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AN ROINN
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

MÄNNYSTRIE O
Poustie, Resydènter Heisin an Fowk Siccar

Healthy Futures 2010 - 2015

The Contribution of Health Visitors and School Nurses in Northern Ireland

March 2010

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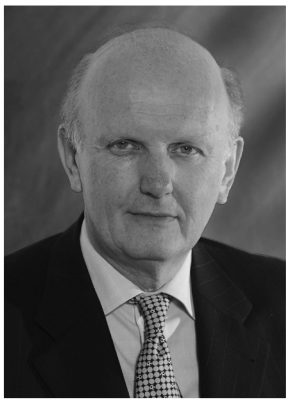

In the last 10 years we have secured numerous improvements to services for patients for example by improving access and reducing waiting times. In the next ten years I want to move towards the provision of excellent services which provide a preventive and people centred approach with a focus away from hospital based services.

To achieve this we need a shift of funding and efforts from hospital towards community services. This will require a change in both the culture and thinking in how we can provide support at the start of life and wise investment to secure the best outcome. Health visitors and school nurses are already working at the forefront of public health and delivering preventive services. They are and have been quite unique in the health service in reaching out and grasping this challenge.

We can no longer assume that extended families provide support and we know that many parents experience isolation, anxiety and depression all of which impacts on our children. It is therefore important that we don't underestimate what these services can do to prevent this happening, identify it early when it does and provide parents with the skills to cope, and support them in developing resilience.

Healthy Futures provides the tools for health visiting and school nursing to deliver universal and targeted services in that it supports practitioners, commissioners and Trusts to deliver real change. There is a real challenge for commissioners to shift funding upstream to make a difference by preventing ill-health and prioritising resources to support this approach.

I am committed to doing everything possible to realise the potential of these services so that our children grow up healthy and in so doing we recognise how early intervention can make a difference through supporting parents at the earliest opportunity and move forward with the clear message that we must invest in prevention and use this workforce with the tools they are being given to improve and develop a preventive health and social care system within Northern Ireland.

Michael McGimpsey
Minister for Health, Social Services and Public Safety

Introduction

A review of health visiting and school nursing was commissioned by the Chief Nursing Officer in September 2008 to consider the future direction of health visiting and school nursing in Northern Ireland. The review was timely in light of an increasing evidence base which clearly indicates that early intervention and prevention is essential to prevent long term, behavioural, emotional and conduct disorders, which in turn can lead to poor lifestyle patterns, increased consumption of alcohol, drug misuse, and criminal behaviours.

Healthy Futures provides those working within child health services and broader stakeholders with information about the role and function of health visitors and school nurses within integrated children's services and describes the contribution of these services to improving health and reducing inequalities within the population.

The contribution and potential to be realised will be achieved through effective commissioning of services which secures access for all children and their families to the Child Health Promotion Programme (Health for all Children, 2003)[1] as it is through the delivery of universal services that needs are assessed and individualised, and targeted responses developed at the earliest opportunity.

Research evidence highlights the importance of early attachment and bonding and the role of health visitors and school nurses to contribute positively to this agenda through early identification of poor parental attachment and parenting capacity throughout the child's life. The shift in emphasis on early engagement to address parenting issues and wider public health priorities is a challenge to the health and social care system where public expectation demands rapid response to health problems and in the context of a financially constrained environment.

The main challenge will be to shift the emphasis from traditional patterns of commissioning and service delivery towards investment in activities where the true outcome will not be fully realised until future years and which impact on the broader determinants of health and wellbeing including educational attainment, access to employment and broader societal issues such as reduction in classroom bullying and school exclusion.

Healthy Futures must be considered within the context of Modernising Nursing Careers, and the review of both pre and post registration nursing education, currently being undertaken across the UK if the preparation of practitioners is to be fully supportive of the challenge ahead to improve health and reduce inequalities.

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[1] Hall D & Elliman D (2003) Health for all Children 4th Ed. Oxford University Press

Healthy Futures 2010 - 2015

The Contribution of Health Visitors and School Nurses in Northern Ireland

This document should be read along with the full consultation document* and action plan* which is to be delivered through the Public Health Agency. These documents detail the process undertaken and evidence considered to inform the way forward in developing early prevention and intervention for children, young people and families, provides full bibliography and references, and signposts to tools and actions for commissioners and Trusts to deliver services within a future direction that puts the child and family at the centre of service delivery.

The outcomes of modernised and reformed health visiting and school nursing services will be central to meeting the public health agenda within Northern Ireland.

* Available at **http://www.dhsspsni.gov.uk/index/nmag/nmag-projectsandreports.htm**

Strategic Context

The total population in Northern Ireland (NI) is 1,754,463. Of this there are 456,328 children aged 0-19 years, 115,307 under 5yrs, 164,354 aged 5-12 years and 176,667 aged 12-19 years (DHSSPS, 2008).

A number of strategic policies impact on the future for children and young people in Northern Ireland and provide context for Healthy Futures including:

- Investing for Health (2002 - to be updated)
- A Healthier Future: A twenty year vision for health and wellbeing in Northern Ireland 2005-2025, (DHSSPS, 2005)
- The review of the public health function in Northern Ireland, (DHSSPS, 2004)
- Caring for People Beyond Tomorrow (DHSSPS, 2005)
- Early Years 0-6 Strategy (DE, anticipated public consultation, 2010)
- Northern Ireland Children's Services Plan (2008-2011)
- Review of Autism Spectrum Disorder Services and Action Plan (2009)
- Northern Ireland Home Accident Prevention: strategy and action plan 2004-2009
- Northern Ireland Road Safety Strategy 2002-2012 (DE,2002)
- Our Children and Young People - Our Pledge - a ten year strategy for children and young people in Northern Ireland 2006-2016 (OFMDFM, 2006)
- Families Matter: Supporting Families in Northern Ireland (2008)
- UNOCINI Thresholds of Need Model (DHSSPS, 2008)
- Our Children and Young People - Our Shared Responsibility-Inspection of Child Protection Services in Northern Ireland (2006)
- Health for All Children, (Hall and Elliman, 4th edition, 2003) (Hall 4)
- Bamford Review (DHSSPS, 2007)
- Promoting Mental Health and Wellbeing Strategy (to be developed 2009/10)
- Hidden Harm Strategy (DHSSPS, 2009)
- Tackling Violence at Home: A 5-year strategy for tackling domestic violence (DHSSPS, 2005)
- NICE guidance on antenatal and postnatal care (NICE, 2007)
- Saving Mothers Lives 7th Report (Lewis G, 2007) CEMACH

Healthy Futures supports the strategic direction laid down by these documents from which key messages have emerged including:

- Increasing health inequalities (Healthy Cities Belfast, 2008) and changes in demography and technological advances in health care have resulted in increasing demand on scarce resource which has led to an even greater focus of attention being given to the role public health practice can play in improving the populations health.

