



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

**Report on the Audit of the Child Health
Screening and Surveillance Programme**

18th May, 2009

Foreword

The screening and surveillance of children for potential health or developmental problems is a key element of the review offered to children and their families by the HSE.

These services have been subject to an ongoing modernisation programme, which started with a systematic review of the evidence of what was effective, which was then coupled with a training and development programme for practitioners, designed to help them put evidence into practice.

As part of this process a set of guidelines were developed, known as 'Best Health for Children Revisited' which clearly set out what activity would be undertaken at each key developmental stage.

This report is the first comprehensive audit of this programme. It attempts to examine to what extent the programme is being implemented across the country and what the challenges were to achieving the standards developed.

It is a tribute to the practitioners and managers involved in delivering their reviews, that by and large there is a high degree of compliance with the guidelines. It has demonstrated the effectiveness of developing a training programme for practitioners, which supports the implementation of more evidence-based practice. This reflects that the implementation was itself, based on the evidence of what is effective in getting evidence into practice.

There was however very considerable challenges in obtaining the information needed to undertake this work, and it is important to note that in some areas that have implemented the Personal Health Record (PHR) this was a far easier exercise. The report also highlighted some considerable variation between different parts of the country which reflect some historical differences in how services have been organised and staffed.

A key finding to emerge is the requirement for an ongoing programme of training and development for practitioners, to update them on new evidence becoming available and to train new practitioners.

There is also a clear need to improve child health information systems, though in a few areas we now have a system which can service a model for the country as a whole, based on the great work done in Limerick on the PHR.

I would like to thank the Project Team for their hard work and enthusiasm in producing a very valuable feedback tool, and for those involved in delivering these important services, for completing the survey.

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Project Chairman

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Acronyms

AMO	Area Medical Officer
<i>BHFC (1999)</i>	Best Health for Children (1999)
<i>BHFCR (2005)</i>	Best Health for Children Revisited (2005)
CAHDO	Child and Adolescent Health Development Officer
CHIS	Child Health Information System
CHISP	Child Health Information Service Project
CHSS	Child Health Screening and Surveillance
DPHN	Director of Public Health Nursing
GM	General Manager
GP	General Practitioner
HSE	Health Service Executive
HSE (NSP)	Health Service Executive National Service Plan
ICT	Information Communication Technology
IT	Information Technology
LHO	Local Health Office
MO	Medical Officer: can refer to AMO, SMO or PMO
NSP	National Service Plan
OCEO	Office of the CEO
PA	Personal Assistant
PAC	Programme of Action for Children
PCCC	Primary, Community and Continuing Care
PHIT	Population Health Information Tool
PHN	Public Health Nurse
PHR	Personal Health Record
PMO	Principal Medical Officer
Pop Health	Population Health
SMO	Senior Medical Officer
PI	Performance Indicator
TDO	Training and Development Officer
UNHS	Universal Neonatal Hearing Screening
WTE	Whole Time Equivalent

Executive Summary

To deliver on the National Service Plan (2008:37) deliverable, a national Project Team was established to undertake an audit of the Child Health Screening and Surveillance (CHSS) programme through surveying the extent of *Best Health for Children Revisited (2005) (BHFCR)* implementation.

This report collates the findings from the audit and identifies a number of recommendations that should be implemented to ensure that the CHSS programme is delivered according to *BHFCR (2005)* standards.

Thirty one of the 32 LHO areas returned questionnaires, although many areas encountered difficulties in providing complete numerical information on the quantity of health checks that are carried out. During the consultation process it became apparent that it would be difficult to obtain complete information. It was decided, however, to proceed and collect what information was available. There are a number of reasons why this may be the case including the possibility that some areas are not carrying out some aspects of the checks, but the most likely reason that emerged is that they are not recording service activity comprehensively and electronically, making retrieval of this information difficult. Additional time was provided to some LHO areas to enable them to manually collate and return the requested information. Areas that are using the Personal Health Record (PHR) and its accompanying electronic child health system provided the most complete information for all checks.

A number of issues emerged from the findings, despite the lack of comprehensive numerical data, on the quantity of the delivery of the health checks and especially in relation to the quality of the delivery. Primary among these issues was the difficulty that many areas have in collating and providing information due to a lack of electronic and standardised information systems. In addition, there are significant divergences between LHO areas in staffing ratios to population cohorts. Despite these barriers to standardised delivery, however, there is consistent high adherence to the *BHFCR (2005)* standards where service delivery is recorded.

The table below shows the percentage of eligible children who **received** each of the five health checks **on time** in the reporting LHO areas.

Health Checks Received on Time		
Health Check	% of eligible cohort	LHO areas
Primary/Postnatal	77	29
3 Months	86	22
7 to 9 Months	70	25
18 to 24 Months	82	22
3.25 to 3.5 Years	77	20

The following table presents the **level of adherence** in the reporting LHO areas to the recommended examination and health promotion activities as per *BHFCR (2005)*.

Adherence to Recommended Examination and Health Promotion Activities		
Health Check	% of complete adherence	LHO areas
Primary/Postnatal	90	29
3 Months	93	28
7 to 9 Months	83	28
18 to 24 Months	93	28
3.25 to 3.5 Years	93	27
School Entry	59	27
School Leaving	62	26

An adherence rate of between 81% and 97% is reported for the delivery of the health checks by the recommended staff.

Respondents specified the resources in place that enabled them to adhere to the health check standards under the following headings: equipment and facilities; staffing and training; documentation and other materials; information systems; and other. Some LHO areas raised issues about having limited equipment available and limited clinical facilities particularly for hearing screening. Ten LHO areas reported difficulties with staffing deficits and unfilled vacancies in clinical and administration posts. While two thirds of respondents report having completed or nearly completed the national training, eight areas report only partial delivery and two report no training received. Eight areas comment on the value of the Child Health Information Service Project (CHISP) in assisting their delivery of the health checks to the required standards, although mention is also made of unavailability of this resource. The PHR documentation and information system is active in six LHO areas and receives widespread support from these, and other LHO areas, for its efficiency in enabling adherence to the recommended standards.

The following recommendations are summarised to provide a synopsis of the steps that are required to address the issues and learning from this report. A full version of the recommendations is provided on page 67.

Summary of Recommendations

Service Delivery

- Staffing levels for the CHSS Programme should be reviewed across the LHO areas to ensure a more equitable provision of staff to population cohorts, to enable them to deliver the required programme.
- Staffing allocations should be standardised throughout LHO areas based on models of best practice and equity of access for the local child health population. These staffing arrangements should be configured as part of the primary and social care networks and primary care teams.
- An in-depth audit focusing on a sample of LHO areas should be carried out to complement the information that has been gathered by this survey.
- The delivery of a 7 day PHN service to meet the required standard for the postnatal/primary visit should be introduced across the country.
- The standards for delivery of the school health checks should be standardised as in *BHFCR* (2005) and supported at LHO area level.

Standards

- A national expert group should be put in place to oversee that child health standards are updated in line with evidence and best practice.
- This national expert group should provide clarity regarding staffing for the 7 to 9 months health checks and school health checks.
- The universal neo-natal hearing screening programme should be implemented.
- The revised hard copy CHISP resources should be made available to support the standardised delivery of the CHSS programme according to best practice.

Training

- The national CHSS training programme should be implemented in all LHO areas that have not received this training to date.
- The national standardised CHSS training should be integrated into pre-registration PHN courses.

Child Health Information Systems

- A standardised electronic child health information system should be implemented. The PHR offers a model of best practice for a comprehensive child health system as evidenced by the returns from the areas where this is active.
- An electronic, comprehensive system used to communicate the birth notification form should be standardised and implemented.
- An electronic, comprehensive system used to communicate the birth health check information should be standardised and implemented.
- An electronic, comprehensive system used to communicate the 6 to 8 weeks health check information should be standardised and implemented.

1. Introduction and Background

The *Health Service Executive National Service Plan* (HSE NSP) 2008 identified the following deliverable by Quarter Three: “an Audit of HSE performance against standards as outlined in ‘Best Health for Children’ should be undertaken” (NSP, 2008:37). The Office of the CEO (OCEO) Primary, Community and Continuing Care (PCCC) and Population Health (Pop Health) were jointly identified as delivering on this audit.

Dr. Sean Denyer, Director of Public Health, Children and Young People’s Team, Pop Health; Mr. Seamus Mannion, Assistant National Director, Children Services, OCEO; and Mr. Hugh Kane, Assistant National Director (responsibility for Children and Family Services), PCCC, agreed that a Project Team, led and managed under the auspices of the OCEO, would be established. The membership of the Project Team, drawn from Pop Health, the OCEO, and PCCC, is included on page iii.

1.1 Project Objective

The objective of the project was to undertake an audit of the Child Health Screening and Surveillance (CHSS) programme through surveying the extent of *Best Health for Children Revisited* (2005) (BHFRCR) implementation.

1.2 Report Structure

This report presents the findings from the CHSS audit questionnaire responses. A full copy of the questionnaire is provided in Appendix I.

- Section 1, ‘Introduction and Background’ outlines the background and the process that underpins the carrying out of the audit.
- Section 2, ‘Results - Recommended Timing of Health Checks’ presents the Local Health Office (LHO) areas performance on carrying out the health checks within the time frame as recommended by the standard; and the reasons for offering or receiving the postnatal/primary visit later than the standard.
- Section 3, ‘Results - Recommended Content, Staffing and Resources’ presents information about whether the health checks were carried out according to the recommended standards for the examination; health promotion activities; and staffing. The reasons for non-adherence and the resources in place that enabled adherence are also presented.
- Section 4, ‘Results - Birth and 6 to 8 Weeks Health Check Information’ focuses on the two health checks that are not carried out by the public health nurse (PHN) or medical officers (MO). The purpose of these questions is to ascertain what information is provided to the child health service on both of these health checks.
- Section 5, ‘Results - Additional Comments’ presents under the key themes that emerged, the collated comments provided by respondents.
- Section 6, ‘Staffing’ summarises information on PHN and MO staffing.
- Section 7, ‘Conclusions and Recommendations’ outlines some conclusions and recommendations arising from the findings.

The information reported from the questionnaires is presented in the following sections of the report:

Issue	Section in survey questionnaire	Section in audit report	Page
Recommended Timing of Health Checks	1	2	8
Recommended Content, Staffing and Resources	2	3	38
Birth and 6 to 8 Weeks Health Check Information	3	4	53
Additional Comments	4	5	55
Staffing	5	6	60

(The information gathered from respondents in Section 6 of the questionnaire is not presented in this report)

1.3 Context

Best Health for Children (1999) (*BHFC*) recommended the required CHSS programme. In line with an evidence-based approach, a review process of recommendations contained in the original *BHFC* report began in 2004. It became apparent that completion of this process was required to allow current best practice to be reflected in national and regional training programmes. To address this need, the National Core Programme Review Group was established by the Programme of Action for Children (PAC) in March 2004.

The terms of reference of the National Core Programme Review Group was: “to establish a standardised, equitable and quality assured national core child health screening, surveillance and health promotion programme” (*BHFCR: 2005:7*). One of the recommendations made by the group was to audit each standard pertaining to the nine health checks i.e. from birth to primary school leaving: “The implementation of a revised national core child health programme needs to be evaluated through audit” (*BHFCR, 2005:8*). See Appendix II for an outline of the *BHFCR* (2005) standards. The need to audit CHSS programmes has also been documented by Hall and Elliman: “Audit should be constructed in a constructive manner with concentration on learning from sub-optimal outcomes.” (Hall and Elliman, 2004:374). They recommend that “....audit is conducted on large populations.” (Hall and Elliman, 2004: 374). This audit was carried out on the total national population of eligible children.

1.4 Audit Process and Methodology

Following a literature review and an assessment of the scope of the project, a questionnaire was developed to survey the LHO areas. The main focus of the questionnaire is the core CHSS programme rather than the broader child health service. The period 01/01/07 to 31/12/07 is used in the questionnaire for health checks before school entry, and the school year 2006 to 2007 is used to answer the school health check questions. While the National Service Plan (NSP) deliverable had identified Quarter Three for completion, it was recognised that there would need to be some flexibility to ensure that the LHO areas were given sufficient time to collate the necessary information; and for the Project Team to be able to cross check its accuracy.

Representatives to take part in the consultation process were sought from the national groups for Directors of Public Health Nursing (DPHNs), Principal Medical Officers (PMOs) and the Child and Adolescent Health Development Officers (CAHDOs)/Training Officers (TOs). It was agreed that eight DPHNs, two PMOs and two CAHDOs/TOs would review the questionnaire. It would have been desirable to have had a longer period of time to carry out further consultation, but given the time frame this was the optimum model to ensure that the views of the key disciplines involved were consulted. A number of issues were raised by the consultees including concerns about the breadth of information that is requested in the questionnaire. Subsequent changes were made. An introductory section to the questionnaire was devised with the following instruction included:

“If information is currently unavailable for a particular section, indicate this on the form by stating ‘not available’. It is noted that some requested information is not available in all areas, however, this should be recorded as ‘not available’ as it will provide useful information for data collection.”

A PCCC Review Group on PHN 48 Hour Postnatal/Primary Visit, established to review Performance Indicators (PIs), contacted the Project Team in October 2008 requesting that additional information would be included in the questionnaire relating to the postnatal/primary visit. The additional questions were included in Section One of the questionnaire (see Appendix I; Q 1.6 to Q 1.7).

A final version of the questionnaire was agreed in October 2008 (see Appendix I). The questionnaire was disseminated through the Local Health Manager (LHM) network on 24th October, 2008 with a return date of 19th November, 2008. Initial concerns were raised by respondents, however, about the lack of available information in some LHO areas. It was recognised that the key concern raised, as in the consultation process, was about their capacity to gather the breadth of information within the time frame. The Project Team decided to proceed with this breadth of information but reassured respondents that it would be acceptable to report ‘not available’ and that this was still useful in ascertaining a national picture. A memo was forwarded to the LHO network clarifying that questionnaires should be returned even if not all information was available to complete them, and addressing the other concerns raised. A copy of the memo is included in Appendix III.

Twenty two areas returned their questionnaires by 19th November 2008. An extended time was allowed for the other areas that had difficulty in providing the information within this time frame. It was also necessary to check the accuracy of some details provided by a number of LHO areas during this time. By mid January 2009, 31 of the 32 LHO areas had returned their questionnaires and the final report was collated. Meath LHO area informed the Project Team that they would not be returning a questionnaire due to staffing constraints.

Incoming data from the survey were collated and analysed by members of the Project Team. To present the data in this report, quantitative data sections follow the chronology and themes of the questionnaire, with results presented as bar charts, pie charts and data tables, whilst the qualitative data received were analysed manually and are summarised according to emerging content themes. Supporting illustrative direct quotes, as entered by respondents, are incorporated.

1.5 Limitations

In general, the most complete responses to the questionnaire were for requested information that is currently collected for PIs (the postnatal/primary visit health check and the 7 to 9 months health check). Areas that have the facility of an electronic child health information system (e.g. the Personal Health Record (PHR) system) were able to provide the most comprehensive information for all the health checks. The unavailability of information may be for a number of reasons, which include availability of staff to collate the information from manual records; or to input information on electronic systems. A limitation of the questionnaire was that by giving the option to return a response of 'not available' the actual reasons the information is not available are not clarified.

The information that was collected on the timing of the school health checks is not included in the report for the following reasons: many areas did not return figures; some areas that did return figures broke them down into sub-categories such as junior and senior infants or particular aspects of the programme that they were carrying out e.g. vision screening. This made the information difficult to collate for statistical purposes. Information was returned in other sections of the questionnaire that explained more completely the difficulties being experienced with the school health checks.

2. Results - Recommended Timing of Health Checks

This section presents the numerical information collected on the health checks in response to questions 1.1 to 1.5 from the questionnaire (see Appendix I). It provides an overview of the quantity of health checks carried out by each LHO area.

Figures 2.1(a) to 2.5(d) present the findings for each of the five health checks undertaken by LHO staff. Each health check is represented by four figures (a), (b), (c) and (d).

Figures labelled (a) identify the total cohort of children eligible for the check, with the number of children offered the check in the time specified by the standard and the number of children that were offered it later.

Figures labelled (b) identify the number of children offered the check in the time specified by the standard and the number of children that were offered it later presented in percentage form.

Figures labelled (c) identify the total cohort of children eligible for the check, with the number that received the check in the time specified by the standard and the number that received it later.

Figures labelled (d) identify the number of children that received the check in the time specified by the standard and the number of children that received it later presented in percentage form.

Additionally for the postnatal/primary visit respondents were asked in questions 1.6 and 1.7 to indicate the reasons why some of the cohort were offered and received the visit later than the time specified by the standard. The information is presented by pie chart in figures 2.1(e) and 2.1(f).

Numerical information on the timing of the two school health checks is not included for reasons provided in section 1.5.

