



**Framework for
The National Healthy Childhood
Programme**

**HSE Strategy & Planning
and
HSE Primary Care Division**

16th October 2018



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Version control

11 th November 2016	Developed by the National Steering Group for the Revised Child Health Programme and circulated to the National Director for Primary Care and National Director for Health & Wellbeing
24 th May 2017	Updated following meeting with the National Director for Primary Care for circulation to the HSE Leadership Team and the Department of Health
16th October 2018 (current version)	Updated information from Carly Cheevers, Researcher & Data Analyst , National Healthy Childhood Programme

Cite as:

“HSE Framework for the National Healthy Childhood Programme, HSE Strategy & Planning and Primary Care Division, Version 3: 16th October 2018”

Foreword

For more than 100 years Ireland has had legislation underpinning our provision of preventative and protective child health services. The needs of children and families have changed considerably over this time period. There have been immense changes in Irish society in the last twenty years. Our population has grown and has become more diverse, family structures have changed and the use of technology in our everyday lives presents challenges and opportunities to health care providers.

In June 2014 the Health & Wellbeing Division established a Child Public Health Group to commence a programme of work to review and update the existing child health programme – *Best Health for Children*, which was last updated in 2005. The evidence review completed by the Child Public Health Group provided the springboard for the work of the National Steering Group for the Revised Child Health Programme. Since October 2014 the national group and subgroups have worked diligently to develop the National Healthy Childhood Programme and the framework for its delivery.

With almost 25% of our population under 18 years the National Healthy Childhood Programme is uniquely placed to ensure that our child health services are delivered to the highest standard and based on the most up to date evidence for prevention and health promotion. Investment in early childhood development, starting from conception, provides one of the most cost effective interventions available to reduce health inequalities and chronic illness in later life. This is because its impact is seen not just on the health of the child but because it also provides the foundation for health, or predisposition to illness, over a person's lifetime. There is, therefore, an economic as well as a social argument to invest in early childhood. The early years present a golden opportunity to improve the health of the whole population.

The delivery of the programme is based on a model of *progressive or proportionate universalism – help for all and extra help for those who need it most*. It is similar to international models and covers child health reviews, vaccinations and screening and the service is free to all children.

The Healthy Ireland Policy Priority Programme Healthy Childhood is a strategic enabler to anchor the changes required to the current services in the new structures for service delivery in Community Health Organisations and Hospital Groups. The Nurture Programme-Infant Health and Wellbeing will make possible many of the actions outlined

in the framework through the implementation of a range of sustainable service developments for children in the 0 to 2 year age group.

We thank the members of the National Steering Group for the Revised Child Health Programme and the subgroups and the Child Public Health Group for their support in bringing the Framework for the National Healthy Childhood Programme to this point. A considerable body of evidence has been gathered that will underpin the delivery of child health services into the future. We are aware of other areas of the child health services that require more detailed review so our work is just beginning.



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Executive Summary

Background

The Irish population is undergoing considerable change with significant population growth (22%) since 2002. In the last twenty years the population has grown by 31%. Between 2006 and 2016, high birth rates and falling death rates are the main contributing factors for population growth in this time period. In 2011, the median age of the population of Ireland was 36.8, the lowest of any EU Member State.

Ireland's child health programme is similar to international models and covers child health reviews, vaccinations and screening. The timing and frequency of child health reviews varies from country to country. Similar to other systems various providers deliver different aspects of the child health programme in Ireland. The service is free to all children.

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*. This was updated in 2005 with the publication of *Best Health For Children Revisited*.

The National Healthy Childhood Programme builds on that work and reflects the emerging evidence of the most effective strategies for the delivery of child health programmes, as researched by the Child Public Health Group and signed off by the National Steering Group for the Revised Child Health Programme.

The National 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.

Healthy Ireland Implementation in the Health Services

The Health and Wellbeing Division in the HSE is leading the implementation of Healthy Ireland in the HSE. The *HSE Healthy Ireland in the Health Services National Implementation Plan 2015-2017* sets out the governance and leadership. It focuses on three priority areas:

Health service reform/Reducing the burden of chronic disease/Improving staff health and wellbeing

As well as national actions and targets, the plan outlines how Community Health Organisations (CHOs) and Hospital Groups will be expected to deliver on a suite of actions relating to each of the policy priority programmes.

- Healthy Childhood
- Healthy Eating and Active Living (HEAL)
- Wellbeing and Mental Health
- Positive Ageing
- Alcohol
- Tobacco Free-

The *Healthy Childhood* Policy Priority Programme is a key enabler for the implementation of National Healthy Childhood Programme.

Better Outcomes Brighter Futures

Of relevance to the implementation of the National Healthy Childhood Programme is the policy context set out in *Better Outcomes Brighter Futures*. The Department of Children and Youth Affairs policy sets out a whole-government approach and provides a framework to achieve the best outcomes for children. The Department of Health is sponsor of Outcome 1 – Active and healthy, physical and mental wellbeing. The aims are that all children and young people are physically healthy and able to make positive health choices, have good mental health, have a positive and respectful approach to relationships and sexual health, and that their lives are enriched through the enjoyment of play, recreation, sports, arts, culture and nature. The Health & Wellbeing Division monitor and report on the actions relevant to the HSE.

Action 1: The National Healthy Childhood Programme in the Health & Wellbeing Division will work in partnership with the Department of Children & Youth Affairs to implement relevant actions from child health & wellbeing strategies

National Clinical Programmes

The Framework for the National Healthy Childhood Programme is informed and influenced by the ongoing development in the National Clinical Programme for Paediatrics and Neonatology, the National Integrated Care Programme for Children and the National Women's and Infants Programme.

Action 2: The National Healthy Childhood Programme in the Health & Wellbeing Division will work with Clinical Strategy & Programmes to support the Neonatal & Paediatric Clinical Programme and the Integrated Care Programme for Children

Action 3: Formal alignment and agreement of integrated work streams, underpinned by a common annual plan, will be agreed between the National Healthy Childhood Programme and Women & Infants Health Programme

Action 5: The National Healthy Childhood Programme in the Health & Wellbeing Division will support the National Maternity Strategy Actions 62-66 regarding the Maternity & Infant Care Scheme.

The Nurture Programme-Infant Health & Wellbeing

The Nurture Programme - Infant Health and Wellbeing is a three-year programme (2015-2018) funded by The Atlantic Philanthropies (Atlantic). The programme focuses on supporting the development and delivery of the universal child health service provided to 0 to 2 year olds. Considerable forward planning, through the development of a Logic Model and Implementation Plan, has been carried out working in tandem with the National Steering Group for the Revised Child Health Programme.

The Nurture Programme is a key enabler of the implementation in the National Healthy Childhood Programme and has received considerable buy-in from across Health & Wellbeing, Primary Care and Acute Hospital Divisions.

Staff from these divisions and external stakeholders are working on the implementation of six work streams:

1. Knowledge and Communications
2. Antenatal to postnatal
3. Health & Wellbeing Promotion and Improvement
4. Infant Mental Health and Supporting Parents
5. Standardised Health Records for Parents and Professionals
6. Training and Resources

Specific actions relevant to Nurture are outlined in the Framework.

National Immunisation & Child health Information System

A project is underway to design and implement a National Immunisation and Child health Information System (NICIS). This system will replace the Primary Immunisations Systems, the Personal/Parent Health Record System and the Schools Information System. The development of NICIS will be a key enabler to the delivery of child health services and the development of child health indicators.

Action 4: The National Healthy Childhood Programme in the Health & Wellbeing Division, working with other partners and agencies, will continue to support the development of child health indicators. The National Immunisation and Child Health System will be a key enable.

Early Years Last a Lifetime

Investment in early childhood development, starting from conception, provides one of the most cost effective interventions available to reduce health inequalities and chronic illness in later life. This is because its impact is seen not just on the health of the child but because it also provides the foundation for health, or predisposition to illness, over a person's lifetime. There is therefore an economic as well as a social argument to invest in early childhood.

Investment in child health programmes that are available to all children and families is an important starting point when addressing the issues relating to health inequality.

Health inequality is caused by an unequal distribution of resources across families, not only in terms of wealth, but also in living conditions, levels of education, supportive family and community networks, social capital and parenting skills. These influences are evident at the individual and at the societal level and are cumulative over a person's lifetime.

Action 6: The National Healthy Childhood Programme will develop an advocacy role, within the HSE and with relevant professional bodies, policy makers and the public, to promote the importance of effecting positive change in children's health and wellbeing.

Developing the National Healthy Childhood Programme

The totality of the National Healthy Childhood Programme is provided from antenatal stage to the first year in second level school.

1. Hospitals and GPs provide antenatal and post natal care (including two checks for the baby at two and six weeks) as part of the Maternity & Infant Scheme. Access to the service is via completion and submission of an application form to the local health centre.
2. GPs deliver the Primary Immunisation Programme (up to 13 months) and there is free GP care to all children up to six years of age, including growth monitoring at two and five years as part of the GP Under 6 contract. Access to the Primary Immunisation Programme is via automatic notification to the mother from the HSE when notification of birth is received. Parents can go online and register to receive

a GP Visit Card for their child in order to receive free GP care for all children under six years.

3. PHNs and Community Health Doctors deliver Child health Screening & Development Surveillance to children from birth to first year in second level school (school immunisations). Access to the service is triggered via notification of birth from the hospital to the PHN, who arranges the first visit within 72 hours of discharge from hospital.

The universal nature of the programme facilitates greater acceptability for parents/families as there is equal access for all children. The community-based screening and surveillance service is generally the first service to see the baby in the home environment and plays a critical role in linking with all related child services.

The time is opportune to review and update the current model (*Best Health for Children*) to take account of the changing policy and strategic context. Notable developments include the implementation of the newborn hearing screening programme, the emerging evidence on developmental surveillance and the ever increasing body of evidence highlighting on the effectiveness of interventions that both promote health and prevent adverse outcomes.

In mid-2014 a Child Public Health Group was established and undertook a review of the evidence base for the delivery of *Best Health for Children*. This provided the ground work for the National Steering Group for the Revised Child Health Programme which was established in October 2014. The steering group identified areas that required further review and subgroups were established (developmental dysplasia of the hip, enuresis, health promotion, infant mental health, developmental surveillance) to carry out this work. The output, to date, from these groups is reflected in the framework presented here. It is acknowledged that the development of services is within a wider health and wellbeing agenda and that the wider determinants of health play a significant part in child and adult health.

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. 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.

Principles of the National Healthy Childhood Programme:

1. All children will have access to defined core (universal) services as underpinned in legislation. There will be supports provided for those identified as requiring extra support or additional services, including children with disabilities (progressive/proportionate universalism).
2. All children will have access to high quality integrated services.
3. Recognises the importance of antenatal care on longterm maternal, child and adult health and the impact of good mental and emotional child and maternal health on longterm child and adult health.
4. Takes into account children's and adults long-term needs and interests as well as children's immediate needs by recognising the importance of early childhood development.
5. All parents will be made aware of the right to universal child health screening and surveillance services. The HSE will promote, support and enable access to the universal child health service.
6. It will empower parents as the primary educators during the critical early years of a child's development.
7. The programme will be evidence-based with a focus on prevention and early intervention (screening and surveillance including health promotion strategies and interventions).
8. The model will be underpinned by a clinical governance framework (regional and national) which supports the provision of quality services by:
 - a. Ensuring integrated care for children via clear referral pathways and formalised networks
 - b. Enabling a culture of continuous quality improvement
 - c. Providing appropriate professional training to the level of competency required
9. An information system that supports parents to avail of and professionals to deliver the child health service. The implementation of the National Immunisation and Child health Information System (NICIS) will be a key enabler to services in reviewing their practice and service delivery and for better integration/communication between service providers (general practice, paediatric services, child & family services).

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10. Recognises the importance of sharing of information with parents. Information on their child's health status at all contact points is important for parent empowerment and improved interaction between services.

Implementing the National Healthy Childhood Programme

The implementation of the National Healthy Childhood Programme will seek to ensure the most effective use of current resources, including minimising duplication in order to efficient delivery of the programme across care settings. The programme will align with current HSE policies in respect of staff engagement. While the Department of Health, the Department of Children and Youth Affairs and Tusla are represented on the National Steering Group, separate and ongoing engagement is also in place to ensure cross-departmental synergies are identified and promoted to ensure best outcomes for children.

In order for the implementation of the National Healthy Childhood Programme to be effective a sustainable infrastructure must be developed. This involves reviewing and developing the structures and processes that underpin the delivery of the programme; developing, improving and sustaining the staff competency; developing environments (policies, partnerships and funding streams) to support the programme.

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 and lack of integration/communication between service providers. It was clear from the range of services currently provided to all children in the State that a review of Best Health for Children 2005 should take cognisance of the totality of the child health service and seek to build on current synergies in the system or establish links where they do not exist in order to provide a more cohesive service for the child (child centered care).

The Health & Wellbeing Division is establishing a standardised approach to the implementation of all six national priority programmes outlined in the HSE Healthy Ireland Implementation Plan. The structure for implementation will see a programme team and a national implementation group established for each priority programme.

Action 7: A National Implementation Group for the National Healthy Childhood Programme, with cross divisional representation, will be established. The tenure of the group will be 2-3 years and will be chaired by the Healthy Childhood Programme lead and reporting to the National Director Health & Wellbeing Division.

At a national level the development and monitoring of child health service falls within the remit of the Health & Wellbeing and Primary Care Divisions. The Health & Wellbeing Division's remit is mainly in terms of policy implementation, strategic development, guidance and advice and includes monitoring of performance against health indicators.

Operationally the delivery of child health service continues through the Primary Care Division, under the new HSE structures of nine Community Health Organisations. The child health budget, apart from the vaccine procurement, is mainly held within the Primary Care structure.

The National Healthy Childhood Programme will implement HSE guiding principles for quality and patient safety in order to ensure compliance with best practice standards to minimise risk and prevent clinical incidents.

Action 8: The National Implementation Team will develop and implement a national governance structure for child health services that supports current CHO and hospital group governance structures.

Action 9: The health & Wellbeing Division will work in partnership with the Primary Care Division to develop a structure for the ongoing delivery of the National Healthy Childhood Programme at CHO level.

Action 10: The National Implementation Team will use existing networks to progress child health at an intersectoral level, for example Local Community Development Committees (LCDCs) and Children and Young People Services Committees (CYPSCs).

The Heads of Service for Primary Care or Health & Wellbeing will have overall responsibility for child health services in the CHO area. The allocation of work portfolios rests with the Chief Officer in each CHO area.

The Principal Medical Officer will be the lead clinician for child health, accountable to the Head of Service Primary Care/Health & Wellbeing for the quality of care provided. Each practitioner providing the child health programme is responsible for their clinical practice, under the scope of practice for their profession, and must ensure that they are trained to deliver the programme to the required standards.

Action 11: Each CHO and hospital group will establish and integrated governance structure for child health services, in line with Action 106 of the HSE Healthy Implementation Plan.

In many CHO areas the child health service is PHN-led with onward referral to the Community Medical doctor for further review and assessment at second-tier clinics. This is the preferred framework for delivery of the programme and will require ongoing engagement with PHNs and Community Medical doctors to ensure its implementation nationally. The pending Department of Health policy to provide direction on the future provision of nursing and midwifery services in the community, the implementation of the community midwifery model from the new Maternity Strategy and the recommendations

from Early Years Strategy, due to be published by the Department of Children and Youth Affairs, will also influence this framework.

In the current child health programme there are twenty-two contacts available to all children (universal). The child receives one or more elements of the programme at these contacts for example screening, vaccination or child health review.

The review of *Best Health for Children* has provided the opportunity to reflect on the current timing of contacts in the community based child health screening and surveillance service within the context of the emerging evidence. Reviews of the evidence carried out by the Child Public Health Group and outputs from the subgroups on Infant Mental Health, Health Promotion, Developmental Surveillance, Enuresis and Developmental Dysplasia of the Hip have all contributed to this update.

Changes are proposed with respect to the timing of three of the child health screening and surveillance contact points based on:

1. The evidence base for screening in the antenatal period, newborn bloodspot screening, newborn hearing, vision and developmental dysplasia of the hip (DDH) screening
2. The crucial time periods in a child's development
3. The way in which antenatal and postnatal services are currently organised and provided by different providers (hospitals, GPs and PHN/Community medical officers).

The changes are outlined as follows:

- A new antenatal contact will be developed
- Primary visit within 72 hours – no change
- 3 month visit – no change
- 7 to 9 months contact will change to 9 to 11 months
- 18 to 24 months contact will change to 21 to 24 months
- Preschool - 3¼ to 3½ years contact will change to 3.8 to 4 years (46 to 48 Months)
- School – change to 4½ to 5 years , the contact will still be at Junior Infants, the revised age bracket takes account of average age of children in Junior Infants

<p>Action 12: The Nurture Programme Antenatal/Postnatal Implementation Team will scope out the requirements to deliver the antenatal contact, including the identification of additional resources required and engage with Higher Education Institutes where appropriate.</p>

The National Healthy Childhood Programme will support the current HSE programme Making Every Contact Count. It will assist in building a culture and environment that supports continuous health improvement

Action 13: The National Implementation Team will empower health care professionals providing the National Healthy Childhood Programme to recognise the role they have in advocating for healthy lifestyle behaviour.

The provision of universal services within a model of progressive universalism means that all children are offered a standard number of contacts. Inherent in the delivery of the model is the ongoing requirement for assessment of need, the delivery of services using evidence-based pathways of care and the requirement for services to work in an integrated way both within and between hospital and community based services.

Action 14: The Nurture Programme Standardised Records for Parents and Professionals Implementation Team will review the current assessment tools in use and other relevant screening tools in order to make recommendations regarding national adoption.

Action 15: The National Implementation Team will progress the implementation of agreed assessment tools to support the identification of children and families requiring additional services.

Action 16: The National Implementation Team will ensure that care pathways and standards developed by the subgroups will support service providers to deliver the programme to agreed standards.

Action 17: The National Implementation Team will work in partnership with the Integrated Care Programme for Children and the Paediatric and Neonatology Clinical Programme to develop referral pathways for children requiring consultant review.

Action 18: The National Implementation team will continue to liaise with the National Coordinating Committee for Primary Care Paediatric Services to progress common agendas.

The twenty three contact points on the National Healthy Childhood Programme present opportunities

- to promote health, wellbeing and development in children and families,
- to monitor and evaluate the child's age appropriate immunisation status and to provide advice and encouragement to keep up to date with the national immunisation schedule,

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- to engage with parents and carers at key transition times and to identify the child's physical, developmental, social and emotional needs,
 - to develop a relationship between the child/family and the service in order to address issues early thereby preventing the need for specialist referrals later,
 - to provide additional support (including onward referral) to children/families with additional needs,
 - to support parents in their parenting role.

Action 19: The Nurture Programme-Infant Health & Wellbeing will prioritise the development of key resources to support service providers to deliver the National Healthy Childhood Programme.

Developing Supporting Environments

The HIQA *National Standards for Safer Better Healthcare* are the standards to which the child health service will be developed and delivered.

The development and implementation of the National Immunisation and Child health Information System (NICIS) presents an huge opportunity to standardise the way data from National Healthy Childhood Programme, including immunisation data, is recorded and reported.

Additional performance indicators are required to reflect the complete range of services provided and to monitor trends and variations.

Action 20: The National Implementation Team will work with the NICIS project team to scope out the data requirements for a child health system.

Screening programmes also benefit from strong effective leadership that clearly articulates the need and direction for the programme while providing support by securing appropriate resources. The governance of screening, surveillance and immunisation programmes needs to include clear definitions of the structures that manage and monitor them.

Action 21: Formal governance and support for the screening programmes of the National Healthy Childhood Programme will be established in the Health & Wellbeing Division.

Health and social care practitioners working in the community, individually and as a group, form an essential component of the healthcare system. They also represent a valuable resource in the delivery and management of the National Healthy Childhood

Programme and in the interface between hospital and community. Highly trained, motivated and engaged practitioners have much to offer children and parents on all components of the National Healthy Childhood Programme. In acknowledging the work undertaken by practitioners and with a view to supporting their education and training needs a programme of education will be developed that reflects the current evidence and the methods of delivery of training will support a blended learning approach.

Action 22: The Nurture Programme-Infant Health & Wellbeing will prioritise the development of training programmes to support the provision of the National Healthy Childhood Programme.

