Dear Colleague

REFRESH OF HEALTH FOR ALL CHILDREN (HALL 4) – REINFORCING THE KEY MESSAGES

This letter is to reinforce key aspects of the Health for All Children 4: Guidance on Implementation in Scotland (commonly referred to as the Hall 4 Guidance) which was issued in April 2005 and to ensure that these messages are taken forward by NHS Boards in the context of the Early Years Framework, Equally Well, Achieving our Potential and GIRFEC’s transformational change programme.

Background

The 2005 Hall 4 Guidance followed a review of child screening, surveillance and health promotion undertaken by the Royal College of Paediatrics and Child Health published in 2003. The Health for All Children review contained recommendations on key screening and surveillance activities which were of optimum benefit to children and young people. The Scottish Guidance built on this review and introduced for the first time a core programme of contacts which every child and young person should receive, with tiered levels of support, depending on individual assessed need. The Scottish guidance was published in April 2005 and contained a timetable for implementation of the different aspects of Hall 4. At this time a Hall 4 Implementation Network was established to provide support to NHS Boards in implementing the guidance.

Through working with the Hall 4 Implementation Network, it has become clear that there are shared concerns regarding implementation of some aspects of Hall 4 including:

- the allocation of the Health Plan Indicator (HPI) and the subsequent continuing support for children and their families;
- issues surrounding optimal health promotion activity and
- The introduction of orthoptist vision screening at 4-5 years.
- Lack of any universal recorded information on growth, development and health between 6-8 weeks and school entry.
Actions

Annexes A and B seek to provide further advice and information regarding these aspects of implementation. As a result of the issues concerning the implementation of Hall 4 there are a number of steps which the Scottish Government is proposing. The background to these is set out in the Annexes, but, in brief, they are:

- Develop and consult on guidance regarding the allocation of the HPI by or at age 1.
- Re-introduce a 24 – 30 month review into the universal programme to ensure issues regarding child development, parenting and health promotion can be addressed. Further detail of how this should be implemented will be contained in the HPI guidance which will follow the consultation.
- Health promotion is a key feature in several HEAT targets including reduction of childhood obesity, promotion of breastfeeding and improvements in oral health. Front line practitioners, whatever their professional discipline, will require to adopt or utilise evidence to ensure that key messages and interventions regarding breast feeding, smoking, weaning, nutrition, oral health, immunisations, development, safety and parenting skills are available to all families. This will be supported by literature and resources available through NHS Health Scotland. We will work with NHS Education for Scotland to ensure that front line practitioners have the appropriate skills and competencies to meet these needs.
- Review Child Health Surveillance Programme (pre-school) (CHSP-PS) as a recording tool to ensure it is fit for purpose in the context of the proposed changes.
- Continue to work across SG Directorates to ensure implementation of the GIRFEC Practice Model.
- Provide input to the Modernising Community Nursing Programme Board to ensure Hall 4 policy is incorporated in future workforce planning for the early years and addressing future training requirements for pre and post registration public health nurses.
- Ensure each NHS Board has in place a Screening Co-ordinator with a responsibility for child vision screening. This could be, for example, the Head or Lead Orthoptist, or the Board's Child Health Commissioner.
- Support NHS Boards who have been unable to put in place a pre-school orthoptist screening programme.

Next Steps

Chief Executives are asked to cascade this information to staff with responsibility for the implementation of Hall 4 guidance and to ensure that the key messages contained within this Chief Executive Letter are addressed. NHS Boards have a responsibility to ensure it is implemented in order to offer optimal and timely support to children and their families.

Yours sincerely

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ANNEX A

Health Plan Indicator and universal contacts

Background

The Health Plan Indicator (HPI) was created as a tool for HV's undertaking Child Health Surveillance in Scotland following the publication of the Hall 4 Guidance. Each child's HV would allocate the child a status according to their needs to be recorded on the CHSP-PS computer system.

The primary purpose of the HPI was to provide a formal and consistent indication of the level of input needed by a children and their family. Prior to its introduction, some HVs operated ad-hoc informal local paper-based systems to indicate the level of need within their caseloads. These systems were often only accessible to the HV and their immediate manager. The HPI system offers a more formal and transparent way of recording need for input and is consistent with a clinical governance approach within Boards.

Hall 4 set out a recommended programme of contacts and health promotion support which every child should receive – the core programme being the minimum number of contacts – with the aim of enabling HVs to prioritise their caseloads, depending on the assessed needs of children and families. It aimed to enable families in need of greater support to receive an enhanced level of input. Hall 4 introduced the concept of targeting support according to need and advised that children should be assessed as having core, additional or intensive needs. These levels of need were based on the experience of HVs during the Starting Well project in Glasgow. They relied largely on the professional judgement and expertise of staff at the front-line. Although no formal guidance was issued on what constitutes additional or intensive needs, many Boards created guidance for local use, resulting in variation in practice across Scotland. Analysis by colleagues at ISD of HPI data has shown wide variation in allocation practice and criteria across Health Boards, mainly in terms of the additional category.

