REPORT

OF

STRATEGY TASK FORCE

ON

CHILD HEALTH

Eastern Health Board

May 1995

MEMBERS OF TASK FORCE

Dr. Rosalee Watters (Chairperson), Acting Director of Community Care and Medical Officer of Health, Community Care Area 4, Old County Road Health Centre, Crumlin, Dublin 12.

Ms. Nora Cummins, Superintendent Public Health Nurse, Community Care Area 3, 1 James' Street, Dublin 8.

Ms. Teresa Downes, Area Administrator, Community Care Area 3, 1 James' Street, Dublin 8.

Ms. Elizabeth Duffy, Superintendent Public Health Nurse, Community Care Area 2, Vergemount Hall, Clonskeagh, Dublin 6.

Dr. Evan Murphy, Area Medical Officer, Community Care Area 8, Coolock Health Centre, Cromcastle Road, Coolock, Dublin 5.

Dr. Lelia Thornton, Senior Area Medical Officer, Community Care Area 9, Poplar House, Poplar Square, Naas, Co. Kildare.

Ms. Bevin Tiernan, Speech and Language Therapist, Community Care Area 2, Vergemount Hall, Clonskeagh, Dublin 6.

Secretary: Dr. Maura O'Connor, Area Medical Officer, Community Care Area 10, Glenside Road, Wicklow.

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CHAPTER 1

INTRODUCTION

INTRODUCTION

The primary aim of the health services is to enhance the health and quality of life of people. The Health Strategy "Shaping a Healthier Future" set out to establish the boundaries within which these aims could be met by providing clearly stated objectives and setting targets. The main theme of the Health Strategy document was the reorientation/reshaping of health services so that improving people's health and quality of life became the primary and unifying focus of efforts. The three underlying principles were equity, accountability and quality of service.

CHILD HEALTH

The Strategy identifies preventive care for children as a key factor in determining their subsequent health status. It identifies four areas of particular relevance to child health - infant care, immunization programmes, health centres and breast feeding - while giving a commitment to implement recommendations on reviews of Maternity and Infant Care (unpublished), Immunization Services (published), and Pre-School and School Health Services (review body yet to be appointed). The result should be an effective service in tune with modern thinking and practice in child health.

PURPOSE

The purpose of the Health Strategy groups (Eastern Health Board) is to make recommendations as to how the Health Strategy targets can be implemented in the Health Board.

AIM

The aim of the Child Health Task Group was to produce a 3-year costed action plan for the Eastern Health Board based on the Strategy targets, identifying what could be achieved within existing resources and indicating where additional resources will be required.

CHAPTER 2

DEMOGRAPHIC AND STATISTICAL FRAMEWORK

INTRODUCTION

To plan effectively for the future, it is first neccessary to review the current demographic profile and population trends within the Eastern Health Board. The Board region includes counties Dublin, Kildare and Wicklow, and is divided into ten community care areas, eight in Dublin, one in Kildare and one in Wicklow.

POPULATION

In the 1991 census, the Eastern Health Board served a population of 1,244,476, or 35% of the population of the Republic of Ireland.

385,493, or 31%, of the Board's population were children under the age of 18 years. Children under 5 years represented 7.7% of the Board's total population, compared with 8.8% in 1986. This reduction reflected changes in the population at the national level due to falling birth rates.

Teenagers, from 13 to 18 years, comprise the largest single population group at 15%. They present the health service with new challenges in meeting the needs of older children.

BIRTHS

The Crude Birth Rate is the number of live births per 1,000 population. The number of births in Ireland and in the Eastern Health Board region has been declining since the early 1980s. There were 11,963 fewer births in the country in 1993 compared with 1986, a reduction of 19.5%. Table 1 shows the decline and indicates that the birth rate is falling in the Eastern Health Board region at a slower rate than that for the rest of the country. The rate of decline in the Eastern Health Board region during the same period was 14.3%.

TABLE 1. NUMBER OF BIRTHS IN THE EASTERN HEALTH BOARD REGION AND IRELAND 1986-1993

	1986	1987	1988	1989	1990	1991	1992	1993
E.H.B.	21,336	20,892	19,633	18.513	19,238	19,655	19,049	18,636
Irl.	61,419	58,864	54,300	51,659	52,954	52,690	51,584	49,456
EHB as % of all	34.8	35.5	36.2	35.8	36.3	37.3	36.9	37.7

The National Crude Birth Rate is now similar to rates obtaining in other European Union countries (see Table 2).

TABLE 2. CRUDE BIRTH RATES IN E.U. COUNTRIES IN 1991

COUNTRY	Live Births per 1,000 population
Ireland	14.6
United Kingdom	13.7
France	13.3
Netherlands	13.2
Luxembourg	12.9
Belgium	12.6
Denmark	12.5
German Federal Republic	10.4
Greece	10.1
Spain	9.9
Italy	9.6

MATERNAL AGE AND MARITAL STATUS

In Dublin, Kildare and Wicklow, most babies are born to women aged between 20 and 34 years. The number of births to unmarried mothers has increased from 9.3% of total births in 1982 to 18% in 1992. The national trend was from 6.2% in 1982 to 18% in 1992.

In 1992, 89.5% of births to mothers under 20 years were to unmarried mothers. Babies born to teenage and single mothers may have medical and social disadvantages when compared with those born to married women. Analysis of births to single and teenage mothers in the Eastern Health Board area published in 1994, revealed, as in other studies, that such babies were significantly more likely to be premature and less likely to be breast fed (Eastern Health Board - The Health and Welfare Needs of Single Mothers, 1994).