- The importance of interdepartmental cross-sectoral working and the government's agenda to tackle wider determinants of health, ensure that healthy choices are an option for all.
- A long-term vision for the development of primary health and social care services, which put patients at the centre of service provision, providing high quality, responsive services closer to where people work and live, better integrated across primary and secondary care and one that utilises the skills of staff across health social care to maximise their impact and benefits to all users.
- The relevance of a healthy lifestyle for young people and commitment of education through schools to working with DHSSPS to develop a joint healthy school policy, including New Nutritional Standards for food available in schools, breakfast clubs, physical activity (PE) in the curriculum, after schools clubs and curriculum sports programme, personal development curriculum which includes drugs and alcohol awareness, and emotional / mental health and wellbeing - counselling in schools and the pupils emotional health and wellbeing programme.
- The need for early identification of health related issues e.g. autism in children is widely recognised and the re-instatement of a home visit by a health visitor at 2 years where an alert to the possibility of the presence of autism could be made.
- The direct impact of an early intervention and prevention service for children and young people.
- A focus which identifies a number of outcomes for children and young people, including 'Be Healthy; Enjoy, Learn and Achieve and Live in Safety and with Stability'.
- The vital need for parents to receive support in their role as educators, primary carers and most significantly as positive role models for children and young people.
- The need for an integrated approach to assessing the needs of children and families using a common framework and common language.
- Every child and parent should have access to a universal or core programme of preventative care with additional or targeted services for those with specific needs and risks.
- The importance of early identification of women at risk, including those subject to domestic violence, those on the child protection register, substance misusers, registered addicts and those with underlying medical conditions e.g. obesity, diabetes and previous mental illness.

Healthy Futures: The Contribution of Health Visitors and School Nurses in Northern Ireland

Our Vision

> ***'Health visiting and school nursing services will lead in supporting children and young people to be successful healthy adults through the promotion of physical, social and emotional health and wellbeing'.***

The review of health visiting and school nursing has highlighted the need to provide a service that is accessible and responsive to the needs of children, young people and their families. The model proposed provides a universal service which focuses on protecting and promoting the quality of life of those least able to protect themselves, including babies, looked after children and those children with specific identified needs.

To ensure children and young people receive the service they deserve, Healthy Futures proposes a 'model' in which provision is through a single point of access and contact for all children and young people aged 0-19 years through 0-19 teams led by a qualified health visitor / school nurse, so as to receive health and social care services when they need them and by the most appropriate person.

Provision should be set within a model of integrated children's services which clearly articulates the roles, responsibilities and relationships of all stakeholders and which benefits from a single framework including clear thresholds of assessment and referral pathways (e.g. Understanding the Needs of Children in Northern Ireland (UNOCINI) Thresholds of Need Model, (DHSSPS 2008)[2].

Functions

The roles will have three key functions:

- ***To lead in delivering the child health promotion programme.***
- ***To work at Level 2 with the most complex and challenging families, through increased intensive home visiting across the 0-19 age range with the implementation of appropriate evidence based parenting programmes.***
- ***To identify and address potential mental health issues relating to parents, infants, children and young people through case managing interventions.***

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[2] DHSSPS (2008) Understanding the Needs of Children in Northern Ireland: Thresholds of Need Model.

Principles

The Service is built upon a number of principles:

- ***A service where the child, young person and family are at the centre of service provision and involved in developing provision.***
- ***A service that promotes equal opportunities by targeting those families who would not otherwise access early years provision, thus providing equity of access.***
- ***Service delivery through 0-19 teams made up of health visitors (0-5 yrs), primary school nurses (5-11 yrs) and post primary school (adolescence) nurses (12-19 yrs), providing seamless delivery of services co-ordinated by a team leader that prevents duplication and identify gaps in service provision.***
- ***0-19 teams should provide and lead the core health provision but function within wider multi-agency health and social care teams as envisaged by the Investing for Health strategy[3].***
- ***Services should be high quality based on achieving the best outcomes for children and measured through a number of public health, mental health and educational outcomes.***

The service will sit within existing structures, its main function to collect data in the form of individual, family and population health needs assessment. This will provide analysis from which service will be delivered. The Area Children and Young Peoples Committees (ACYPC), should use that data to plan services within the context of wider strategic aims and objectives. They will undertake risk assessment and direct in the planning of services. Whereas the Trusts main function will be the commissioning and performance management of service delivery it is envisaged there will be good communication channels between the ACYPC and frontline staff using data from needs assessment, to enable more effective and user led commissioning.

Skill Mix

In addition, 0-19 Teams should include a range of skill mix to increase capacity without diluting skilled practice, including administrative staff, as well as staff nurses in paediatrics and mental health and nursery nurses.

[3] DHSSPS, (2006) *Investing in Health: Update*. Belfast.

Targeted Interventions

Health visiting and school nursing interventions should be targeted to:

- Safeguarding children with an emphasis on prevention and early identification.
- Address public health priorities i.e. breastfeeding rates, infant mortality, smoking cessation, teenage pregnancy, immunisations and drug and alcohol misuse, through universal service provision and measured by performance outcomes.
- Work in close collaboration with CAMHS services providing an effective Tier 1 and 2 preventative interventions in maternal, infant and child and adolescent mental health.

0-19 teams should function within a community development approach (evidence suggests this helps to deliver better health and social care outcomes), co-ordinating their work across health, social care and voluntary and community sectors.

In order to increase the effectiveness of such a model, 0-19 teams should have a voice at both operational and strategic level, informing commissioning decisions, the regional Public Health Agency and the development of the children and young people's plan. There should be a clear commissioning framework outlining a service specification and outcome measures.

Moving From	Moving To
Health visitors and school nurses working as discrete services	An integrated Public Health Nursing Service with a focus and expertise in 0-5 yrs, primary and post primary aged children and young people
Health visitors responsible for all child protection cases	To share responsibility across health visiting and school nursing, with the key worker identified as being the most relevant in each case
Limited skill mix	Much greater use of skill mix to support children, young people and families based on competence and skill
From independent working	Leading skill mixed teams to best meet the needs of the child / young person and their family
Emphasis on cradle-to-grave - health visitors	Working from pre-pregnancy period to 5 years
School nurses working whole school age population	Two discrete skill sets primary and post primary
From two separate services	A single service combining skills of health visitors (0-5) and school nurses in primary and post primary aged young people
From professionally driven service	Child, young person and family centred service delivered at times that suit the child / young person and influenced by their views

Moving From	Moving To
From working with all children, young people and families	To better utilise the skills and competence of the most experienced staff to work with those families experiencing the most challenging issues, whilst securing a universal service through teamworking
Identifying attachment and parenting capacity	Much greater emphasis on attachment and bonding and implementing universal parenting interventions and programmes to support parents
From recognition of emotional health and issues	To building resilience with greater emphasis on children and young peoples emotional health and wellbeing and early intervention
From monitoring families where there were child protection issues	To a more pro-active role focusing on health needs
From caseload management	To case management of targeted interventions with exit strategies
From a position of measuring contacts and visits	To a performance outcome measured service, measured against public health priorities e.g. smoking, teenage pregnancy, breastfeeding, obesity
Limited career progression in public health practice	To an educational pathway across all levels of the Skills for Health Public Health Career Pathway (SfH, 2008)

Themes and Recommendations

Healthy Futures examines the roles of health visitors and school nurses within five key themes which detail specific recommendations in relation to current provision and the actions required to meet key public health priorities which will result in improved health and a reduction in health inequalities:

Theme 1

Clarifying and Understanding the role and contribution of health visitors and school nurses within integrated children's services

Theme 2

Prevention, Early Intervention, Mental Health Promotion and Addressing Public Health outcomes

Theme 3

Provision of Evidence Based Programmes

Theme 4

Leadership and Education

Theme 5

Robust Information Technology and Systems to support the delivery of 0-19 services

The following sections which detail the five key themes of Healthy Futures should be read in conjunction with the Action Plan* which includes the supporting actions required along with how these should be led, the timescales within which they should be achieved and the desired outcomes and benefits from each.