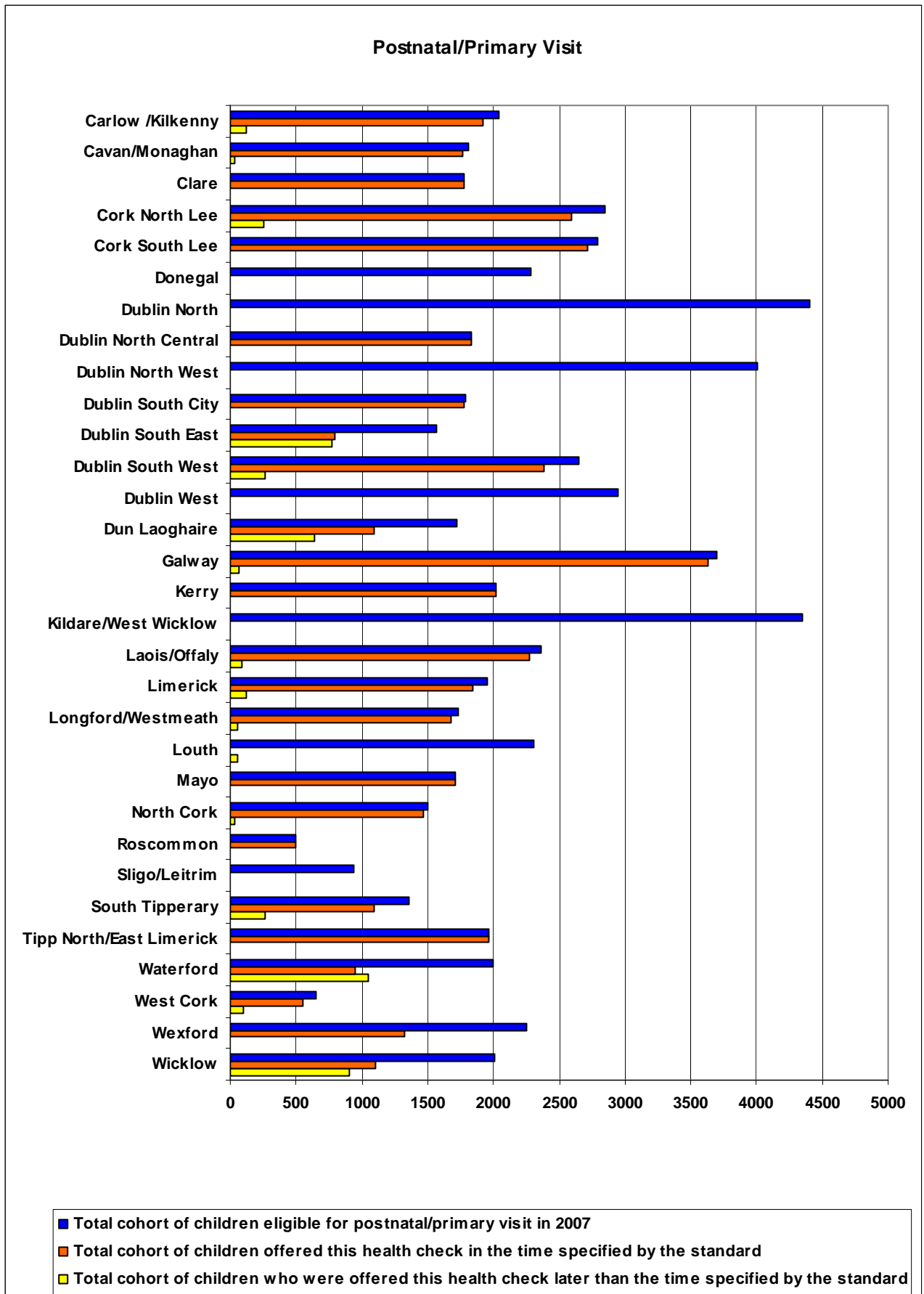
Note:

- LHO areas that recorded zero figures or gave no response have not been included in the analysis.
- A number of LHO areas provided information on only some aspects of service delivery on the questionnaire, e.g. they may have recorded how many children received a specific health check but not how many children were offered the specific health check. This lack of full information may not infer that the service is not being carried out; rather it could be due to a lack of service activity recording.
- Where bars for certain LHO areas do not appear in figures 2.1(a) to 2.5(d) this reflects gaps in information provided in response to questions in the questionnaire.

2. 1 Postnatal/Primary Visit

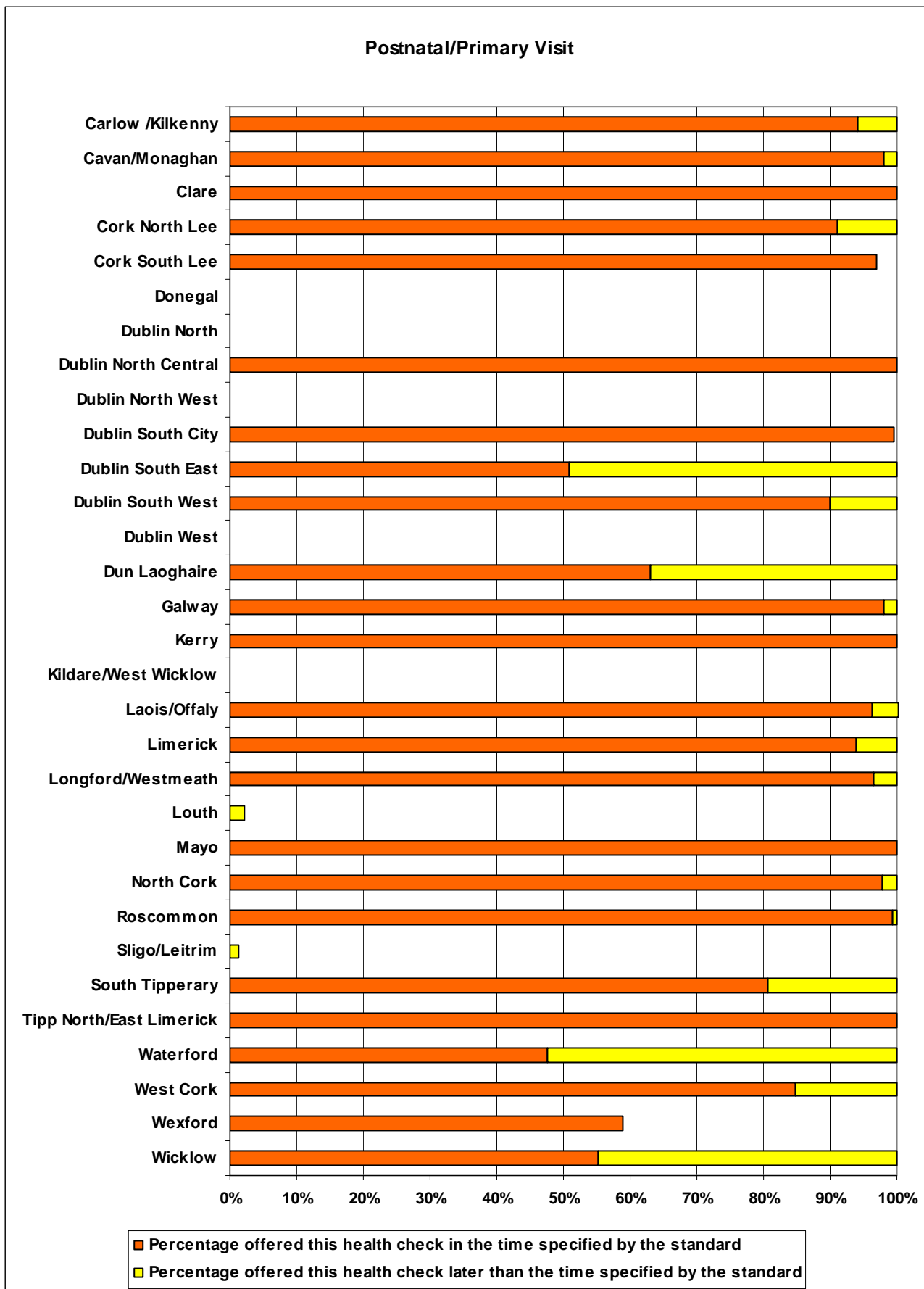
In figure 2.1(a) the blue bar shows, for each LHO area, the eligible cohort for the visit; the orange bar presents the cohort that was **offered** the visit **in the time** specified by the standard; and the yellow bar presents the cohort that was **offered** the visit **later** than the time.

Figure 2.1(a)



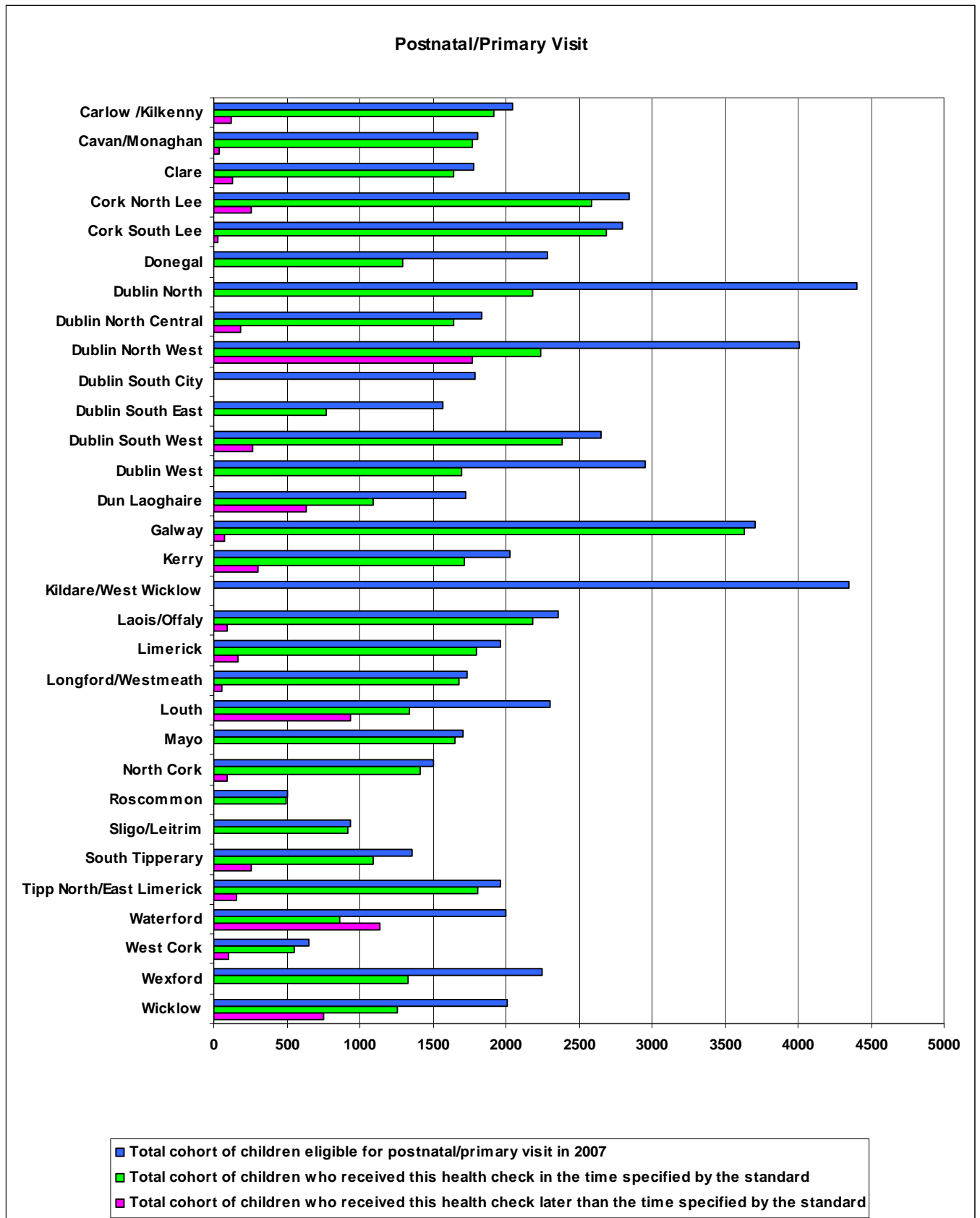
In figure 2.1(b) the orange section of the bar illustrates, for each LHO area, the percentage of the total cohort that was **offered** the visit **in the time** specified by the standard; and the yellow section of the bar illustrates the percentage of the total cohort that was **offered** the visit **later** than the time.

Figure 2.1(b)



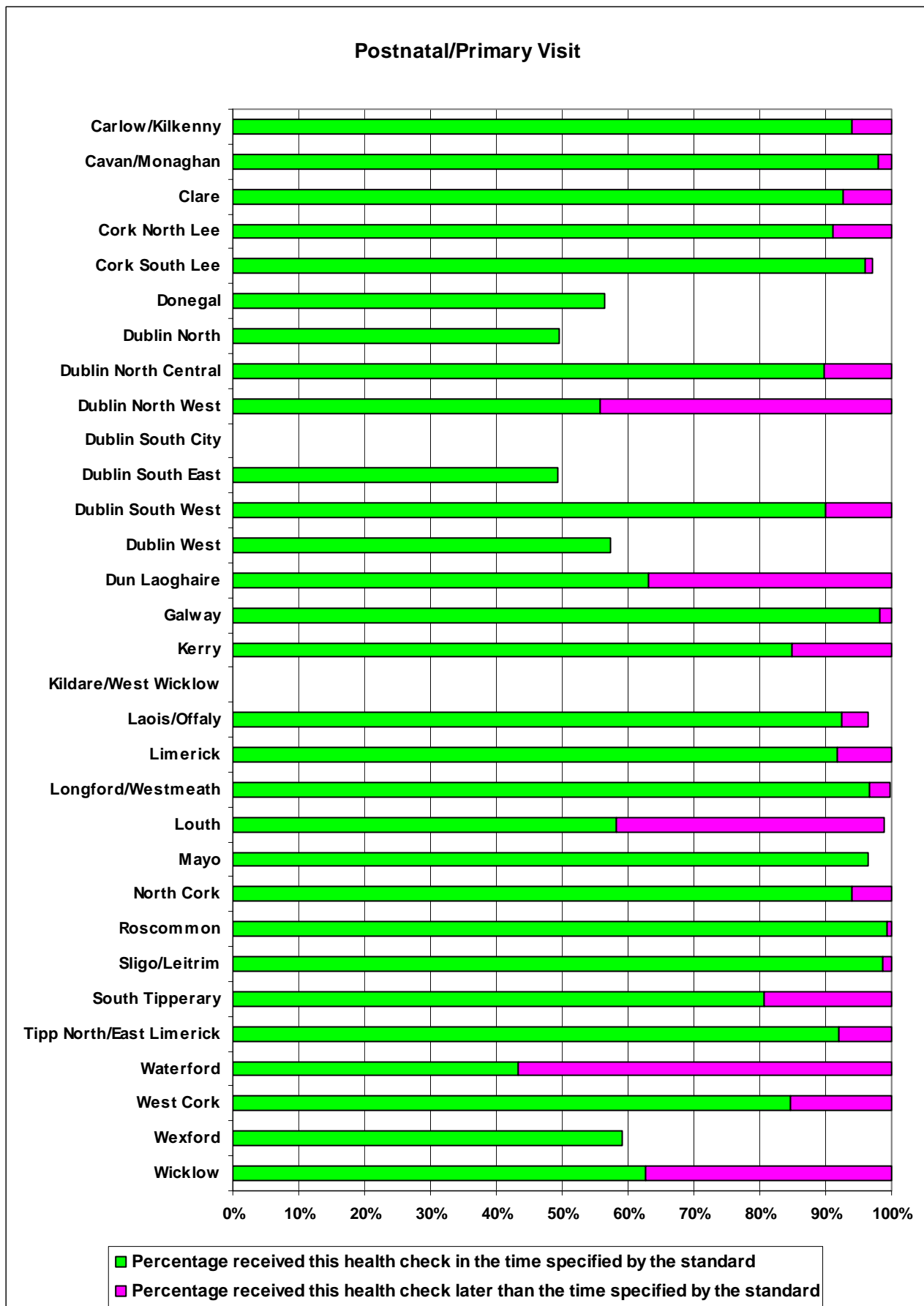
In figure 2.1(c) the blue bar shows, for each LHO area, the eligible cohort for the visit; the green bar presents the cohort that **received** the visit **in the time** specified by the standard; and the pink bar presents the cohort that **received** the visit **later** than the time.

Figure 2.1(c)



In figure 2.1(d) the green section of the bar illustrates, for each LHO area, the percentage of the total cohort that **received** the visit **in the time** specified by the standard; and the pink section of the bar illustrates the percentage of the total cohort that **received** the visit **later** than the time.

Figure 2.1(d)



The following conclusions can be drawn from figures 2.1(a) to 2.1(d)

Postnatal/Primary Visit			
Question	No. of LHOs that gave no response	No. of LHOs that gave a response of zero	No. of LHO returns (excluding no response and zero)
offered on time	7	-	24
offered later	8	5	18
received on time	2	-	29
received later	8	-	23

- Based on the 24 LHO areas reporting (accounting for 46,544 children), 88% (40,769) were offered the visit in the time specified by the standard.
- Based on the 18 LHO areas reporting (accounting for 33,644 children), 14% (4,834) were offered the visit later than the time specified by the standard.
- Based on the 29 LHO areas reporting (accounting for 61,651 children), 77% (47,636) received the visit in the time specified by the standard.
- Based on the 23 LHO areas reporting (accounting for 46,478 children), 16% (7,584) received the visit later than the time specified by the standard.