PREMATURE BIRTHS

Prematurity. or birth before 37 weeks gestation, is a significant cause of morbidity and mortality. The rate for premature births ranges between 6% and 7%.

MORTALITY

National and Eastern Health Board child mortality rates have declined in recent decades. The data indicates a levelling out since the mid-1980s.

INFANT MORTALITY

The Infant Mortality Rate (the number of deaths in a year of children under one year of age per 1,000 live births in that year) is an important measure in public health because it reflects both social standards and quality of antenatal care. Table 3 traces the fall in infant mortality in Ireland and the Eastern Health Board since 1984. The fall reflects improvement in factors such as economic conditions, nutrition, sanitation and medical care.

TABLE 3. INFANT MORTALITY RATES FOR IRELAND AND THE EASTERN HEALTH BOARD REGION 1984-1992

	1984	1985	1986	1987	1988	1989	1990	1991	1992
E.H.B.	10.1	8.9	7.7	7.3	9.6	7.5	7.2	8.9	7.5
Ireland	10.1	8.9	8.7	7.4	9.2	7.5	8.2	8.2	6.6

The commonest causes of death are sudden deaths (cause unknown), congenital abnormalities and infections.

CHILDHOOD MORTALITY

The number of deaths per year in children aged from 1 to 14 years has declined by 30% from approximately 300 in the mid-1980s to approximately 200 in the early 1990s. Most of the deaths are due to accidents and are preventable. Road traffic accidents comprise 40% of the deaths due to accidents, falls 20%, and fires and burns 7%. The Strategy document lays particular emphasis on accidents in a general context under the section on Health Promotion.

MORBIDITY

Measures of morbidity in children are less readily available than those of mortality because of a lack of clear definitions

of illness and morbidity and because of poorly developed data collection systems. Two areas of significant morbidity are congenital malformations and infectious diseases.

CONGENITAL MALFORMATIONS

The 1992 rate of congenital malformations was 19.7 per 1,000 live births in the Eastern Health Board region. Rates of congenital malformation have declined since 1980 when the rate was 28.6/1,000. The commonest congenital malformations are congenital heart disease (4.5/1,000) and chromosomal disorders including Down's syndrome (2.2/1,000).

Better nutrition and vitamin, including folic acid supplementation, have led to a dramatic fall in neural tube defects from 4.7/1,000 live births in 1980 to 1.7/1,000 in 1992.

INFECTIOUS DISEASES

Infectious diseases remain a major cause of largely preventable morbidity and some mortality, despite immunizations and improvements in hygiene standards. New infectious agents are constantly arising, the global epidemic of HIV infection since the early 1980s being the most notable example. In addition, the advent of antibiotic resistant superbacteria is worrying. Even where prevention is possible, infections persist. Measles, now totally preventable by vaccine, is still a problem among Irish children.

The system of statutory notifications of specified infectious diseases demonstrates trends but is inaccurate because of significant under reporting. In the Eastern Health Board region, the clinical surveillance system is augmented by data from a laboratory surveillance system, but development of a National Disease Surveillance Unit is essential to provide accurate information on the incidences of infectious diseases.

SUMMARY

While Ireland still has a high number of births when compared with other European Union countries, there has been a shift towards the adolescent age group as the largest single population group. The Strategy document in the section on Child Health focuses on services for Infants, Pre-School and National School children. Demographic studies underline the importance of the development of health services for adolescent children as well. The high number of births to single and teenage mothers is of particular concern and requires special attention in the current health services.

Mortality and morbidity statistics are incomplete because of the slow development of surveillance units and comprehensive information systems. Studies of existing statistics indicate that attention to health promotion in the areas of congenital malformations, infectious diseases and accident prevention should lead to a further significant improvement in the health of our children.

CHAPTER 3

INFORMATION SYSTEMS

INTRODUCTION

Health services doe not exist in isolation. To serve the population, they must interact effectively and efficiently with the targetted population and all relevant service providers. This is especially true of the child health services, where preventive care is the key factor for determining subsequent health status right into adult life.

CURRENT POSITION

The computerised Child Health System in the Eastern Health Board was developed in 1989 from an adaptation of the Regional Interactive Child Health System (RICHS) developed by North East Thames Regional Health Authority in the United Kingdom. The present system has three modules, and there is a facility for the incorporation of others.

The primary module is the child register. This is the core of the RICHS system. It contains data on each child living in the Eastern Health Board area. All other modules derive from this. The register is established at central headquarters from birth notifications sent in by maternity units, private midwives, etc. Birth notifications are transmitted to the appropriate community care area based on a child's home address. As each area is independent, a specific set of procedures is followed when a child's record is transferred to another area, e.g. on moving address.

The same procedures apply when a child, who is not previously registered, comes to reside in the Board's area. Clerical staff in each area are assigned tasks on the system under the supervision of the area systems administrator.

Information on innupta births is retained at central headquarters until cleared for transmission to the local community care area by the maternity unit social worker (see chapter 4).

The functions of the child register include:

- production of baseline demographic data for the child health home visiting record card of the public health nurse;

- identification of innupta births;

- area and Eastern Health Board statistical records;

- baseline data for other modules.

In the immunisation module of the RICHS system, M.M.R. is the only immunisation service currently computerised in all community care areas. The module contains call/recall facilities, G.P. payment details, defaulter identification and statistics. A pilot project incorporating all primary immunisations, except B.C.G., is under way in Kildare.

The pre-school (developmental) module incorporates the following:-

- call/recall for developmental examinations;

- clinic identification;

- clinic lists;

- results of developmental examinations, and

- statistical records.

