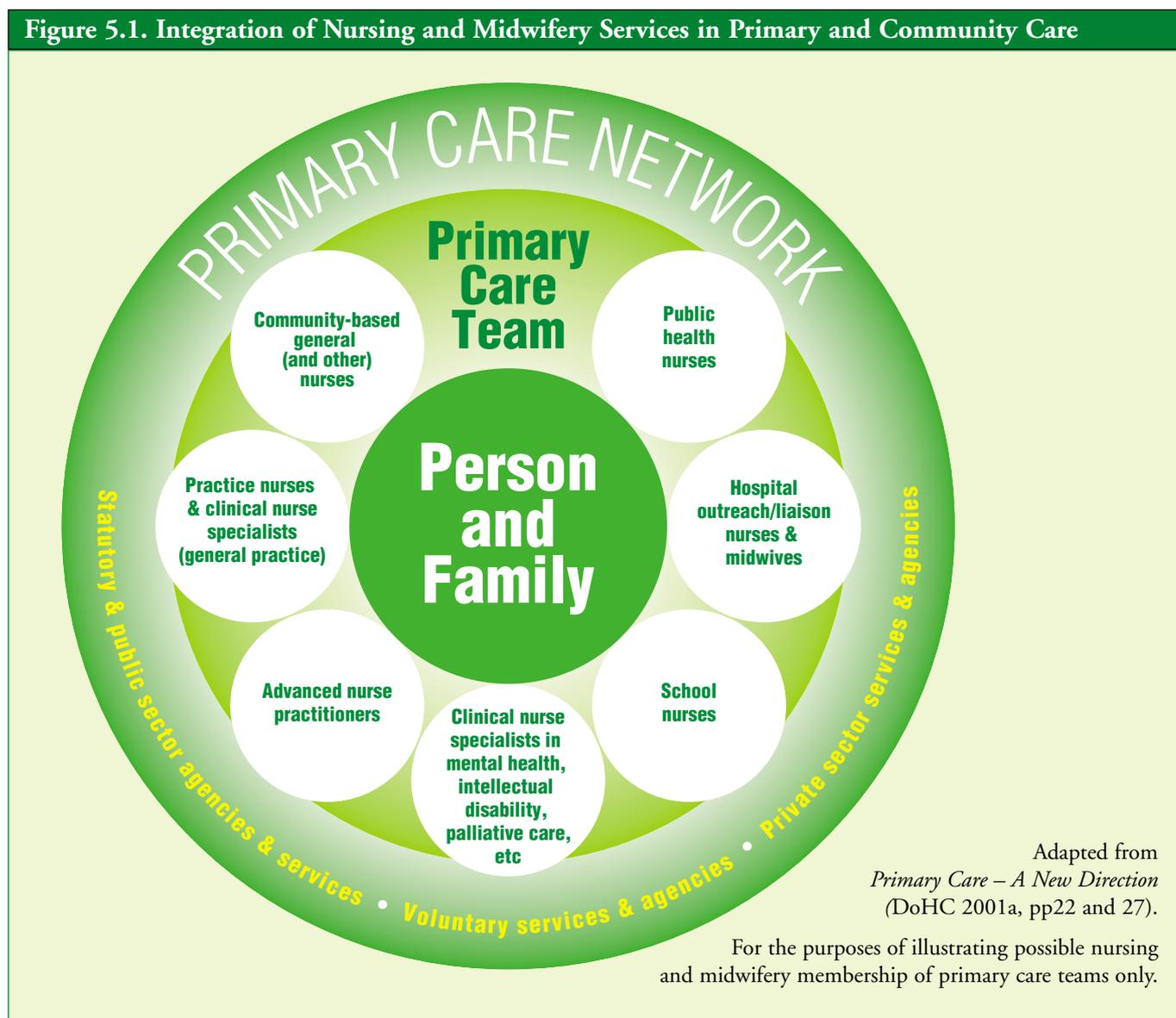
Directors of public health nursing echoed the comments of the other grades about the perceived lack of leadership, claiming that there was "a lack of leadership at leadership level." They attributed this to many factors including the increasing pressure on the public health nursing service stemming from the changes in health policy and health service structures which had taken place without, they felt, adequate consultation with PHNs.