Action 23: HSE Primary Care and Acute Hospital Divisions will facilitate relevant staff to attend revised training programmes as per Action 109 of the Healthy Ireland Implementation Plan.

Evidence based resources will be developed for professionals to support the delivery of the child health programme. New information sources, both online and paper-based, will be developed to empower parents in their caring and parenting roles.

Action 24: The Nurture Programme-Infant Health & Wellbeing will prioritise the development of standardised records for parents and professionals

The delivery of the National Healthy Childhood Programme is dependent on having a skilled workforce in place to deliver the individual contacts and to recognise and refer children who require additional services and supports.

Action 25: The National Implementation team will engage with CHOs to ascertain if efficiencies exist across the system and to identify additional resources required to support the implementation of the framework.

1. Introduction

The National Healthy Childhood Programme is provided by a number of health services across a range of settings, from homes to hospitals. This document sets out the framework for the delivery of the revised child health programme within HSE settings and where relevant it references key contact points in other settings. The key principles underpinning the National Healthy Childhood Programme are outlined along with the actions to support the delivery of the revised programme.

The framework synthesises data from the Evidence Review for the Child Health Model,¹ prepared by the Child Public Health Group. It sets out the background to the National Healthy Childhood Programme in terms of relevant legislation, policy and strategy. It brings together the outputs from the subgroups of the National Child Health Steering Group, the work strands of The Nurture Programme-Infant Health & Wellbeing and the relevant actions from the HSE Healthy Ireland Implementation Framework.²

In providing the demographic and health & wellbeing context for the delivery of child health services the framework sets out critical areas for consideration to address health inequality and its long term impact on chronic disease. Actions are numbered and highlighted in blue boxes in their relevant sections.

2. Background

It is acknowledged that the wider determinants of health play a significant part in child and adult health. Policies aimed at improving social and environmental conditions have an enduring effect on the health outcomes of children and adults. Children face numerous environmental and social challenges in the contexts of families, schools, and communities that significantly affect their well-being and health outcomes.

There is a gradient in health all the way up the social ladder. Those who are poorest have the worst health, while those at the highest social level have the best health. This unequal distribution of health is not inevitable, but is associated with an unequal distribution of income and education, living and working conditions and of supportive family and community networks.

Changes in economic arrangements and in social policies and programmes have been shown to reduce the health gap. These changes can save both lives and money. While changes are needed across different groups and settings, early childhood is a special case.

¹ Evidence Review for the Child Health Model Version 5 HSE Health & Wellbeing Division Child Public Health Group March 2015

² Healthy Ireland in the Health Services National Implementation Plan 2015-2017 Accessed at: <http://www.hse.ie/eng/health/hl/hi/hihs/>

*'The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being – from obesity, heart disease and mental health to educational achievement and economic status.'*³ Marmot, 2010

Ireland's child health programme is similar to international models and covers child health reviews, vaccinations and screening. The timing and frequency of child health reviews varies from country to country. Similar to other systems various providers deliver different aspects of the child health programme in Ireland. The service is free to all children.

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*⁴. This was updated in 2005 with the publication of *Best Health For Children Revisited*.⁵

The National Healthy Childhood Programme builds on that work and reflects the emerging evidence of the most effective strategies for the delivery of child health programmes, as researched by the Child Public Health Group and signed off by the 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.*⁶

An outline is given below of the policy and legislative platforms that mandate the provision of services, the population that receives services and the systems in place to provide those services.

³ Marmot, M. Fair Society, Healthy Lives The Marmot Review Strategic Review of Health Inequalities in England post 2010 Accessed at: <http://www.instituteofhealthequity.org/>

⁴ 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>

⁵ Best Health for Children Revisited Report from the National Core Child Health Programme Review Group to HSE 2005 Accessed at: www.lenus.ie

⁶ 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

3. Context

3.1 Legislation

A review of the context for the development and delivery of the National Healthy Childhood Programme aids understanding of the environment within which those services are delivered.

The key pieces of legislation that form the basis of the provision of the National Healthy Childhood Programme are:

1. The Notification of Births Act 1907 and 1915 (Extension)
 - Section (1) Subsections (1) and (2) of the Notification of Births Act, 1907 and Notification of Births (Extension) Act, 1915 provides that it is the duty of the parent and any person in attendance on the mother at the birth, or within six hours of the birth, whether the child is born alive or dead, to notify, within thirty-six hours, the medical officer of health of the district of the birth.⁷

Practice Standard 1 of the Practice Standards for Midwives also states that '*a Birth Notification Form (Form BNF/01) should be completed for each live birth.*'⁸

The Civil Registration Act, 2004 requires the parent(s) of a new-born child to register the birth, not later than 3 months from the date of the *birth*.⁹

2. The Local Government Act 1925 provided for the appointment of County Medical Officers of Health (MOH) who were given responsibility for environmental and personal health services, including maternity and child welfare services and school health services.¹⁰
3. Twenty-two years later the Health Act of 1947¹¹ enacted the establishment of the Department of Health, which took over responsibility for personal health services from the Department of Local Government and Public Health. It also provided for the establishment of County or City Medical Officer (CMO) posts including the transfer of MOH post holders into this role.
4. The Health Act 1970¹² provided for the establishment of eight health boards and the responsibility for the provision of health services transferred from the 27 health authorities. The post of Director of Community Care was established – post holders had the wider brief of the CMO role and responsibility for the provision of all community care services.

⁷ The Notification of Births Act 1907 and 1915 Accessed at: <http://www.irishstatutebook.ie/1915/en/act/pub/0064/print.html>

⁸ The Practice Standards for Midwives An Bord Altranais 2010 July Accessed at: www.nursingboard.ie

⁹ The Civil Registration Act 2004 Accessed at: <http://www.irishstatutebook.ie/2004/en/act/pub/0003/>

¹⁰ Local Government Act 1925 Accessed at: <http://www.irishstatutebook.ie/1925/en/act/pub/0005/>

¹¹ Health Act 1947 Accessed at: <http://www.irishstatutebook.ie/1947/en/act/pub/0028/>

¹² Health Act 1970 Accessed at: Accessed at: <http://www.irishstatutebook.ie/1970/en/act/pub/0001/>

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- Sections 63, 66 and 67 form the legislative basis for the current child health service. It placed an obligation on health boards to provide without charge medical, surgical and nursing services for children up to the age of six weeks including choice of GP; a health examination without charge at clinics, health centres and national schools including follow up treatment for any conditions identified for children up to 6 years of age.
5. The Health Act 2004¹³ provides the legislative basis for the Health Service Executive. Health boards were abolished and the national executive established with a governing board to *‘to use the resources available to it in the most beneficial, effective and efficient manner to improve, promote and protect the health and welfare of the public.’*
 6. The Disability Act, 2005, children under 5 years old are entitled to an independent assessment of health and educational needs. Following the assessment, the HSE is obliged to provide a statement of the services that will be provided. Children with disabilities need a wide range of services that extend across the board from specific health interventions to community and hospital-based therapies to preschool and school education.¹⁴
 7. The Children First Act, 2015 puts elements of the *Children First: National Guidance for the Protection and Welfare of Children (2011)* on a statutory footing and forms part of a suite of child protection legislation which already includes the National Vetting Bureau (Children and Vulnerable Persons) Act, 2012 and the Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012. The Act obliges certain professionals and others working with children to report child protection concerns to the Child and Family Agency and to assist the Agency, if requested to do so, in its assessment of a child protection risk. The Children First Act 2015 also provides for an amendment to the Non-Fatal Offences Against the Person Act 1997 to abolish the common law defence of reasonable chastisement.¹⁵

3.1.1 Relevant Legislation

8. The Assisted Decision Making (Capacity) Act, 2015 reforms Ireland’s Capacity legislation which has been in place since the 19th century. It establishes a modern statutory framework to support decision-making by adults who have difficulty in making decisions without help. It means that a person whose Decision-Making capacity is in question can appoint a person to assist, co-decide or represent them for

¹³ Health Act 2004 Accessed at: <http://www.irishstatutebook.ie/2004/en/act/pub/0042/sec0007.html#sec7>

¹⁴ <http://www.justice.ie/en/JELR/DisabilityAct05Guide.pdf/Files/DisabilityAct05Guide.pdf>

¹⁵ <http://www.oireachtas.ie/documents/bills28/acts/2015/a3615.pdf>

the purpose of making a decision. A Decision Support Service, as part of the court service, will be established to deal with assistant decision making.¹⁶

9. The Children & Family Relationships Act 2015, signed into law in April 2015, is intended to create a legal structure to underpin diverse parenting situations and provide legal clarity on parental rights and duties in diverse family forms.¹⁷
10. The Child and Family Agency Act 2013 led to the establishment of the Child and Family Agency, Tusla, in January 2014. Tusla brings together a number of children and family services in the one agency for the first time, including child welfare and protection services previously operated by the HSE, the Family Support Agency, the National Educational Welfare Board and a range of other services.¹⁸

3.2 Policy

3.2.1 Government

The current programme for government, *A Programme for a Partnership Government*,¹⁹ contains general and specific commitments relevant to child health. General commitments include providing additional funding for health services, continuing with the reform agenda which will see the HSE evolving into a Health Commission, developing HSE ICT infrastructure, establishing an independent patient advocacy service and developing a single long term (over 10 year period) plan for healthcare.

Of specific relevance to children are the commitments to

- Develop primary care, including staff and resources in general practice.
- Improve access through the provision of free GP care to under 18 year olds and a dental package for under 6's.
- Implement the national Maternity Strategy.
- Implement Public health policy interventions (smoking, alcohol, sugar-sweetened drinks) and the extension of the childhood vaccination programme to include meningitis B and rotavirus vaccines.
- Implement public health strategy interventions including the implementation of the national physical activity plan, the proposed national obesity plan, and a sexual health strategy.
- Publish a National Parenting Support Plan.

¹⁶ <http://www.inclusionireland.ie/sites/default/files/attach/basic-page/512/factsheet-assisted-decision-making-bill-june-2015.pdf>

¹⁷ http://www.citizensinformationboard.ie/downloads/relate/relate_2015_05.pdf

¹⁸ <http://www.irishstatutebook.ie/eli/2013/act/40/enacted/en/html>

¹⁹ A Programme for a Partnership government May 2016 Accessed at: http://www.merrionstreet.ie/MerrionStreet/en/ImageLibrary/Programme_for_Partnership_Government.pdf

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- Provide in-school speech and language services.
 - Establish a Prevention and Early Intervention unit in the Department of Public Expenditure & Reform.

3.2.2 Department of Health

The Department of Health (DoH) is responsible for the development and evaluation of child health policy. The HSE has the remit for the delivery of child health services. These services are provided directly by the HSE or the HSE can contract their provision. For example HSE staff (PHNs and community medical officers) delivers the child health screening and development programme while GPs are contracted to provide the primary childhood immunisation programme and the Maternity & Infant Scheme.

The policy frameworks aimed at improving the overall health and wellbeing of the population (*Healthy Ireland*) and that of children and young people specifically (*Better Outcomes Brighter Futures*) are setting the agenda for the development and delivery of child health and wellbeing services. Both are overseen by a Cabinet Subcommittee.

*Healthy Ireland A framework for Improved Health & Wellbeing 2013-2025*²⁰ sets out the government's commitment to improving the health and wellbeing of the population. The Health & Wellbeing Programme in the Department of Health is responsible for strategic planning and coordination of the implementation framework.

The Physical Activity Action Plan 2016,²¹ has a number of relevant recommendations including

- Review the National Play and National Recreation Policies and develop a new strategic direction for promoting physically active play (Department of Children & Youth Affairs (DCYA))
- Include children and young people in the development and implementation of programmes in which they are involved (DCYA, Department of Education & Skills (DES))
- Conduct the LifeSkills Survey every three years (DES)
- Evaluate the Be Active After School Initiative (HSE)
- Develop National Guidelines on Physical Activity for early childhood (0-5 years) (DoH HSE)

The recently published *A Healthy Weight for Ireland Obesity Policy and Action Plan 2016-2025* sets out an '10 Steps Forward' action plan that aims to reverse the obesity trends,

²⁰ Healthy Ireland A framework for Improved Health & Wellbeing 2013-2025 Department of Health <http://health.gov.ie/wp-content/uploads/2014/03/HealthyIrelandBrochureWA2.pdf>

²¹ <http://health.gov.ie/wp-content/uploads/2016/01/Get-Ireland-Active-the-National-Physical-Activity-Plan.pdf>

prevent complications associated with obesity such as Type 11 diabetes, and reduce the overall burden for individuals, their families and the health system.²²

The DoH published the first National Maternity Strategy *Creating a Better Future Together 2016-2026* in January 2016.²³ The Strategy identifies four priorities:

- A Health & Wellbeing approach should be adopted to ensure that babies get the best start in life. Mothers and families should be supported and empowered to improve their own health and wellbeing;
- Women should have access to safe, high-quality, nationally consistent, woman-centred maternity care;
- Pregnancy and birth should be recognised as a normal physiological process, and insofar as it is safe to do so, a woman’s choice in pregnancy and childbirth should be facilitated;
- Maternity services should be appropriately resourced, underpinned by strong and effective leadership, management and governance arrangements, and delivered by a skilled and competent workforce, in partnership with women.

In 2015, the Chief Nursing Officer in the DoH published a *Strategy for the Office of the Chief Nursing Officer 2015-2017*.²⁴ Of particular relevance to the National Healthy Childhood Programme are the priority actions to develop:

- A policy to provide direction on the future provision of nursing and midwifery services in the community to support the overall health reform programme
- A policy to provide direction on the future development of advanced and specialist nursing and midwifery practice within the context of the overall health reform programme.

3.2.3 Department of Children and Youth Affairs

The establishment of the DCYA in 2011 and the Child and Family Agency (Tusla) in 2014 are having a profound influence on the delivery of child health and wellbeing services.

Action 1

The National Healthy Childhood Programme in the Health & Wellbeing Division will work in partnership with the Department of Children & Youth Affairs to implement relevant actions from child health & wellbeing strategies

²² A Healthy Weight for Ireland Obesity Policy and Action Plan 2016-2025 Department of Health September 2016

<http://health.gov.ie/wp-content/uploads/2016/09/A-Healthy-Weight-for-Ireland-Obesity-Policy-and-Action-Plan-2016-2025.pdf>

²³ <http://health.gov.ie/wp-content/uploads/2016/01/Maternity-Strategy-web.pdf>

²⁴ Strategy for the Office of the Chief Nursing Officer 2015-2017 Department of Health Dublin, www.health.gov.ie

The DCYA policy *Better Outcomes Brighter Futures 2014-2020*²⁵ sets out a whole-government approach and provides a framework to achieve the best outcomes for children. The DoH is sponsor of Outcome 1 – Active and healthy, physical and mental wellbeing. The aims are that all children and young people are physically healthy and able to make positive health choices, have good mental health, have a positive and respectful approach to relationships and sexual health, and that their lives are enriched through the enjoyment of play, recreation, sports, arts, culture and nature.

The commitments under the transformational goal of earlier intervention and prevention, central to the delivery of Outcome 1 are:

- Bring a focus to healthy early development, prioritising the under-two year-olds, strengthening pre-natal and ante-natal supports around the mother, addressing maternal health and wellbeing, and raising breastfeeding and vaccination rates in line with international norms. (DoH, HSE, DCYA, Tusla).
- The HSE, in collaboration with Tusla, The Child and Family Agency, will explore the provision of an integrated maternal ante-natal and early childhood development service, building on the review of the Community Nursing Services. (HSE, Tusla, DoH, DCYA)

The DCYA is due to publish a new National Early Years Strategy, which will be informed by the output of the Early Years Advisory Group.²⁶ The DoH and DCYA Business plans commits them to developing a Child Injury Action Plan in 2016 as part of a commitment given in *Better Outcomes Brighter Futures*.

3.2.4 Health Information & Quality Authority

The Health Information and Quality Authority (HIQA) is the independent Authority established in May 2007 to drive continuous improvement in Ireland's health and social care services. Reporting directly to the Minister for Health and the Minister for Children and Youth Affairs, their role is to promote quality and safety in the provision of health and personal social services for the benefit of the health and welfare of the public.

HIQA is responsible for driving quality, safety and accountability in residential services for children, older people and people with disabilities and have published a range of relevant standards.²⁷

²⁵ Department of Health and Youth Affairs *Better Outcomes Brighter Futures The National Policy Framework for Children and Young People 2014-2020*

²⁶ *Right from the Start Report of the Expert Report of the Expert Advisory Group on the Early Years Strategy* September 2013 Department of Children and Youth Affairs Accessed at: <http://www.dcy.gov.ie/>

²⁷ <https://www.hiqa.ie/standards/social-care>

HIQA has also published *National Standards for Safer Better Healthcare*²⁸ that set out the dimensions of quality under eight different themes:

1. Person-centred care and support – how services place the service user at the centre of their delivery of care. This includes the concepts of access, equity and protection of rights.
2. Effective care and support – how services deliver best achievable outcomes for service users in the context of that service, reflecting best available evidence and information. This includes the concepts of service design and sustainability.
3. Safe care and support – how services avoid, prevent and minimise harm to service users and learn from when things go wrong.
4. Better health and wellbeing – how services identify and take opportunities to support service users in increasing control over improving their own health and wellbeing.

Delivering improvements within these quality dimensions depends on service providers having capability and capacity in four key areas:

5. Leadership, governance and management – the arrangements put in place by a service for clear accountability, decision making, risk management as well as meeting their strategic, statutory and financial obligations.
6. Workforce – planning, recruiting, managing and organising a workforce with the necessary numbers, skills and competencies.
7. Use of resources – using resources effectively and efficiently to deliver best possible outcomes for service users for the money and resources used.
8. Use of information – actively using information as a resource for planning, delivering, monitoring, managing and improving care.

²⁸ <https://www.higa.ie/standards/health/safer-better-healthcare>

3.2.5 Health Service Executive

Healthy Ireland Implementation in the Health Services

The Health and Wellbeing Division in the HSE is leading the implementation of *Healthy Ireland*²⁰ in the HSE. The HSE *Healthy Ireland in the Health Services National Implementation Plan 2015-2017*² sets out the governance and leadership. It focuses on three priority areas:

- Health service reform
- Reducing the burden of chronic disease
- Improving staff health and wellbeing



As well as national actions and targets, the plan outlines how Community Health Organisations (CHOs) and Hospital Groups will be expected to deliver on a suite of actions relating to each of the policy priority programmes.

- Healthy Childhood
- Healthy Eating and Active Living (HEAL)
- Wellbeing and Mental Health
- Positive Ageing
- Alcohol
- Tobacco Free



The *Healthy Childhood* Policy Priority Programme is a key enabler for the implementation of National Healthy Childhood Programme. The *Healthy Childhood* actions for CHOs and Hospital Groups are shown in Appendix 1.

HSE Corporate Plan 2015-2017

The HSE Corporate Plan 2015-2017²⁹ sets out five goals, all of which are relevant to child health. Table 1 outlines these goals and the actions relevant to child health.

Table 1: HSE Corporate Plan 2015-2017 Goals and relevant child health actions

Goals	Relevant Actions
1. Promote health and wellbeing as part of everything we do so that people will be healthier.	Implement a child screening model and improve national immunisation rates Increased uptake rate for childhood immunisation to 95%
2. Provide fair, equitable and timely access to quality, safe health services that people need.	Implement a number of key Integrated Care Programmes including older persons, chronic disease prevention and management, child and maternal health, and improve patient flow
3. Foster a culture that is honest, compassionate, transparent and accountable.	Enhance our engagement with patients and service users, their families and carers and involve them in the design and delivery of services
4. Engage, develop and value our workforce to deliver the best possible care and services to the people who depend on them.	Develop our capability through alternative ways of working Support front line staff to contribute to and drive improvement in the care they provide
5. Manage resources in a way that delivers best health outcomes, improves people's experience of using the service and demonstrates value for money.	Continue to implement major projects, for example <ul style="list-style-type: none">• the new Children's Hospital• new national Maternity Hospital• additional Primary Care Centres

The Corporate Plan also sets out the following in respect of the changes to the future delivery model for health services:

- Creating an empowered and accountable health delivery system through the establishment of Community Healthcare Organisations, Hospital Groups, and the reform of the Primary Care Reimbursement Service and the National Ambulance Service
- Building and designing models of care which are patient-centred, evidence-based and clinically led across the whole organisation
- Fostering an environment that supports research and education
- Reforming the key support functions of Human Resources, Information and Communication Technology, Finance and Health Business Services (Shared Services)
- A number of key policies and strategies will guide and govern health service delivery over the course of this Corporate Plan.