Problems identified with the current system

There are a number of factors which contribute to the current difficulties surrounding the implementation of the HPI:

- Current practice issues

An unintended consequence of the 2005 Hall 4 Guidance is that many HVs may no longer have regular contact with those children who are receiving the 'core' programme after the 6-8 week check. This is principally because routine universal surveillance checks at 8 months, 24 months and 39 months were discontinued. It is also partly as a result of changing practice in the provision of immunisations – the administration of which varies across the country with a variety of practitioners undertaking this. As well as suggesting that HVs allocate the HPI at this early stage when they may not know the family sufficiently, there has also been a perceived loss of the HV health promotion contacts which the Hall 4 guidance associated with immunisation contact points. As a consequence, core families may receive limited or no HV support after their child's 6-8 week check.
Concerns have arisen that significant developmental problems such as speech and language delay may not be coming to the attention of primary care teams through reduced universal contact with families, and therefore intervention (for example by a speech and language therapist) may be delayed at a crucial time.

The experience to date of allocating children at this early stage has been problematic. In cases where the HV has worked with the family previously and has knowledge of their circumstances, history and has developed a good relationship with the family, early allocation is much easier. However, in many cases (almost half of babies born in Scotland are first children), it is much more difficult to carry out a full assessment in this timescale and accurately assign the child to a specific level of support and/or intervention. In general, the current timescale for allocating the HPI has been found to be inappropriate and has caused concern amongst professionals that children may not be receiving the support they require. Evidence from the Starting Well project in 2 deprived areas of Glasgow (Wright et al) showed that family assessments carried out before 6 months of age were poor predictors of need at 3 years.

- Recording issues

Under current practice, the HPI is recorded on the CHSP-PS system at 6-8 weeks. A form is generated from the system at this stage which allows the recording of the HPI and other important surveillance data. In order for HVs to reassess the HPI at any other point, they are required to complete an "unscheduled visit form" which creates additional work for the HV as well as for the Child Health Administration teams within Boards. Relying on the CHSP-PS as a recording tool has led HVs to feel that they need to make a decision on the HPI category of need at 6-8 weeks. It has also caused difficulty in the reassessment and reallocation of the HPI when circumstances change for the child, the family, or both.

- Assessment techniques and tools

The ongoing roll out and national implementation of GIRFEC will result in the standardisation of assessment for all children and young people. Adoption of the GIRFEC principles and practice model is central to this process. Work currently being undertaken by NHS Quality Improvement Scotland (NHS QIS) on the development of pathways for vulnerable families from conception to age three will help to demonstrate GIRFEC in practice. The Practice Model is being implemented across agencies and will require agencies to adopt a consistent approach. This approach will support information sharing and responding to the needs of a child in a single or multi-agency context and to identify when to call in other help or support. HVs should involve parents and other carers involved with the child when using the model.

Health Plan Indicator Working Group

As a result of these issues, a working group was established to look at the concerns around the allocation and recording of the HPI. This group was chaired by Dr Charles Clark, Child Health Commissioner for NHS Lanarkshire and comprised members from the Hall 4 Implementation Network. The work of this group was also informed by work commissioned through NHS Quality Improvement Scotland which looked at practitioner issues regarding the HPI. The group has made the following recommendations:

- The HPI is considered a useful tool by HVs and managers and should continue to be used
• The current use of the HPI is too inflexible and, in some cases, is being used as a management tool to assess workload and allocate staff to localities rather than indicating the needs of children and families.

• The process of allocating the HPI requires to be much more flexible, enabling HVs to allocate it at an appropriate time following a period of assessment, up to the age of 12 months. There also needs to be flexibility around re-assessment of the HPI when family circumstances change.

• It should be easier for an HV to change the level of need recorded for a child at the time when the decision to change the indicator is made.

• There needs to be fresh guidance issued to NHS Boards regarding the criteria, recording and use of the HPI as well as a refresh of the aims and intentions of Hall 4.

• There should be a series of workshops to support the refreshed guidance.

Workforce and training issues

The recruitment and deployment of HVs is a matter for Health Boards who determine their workforce based on the needs and demographics of their population. This is carried out by taking account of user needs, demographics, shifting the balance of care and workforce issues to ensure the population’s needs are met. NHS Boards are encouraged to consider using a wide range of skills and a multiagency approach to providing care to ensure that those people who are most vulnerable receive the right care they need when they need it.

From feedback from the Hall 4 Network Group members, discussion with key stakeholders, including NES, and QIS sponsored work with HVs across Scotland, it is apparent that there is a mismatch in some localities between HV workforce numbers and local need. More stringent requirements in relation to, for example, Child Protection work and increased demands to assess and meet the needs of all vulnerable families may have reduced capacity for universal support during the early weeks and months of a child’s life when the HV is getting to know a family.