5.4 Skill-mix and multidisciplinary team-working in the community

It has been suggested that PHNs are ideally placed for and ideally suited to the role of co-ordinator of primary care in the geographical area to which they are attached (Hanafin 1997). However, public health work requires social and environmental interventions, as well as clinical interventions, and so requires a multidisciplinary, multi-sectoral, partnership approach to improve health and to narrow the health gap between different sections of the population (Dalziel 2003; PHAI 2004).

Although public health is more concerned with population groups than with individuals (Dalziel 2003), PHNs

Figure 5.1. Integration of Nursing and Midwifery Services in Primary and Community Care



Adapted from
Primary Care – A New Direction
 (DoHC 2001a, pp22 and 27).

For the purposes of illustrating possible nursing and midwifery membership of primary care teams only.

themselves expect, and are expected by others, to work with individuals in a prescribed geographical area. However, their work is supported in many areas by community-based general nurses, some of whom now have their own caseload. PHNs participating in the consultation process reported an unequal allocation of the general nurses ("*adequate*" or "*inadequate*"). They also reported that the quality of working relationships varied: in some areas there were "*good collaborative working relationships*" and a "*team approach*", while in others the general nurses were not seen as fully integrated members of the nursing team or else more effective communication with them was required.

Today PHNs work alongside many other community-based nurses and midwives, but not necessarily in an interdependent way. These other nurses and midwives are employed by, for example, voluntary organisations, acute hospital outreach programmes, statutory mental health services or general practitioners, and operate in response to an identified community health or health service need (see Figure 5.1). PHNs expressed the view that some nurses currently working in the community may not have received adequate preparation¹ and in some instances required a lot of support from the PHNs. However, it was unclear to what extent the participants have worked with other nurses and midwives based in the community.

¹The Faculty of Nursing and Midwifery, Royal College of Surgeons in Ireland, has delivered a thirty-hour module Developing Excellence in Nursing Practice targeted at community-based general nurses. This has been provided on three occasions since the late 1990s, most recently in 2003.

The National Council has funded a number of programmes for nurses and midwives that are concerned with practice and practice development in community and primary care nursing.

Agenda for Future Development

6.1 Demographic and epidemiological issues

Population trends and issues identified by the CSO such as declining fertility rates, the ageing population and increase in the number of immigrants (CSO 2004a, 2004b, 2005) suggest that PHNs may need to review current and future caseload expectations. In some areas PHNs can expect to have less involvement in antenatal care and to have proportionately fewer infants and children in their caseload, whereas in others they may be required to have a greater involvement in care of older people and in supporting them to remain in their own homes. Again PHNs working in some areas can expect to meet the public health nursing needs of people from a range of ethnic backgrounds and diverse cultures, which may have implications for PHNs' continuing professional development.

6.2 Health inequalities

The public health agenda is currently concerned with health inequalities, particularly those experienced by lower socio-economic groups (PHAI 2004) and other specific population groups (DoHC 2002b). PHNs' actual contribution to improving the health of these groups has already been identified. In the future they may need to expand relevant knowledge and skills in order to enhance and expand the services they provide to these constituent groups of their caseload and to give consideration to anticipating those population groups that may become part of their caseload. The relevant knowledge and skills include those relating to a community development and population-focused approach to public health nursing (Dalziel 2003).