²⁹ Building a high quality health service for a healthier Ireland Health Service Executive Corporate Plan 2015-2017 March 2015
Accessed at: <http://www.hse.ie/eng/services/publications/corporate/corporateplan15-17.pdf>

HSE Clinical Care Programmes

In 2010 the HSE established a number of clinical programmes *‘to improve and standardise patient care throughout the Health Service by bringing together clinical disciplines and enabling them to share innovative solutions to deliver greater benefits to every user of HSE services’*.³⁰

Since then a number of programmes relevant to children and child health have commenced.

Paediatric & Neonatology Clinical Programme

The HSE Paediatric & Neonatology clinical programmes were established in 2011 to achieve the following objectives:

- | | |
|---------|---|
| Quality | <ul style="list-style-type: none">• Ensure high quality standards of care are provided in all paediatric and neonatal units nationally through the development of a model of care for paediatrics and neonatology• Implement a national Paediatric Early Warning Score• Develop guidelines and algorithms to help standardise clinical care nationally |
| Access | <ul style="list-style-type: none">• Extend the National Neonatal Transport Programme to a 24/7 service, and implement an efficient retrotransfer programme• Introduce a dedicated paediatric emergency transport service• Ensure all infants have rapid and equal access to neonatal intensive care and surgical treatment irrespective of geographical location• Reduce outpatient appointment wait times• Ensure access to insulin pump therapy for all children under 5 with type 1 diabetes |
| Value | <ul style="list-style-type: none">• Eliminate duplication and fragmentation in the provision of specialist newborn intensive care services• Ensure all care is provided in the right setting, by the most appropriate clinician• Maintain child health through appropriate preventative initiatives: Screening, Nutrition and Immunisation.• Reduce HbA1c levels in children and adolescents with diabetes, thereby reducing long-term complications and adult healthcare utilisation |

The Model of Care for Paediatric Healthcare in Ireland sets out a vision for an *‘integrated national network for paediatric health services, with the new children’s hospital at the centre as the ‘hub’ and the regional and local paediatric units as the ‘spokes’ that link to each other and to the new children’s hospital.*³¹

³⁰ <http://www.hse.ie/eng/about/Who/clinical/>

³¹ http://www.hse.ie/eng/about/Who/clinical/natclinprog/paediatricsandneonatology/modelsofcare/PaediatricMoC_FinalDraftChapters.html

Integrated Care Programme for Children

The Integrated Care Programme for Children is one of five integrated care programmes currently established by Clinical Strategy & Programmes. The programmes *'will work with the existing National Clinical Programmes, our Service Divisions and other key enablers to ensure the correct business supports are available to deliver seamless person-centred health and social care services.'*³² The plan is to introduce the Integrated Programmes on a phased basis over 2-5 years.

Action 2
The National Healthy Childhood Programme in the Health & Wellbeing Division will work with Clinical Strategy & Programmes to support the Neonatal & Paediatric Clinical Programme and the Integrated Care Programme for Children

The National Women & Infants Health Programme

The HSE is establishing a national Women & Infants Health Programme, which will have a cross-divisional focus, *'to lead the management, organisation and delivery of maternity, gynaecological and neonatal services within the HSE. The Programme will span obstetrics, gynaecology and neonatal services, across the spectrum of primary, community and secondary care.'*²³

The first task will be to develop a detailed implementation plan.

Of particular relevance to the National Healthy Childhood Programme is the development of a community midwifery model; the proposal to review the Maternity & Infant Scheme with a view to centralising the scheme, providing additional contacts and developing a standardised dataset for GPs.

The Health & Wellbeing Division Child Health Programme will work with the HSE Women & Infants Health Programme to align and agree relevant areas for implementation, on an annual basis. This will include integration with the relevant implementation plan of the Nurture Programme.

Action 3
Formal alignment and agreement of integrated work streams, underpinned by a common annual plan, will be agreed between the National Healthy Childhood Programme and Women & Infants Health Programme

³² <http://www.hse.ie/eng/about/Who/clinical/integratedcare/>

The Nurture Programme-Infant Health & Wellbeing

The Nurture Programme - Infant Health and Wellbeing is a three-year programme (2015-2018) which completes a long-term cycle of investment by The Atlantic Philanthropies (Atlantic) with the aim of creating evidence-based policy, services and practices in Ireland.

The Programme is managed through a grant from Atlantic to the Katharine Howard Foundation (KHF) and the work programme will be delivered by the HSE with support from the Centre for Effective Services (CES).

A Reference Group consisting of a range of child health and allied health professionals was convened in July 2014 and developed a Logic Model for the Programme.

A high level Oversight Group and a Programme Steering Group comprising the main stakeholders, Atlantic, KHF, HSE and CES oversee the programme's implementation.

The Planning Implementation Group of the National Steering Group, consisting of representatives from HSE, CES and KHF, completed the Implementation Plan for the programme. The programme was officially launched in May 2016.

The outputs from the Logic Model have been incorporated into the Implementation Plan and will now be realised through implementation teams across six work streams:

1. Knowledge and Communications
2. Antenatal to postnatal
3. Health & Wellbeing Promotion and Improvement
4. Infant Mental Health and Supporting Parents
5. Standardised Health Records for Parents and Professionals
6. Training and Resources

The Nurture Programme is a key enabler of the implementation in the National Healthy Childhood Programme.

4. The Health & Wellbeing of Ireland's Children

The Irish population is undergoing considerable change with significant population growth (22%) since 2002. In the last twenty years the population has grown by 31%. Between 2006 and 2016, high birth rates and falling death rates are the main contributing factors for population growth in this time period.

In 2017, the median age of the population of Ireland was 36.8, the lowest of any EU Member State.

4.1 Population Stats

The consequences for the delivery of child health services are clear when the population figures for children are shown:³³

- Of the total population of 4,761,865 people in 2016, 25% (1,190,502) were aged less than 18 years old. The child population of Ireland increased by 14.8% between 2006 and 2016.
- In 2015, Ireland had the highest percentage of children in the European Union (at that time estimated to be 26%). The EU-28 average was 19%.
- The number of foreign national children increased by 27.8% between 2006 and 2016; approximately 6.7% of the total child population.
- The number of pre-school children increased by 9.7% between 2006 and 2016.
- The family profile in Ireland has changed
 - Between 2011 and 2016 there was a 3.3% increase in the number of families
 - Family size has declined to an average of 1.4 children
 - 21.2% of family units with children aged 18 and younger in 2016 were one parent families, the vast majority were headed by mothers (19.4%) and 1.9% were one parent families headed by fathers.
- Just over 6% of the child population have a disability and approximately 1 in 3 children on the National Physical and Sensory Disability Database are registered as having multiple disabilities.³⁴
- At the end of 2017, 6,189 children were in the care of Tusla, an increase of approximately 15.5% between 2008 and 2013.³⁵

³³ Census 2016 Statbank www.cso.ie

³⁴ State of the Nation's Children: Ireland 2016 Department of Children and Youth Affairs Dublin: Government Publications Available at: www.dcyw.ie

³⁵ Tusla Monthly Performance and Activity Data 2017 Available at: www.tusla.ie

4.2 General Health

- The infant mortality rate has dropped; from 5.7/1,000 live births in 2001 to 2.8/1,000 live births in 2017, the comparable rate for the EU28 in 2016 was 3.6/1,000 live births.³⁶
- Infant mortality is significantly higher among lower income groups and is 3.5 times higher among Travellers.
- Ireland's under 5 mortality has been lower than the EU average since 2004.
- Some health conditions are commoner in Irish children
 - In 2013, the crude incidence rate of VTEC (a notifiable EColi infection) was 15.3 per 100,000, compared to an overall EU rate of 1.15 per 100,000.³⁷
 - Ireland has a higher prevalence of cystic fibrosis at 2.98/10,000 compared to a EU27 rate of 0.737/10,000.³⁸
 - It is reported that more Irish young people die by suicide than in other countries.³⁹

In terms of **risk and protective factors**, survey data show that

- 25% of three year olds are overweight (19%) or obese (6%), with children in this age group from lower social classes more likely to be obese (9% versus 5%).⁴⁰
- 26% of nine year olds are overweight (19%) or obese (7%), with obesity more prevalent in children from lower social classes (11% versus 4%).⁴¹
- 16% of ten to seventeen year olds report that they have ever smoked, 10% reported being drunk in the last thirty days and 8% reported using cannabis in the last 12 months.⁴²
- Physical activity levels are high in ten to seventeen year olds, with 52% reporting exercising four or more times a week. However rates are lower for girls and those in lower social classes.⁴²
- National immunisation uptake rates in 2014 show that rates in:⁴³

³⁶ Eurostat. Accessed at <http://ec.europa.eu/eurostat/>

³⁷ HPSC Annual Epidemiological Report 2013 HSE Accessed at: http://www.hpsc.ie/AboutHPSC/AnnualReports/File_15139_en.pdf

³⁸ Farrell, PM. The prevalence of cystic fibrosis in the European Union *Journal of Cystic Fibrosis* 7 (2008) 450–453

³⁹ Scoliers G, Portzky G, Madge N, Hewitt A, Hawton K, Wilde EJD, et al. (2009). Reasons for adolescent deliberate self-harm: a cry of pain and/or a cry for help? Findings from the child and adolescent self-harm in Europe (CASE) study. *Social Psychiatry and Psychiatric Epidemiology*; 44(8):601-607.

⁴⁰ Growing Up in Ireland: Key Findings: Infant Cohort (at 3 years), No. 1 The Health of 3 year olds 2011 Accessed at: www.growingup.ie

⁴¹ Growing Up in Ireland: Key Findings: 9 year olds, No. 4 The Health of 9 year olds Accessed at www.growingup.ie

⁴² HBS Study 2014 Department of Health & National University of Ireland, Galway December 2015

- Children at 12 months of age were 92% for D₃, T₃, P₃, Hib₃, Polio₃, HepB₃, MenC₂ and PCV₂ – lower than the national target of 95%.
- Children at 24 months for MenC₃ (88%), Hib_b (92%), PCV₃ (92%) and MMR₁ (93%) were lower than the target uptake of ≥95%.
- Children at 24 months of age for D₃, T₃, P₃, Hib₃, Polio₃ and HepB₃ reached the target rate of ≥95%.
- Children at 12 months of age were 89% for BCG (estimate only).
- 22% of children aged 10 to 17 years reported ever going to school or bed hungry because there was not enough food at home.⁴²

4.3 Wellbeing

The general health and wellbeing of Ireland's children is good, for example:

- 40% of boys and 29% of girls in the 10-17 years age group report excellent health with a higher percentage (51%) of younger boys and younger girls (47%) reporting excellent health.⁴²
- 47% of children in the 10-17 years age group and 74% of younger children report feeling very happy with their life at present.⁴²

However, data from established sources point to the effects of the recession on living standards in general and the disproportionate burden carried by children.

- Trends from the Survey on Income and Living standards⁴⁴ show that between 2007 and 2012 children (0-17 years) were the population group most likely to be at risk of poverty (18.8% in 2012) and live in consistent poverty (9.9% in 2012). They also experienced the highest deprivation rates (32.3% in 2012), among the three age bands, over the six year period.
- A recent UNICEF report looking at the impact of the recession on children showed that Ireland's increase in child poverty, from 18% to 28.6% in four years in 2008 to 2012, ranked fifth highest among a group of 42 developed countries.⁴⁵
- The effects of the recession on families are shown in the data emerging from the *Growing Up in Ireland Study*

⁴³ Annual Report on Immunisation Uptake at 12 and 24 months, 2014 Accessed at: <http://www.hpsc.ie/A-Z/VaccinePreventable/Vaccination/ImmunisationUptakeStatistics/Immunisationuptakestatisticsat12and24monthsofage/AnnualReport.s/>

⁴⁴ Survey on Income and Living Conditions (SILC) CSO April 2014 www.cso.ie

⁴⁵ UNICEF Office of Research (2014). 'Children of the Recession: The impact of the economic crisis on child well-being in rich countries', Innocenti Report Card 12, UNICEF Office of Research, Florence

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- For the child cohort at 13 years (Nov. 2012): 61% families said they were experiencing some level of difficulty making ends meet.⁴⁶
 - For the infant cohort at 5 years (Nov. 2013): 67% of families were experiencing some level of difficulty making ends meet.⁴⁷
 - The proportion experiencing difficulty increase in both cohorts across the time period.
 - In both cohorts higher percentages of one-parent families experienced difficulties making ends meet, compared to two-parent families.
- Poor children start school at a disadvantage, whether it is through poorer health, having more behavioural issues or not adequate skills to prepare them for school.^{48, 49}

⁴⁶ Growing Up in Ireland National Longitudinal Study of Children Key Findings: 13-Year-Olds No. 3 The Family and Financial Circumstances of 13-Year-Olds Accessed at: <http://www.growingup.ie/index.php?id=83>

⁴⁷ Growing Up in Ireland National Longitudinal Study of Children Key Findings: Infant Cohort (at 5 years) No. 4 The Family Circumstances of 5-Year-Olds Accessed at: <http://www.growingup.ie/index.php?id=83>

⁴⁸ Isaccs, JB. Starting School at a Disadvantage: The School Readiness of Poor Children The Social Genome Project March 2012 Assessed at: www.brookings.edu

⁴⁹ Doyle, O. UCD Geary Institute Discussion Paper Series: Skills, Capabilities and Inequalities at School Entry in a Disadvantaged Community Accessed: <http://www.ucd.ie/geary/static/publications/workingpapers/gearywp201014.pdf>

4.4 Child Health Indicators

During 2015, the Child Health Profiles Subgroup (a subgroup of the Child Public Health Group) explored the possibility of producing child health profiles at a county level. Profiles are produced using health indicators that reflect the wider determinants of health and reach beyond the boundaries of traditional health care and public health services and include areas such as education, housing, transportation, agriculture, and environment. They are described as providing *'a snapshot of child health and wellbeing for each local authority in England using key health indicators, which enables comparison locally, regionally and nationally...they provide a snapshot of the overall health of the local population, and highlight potential problems through comparison with other areas and with the national average.'*⁵⁰

The group agreed the following criteria for selection that data supporting the individual child health indicator must be:

- reliable,
- consistent,
- easily understood by stakeholders
- ideally internationally comparable,
- available at local, regional and national level.

Based on these criteria a list of indicators from national and international reports was compiled resulting in approximately 35 indicators. The group identified an initial set of 13 core indicators (listed below) that met the selection criteria and could be included in the child health profile for 2016. The indicators were grouped into categories derived from Public Health England's Child Health Profiles.⁵⁰

The group also liaised with the team in the DCYA that is tasked with the development of indicators for *Better Outcomes Brighter Futures*. A member of the Child Health Profiles Group is on the Expert Advisory Group developing outcome indicators in DCYA.

Domain 1. Premature Mortality

1. Infant Mortality Rate
2. Child Mortality Rate 2013 (age 1 to 19)
3. Child Mortality – Five year age standardised death rate (age 1 to 19)

Domain 2. Health Protection

4. MMR Vaccination for one dose (2 years)
5. 6-in-1 Vaccination for three doses Tetanus/Diphtheria/Pertussis (Tdap)/Inactivated Poliomyelitis (IPV)/Haemophilus Influenzae B (Hib)/Hepatitis B
6. HPV Vaccination in girls in their first year of second level school

⁵⁰ Public Health England National Child and Maternal Health Intelligence Network Assessed at: <http://www.chimat.org.uk/profiles>

-
7. MMR Vaccination uptake junior infants

Domain 3. Wider Determinants of Health

8. Children in care

Domain 4. Health Improvement

9. Low birth weight of all babies
10. Sexual health and behaviour – teenage mothers

Domain 5. Prevention of Ill-health

11. Hospital admissions caused by injuries in children (0-14 years)
12. Hospital admissions for asthma (0 to 18 years)
13. Breastfeeding rates at time of discharge from hospital

The full list of child health indicators considered are outlined in Appendix 6. A sample county child health profile was produced proof of concept.

This work will be progressed in the context of overall county level profiles currently underway in the Health & Wellbeing Division.

The development of the National Immunisation and Child health Information System (NICIS) will be a key enabler in this context.

Action 4

The National Healthy Childhood Programme in the Health & Wellbeing Division, working with other partners and agencies, will continue to support the development of child health indicators. The National Immunisation and Child health System will be a key enabler.

5. Early Years Last a Lifetime

Investment in early childhood development, starting from conception, provides one of the most cost effective interventions available to reduce health inequalities and chronic illness in later life. This is because its impact is seen not just on the health of the child but because it also provides the foundation for health, or predisposition to illness, over a person's lifetime. There is, therefore, an economic as well as a social argument to invest in early childhood.

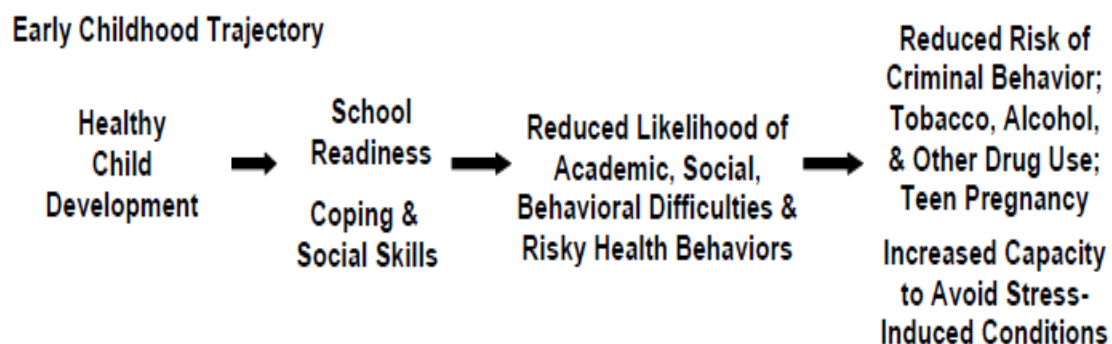
Investment in child health programmes that are available to all children and families is an important starting point when addressing the issues relating to health inequality.

Health inequality is caused by an unequal distribution of resources across families, not only in terms of wealth, but also in living conditions, levels of education, supportive family and community networks, social capital and parenting skills.^{3,51} These influences are evident at the individual and at the societal level and are cumulative over a person's lifetime.

To have an impact on health inequalities and on chronic disease in later life, it is vital to address the social gradient in children's access to positive early experiences. Later interventions, though important, are considerably less effective, and are more costly, where good early foundations are lacking.

Studies from various fields (neurobiology, neurodevelopment, early intervention) show that birth to school age is a crucially important time in brain development and has a profound affect on adult life. During this time children develop the language and cognitive skills required for learning, develop their ability to manage emotions and stress and learn to cooperate with others.

Figure 1: Early Childhood Trajectory



Source: *The Link between Early Childhood Education and Health Economic Opportunity Institute* www.EOonline.org

Figure 1 shows the context for healthy child development and its influence across the life course.

⁵¹ Wilkinson R, Pickett K (2009) *The Spirit Level - Why equality is better for everyone.*

In Ireland, life expectancy at birth for males living in the fifth quintile of most deprived areas is 4.3 years less than that for males living in least deprived quintile (i.e. most affluent areas) (73.7 years vs. 78 years).⁵² For females, life expectancy for those living in the most deprived areas is 2.7 years less than that for females living in the least deprived areas (80 years vs. 82.7 years).

Low birth weight impacts on subsequent health.⁵³ The most important determinant of low birth weight in children is maternal smoking during pregnancy. Nearly 1 in 5 mothers (17.6%) of children in the infant cohort of the Growing Up in Ireland study reported smoking at some stage during their pregnancy. Women from lower income and social-class households and those with lower levels of education were significantly more likely to smoke during pregnancy.⁵⁴

Ireland has one of the lowest national levels of breastfeeding in the world.⁵⁴ Overall, the *Growing Up in Ireland* data show that 56% of women breastfed their child to some extent. However, women of lower income, education and social class were much less likely to breastfeed, and tended to breastfeed for a shorter time.