An independent computer programme has been designed for travellers and incorporates details of some of the services provided by public health nurses through the travellers' mobile clinic.

FUTURE

Targets to improve child health cannot be set without adequate information on disease prevalence and morbidity rates. These targets then form the basis for the provision of appropriate health services which are equitable and accessible. In the future, child health information systems must be integrated across all groups of children, contain appropriate and accurate data, interlink in a user-friendly manner across all relevant health service providers, and remain confidential.

RECOMMENDATIONS

1. Appointment of a central systems administrator to the existing vacant post.

   Starting date: Immediately.
   Additional cost: Nil.

2. Identification of the area systems administrator in each community care area.

Starting date: Immediately.
Additional cost: Nil.

3. Identification of childcare unit and trained interchangeable clerical staff in each area with specific responsibility for all child health.

Starting date: September 1995.
Additional cost: Nil.

4. Implementation, following immediate evaluation, of RICHS module for childhood immunisations.

Starting date: January 1996.
Additional cost: £30,000.

5. Design and implementation of RICHS module for school health examinations, following report of the National Review Group - see chapter 6.

Starting date: Summer 1996.
Additional cost: £70,000.

6. Installation of terminals in main health centres to interface with central computer in headquarters.

Starting date: January 1996.
Additional cost: £25,000.

7. More rapid inputting of new/renamed streets to appropriate district electoral divisions.

Starting date: September 1995.
Additional cost: Nil.

8. Inputting of family doctor's name following first postnatal visit by public health nurse.

Starting date: Immediately.
Additional cost: Nil.

9. Equal handling of the transfer of marital and non-marital birth information, including birth notifications, to and within the health board (see chapter 4). This will require negotiation with the various maternity hospitals as well as internal policy changes.

Starting date: September 1995.
Additional cost: Nil.

10. All computerised information on children's health, including travellers, to be made fully interchangeable with RICHS.

Starting date: September 1995.
Additional cost: Nil.

11. Birth notification information on feeding methods (breast and formula feeds) to be recorded on RICHS.

Starting date: Immediately.
Additional cost: Nil.

12. Standardisation of the transfer of child health information to and between community care areas.

Starting date: September 1995.
Additional cost: Nil.

13. Continuing programmes of relevant education and training in computer systems for medical, nursing, paramedical and clerical staff.

Starting date: Immediately.
Additional cost: Dependent upon programmes undertaken.

CHAPTER 4

MATERNITY AND INFANT CARE

INTRODUCTION

Maternity and infant care involves the care of mothers and children from conception to the end of the first year of life. The aim of this care is to prevent later health problems, in so far as possible, and to detect early those which cannot be prevented.

The Strategy document recommended that every baby would be visited by the public health nurse within 24 hours of discharge from the maternity hospital and that each baby would have a designated visit to his/her G.P. at 2 weeks and 6 weeks old. It also recommended that liaison arrangements between G.P.'s and public health nurses would be strengthened "to ensure continuing care as required".

CURRENT POSITION

Preparation for parenthood is combined with the preparation for childbirth. Maternity hospitals and G.P.'s provide maternity services and postnatal care to mothers for 6 weeks. In some suitable health centres, parentcraft classes are conducted by public health nurses. Where such classes are provided by maternity hospitals and G.P.'s, there is limited or no public health nurse input. In most cases, the first contact by the public health nurse with the mother is when a home visit is made after the birth of the baby.

Under the present system, the care of the mother from conception to birth is, in the main, provided by maternity hospitals, G.P.'s and some community midwives. The current starting point for the involvement of community care is the notification of births. Notifications to Dr. Steevens' Hospital from the three largest maternity hospitals in the Eastern Health Board are as follows:

Coombe Hospital: via computer link daily;

National Maternity Hospital: via photocopy of delivery ward record book posted daily;

Rotunda Hospital: photocopy of birth notifications to the registrar of births forwarded twice weekly by courier;

Domiciliary Births: private midwives are required to notify the local Director of Community Care/Medical Officer of Health within 36 hours of a home birth.

Notifications of births to unmarried mothers are retained in Dr. Steevens' Hospital pending clearance for release by social workers in the maternity hospitals, as follows:

Coombe Hospital: the record is released following contact between social workers and staff in Dr. Steevens' Hospital;

National Maternity Hospital: weekly release of records following contact between staff in Dr. Steevens' Hospital and the senior social worker;

Rotunda Hospital: a cover note with the birth notification form states whether the child is remaining with the mother or being adopted/fostered.

Staff in Dr. Steevens' Hospital transfer birth notification information to each community care area's headquarters. The methods of dispersal from each headquarters to the public health nurses in health centres are:

(i) by post, taking from 1 to 5 days;
(ii) by hand, taking from 1 to 9 days.

The public health nurse visits the new mother as early as possible and continues to visit up to 3 years of age and in cases of vulnerability up to 6 years, to monitor progress. Nurse clinics are also provided for all age groups. Some mothers have access to community mother programmes. Six week baby checks are provided by hospital staff, G.P.'s and A.M.O.'s. Other services are also provided - see chapter 6 for details.

The current notification system does not allow public health nurses to visit mothers and infants within 24 hours of discharge from maternity hospitals for the following reasons:

(1) Manual transfer of birth notifications results in delays. The Coombe Hospital has an interfaceable computer system, which is the more efficient system;

(2) Delays caused by the methods of transfer of information within community care areas to public health nurses, regardless of the method of transfer used.

(3) Long delays in the release of records for unmarried mothers.