6.3 Interdisciplinary working

The current national health strategy (DoHC 2001b) and primary care strategy (DoHC 2001a) both urge health and social care professionals to work together in a more integrated and interdisciplinary manner. Developments in health and social service provision have resulted, inter alia, in a wider range of nurses and midwives working in the community and in the creation of non-nursing posts concerned with health promotion. There may be a lack of clarity around the health service structures and lines of accountability that have emerged at a regional level in the last decade, as well as around the roles to be played by specific groups of nurses in the community. While it is important for health and social care professionals to retain a strong professional identity in circumstances in which traditional boundaries may become blurred (Melling & Hewitt-Taylor 2003), there is also a need for PHNs to be able to determine their own contribution to multidisciplinary interventions (Elliott et al 2004) as well as enhancing their understanding of the roles and contributions of others and of multi-sectoral and multi-agency working.

The publication of the NAMIC strategy may provide clearer directions for PHNs regarding the above.

6.4 Workload issues

Workload issues have long been a concern for PHNs. Begley et al (2004) set out to develop a tool, the *Community Client Need Classification System*, that would include measurement of the client's total need for nursing care including education, rehabilitation and psychological care. This tool succeeds in measuring the direct care aspects that pertain to the individual and indirect care aspects such as organising services and communication with other staff. While the tool goes some way to increasing understanding of the diversity and complexity of PHN work, the authors point out that the larger role in assessing the health needs of populations at large is less tangible and more difficult to measure. Workload difficulties are apparently exacerbated by the open referral system that prevails. An audit of referrals at local and regional levels and consultation with relevant stakeholders may provide the evidence required for a review of the referral system to PHNs.

6.5 Role development

The current job description for PHNs (DoHC Circular No 41/2000) indicates that PHNs have a generalist caseload, which would suggest that specialist nursing practice should develop in accordance with identified service need or in response to the needs of groups identified in the various strategy documents and reports published in recent years (see Appendix 2). These specialist practice areas might include tissue viability/wound management, child health and child protection, while specific groups might include Travellers and people in the community with cardiac diseases. Advanced practice roles could include primary care, nurse-led community services or specific population groups (e.g., older persons, Travellers, people with disabilities and homeless people). Analysing service needs will enable directors of public health nursing (1) to identify appropriate CNS and ANP posts and roles and (2) to develop these roles in order to enhance existing service provision and support existing roles. Such service needs analyses should take place at a service level.

As new roles emerge in specialised areas PHNs will need to undertake further relevant professional development that incorporates the competencies required. Educational preparation for such roles in public health nursing may contain elements required by other nurses seeking to follow a clinical career pathway in primary or community care, so the relevant stakeholders (e.g., third-level education providers, the NMPDUs, the centres of nurse education and directors of

public health nursing) may need to review current provision and the extent to which it meets the needs of the interested parties.

There is also a need for PHNs to standardise clinical and other nursing practice. This will necessitate an audit or a review of current practice, competencies and practice guidelines. The establishment of such posts as nursing practice development co-ordinators and clinical placement co-ordinators in public health nursing may contribute to the development of these standardised guidelines, as may clarification of PHN managers' roles regarding monitoring of practice. The development of practice guidelines will also support the development of the clinical career pathway. A further aid to the development of standardised practice (and communication between PHNs) is the use of information and communications technology.

6.6 Leadership

PHNs of all grades were in agreement about the need for more effective leadership and a clear strategy for public health nursing, with more junior grades seeking this leadership from directors and assistant directors, and directors seeking it from regional and national structures. It is envisaged that a vision statement for public health and community nursing would facilitate a clearer definition of the PHN role and enhance proactive service planning and delivery, thus helping to minimise any misperceptions of the PHN service among significant stakeholders. An example of strategic planning was identified in the southern area, whereby on the basis of a needs analysis of the population of a particular county, the public health nursing service was able to prioritise the delivery of services offered by PHNs. Accordingly, funding was allocated (in order of priority) to services for older people, child welfare and family (and related) support services, Traveller health projects and asylum seekers, to name but a few.