The Modernising Community Nursing Programme Board has agreed to focus on three specific priority areas in the first phase of its work, one of which is early years and parenting. The work plan is not yet agreed but a key output will be having an appropriate workforce to meet identified need for the community nursing service. As the needs of families change and we collectively address the challenges of health inequalities, the requirement to provide flexible responsive community nursing services becomes a key priority. NHS Scotland is supporting the reconfiguration of the existing workforce and introducing a new range of cross-sectoral competencies for Band 4 practitioners to help to meet these challenges.

A workforce planning strategy, Better Health, Better Care: Planning Tomorrow’s Workforce Today published in December 2007 sets out NHS Boards’ requirements to publish annual workforce plans and to submit staffing forecasts to the Scottish Government Health Directorates. All NHS Boards are required to complete a workforce projections template, as this information continues to be crucial both for assisting the Scottish Government in determining the overall demand for staff and in informing decisions about the future training supply for regulated professional groups such as nursing and midwifery.
Proposals for the future

- The scope of universal services should be broader than it is at present with the assumption that the HV/PHN will be the named professional for children under the age of five. HVs should work within a skill-mixed team to support children and their families during their early years.
- All members of the primary healthcare team, including HVs will use Getting it Right for Every Child (GIRFEC) principles and practice model in their local interagency settings.
- The HPI will be allocated according to the needs of the child – not according to the required level of HV input. For example, some children with complex needs may well require intensive support from multi-professional/multi-agency services, while HV input may be little. The HV will remain the named professional and may also be expected to take on the coordinating role of lead professional if appropriate.
- Make clear that the core programme as set down by the Hall 4 guidance is the minimum number of contacts a child should receive. HVs are required to use professional decision making, supported by the application of the GIRFEC Practice Model to assess a child and family’s needs and determine an agreed programme of contacts with the family and the appropriate professionals, depending on those assessed needs.
- Allocation of the HPI is to be viewed as a supportive tool not the main purpose of surveillance. Guidance issued following the consultation will provide clarification on the application of the HPI and will identify potential training implications.
- The process of needs assessment will change from core/additional/intensive categories to a much more dynamic process of providing services according to assessed need. The new indicators will form part of the consultation process however, they should reflect a continuum from the core universal programme to a higher level of need which will require more intensive, evidence based interventions and support e.g. Triple P, Webster Stratton, Mellow Parenting, and Family Nurse Partnership. The aim is to change the present approach of assigning children to specific categories within a certain timescale – which is largely tied to the timetable set by the universal contacts recorded in CHSP (P-S) – relying on professional decision making in the assessment and support of children and their family’s needs. This will be supported by the GIRFEC principles by putting the child at the centre and assessing their needs, using the GIRFEC Practice Model.
ANNEX B

Pre-school Vision Screening

Based on recommendations by the UK National Screening Committee and Hall 4, the guidance on implementation in Scotland recommends:

- Each NHS Board should designate a Child Health Vision Screening Co-ordinator (similar to the Pregnancy & Newborn Screening Co-ordinator) to take overall responsibility for monitoring vision screening programmes and ensuring the Hall 4 recommendations on vision screening are implemented (Timescale: 2005/06)

- All children should be screened by an orthoptist in their pre-school year, between the ages of four and five years. Once this is in place, vision screening on school entry should cease (Timescale: 2006/07)

- Until an orthoptist pre-school vision screening programme is in place, children’s visual acuity should be tested on school entry by an orthoptist, or through a programme which is supervised by an orthoptist or an optometrist (Timescale 2005/06)

Proposals for the future

The Scottish Government is aware of difficulties in the recruitment of orthoptists across Scotland and a number of NHS Boards have reported problems in introducing pre-school orthoptic screening due to difficulties in recruiting orthoptic staff. NHS Education for Scotland (NES) has been taking steps to address this issue, including setting up a bursary scheme to aid recruitment in Scotland; supporting a review of opportunities to maximise orthoptists’ availability and skills; commissioning a study to map out pre-registration and support worker education requirements; and working with Scottish heads of orthoptists’ services to ensure an increased capacity for student placements.

Action required by NHS Boards:

- Based on the above, each NHS Board is asked to advise the Scottish Government who their designated Co-ordinator with a responsibility for child vision screening is.
- NHS Boards who have not yet introduced such a programme are required to submit their proposals for introducing pre-school orthoptist screening. Where no orthoptist service is available, NHS Boards should work to find local solutions to ensure a screening programme is in place. As an interim measure, this may be through a programme which is supervised by an orthoptist or an optometrist.

The above information should be sent to Mary Sloan, Policy Manager using the address at the top of this CEL or by emailing Mary.Sloan@scotland.gsi.gov.uk by 31 May 2010.