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* Available at **http://www.dhsspsni.gov.uk/index/nmag/nmag-projectsandreports.htm**

Theme 1

Clarifying and Understanding the role and contribution of health visitors and school nurses within integrated children's services

Recommendation 1
The role of health visiting and school nursing should be clearly communicated within the Health and Social Care and to the Public.

The review has demonstrated the need to define health visiting and school nursing roles and to place clear boundaries within the respective roles.

If clarity is sought this will empower the workforce to deliver their public health function within specific evidence based interventions that will improve the health and long term outcomes for children and young people, which in turn will improve morale by valuing the contribution of health visitors and school nurses.

Defining the role serves several purposes, as users will have a clearer understanding of how they may benefit from health visiting and school nursing input, enable the implementation of relevant and appropriate performance measures, which will demonstrate worth across a range of partners, and prevent duplication of service provision and ensure appropriate skill mix is in place to support health visitors and school nurses.

Findings from this exercise define the role as:

> ***'to promote the physical, social and emotional health and wellbeing of children and young people within the context of their families across the antenatal to 19 year age range'.***

Recommendation 2
Health visiting and school nursing should be delivered as an integrated 0-19 service.

Effective integration of services is achieved at uni-professional, inter-professional, cross-programme, inter-agency and inter-sectoral levels in partnership with voluntary and community stakeholders. This can be achieved through membership of specific teams which may include a range of working arrangements including virtual teamwork and service specific arrangements comprised of a range of stakeholders who work as a group to achieve common goals and objectives.

It is important that health visiting and school nursing services work with the broad range of stakeholders within effective arrangements to achieve successful outcomes which benefit children, young people and families. Where this already exists and is working well, for example the team arrangements which secure health visitors as part of the primary care team within general practice and school nurses named to schools, these arrangements should be consolidated and built upon.

Regarding securing effective and integrated teamwork between health visitors and school nurses, the development of an integrated health visiting, school nursing, 0-19 team which promotes early intervention as well as providing additional support for more vulnerable families, fits with the *'ten year strategy for children and young people in Northern Ireland 2006-2016'*[4] and provides the mechanism to address the health related outcomes of the ten year strategy for children and young people in Northern Ireland (2006-2016).

An integrated health visiting, school nursing, 0-19 years early intervention and preventive service, if based in localities would be responsive to population need. There may be an opportunity to increase capacity through re-design by incorporating skill mix of both adult staff nurses and mental health as appropriate, nursery nurses, tier 2 mental health workers and support workers (to undertake administration and basic screening).

A population based approach would enable resources to meet the needs of the whole 0-19 population, within the context of the family, ensure seamless continuity of care (transition periods are key to breakdown of emotional health and wellbeing), prevent families from 'repeating their story' to a number of professionals, prevent duplication, identify gaps in service provision and provide support to members of the team.

[4] Office First Minister and Deputy First Minister (2006) Our Children and Young People - Our Pledge - a ten year strategy for children and young people in Northern Ireland 2006-2016.

The effectiveness of a 0-19 approach should be supported with access to resources (e.g. direct referral) devolved to teams to support early intervention e.g. sponsored day care, parenting programmes.

Integrated service delivery would wrap around the needs of the child and young person, within the context of the family. Health visitors and school nurses provide level 1 & 2 services, however they do not work in isolation and form part of a multi-disciplinary /multi-agency framework including both statutory and voluntary sectors.

Recommendation 3
The role of health visitors and school nurses in safeguarding and Looked After Children should be clarified and strengthened.

Although more child abuse occurs in the first year of life than in any other, the early years are critically important to the child's later social development for the pathways to violence are often laid down by the age of two or three (Hosking, 2001)[5]. There is a need for health visitors and school nurses to be vigilant in their identification of children in need of protection throughout their whole childhood. Children require protection from physical, emotional and sexual abuse as well as neglect.

In addition children and young people may experience factors that impact on their potential to lead happy and fulfilling lives but do not meet the criteria for child protection. The health visitor and school nurse have a key role in monitoring these children and ensuring the child and family receive the support they require to ameliorate such factors. Health visitors and school nurses are the only service which through the delivery of universal services have ongoing contact with these children and families, who may not at this point be referred as a higher level of risk but more appropriately managed at Level 2 by the health visiting and school nursing services.

In 2007 a Reform Implementation Team which included nursing and midwifery representation, was established to drive reforms in child protection services in each of the five health and social care trusts and a number of policies and guidance documents continue to be developed and published.

[5] Hosking G, 2001, 'Nursery Crimes', Relational Justice Bulletin 9; Shaw DS, Owens EB, Giovennelli J & Winslow EB, 2001, *'Infant and toddler pathways leading to early externalizing disorders', Journal of the American Academy of Child & Adolescent Psychiatry* 40 36-43

Within this process nursing and midwifery have initiated a work programme which, whilst developmental, has already identified a number of priorities that need to be addressed, to ensure that best practice in relation to safeguarding children continues to be developed and shared across Northern Ireland and to secure consistency as the Review of Public Administration continues to be realised.

One work stream relating to the development of a model for safeguarding supervision seeks to support nurses and midwives who have a substantial safeguarding role. The pilot is ongoing across Northern Ireland, and is funded and based on draft DHSSPS policy ('Safeguarding Supervision and Standards for Nurses' 2008) which is expected to be issued when the project has been completed and evaluated.

Another work stream will update the Family Health Assessment that will be used by health visitors and school nurses, to secure individual assessment within the UNOCINI[6] assessment framework. The development of an electronic record will be sought as a solution to sharing information within this process and it is envisaged this will provide comprehensive individual and population based public health data along with information already collated on the Child Health System.

Family Health Assessment is a holistic assessment of the health and wellbeing of all family members. In addition to the children and parent's health and wellbeing it looks at parenting capacity and family and environmental factors. It is a vehicle used by health visitors to promote health and wellbeing and is key to identifying children with high risk and low protective factors and to ensure that these families receive a personalised service. Although public health data e.g. incidence of disclosure re domestic abuse, smoking, alcohol use/misuse, has been gathered by health visitors for many years this data is held in paper format and not utilised other than to inform individual interventions with families and as part of the caseload profile. Currently this data is manually collated. The NIMATS system and in particular the Maternity Hand Held Record should be utilised for its important role during pregnancy in relation to health assessment.

Further work to be initiated will focus on the development of a caseload / population weighting tool to be used within health visiting and school nursing services as part of the supervision process and in the future should have the potential to support performance management.

Family Health Assessment forms part of the UNOCINI Thresholds of Need Model (DHSSPS, 2008)[6]. All children and young people enter health visiting and school nursing services at a universal level 1 service, the majority are new births, but also include families moved into the area, through A&E notifications or maybe through older children accessing school in the area. A family health assessment is undertaken at the first contact with any family and includes where possible all members of the family including fathers.

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[6] DHSSPS (2008) Understanding the Needs of Children in Northern Ireland: Thresholds of Need Model

The focus is on the identification of need, with consideration given to the emotional health and wellbeing of all family members as well as the physical and social aspects of their care, weighing needs and risk against protective and resilience factors present.