(4) Delays in notifications of births of children born in hospitals outside the Eastern Health Board area to mothers living in the health board area.

FUTURE

To ensure continuity of care, the role of the public health nurse in maternity and child care should commence in the antenatal period. This combined with an effective notification system should result in the ideal of a visit by the public health nurse during the first 24 hours after discharge from the maternity hospital/unit. A faster and more efficient transfer of birth notification information from maternity hospitals through Dr. Steevens' Hospital and community care areas to the nurses is achievable through upgrading, extending and integrating computerised information systems into health centres.

RECOMMENDATIONS

1. Computers are the most efficient means of transfer of information. We recommend that the computer systems of maternity hospitals be made compatible with the Eastern Health Board computer system.

   Starting date: October 1995.
   Additional cost: Nil to Eastern Health Board.

2. Installation of modern technology in health centres, i.e. computer terminals, fax machines, mobile telephones, etc., for the efficient transmission of information to public health nurses.

Starting date: January 1996.
Additional cost: £50,000.

3. Release of records for unmarried mothers in the same manner as other birth notifications unless specifically requested by the maternity hospital to retain the record.

Starting date: Immediately.
Additional cost: Nil.

4. Streamlining of procedures between all community care areas within the Eastern Health Board.

Starting date: September 1995.
Additional cost: Nil.

5. All mothers attending maternity hospitals, G.P.'s or private midwives antenatally should be advised to contact their public health nurse. A process should be put in place to enable the referring agency, with consent, to forward mother's name, address and telephone number to community care area headquarters for onward transmission to the nurse.

Starting date: January 1996.
Additional cost: Nil.

6. In the interests of better infant care, liaison arrangements should be strengthened, not just between G.P.'s and P.H.N.'s as proposed in the Strategy document, but also between all healthcare professionals.

Starting date: Immediately.
Additional cost: Nil.

The Strategy document confined us to recommendations pertaining to ensuring early visits by the P.H.N.'s to mothers following discharge from maternity hospitals. There are other areas to which we wish to refer.

1. The statutory birth notification form has now been in place for many years. We recommend that the National Review Group should examine and update the form. For example, method of feeding and baseline centile information is not included in the present form.

2. There should be a recognition of indicators of vulnerability/risk to mothers and infants leading to equal access to support systems across all socioeconomic groups.

CHAPTER 5

INFANT FEEDING

INTRODUCTION

The Strategy document confined itself to two targets in the area of infant feeding, both of which relate to breast feeding. These aim to increase breast feeding so that:

(a) the initiation rate (the proportion of all newborn babies who are breast fed at first) will have increased to 35% by 1996 and 50% by the year 2000, against a base rate of 32% in 1990;

(b) by 2000, 30% of all babies will be breast fed at the age of four months, against a base rate of 12% in 1990.

CURRENT POSITION

The exact incidence and prevalence of breast feeding in each community care area is not known, although some areas have attempted to obtain this information. A National Policy was recently adopted by the Department of Health to address the low incidence of breast feeding in Ireland. Factors which hinder the success of this policy include:

(1) The birth notification form identifies whether a mother intends to breast feed, but the initial alert to the public health nurse that a mother and baby are being discharged to her area does not carry this information.

(2) Up to the age of six weeks, children of economically-disadvantaged parents receive free artificial milk. Breast feeding mothers do not rfeceive anything.

(3) There is no agreed policy on the provision or use of breast pumps.

(4) There is no uniformly-applied guide or policy on feeding or weaning for use by all healthcare workers.

Public health nurses give ongoing support and encouragement to mothers who are breast feeding. Where mothers decide to give formula feeds, P.H.N.'s advise on methods of preparation, types of feed and hygiene. Pamphlets on breast and bottle feeding and weaning produced by the Eastern Health Board and the Health Promotion Unit in the Department of Health are useful in the education of mothers.

FUTURE

The achievement of the targets set in the Strategy document requires implementation of the following recommendations.

RECOMMENDATIONS

1. Uniform feeding policy, including policy on weaning, across hospitals and community care and between all disciplines. Policy should be reviewed on a yearly basis.

   Starting date: September 1995.
   Additional cost: nil.

2. Speedier notification of births, including details of feeding, to public health nurses. To facilitate this, each health centre should be equipped with computer terminals, faxes and mobile telephones.

Starting date: January 1996.
Additional cost: £50,000.

3. Review of policy of support for breastfeeding mothers aimed at equalizing supports for economically-disadvantaged breast and bottle feeding mothers. Consideration should be given to providing food supplements for the mother until breast feeding is discontinued and home help for approximately three weeks until breast feeding is established. The Health Board is empowered under the Health Act 1970 to provide home help to any mother and priority should be given to mothers who are breast feeding.

Starting date: July 1995.
Additional cost: Dependent on outcome of review.

4. The Health Board should develop a policy on provision of breast pumps which should be communicated in writing to the maternity hospitals. We suggest that the provision of breast pumps should be restricted to limited medical criteria.

Starting date: June 1995.
Additional cost: Dependent on policy formulated.

5. In order to follow trends in breast feeding and to target intervention at critical times, there should be ongoing collection and evaluation of information. The only feasible way this can be achieved is through the use of computerised information systems.

Starting date: January 1996, as computer terminals are installed in the main health centres.
Additional cost: Nil outside the cost of installation of technology.

6. Updated information/education on breastfeeding and the management of associated problems should be provided to all relevant staff.

Starting date: Immediately.
Additional cost: Nil.

