Submission to Department of Health's Health Service Capacity Review, September 2017

From: Child Health Advocacy Committee of Faculty of Public Health Medicine,

Royal College of Physicians of Ireland.

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Questions:

Given the demographic and epidemiological changes discussed in the paper:

1. What changes in models of care and in the way we deliver care are (a) most urgent and (b) what implications will this have on capacity requirements?
2. How can current capacity be more effectively used?
3. What do you consider to be the priorities for capital investment over the next 15 years?

Question 1. (a)

Recommendation:

A **child health nursing workforce**, dedicated to child health work and which is deployed based on the needs of the child population in an area, **is needed** in order to best meet the needs of children, in order to improve our population's health.

A **Child Health Office should be established within the HSE**. The main role of this office would be to lead nationally on the identification of population need, evidence-based policies and protocols and training standards, and monitoring the delivery of the national child health and wellbeing service.

Rationale for this recommendation:

The health of our current child population predicts the health of our future adult population. The origins of many adult diseases are often found among developmental and biological disruptions occurring during the early years of life, starting from the time of conception, and which cause chronic health problems which may not emerge until well into adulthood.

For more detail on the evidence base, see: *'The Impact of Early Childhood on Future Health - Position paper of the Faculty of Public Health Medicine, Royal College of Physicians of Ireland',* May 2017 at: https://rcpi-live-cdn.s3.amazonaws.com/wp-content/uploads/2017/05/Impact-of-Early-Childhood-on-Future-Health.pdf

Additionally**, there is good evidence that interventions,** provided both by the health sector itself and by the health sector in conjunction with other agencies, **which improve childhood experiences, are one of the most cost-effective policies available** to improve adult health and wellbeing.

The capacity of the current health service to deliver a universal and progressive child health screening, surveillance and support service, based on need, **has been limited in recent years.** Diminished resources and increased demands due to an aging population have compromised the ability of the community nursing service to deliver the preventive child health and wellbeing service.

Chronic disease, and its prevention and management, is almost exclusively discussed within the context of the adult population. There is a need for a **paradigm shift by government and by health service planners to enable health service providers to begin to address the causes of chronic disease, particularly from conception to the first three years of life (the critical first 1000 days**).

Question 1 (b)

Recommendation:

Current models of resource allocation and of service delivery need to be re-assessed, and **additional resources identified, in order to invest in early childhood**.

Rationale:

The community nursing workforce compromises mainly of public health nurses (PHNs) and community registered general nurses (CRGNs). PHNs are trained to work with all client groups within a community, both adults and children, while CRGNs generally work only with adult clients.

In recent years, the public health nursing service has been squeezed between the demands of providing care in the community for an ageing population and providing the child health and wellbeing service. When resources are stretched, as has recently been the case, it is often the preventive child health work which is compromised.

The **employment of additional CRGNs to free up current PHN time** and the **designation of a child health nursing workforce specifically ring-fenced for child health work would be a more efficient use of health resources**. See Appendix 1 for detailed background information.

Question 2.

Recommendation:

The recommendation under 1 (b) above would provide for a more efficient use of the PHN workforce which is trained to work with children and their families.

Question 3.

Recommendation:

The development of a **National Immunisation and Child Health Information System** (NICIS) should be a priority for capital investment.

Rationale:

There is currently no national child health information system and no national system for all immunisations. The development of a **National Immunisation and Child Health Information System** (NICIS) should be a priority for capital investment in order to allow for integrated care, including following up children who change address, and for the monitoring of service need and service delivery.

Appendix 1: Background information in relation to the recommendation outlined in Question 1 (b).

Introduction

Currently 25% of the Irish population are children under eighteen years of age. This submission relates to this population group and **advocates for the prioritisation of the needs of children and increased investment in children in the first three years of life.**

What a national child health and wellbeing service would look like?

- Ireland has a universal child health and wellbeing service that is similar to international models and covers **child health reviews, vaccinations, screening, health needs assessment and parental support**. The timing and frequency of child health reviews varies from country to country. Similar to other health systems various providers deliver different aspects of the child health programme in Ireland
- The service is **free to all children**.
- It is provided from antenatal stage to the first year in second level school.
- The provision of child health services is enshrined in various laws passed between 1907 and 2004 and the most recent initiative to develop a coherent standardised service commenced in 2000 with the publication of *Best Health for Children-Developing a Partnership with Families.*[i] This was updated in 2005 with the publication of *Best Health for Children Revisited*.[ii]

Since 2014 the HSE Health & Wellbeing Division has undertaken a programme of work to update the child health programme. This is referred to as the **National Healthy Childhood Programme.** It builds on *Best Health for Children* and reflects the emerging evidence of the most effective strategies for the delivery of child health programmes, as researched by the HSE Child Public Health Group and signed off by the HSE National Steering Group for the Revised Child Health Programme.