From this initial/subsequent contact it may be identified that a child, young person or family require targeted intervention at Level 1/2 (e.g. additional support - nutrition, sexual health, immunisations, attachment, behaviour management, parenting, etc), that would be undertaken where relevant. If additional needs are identified that require support at Level 3/4 (e.g. child with disability, child protection concerns, developmental delay), appropriate referrals should be made with a view to 'managing interventions' in that where appropriate, children revert back to universal service provision when their needs are met with pre-determined exit strategies and outcome measures in place. It is acknowledged for some families they will require Level 3/4 services long term but for many this will be for a period of time.

Recommendation 4
A review of the funding allocation to pre-school immunisations should be undertaken to ensure an effective and efficient immunisation service is offered universally.

The current schedule of contacts is mainly clinic based and in many areas this facilitates immunisation delivered within GP premises by health visitors. This has, to date, coincided with the contact schedule of 'Health for All Children' (Hall 4) which will change in the near future and at which stage contacts for the programme are likely to differ from those within the preschool immunisation schedule. In addition evidence from workshops highlighted concerns that the immunisation of children is often neither cost effective nor appropriate if delivered alongside the Hall 4 programme within busy clinic settings.

Serious consideration must be given to immunisation being undertaken and delivered from where funding is currently directed (i.e. General Practice). However, it remains a key role of health visitors to work closely with general practice to promote immunisation and to educate and support parents in this area.

Uptake rates in Northern Ireland are the highest in the UK and in terms of public health it is imperative that any changes to current services do not reduce uptake rates. For this reason, responsibility for immunisation programmes should remain with General Practice, the role for health visitors being to educate and promote the benefits of immunisation, opportunistically immunising children who do not access routine service provision. Trusts will need to develop Service Level Agreements (SLAs) with GMS Contractors to augment capacity where health visitors are essential to the delivery of this service on behalf of General Practice.

As commissioners are contractually obliged to continue to fund general practice to deliver this service, Trusts must engage through the Health and Social Care Board and Public Health Agency with GMS Contractors to ensure cost effective use is made of existing allocated funding, if Trusts are to continue to provide this service.

Recommendation 5
The role health visitors and school nurses have in identifying and addressing public health priorities should be recognised and measured through performance outcome measures.

Addressing public health priorities through the portal of the family enables universal health promotion to be embedded within a cultural context of the 'fully engaged' scenario described by Wanless[7], by supporting people to take responsibility for their own health.

Pathways to good health start before conception and continue throughout life. Health visitors and school nurses access children, young people and their families at key points in their life and have the opportunity to influence behaviour change to make healthy choices and this should be maximised.

Key public health priorities for 0-19 services include increasing breastfeeding, reducing infant mortality, smoking, teenage pregnancy and sexually transmitted diseases.

Breastfeeding has a major role to play in public health with both health and economic benefits in the short and long term. The UK Infant Feeding Survey (2000) showed initial breastfeeding rates in Northern Ireland were 54% compared to 71% in England and Wales and 63% in Scotland. Increasing breastfeeding impacts on reducing infant mortality, inequalities in health outcomes, reducing preventable infections and unnecessary hospital admissions and halting the rise in obesity (WHO, 2001)[8].

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7 Wanless, D. (2004) *Securing Good Health for the Whole Population*. HM Treasury, London.
8 WHO Commission on the Social Determinants of Health. August 2008. *Closing the Gap in a Generation*, Geneva: WHO, **http://www.who.int/social_determinants/final_report/en/index.html.**

Infant mortality is recognised globally as an indicator of poverty and social exclusion. Three of the causative factors: poor diet, lack of nutrition and teenage pregnancy, are key areas in which health visiting and school nursing could influence. Routine antenatal contact will increase access to maternity services for all women and through interventions in school, nurses have the potential to influence teenage pregnancies and by early intervention provide greater opportunity for choice for these young women.

Teenage conception rates across Northern Ireland vary from 12.4 per 100,000 births to 28.9 in the most deprived areas. Across Northern Ireland ten district councils have teenage conception rates which are significantly higher than the national rate. The 2008/9 PSA target is to achieve a 40% reduction in the rate of births to mothers under 17 by March 2010. In addition sexually transmitted infections are steadily increasing especially Chlamydia with the highest rates in women aged 16-24 years.

Many Looked After Children have additional health needs including emotional and behavioural problems, females are six times more likely to be a parent than their peers at aged 19. Within each Board the health visiting and school nursing teams should ensure that all 'Looked After Children' receive a universal service and where necessary additional needs should be identified and met through access to health visitors and school nurses with expertise in working with 'Looked After Children' across the 0-19 age range.

Health visitors and school nurses have a key role to play in addressing public health priorities. Through individual and family health assessment a vast amount of data is collected which if aggregated at population level, a number of public health priorities may be identified at a very localised level (medium super output areas).

This information is crucial in determining commissioning of resources to meet need. This may be undertaken in terms of children and young people but also in consideration being given to additional resource required to deliver any given public health priority.

Theme 2

Prevention, Early Intervention, Mental Health Promotion and Addressing Public Health outcomes

Recommendation 6
Service delivery should focus on Early Intervention, Mental Health Promotion and address Public Health outcomes.

There is increasingly strong evidence about the importance of the pre and postnatal period, and the early years, in determining future health, social wellbeing and educational achievement (Barlow, 2008)[9]. In addition the key vehicles for delivery of health visiting and school nursing services i.e. home visiting, community outreach and group support, are all very effective in reducing health inequalities.

Both school nurses and health visitors have a role to promote health pre-conceptually and this should be undertaken both opportunistically and routinely to all women and their partners. This would include advice on lifestyle behaviours and routine screening and surveillance.

Health visitors should visit all mothers and fathers-to-be antenatally and usually be the public health practitioner working with the family until the child goes to school. In the case of a teenage mother it may be more appropriate for the school nurse to be the key worker within the family. Health visitors have a critical role to play in promotion of infant mental health, in early identification of poor bonding and attachment and to assist parents to help them to understand and appreciate the capacities of their babies as they grow and change. Assessment and promotion of child development are key factors in bonding and attachment, specifically in areas of speech and language, where simple measures such as the importance of reading to children from an early age has significant impact on their developmental progress and attachment processes.

Support in response to child care needs should not be the only role of health visiting, although beneficial to many, attention should be prioritised to the importance of attachment, nurturing and emotionally attuned responsiveness.

[9] Barlow J, Schrader-McMillan A, Kirkpatrick S, Ghate G, Smith M, Barnes J (2008) *Health-led Parenting Interventions in Pregnancy and Early Years*. University of Warwick

Two evidence based tools are recommended to assist health professionals : - The *Brazelton Neonatal Behavioural Assessment* (Brazelton, 1984)[10] which should be demonstrated to all parents before discharge or at home after early discharge to alert parents to the capacities of newborns, and the *Maternal Assessment of the Behaviour of her Infant* (MABI) should be completed after birth and every week until four weeks to raise parent's awareness. These particular tools have been identified on the basis of the evidence base and ease of use. Health visitors could use them as part of a structured evaluation of the family's need for additional support in the first few weeks, in keeping with the recommendations of 'Health for All Children' (Hall 4).