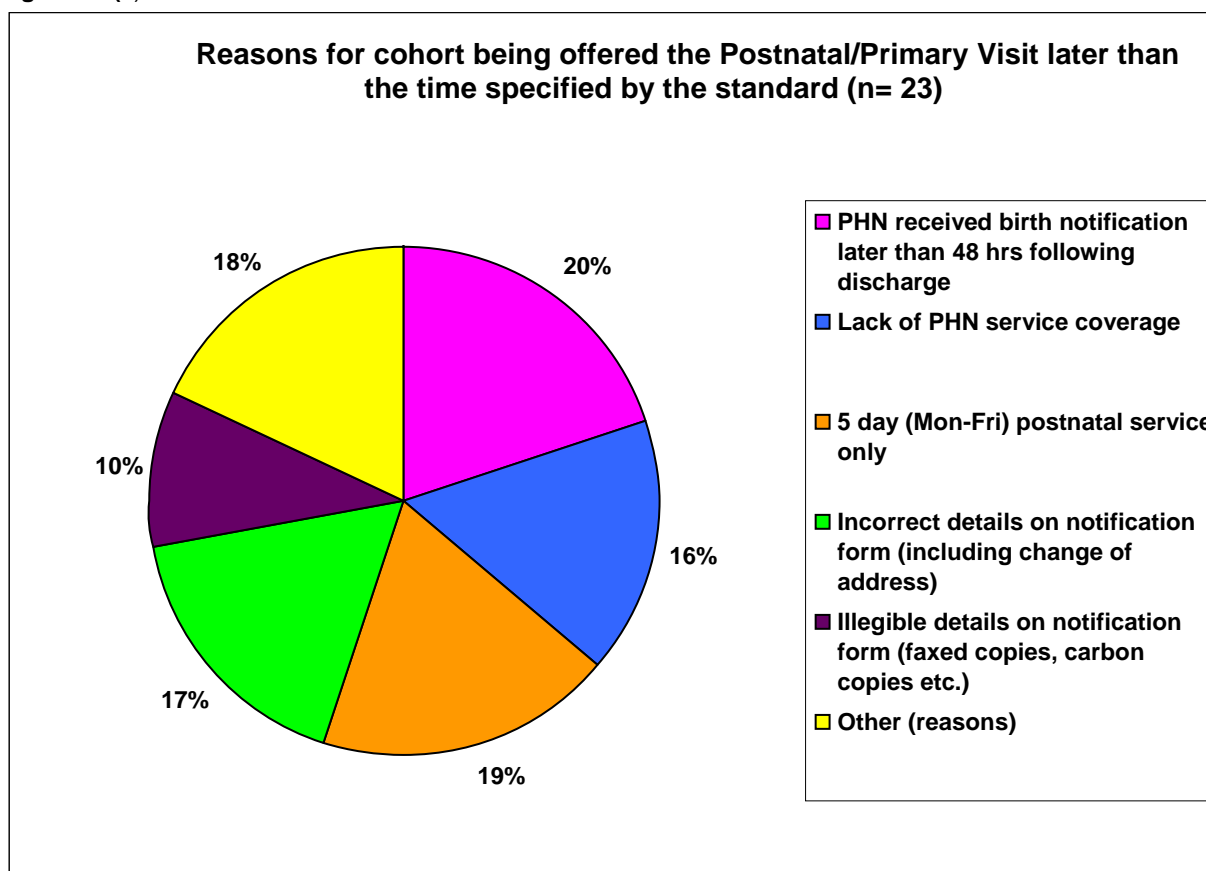
2.1.1 Reasons for the Postnatal/Primary Visit being offered and being received later than the time specified by the standard

Respondents were also asked in relation to the postnatal/primary visit;

- To indicate the reason(s) this cohort were offered this health check later than the time specified by the standard (drawn from question 1.6).
- To indicate the reason(s) this cohort received this health check later than the time specified by the standard (drawn from question 1.7).

Figure 2.1(e) shows the reasons given by the 23 LHO areas why the eligible cohort was **offered** the postnatal/primary visit later than the time specified by the standard.

Figure 2.1(e)



The reasons for 'Other' were elicited from the responses to question 1.6 and are presented as direct quotes. They have been included under the following headings: data collection; information; service delivery and staffing.

Data Collection

"Data not available on PHR re: incorrect details."

"Unknown data as not available on Child Health System."

Information

"There are currently difficulties in receiving accurate information on notification visit."

"Details sent to CHSS are often not accurate i.e. phone numbers often change."

"There is difficulty sometimes in sourcing information from the Maternity Hospital though we have a system in place to facilitate this and we are seeking to improve this system presently."

“Missing last digit of mobile phone number on birth notification and unable to access mother.”
“Delayed notification from other Hospitals.”
“Incorrect info provided on discharge form.”
“Moved from address given.”

Service Delivery

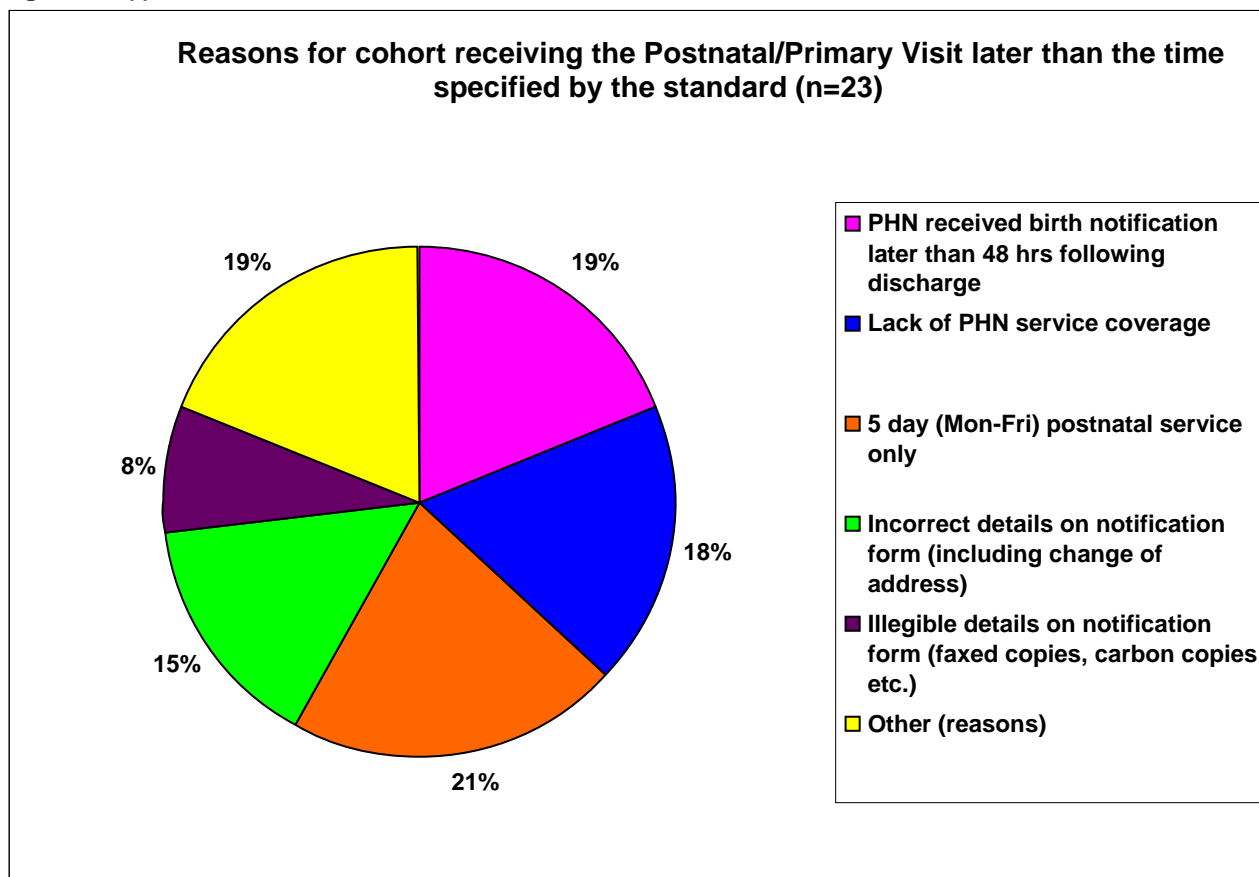
“Baby in special care baby unit.”
“Child deceased therefore no service offered.”
“The service is offered on time in most cases, but there may be a high rate of non-attendance at clinic appointments. The child then may attend a second appointment but unfortunately this may result in the child’s age being outside the cohort and hence the assessment of the child while carried out is not recorded for statistical purposes.”
“Approx 400 infants and mothers of the birth cohort were receipting [sic] services from the Early Discharge Team Rotunda Hospital.”
“Mum staying with extended family post birth and not at home when nurse calls.”
“Approx 350 mothers and infants were receiving visits from the early discharge team Coombe Hospital.”
“Occasionally baby transferred to children’s hospital or mum re-admitted.”
“Occasional service refusal.”
“Delay at maternal request.”
“Discharge after 48 hours.”
“Children may not have been living in this area when they were due checks.”

Staffing

“Many nurses are also cross covering two areas and at 62% staffing rates there is also the chance that they cannot see all birth notifications within 48 hours.”
“Weekend an issue as mostly no PHN on duty, therefore late primary visit.”

Figure 2.1(f) shows the reasons given by the 23 LHO areas why the eligible cohort **received** the postnatal/primary visit later than the time specified by the standard.

Figure 2.1(f)



The reasons for 'Other' were elicited from the responses to question 1.7 and are presented as direct quotes. They have been included under the following headings: data collection; information; service delivery and staffing.

Data Collection

“Unknown as data not available on the Child Health System”.

Information

“Unable to contact”.

“Lack of telephone number and unable to access same from hospital”.

“Missing last digit of mobile phone number on birth”.

“Families move – no forwarding address, particularly asylum seekers. No information can be obtained re: Traveller”.

Service Delivery

“Baby in hospital”.

“Refusal of service”.

“Movement in/out”.

“Sometimes the service was offered on time but the parents were unable to arrange for the assessment to be carried out due to work commitments”.

“Failure to keep appointment”.

“Approx 400 infants and mothers of the birth cohort were receipting [sic] services from the Early Discharge team Rotunda Hospital”.

“Language barrier with our foreign national cohort required an interpreter to be present therefore some delays occurred – this would be a very small number even though North West Dublin has

a large non-national [sic] cohort”.

“Notification”.

“Delay at maternal request”.

Staffing

“Core child health screening targets unmet due to staff deficits, high clinical caseloads and high PHN area populations”.

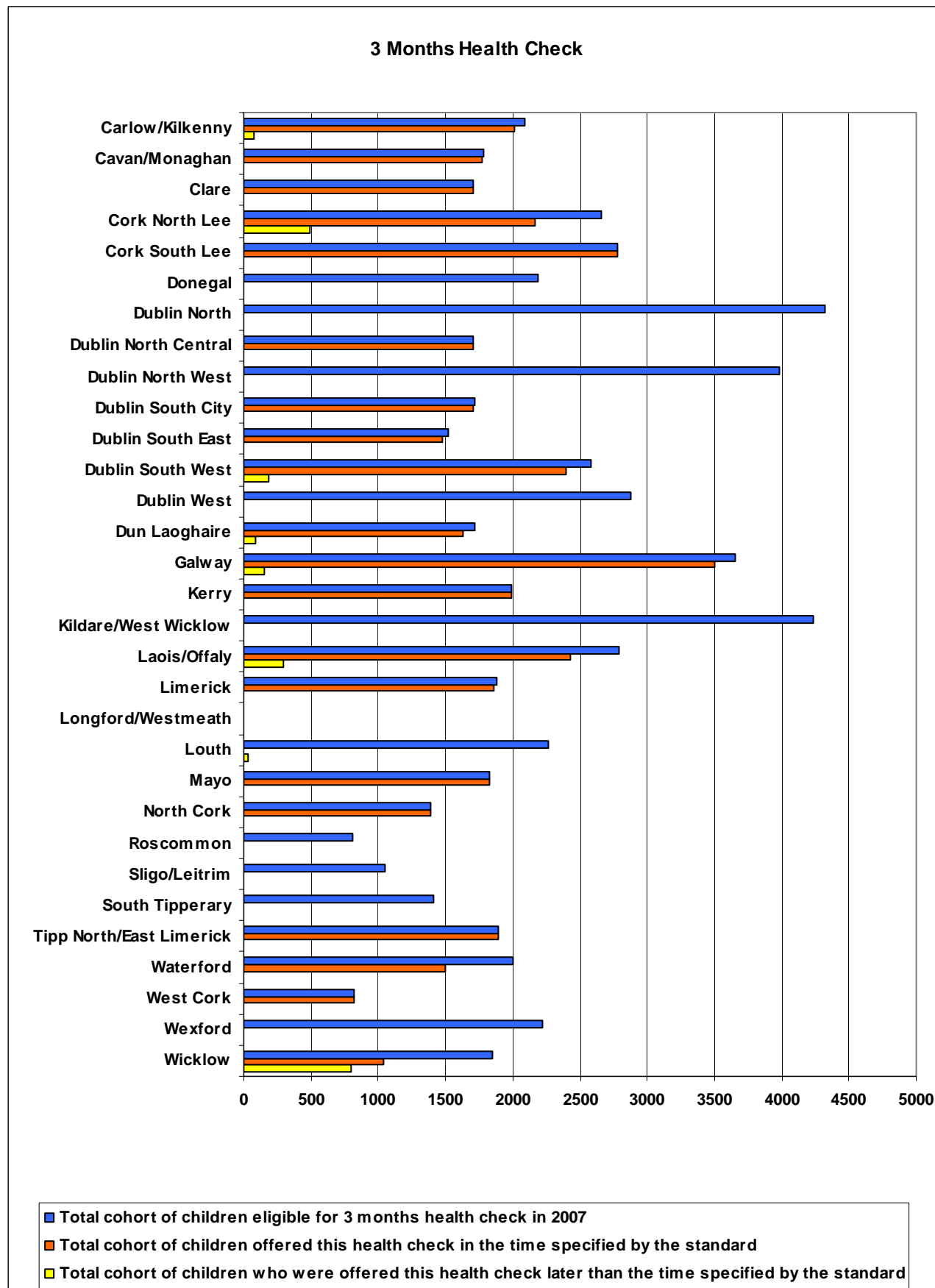
“Many nurses are also cross covering two areas and at 62% staffing rates there is also the chance that they cannot see all birth notifications within 48 hours”.

“Weekend an issue as mostly no PHN on duty for planned essential services”.

2.2 3 Months Health Check

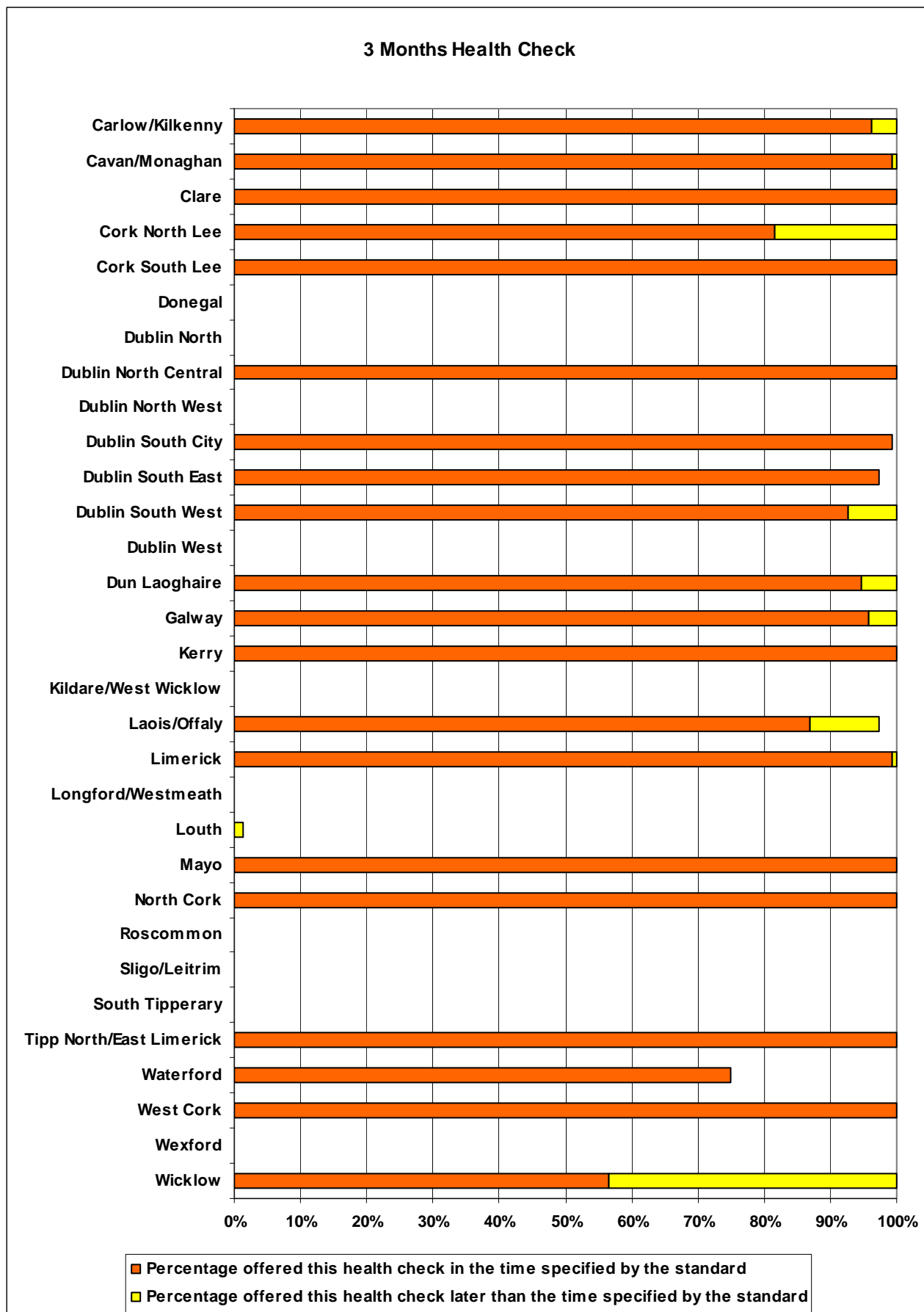
In figure 2.2(a) the blue bar shows, for each LHO area, the eligible cohort for the health check; the orange bar presents the cohort that was **offered** the health check in **the time** specified by the standard; and the yellow bar presents the cohort that was **offered** the health check **later** than the time.