7. Public health nurse input to the care of all antenatal mothers.

Starting date: January 1996.
Additional cost: Nil - by existing staff and within existing resources.

8. (a) P.H.N.'s to encourage the establishment of voluntary support groups where required. The P.H.N. should be available to facilitate and liaise with these groups.

/continued over

(b) Display in health centres of notices from established support groups.

Starting date: September 1995.
Additional cost: Nil.

Discussion of infant feeding in the Strategy document was confined to the area of breast feeding and we have not addressed other issues such as mothers who cannot or do not wish to breast feed. We feel that this area needs attention but was not within our present remit.

CHAPTER 6

PRE-SCHOOL AND SCHOOL HEALTH SERVICES

INTRODUCTION

The Strategy document states that a fundamental review of the pre-school and school health services would be carried out in 1994 with "the aim of implementing recommendations as to the most effective service in tune with modern thinking and practice in child health".

The most recent national review of child health services took place in 1967. Recommendations as to the most appropriate pre-school and school services were made based on knowledge and medical practice current at the time. These recommendations were for the most part implemented and largely remain the basis of the community child health services in Ireland today.

CURRENT POSITION

(A) PRE-SCHOOL HEALTH SERVICES

The statutory requirements under section 66 of the Health Act 1970 direct health boards to make available without charge a health examination and treatment service for children under 6 years of age. In the Eastern Health Board region, the service includes:

(1) Guidance to parents and ongoing review by public health nurses up to 3 years of age for children with normal development, to 6 years of age for vulnerable children, and throughout life for those who are handicapped.

(2) Developmental paediatric examination at approximately 9 months old. Based on the 1967 review recommendations, this examination was confined to areas of population greater than 5,000. However, current practice is to offer all children the option regardless of area of residence. In the Eastern Health Board, a computerised system for issuing appointments and recording outcomes has confirmed a high defaulter rate. Uptake of appointments varies between community care areas (57% to 90%, average 75%), as does the issue of repeat appointments to those who default from clinic services. Accessibility to clinics is a problem in rural areas and among working mothers.

(3) Special clinics run by the area medical officers for all pre-school children referred from public health nurses, parents, and others, with onward referral to other agencies within and outside community care as appropriate.

(4) Day nurseries, the majority of which are administered by voluntary agencies, and the remainder by the Eastern Health Board. The Board funds 90% of their expenditure or deficit, whichever is the lesser. The present service has developed on an ad hoc basis and is not evenly spread among areas of high social disadvantage.

(B) SCHOOL HEALTH SERVICE

The statutory requirements under section 66 of the Health Act 1970 direct the health board to make available without charge a health examination and treatment service for pupils attending national schools. The 1967 study group recommended a medical examination at 6 years of age, selective examination of 9 year old children, routine annual screening by the district nurse and selective further examinations.

As a result, a significant proportion of available resources was concentrated on the examination of large numbers of mostly healthy children to fulfil the obligations of the Health Act 1970. There has been wide variation and change in the implementation of this policy in recent years. The service is primarily one of screening and, apart from the immunisation programme, health promotion and disease prevention do not feature very strongly. Only three community care areas continue to provide a screening medical examination for all children in the designated classes. Seven areas provide selective examinations in which only those children brought to the attention of area medical officers by public health nurses, parents and teachers are seen. Most Directors of Community Care/Medical Officers of Health believe that the system of selective examination allows direction of resources towards children with the greatest needs.

Despite changes in policy implementation, all community care areas have continued universal screening of vision and hearing by public health nurses. Screening for scoliosis continues in two community care areas. The Hall Report working party recommended its discontinuation except where evaluation could be undertaken.

(C) HEALTH PROMOTION

Few resources have been directed specifically to the subject of health promotion in schools. But despite this, for many years, all community care areas have taken health promotion initiatives following agreement with parents' groups, school principals and teachers.

(D) CHILD HEALTH RECORD CARDS

Four separate child health records are maintained on each child in the Eastern Health Board area. These are:

(i) the child health home visiting record card ("green" card"), held by the public health nurse,

(ii) the developmental clinic card,

(iii) the immunisation record card, and

(iv) the school examination card.

Information from the first three cards is not carried forward to the school card with a consequent deficit of data on vulnerable children, immunisation defaulters, and those who are developmentally delayed. There is thus no early warning system of at-risk children in school. Integration of information was recently piloted in the Eastern Health Board by the use of a single record card, but preliminary reports indicate problems.

(E) SPEECH AND LANGUAGE THERAPY SERVICE

The total number of speech therapists currently employed by the Eastern Health Board is 70, and the majority work in community care. The sources of referral vary between community care areas. Children are referred primarily by area medical officers, public health nurses and parents. Referrals from teachers and G.P.'s account for a small, but significant, number of clients. In some areas, only medical referrals are permitted.

Although there has been a significant increase in the number of speech therapists, this has not been matched by an appropriate increase in funding for equipment and services. At present, there are long waiting lists in most community care areas - up to 20 months in one area. Priority is given to the early detection of defects in pre-school children.

FUTURE

There is clearly an urgent need for the establishment of the National Review Group in accordance with the proposals in the Strategy document. No targets for the pre-school and school health services can be set until this group makes its recommendations. However, while awaiting this report, there are areas which can be addressed.

Fundamental to the effective delivery of child health services is coordination of these services. This could be achieved most effectively by putting in place a designated senior area medical officer with responsibility for coordination of all the child health services in each

community care area. This medical officer would give priority to child health services above all other activities and would organise multi-disciplinary and inter-agency meetings regarding children with special needs.