The South Eastern Trust are piloting a new programme funded through Investing for Health initiative that is aimed at reducing health inequalities. Through an 'Enhanced Professional Support Initiative' the aim is to support emotionally vulnerable mothers-to-be through pregnancy, to build parental self-esteem and secure loving bonds with their infants.

On entry to school the leadership role should be handed over to a school nurse with a key responsibility for primary school aged children, who will be responsible for co-ordinating the universal early intervention and prevention health care input until the young person reaches adolescence, at which point a school nurse with specific skills in working with this age group should take over leadership. This should be within the context of an integrated team and professional judgement should determine the key worker and roles specific health care professional's play in supporting the family.

Good health has a positive impact on a child or young person's enjoyment of school and their levels of achievement. School nurses as part of the wider school health team can act as an effective bridge between education, health and social care supporting work on health issues in school and making health services more accessible to pupils, parents, carers and staff.

This review indicates school nurses should function across a range of settings, the title 'school' relating to the age of the child not the setting in which the practitioner functions. This would include an increase in the number of home visits undertaken by school nurses and the provision of outreach services in local facilities e.g. community centres, youth clubs etc.

Schools for children with special needs were not the remit of this study, however the recommendation from this review would be that children in special schools, regardless of additional nursing support and those who are 'Looked After' should receive the full core universal service through the integrated health visiting/school nursing team.

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[10] Brazelton TB. N*eonatal Behavioural Assessment Scale Clinics in Developmental Medicine*. London: SIMP, 1984.

Families will be seen throughout the child's life from age 0-19 years. All children will continue to receive a universal service, initially delivered through midwifery services, a joint needs/risk assessment should be undertaken and shared between health visiting and midwifery in the antenatal period. Children will continue to receive a universal service at Level 1&2 and where needs can be met through a range of Level 2 interventions, this may be undertaken throughout 0-19 years by the integrated health visiting and school nursing team. Where children's needs cannot be met through a universal service a UNOCINI preliminary assessment should be undertaken and referral made to other agencies via Level 3&4 services.

Recommendation 7
Based on the increasing evidence on the effectiveness of home visiting, in particular in identifying and meeting complex and challenging needs within families, the value of home visiting should be recognised and where appropriate should be increased.

All families should receive a comprehensive universal service but where there is additional need, a progressive service should be offered, reverting back to the universal service provision as necessary.

A universal service is one that is provided to all children, young people and families irrelevant of need. Its purpose is to identify health need and any factors that may impact on the health outcomes of children and young people. It provides the means to develop therapeutic relationships with families and provide early intervention so as to prevent escalation of need to a more progressive level.

For some families, they may require more intensive support to assist them through specific periods but once resolved they may then revert to a universal service.

'Health for all Children' (Hall 4) is core to the identification of need, promoting health and wellbeing and providing early intervention and prevention however the majority of respondents within the review of services reported that where contact had become clinic based this inhibited the development of a therapeutic relationship with families.

Arguably, the most effective preventive mechanism for improving parent-child relationships is regular home visits from health visitors in a child's early years. Early child development is a vital time for influencing life patterns that lead to health inequalities, but only if concerns are identified sufficiently early to prevent the infant from entering an adverse life trajectory, with established physiological and behavioural patterns. (Karoly et al, 2005)[11].

[11] Karoly L.A., Kilburn M. R, Cannon J.S (2005) *Early childhood interventions: Proven Results, Future Promise*. Santa Monica CA, Rand Corporation, **http://www.rand.org/**

The increasing evidence base on the effectiveness of home visiting, specifically for families with complex and challenging need, indicates the effectiveness is dependent on a number of factors including the need for early intervention (antenatal), the number of home visits in excess of 12, and delivered by professionals and focused on a broad range of outcomes (Barlow et al, 2007)[12].

Home visiting provides a wealth of information in determining future outcomes for children including the perinatal mental health of the mother. The increasing evidence base on the importance of early attachment and the 'wiring of the brain' indicates the need to intervene appropriately at this early stage in the parent-infant relationship, not just in terms of behavioural outcomes but also academic attainment in school. Furthermore:

- the identification of domestic violence and the subsequent long term consequences for the child
- the identification of children at risk
- the prevention of childhood accidents

are far more likely to be realised through home visiting than contacts made in a clinic environment.

To maximise the opportunity to improve the health outcomes for children this review recommends that the number of home visits (as opposed to the practice of clinic based contacts), should be increased and this should be seen as a priority.

The recent consultation and action plan on Autism Spectrum Disorder (ASD)[13] for Service Provision in Northern Ireland in 2008 recommends the need to re-introduce the 2 year home visit by health visitors, which is welcomed. A review of the current Child Health Promotion Programme (known locally as Hall 4) is a recommendation of this review and should take this recommendation of the ASD Review forward. In addition early intervention should include information regarding speech, language and communication and early alert signs should be recorded and contained as information for parents in the parent held record.

As children and young people move in and out of need, services should be flexible and responsive enough to ensure families receive appropriate intervention when required, but that exit strategies are built into 'intervention management' in the form of case planning.

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[12] Barlow J, Kirkpatrick S, Wood D, Ball M, Stewart-Brown S (2007) *National evaluation summary. Family and Parenting Support in Sure Start Local Programmes*. DfES Publications, London

[13] Department of Health, Social Services & Public Safety (2009) *Autism Spectrum Disorder ASD Strategic Action Plan.*

Recommendation 8
Health visitors and school nurses should focus on reducing health inequalities through providing a universal service that targets 'hard to reach' groups.

A 0-19 early intervention service incorporating both health visiting and school nursing provides both a robust comprehensive universal service that identifies and targets those in most need as the most effective way to tackle health inequalities.

Evidence suggests as individual practitioners, health visitors focus their efforts on the most deprived families on their caseload, but strategically practice is unrelated to areas of deprivation (Kings College, 2007)[14]. In order to address health inequalities, practice needs to be directed to ensure valuable scarce resource is directed to individuals with greatest need and those in areas of deprivation. As a universal service health visitors and school nurses are the only workforce who can pro-actively visit those children, young people and families who do not access other forms of early year's provision. This is key to addressing health inequalities by providing the same service to 'hard-to-reach' families as those who choose or know how to access services, ensuring equity of provision.

The health of the most disadvantaged has not improved as quickly as that of the better off. Inequalities in health persist and in some cases have widened. To make progress we need to recognise and accept that health inequalities are everyone's business. Health inequalities may be addressed by targeting hard-to-reach individuals and disadvantaged populations. This requires commissioners to acknowledge the impact that both individual and aggregated population interventions might have on the reduction of health inequalities.

Developments in service provision have resulted in increased support for families of young children, through some of our partner agencies e.g. social services and early years provision; this has the potential to lead to duplication of provision thus it is essential that all agencies work effectively together. Joined up commissioning of services across partner agencies will be crucial to deliver on this.

For those families that do not use early years provision, it is essential health visiting and school nursing services provide support as the universal provider to this group. This will be key to addressing inequalities and embedding universal early intervention to all.

The commissioning cycle for health visiting and school nursing provision should be based on public health/individual outcomes. Individual and family health assessment should provide data to identify need that in turn determines future delivery of services and outcome measures in terms of public health and individual health. The outcome measures should inform the next cycle of commissioning.

[14] Kings College (2007) NHS *Contribution to reducing Health Inequalities*. Kings College, London.

Recommendation 9
Health visitors and school nurses have a key role in mental health promotion.