There is evidence that mental health problems in pregnancy and the post-natal period are associated with adverse outcomes for the child, both in the short term and long term.⁵⁵ Up to 20% of women have mental health problems (including depression anxiety, psychosis, post-traumatic stress disorder) in the antenatal and postnatal periods.⁵⁶ The Irish Maternal Health And Maternal Morbidity in Ireland (MAMMI) study reports a 3-month post natal self-reported prevalence of depression of 17.7%.⁵⁷

Parenting styles are shown to be linked with infant development. Three quarters of mothers (77%) and 68% of fathers of 9-year-olds used an authoritative style of parenting, which is considered the optimal style. Children whose parents used an authoritarian style of parenting (4% mothers and 7% fathers) or an indulgent or permissive style (16% mothers and 20% of fathers) had more social and emotional problems.⁵⁸

⁵² Central Statistics Office (2010). Mortality Differentials in Ireland. Dublin: CSO.

⁵³ Barker DJP (1995) Fetal origins of coronary heart disease. *BMJ*; 1995: 311: 171-174.

⁵⁴ Layte R and McCrory C (2014). Maternal health behaviours and child growth in infancy. Analyses of the Infant cohort of the Growing Up in Ireland study. Dublin: DCYA. Accessed at:

http://www.growingup.ie/fileadmin/user_upload/documents/Maternal_Health_Report/GUI_Infant_Maternal_Health_4_web.pdf

⁵⁵ National Collaborating Centre for Mental Health (2014) Antenatal and Postnatal Mental Health – the NICE guideline on clinical management and service guideline. London. Accessed at: <http://www.ncbi.nlm.nih.gov/books/NBK54487/pdf/TOC.pdf>

⁵⁶ Bauer A, Parsonage M, Knapp M, Lemmi V, Adelaja B (2014) Costs of perinatal mental health problems. London School of Economics and Political Science, London, UK.

⁵⁷ The Silent Morbidities: Early Results of the MAMMI study (Maternal Health And Maternal Morbidity in Ireland) Assessed at:

<http://www.mammi.ie/downloads/Maternal%20Morbidity.pdf>

⁵⁸ Williams J et al. (2009) Growing Up in Ireland: National Longitudinal study of children – The Lives of 9-year-olds. Report 1. Dublin: OMCYA. Accessed at: http://www.growingup.ie/fileadmin/user_upload/documents/1st_Report/Barcode_Growing_Up_in_Ireland_-_The_Lives_of_9-Year-Olds_Main_Report.pdf

Along with poverty, the next most prevalent risk factors for children at risk of experiencing social and emotional problems and of poorer cognitive development are living in social housing and having a lone parent.⁵⁹ In 2011, there were 43,578 households with children in Ireland in need of social housing.³⁴ Nearly 1 in 5 children (18.3%) lived in a lone parent household. This proportion increased to 27.3% for children with a disability.

Parental education, particularly the mother's, is a central factor in a child's early development.^{58, 60} Nearly a third of mothers (31%) of 9-year-old children had achieved an educational level of lower second level school or less; a further 37% had reached Leaving Certificate level while the remaining 32% had achieved a third level qualification.⁵⁸

Hertzman, in his work on early childhood development, sums it up when he says *'The early years last a lifetime. Although this statement can be dismissed as a truism, it is profoundly significant. There is now an impressive body of evidence, from a wide range of sources, demonstrating that early childhood development affects health, wellbeing and competence across the balance of the life course.'*⁶¹

5.1 Cost Effective Investments in Early Childhood

It is known that investment in early intervention initiatives aimed at child development, educational disadvantage and parenting has been shown to provide a greater rate of return than later interventions, with the most effective time for intervention being before birth and in early childhood.^{34, 62, 63, 64, 65}

Conversely, most developed countries spend proportionately more on children as they get older.⁶⁶ This is particularly the case in Ireland.

Within the health and social sphere in Ireland a number of interventions in childhood have been shown to work on improving child and adult health and social outcomes and have been shown to be cost effective.^{67,68}

⁵⁹ Blank L, Baxter S, Messina J, Fairbrother H, Goyder L, Chilott J Summary review of the factors relating to risk of children experiencing social and emotional difficulties and cognitive difficulties. Accessed at:

<http://www.nice.org.uk/resource/7ybbnfvqj4xju6y3a6ibfsw3q4>

⁶⁰ Doyle O and Timmins L (2010) School Readiness Matters: Socioeconomic Inequalities in Early Childhood Skills. Policy Briefing No. 2. UCD Geary Institute. Accessed at: http://www.ucd.ie/geary/static/publications/policybriefings/UCD_Geary_policy_no2.pdf

⁶¹ Hertzman, C. Making Early Childhood Development a Priority: Lessons from Vancouver Canadian Centre for Policy Alternatives May 2004

⁶² National Scientific Council on the Developing Child (2010) The foundations of lifelong health are built in early childhood. Centre on the Developing Child, Harvard University. Accessed at:

http://developingchild.harvard.edu/resources/reports_and_working_papers/foundations-of-lifelong-health/

⁶³ Heckman J and Masterov D (2007) The productivity argument for investing in young children. NBER Working Paper No. 13016.

Accessed at: http://jenni.uchicago.edu/human-inequality/papers/Heckman_final_all_wp_2007-03-22c_jsb.pdf

⁶⁴ Carneiro P and Heckman J (2003) Human Capital Policy. National Bureau of Economic Research Working Paper 9495. Accessed at:

<http://www.nber.org/papers/w9495.pdf>

⁶⁵ Wave Trust (2013) The economics of early years' investment, Appendix 4 in Conception to age 2 – the age of opportunity report.

Accessed at: http://www.wavetrust.org/sites/default/files/reports/conception-to-age-2-full-report_0.pdf

⁶⁶ OECD (2009) Doing Better for Children. Accessed at: <http://www.oecd.org/els/family/doingbetterforchildren.htm>

⁶⁷ Devaney C, Canavan J, Landy F and Gillen A. (2013) What works in Family Support? Dublin: Child and Family Support Agency

Accessed at: <http://www.drugsandalcohol.ie/21893/1/CFAWhatWorksInFamilySupport.pdf>

Interventions can be provided universally, can be targeted to those with greater needs or can provide elements of both. Of those that are targeted, they can be area-based (e.g. in disadvantaged areas), child- or family-based (e.g. child or parent with disability) or targeted at a specific group (e.g. Travellers).

When cost effectiveness studies have been carried out, most such interventions have been found to be cost effective. In general, greater returns have been found for those interventions targeted at families which experience greater adversity. However, there is some evidence that programmes which provide elements of both universal and targeted interventions can have greater returns on investment than more targeted programmes.^{65, 69}

Marmot recommends that the proportion of social expenditure allocated to the early years be increased and that it is focused progressively across the social gradient.³ However, research suggests that unequal access, poor quality or inappropriate programmes can actually increase health inequality.

Reversing the trend towards a higher rate of income deprivation and overall poverty in childhood compared to other age bands may have an impact on children's health, especially where this investment is concentrated on the early years.^{3, 66, 70}

⁶⁸ Rochford S, Doherty N, Owens S (2014) Prevention and Early Intervention in Children and Young People's Services: Ten years of Learning. Dublin: Centre for Effective Services. Accessed at: http://www.effectiveservices.org/images/uploads/PEII_10_Years_of_Learning_Report.pdf

⁶⁹ Washington State Institute for Public Policy (WSIPP) (2012). Return on Investment Evidence-Based Options to Improve Statewide Outcomes: April 2012 Update.

⁷⁰ Adamson P (2014) Measuring child poverty – New league tables of child poverty in the world's richest countries. Innocenti Research Centre, Report Card 10, UNICEF. Accessed at: <https://www.unicef.ie/Downloads/RC10-ENG-web-Final-29May.pdf>

6. National Healthy Childhood Programme

6.1 Introduction

Ireland's child health programme is similar to international models and covers child health reviews, vaccinations and screening. The timing of the contacts differs from country to country.

The service is free to all children and is enshrined in law which provides for the statutory notification of births, the provision of personal health services and the establishment of the various health authorities. These authorities have been tasked with providing those health services over the years since 1907.

The National Healthy Childhood programme covers every child resident in Ireland. The universal nature of the programme facilitates greater acceptability for parents/families as there is equal access for all children. The community-based screening and surveillance service is generally the first service to see the baby in the home environment and plays a critical role in linking with all related child services.

6.2 Providers of the National Healthy Childhood Programme

The totality of the National Healthy Childhood Programme is provided from antenatal stage to the first year in second level school.

1. Hospitals and GPs provide antenatal and post natal care (including two checks for the baby at two and six weeks) as part of the Maternity & Infant Scheme. Access to the service is via completion and submission of an application form to the local health centre.
2. GPs deliver the Primary Immunisation Programme (up to 13 months) and there is free GP care to all children up to six years of age, including growth monitoring at two and five years as part of the GP Under 6 contract. Access to the Primary Immunisation Programme is via automatic notification to the mother from the HSE when notification of birth is received. Parents can go online and register to receive a GP Visit Card for their child in order to receive free GP care for all children under six years.
3. PHNs and Community Health Doctors deliver Child health Screening & Development Surveillance to children from birth to first year in second level school (school immunisations). Access to the service is triggered via notification of birth from the hospital to the PHN, who arranges the first visit within 72 hours of discharge from hospital.

Table 2 shows the number of contacts offered by each part of the overall universal child health & wellbeing programme.

Table 2: National Healthy Childhood Programme – number of contacts

	1. Maternity & Infant Scheme		2. Free GP Care		3. HSE Child Health Immunisation, Screening & Surveillance Service
	a. Hospital	b. GP	a. Primary Immunisations	b. GP Under 6s contract	
Antenatal	6	6	-	-	
0 to 2 years	1 ♣ ♠ ♦	2 (mother & baby)	5	1	4 ♠ ♦
3 to 5 years	-	-	-	1	3 contacts - 1 CHSS Preschool - 1 School Screening - 1 School Immunisation*
5 to 14 years	-	-	-	-	2 (Dental)** 1 Immunisation (+2 HPV Girls)
Total	7	8	5	2	13*

♣ Neonatal Examination & Hearing Screening
 ♠ Newborn Blood Spot Screening can be done in hospital or by PHN
 ♦ BCG (vaccine currently not available)

*GPs in Donegal and Sligo/Leitrim give these immunisations
 **Dental at 2nd/4th/6th class but provision varies between CHOs

The school exit (5th/6th class) contact for vision screening was discontinued 2015 pending the publication of a review by the Primary Care Eye Services Review Group.

6.2.1. Maternity & Infant Scheme

The Maternity & Infant Care Scheme is available free to all pregnant mothers. It is provided by the patient's GP and the hospital. During the antenatal GP visits a range of clinical parameters are recorded on a Combined Obstetric Card which is held by the mother. This card is furnished at each antenatal hospital clinic visit. Mothers are entitled to free inpatient and outpatient public hospital services for the duration of the pregnancy and the birth. Table 3 show the number of contacts and the time of each contact.

Table 3: Number of contacts-Maternity & Infant Scheme

Number of Weeks of Pregnancy	GP Contacts	Maternity Hospital/unit Contacts
Before 12 weeks	√	-
Before 20 weeks	-	√
24 weeks	√	-
28 weeks	√ (except in case of 1 st pregnancy)	√ (in case of 1 st pregnancy)
30 weeks	√	-
32 weeks	-	√
34 weeks	√	-
36 weeks	-	√
37 weeks	√	-
38 weeks	-	√
39 weeks	√	-
40 weeks	-	√
Birth	-	√
2 weeks for baby	√	-
6 weeks for mother and baby	√	-
Total	8	7

The GP contract is between the HSE and the GP to provide medical and surgical services to mothers and infants under Section 62 and 63 of the Health Act 1970 and payment is made by the HSE to the GP upon receipt of a completed form that shows the number of visits completed.

The scheme is administered through community services in each CHO area. While the contract states that the GP should submit information pertaining to the 2-week and 6-week post natal visits, in practice this information is not submitted.

There is a section on the application form where the applicant can tick if they wish to receive information in the antenatal period from the PHN but anecdotal evidence suggests that this is not availed of and is not standard practice across the country. Data from the scoping study, carried out as part of the Nurture Programme-Infant Health & Wellbeing, shows that over two-thirds of PHNs areas do not receive any information from the Maternity & Infant Scheme which would enable an antenatal contact.⁷¹

The new Maternity Strategy (2016) has a number of actions for completion by the HSE with respect to the Maternity and Infant Scheme. These include a review of the scheme, the option to add additional contacts, the centralisation of the scheme under the Primary Care Reimbursement Service (PCRS) and the development of a detailed GP dataset to support the monitoring and evaluation of the scheme.²³ This will provide the opportunity to develop closer links between the Maternity

Action 5
The National Healthy Childhood Programme in the Health & Wellbeing Division will support the National Maternity Strategy Actions 62-66 regarding the Maternity & Infant Care Scheme

⁷¹ Marsden, P. Report 6: Analysis of the Director of Public Health Nursing Questionnaire from the Nurture Programme Scoping – Ante and Post Natal Services Version 1 July 2016 Copy on file

and Infant Scheme and other aspects of the child health programme in particular the potential to share data from the Maternity and Infant Scheme with community services in order to facilitate contact in the antenatal period.

6.2.3 Free GP Care

2a. Primary Immunisation

Immunisation programmes are one of the central aspects of most child health programmes. In Ireland there are three immunisation programmes relevant to child health:

1. Vaccines recommended pre-conception – MMR; in the antenatal period - influenza and pertussis (pertussis vaccine can also be given in the first post natal week)
 - These vaccines are available free of charge. GPs charge a fee to non-medical and non-GP visit card holders for administration of influenza and MMR vaccines. GPs charge all a fee for administration of pertussis vaccine.
2. The Primary Childhood Immunisation (PCI) schedule for children is administered at birth, two, four, six, twelve and thirteen months.
 - Free to all children and delivered in GP practices mainly by practice nurses, with GPs contracted and incentivised to provide the service
3. The school immunisation programme – 4:1 booster and second dose MMR at junior infants; MenC and Tdap and HPV vaccine (girls only) at first year in second level schools.
 - Free to all children and delivered by the HSE child health schools programme (GP delivered in Sligo/Leitrim and Donegal)

The Primary Childhood and School Immunisation Programmes are coordinated by the HSE National Immunisation Office and some HSE areas have an Immunisation Officer who works with the GPs in that area to ensure that targets are met with regard to the full schedule of immunisations.

Table 4: Number of contacts in the Primary Childhood and School Immunisation Schedules

Primary Childhood Immunisation Schedule for Babies born after 1st October 2016	
Age	Vaccine
Birth	BCG (vaccine currently not available)
Two months	6 in 1 + PCV+ MenB + Rotavirus
Four months	6 in 1 + MenB + Rotavirus
Six months	6 in 1 + PCV + MenC
Twelve months	MMR + MenB
Thirteen months	Hib/MenC + PCV
School Immunisation Schedule	
Four/five years-junior infants	4 in 1 booster; 2 nd dose MMR
Twelve to fourteen-first year second level school	Tdap and MenC boosters Girls only are given 1 st and 2 nd doses HPV

National Immunisation Advisory Committee recommend school vaccination for 12 -13 years – first year in second level schools – however in reality, all children in first year are vaccinated so the age range can vary from 12 –14 years.

Performance indicators (PIs) for the service are monitored as part of the HSE national performance indicator suite:⁷²

- % children aged 24 months who have received 3 doses of the 6 in1 vaccine
Target 95% uptake Reported on a quarterly basis
- % children aged 24 months who have received the Measles, Mumps, Rubella (MMR) vaccine
Target 95% uptake Reported on a quarterly basis
- % of first year girls who have received two doses of HPV vaccine
Target 85% Reported on an annual basis

2b. GP Under 6s Contract

All children under six years are now entitled to free GP care. This is seen as the first step in the delivery of the Governments health policy, to provide universal GP care.⁷³ This includes two ‘Periodic Assessments’ at 2 and 5 years (growth monitoring) and scheduled programme of care for children with asthma. This is in addition to the existing two and six-week postnatal checks, as part of the Maternity & Infant Scheme.

Periodic Assessments are age based preventive checks focused on health and wellbeing and prevention of disease. The GP records the age, gender, weight and height of the child at aged two and five years, and plots it on a centile chart, provides health promotion advice, brief intervention and support, or referral to specialist services.

6.2.4 HSE Child Health Screening & Surveillance Service

The HSE provides child health screening & surveillance in the community. Access to the service is triggered by the mandated birth notification from delivery services (usually maternity hospitals) to community services (PHNs). Under the current arrangement the child will have four contacts with the service between 0 and 2 years and three contacts between 3 and 5 years. Further intervention required as a result of problems identified by screening and surveillance are provided free of charge. In fulfilling their child protection role PHNs maintain a close working relationship with the Child & Family Agency (Tusla).

The community services (PHN and Community Medical Doctors) are committed to providing child health services. However the capacity of the service to deliver has been

⁷² Accessed at: <http://www.hse.ie/eng/services/publications/corporate/serviceplans/nsp16.pdf>

⁷³ <http://www.hse.ie/eng/about/Who/gmscontracts/under6GPcontract/explanatorynote.pdf>

challenged in recent years by a reduction in resources, competing priorities and in particular pressure from acute hospital services. The increase in the number of babies born and the increasing demand for clinical nursing services for children with long term conditions are also key factors.

Child health reviews, screening and surveillance are carried out by PHNs and Community Medical Doctors in some areas, while in other areas the service is PHN-led with secondary referral to Community Medical Doctors. A child health service is also provided in schools by PHNs and Community Medical Doctors and covers screening, surveillance and vaccinations, with some areas having dedicated School Health and Immunisation teams.

The current model for the delivery of the HSE-delivered child health programme is Best Health for Children Revisited (2005).⁵ A comprehensive review of the development and implementation of BHFC is available in the evidence review.¹ Table 5 sets out the current contacts.

Table 5: Current number of contacts in the child health screening and development service

No. of Contacts	Timing of Contact
1.	Neonatal examination (generally in the hospital, except for home births)
2.	1 st Postnatal visit (within 72 hours of discharge from hospital)
3.	3 months contact
4.	7 to 9 months contact
5.	18 to 24 months contact
6.	39 to 42 months (3.25 to 3.5 years) contact
7.	48 to 60 months (4 to 5 years) (School Entry Junior Infants)

The school exit (5th/6th class) contact for vision screening was discontinued 2015 pending the publication of a review by the Primary Care Eye Services Review Group.

PIs for the service are monitored as part of the HSE national performance indicator suite:

- % of newborn babies visited by a PHN within 72 hours of discharge from maternity services
Target 97% Reported on a quarterly basis
- % of children reaching 10 months within the reporting period who have had child development health screening on time or before reaching 10 months of age.
Target 95% Reported on a monthly basis
- % of first year girls who have received two doses of HPV vaccine
Target 85% Reported on an annual basis

Services for children with specific social care needs can be provided by statutory and voluntary providers (funded from the public purse).

Dental Services

The 1994 Dental Health Action Plan, arising from Shaping a Healthier Future (DoH 1994) is the current policy for Irish Oral Health Services although a new policy is currently being developed to replace it. The public dental service is provided by staff employed by the HSE. The service is provided free of charge to children up to sixteen years. The school dental screening programme will see children in second or fourth or sixth class. Screening visits are not provided by all HSE areas at all three contact points but all areas strive to provide at least two school screening visits.⁷⁴

Child and Family Agency

The Child and Family Agency has primary responsibility for child protection and welfare; the provision of alternative care and provides targeted family and community supports. The Agency is also responsible for inspecting pre-schools, play groups, nurseries, crèches, day-care and similar services which cater for children aged 0-6 years, which are important early environments for children.⁷⁵ All HSE staff are mandated to implement the Children First Guidelines.⁷⁶

A large number of non-governmental organisations provide targeted services to children and their families, such as parenting support, education programmes and health-related programmes.

Appendix 2 shows all of the current contacts provided as part of the National Healthy Childhood Programme.

6.3 Updating the National Healthy Childhood Programme

The time is opportune to review and update the current model BHFC⁵ to take account of the changing policy and strategic context. Notable developments include the implementation of the newborn hearing screening programme, the emerging evidence on developmental surveillance and the ever increasing body of evidence highlighting the effectiveness of interventions that both promote health and prevent adverse outcomes.