The school health service needs major restructuring to include the implementation of health promotion and social gain strategies in line with the improved physical health status of children.

The development of day nursery services should be based on a formal needs assessment study and should be coordinated with the development of the pre-school service run by the Department of Education. Day nurseries are particularly important to children from vulnerable families and to parents with inadequate parenting skills.

There is a requirement in the Health Board for a designated public health doctor with particular expertise in developmental paediatrics. Such a position existed on an informal basis up to the late 1980s and should be reactivated. This doctor would be available in a consultative capacity to area medical officers and other health professionals, and could receive and advise on referrals.

In the area of speech and language therapy, the Eastern Health Board document "The Way Forward" recommends a planned annual increase in therapists over the next 10 years, having regard to availability of resources. In addition, there is a need to educate and inform health professionals, teachers and parents in order to improve the appropriateness of referrals. Computerisation of records will direct the planning and development of the service through provision of

information on epidemiology, referral patterns and procedures, and optimum patterns of intervention.

Adolescents have specific health needs, especially in this age of rapid social change. In order to meet this challenge, the Health Board needs to provide a targetted range of services which are accessible to teenagers both within and without the formal setting of school. General areas which require attention include healthy eating patterns, healthy behaviour, avoidance and control of addiction, sexual development and related problems.

RECOMMENDATIONS

1. The Eastern Health Board should actively seek the establishment of the National Review Group on Pre-School and School Health Services.

   Starting date: July 1995.
   Completion date: June 1996.
   Additional cost: Nil.

2. The Health Board should also seek the establishment of an Inter-Departmental Committee between the Departments of Health and Education, with representatives from disciplines providing services, to define clearly each Department's responsibility in the areas of psychological services and pre-school and nursery services.

   Starting date: October 1995.
   Completion date: March 1996.
   Additional cost: Nil.

3. Establishment of a formal needs assessment study for day nursery services.

Starting date: Immediately.
Additional cost: Researcher post at £22,000 (including travel, telephone, stationery, etc.).

4. Immediate implementation of the system for inspection and supervision of day nursery services in accordance with the requirements laid down in the Child Care Act.

Starting date: Immediately.
Additional cost: from resources allocated for implementation of the Child Care Act.

5. Designated Coordinator for Child Health Services in each community care area. New post to be created at at senior area medical officer level.

Starting date: July 1996.
Additional cost: £38,000 per community care area.

6. Appointment of senior area medical officer with special expertise in developmental paediatrics.

Starting date: January 1997.
Additional cost: £38,000.

7. Filling of vacant public health nurse posts.

Starting date: Immediately.
Additional cost: Nil.

8. Appointment of registered general nurses to free public health nurses of procedure type care and allow them time to develop their child health role.

Starting date: Immediately.
Additional cost: refer to other Task Force reports.

9. Development of the speech and language therapy service in accordance with the recommendations in the Eastern Health Board document "The Way Forward" and based on resource availability.

Starting date: Immediately, with
Completion over 8 to 10 years.
Additional cost: see "Speech and Language Therapy: The Way Forward".

10. Development of school module in RICHS.

Starting date: Summer 1996.
Additional cost: £70,000.

11. Establishment of a multi-disciplinary group to integrate the child health record cards.

Starting date: September 1995.
Completion date: September 1996.
Additional cost: Nil.

12. Uniform health board policy for cessation of screening for scoliosis in school medical examinations.

Starting date: Immediately.
Additional cost: nil.

13. The National Review Group (see 1 above) to include in its deliberations extension of the school health service to adolescents.

Starting date: July 1995.
Completion date: June 1996.
Additional cost: Depending on recommendations.

CHAPTER 7

IMMUNISATION

INTRODUCTION

The objective of any childhood immunisation programme is to immunise all eligible children. The aim of our immunisation programme today is to eliminate tuberculosis, diphtheria, tetanus, pertussis, polio, haemophilus influenza type B, measles, mumps and rubella from the community. The Strategy document sets an uptake level of 95% as the target.

CURRENT POSITION

Table 4 shows the current immunisation schedule. B.C.G., D.P.T., H.I.B. and M.M.R. are the primary vaccines. D.T. at school entry and M.M.R. at 10-12 years are the boosters.

Immunisations are given through a variety of channels and health professionals including hospitals, clinics, health centres, G.P.'s surgeries, mobile clinics and schools.

Completed records are only available for public health administered vaccines except for M.M.R., and are stored centrally in each community care area. These are collected and stored manually, except those of the M.M.R. vaccines which are computerised.

Special clinics are held on an ad hoc basis and, where neccessary, children with selected chronic diseases and conditions are also referred to consultant paediatricians

for advice on and administration of vaccines.

TABLE 4. CURRENT SCHEDULE OF IMMUNISATIONS IN IRELAND.

4 days after birth	B.C.G. (tuberculosis)
2 months	1st dose D.P.T. (diphtheria, pertussis, tetanus), H.I.B. (haemophilus influenza type B) and oral polio.
3 months	2nd dose D.P.T. and oral polio.
4 months	3rd dose D.P.T. and oral polio. 2nd dose H.I.B..
6 months	3rd dose H.I.B..
15 months	M.M.R. (measles, mumps, rubella).
5 years	Booster D.T. and oral polio.
10-12 years	M.M.R. (measles, mumps, rubella).

FUTURE

To achieve the target set in the Strategy document of a level of vaccine uptake of 95%, the following should be the objectives:

(a) there must be a recognition that the 95% uptake level in one year is achievable and, when achieved, this level must be maintained;

(b) implementation of a comprehensive and accurate information system on vaccinations;

(c) identification of geographical areas and specific groups where uptake is unacceptably low, and targetting of these groups;

(d) development and maintenance of an awareness of the benefits of immunisation among health professionals and the public in order to attain and maintain the 95% uptake level.