The steering group has adopted the 2004 National Research Council & Institute of Medicine definition of child health that acknowledges the influences of biological, social and physical environments on health trajectories.

> *Children's health is the extent to which individual children or groups of children are enabled to (a) develop and realise their potential; (b) satisfy their needs; and (c) develop the capacities that allow them to interact successfully with their biological, physical, and social environments.*[iii]

The delivery of the National Healthy Childhood Programme is based on a model of **progressive or proportionate universalism**. This has been identified as a key concept within which services for children should be developed.

- It is described as *'a perspective that combines universalism with the targeting of resources on those that have special needs for support or protection; in other words, help to all and extra help for those who need it most.*[iv]
- This is an approach to child health that aims to level up the health gradient by providing a range of responses to different levels of need in the population.

Resourcing the child health specialist nurse workforce (PHNs) to deliver the Healthy Childhood Programme

Community nursing comes under the remit of the Director of Public Health Nursing (DPHN). The DPHN geographical area is the 'old' Local Health Office areas so there are currently 32 DPHNs in post.

- Community nursing comprises public health nurses (PHN), community registered general nurses (CRGN) and specialist nurses in different roles such as palliative care, diabetes, continence promotion.
- While PHNs have a *'cradle to grave approach'* or *'generalist approach'*, CRGNs generally work with adult clients.
- PHNs are trained to deliver child health services as part of their Higher Diploma in Public Health Nursing.

There are approximately 1,500 PHNs currently working in the HSE. Due to the *generalist* nature of the role it is difficult to provide an accurate number of PHNs working specifically in child health. In the scoping study, carried out as part of the preparation for the implementation of the Nurture-Infant Health & Wellbeing Programme, DPHNs reported that almost 85% of PHNs deliver child health services. The public health nursing service, in general, is facing challenges as a result of social, economic and policy shifts.

- We know that the capacity to deliver child health services on a universal basis has proven difficult due to competing priorities from other service areas resulting in child health not being prioritised.
- PHNs report filling gaps in services that would better be provided by other staff, for example administration tasks, social work etc.
- PHNs report time pressures resulting in reduced time for home visiting with clinic visits being favoured instead, resulting in further disadvantage for those groups that need the service most. The consequences for those living in rural areas are also obvious. Although the KPI target of all mothers being visited within 72 hours of discharge from hospital is reached, the PHN service is reporting an inability to provide the other mandated services due to pressures from the acute hospitals.

The debate on generalist versus specialised model is currently being discussed within the policy context. The consultation on the proposed community nursing policy was launched (by Minister Harris) on Monday 27th March.

The model of community nursing in the UK is unlike the Irish model in that they have three distinct groups of nurses:

- district nurses who deal with older people and hospital discharges;
- midwives who look after new mothers and
- health visitors who *'work with families and communities to improve access, experience, outcomes and reduce health inequalities.'*

The UK has invested hugely in its health visiting service over the last six years and targeted the provision of an additional 4,500 health visiting posts.[v]

Based on an estimated PHN workforce of 1,500 WTE and an estimated 85% of whom may have a remit for child health, it is projected that there are 10.5 WTE PHNs/10,000 population under 19 years. This compares to an estimated 9.5 FTE Health Visitors/10,000 population under 17 years in the UK. See Table 1.

Table 1: Estimates of PHNs vis-à-vis Health Visitors

Ireland	
Est. No PHNs (WTE)	1,500[1]
Est. % of PHNs with some remit for Child Health *	85%[2]
Est. number of PHNs with some remit for Child Health*	1,275
Population under 19 years (Census 2011)	1,200,000[3]
Est. number of PHNs with some remit for Child Health/10,000 population*	10.6
UK & Wales	
Number of FTE Health Visitors (Oct. 2015)	11,643[4]
Est. Population UK & Wales under 17 years (2015)	12,305,774[5]
Est. number of HVs/10,000 population under 17	9.5

*While DPHN have reported 85% of PHNs having a child health remit this should not be interpreted as a full time role for the PHN. The PHN carries a wide range of clients in a caseload.