The HSE is tasked with the delivery of many of the objectives in current child health-related policy -Healthy Ireland, Better Outcomes Brighter Futures and actions outlined in the new Maternity Strategy.^{2, 77, 23} The Health & Wellbeing Division has prioritised the child health agenda for strategic development and the *Healthy Childhood* programme is

⁷⁴ Department of Health Dental Health Action Plan 1994 Accessed at: <http://lenus.ie/hse/bitstream/10147/81261/1/DentalHealthActionPlan94DOHC.pdf>

⁷⁵ Accessed at: <http://www.tusla.ie/services>

⁷⁶ <http://www.dcyh.gov.ie/documents/Publications/ChildrenFirst.pdf>

⁷⁷ Implementation Plan for the first phase (2014-2017) of Better Outcomes, Brighter Futures: The National Policy Framework for Children and Young People, 2014-2020 Department of Children and Youth Affairs September 2015

one of policy priority programmes in Healthy Ireland. The Nurture Programme-Infant Health and Wellbeing is a key enabler to the implementation of the National Healthy Childhood Programme.

In mid-2014 a Child Public Health Group was established and undertook a review of the evidence base for the delivery of BHFC. This provided the ground work for the National Steering Group for the Revised Child Health Programme which was established in October 2014. The steering group identified areas that required further review and subgroups were established (developmental dysplasia of the hip, enuresis, health promotion, infant mental health, developmental surveillance) to carry out this work. The output, to date, from these groups is reflected in the framework presented here.

It is acknowledged that the development of services is within a wider health and wellbeing agenda and that the wider determinants of health play a significant part in child and adult health.

6.4 Principles of the National Healthy Childhood Programme

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.'*⁷⁸ While having its roots in social justice and social policy it now underpins child health programmes in other countries.^{79,80} It will underpin the proposed Department of Children and Youth Affairs *Early Years Strategy*⁸¹ and is a goal of *Better Outcomes Brighter Futures*.²⁵

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.

Principles:

1. All children will have access to defined core (universal) services as underpinned in legislation. There will be supports provided for those identified as requiring extra support or additional services, including children with disabilities (progressive/proportionate universalism).

⁷⁸ The Agenda for Children's Services: A Policy Handbook Office of the Minister for Children Department of Health and Children December 2007

⁷⁹ Healthy Child Programme: pregnancy and the first five years of life Department of Health October 2009 Accessed at: <http://www.rcpch.ac.uk/hcp>

⁸⁰ Health for All Children 4: Guidance on Implementation in Scotland Getting it right for Scotland's children Scottish Executive Edinburgh 2005 Accessed at: <http://www.gov.scot/Publications/2005/04/15161325/13269>

⁸¹ Right from the Start Report of the Expert Advisory Group on the Early Years Strategy Department of Children and Youth Affairs September 2013

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2. All children will have access to high quality integrated services.
 3. Recognises the importance of antenatal care on longterm maternal, child and adult health and the impact of good mental and emotional child and maternal health on longterm child and adult health.
 4. Takes into account children's and adults long-term needs and interests as well as children's immediate needs by recognising the importance of early childhood development.
 5. All parents will be made aware of the right to universal child health screening and surveillance services. The HSE will promote, support and enable access to the universal child health service.
 6. It will empower parents as the primary educators during the critical early years of a child's development.
 7. The programme will be evidence-based with a focus on prevention and early intervention (screening and surveillance including health promotion strategies and interventions).
 8. The model will be underpinned by a clinical governance framework (regional and national) which supports the provision of quality services by:
 - a. Ensuring integrated care for children via clear referral pathways and formalised networks
 - b. Enabling a culture of continuous quality improvement
 - c. Providing appropriate professional training to the level of competency required
 9. An information system that supports parents to avail of and professionals to deliver the child health service. The implementation of the National Immunisation and Child health Information System (NICIS) will be a key enabler to services in reviewing their practice and service delivery and for better integration/communication between service providers (general practice, paediatric services, child & family services).
 10. Recognises the importance of sharing of information with parents. Information on their child's health status at all contact points is important for parent empowerment and improved interaction between services.

The implementation of the National Healthy Childhood Programme will seek to ensure the most effective use of current resources, including minimising duplication in order to enable the efficient delivery of the programme across care settings. The programme will align with current HSE policies in respect of staff engagement. While the Department of Health, the Department of Children and Youth Affairs and Tusla are represented on the

National Steering Group, separate and ongoing engagement is also in place to ensure cross-departmental synergies are identified and promoted to ensure best outcomes for children.

7. Implementing the National Healthy Childhood Programme

In order for the implementation of the National Healthy Childhood Programme to be effective a sustainable infrastructure must be developed. This involves reviewing and developing the structures and processes that underpin the delivery of the programme; developing, improving and sustaining the staff competency; developing environments (policies, partnerships and funding streams) to support the programme.

The capacity to deliver the 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 and lack of integration/communication between service providers. It was clear from the range of services currently provided to all children in the State that a review of Best Health for Children 2005 should take cognisance of the totality of the child health service and seek to build on current synergies in the system or establish links where they do not exist in order to provide a more cohesive service for the child (child centered care).

The National Healthy Childhood Programme builds on current strengths within the system and is based on a review of the evidence base for child health programmes. Delivering the programme to a model of progressive universalism means that children and family needs will be assessed and services to meet those needs put in place. While many CHO areas are using standardised assessment tools, national agreement on a common tool is required.

The National Healthy Childhood Programme is explicit about the health and wellbeing agenda, including the emerging evidence in relation to effective strategies to tackle health inequalities. There is a stronger focus on health promotion and improvement. It outlines the key components of a child health programme, including the actions required to develop and sustain the programme into the future.

7.1 Advocacy

Positive early childhood experiences impact on children's health, and on their future health as adults. While many of the influences on children's health and wellbeing lie outside the health domain, the health services also have an important role to play.

Action 6

The National Healthy Childhood Programme will develop an advocacy role, within the HSE and with relevant professional bodies, policy makers and the public, to promote the importance of effecting positive change in children's health and wellbeing.

In health, as in other public policy areas, urgent problems catch the limelight. It is often difficult to focus on opportunities for prevention and to measure positive experiences, especially those which are long-term, such as those from early childhood interventions.

The National Healthy Childhood Programme will address this issue by developing an advocacy role, within the HSE and with relevant professional bodies, policy makers and the public, to promote the importance of effecting positive change in children's health and wellbeing.

7.2 Structures for Delivery and Governance

The Health & Wellbeing Division is establishing a standardised approach to the implementation of all six national priority programmes outlined in the HSE Healthy Ireland Implementation Plan. The structure for implementation will see a programme team and a national implementation group established for each priority programme.

In this context a **National Implementation Group** for the implementation of the *Healthy Childhood* programme will be established. The implementation of the required changes and their full integration into routine practice will be the goals of the National Implementation Group. The tenure of the group will be 2-3 years and will be chaired by the Healthy Childhood Programme lead and reporting to the National Director Health & Wellbeing Division. The implementation will be in stages.

Action 7
A National Implementation Group for the National Healthy Childhood Programme, with cross divisional representation, will be established. The tenure of the group will be 2-3 years and will be chaired by the Healthy Childhood Programme lead and reporting to the National Director Health & Wellbeing Division.

The work completed to date by the Child Public Health Group, the various subgroups of the National Steering Group and the scoping of current services carried out as part of the Nurture Programme represent a considerable body of the exploratory and planning activities required to update the current programme.

The National Steering Group for the Revised Child Health Programme will continue to provide programme oversight and the Child Public Health Group will continue to provide expert support to the national implementation group and National Steering Group.

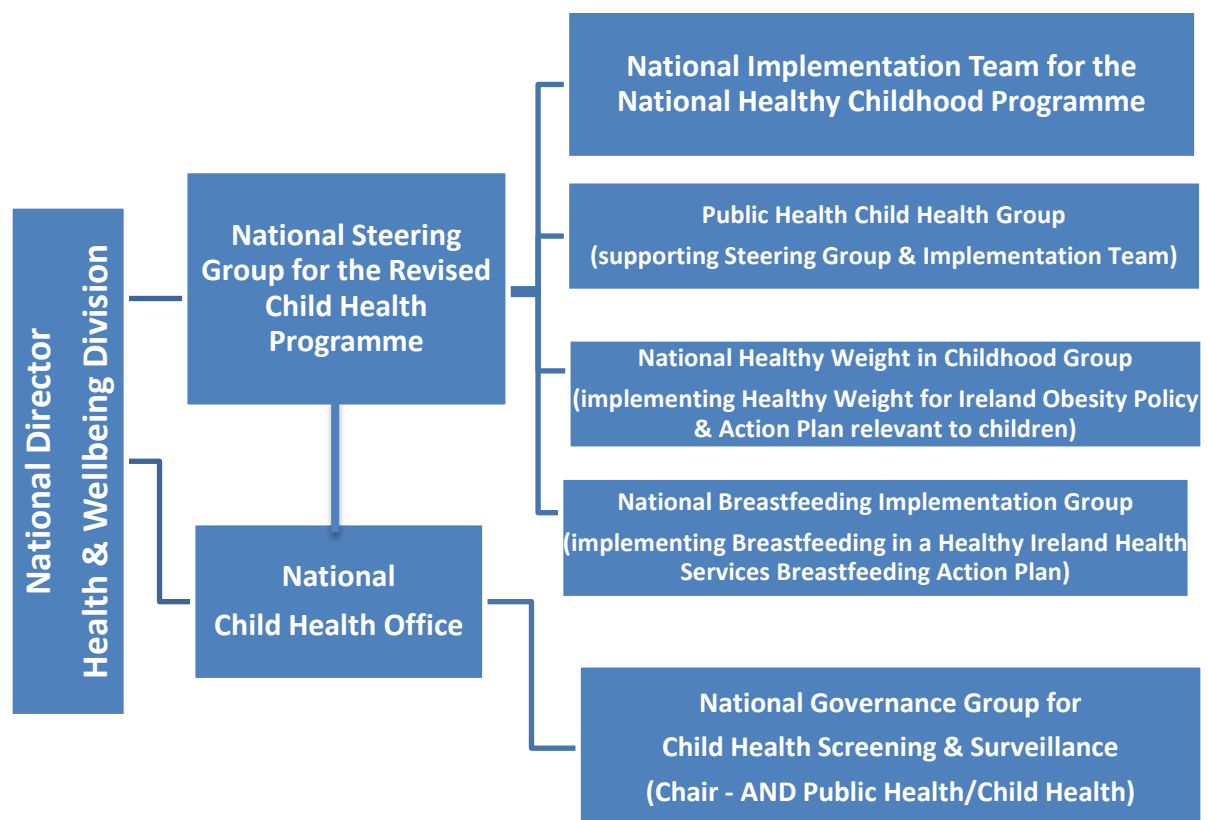
Two other significant policy and strategy related work programmes came under the stewardship of the National Healthy Childhood Programme in 2017. In 2016 the HSE launched Breastfeeding in a Healthy Ireland Health Services Breastfeeding Action Plan

2016-2021.⁸² A National Breastfeeding Implementation Group has been established and is tasked with developing an implementation plan and working with the relevant HSE divisions to ensure its implementation.

The launch of the DOH obesity policy and action plan in 2016 has placed a renewed emphasis on prevention and the importance of maintaining a healthy weight in children.⁸³

The Healthy Eating & Active Living Policy Priority Programme(HEAL) (from Healthy Ireland) is tasked with the implementation of the action plan in the HSE. The National Healthy Childhood Programme is working in partnership with HEAL to establish the Healthy Weight in Childhood Group. This group is tasked with the development of a healthy weight in children promotion and prevention programme.

Figure 2: National structures for implementation and oversight of the National Healthy Childhood Programme



⁸² Breastfeeding in a Healthy Ireland Health Services Breastfeeding Action Plan 2016-2021 Health Service Executive Accessed at: <https://www.breastfeeding.ie/Uploads/breastfeeding-in-a-healthy-ireland.pdf>

⁸³ A Healthy Weight for Ireland Obesity Policy and Action Plan 2016-2025 Department of Health 2016 Accessed at: <http://health.gov.ie/blog/publications/a-healthy-weight-for-ireland-obesity-policy-and-action-plan-2016-2025/>

7.2.1 Governance

As previously outlined (Section 6.2) there are many providers of the overall National Healthy Childhood Programme. Those aspects provided by the hospital groups (generally the antenatal and newborn contacts) come under the corporate and clinical governance structures at hospital group and individual hospital level. Governance of the primary and school immunisation contacts and the screening and surveillance contacts rests with Primary Care within the CHO.

Table 6: Current Governance Structures

Programme	Governance Structure
1. Maternity & Infant Scheme	
a. Hospital	Individual hospital and hospital group via KPI monitoring and risk management
b. GP	Individual GP practices No national KPIs or monitoring system in place
2. Free GP Care	
a. Primary Immunisations	Individual GP practices Nationally through the HSE National Immunisation Office for monitoring of KPIs and policy implementation. KPIs are reported by the Health & Wellbeing Division.
b. GP Under 6s contract	Individual GP practices National KPIs are not yet agreed for this contract. Of particular relevance are the ' <i>Periodic Assessment</i> ' visits at two and five years
3. HSE Child Health Immunisation, Screening and Surveillance	Clinical governance rests with Primary Care, within the CHO structure. Monitoring is carried out, at CHO and national level, of agreed KPIs for certain screening, immunisation and surveillance contacts. From 1 st January 2017 these KPIs are monitored and reported by the Primary Care Division.

At a national level the development and monitoring of child health service falls within the remit of the Health & Wellbeing and Primary Care Divisions. The Health & Wellbeing Division's remit is mainly in terms of policy implementation, strategic development, guidance and advice and includes monitoring of performance against health indicators (immunisations only). Operationally the delivery of child health service continues through the Primary Care Division, under the new HSE structures of nine Community Health Organisations. The child health budget, apart from the vaccine procurement, is mainly held within the Primary Care structure.

The National Healthy Childhood Programme will implement HSE guiding principles for quality and patient safety in order to ensure compliance with best practice standards to minimise risk and prevent clinical incidents.

The HSE Quality Improvement Division describes formal governance as systems where everyone is aware of their responsibilities, authority and accountability and work towards achieving better patient outcomes. It states that '*effective governance recognises the*

*inter-dependencies between corporate and clinical governance across services and integrates them to deliver high quality, safe and reliable healthcare.*⁸⁴

It further defines clinical governance as ‘*a framework through which healthcare teams are accountable for the quality, safety and satisfaction of patients in the care they deliver. It is built on the model of the chief executive officer/general manager or equivalent working in partnership with the clinical director, director of nursing/midwifery and service/professional leads. A key characteristic of clinical governance is a culture and commitment to agreed service levels and quality of care to be provided.*’

The key elements in all of these definitions are

- Accountability
- Quality of care

The HSE Quality Improvement Division provides five key areas for consideration when implementing systems to enhance quality and patient safety⁸⁵

1. Leadership, governance and management
2. Person-centred care
3. Safe care
4. Effective care
5. Better health and wellbeing

The National Implementation Group will develop and implement a national governance structure for child health services. This will reflect the new service delivery structures at hospital and CHO level and will support the CHOs and hospital groups in delivering ‘*improved governance for child health services*’ as

outlined in the HSE Healthy Ireland Implementation Plan. (See Action 106 Policy Priority Programme - Healthy Childhood - Appendix 1).

Action 8
The National Implementation Group will develop and implement a national governance structure for child health services that supports current CHO and hospital group governance structures

Action 9
The Health & Wellbeing Division will work in partnership with the Primary Care Division to develop a structure for the ongoing delivery of the National Healthy Childhood Programme at CHO level

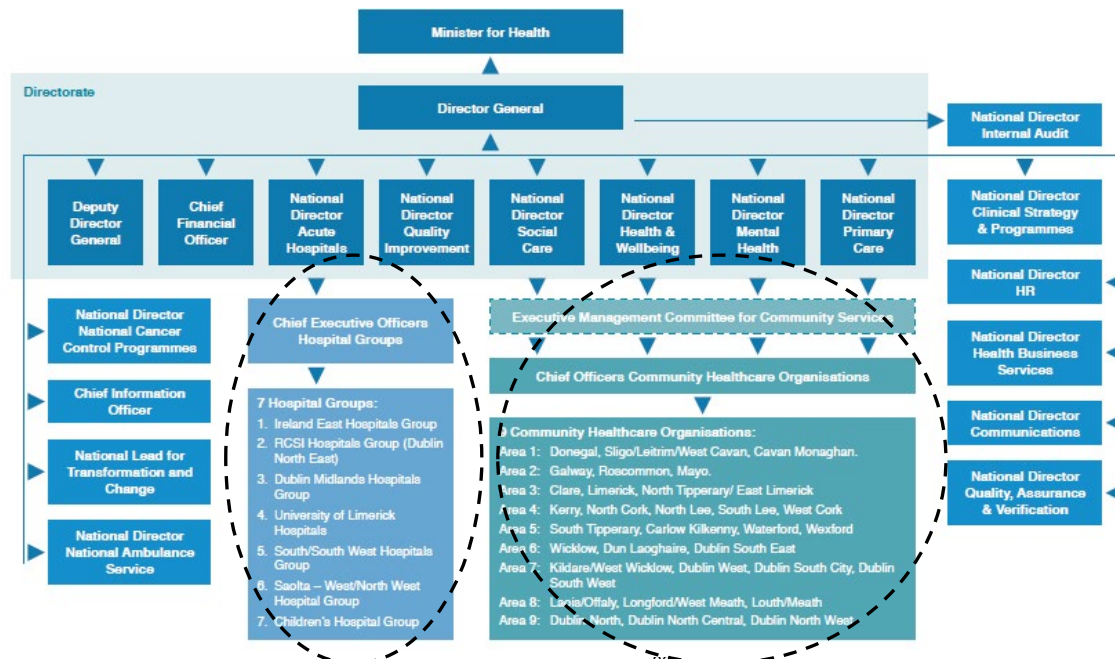
Action 10
The National Implementation Group will use existing networks to progress child health at an intersectoral level, for example Local Community Development Committees (LCDCs) and Children and Young People Services Committees (CYPSCs)

⁸⁴ http://www.hse.ie/eng/about/Who/qualityandpatientsafety/Clinical_Governance/CG_docs/clingovinformleafletFeb2012.pdf

⁸⁵ http://www.hse.ie/eng/about/Who/qualityandpatientsafety/Clinical_Governance/CG_docs/QS_prompts.pdf

The overall HSE governance structure is shown in Figure 2. Of relevance to child health services are the sub structures established at hospital group and CHO level.

Figure 3: HSE Governance Structure



Source: Health Service Executive Code of Governance⁸⁶

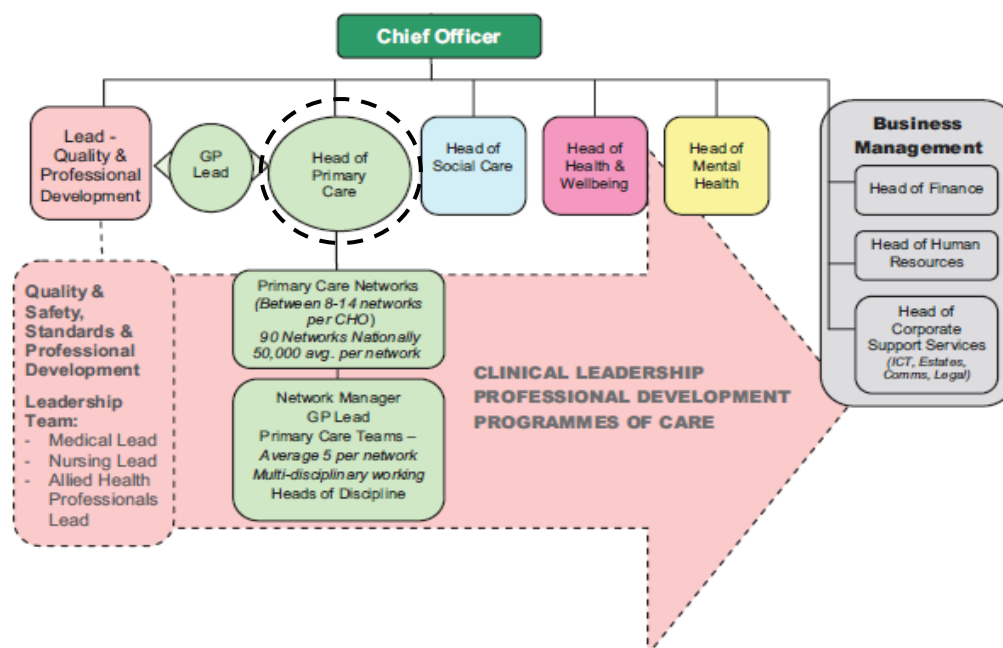
The national leadership team of the HSE is currently being transformed with the addition of three new posts

- The Chief Operations Officer will be responsible for Acute Hospitals, Community Care (Primary Care, Social Care and Mental Health), National Ambulance Services, Primary Care Reimbursement Services (PCRS) and the Special Delivery Unit (SDU).
- The Chief Strategy and Planning Officer will have overall responsibility for strategic planning and overseeing the ongoing programme for health services improvement.
- The National Medical Director will assume responsibility for the clinical programmes and quality improvement functions, including the Women and Infant Health Programme.