RECOMMENDATIONS

The Health Board must set age-specific targets for vaccine uptake. Our recommendations are designed to show how these targets can be attained and maintained.

1. Implementation, following immediate evaluation, of RICHS module for childhood immunisations.

   Starting date: January 1996.
   Additional cost: £30,000.

2. Coordinator of child health services in each Community Care Area to include overseeing and evaluating immunisations as part of his/her responsibilities.

   Starting date: July 1996.
   Additional cost: £38,000.

3. Investigating/following up/reporting/supporting children with possible vaccine-related side effects.

Starting date: January 1996.
Additional cost: Nil.

4. Opportunistic vaccinations at developmental examinations and routine outpatient clinic visits.

Starting date: Immediately.
Additional cost: Nil.

5. Continuing medical education for all relevant health care workers. All public health nurses and doctors to receive a copy of the manual "Immunisation against Infectious Diseases" (H.M.S.O.).

Starting date: Immediately.
Additional cost: £5,000.

6. Extension of accessible vaccination clinics to all consumers in an equitable manner.

7. The Health Board to develop an agreed definition of "defaulter" from vaccination services. The Task Group suggests:

(i) failure to start first immunizations by 9 months old;

(ii) failure to complete primary immunizations by 15 months;

/continued over

(iii) failure to complete M.M.R. by 24 months;

(iv) failure to obtain school boosters in appropriate years.

Starting date: January 1996.
Additional cost: Nil.

8. An action team for defaulters led by the child health service coordinator in each community care area.

Starting date: November 1996.
Additional cost: Nil.

Finally, the Task Group acknowledges the need for a National Centre for Disease Surveillance as a matter of urgency.

CHAPTER 8

HEALTH CENTRES

INTRODUCTION

The Strategy document emphasizes the crucial importance of health centres in the provision of preventative and other health services to the community and, in particular, to children. The document states: "The consumers's perception of the quality of the service he or she receives will be greatly influenced by factors such as the efficiency of the organization, the courtesy shown and the physical surroundings in which the service is delivered."

CURRENT POSITION

Child health services delivered through the community care programme are mainly based in health centres which are owned and operated by the Eastern Health Board. The premises are of varying sizes and designs. Some are modern and purpose-built; others are ancient dispensaries which have been altered over the years in an attempt to meet increasing demands; others still are converted residential premises. Of the 120 health centres in operation, most are used for a combination of health (including child health) and welfare services.

FUTURE

The establishment of a Task Force for Health Centre Develop-

ment this year underlines the importance of health centres in the delivery of health care services. The Eastern Health Board has acknowledged that many health centres require refurbishment and decoration, with attention to upgrading exterior walls and surroundings, and is examining requirements for capital, maintenance and replacement costs.

Demographic trends and developments in health services and health care provision make adaptability an essential requirement of future health centre developments. Such developments should incorporate local community involvement and partnerships with other health service providers.

RECOMMENDATIONS

1. Health centres should have selected reception staff with customer-oriented training.

   Starting date: January 1996.
   Additional cost: Reception staff 3-day training course: external price - £500 per trainee, but in view of numbers requiring training, it may be possible to buy in at a more competitive price.

2. Health centres should have a warm and friendly atmosphere. The waiting areas should be attractively and comfortably furnished and buggy-friendly.

   Starting date: January 1996.
   Additional cost: £5,000 per health centre for equipment and £1,000 per health centre per year for upkeep.

3. Designated room for breast feeding, which is appropriately furnished.

   Starting date: September 1995 where space available.
   Additional cost: Dependent upon rooms currently available and future health centre developments.

4. Separate multi-purpose room for meetings to facilitate activities such as encouragement of breast feeding.

   Starting date: September 1995 where space available.
   Additional cost: Dependent upon rooms currently available and future health centre developments.

5. Each health centre should have adequate numbers of telephone lines, including mobile telephones, and answering and fax machines, to facilitate liaison between health professionals and to ensure continuity of care.

   Starting date: January 1996.
   Additional cost: £1,000 per health centre, plus later service and maintenance.

CHAPTER 9

THE CHALLENGE

The Health Strategy identified accountability, equity and quality of service as the three principles of the future health service. It set down a four-year action plan from 1994 to 1997 for the implementation of the Strategy with the aim of achieving health and social gain.

This Task Force examined the important area of Child Health Services and has produced a 3-year costed action plan based on the targets set in the Health Strategy. In that regard, we can now summarize our key recommendations:

1. Service providers should be given targetted budgets to resource their professional activities. The challenge is to identify needs and to resource them based on objective criteria.

2. Immediate convening of the National Review Group to examine all aspects of the pre-school and school health services and to make recommendations for the future direction and development of these services.

3. Development of user-friendly, effective, integrated and compatible information systems. The systems are the fundamental requirement for the coherent and intelligent planning of equitable, accountable and quality Maternity and Infant Services, Pre-School and School Health Services, and

Immunization Programmes. Much can be done using systems presently in position through a firm commitment to reorganization, but many new modules need to be developed as a matter of urgency.

4. Coordinators for child health services to be appointed at senior area medical officer level to coordinate developments in child health between all healthcare professionals in each community care area.