1. Report on Current Public Health Nursing Services/Houses of the Oireachtas Joint Committee on Health & Children Debate 27th June 2013
2. HSE Scoping Study for the Nurture-Infant Health & Wellbeing Programme
3. Census 2011 www.cso.ie
4. https://data.gov.uk/dataset/6a537c1d-786f-42c1-98f6-c823aa8b894c/resource/29c5572e-ee31-43e2-a0e5-e38631da35be
5. https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/2011censuskeystatisticsforenglandandwales/2012-12-11

Of course it must be remembered that Health Visitors have a sole remit for child health. They provide a follow-on service from community midwives who also provide services in the community in the first week of life (the number of FTE community midwives could not be sourced).
The development of a community midwifery model is one of the actions of the Maternity Strategy.

It is estimated that an additional 80 to 100 WTE CRGNs per each Community Health Organisation (CHO) are required to facilitate PHN to focus solely on the delivery of child health services. The costs are shown in Table 1 and Table 2 below.

Table 2: Cost of community registered general nurse post

Number of Community Health Organisations	9
Number of CRGNs required per CHO	80 to 100 WTE
Total Number of CRGNs required nationally	720 to 900 WTE
Costing for CRGN post	
Staff Nurse (mid-point of scale)	*€34,666*
PRSI @ 10.75%	*€3,727*
Total Pay	€38,393
Total Non-Pay @ 20%	€7,679
Total Cost per post	€46,071 (€0.046m)

Table 3: Cost of increasing CRGN workforce over 5 year cycle (2018 to 2022)

Total Cost of 80 to 100 CRGN posts per CHO			**€3.680m to €4.60m per CHO**	
Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
(16 to 20 WTE)	(16 to 20 WTE)	(16 to 20 WTE)	(16 to 20 WTE)	(16 to 20 WTE)
€0.74m -€0.92m	€0.74m -€0.92m	€0.74m -€0.92m	€0.74m -€0.92m	€0.74m -€0.92m
Overall Costs of 720 to 900 WTE CRGN posts			**€33.1m to €41.4m nationally**	
Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
(144 to 180 WTE)	**(144 to 180 WTE)**	**(144 to 180 WTE)**	**(144 to 180 WTE)**	**(144 to 180 WTE)**
€6.62m - €8.22m	**€6.62m - €8.22m**	**€6.62m - €8.22m**	**€6.62m - €8.22m**	**€6.62m - €8.22m**

Can this happen quickly? – could the staff be recruited/deployed if the money and leadership is there?

The community nursing service would require resources to allow a high percentage of PHNs to take up a full time role in child health. This would involve:

- Prioritising the child health service by ring-fencing and facilitating PHNs to focus on their child health role. The allocation of additional CRGN posts, under the direction of the DPHN, to support non-child health services currently being carried out by PHNs. The HSE in general is currently experiencing recruitment difficulties for certain posts including nursing.
- The allocation of PHNs to child health populations should be based on both population size and underlying population need. For example areas with high levels of deprivation, including rural populations, should receive increased resources.
- The child health programme is being updated to bring it in line with new evidence in areas such as infant mental health and developmental surveillance. A range of new training programmes and resources are currently being developed as part of the Nurture-Infant Health & Wellbeing Programme. This will facilitate PHNs and community doctors to refresh and develop their public health skills and enhance the service they provide to families and communities.
- Having supporting services available for the smaller percentage of children who require referral to specialist services such as occupational therapy, speech therapy, social work etc would ensure implementation of a prevention and early intervention model. We have good evidence from Preparing for Life regarding models that could be implemented to support the PHN as well as harnessing existing community supports.
- The role of the community medical doctor is crucial also in the context of the child health service. These doctors provide second tier clinics for children identified with delayed development and medical issues. The community-based second tier clinics prevent unnecessary referrals to the acute paediatric services when the child's needs can be met by community professionals. It is crucial that this medical tier is maintained as it is part of the overall paediatric model of care for the country.

References:

[i] Best Health for Children Developing a partnership with families Report of the national conjoint child health committee 1999 Accessed at: http://www.lenus.ie/hse/bitstream/10147/45180/1/6871.pdf

[ii] Best Health for Children Revisited Report from the National Core Child Health Programme Review Group to HSE 2005 Accessed at: www.lenus.ie

[iii] National Research Council & Institute of Medicine Children's health, the nation's wealth: Assessing and improving child health Committee on Evaluation of Children's Health; Board on Children, Youth, and Families; Division of Behavioral and Social Sciences and Education Washington, DC National Academies Press June 2004

[iv] The Agenda for Children's Services: A Policy Handbook Office of the Minister for Children Department of Health and Children December 2007

[v] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213110/Health-visitor-implementation-plan.pdf