The operational role of National Directors for Primary Care, Mental Health, Social Care and Health & Wellbeing will transition to the Chief Operations Officer and the strategic aspects will transition under the Chief Strategy and Planning Officer.

⁸⁶ <http://www.hse.ie/eng/about/Who/directoratemembers/codeofgovernance/governance.html>

Figure 4: HSE CHO Structure



Source: <http://www.hse.ie/eng/services/publications/corporate/CHORreport.html>

As outlined in Figure 4 the Heads of Service for Primary Care and Health & Wellbeing report to the Chief Officer in each health CHO area, this includes accounting for overall budgetary performance. The Heads of Service for Primary Care or Health & Wellbeing will have overall responsibility for child health services in the CHO area. The allocation of work portfolios rests with the Chief Officer in each CHO area.

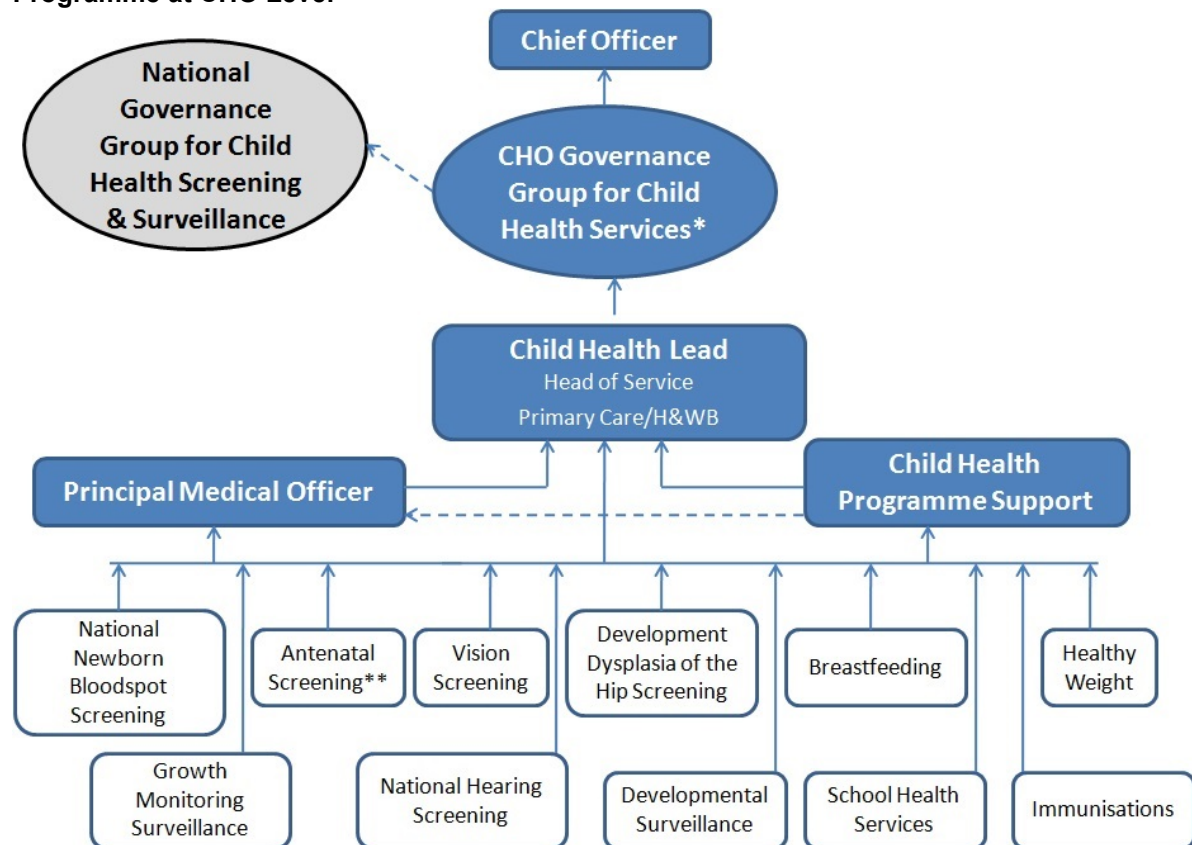
The Principal Medical Officer will be the lead clinician for child health, accountable to the Head of Service Primary Care/Health & Wellbeing for the quality of care provided.⁸⁷ Each practitioner providing the child health programme is responsible for their clinical practice, under the scope of practice for their profession, and must ensure that they are trained to deliver the programme to the required standards. See Figures 5.

Table 7 outlines the suggested membership of the CHO Child Health Governance Group. Draft Terms of Reference are available Appendix 7.

Action 11
Each CHO and hospital group will establish an integrated governance structure for child health services, in line with Action 106 of the HSE Healthy Ireland Implementation Plan

⁸⁷ Recommendations of Community Medical Review Revisited by PMO Group May 2014 (copy on file)

Figure 5: Proposed Clinical Governance Structure for the National Healthy Childhood Programme at CHO Level



*See Table 7 below for suggested membership of the CHO Governance Group for Child Health Services.

** Antenatal Screening is mainly carried out in hospitals, some follow up in the community may be required.

Table 7: Suggested membership of the CHO Child Health Governance Group

<p>The suggested membership, under the Chairmanship of the Child Health Lead, includes:</p> <ul style="list-style-type: none"> - Chairperson - CHO Child Health Lead (Head of Service Primary Care or Health and Wellbeing) - Head of Service Primary Care or Health and Wellbeing (whichever person is not chairing) - Principal Medical Officer - Directors of Public Health Nursing - Community Medical Doctor - Specialist in Public Health Medicine - Allied Health Professionals – to be decided by Group - General Practice - Practice Nurse Co-ordinator or representative - Child Health Programme Support person - Community Paediatrician - Others as determined by the Governance Group, for example, representative from the relevant hospital group/s, representative from the disability and mental health services
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7.3 Processes for delivery of the National Healthy Childhood Programme

7.3.1 Referral Pathways

As outlined in Section 6.2 access to the child health screening and surveillance service is triggered by notification of the birth from the hospital to the PHN. The service is offered to all children (universal) and is free of charge.

In many CHO areas the child health service is PHN-led with onward referral to the Community Medical doctor for further review and assessment at second-tier clinics. This is the preferred framework for delivery of the programme and will require ongoing engagement with PHNs and Community Medical doctors to ensure its implementation nationally. The Paediatric & Neonatology Clinical Programme is supporting the role of the community medical doctor in the context of the delivery of the Paediatric Model of Care.

The pending Department of Health policy to provide direction on the future provision of nursing and midwifery services in the community, the implementation of the community midwifery model from the new Maternity Strategy⁸⁸ and the recommendations from Early Years Strategy, due to be published by the Department of Children and Youth Affairs, will also influence this framework.

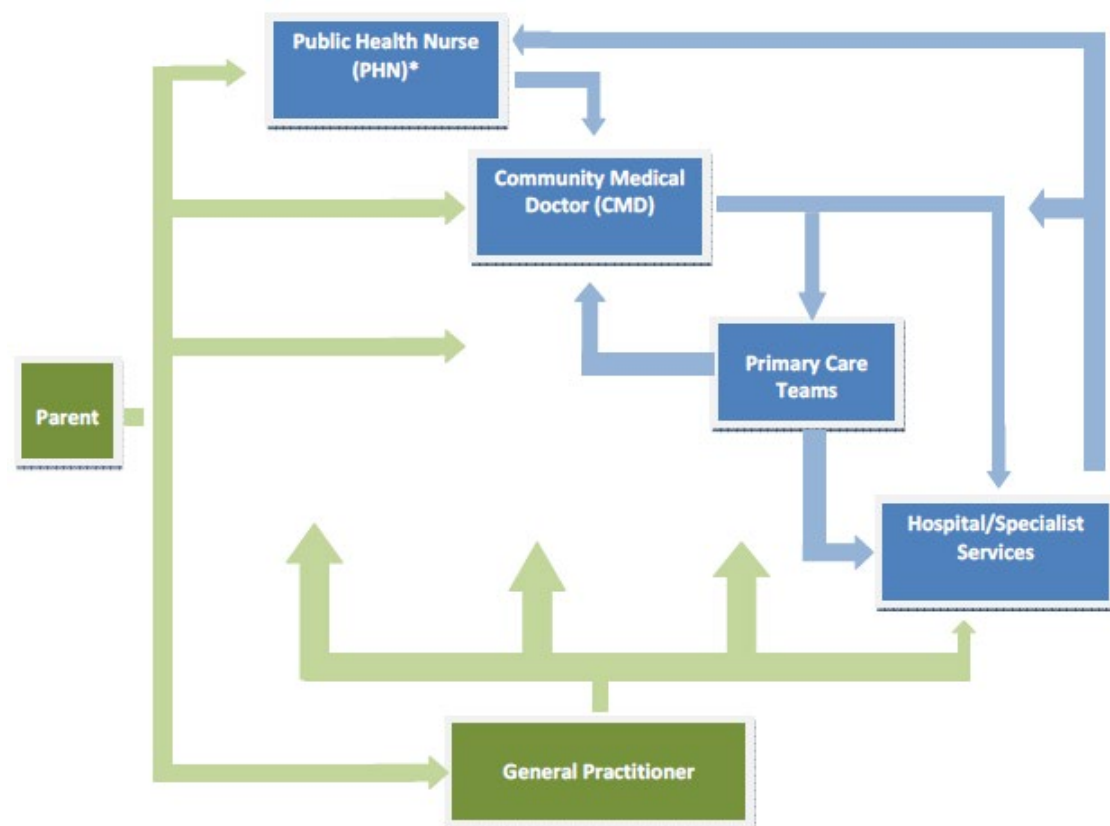
Figure 6 below shows the trajectory for the care pathways and the current referral pathways for parents and GPs. The preferred care pathway is from the PHN to the Community Medical Doctor with onward referral to Primary Care Teams and/or Specialist or Hospital Services. It is acknowledged that in certain circumstances the PHN will refer directly to the GP or the Primary Care Team. Clearly defined pathways will be developed to support the delivery of screening and surveillance services.

⁸⁸ Relevant Actions from the National Maternity Strategy 2016-2026

9. A hospital outreach, community midwifery service will be developed; this service will be provided by a team of midwives, within a broader multidisciplinary team, and will rotate between the community and hospital, offering continuity of care(r) that supports the woman through all stages of pregnancy, childbirth and postnatal care.

10. The National Women & Infants Health Programme will ensure a co-ordinated approach between the community midwifery team and the public health nursing and general practice services, to support postnatal women and new babies in the community.

Figure 6: Framework for the delivery of the National Healthy Childhood Programme



Referral Pathway

Care Pathway

* PHN who recognises acute medical issue can refer parent directly to the GP
Depending on care pathway the PHN can refer to Primary Care Teams

7.3.2 Child Health Contacts

In the current child health programme there are twenty-two contacts available to all children (universal).

- 2 contacts as part of the Maternity & Infant Scheme at two and six weeks
- 5 contacts as part of the Primary Immunisation schedule
- 2 contacts as part of the GP Under 6 contract for periodic assessment at 2 and 5 years
- 13 contacts as part of the community based child health screening and surveillance service

The child receives one or more elements/components of the programme at these contacts for example screening, vaccination or child health review. (See Section 7.3.3)

A review of the child health systems in a number of countries shows the commonalities and the differences across both the delivery and content of these systems. All include immunisations, screening and child health reviews. However differences exist in the

delivery and content.⁸⁹ Overall there is no clear evidence pointing to one set number of minimum contacts or to the specific optimum timing of those contacts.

The review of BHFC has provided the opportunity to reflect on the current timing of contacts in the community based child health screening and surveillance service within the context of the emerging evidence. Reviews of the evidence carried out by the Child Public Health Group¹ and outputs from the subgroups on Infant Mental Health, Health Promotion, Developmental Surveillance, Enuresis and Developmental Dysplasia of the Hip have all contributed to this update.

Changes are proposed with respect to the timing of three of the child health screening and surveillance contact points (delivered by HSE community based child health screening and surveillance service):

- The contact at 7 to 9 months
- The contact at 18 to 24 months
- The contact at 3¼ to 3½ years
- The contact at 4 to 5 years (will still be delivered in Junior Infants)

The timings are revised based on:

1. The evidence base for screening in the antenatal period, newborn bloodspot screening, newborn hearing, vision and developmental dysplasia of the hip (DDH) screening
2. The crucial time periods in a child's development
3. The way in which antenatal and postnatal services are currently organised and provided by different providers (hospitals, GPs and PHN/Community medical officers).

It is proposed to develop an additional contact, at the antenatal stage. The Nurture Programme Antenatal to Postnatal Implementation Team will collaborate with the HSE Women & Infants Health Programme and the Primary Care Division to scope out the requirements in terms of content and delivery. The team will engage with Higher Education Institutes in relation to future training needs of PHNs.

Action 12
The Nurture Programme
Antenatal/Postnatal
Implementation Team will scope out
the requirements to deliver the
antenatal contact, including the
identification of additional
resources required and engage with
Higher Education Institutes where
appropriate

⁸⁹ Wood, R. Blair, M. A comparison of child health programmes recommended for preschool children in selected high-income countries Child: care, health and development 2014; Volume 40: Issue 5: pages 640-653

Table 8 shows there will be twenty three potential contact points in the National Healthy Childhood Programme. A summary of the proposed changes to some of the child health screening and surveillance contact points are as follows:

- A new antenatal contact will be developed
- Primary visit within 72 hours – no change
- 3 month visit – no change
- 7 to 9 months contact will change to 9 to 11 months
- 18 to 24 months contact will change to 21 to 24 months
- Preschool - 3¼ to 3½ years contact will change to 3.8 to 4 years (46 to 48 Months)
- School – change to 4½ to 5 years , the contact will still be at Junior Infants, the revised age bracket takes account of average age of children in Junior Infants

There may be changes to the other contacts in the future. For example, as a review of the Maternity & Infant Scheme is recommended in the Maternity Strategy the two current GP contacts (at 2 and 6 weeks) could change. The number and timing of the immunisation contacts could also change in the future.

Table 8: The revised child health contact points

Contact No.	Age		Type of Contact	Provider
		Antenatal		Maternity & Infant Scheme – Hospital (7 visits)
			Maternity & Infant Scheme – GP (8 visits)	GP
1			<i>New Antenatal Contact to be developed</i>	<i>PHN**</i>
2	Weeks	0	Neonatal Exam/Bloodspot Screening/Hearing Screening/BCG*	Hospital
3		1	1a Child Health Screening & Surveillance/Bloodspot Screening/BCG*	PHN**
			1b BCG*	Community Medical Doctor
4		2	Maternity & Infant Scheme	GP
5		6	Maternity & Infant Scheme	GP
6	Months	2	Immunisation 6 in 1 +PCV + MenB + Rotavirus	GP
7		3	Child Health Screening & Surveillance	PHN**
8		4	Immunisation 6 in 1 + MenB + Rotavirus	GP
9		6	Immunisation 6 in 1+PCV + MenC	GP
10		9	Child Health Screening & Surveillance	PHN**
		10		
		11		
11		12	Immunisation MMR + MenB	GP
12		13	Immunisation MenC+Hib + PCV	GP
13		21	Child Health Screening & Surveillance	PHN**
		22		
		23		
		24		
14	Years	2.25	Periodic Assessment	GP
		2.50		
		2.75		
		3.00		
15	3.80	Child Health Screening & Surveillance	PHN**	
	4.00			
16 & 17	4.50	Child Health Screening & Surveillance – Schools Including immunisation – 4 in 1 booster and 2 nd dose MMR	PHN**	
	4.75			
	5.00			
18	5.00 to 6.00	Periodic Assessment	GP	
19 & 20	8/9	Dental contact 2 nd Class***	Community-Dental	
	10	Dental contact 4 th Class***		
	11	Dental contact 6 th Class***		
21/22/23	12	Immunisation – Tdap and MenC boosters	PHN	
	13/14	Girls – first and second doses HPV		

*BCG vaccine currently not available

**In most cases onward referral will be to the Community Medical Doctor at the second tier clinic in the community.

***Dental contacts at 2nd/4th/6th class but provision varies between CHOs.

The rationale for each contact is outlined in Appendix 8.

The National Healthy Childhood Programme will support the current HSE programme Making Every Contact Count. It will assist in building a culture and environment that supports continuous health improvement through its contact with parents and children.

Action 13
The National Implementation Team will empower health care professionals providing the National Healthy Childhood Programme to recognise the role they have in advocating for healthy lifestyle behaviour.

The provision of universal services within a model of progressive universalism means that all children are offered a standard number of contacts. Inherent in the delivery of the model is the ongoing requirement for assessment of need, the delivery of services using evidence-based pathways of care and the requirement for services to work in an integrated way both within and between hospital and community based services.

Currently additional contacts are provided by the child health screening and surveillance service based on issues identified at each contact point. Some HSE areas have also implemented assessment tools such as the Child & Family Health Needs Assessment tool (for child welfare and protection issues) and screening tools such as the Edinburgh Depression Scale, Maternal Health Questionnaire and the Ages & Stages questionnaire.

Action 14
The Nurture Programme Standardised Records for Parents and Professionals Implementation Team will review the current assessment tools in use and other relevant screening tools in order to make recommendations regarding national adoption

Additional supports are provided and referral to Primary Care Teams, specialist or hospital services are made on the basis of the results.

It is proposed that additional/progressive health, developmental or support needs will be identified as part of the universal contact using standard assessment tools.

Action 15
The National Implementation Group will progress the implementation of agreed assessment tools to support the identification of children and families requiring additional services

In some instances the additional needs will be met within the universal service, for example at second tier clinics by community medical doctors. Some children may require referral to secondary care or specialist services, for example Early Intervention Teams.

Action 16
The National Implementation Group will ensure that care pathways and standards developed by the subgroups will support services providers to deliver the programme to agreed standards

In order to implement the framework for the delivery of the National Healthy Childhood Programme it is proposed to develop a formal structure to support the provision of second tier clinics by Community Medical Doctors. This will involve the development of agreed care pathways, including referral pathways to specialist and hospital consultant provided services.

Action 17
The National Implementation Group will work in partnership with the Integrated Care Programme for Children and the Paediatric and Neonatology Clinical Programme to develop referral pathways for children requiring consultant review

The work of the National Co-ordinating Committee for Primary Care Paediatric Services is important in this context also. Their role is to scope out the requirements (resources and governance) for the provision of nursing, therapy and medical services to children with non-complex needs in Primary Care.

Action 18
The National Implementation Group will continue to liaise with the National Co-ordinating Committee for Primary Care Paediatric Services to progress common agendas

The National Healthy Childhood Programme is already liaising with Primary Care in this regard.

7.3.3 Components of the contact

The content of the child health & wellbeing contacts is influenced by the evidence for Early Childhood Development (ECD)⁹⁰ which shows that the early years

- a. are marked by the rapid development of the central nervous system
- b. there are a number of 'critical periods' of brain development during this time
- c. the environmental conditions to which children are exposed during this time can 'sculpt' the brain
- d. provide the building blocks for lifelong economic, social and physical wellbeing
- e. can determine health and wellbeing across a lifetime.