Support to both mothers and fathers during the perinatal period should be focused on the parent-infant relationship, and throughout pregnancy the focus should be on the parent's feelings about the pregnancy and the developing baby. Postnatally early identification of maternal mental health issues is essential to the long term health and wellbeing of the child.

Maternal mental health issues are thought to affect approximately 13 per cent of women during the early months following childbirth (O'Hara, 1996)[15].

The Confidential Enquiry into Maternal and Child Health (CEMACH)[16], 'Saving Mothers Lives: Reviewing maternal deaths to make motherhood safer, (7th Report, 2007) highlighted the serious consequences of failure to address mental health adequately and identified that suicide is a rising cause of maternal death.

The management of maternal mental health requires a multi-disciplinary approach. This is supported by the recently published NICE guidelines on antenatal and postnatal care for women 2007 (NICE, 2006; 2007)[17], which sets out a number of key priority areas for improved service frameworks and pathways. The four Boards were requested by DHSSPS to produce a Regional Report and Action Plan (Jan 2009) to inform the implementation of the NICE Guidelines for antenatal and postnatal mental health services across Northern Ireland. This work is near completion and includes recommendations for the role of health visitors around prediction and detection, and more dedicated roles for local and regional teams to provide treatment and co-ordinate care for local women under the steer of a Regionally Managed Clinical Network.

The review also highlighted the importance of recognising the skills and competencies health visitors and school nurses have in addressing Level 1 & 2 child and adolescent mental health and the importance of closer integration between the two services. Early intervention can prevent significant long term effect on the emotional health and wellbeing of children and young people, resulting in sizeable cost-effectiveness in terms of substance misuse, alcohol misuse, obesity and mental health interventions.

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15 O'Hara MW & Swain AM, 1996, *'Rates and risk of postnatal depression-a meta-analysis'*, International Review of Psychiatry 8 37-54

16 Lewis, G. (2007): Confidential Enquiry into Maternal and Child Health. Saving Mothers Lives: Reviewing Maternal Deaths to Make Motherhood Safer: 2003-05. 7th Report into Confidential Enquiry into Maternal and Child Health. London.

17 National Institute for Health and Clinical Excellence (2006b). *Routine postnatal care of women and their babies*. London: NICE. National Institute for Health and Clinical Excellence (2007). *Antenatal and Postnatal Mental Health*. London: NICE.

Theme 3
Provision of Evidence Based Programmes

Recommendation 10
All health visitors and school nurses should be trained in agreed evidence based cost-effective, parenting programmes at Levels 1 and 2.

There is a clear consensus about the importance of 'working in partnership with parents' and of staff having the necessary skills to do this, including the ability to listen effectively, motivate families to change, and plan problem-solving strategies. Good parent and child relationships are vital for flourishing mental health in childhood and later life.

Group based parenting programmes have been found to have positive effects on the mental health of both children and parents.

Although universal parenting interventions may be effective (and cost-effective) for less severe parenting problems, targeted interventions are required for families with higher levels of need. Certainly, the evidence on intensive home visiting programmes suggests the need to target families in order to realise long-term cost savings, (Barlow, 2008)[18].

Evidence from Barlow, 2008 suggests that multimodal support/education interventions are effective as a means of supporting young mothers. They should begin before or soon after birth, provide demonstrations with real infants, have frequent home visits (e.g. visits 2 - 3 times a month) with hands-on parental education, using video therapy and group discussions, and continue for at least one year. Such interventions should, as far as is possible, be tailored to meet the needs of individual young parents in terms of their developmental stage, coping strategies and exposure to stressful situations.

Although, it is important to intervene early, it is essential that we support all children in promoting social and emotional capabilities, in particular that of empathy as the antidote to anti-social behaviour, including violence. As future parents we need to prepare them for their future role rather than focus on remedial action alone.

[18] Barlow J, Schrader-McMillan A, Kirkpatrick S, Ghate G, Smith M, Barnes J (2008) H*ealth-led Parenting Interventions in Pregnancy and Early Years*. University of Warwick

Where support from education services are already in place and work with parents ongoing it is essential the school nurse co-works with Educational Psychology, Education Welfare Service (EWS), Inclusion and Diversity Service and school's pastoral care staff/counselling services. Traditionally the public sector have addressed some of our more entrenched societal issues by fire-fighting and picking up the pieces. This represents a significant waste of both financial resources as well as equally precious human potential - the 16-year-old who presents anti-social behaviour, who is in a secure unit, at a cost of £230,000 per year may never have needed the place if a few hundred pounds worth of help to his mother on parenting skills in his early years had been offered, 16 years earlier.

A number of US studies have demonstrated significant cost benefits of parenting and pre-school programmes in the long term (Karoly et al, 1998; Olds et al, 1993)[19].

There is an increasing evidence base that investing in early intervention provides value for money, if significant funding is not invested in infant mental health services as part of a longer-term mental health strategy, the alternative is to keep on responding to the more entrenched mental health difficulties as they emerge in later life.

The case for 'value for money' in early interventions must be considered not only in terms of the huge cost to society of caring for later physical and mental health problems but also the economic cost of the loss to society of the contribution that individual is unable to make because of disability.

A number of researchers have also identified how the cost to society of violent and anti-social behaviour including criminality massively outweighs the cost of earlier preventative interventions.

Friedl and Parsonage (2007)[20] estimate cost savings through the prevention of conduct disorders in the most disturbed children amounts to £150,000 (lifetime costs) and that by promoting positive mental health in those with moderate mental health issues would yield lifetime benefits of £75,000 per case.

Three studies of interventions involving little personal contact between services and parents have been shown to have significant effects on maternal sensitivity and attachment with large effect sizes. These programmes require a minimal investment of professional time and therefore expense. Since these programmes have low cost and a large effect size, (despite some variability), they can be highly recommended.

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[19] Karoly LA, Greenwood PW, Everingham SS, Hoube J, Kilburn MR, Rydell CP, Sanders M, Chelsea J (1998) *Investing in our children: 'What we know and don't know of the costs and benefits of early childhood interventions'*. Santa Monica,CA: RAND Corporation.
Olds D, Henderson CR, Cole R, Eckenrode J,Kitzman H, Luckey D, Pettitt L, Sidora K, Morris P & Powers J, (1998) '*Long-term effects of home visitation on maternal life course and child abuse and neglect', Journal of the American Medical Association* 278 637-643

[20] Friedl, L & Parsonage M (2007) '*Building an economic case for mental health promotion': Part 1.* Journal of Public Mental Health; Sep 2007;6,3; Health & Medical Complete pg.14.

The Solihull Approach Model provides professionals with a framework for thinking about children's behaviour that develops practice that can support effective and consistent approaches across agencies. Several small-scale studies have been carried out, an effectiveness study, suggested using this approach resulted in both an impact on the severity of symptoms and a 66% reduction of parental anxiety (Douglas & Ginty, 2001; Douglas & Brennan, 2004)[21].

Family Nurse Partnership Programme: This programme, strongly recommended by the Wave Trust has been well evaluated in a number of countries. It is an expensive programme to put in place in terms of the training and the practitioner time required, but evaluations demonstrate there is a very robust value for money case to be made. Family - Nurse Partnership is the most rigorously tested programme of its kind. (Olds 2002; Olds, Henderson & Eckenrode, 2002; Olds et al. 1997, 1998, 2002, 2004, 2005)[22].