Figure 2.2 (a)



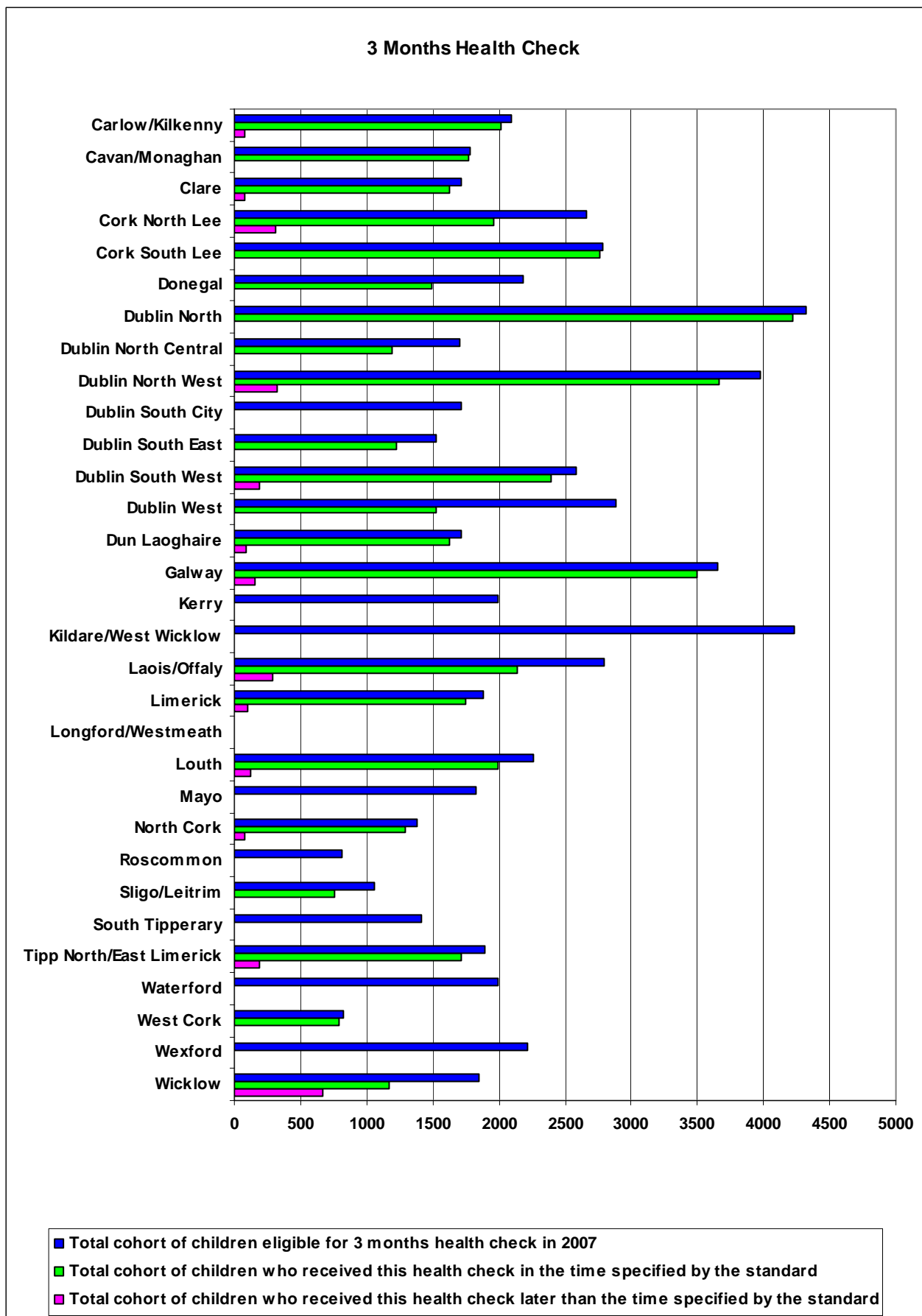
In figure 2.2(b) the orange section of the bar illustrates, for each LHO area, the percentage of the total cohort that was **offered** the health check **in the time** specified by the standard; and the yellow section of the bar illustrates the percentage of the total cohort that was **offered** the health check **later** than the time.

Figure 2.2 (b)



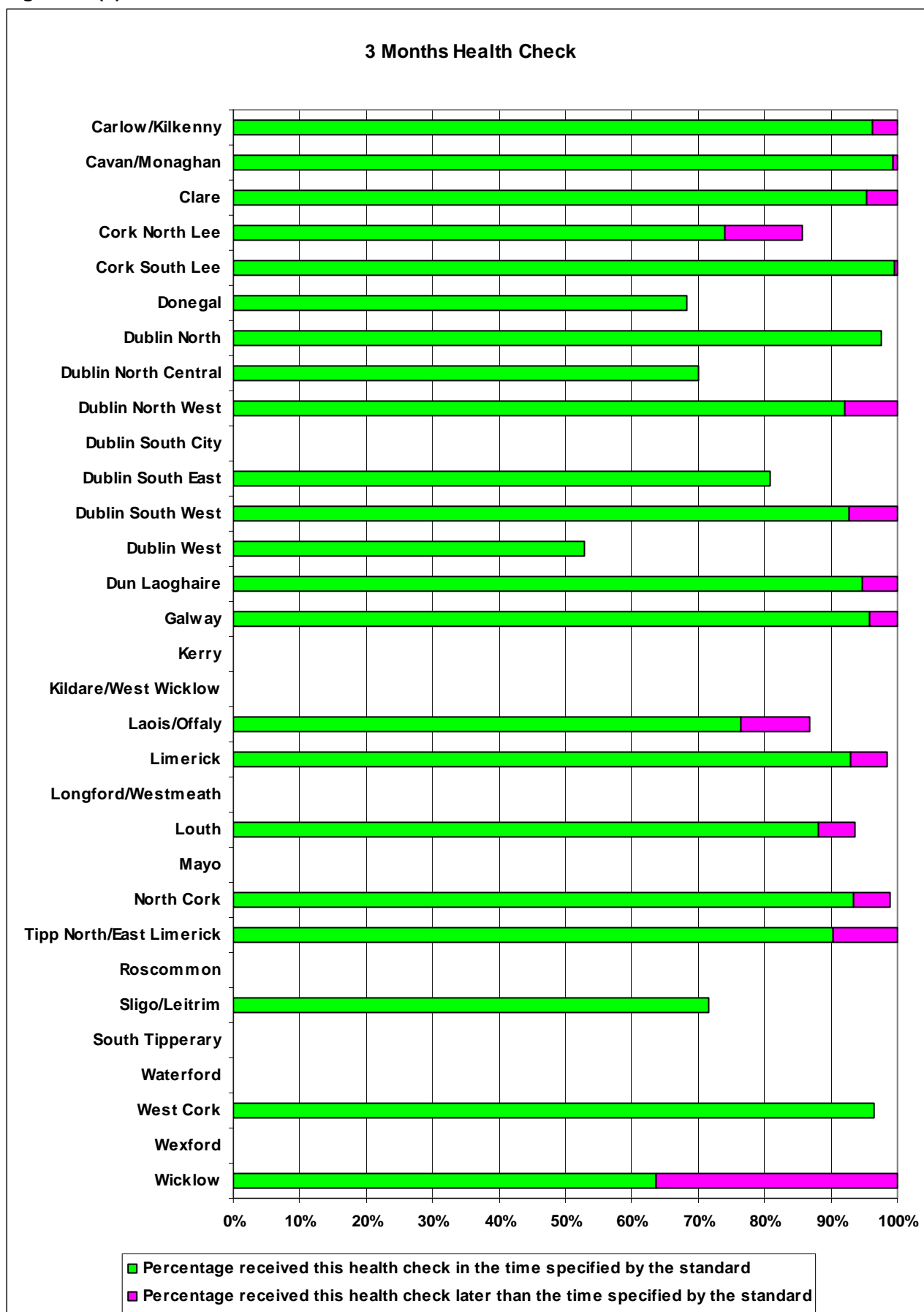
In figure 2.2 (c) the blue bar shows, for each LHO area, the eligible cohort for the health check; the green bar presents the cohort that **received** the health check **in the time** specified by the standard; and the pink bar presents the cohort that **received** the health check **later** than the time.

Figure 2.2(c)



In figure 2.2(d) the green section of the bar illustrates, for each LHO area, the percentage of the total cohort that **received** the health check **in the time** specified by the standard; and the pink section of the bar illustrates the percentage of the total cohort that **received** the health check **later** than the time.

Figure 2.2(d)



The following conclusions can be drawn from Figures 2.2(a) to 2.2(d)

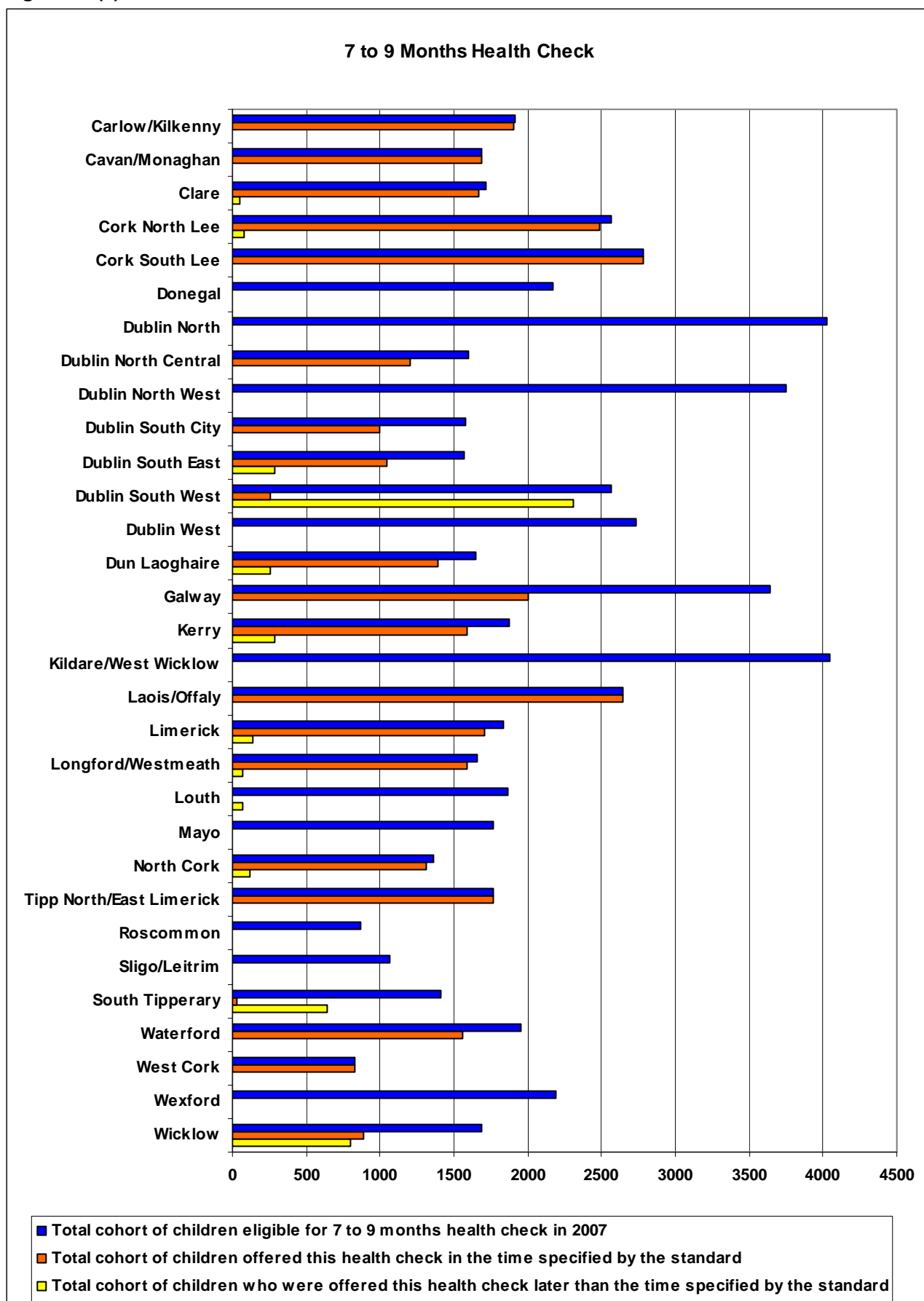
3 Months Health Check			
Question	No. of LHOs that gave no response	No. of LHOs that gave a response of zero	No. of LHO returns (excluding no response and zero)
offered on time	12	-	19
offered later	16	5	10
received on time	9	-	22
received later	16	-	15

- Based on the 19 LHO areas reporting (accounting for 48,194 children), 71% (34,120) were offered the health check in the time specified by the standard.
- Based on the 10 LHO areas reporting (accounting for 23,270 children), 9% (2,146) were offered the health check later than the time specified by the standard.
- Based on the 22 LHO areas reporting (accounting for 49,524 children), 86% (42,598) received the health check in the time specified by the standard.
- Based on the 15 LHO areas reporting (accounting for 35,024 children), 8% (2,701) received the health check later than the time specified by the standard.

2.3 7 to 9 Months Health Check

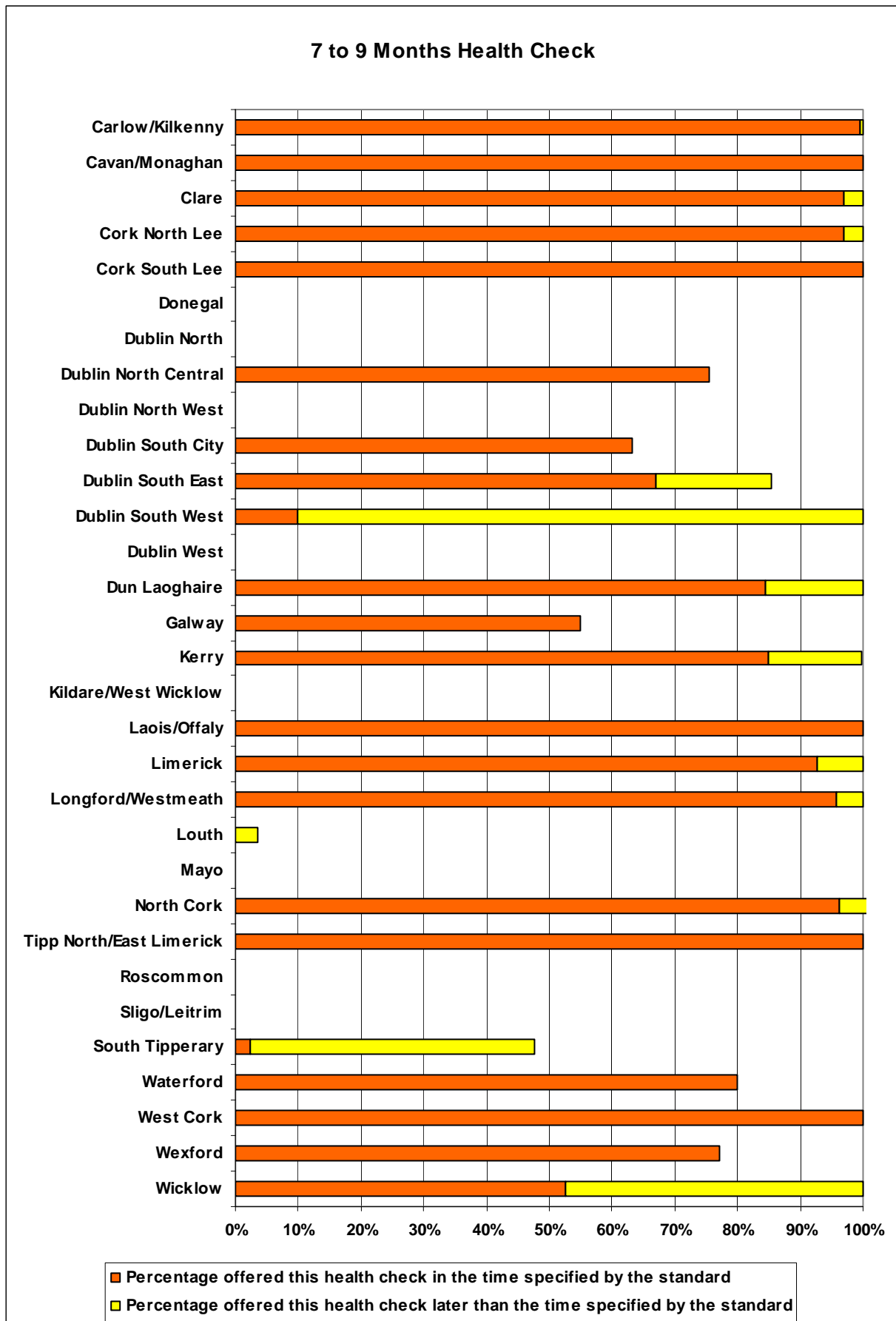
In figure 2.3(a) the blue bar shows, for each LHO area, the eligible cohort for the health check; the orange bar presents the cohort that was **offered** the health check **in the time** specified by the standard; and the yellow bar presents the cohort that was **offered** the health check **later** than the time.