The development of nursing management competencies specific to public health nursing is also required, as well as the implementation of management development activities such as mentoring and coaching. The Office for Health Management (OHM) has already published a framework for nursing management competencies and for commissioning management development programmes (OHM 2000, 2002a) which may form the basis for this work. The OHM has also provided a leadership programme for senior PHNs (OHM 1999), but PHNs could consider programmes such as the *Leading an Empowered Organisation* (LEO) programme or the Institute for Public Health's *Leadership for Building a Healthy Society* programme. The development of stronger links and closer working relationships with regional structures such as the regional health office, health promotion units and departments of public health can assist PHN managers to raise the profile of PHNs and to clarify their roles and contribution to the public health agenda. More effective collaboration with the NMPDUs, the centres of nurse education, third-level education providers and the academic centres referred to in the Primary Care Strategy (DoHC 2001a) should be promoted, particularly with regard to identifying CPD needs and resources.

6.7 Continuing professional development

Apart from the need to develop closer links with and a greater understanding of the respective roles of the various nurses and midwives now working in the community, there is also a need to examine the CPD requirements of the public health nursing team, including the community-based general nurses. Resources for CPD already exist within the NMPDUs and the centres of nurse education. PHN managers can work with staff in these locations to develop appropriate learning activities and programmes. At the same time they can support the career development of their own staff of all grades by means of the personal development planning process (DoHC & HSEA 2002; OHM 2002b, 2003; NCNM 2003b).

6.8 Moving forward

Directors of public health nursing are the central figures in supporting the development of the processes required to move this agenda forward. The National Council will work closely with them and other key stakeholders, including the relevant third-level education providers, the centres of nurse education and the NMPDUs, in order to support this development.

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Appendix 1 – List of Submissions

1. Ms Patricia Treacy, Bride Street Health Centre, 36a Bride Street, Dublin 8
2. Ms Elizabeth Healy, Ballyphehane Health Centre, Lower Friars Walk, Ballyphehane, Cork
3. Ms Mary Queenan, Ms Melissa Collins, Ms Paula Duggan and Ms Brigid Dockery, Boyle, Co Roscommon
4. Ms Sheila O'Reilly, Sr Anne Marie O'Sullivan and Ms Josephine Murphy, Health Centre, Innishmore, Ballincollig, Co Cork
5. Ms Helen Deely, Area 4, Public Health Nursing Section, South-Western Area Health Board, Old County Road, Crumlin, Dublin 12
6. Ms Mary O'Flynn, Southern Health Board, Community Services, Rathealy Road, Fermoy, Co Cork
7. Ms Edel Deane, Ballycastle Health Centre, Ballycastle, Co Mayo
8. Ms Teresa Bruen and Ms Marion Duffy, Public Health Nursing Department, Health Centre, Ballaghaderreen, Co Roscommon
9. Ms Mary Mac Mahon, Health Promotion, Museum House, Frances Street, Ennis, Co Clare
10. Ms Anne Costello, Limerick Health Promotion Service, Carnegie Centre, Bishops Street, Newcastle West, Co Limerick
11. Ms Gillian Paul, School of Nursing, Dublin City University, Glasnevin, Dublin 9
12. Ms Catriona Murphy, Ms Eileen Courtney and Ms Anne Matthews, School of Nursing, Dublin City University, Glasnevin, Dublin 9
13. Mrs Brid Brennan, Pre-School Services, Community Care Headquarters, James' Green, Kilkenny
14. Prof Cecily Begley, School of Nursing and Midwifery Studies, University of Dublin, 24 D'Olier Street, Dublin 2
15. Ms Anita Roddy, Redeemer Family and Resource Centre, Cedarwood Park, Dundalk, Co Louth
16. Ms Marcella Kelly, Galway
17. Public Health Nursing Team, School of Nursing and Midwifery, University College, Dublin
18. Ms Anna Madden, St Angela's College, Lough Gill, Sligo, and Ms Dolores Gallagher, NMPDU, Iona House, Ballyshannon, Co Donegal.

Appendix 2

Strategy Documents and Reports Referring to the Actual or Potential Contribution of Public Health Nurses to Health and Social Services

Children First: National Guidelines for the Protection and Welfare of Children (DoHC 1999)

PHNs are identified as a contact point for persons with concerns about child abuse.