The Roots of Empathy Programme[23] is another extremely well evaluated programme that is school-based and can be best put in place in a collaborative partnership with schools, parents, health visitors and school nurses. It is a Canadian school-based parenting programme aimed at breaking the inter-generational cycle of violence and neglectful parenting. It helps prepare children for emotionally responsive and responsible parenting and has a strong focus on abuse prevention.

Many other countries have adopted the use of preventative programmes to address some of their most entrenched problems, including Australia, New Zealand and the USA. The Netherlands have invested heavily in attachment based interventions in terms of mental health services for mothers whose needs are identified in the antenatal period.

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[21] Douglas H, Ginty M. *The Solihull Approach: 'Changes in health visiting practice'*. Community Practitioner 2001; 74(6):222-224.

[22] Olds D, (2002) *'Prenatal and home visiting by nurses: from randomised trials to community replication', Prevention Science* 3 153-172.
Olds D, Henderson CR & Eckenrode J, 2002, 'Preventing child abuse and neglect with parental and infancy home visiting by nurses' in KD Browne, H Hanks, P Stratton, MA Cerezo (eds) Early prediction and prevention of child abuse: a handbook 165-182.
Olds D et al, 2004 *'Effects of Nurse Home-Visiting on Maternal Life Course and Child Development: Age 6 Follow-Up Results of a Randomized Trial', Paediatrics* 114 1550-1559.

[23] **www.rootsofempathy.org**

Theme 4
Leadership and Education

Recommendation 11
Implementation of the Vision should be led through the Public Health Agency.

There is a need for work to be undertaken strategically and locally to re-evaluate the public health nurses (health visitors/school nurses) contribution to the public health agenda and to seek out new ways of working that more effectively support collective, as well as individual approaches, to health care.

The majority of respondents to the Review expressed concern that the move to health and social care trusts has led to a reduction in the capacity to undertake a public health role, in particular in engaging with communities and addressing some of the wider determinants that impact on health.

Universal health visiting services are a primary line of defence against social exclusion, since they reach out to all families with new born babies, providing support for parents and for parenting at the most vulnerable and significant period of an infant's life.

The diversity and breadth of public health practice has always resulted in a difficulty for policy makers, NHS colleagues and the public to understand the role of health visiting and school nursing. With frequent changes in strategic direction the role of health visitors and school nurses have repeatedly shifted to respond to the policy of the day, hence the role of the PHA in leading to implement the vision for services is to ensure this remains focused and that measurable outcomes can be evidenced in the medium to longer term to improve health and wellbeing of the population.

Recommendation 12
A review of the workforce should be undertaken to assess the resources required to implement the recommendations of this review.

The capacity of current services within health visiting and school nursing will facilitate the delivery of Level 1 services.

Regarding Level 2 services, further work is required to identify and agree a range of evidenced based models which can progressively target and respond effectively to the needs of children, young people and families through early intervention. These should fit within the pathways of the UNOCINI Thresholds of Need model.

The future outcomes of work being led by the Department of Health, England, in relation to the Family Nurse Partnership should be considered within the menu of services for the most 'Hard to Reach' families.

It is anticipated that training will be required for all practitioners and as such an effective Education Strategy will be required to deliver the required outcomes. The resources for this should be secured from within the existing education commissioning process.

Recommendation 13
Development of Education and Training should be reviewed.

To use health visiting and school nursing more effectively in the future it is essential they are supported through education and training, to be effective in addressing the emotional aspects of maternal and child development as they are with the physical and nutritional aspects.

Inclusion of 'regionally agreed' evidence based parenting programmes at both universal and progressive levels of intervention should be included in all education and training programmes for health visitors and school nurses.

There was a call by some participants for an increased number of specialist roles within early years intervention and preventive services. All qualified health visitors and school nurses are specialist practitioners, therefore better use of their skills and competence could be considered, enabling them to take a leadership role in specific areas of practice (e.g. perinatal mental health, positive parenting, obesity prevention, infant feeding, teenage pregnancy etc), rather than proposing new specialist roles.

The traditional training of health visitors and school nurses has been a specialist practice programme that supports a leadership role in practice. There is little evidence that practitioners utilise these skills as they have often worked autonomously and have had no team to 'lead' or delegate to. Empowering health visitors/school nurses to lead the team and make decisions with families and partner agencies would make better use of skills and competencies.

In meeting the breadth of need, increasing relevant skill mix, and empowering specialist community public health nurses (health visitors/school nurses) to take a leadership role would enable the development of a career pathway in public health and ensure 'value for money' in delivery of services.

The development of a pre-registration programme focused on public health practice would equip newly qualified staff working in the community to practice public health but with the option to advance their practice in public health through a modularised pathway.

This would fit with modernising nursing careers (DH et al, 2007)[24] and the development of a public health career pathway (Skills for Health; PHRU, 2008)[25]. Furthermore those specialist community public health nurses working at an advanced level could pursue a master's level qualification in public health and so further their career in public health e.g. applying for registration on the United Kingdom Voluntary Public Health Register (UKVPHR) (Faculty Public Health, 2003).

[24] Department of Health, Department of Health, Social Services and Public Safety Northern Ireland, Scottish Executive Health Department, Welsh Assembly Government (2006) *Modernising Nursing Careers: Setting the Direction*. Department of Health, London.

[25] Skills for Health and Public Health Resource Unit (2008) *Public Health Skills and Career Framework: Multi-disciplinary/ multi-agency/multi-professional.* Skills for Health and Public Health Resource Unit, Bristol and Oxford.

Recommendation 14
Health visitors and school nurses should take a leadership role within early intervention and prevention services working with the most complex families.

Public health nurses have the ability to respond and adapt to political and professional change (Brocklehurst, 2004a)[26]. If they are prepared to delegate some of their practice and work more strategically with our partners in education and social care, they can address some of these public health priorities both at individual level but also strategically be a key to making a difference.

The way forward requires practitioners to recognise and accept the opportunities available to them and to form strategic alliances with other agencies and support local communities to identify and develop their own services (Brocklehurst, 2004b)[27].

In order to do so, their managers and commissioners must empower and enable them to take responsibility at a local level and provide them with the opportunities they require to implement the services required to support the population they serve.

Investment in prevention is essential to prevent increased expenditure in the long term. Maintaining a reactive service delivery goes against the strategic direction of government policy. This review recommends a review of resource implications to implement review recommendations which should include a redesign of services and the use of skill mix to support existing provision and enable a more proactive response to identified need.

[26] Brocklehurst, N. (2004a) '*The new health visiting: thriving at the edge of chaos'*. Community Practitioner, 77(4), 135–139.
[27] Brocklehurst, N. (2004b) '*Is health visiting 'fully engaged' in its own future wellbeing?'* Community Practitioner, 77(6), 214–218.

Theme 5

Robust Information Technology and Systems to support the delivery of 0-19 services

Recommendation 15
Priority should be given to developing robust information technology systems to support the delivery of 0-19 services.

Robust data collection and record keeping should be integral to service delivery. To ensure public health priorities are met it is essential to have a system in place that captures relevant data in particular of health visiting and school nursing activity that meet PSA targets.

A single assessment process which includes Family Health Assessment and UNOCINI should be used to identify need and where more intensive services are required.

An electronic record which enables the capture of data to support clinical decision making at individual and population levels should be in place to support governance structures.