Figure 2.3(a)



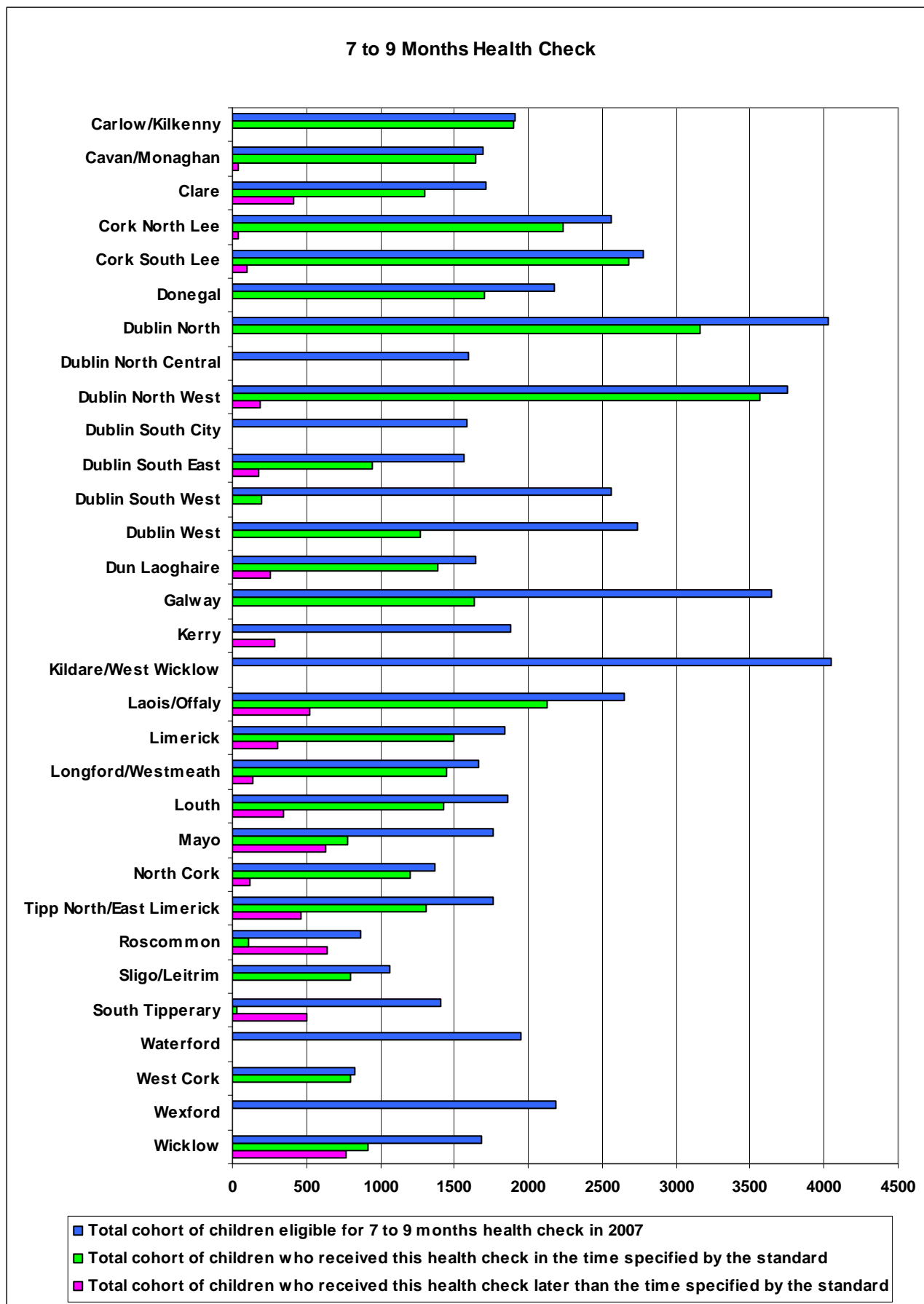
In figure 2.3(b) the orange section of the bar illustrates, for each LHO area, the percentage of the total cohort that was **offered** the health check **in the time** specified by the standard; and the yellow section of the bar illustrates the percentage of the total cohort that was **offered** the health check **later** than the time.

Figure 2.3(b)



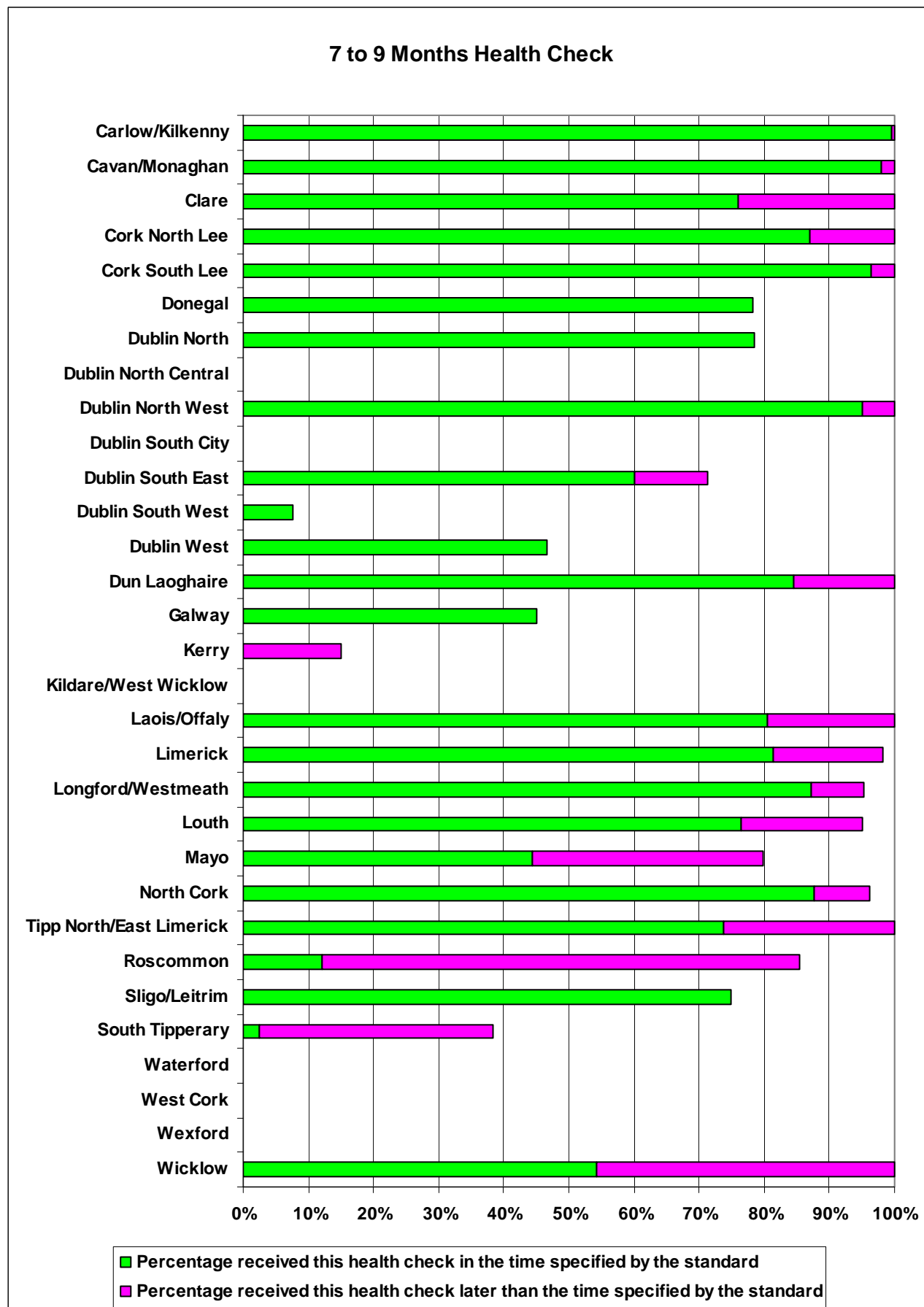
In figure 2.3(c) the blue bar shows, for each LHO area, the eligible cohort for the visit; the green bar presents the cohort that **received** the health check **in the time** specified by the standard; and the pink bar presents the cohort that **received** the health check **later** than the time.

Figure 2.3(c)



In figure 2.3(d) the green section of the bar illustrates, for each LHO area, the percentage of the total cohort that **received** the health check **in the time** specified by the standard; and the pink section of the bar illustrates the percentage of the total cohort that **received** the health check **later** than the time.

Figure 2.3(d)



The following conclusions can be drawn from Figures 2.3(a) to 2.3(d)

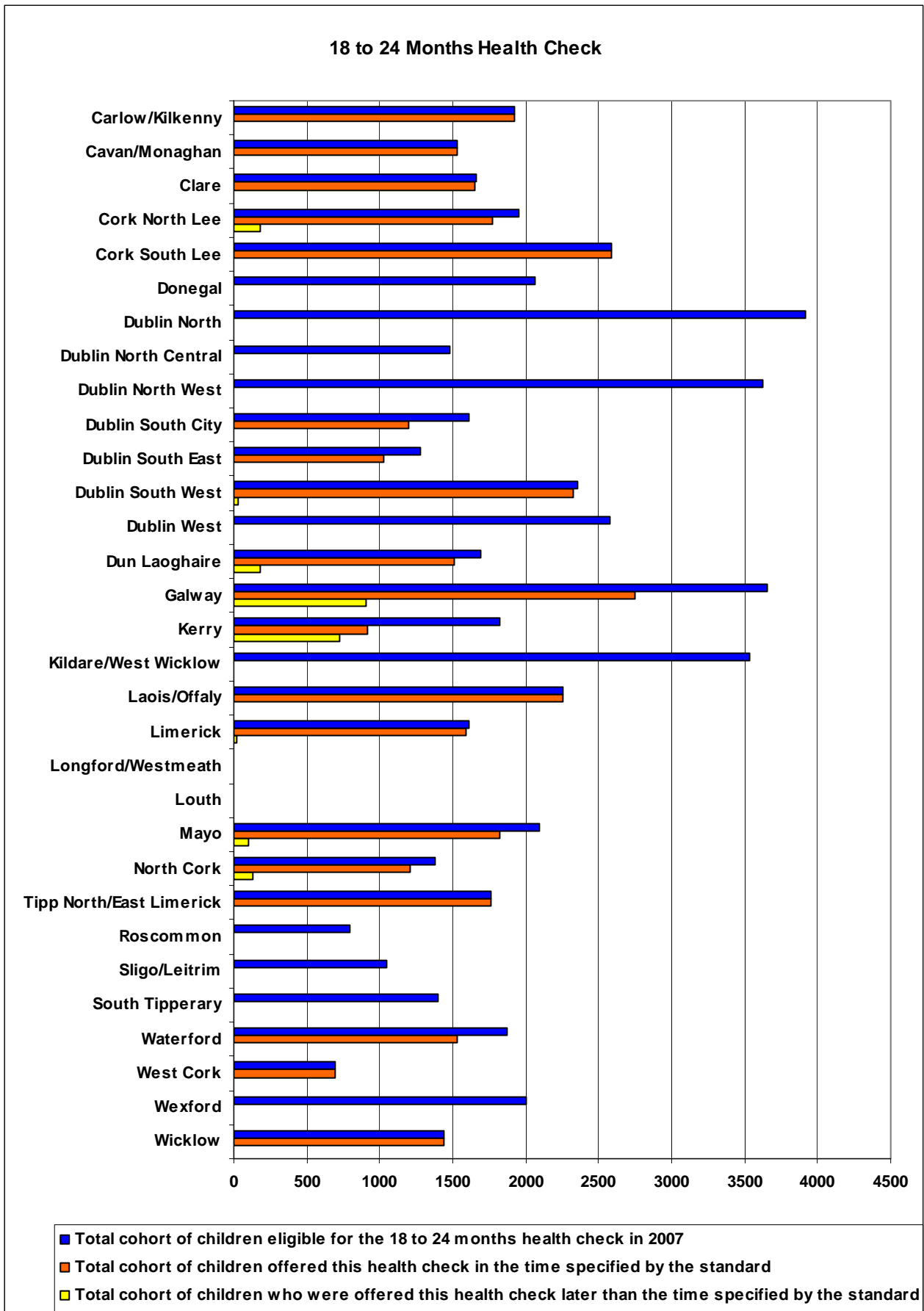
7 to 9 Months Health Check			
Question	No. of LHOs that gave no response	No. of LHOs that gave a response of zero	No. of LHO returns (excluding no response and zero)
offered on time	10	-	21
offered later	14	4	13
received on time	6	-	25
received later	12	-	19

- Based on the 21 LHO areas reporting (accounting for 40,289 children), 78% (31,351) were offered the health check in the time specified by the standard.
- Based on the 13 LHO areas reporting (accounting for 23,668 children), 22% (5,104) were offered the health check later than the time specified by the standard.
- Based on the 25 LHO areas reporting (accounting for 51,530 children), 70% (36,053) received the health check in the time specified by the standard.
- Based on the 19 LHO areas reporting (accounting for 36,371 children), 16% (5,930) received the health check later than the time specified by the standard.

2.4 18 to 24 Months Health Check

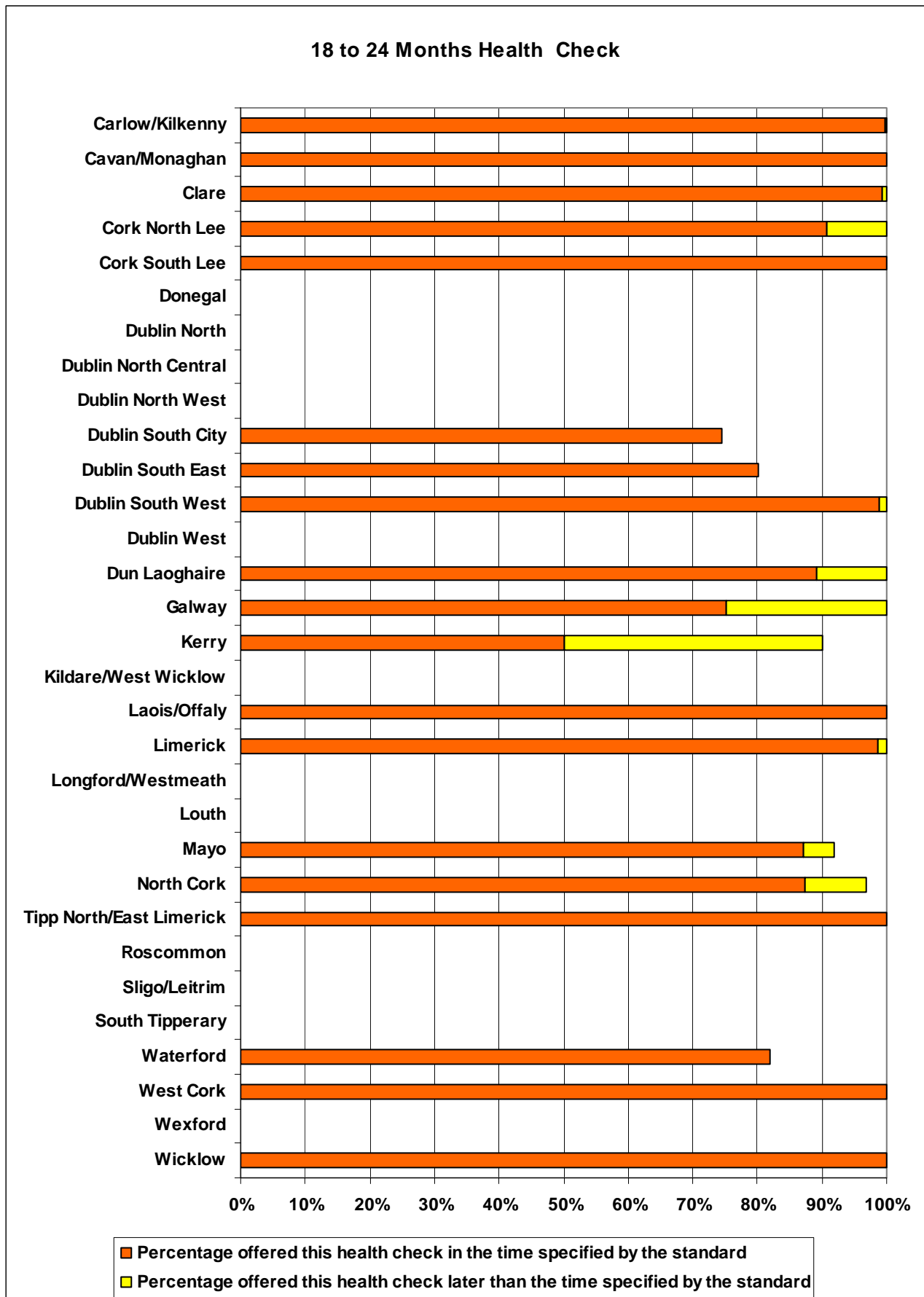
In figure 2.4(a) the blue bar shows, for each LHO area, the eligible cohort for the health check; the orange bar presents the cohort that was **offered** the health check in **the time** specified by the standard; and the yellow bar presents the cohort that was **offered** the health check **later** than the time.