The twenty three contact points on the National Healthy Childhood Programme present opportunities

- to promote health, wellbeing and development in children and families,

⁹⁰ Accessed at: http://www.who.int/social_determinants/themes/earlychilddevelopment/en/

-
- to monitor and evaluate the child's age appropriate immunisation status and to provide advice and encouragement to keep up to date with the national immunisation schedule,
 - to engage with parents and carers at key transition times and to identify the child's physical, developmental, social and emotional needs,
 - to develop a relationship between the child/family and the service in order to address issues early thereby preventing the need for specialist referrals later,
 - to provide additional support (including onward referral) to children/families with additional needs,
 - to support parents in their parenting role.

A universal child health & wellbeing contact comprises up to nine components or elements, depending on the timing and reason for the contact.

1. Health Promotion
2. Infant and Maternal Mental Health Promotion
3. Screening
4. Surveillance of Physical health
5. Developmental Surveillance
6. Growth Monitoring
7. Immunisations
8. Needs Assessment
9. Dental

Appendix 9 provides further details on each component and Appendix 10 shows how the components align with each contact. The outputs from the Developmental, Enuresis, DDH and other subgroups will inform the scoping out of the contacts.

The Nurture Programme-Infant Health & Wellbeing will update current resources and develop additional resources required by staff to deliver the nine components of the National Healthy Childhood Programme for the 0-2 year's age group.

Action 19
The Nurture Programme-Infant Health & Wellbeing will prioritise the development of key resources to support service providers to deliver the National Healthy Childhood Programme

7.4 Developing Supporting Environments

7.4.1 Quality

The HIQA *National Standards for Safer Better Healthcare*²⁷ are the standards to which the child health service will be developed and delivered.

The standard is based on the dimensions of quality under eight different themes:

1. Person-centred care and support – how services place the service user at the centre of their delivery of care. This includes the concepts of access, equity and protection of rights.
2. Effective care and support – how services deliver best achievable outcomes for service users in the context of that service, reflecting best available evidence and information. This includes the concepts of service design and sustainability.
3. Safe care and support – how services avoid, prevent and minimise harm to service users and learn from when things go wrong.
4. Better health and wellbeing – how services identify and take opportunities to support service users in increasing control over improving their own health and wellbeing.

Delivering improvements within these quality dimensions depends on service providers having capability and capacity in four key areas:

1. Leadership, governance and management – the arrangements put in place by a service for clear accountability, decision making, risk management as well as meeting their strategic, statutory and financial obligations.
2. Workforce – planning, recruiting, managing and organising a workforce with the necessary numbers, skills and competencies.
3. Use of resources – using resources effectively and efficiently to deliver best possible outcomes for service users for the money and resources used.
4. Use of information – actively using information as a resource for planning, delivering, monitoring, managing and improving care.

The development and implementation of the National Immunisation and Child health Information System (NICIS) presents an huge opportunity to standardise the way data from National Healthy Childhood Programme, including immunisation data, is recorded and reported.

Action 20
The National Implementation Group will work with the NICIS project team to scope out the data requirements for a child health system

Additional performance indicators are required to reflect the complete range of services provided and to monitor trends and variations.

7.4.2 National Governance of Child Health Screening and Surveillance

In order to provide good governance of screening and surveillance programmes clarity on the structures that manage and monitor them is required. It also needs to include the processes that are required to ensure that the service delivered is a quality service that reaches recognised standards. This will include managerial responsibility for services provided and supporting governance committees. The other generic elements of clinical governance also need to be in place.

For most screening programmes well people are invited to participate so it is important that the services 'do no harm'. Safety is a key component of the monitoring of the quality of screening programmes.

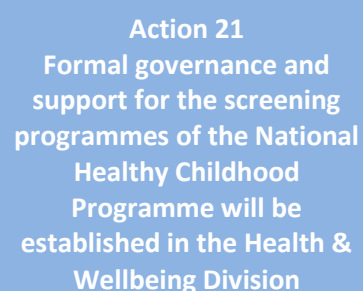
Achieving maximum outcomes usually depends on high uptake by the targeted cohort, for example all babies should have bloodspot screening. That uptake should also be uniform across the cohort and not exacerbate inequalities in health by differential uptake between, for example, socio-economic groups. This needs to be monitored.

Screening programmes also benefit from strong effective leadership that clearly articulates the need and direction for the programme while providing support by securing appropriate resources.⁹¹

It is proposed that support will be provided by the Health & Wellbeing Division to establish a National Child Health Governance Group for Child Health Screening and Surveillance.

The following child health screening and surveillance programmes will be supported

1. Antenatal Screening
2. National Bloodspot Screening.
3. Hearing Screening
4. Vision Screening
5. Screening for Developmental Dysplasia of the Hip
6. Growth Monitoring Surveillance
7. Developmental Surveillance
8. CDH screening including pulse oximetry



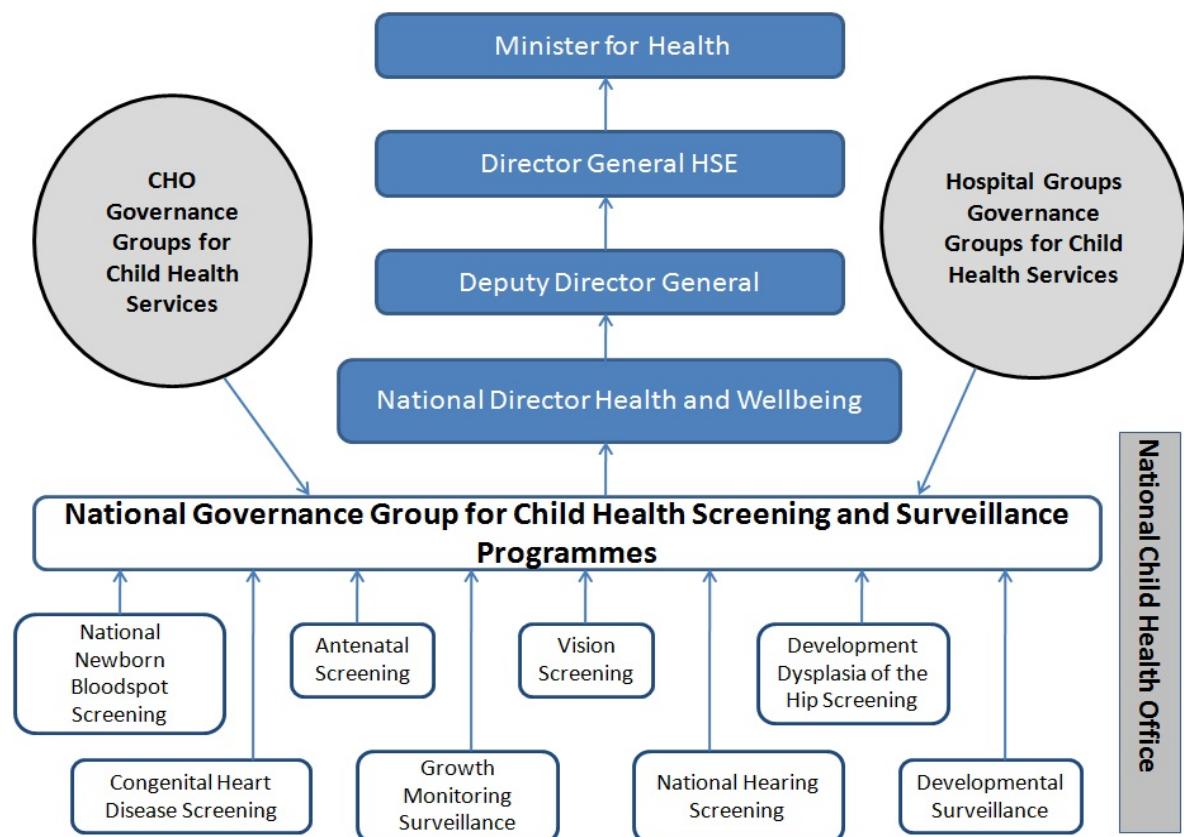
Action 21
Formal governance and support for the screening programmes of the National Healthy Childhood Programme will be established in the Health & Wellbeing Division

Figure 7 shows how this committee will interact established governance structures currently in place for specific areas, for example, National Bloodspot Screening Governance Group. Discussions will also be held with current governance committees to

⁹¹ Mason Mohan, C. Discussion Paper for the Governance of the National Developmental Dysplasia of the Hips Screening Programme September 2015 (copy on file)

identify programme governance requirements and plan for the national governance structure. Supporting administrative and project management functions of a 'national child health office', are currently being put in place.

Figure 7: National Governance Structure for Child Health Screening and Surveillance



7.4.3 Training

Health and social care practitioners working in the community, individually and as a group, form an essential component of the healthcare system. They also represent a valuable resource in the delivery and management of the National Healthy Childhood Programme and in the interface between hospital and community. Highly trained, motivated and engaged practitioners have much to offer children and parents on all components of the National Healthy Childhood Programme. In acknowledging the work undertaken by practitioners and with a view to supporting their education and training needs a programme of education will be developed that reflects the current evidence and the methods of delivery of training will support a blended learning approach.

The current BHFC training programme includes the following nine modules⁹²

- Unit 1 Health promotion
- Unit 2 Vision Screening
- Unit 3 Hearing screening
- Unit 4 Medical and orthopaedic assessment
- Unit 5 Developmental Assessment
- Unit 6 Growth monitoring
- Unit 7 Food and Nutrition
- Unit 8 Newborn Blood Spot Screening
- Unit 9 Child emotional and mental health

The implementation of the training programmes has varied between HSE areas and the number of programmes delivered. The training programme was initially implemented in most areas by dedicated Child Health Training and Development Officers but in recent years the delivery of the training programme has been patchy due to difficulties releasing staff to attend, coupled with the need to review and update the modules and the non-filling of training posts.

The National Immunisation Office has materials and training supports available to all professionals providing immunisations.⁹³

The current modules require updating in line with the current evidence base and additional resources are required to support the implementation of the revised modules. The training programme will be updated to reflect the current evidence and the methods of delivery of training will support a blended learning approach.

Action 22
The Nurture Programme-Infant Health & Wellbeing will prioritise the development of training programmes to support the provision of the National Healthy Childhood Programme

Ongoing monitoring and quality assurance of the revised training programme will be supported through national and regional child health governance structures.

It will draw on the ongoing work within the HSE to develop and deliver brief intervention training that will focus on Making Every Contact Count.

Links will be established, where relevant, with the Higher Education Institutes in relation to PHN training.

The training will be made available to all professionals who provide a service to children, for example, PHNs, community medical doctors, physiotherapists, speech and language therapists, GPs and practice nurses etc.

⁹²

http://www.hse.ie/eng/services/Publications/Children/Training_Programme_for_Nurses_and_Doctors_in_Child_Health_Screening,_Surveillance_and_Health_Promotion.html

⁹³ <https://www.hse.ie/eng/health/immunisation/hcinfo/trainingmanual/>

The provision of this aspect of the National Healthy Childhood Programme will be progressed through the Nurture Programme-Infant Health & Wellbeing.

The CHOs and Hospital Groups will be supporting the training programme through the delivery of actions outlined in the Healthy Childhood actions (see Appendix1).

Action 23
HSE Primary Care and Acute Hospital Divisions will facilitate relevant staff to attend revised training programmes as per Action 109 of the HSE Healthy Ireland Implementation Plan.

7.4.4 Resources

Evidence based resources will be developed for professionals to support the delivery of the child health programme. New information sources, both online and paper-based, will be developed to empower parents in their caring and parenting roles.

Action 24
The Nurture Programme-Infant Health & Wellbeing will prioritise the development of standardised records for parents and professionals

There is a requirement to agree and implement a standard national child health record. Some areas have been innovative in developing a multidisciplinary record and this will provide a good starting point for this work.

The Personal Held Record (PHR) is used in some but not all HSE areas. Through the Nurture Programme the feasibility of implementing a personal held record will be explored.

The process to develop and implement additional resources to support the child health programme will include the implementation of an ongoing national oversight structure of all resources developed.

7.4.5 Workforce Planning and Development

The delivery of the National Healthy Childhood Programme is dependent on having a skilled workforce in place to deliver the individual contacts and to recognise and refer children who require additional services and supports.

Action 25
The National Implementation group will engage with CHOs to ascertain if efficiencies exist across the system and to identify additional resources required to support the implementation of the framework

The National Implementation group will engage with CHOs to ascertain if efficiencies exist across the system and to identify additional resources required to support the implementation of the framework.

Appendix 1: Community Healthcare Organisations (CHOs) and Hospital Groups Actions for Healthy Childhood Policy Priority Programme



**Six Policy
Priority
Programmes**

Healthy Childhood	
106	<ul style="list-style-type: none"> Establish improved governance for child health services in CHOs
107	<ul style="list-style-type: none"> Collaborate with the development of the revised evidence based universal child health screening and development programme
108	<ul style="list-style-type: none"> Identify those groups requiring additional support and services and ensure programmes developed encompass the wider determinants of health
109	<ul style="list-style-type: none"> Support training and up-skilling of staff so that the new screening and development programme can be implemented
110	<ul style="list-style-type: none"> Implement the revised evidence based universal child health screening and development programme when finalised
111	<ul style="list-style-type: none"> Support pregnant women, mothers and their partners to quit smoking
112	<ul style="list-style-type: none"> Promote alcohol-free pregnancy
113	<ul style="list-style-type: none"> Promote breastfeeding among all pregnant women and mothers with a focus on groups where rates of breastfeeding are low
114	<ul style="list-style-type: none"> Promote good maternal nutrition
115	<ul style="list-style-type: none"> Promote smoking cessation among parents and young people
116	<ul style="list-style-type: none"> Provide information and support on infant and child nutrition
117	<ul style="list-style-type: none"> Promote healthy eating among children
118	<ul style="list-style-type: none"> Promote physical activity to increase the proportion of children taking regular physical activity
119	<ul style="list-style-type: none"> Promote the parent-child relationship and positive parenting through empowering parents by provision of information and parenting programmes

Appendix 2: Current National Child Health Programme- Best Health for Children

Contact No.	Age		Type of Contact	Provider	
		Antenatal		Maternity & Infant Scheme – Hospital (7 visits)	Hospital
			Maternity & Infant Scheme – GP (8 visits)	GP	
1	Weeks	0	Neonatal Exam/Bloodspot Screening/Hearing Screening/BCG	Hospital	
2		1	Child Health Screening & Surveillance (CHSS)	CHSS*	
3		2	Maternity & Infant Scheme	GP	
4		6	Maternity & Infant Scheme	GP	
5	Months	2	Immunisation 6 in 1 +PCV	GP	
6		3	Child Health Screening & Surveillance	CHSS*	
7		4	Immunisation 6 in 1+MenC	GP	
8		6	Immunisation 6 in 1+PCV	GP	
9		7			
		8	Child Health Screening & Surveillance	CHSS*	
		9			
10		12	Immunisation MMR+PCV	GP	
11		13	Immunisation MenC+Hib	GP	
12		18			
		19			
		20			
		21	Child Health Screening & Surveillance	CHSS*	
		22			
	23				
13	Years	2.25			
		2.50	Periodic Assessment	GP	
		2.75			
		3.00			
14	3.25	Child Health Screening & Surveillance	CHSS*		
	3.50				
15 16	4.00				
	4.25	Child Health Screening & Surveillance – Schools Including immunisation – 4 in 1 booster and 2 nd dose MMR	CHSS* (Immunisation delivered by GPs in Sligo/Leitrim and Donegal)		
	4.50				
	4.75				
17	5.00 to 6.00	Periodic Assessment	GP		
	8				
18 & 19	9	Dental contact 2 nd Class	Community - Dental		
	10	Dental contact 4 th Class			
	11	Dental contact 6 th Class			
	12	School Exit (5 th /6 th class) contact for vision screening was discontinued in 2015	CHSS*		
20/21/22	12-14	Immunisation – Tdap and MenC boosters Girls – first and second doses HPV	CHSS*		

*CHSS –Child Health Screening & Surveillance

Appendix 3 Membership of the Child Public Health Group (June 2014 to date)

Name	Current Title/Location	Lead role on the group
Dr. Phil Jennings	Director of Public Health/Dept. Public Health Tullamore	National lead for Child Health Chairperson of group
Dr. Kevin Kelleher	Assistant National Director/Health & Wellbeing Division	Public Health & Child Health
Dr. Melissa Canny	Specialist in Public Health Medicine/HSE West	Breastfeeding Developmental assessment
Dr. Áine McNamara	Specialist in Public Health Medicine/HSE West	Screening-hearing & vision
Dr. Julie Heslin	Specialist in Public Health Medicine/HSE South (South East)	Health promotion and education including parenting
Dr. Caroline Mason Mohan	Specialist in Public Health Medicine/HSE West (North West)/	HIP and UDT screening
Dr. Tessa Greally	Specialist in Public Health Medicine/HSE West (Mid-West)	Child health data and data sets Universal health identifier
Carmel Brennan	Programme Manager Child Health/Dept. Public Health Tullamore	Programme Manager for group
Mary Roche	Project Manager - Child Health and Screening, Children and Young People's Team (July 2014-December 2015)	Growth monitoring Childhood injuries Adolescent health
Dr. Anna Clarke	Specialist in Public Health Medicine/National Immunisation Office (August 2015)	
Anne Pardy	HSE Programme Manager for the Nurture Programme-Infant Health & Wellbeing (September 2015)	
Jacinta Egan/Brenda McCormack	Administration Support to the group	Minutes Group communications Document preparation

Appendix 4: National Steering Group for the Revised Child Health Programme (October 2014 to date)

Name	Title
Dr. Kevin Kelleher	Assistant National Director for Health & Wellbeing, Public Health & Child Health (Chairperson)
Aisling Heffernan (Representing Brian Murphy on this group)	HSE Primary Care nominee
Anne Lynott	Director PHN, nominee from HSE Directors of PHN Group
Anne Pardy	HSE Lead, Nurture Infant Health and Wellbeing Programme
Biddy O'Neill	Health Promotion & Improvement representative until October 2015
Jacinta Egan	Administrative Support
Carmel Brennan	Programme Manager Child Health
Catherine Maguire	Senior Clinical Psychologist
Dr. Anna Clarke	Specialist in Public Health Medicine from National Immunisations Office
Dr. Caroline Mason-Mohan	Specialist in Public Health Medicine nominee from the Child Public Health Group
Dr. David Hanlon	HSE National Clinical & Group Lead for Primary Care
Dr. Davina Healy	Principal Medical Officer nominee
Dr. Dymphna Kavanagh	Assistant National Director-Oral Health, Dental Health nominee
Dr. Jackie McBrien	Community Paediatrician with special interest in Child Health.
Dr. Joe Clarke	General Practice nominee
Dr. Johanna Joyce Cooney	Community Medical Doctor nominated by the ISCPHM
Dr. Patrick Quinn	Senior Dental Surgeon, Dental Health nominee
Dr. Phil Jennings	Director of Public Health Lead for National Healthy Childhood Programme
Dr. Ruth McDermott	Specialist Registrar in Public Health Medicine
Dr. Sean Denyer	Dept of Health/Dept Children & Youth Affairs nominee
Dr. Una Donohue	Area Medical Officer Representative
Eileen Maguire	Child Health Training and Development Officers nominee
Emma Benton	Allied Health Professionals nominee/Primary Care
Geraldine Duffy	Director of Midwifery nominee
Grace Turner	Manager Integrated Children's Programme, Clinical Strategy & Programmes
Janet Gaynor	Health Promotion nominee, replaced Biddy O'Neill at the end of 2015
Margaret O'Neill	National Dietetic Advisor
Maria Larkin	Child & Family Agency (TUSLA) nominee
Michelle Megan	Director of Public Health Nursing nominee
Patricia McLoughlin	PHN with special interest in child health nominee
Patricia O'Dwyer	Institute of Community Health Nursing nominee
Prof. Alf Nicholson	National Clinical Lead for the Paediatric Clinical Programme
Susan Kent	Department of Health nominee
Virginia Pye	National Lead for Public Health Nursing

Appendix 5 Subgroups of the National Steering Group for the Revised Child Health Programme