National Health Promotion Strategy 2000-2005 (DoHC 2000)

PHNs are identified alongside other health care professionals working in the primary care sector as being the first point of contact with the health service for some service users, as being ideally placed to provide a supportive environment that promotes health and to undertake brief interventions with clients.

Primary Care – A New Direction (DoHC 2001)

PHNs acknowledged as contributing to existing primary care services, although professionals noted to be working in isolation very often. Mooted as members of the primary care team. Modules of interdisciplinary training between different disciplines at postgraduate level proposed so as to enhance teamwork and leadership.

Final Evaluation Report of the Teen Parents Support Initiative (DoHC 2002)

Contributions of PHNs to interventions with young parents and their children.

Our Duty to Care: The Principles of Good Practice for the Protection of Children and Young People (DoHC 2002)

Potential role of PHNs in reporting suspected abuse identified.

Protecting Our Future: Report of the Working Group on Elder Abuse (DoHC 2002)

Awareness of elder abuse advocated for inclusion in continuing professional development programmes for PHNs. Their role in reporting systems noted.

Traveller Health – A National Strategy 2002-2005 (DoHC 2002)

PHNs' front-line role in the promotion of better health for Travellers is outlined.

A National Breastfeeding Policy for Ireland (DoHC 2003)

PHNs are identified as resource persons in each community care area with expertise in breastfeeding, with a view to providing support and in-service training for colleagues, as well as providing appropriate support to mothers of infants. Their own potential needs for further training in this area are noted.

Ireland's Changing Heart (Second Report on the Implementation of the Cardiovascular Strategy) (DoHC 2003)

PHNs are identified as "key players" in primary care. Their links with community dietetics services are noted, particularly in relation to obesity and overweight, as is their contribution to community-based smoking cessation clinics. The development of training programmes for PHNs in health promotion, brief intervention techniques for behaviour change in life-styles and basic life support is noted. Recommendations include developing the role of PHNs in health promotion and disease prevention.

An Evaluation of Cancer Services in Ireland: A National Strategy 1996 (DoHC 2003)

Role of primary care (including PHNs) in prevention and health promotion found to have been under-utilised. Poor communication between hospital teams, general practitioners and PHNs noted. PHNs' role in early detection of breast cancer and the promotion of screening noted, but demands of workload recognised.

Empowerment Narratives: A Collection of Exemplars Illustrating Empowerment of Nurses and Midwives (DoHC 2003)

PHNs' projects concerned with community-based health initiatives are outlined.

Towards Best Practice in the Provision of Health Services for People with Disabilities in Ireland (National Disability Authority 2003)

Counselling nurse service by PHN noted in the former Mid-Western Health Board for children and adults with physical and sensory or learning disability and provision of on-going and early intervention support to families.

Phase 1: Health Service Reform Programme – Composite Report (DoHC 2004)

The ability to plan and deliver integrated services to the consumer is a core objective of the health service reform programme. Effective integration between the DoHC and the various structures supporting these organisations in service delivery will be essential for the effectiveness of the healthcare system as a whole. Integration within community services refers to that between general practice, public health, child care, disability, mental health and other community-based services, as well between acute and non-acute services and between voluntary and statutory services.

Health Information – A National Strategy (DoHC 2004)

The relevance and potential of new service delivery models using mobile communication technologies for public health nurses is noted.

Working for Children and Families: Exploring Good Practice (DoHC 2004)

The contribution of PHNs to good practice in child and family services is noted, as is their close co-operation with other health and social care professionals in interventions with vulnerable families.

Review of the National Health Promotion Strategy 2004 (DoHC 2005)

The development at a regional level of breastfeeding strategies and the establishment of local steering groups in partnership with hospitals, public health nurses and midwives is noted.

Obesity: The Policy Challenges. The Report of the National Task Force on Obesity (DoHC 2005)

Situations specified in which public health nurses can engage in health-promoting activities with parents.