Figure 2.4(a)



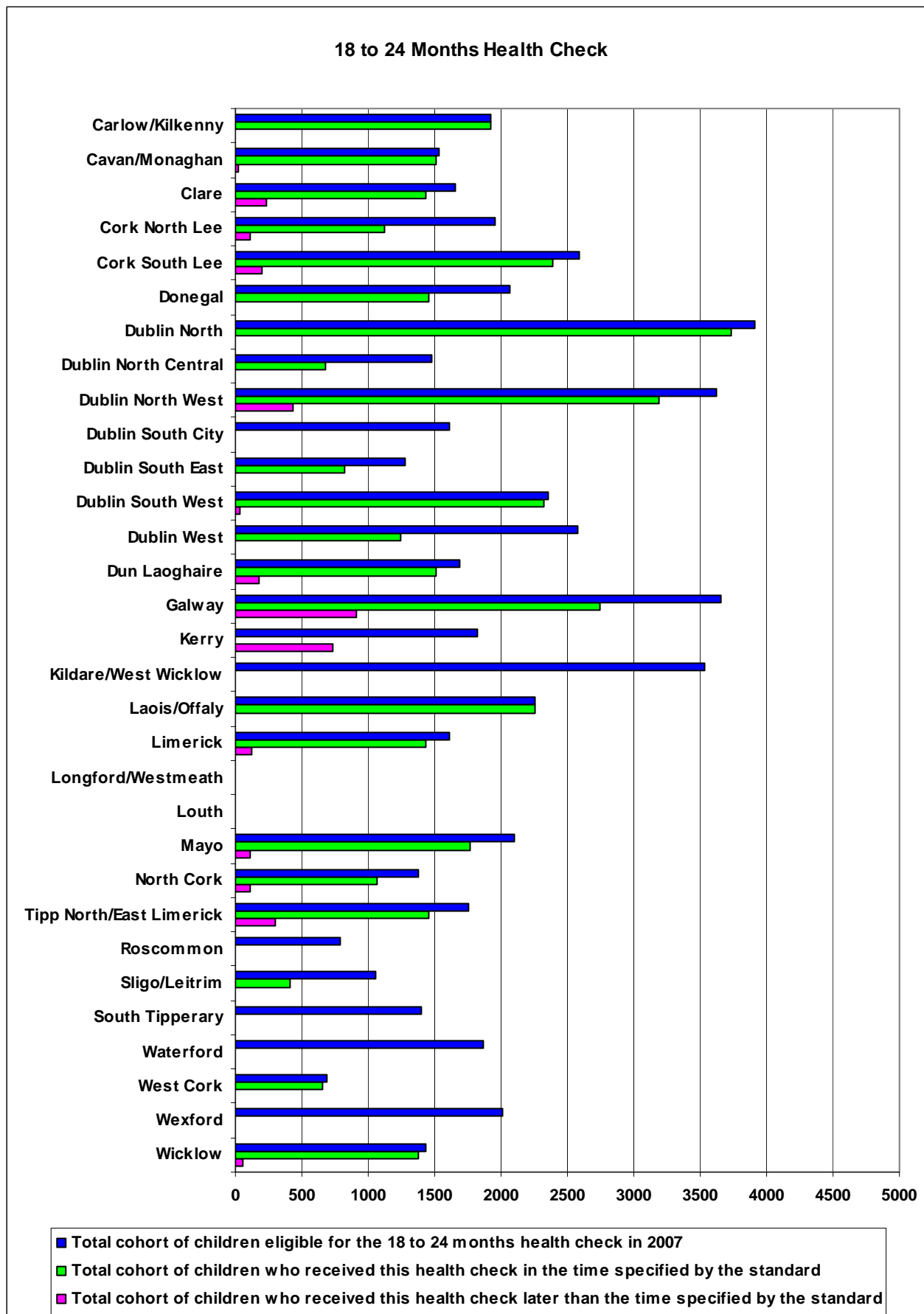
In figure 2.4(b) the orange section of the bar illustrates, for each LHO area, the percentage of the total cohort that was **offered** the health check **in the time** specified by the standard; and the yellow section of the bar illustrates the percentage of the total cohort that was **offered** the health check **later** than the time.

Figure 2.4(b)



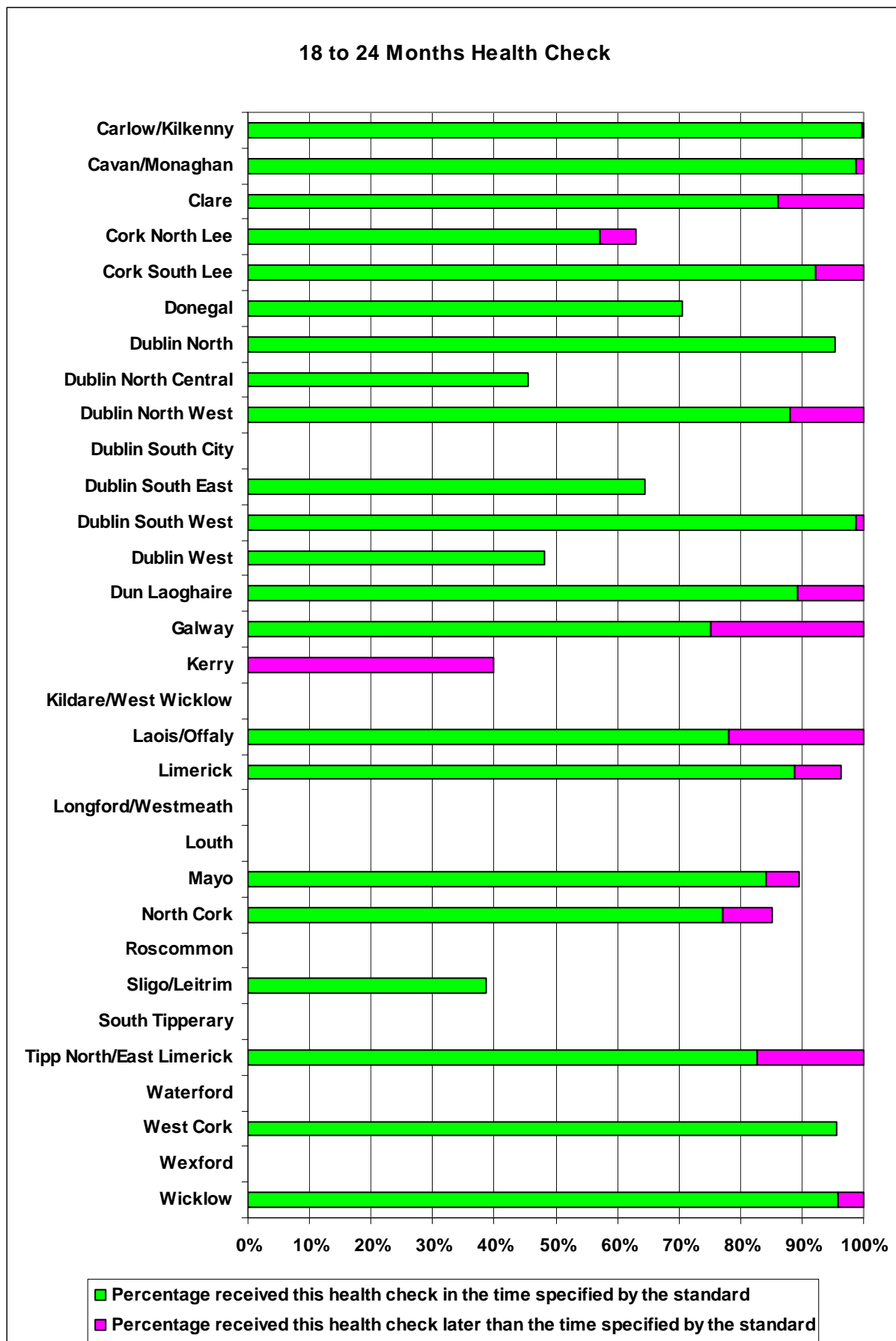
In figure 2.4(c) the blue bar shows, for each LHO area, the eligible cohort for the visit; the green bar presents the cohort that **received** the health check **in the time** specified by the standard; and the pink bar presents the cohort that **received** the health check **later** than the time.

Figure 2.4(c)



In figure 2.4(d) the green section of the bar illustrates, for each LHO area, the percentage of the total cohort that **received** the health check **in the time** specified by the standard; and the pink section of the bar illustrates the percentage of the total cohort that **received** the health check **later** than the time.

Figure 2.4(d)



The following conclusions can be drawn from Figures 2.4(a) to 2.4(d)

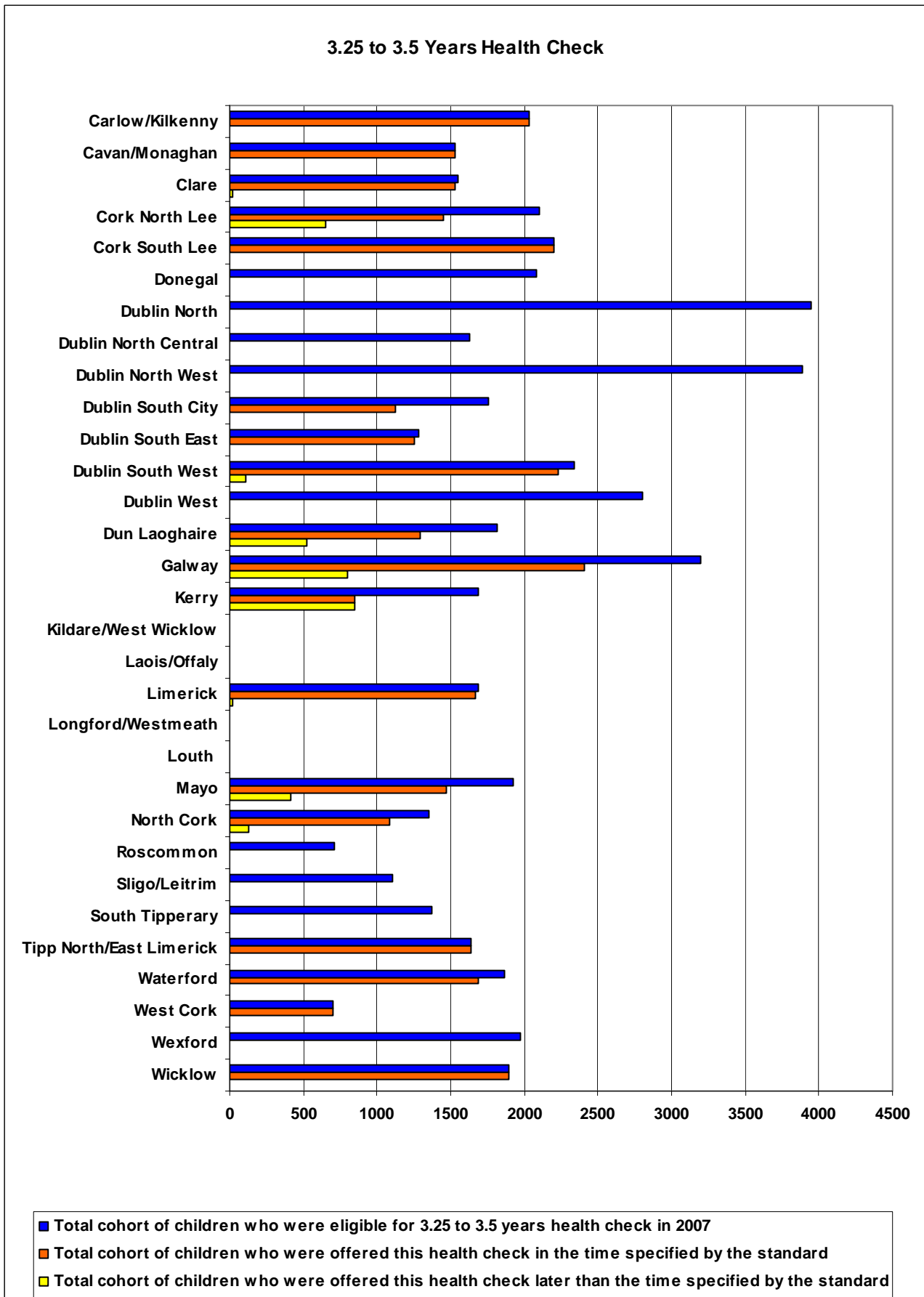
18 to 24 Months Health Check			
Question	No. of LHOs that gave no response	No. of LHOs that gave a response of zero	No. of LHO returns (excluding no response and zero)
offered on time	12	-	19
offered later	17	4	10
received on time	9	-	22
received later	16	-	15

- Based on the 19 LHO areas reporting (accounting for 35,175 children), 90% (31,483) were offered the health check in the time specified by the standard.
- Based on the 10 LHO areas reporting (accounting for 20,145 children), 11% (2,295) were offered the health check later than the time specified by the standard.
- Based on the 22 LHO areas reporting (accounting for 44,576 children), 82% (36,488) received the health check in the time specified by the standard.
- Based on the 15 LHO areas reporting (accounting for 31,086 children), 11% (3,553) received the health check later than the time specified by the standard.

2.5 3.25 to 3.5 Years Health Check

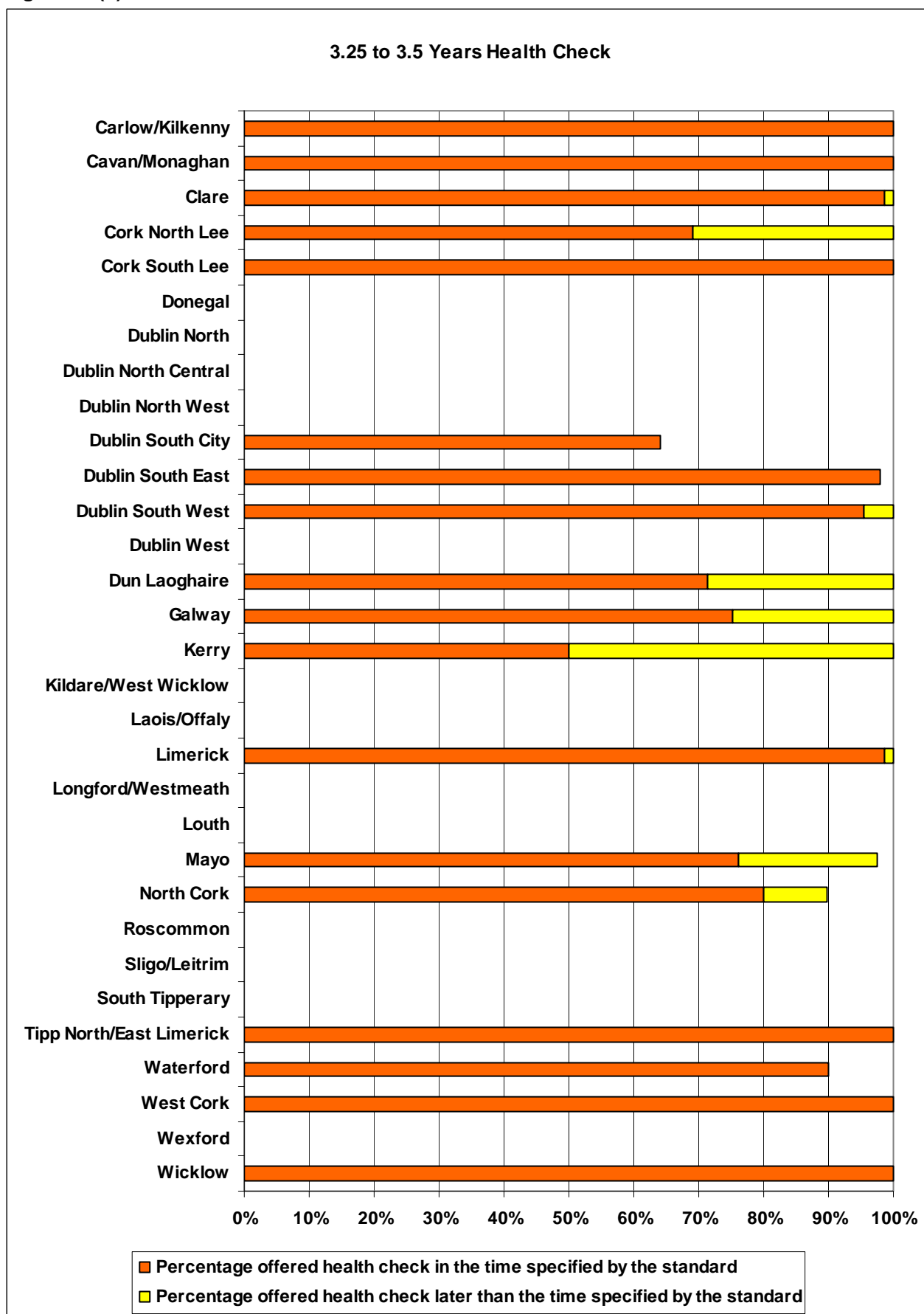
In figure 2.5(a) the blue bar shows, for each LHO area, the eligible cohort for the health check; the orange bar presents the cohort that was **offered** the health check in **the time** specified by the standard; and the yellow bar presents the cohort that was **offered** the health check **later** than the time.