5. A recognition of the critical role of the public health nurse, not just in the areas of postnatal mother and infant care and pre-school and school health services, but in the total care of mother and infant and in the encouragement and support of breast feeding. Earlier involvement of the public health nurses during the antenatal period, and improved communication of information from maternity hospitals will provide the means and incentive to fulfil the targets and aspirations of the Strategy document.

6. We recommend the filling of the vacant public health nurse posts over the next three years, and the employment of registered general nurses to free up the P.H.N.'s of procedure type care and allow time for them to adequately develop their public health role.

7. Development of the speech and language therapy service in accordance with the recommendations in the Eastern Health Board document "The Way Forward" and based on resource availability.

8. Establishment of a National Centre for Disease Surveillance to monitor, control and develop policies for infectious diseases.

We have confined our discussion and recommendations to the areas defined in the Strategy document. But the document is incomplete in its discussion of children's health. We are aware that areas such as genetic counselling, prenatal screening, adolescent health, prevention of accidents and the development of the psychological services, among others, have been omitted. These important areas are also integral parts of our child health service.

"But what am I
An infant crying in the night
An infant crying for the light
And with no language but a cry"

Tennyson.

TIMETABLE OF RECOMMENDATIONS

IMMEDIATELY

1. Appointment of a central systems administrator to the existing vacant post.

2. Identification of the area systems administrator in each community care area.

3. Inputting of family doctor's name following the first postnatal visit by the public health nurse.

4. Birth notification information on feeding methods (breast and formula feeds) to be recorded on RICHS.

5. Continuing programmes of relevant education and training in computer systems for medical, nursing, paramedical and clerical staff.

6. Release of records for unmarried mothers in the same manner as other birth notifications unless specifically requested by the maternity hospital to retain the record.

7. Liaison arrangements should be strengthened, not just between G.P.'s and P.H.N.'s, but between all healthcare professionals.

8. Updated information/education on breastfeeding and the management of associated problems should be provided to all relevant staff.

9. Establishment of a formal needs asssessment study for day nursery services.

10. Implementation of the system for inspection and supervision of day nursery services in accordance with the requirements laid down in the Child Care Act.

11. Filling of vacant public health nurse posts.

12. Appointment of registered general nurses to free public health nurses of procedure type care and allow them time to develop their child health role.

13. Development of the speech and language therapy service in accordance with the recommendations in the Eastern Health Board document "The Way Forward" and based on resource availability.

14. Uniform health board policy for cessation of screening for scoliosis in school medical examinations.

15. Opportunistic vaccinations at developmental examinations and outpatient clinic visits.

16. All public health nurses and doctors to receive a copy of the manual "Immunisation against Infectious Diseases" (H.M.S.O.).

JUNE 1995

1. The Health Board should develop a policy on provision of breast pumps which should be communicated in writing to the maternity hospitals.

JULY 1995

1. Review of policy of support for breastfeeding mothers aimed at equalizing supports for economically-disadvantaged breast and bottle feeding mothers.

2. Establishment of the National Review Group on Pre-School and School Health Services.

3. The National Review Group to include in its deliberations extension of the school health service to adolescents.

SEPTEMBER 1995

1. Identification of childcare unit and trained interchangeable clerical staff in each area with specific responsibility for all child health.

2. More rapid inputting of new/renamed streets to appropriate district electoral divisions.

3. Equal handling of the transfer of marital and non-marital birth information, including birth notifications, to and within the health board.

4. All computerised information on children's health, including travellers, to be made fully interchangeable with *RICHS*.

5. Standardisation of the transfer of child health information to and between community care areas.

6. Public health nurses to encourage the establishment

of voluntary support groups where required.

7. Display in health centres of notices from established support groups.

8. Uniform feeding policy, including policy on weaning, across hospitals and community care and between all disciplines. Policy should be reviewed annually.

9. Establishment of a multi-disciplinary group to integrate the child health record cards.

10. Designated room for breast feeding in each health centre.

11. Multi-purpose room for meetings in health centres.

OCTOBER 1995

1. Computer systems of maternity hospitals to be made compatible with the Eastern Health Board system.

2. Establishment of an inter-departmental committee between the Departments of Health and Education, with representatives from disciplines providing services, to define clearly each Department's responsibility in the areas of psychological services and pre-school and nursery services.

JANUARY 1996

1. Implementation, following immediate evaluation, of RICHS module for childhood immunisations.

2. Installation of terminals in main health centres to interface with central computer in headquarters.

3. Installation of adequate numbers of telephone lines, telephones and mobile telephones, and fax machines in health centres.

4. All mothers attending maternity hospitals, G.P.'s or private midwives antenatally should be advised to contact their public health nurse. A process to be put in place to enable the referring agency, with consent, to forward mother's name, address and telephone number to community care area headquarters for onward transmission to the public health nurse.

5. Public health nurse input to the care of all antenatal mothers.

6. Speedier notification of births, including details of feeding, to public health nurses.

7. Collection and evaluation of breast feeding information through the use of computerised information systems.

8. The Health Board to develop an agreed definition of "defaulter" from vaccination services.

9. Training schemes for reception staff in health centres.

10. Annual financial allocation to each health centre to permit attractive and comfortable furnishing of waiting areas.

SUMMER 1996

1. Design and implementation of RICHS module for school health examinations.

JULY 1996

1. Designated Coordinator for Child Health Services in each community care area. New post to be created at senior area medical officer level.

2. Coordinator for child health services to include overseeing and evaluating immunisations as part of his/her responsibilities.

NOVEMBER 1996

1. An action team for defaulters led by the child health service coordinator in each community care area.

JANUARY 1997

1. Appointment of senior area medical officer with special expertise in developmental paediatrics.

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