An electronic record to support caseload allocation based on need and deprivation enables more equitable distribution of cases and supports safeguarding supervision in practice.

Model of Delivery

The model for delivery is based on the UNOCINI Thresholds of Need with health visiting and school nursing services functioning primarily at Levels 1 and 2 in the early identification of health need. The most skilled staff should work with individuals and families where there are the most challenging and complex needs and integrated working with specialist services across physical disability and mental health.

This model which is based on Progressive Universalism is based on a universal team which delivers the child health promotion programme and identifies children, young people and families in need. The team which is made up of a skill mix enables those with greatest skill and competence to work with families with the most complex and challenging needs. All members of the team should work collaboratively and utilise the range of skills in the team.

The health visitor's role should focus on families until the child reaches primary school age, when a school nurse should take over lead responsibility for all aspects of the family and child care needs. On entry to secondary school, a school nurse, specialist in engaging adolescents, should work with young people and their families until they leave school, go onto further education or enter employment.

The model utilises a range of skill mix where the health visitor and school nurse, as the specialist community public health nurse, should undertake an initial health assessment and subsequently delegate to relevant members of the team to work with families to ensure a child or young person reaches their health and educational potential.

Where individuals and families require more intensive progressive intervention, this should be undertaken through the implementation of intensive home visiting and the implementation of evidence based parenting programmes. Only where specialist help is required e.g. acute illness, significant physical disability or mental health issues, is the child or young person referred outside of the core team. Exit strategies must be in place in order that when families no longer require progressive intervention they revert to a universal service.

Throughout the period of 0-19 years, children and young people should receive the service as part of the child health promotion programme and a number of evidence-based interventions should be implemented in response to identified need. This will contribute to the PSA target 'by 2011, provide family support interventions to 3,500 children in vulnerable families each year'.

As the model is mainstreamed the next steps to develop more fully integrated children's services should consider how pooled resources across all children's services including preventative, curative and specialist services across health (physical and mental health) and social care can effectively deliver earlier prevention thus necessitating fewer referrals to Level 3 and 4 services. The developed model will require a significant shift in culture across all services to work collaboratively to place equal emphasis on prevention as specialist services. It will require work to be undertaken to identify and agree thresholds across the whole spectrum of health care which has clear pathways for referral. At this stage teams should be made up of the whole range of service provision wrapped around children and families who are at the centre of care and provision.

As the model continues to develop and when Level 2 services are agreed and delivered within an effective integrated children's services framework it will be timely to examine how the public health nursing team can work most effectively with the more complex and challenging families. Those who meet strict criteria could receive additional support that follows a rigid programme of intervention. The future outcomes of work being led by Department of Health, England in relation to the Family Nurse Partnership should be considered within the menu of services for the most 'Hard to Reach' families (i.e. Olds - Family Nurse Partnership Model). In this model the families receive progressive intervention following a 'Licensed Model' in which there is a prescribed programme of intervention. Over time the families are assisted in disengaging from the programme which is targeted to families with children aged 0-2 years.

The advantages and challenges to this model for health visiting and school nursing are summarised in the following table.

Model of Progressive Universalism

ADVANTAGES	Values all staff as equal contributing to the long term health outcomes for all children 0-19	Require school nurses to enhance their role to encompass safeguarding	CHALLENGES
	Utilises workforce to use their skills and competencies to the best outcome for families	Existing workforce will need to develop skills in delegation and leadership	
	Provides a service that puts the child at the centre of service delivery		
	Ensures collaborative working with partners in health, social care and education	As a discrete service within a health and social care integrated team, a pro-active approach will be required to ensure partnership working	
	Identifies children and young people where safeguarding is an issue		
	Focuses on prevention and delivery of child health promotion programme		
	Skill mix will free up highly skilled staff to work with the most challenging and complex families	Potential for staff to 'burn out' without adequate supervision and mentorship	
	Early identification of mental health issues and parental capacity	Education and training of core programme will need to be modified to respond to shift in emphasis	
	Potential to develop a public health career pathway	Not all staff value the advantages of a public health career	
	Enables performance management to assess value of services	Performance management seen negatively by existing workforce	
	Single service - ease of referral by range of agencies	Risk that acute services would be prioritised above preventative services	
	Ensures holistic services to children and families		

Model of Progressive Universalism

Intensive Specialist Home Visiting within a developed model

ADVANTAGES	CHALLENGES
Developmental approach	There needs to be an effective change management programme which ensures that all professionals and services are valued for their contribution within integrated children's service teams
Improved understanding of the broader range of services for children	Risk early signs of safeguarding not identified due to focus on acute services
Parents would theoretically not need to 'share their story' repeatedly across a number of professionals	Data collection systems - not sophisticated enough to share information across all agencies and services
Safeguarding would become the equal responsibility of every service involved with children and young people	Teams would need to be virtual and thus robust communication systems need to be in place
The most challenging families receive specialist support that empowers them in the nurturing of their children	Criteria for intervention targeted at young mothers who are most disadvantaged - many families would not meet the criteria however will receive less intensive programmes
Robust rigorous programme of intervention that is evidence based	Lack of flexibility of a 'licensed' programme
Target the most disadvantaged families and offer a 'solution' to families with trans-generational intractable problems	Potential to produce a two tier service within health visiting - impact negatively on staff morale
Long term benefits indicate worthwhile with significant longer term cost savings evidenced within other sectors including employment, education, justice etc	Requires investment in early years
Frees up the remaining workforce to deliver the child health promotion programme	Potential to minimise the importance of early identification of developmental and parenting issues
Targeted to children 0-2 where greatest impact can be made	No comparative service for school aged children who are future parents and have not benefited from such an intervention in their early years

Conclusion

Healthy Futures has been informed by evidence, government policy and the views of the current frontline workforce as well as a wide range of stakeholders. The recommendations reinforce the direction of government policy in its aim 'to improve the health and wellbeing of the population and putting the needs of the people and communities who rely on our services to the forefront of our work'. (Investing for Health, DHSSPS, 2006)[28].

Commissioners will need to consider the implications of resource allocation on the re-design of services to a model of early intervention and prevention to realise the vision from the Review. There is a real challenge to shift funding upstream to make a difference by preventing ill-health and prioritising resources to support this approach.

The implementation of the recommendations and supporting actions within the Action Plan will depend on a strengthening of commissioning of early intervention and preventive services for children and young people, more collaborative working in infant and maternal mental health, modernising nursing careers and a willingness by the workforce to modernise and take their profession forward.

There is still much to do to successfully reduce health inequalities. People who experience disadvantage, social exclusion, lower educational attainment or poor housing are still more likely to suffer poorer health and an earlier death when compared with the rest of the population. The role of health visitors and school nurses recommended in this review must be fed into the forthcoming DHSSPS revision of 'Investing for Health'. This is seen as essential in taking the health visitor/school nurse profession forward offering a comprehensive service for children and young people that offers the best in protection, promotion and assessment of health need universally.

Nonetheless reducing health inequalities is a key aim of government. Health visiting and school nursing are the only workforce who offer a programme of universal services to all children, young people and families, with the skills to work in community engagement and address a number of public health priorities. This would be a missed opportunity not to invest in this unique service which is well accepted by mothers, fathers, children and young people.

[28] Department Health, Social Services and Public Safety (2006) *Investing in Health: Update*. DHSSPS. Belfast.

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