Figure 2.5(a)



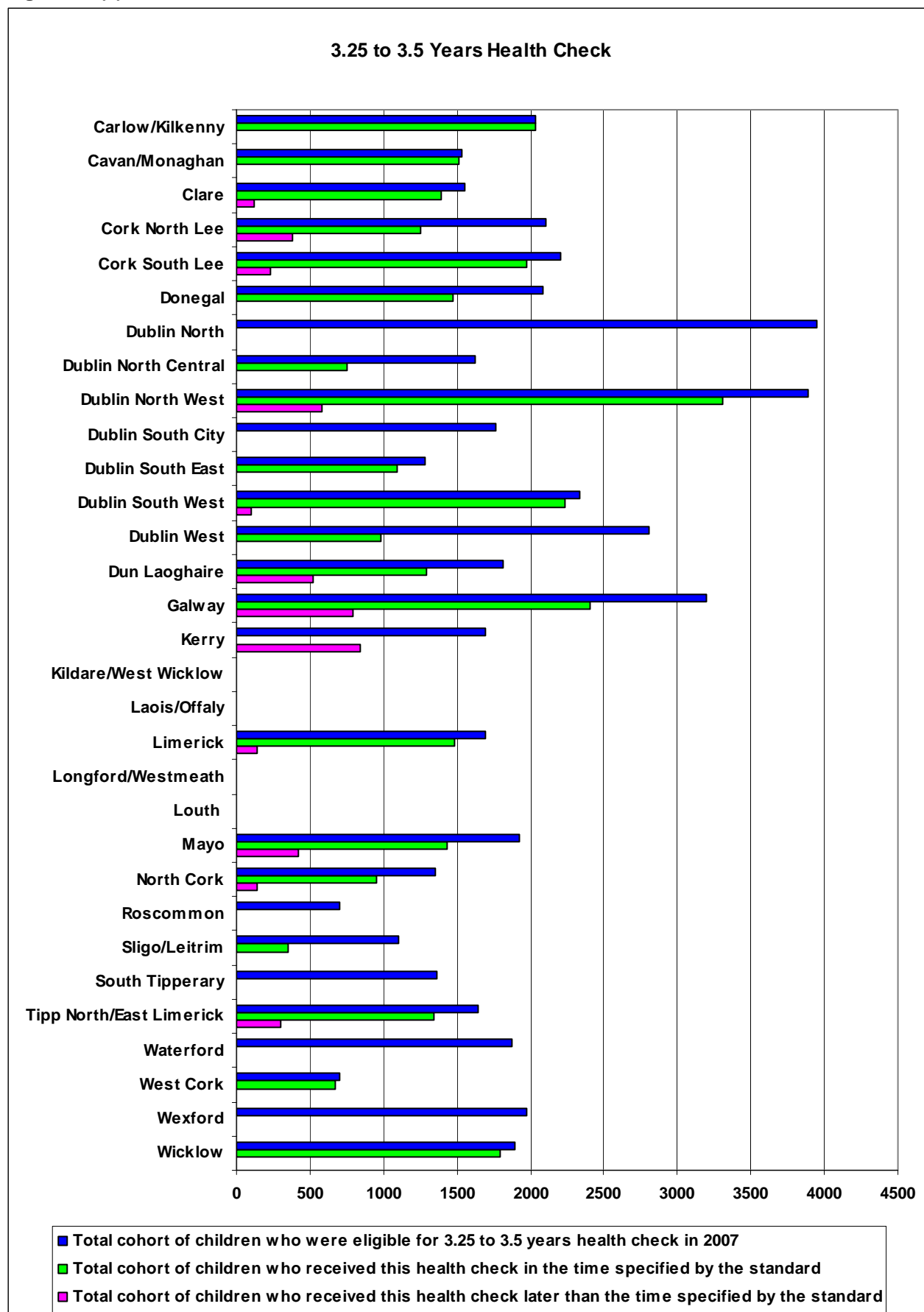
In figure 2.5(b) the orange section of the bar illustrates, for each LHO area, the percentage of the total cohort that was **offered** the health check **in the time** specified by the standard; and the yellow section of the bar illustrates the percentage of the total cohort that was **offered** the health check **later** than the time.

Figure 2.5(b)



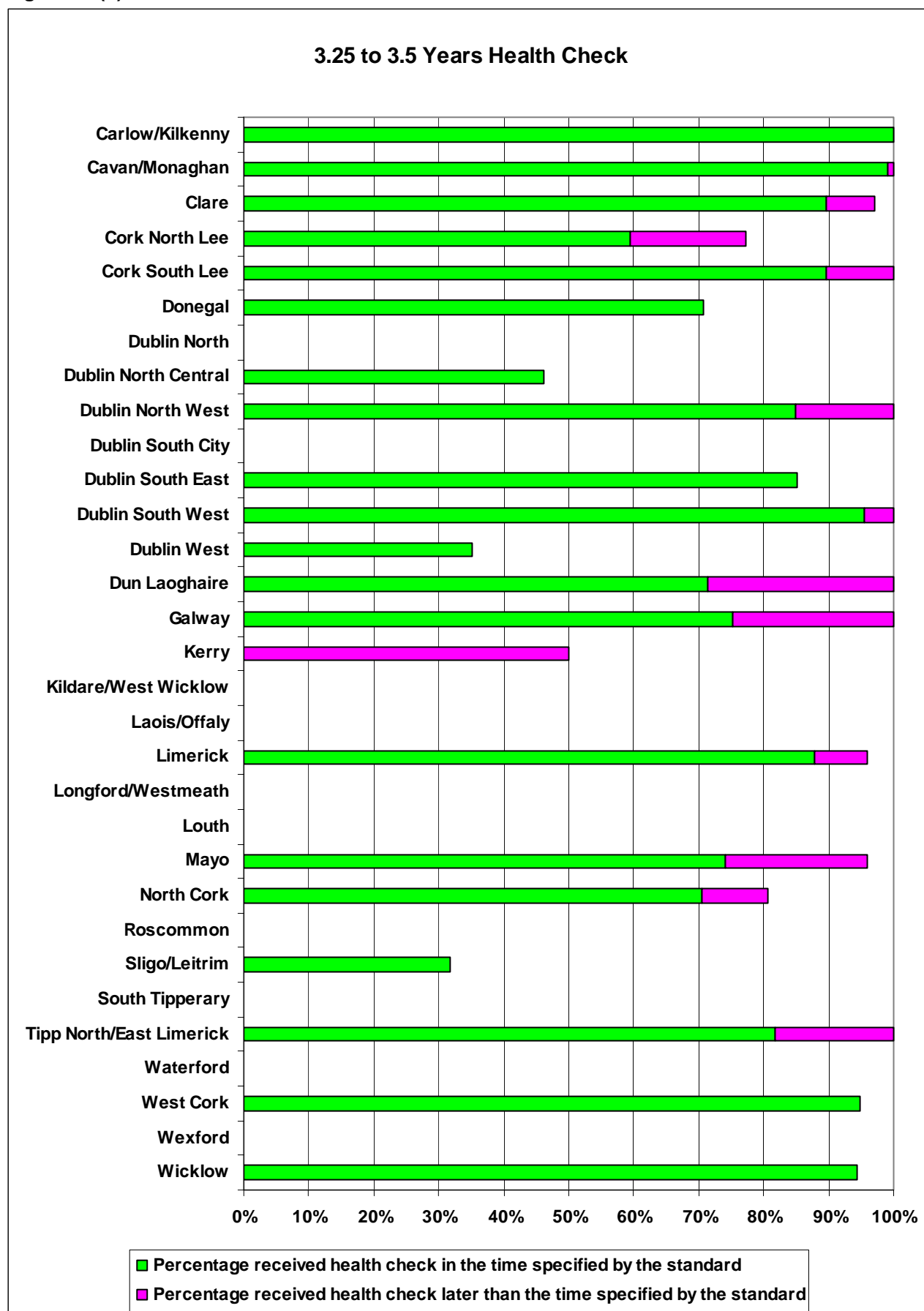
In figure 2.5(c) the blue bar shows, for each LHO area, the eligible cohort for the visit; the green bar presents the cohort that **received** the health check **in the time** specified by the standard; and the pink bar presents the cohort that **received** the health check **later** than the time.

Figure 2.5(c)



In figure 2.5(d) the green section of the bar illustrates, for each LHO area, the percentage of the total cohort that **received** the health check **in the time** specified by the standard; and the pink section of the bar illustrates the percentage of the total cohort that **received** the health check **later** than the time.

Figure 2.5(d)



The following conclusions can be drawn from Figures 2.5(a) to 2.5(d)

3.25 to 3.5 Years Health Check			
Question	No. of LHOs that gave no response	No. of LHOs that gave a response of zero	No. of LHO returns (excluding no response and zero)
offered on time	12	1	18
offered later	19	3	9
received on time	11	-	20
received later	17	1	13

- Based on the 18 LHO areas reporting (accounting for 32,582 children), 86% (28,043) were offered the health check in the time specified by the standard.
- Based on the 9 LHO areas reporting (accounting for 17,668 children), 20% (3,506) were offered the health check later than the time specified by the standard.
- Based on the 20 LHO areas reporting (accounting for 38,767 children), 77% (29,705) received the health check in the time specified by the standard.
- Based on the 13 LHO areas reporting (accounting for 26,926 children), 17% (4,581) received the health check later than the time specified by the standard.

3. Results - Recommended Content, Staffing and Resources

This section focuses on the quality of the service on delivery of the seven health checks. It details the extent to which the standards as outlined in *BHFCR* (2005) are adhered to in the seven health checks carried out by the community child health service. It differs from Section 2 which focuses quantitatively on the timing of the health checks.

The following questions were asked of respondents in relation to the recommended examination and health promotion activities (content); the recommended health care staff; and the recommended resources:

- *Was this health check carried out according to the recommended examination and health promotion activities as outlined in BHFCR (2005)?*
Respondents were asked to indicate their answer by placing a check in the box opposite “completely”, “partially”, or “not at all”. If their answer was either “partially” or “not at all” they were asked to specify the reasons for non-adherence. Some areas despite providing “completely” as a response also provided comments in this section which have been included in table 3.1(b).
- *Was this health check carried out by the health care staff as recommended in BHFCR (2005)?* Respondents were asked to indicate their answer by placing a check in the box opposite “completely”, “partially”, or “not at all”. If their answer was either “partially” or “not at all” they were asked to specify the reasons for non-adherence. Some areas providing “completely” as a response also provided comments in this section which have been included in table 3.2(b).
- *Please specify the resources in place which enabled adherence to health check standards as recommended in BHFCR (2005).*

3.1 Content

The following pie charts present the combined totals of reporting LHO areas (n) in relation to the extent to which each of the seven health checks was carried out according to the recommended examination and health promotion activities.

Figure 3.1(a)

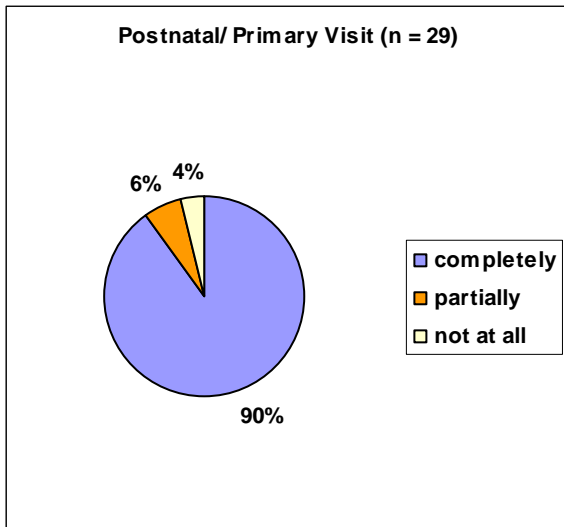


Figure 3.1(b)

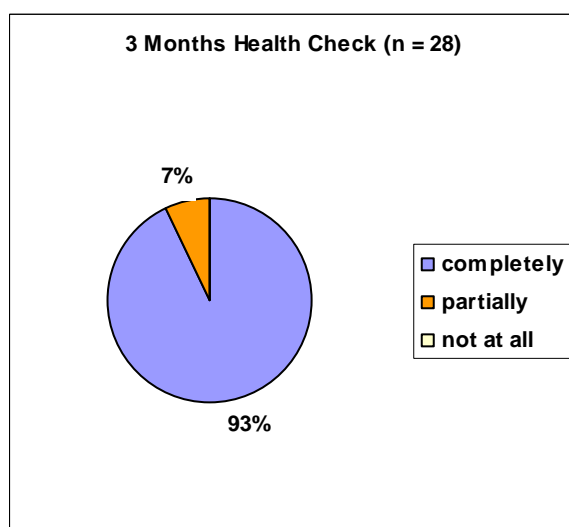


Figure 3.1(c)

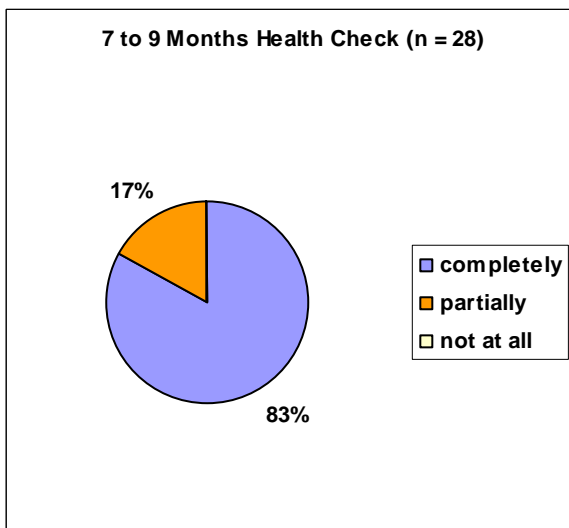


Figure 3.1(d)

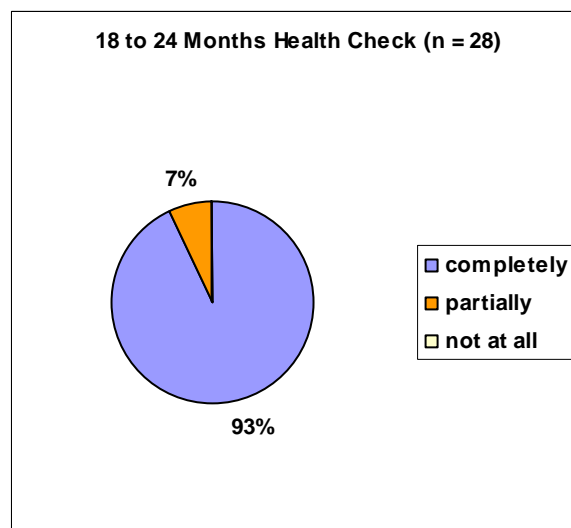


Figure 3.1(e)

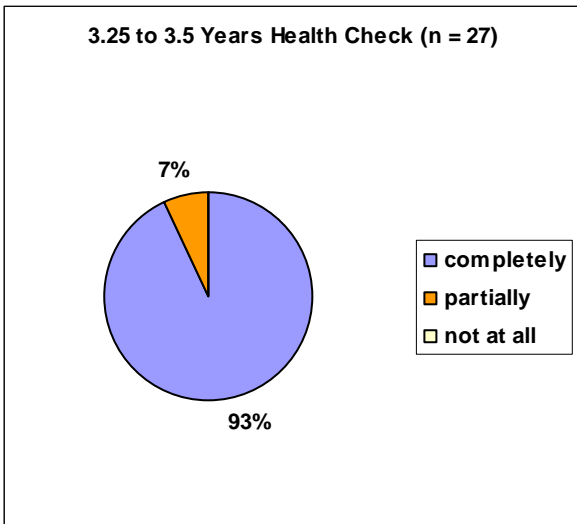


Figure 3.1(f)

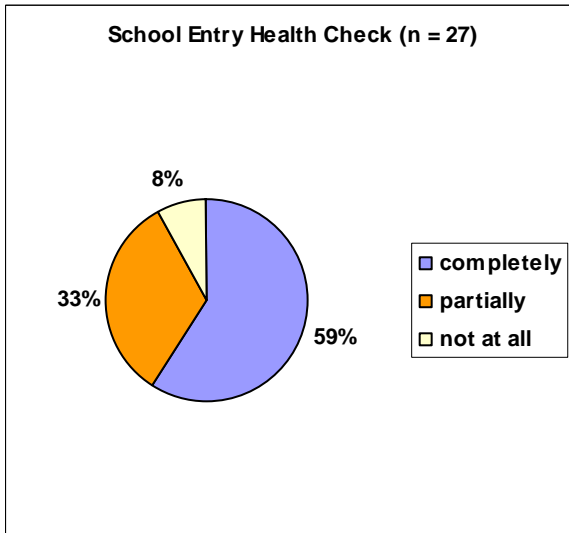


Figure 3.1(g)

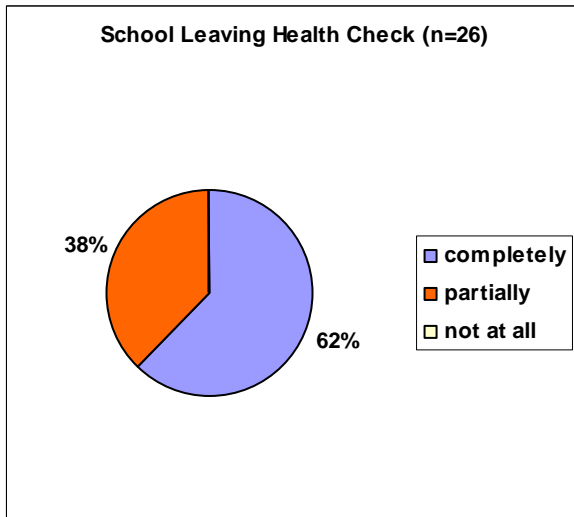


Table 3.1(a) presents the extent to which each of the seven health checks was carried out by each LHO area, according to the recommended examination and health promotion activities as outlined in *BHFCR* (2005).