<p style="text-align: center;"><u>Infant Mental Health</u></p> <p>Chair - Catherine Maguire, Senior Clinical Psychologist & Infant Mental health Specialist, North Cork Patricia McLoughlin – Early Intervention / Child Health Specialist Carmel Brennan – Programme Manager Child Health, Department of Public Health Tullamore Jacinta Egan – Assistant Staff Officer, Department of Public Health Tullamore Geraldine O’Riordan – Principal Clinical Psychologist, Louth Dr. Julie Heslin – Consultant Public Health Medicine, HSE South East Mari O’Donovan – Child & Adolescent Health Training & Development Officer, HSE Cork Marie McSweeney – TUSLA</p>	<p style="text-align: center;"><u>Developmental Dysplasia of the Hip</u></p> <p>Chair - Dr. Caroline Mason Mohan, Consultant in Public Health Medicine, Department of Public Health Donegal Dr. Ruth McDermott, SpR Public Health Medicine, Department of Public Health Tullamore Dr. Davina Healy, Principal Medical Officer Dr. Eoghan Laffan, Consultant Radiologist Dr. Ethna Phelan, Consultant Radiologist, Crumlin Carmel Brennan, Programme Manager Child Health Carmel Costello, Assistant Staff Officer, Sligo Dr. Paula Kelly, Orthopaedic Surgeon Dr. Johanna Joyce Cooney, Principal Medical Officer Prof. John Murphy, Consultant Neonatologist Holles Street Dr. David Moore, Orthopaedic Consultant, Crumlin Dr. Ailbhe Tarrant, Consultant Radiologist, Rotunda Geraldine Duffy, Assistant Director, Holles Street Michelle Megan, Director of Public Health Nursing</p>
<p style="text-align: center;"><u>Enuresis</u></p> <p>Chair - Dr. Davina Healy DH, Principal Medical Officer Dublin Dr. Caroline Mason Mohan, Consultant in Public Health Medicine - Chair Dr. Una Donohoe, Senior Medical Officer Dr. Eve Robinson, Specialist Reg. Public Health Medicine Bridgette Argue, Clinical Nurse Specialist in Disability Services Maeve Smyth, Public Health Nurse Dr. Nick van der Spek, Consultant Paediatrician Cavan/Monaghan Carmel Costello, Administration Helen Browne, Director of Public Health Nursing</p>	<p style="text-align: center;"><u>Health Promotion & Improvement</u></p> <p>Chair - Janet Gaynor, Functional Manager-Health Promotion & Improvement, Health Promotion Nominee Carmel Brennan , Programme Manager Child Health Brenda McCormack, Administrative Support Ruth McDermott, Specialist Registrar in Public Health, HSE Midlands, Tullamore Anne Lynott, DPHN – nominee HSE Director of PHN Group Eileen Maguire, Regional Training & Development Officer HSE North East – nominee for training and development officers Siobhán Hourigan, National Breastfeeding Co-ordinator</p>
<p style="text-align: center;"><u>Developmental Assessment</u></p> <p>Chair - Dr Melissa Canny, Specialist in Public Health Medicine, HSE West Dr. Farhana Sharif, Consultant Paediatrician, Mullingar General Hospital Dr Una O’ Donoghue, Area Medical Officer, Ennis, County Clare, Patricia McLaughlin, PHN with special interest in child health, HSE Midlands.</p>	<p style="text-align: center;"><u>Child Health Profiles</u></p> <p>Chair - Dr Áine McNamara, Specialist in Public Health Medicine HSE West Carmel Brennan, Programme Manager Child Health Jacinta Egan, Assistant Staff Officer, Department of Public Health Tullamore Paul Marsden, Researcher, Department of Public Health Tullamore Dr. Maire Casey, Specialist in Public Health Medicine, Department of Public Health Limerick Dr. Tessa Greally, Specialist in Public Health, Department of Public Health Limerick</p>
<p style="text-align: center;"><u>Neonatal Physical Examination</u></p> <p>Chair - Dr. Caroline Mason Mohan Grace Turner, Programme Manager for the Integrated Care Programme for Children</p>	<p style="text-align: center;"><u>Oral/Dental Health</u></p> <p>Chair - Dr. Marie Tuohy, Assistant National Oral Health Lead (Child Health): Dr. Padraig Creedon, Principal Dental Surgeon</p>

<p>Prof. John Murphy, Consultant Neonatologist Geraldine Duffy, Assistant Director of Midwifery Carmel Brennan, Programme Manager, National Healthy Childhood Programme, Jacinta Egan, Assistant Staff Officer Dr. Jacqui McBrien, Consultant Paediatrician (resigned April 2017) Dr. Fiona McGuire, SMO, Public Health (October 2016) Dr. Jana Semborova, Consultant Neonatologist (May 2017)</p>	<p>Dr. Evelyn Connolly, Senior Paediatric Dental Surgeon Dr. Patrick Quinn, Principal Dental Surgeon, Dr. Mairead Harding, Deputy Director, Oral Health Services Research Centre, UCC</p>
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Appendix 6 List of Child Health Indicators considered by Child Health Profiles Group

Domain 1: Premature Mortality

Child Health Indicators

- 1.1 Infant Mortality
- 2.1 Child Mortality
- 2.2 Child Mortality by Cause
- 2.3 Child Mortality by Socio-economic group

Domain 2: Health Protection

Child Health Indicators

- 3.1 MMR Vaccination for one dose (2 years)
- 3.2 DtaP/IPV/Hib Vaccination
- 3.3 Children in care immunisations
- 4.1 Acute sexually transmitted infections (including chlamydia)
- 5.1 Percentage of children aged 24 months who have received MMR - 2014 target 95%
- 6.1 Percentage of children 12 months who have received the 6-in-1 vaccine-2014 target 95%
- 7.1 Percentage of first year girls who have received third dose of HPV vaccine by August 2014 - 2014 targets 80%
- 8.1 Percentage of first year girls who have received third dose of HPV vaccine by August 2014 - 2014 targets 80%

Domain 3: Wider determinants of health

Child Health Indicators

- 9.1 Children achieving a good level of development at the end of reception
- 10.1 Leaving (?Junior) Certificate achieved (5A-C including English and Maths)
- 11.1 Leaving (?Junior) Certificate achieved for children in care (5 A-C including English and Maths)
- 12.1 16-18 year olds not in education, employment or training
- 13.1 First time entrants to the youth justice system
- 14.1 Children in poverty (under 17 years)
- 14.2 Children in poverty (under 17 years)
- 15.1 Family homelessness
- 16.1 Children in care
- 17.1 Children killed or seriously injured in road traffic accidents

Domain 4: Health Improvement

Child Health Indicators

- 18.1 Health of the infant at birth
- 19.1 Low birthweight of all babies
- 19.2 Low birthweight of all babies by socioeconomic group
- 20.1 Obese children (4-5 years)
- 21.1 Obese children (10-11 years)
- 22.1 Children with one or more decayed, missing or filled teeth
- 23.1 Sexual Health and Behaviour - Teenage Mothers
- 24.1 Mental Health - Hospital admissions due to alcohol specific conditions
- 24.2 Mental Health - Hospital admissions due to substance misuse
- 24.3 Admissions of children to Child and Adolescent Inpatient Units as a % of the total number of admissions of children to mental health acute inpatient units (quarterly) - 2014 target >75%
- 24.4 Percentage of accepted referrals/re-referrals offered first appointment and seen within 12 weeks/3 months by Child and Adolescent Community Mental Health Teams (monthly) - 2014 target >75%
- 25.1 Chronic health conditions and hospitalisation

Domain 5: Prevention of Ill Health

Child Health Indicators

- 26.1 Smoking status at time of delivery
- 26.2 Cigarette use in past 30 days
- 26.3 Smoking initiation rates
- 26.4 Smoking prevalence in pregnancy
- 27.1 Breastfeeding initiation
- 27.2 Breastfeeding prevalence at 6 to 8 weeks after birth
- 28.1 Nutrition
- 29.1 A&E attendances (0-4 years)
- 30.1 Hospital admissions caused by injuries in children (0-14 years)
- 31.1 Hospital admissions caused by injuries in young people (15-24 years)
- 32.1 Hospital admissions for asthma (under 19 years)
- 33.1 Hospital admissions for mental health conditions
- 34.1 Hospital admissions as a result of self-harm (10-24 years)
- 35.1 Screening for growth and development

Appendix 7: Draft Terms of Reference for CHO Child Health Governance Groups

The Committee may have the following functions:

- Advising the Chief Officer and Heads of Service on matters relating to the quality and safety of child health services provided in the area. Including strategies for the following:
 - Ensuring services and programmes are delivered equitably and in a coordinated manner.
 - Reducing variations in programmes and clinical care.
 - Improving the experience for children, parents and families who are receiving services.
 - Complying with National statutory responsibilities
 - Implementation of local and national strategies.
- Reviewing and monitoring population screening programmes ensuring that target levels are maintained at all times.
- Promoting improvements in the quality of child health services by ensuring all child health services have a framework for quality assurance.
- Collaborating with Children and Young Person's Services Committees (CYPSCs), TUSLA and other agencies to ensure better health outcomes for children.
- Reviewing best practice and discussion of international, national and local developments that have a positive impact on child health services.
- Acting as a project board for existing and new child health development projects.

Appendix 8: Timing of the HSE National Healthy Childhood Programme contacts

Contact	Rationale	Provider
1. Antenatal	<i>To introduce the Child Health Programme To promote health lifestyles in both parents To promote positive mental health To promote maternal immunisation-Influenza and Pertussis This is a new contact to be developed as part of the Nurture Programme-Infant Health & Wellbeing</i>	HSE Primary Care - Child Health Screening & Surveillance Service
2. Birth	As well as the general care of the mother and baby, before leaving the hospital, the baby receives a general neonatal physical examination, is screened for DDH, vision and hearing. The national bloodspot screening is carried out (either in hospital or at the first PHN visit in the home). BCG vaccination may be given.	HSE Hospital
3. Within 72 hours of discharge from hospital	This contact is generally carried out in the child's home visit i.e. familiar surroundings for the parents which are probably more convenient and acceptable for them. It also provides the HSE with the opportunity to undertake a comprehensive assessment by observing parents in their own environment and to promote a healthy home environment. Through this visit parents are provided with support and information that is tailored to their needs. The BCG vaccination is given at the HSE clinic by community medical doctor if not previously given in hospital.	HSE Primary Care - Child Health Screening & Surveillance Service
4. Within 2 weeks of birth	<i>'This visit enables the GP to check on the mother's health status, to review the hospital care experience and to discuss any difficulties in the management of the baby. It also provides the opportunity of meeting the baby: to establish a programme for monitoring growth and development (percentile measurements); to review screening status.'</i> ⁹⁴	GP
5. Six weeks after the birth	<i>'A postnatal examination of the mother should be carried out by the GP during this visit. This visit also enables the GP to review the general health of the baby; to conduct another developmental examination; to review feeding practices and the overall management of the baby and to finalise immunisation plans.'</i> ⁹⁴	GP
6. At 2 months	Immunisation Contact for 6 in 1 and PCV	GP
7. At 3 months	This contact is generally provided in a clinic setting. It provides the opportunity for the PHN to undertake developmental surveillance in partnership with parents and to provide anticipatory guidance with respect to changes over the coming months; to conduct a physical examination of the baby; to identify possible maternal or psychosocial issues and to promote maternal-infant attachment.	HSE Primary Care - Child Health Screening & Surveillance Service
8. At 4 months	Immunisation Contact 6 in 1 and MenC	GP
9. At 6 months	Immunisation Contact 6 in 1 and PCV	GP
10. At 9 to 11 months	This contact is generally provided in a clinic setting. It provides the opportunity for the PHN to conduct a physical examination of the baby; to continue developmental surveillance in partnership with parents and to provide anticipatory guidance with respect to changes over the coming months in particular the baby's motor, language and cognitive skills; to identify possible maternal or psychosocial issues. <i>Timing of this contact has been changed from 7-9 to 9 – 11mths</i>	HSE Primary Care - Child Health Screening & Surveillance Service

⁹⁴ From Agreement between the Department of Health & Children and the Irish Medical Organisation in respect of a contract between the HSE and GPs for the provision of medical and surgical services to Mothers and Infants under Section 62 and 63 of the Health Act 1970. (copy on file)

Appendix 8 continued

Contact	Rationale	Provider
11. At 12 months	Immunisation Contact MMR and PCV	GP
12. At 13 months	Immunisation Contact MenC and Hib	GP
13. At 21 to 24 months	This contact is generally provided in the clinic setting. This contact is carried out at an important time in the child's development. It will allow developmental surveillance to continue which includes eliciting parents concerns, taking a developmental history, observation of the child and the use of the ASQ-3; it also allows growth monitoring to be undertaken. The baby's motor, language and cognitive skills are assessed and any possible maternal or psychosocial issues identified and appropriate support given. <i>The timing of this contact has been changed from 18-24 months to 21 - 24 months</i>	HSE Primary Care - Child Health Screening & Surveillance Service
14. Age 2 to 3 years	Periodic Assessment <i>'Periodic Assessments are age based preventive checks focused on health and wellbeing and prevention of disease. The Medical Practitioner shall take an active approach toward promoting health and preventing disease through the provision of Periodic Assessments to Child Patients.'</i> ⁹⁵	GP
15. At 46 to 48 months (3.8-to 4 years) Pre-school contact	This contact is generally provided in the clinic setting and is sometimes referred to as the pre-school or school readiness check. Domains of readiness include: - Physical well-being and motor development - Social and emotional development - Child's approach to learning - Language development - Cognition and general knowledge This contact will allow developmental surveillance to continue which includes eliciting parents concerns, taking a developmental history, observation of the child and it allows growth monitoring to be undertaken. <i>The timing of this contact has been changed from 39-42 months to 46 to 48 months</i>	HSE Primary Care - Child Health Screening & Surveillance Service
16. At 4½ to 5 years School Contact	This contact is generally provided in the school setting. It allows for hearing and vision screening to be carried out; growth monitoring to be undertaken. Parents complete a health questionnaire and have the opportunity to express any concerns. <i>The timing of this contact has been changed from 48-60 months to 54 to 60 months</i> Immunisation contact - 4 in 1 and MMR vaccinations given	HSE Primary Care – Schools Screening Service HSE School Immunisation Service ⁹⁶
17. At 4 to 5 years		
18. At 5 to 6 years	Periodic Assessment <i>'Periodic Assessments are age based preventive checks focused on health and wellbeing and prevention of disease. The Medical Practitioner shall take an active approach toward promoting health and preventing disease through the provision of Periodic Assessments to Child Patients.'</i> ⁹⁵	GP
19/20 Dental contacts at 2 nd Class (8/9 years) and 4 th /6 th Class (10-12 years) <i>Rationale to be agreed with Dental Service</i>		HSE Dental Service
21/22/23 At 1 st Year Second Level school (12/14 years)	Immunisation Contact for Tdap and MenC boosters. Girls – first and second doses HPV	HSE School Immunisation Service

⁹⁵ Registered Medical Practitioners for provision of services to children under 6 years old pursuant to the Health (General Practitioner Service) Act 2014 (Under 6 year olds) Accessed at: <http://www.hse.ie/under6contract/>

⁹⁶ GPs in Donegal and Sligo/Leitrim give these immunisations

Appendix 9: Components of child health contacts

Component	Details
1. Health Promotion	<p>The health promotion component of the programme is included at each contact, with specific reference to four main areas</p> <ol style="list-style-type: none"> Parenting and emotional wellbeing Healthy lifestyle Nutrition Promoting development-physical, social and emotional Keeping safe-including promotion of immunisation <p>The emphasis will change for each contact. For example parenting & emotional wellbeing, healthy lifestyle, maternal immunisation and nutrition will figure prominently in the antenatal contact.</p>
2. Infant and Maternal Mental Health Promotion	<p>An infant's early development is the product of the infant's characteristics (including genetic), infant-caregiver relationships and the environment within which these relationships unfold. These collective factors influence an infant's mental health.⁹⁷</p> <p>As well as the health promotion components relevant to this area, the assessment of psychosocial issues, including the mental health of the mother, is important at each contact.</p>
3. Screening	<p>There are six screening components of the universal child health programme. Each is relevant at different contact times</p> <ol style="list-style-type: none"> Antenatal screening for HIV, HepB, Syphilis and Rubella (TBC) National Bloodspot Screening is carried out at birth, in hospital or by the PHN at the first visit within 72-120 hours of birth to detect rare conditions identified as amenable to early treatment. Developmental Dysplasia of the hip screening has three core screening points-at the newborn physical examination, at the six week check by the GP and for babies with risk factors when targeted ultrasound is carried out. Hearing screening is usually first carried out while the baby is still in hospital. Vision screening is also usually first carried out as part of the physical examination at birth. Congenital heart defects – pulse oximetry is carried out as part of the newborn physical examination as part of the newborn physical examination.
4. Surveillance of Physical health	<p>Physical examinations are carried out at different contact times. The intensity and emphasis of the check varies by visit. For example the first physical examination (usually undertaken in the hospital) is a comprehensive physical examination of the baby including family history and birth experience.</p>

⁹⁷ The Centre for the Social and Development Foundations of Early Learning Infant Mental Health and Early Care and Education Providers Accessed at: www.csefel.vanderbilt.edu

Appendix 9 continued

<p>5. Developmental Surveillance</p>	<p>Developmental surveillance is monitoring a child's development over time to promote healthy development and identify children who may have developmental problems. Surveillance is an ongoing flexible system that is mainly focused on identification of red flags in development.</p> <p>The five main components to developmental surveillance as identified by the American Academy of Paediatrics (AAP) are: ⁹⁸</p> <ol style="list-style-type: none"> a) Eliciting and attending to the parents' concerns b) Maintaining a developmental history c) Making informed and accurate observations of the child d) Identifying the presence of risk and protective factors e) Document the process and findings
<p>6. Growth Monitoring</p>	<p>Growth is the most sensitive indicator of health as normal growth only occurs if a child is healthy. Growth assessment is an essential part of the examination or investigation of any child.</p> <p>It allows the</p> <ul style="list-style-type: none"> • objective detection of growth disorders at population level at earliest opportunity • Early identification and treatment improves outcome • Identification of under or over nutrition
<p>7. Immunisations</p>	
<p>8. Needs Assessment</p>	<p>This is part of the delivery of the universal child health model. Needs will be assessed in a manner relevant to the component of the contact, based on concern/s identified by the practitioner or expressed by the parent/care giver and including the need for child protection and welfare support.</p> <p>For example the <i>Whooley Questions</i> are used in as part of the nursing assessment in some but not all HSE areas to assess maternal mental health. Further assessment is recommended for women who answer "Yes" using, for example, self report measures such as the Edinburgh Postnatal Depression Scale (EPDS).</p>
<p>9. Dental</p>	<p>Content to be agreed, evidence review currently being completed by the Oral/Dental Health Subgroup</p>

⁹⁸ Identifying Infants and Young Children with Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening. Council on Children with Disabilities, Section on Developmental Behavioural Paediatrics, Bright Futures Steering Committee and Medical Home Initiatives for Children with Special Needs Project Advisory Committee. Paediatrics 2006; 118; 405.

Appendix 10: Contacts and components of the HSE National Healthy Childhood Programme

	1					2	3						4	5	6	7	8	9	
	Health Promotion					Infant Mental Health	Screening						Physical health	Developmental Surveillance	Growth Monitoring	Immunisations	Needs Assessment	Dental	
	Parenting	Lifestyle	Nutrition	Development	Keeping Safe		Antenatal	Bloodspot		DDH (Hips)	Hearing	Vision	CHD (Heart)	General	Males only-UDT				TBA
1. Antenatal																			
2. Neonatal																			
3. Within 72 of discharge from hospital																			
4. Within two weeks of birth																			
5. At six weeks after birth																			
6. At two months																			
7. At three months																			
8. At 4 months																			
9. At six months																			
10. At nine to eleven months																			

Appendix 10 continued

	1					2	3					4	5	6	7	8	9	
	Health Promotion					Infant Mental Health	Screening					Physical health	Developmental Surveillance	Growth Monitoring	Immunisations	Needs Assessment	Dental	
	Parenting	Lifestyle	Nutrition	Development	Keeping safe		Antenatal	Bloodspot	DDH (Hips)	Hearing	Vision	CHD	General	Males only-UDT (Testes)				TBA
11. At twelve months																		
12. At thirteen months																		
13. At 21 to 24 months																		
14. At 24 to 36 months (2 to 3 years)																		
15. At 46 to 48 months (3.8-to 4 years)																		
16. & 17 At 54 to 60 months (4.5 to 5 years)																		
18. At 5 to 6 years																		
19. & 20. Dental contact																		
21/22/23. 12-14 years																		