Table 3.1(a) Content

LHO Area	Health Checks						
	Post N./ Primary Visit	3 Months	7 to 9 Months	18 to 24 Months	3.25 to 3.5 Years	School Entry	School Leaving
Carlow/Kilkenny	C	C	C	C	C	C	C
Cavan/Monaghan	C	C	C	C	C	C	C
Clare	C	C	C	C	C	C	C
Cork North Lee	C	C	C	C	C	C	C
Cork South Lee	C	C	C	C	C	P	P
Donegal	C	C	C	C	C	C	C
Dublin North	C	C	C	C	C	C	C
Dublin North Central	C	C	C	C	C	P	P
Dublin North West	C	C	C	C	C	N	P
Dublin South City	C	C	C	C	C	P	P
Dublin South East	C	C	C	C	C	NR	NR
Dublin South West	C	C	C	C	C	C	NR
Dublin West	C	C	P	C	C	NR	P
Dun Laoghaire	C	C	C	C	C	P	P
Galway	C	P	C	P	P	C	C
Kerry	C	C	C	C	C	P	C
Kildare/ West Wicklow	C	C	P	C	NR	NR	NR
Laois/Offaly	C	C	C	C	C	C	C
Limerick	C	C	C	C	C	P	P
Longford/Westmeath	C	NR	C	NR	NR	C	NR
Louth	C	C	C	NR	NR	C	C
Mayo	C	C	P	C	C	C	C
North Cork	P	C	C	C	C	C	C
Roscommon	P	P	P	P	P	P	P
Sligo/Leitrim	C	C	C	C	C	C	C
South Tipperary	C	C	C	C	C	P	C
Tipperary North/East Limerick	C	C	C	C	C	P	P
Waterford	C	C	P	C	C	C	C
West Cork	C	C	C	C	C	C	C
Wexford	N	NR	NR	NR	NR	NR	NR
Wicklow	C	C	C	C	C	N	P

Table 3.1(b) presents the comments, as direct quotes, received from each LHO area in response to the **partially** or **not at all answers** in relation to the extent to which each of the seven health checks was carried out according to the recommended examination and health promotion activities as outlined in *BHFCR* (2005).

Table 3.1(b) Content

Postnatal/Primary Visit	
North Cork	Weekend an issue as mostly no PHN on duty except for planned essential services; therefore late primary visit – only Metabolic Screening undertaken at weekend if no PHN is on duty.
Roscommon	Training for AMOs and PHNs on revised programme has not taken place due to absence of Training Officer.
Wexford	PAC training was partially completed in 2007 i.e. 2 modules have not been delivered and since 2007 all developmental checks have been carried out to the recommended standard. Wexford Public Health Nursing Dept. launch a Policies and Procedures Manual in March 08 these Policies and Procedures include the S.O.P.s regarding the PAC child health programme.
3 Months Health Check	
Galway	No training provided for staff on Programme of Action for Children.
Roscommon	Training for AMOs and PHNs on revised programme has not taken place due to absence of Training Officer.
7 to 9 Months Health Check	
Carlow/Kilkenny	No distraction test done since handover to PHNs from AMO and PHN service introduction of 2 nd tier medical clinics. No Montessori type furniture in clinics. No SLM/warbler/handheld audiometer except one for training i.e. not issued per AMO/Clinic.
Cork North Lee	Some delays in offering screening due to PHN staff shortages.
Dublin South City	By Community Health Doctors (AMOs and SMOs).
Dublin South West	By Community Health Doctors (AMOs and SMOs).
Dublin West	PHN only, No medical examinations carried out at 7 to 9 months. All medical developmental examinations appear to have been stopped during 2005.
Kildare/West Wicklow	Sound level meter checks not carried out yet Medical Developmentals up to date in some areas but none provided in some 40% of health centres.
Roscommon	Training for AMOs and PHNs on revised programme has not taken place due to absence of Training Officer. Shortage of AMO staff for Developmental Clinics resulting in children not being seen within recommended time frame.
Waterford	No Medical Officers participate in developmental checks.
18 to 24 Months Health Check	
Galway	No training provided for staff on Programme of Action for Children.
Roscommon	Training for AMOs and PHNs on revised programme has not taken place due to absence of Training Officer.
3.25 to 3.5 Years Health Check	
Galway	No training provided for staff on Programme of Action for Children.
Roscommon	Training for AMOs and PHNs on revised programme has not taken place due to absence of Training Officer.

School Entry Health Check	
Cork South Lee	School Health Nurses are due to receive Growth Training, when one School Health Nurse is trained as Instructor for Growth Monitoring.
Dublin North Central	Limited equipment.
Dublin North West	School health vision and audiometry is carried out on Senior infant children. Sonskin silver is not implemented. However the Kay chart was used with this cohort of children and defects were referred directly to the Community Ophthalmologist. There is no dedicated school health nurse in the LHO. Each PHN covers the national schools in her geographical area for Vision screening.
Dublin West	Junior infants are not screened. Vision and audiometry carried out in senior infants. Special PHN for audiometry in schools. Vision testing carried out by PHN in schools in her area.
Dublin South City	Screened for Vision & Hearing only.
Dun Laoghaire	No clerical admin staff in post school section.
Kerry	Time to implement the change process, change in skill mix.
Kiildare/West Wicklow	Service not provided to this age group.
Limerick	Please note vision done in jNR. Infants as per PAC. Hearing is in transition. Over a 3 yr period we are moving incrementally from sNR. Infants as per old BHFC guidelines to jNR. Infants. Hence some hearing in SI growth monitoring not done due to resource limitations.
Roscommon	Training for AMOs and PHNs on revised programme has not taken place due to absence of Training Officer. Senior Infants Hearing & Vision Completed. 2 nd Class Vision completed. Height and Weight Measurements only if problem suspected.
South Tipperary	Training not rolled out in relation to Growth Monitoring.
Tipperary North/East Limerick	Growth check not routinely carried out. Audiometry screening was carried out in SNR. Infants. In 2006/2007 27% of JNR. Infants received audiometry screening as we are moving from SNR. Infant to JNR. Infant screening as per PAC Guidelines.
Wicklow	Vision tools not available to test Junior Infants, Senior Infants are screened in LHO Wicklow. Growth not done by PHN Service.
School Leaving Health Check	
Cork South Lee	School Health Nurses are due to receive Growth Training, when one School Health Nurse is trained as Instructor for Growth Monitoring.
Dublin North Central	No colour vision testing.
Dublin North West	As the PHN service did not screen for colour vision prior to BHFC Revisited we did not undertake to include this in our screening as was given as an option in BHFC.
Dublin South City	Screened for vision only.
Dublin West	No screening for colour vision carried out.
Dun Laoghaire	No clerical admin staff in post school section.
Kildare/West Wicklow	Service not provided to this age group.
Limerick	Colour vision not done due to resource limitations.
Roscommon	Training for AMOs and PHNs on revised programme has not taken place due to absence of Training Officer.
Tipperary North/East Limerick	Colour vision not routinely carried out.
Wicklow	Colour vision survey not done.

3.2 Recommended Health Care Staff

The following pie charts present the combined totals of reporting LHO areas (n) in relation to the extent to which each of the seven health checks was carried out by the recommended health care staff.

Figure 3.2 (a)

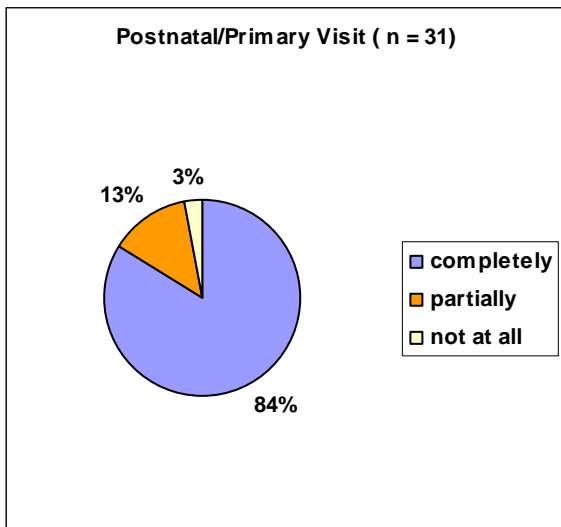


Figure 3.2 (b)

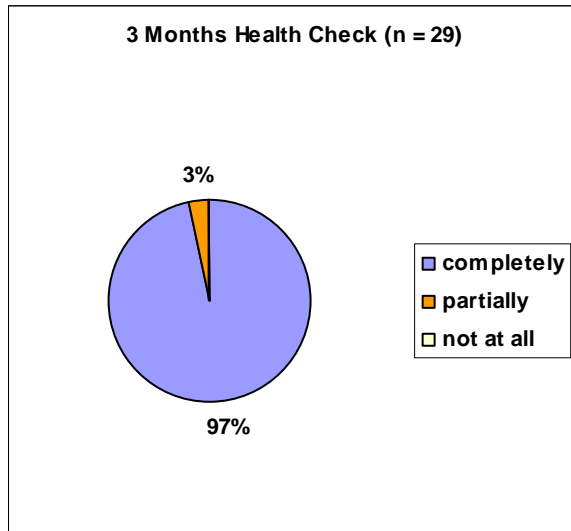


Figure 3.2 (c)

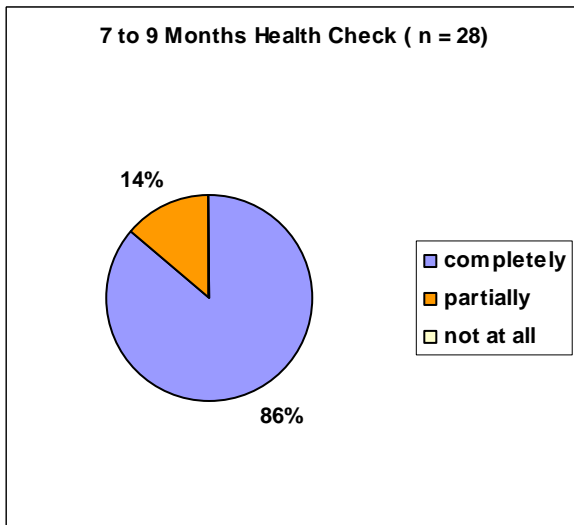


Figure 3.2 (d)

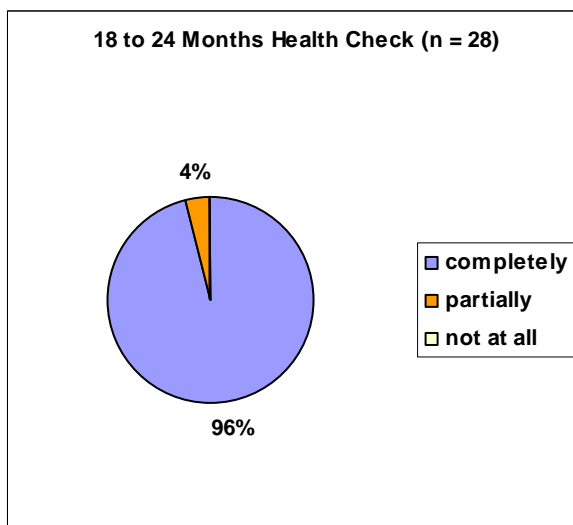


Figure 3.2 (e)

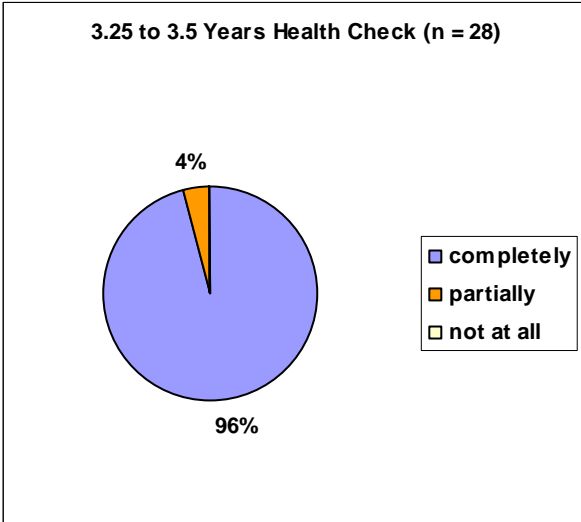


Figure 3.2 (f)

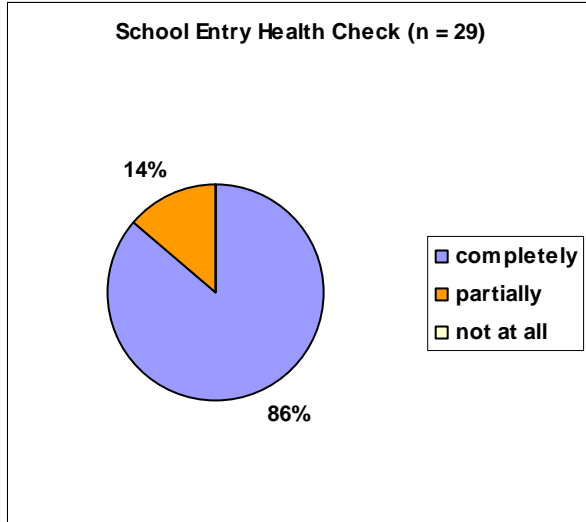


Figure 3.2 (g)

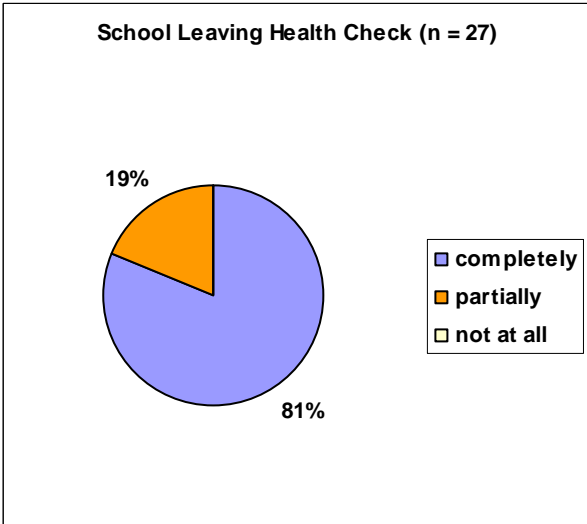


Table 3.2 (a) presents the extent to which each of the seven health checks was carried out by each LHO area, according to the recommended health care staff as outlined in *BHFC* (2005).

Table 3.2 (a) Staffing

LHO Area	C = Completely	P = Partially	N = Not at all	NR = No Response			
	Post N./ Primary Visit	3 Months	7 to 9 Months	Health Checks			
				18 to 24 Months	3.25 to 3.5 Years	School Entry	School Leaving
Carlow/Kilkenny	C	C	P	C	C	C	C
Cavan/Monaghan	C	C	C	C	C	C	C
Clare	C	C	C	C	C	C	C
Cork North Lee	C	C	C	C	C	C	C
Cork South Lee	C	C	NR	C	C	C	C
Donegal	P	C	C	C	C	C	C
Dublin North	C	C	C	C	C	C	C
Dublin N/C	C	C	C	C	C	P	P
Dublin North West	C	C	C	C	C	C	C
Dublin South City	C	C	C	C	C	P	P
Dublin South East	C	C	C	C	C	C	C
Dublin South West	C	C	C	C	C	C	C
Dublin West	C	C	P	C	C	C	C
Dun Laoghaire	C	C	C	C	C	C	C
Galway	P	P	P	P	P	P	P
Kerry	C	C	C	C	C	C	C
Kildare/West Wicklow	C	C	P	NR	NR	NR	NR
Laois/Offaly	C	C	C	C	C	C	C
Limerick	C	C	C	C	C	C	C
Longford/Westmeath	C	NR	C	NR	NR	C	NR
Louth	C	C	C	C	C	C	C
Mayo	C	C	C	C	C	C	NR
North Cork	C	C	C	C	C	C	C
Roscommon	P	C	C	C	C	C	C
Sligo Leitrim	C	C	C	C	C	C	C
South Tipperary	P	C	C	C	C	C	C
Tipperary North/East Limerick	C	C	C	C	C	P	P
Waterford	C	C	NR	C	C	C	C
West Cork	C	C	C	C	C	C	C
Wexford	N	NR	NR	NR	NR	NR	NR
Wicklow	C	C	C	C	C	N	P

Table 3.2 (b) presents the comments, as direct quotes, received from each LHO area in response to the **partially** or **not at all answers** in relation to the extent to which each of the seven health checks were carried out by the recommended health care staff as outlined in *BHFC* (2005).

Table 3.2 (b) Staffing

Postnatal/Primary Visit	
Donegal	PHN /locum PHN with a midwifery qualification. Guthries carried out independently by locums at weekends.
Galway	Child health screening carried out by health care staff as recommended in line with BHFCR, but in the absence of training – as such not complete.
Roscommon	PHNs and Registered Midwives.
Sligo/Leitrim	PHN/locum PHN with a midwifery qualification.
South Tipperary	4 RGNs have had PAC training and may complete the primary visit during leave if PHN staff not available. This is not a regular occurrence.
Wexford	PAC Training was partially completed in 2007 i.e. 2 modules have not been delivered and since 2007 all Developmental checks have been carried out to the recommended standard. Wexford Public Health Nursing Dept. launch a Policies and Procedures Manual in March 08 these Policies and Procedures include the S.O.P.'s regarding the PAC child health programme.
3 Months Health Check	
Galway	Child health screening carried out by health care staff as recommended in line with BHFCR, but in the absence of training – as such not complete.
7 to 9 Months Health Check	
Cavan/Monaghan	No AMO involvement in this programme due to lack of AMO manpower resources. 7-9 months developmental carried out by two PHNs working together.
Carlow/Kilkenny	As indicated in 2.2 PHN's not issued with ophthalmoscopes to check red reflex, therefore, at handover advised must audit if 6 week check did by GP or else refer for same.
Donegal	2 PHNs in a clinic setting.
Dublin South City	Community Health Doctors.
Dublin South West	Community Health Doctors.
Dublin West	PHNS carried out 7-9 month developmental screening. Developmental examination not carried out. AMOS not available. No Community Health Doctors currently delivering this service (since 2005).
Galway	Child health screening carried out by health care staff as recommended in line with BHFCR, but in the absence of training – as such not complete.
Kildare/West Wicklow	Insufficient doctors available for this work.
Louth	PHN complete this check. No AMO involvement in this programme due to lack of AMO manpower resources.
North Cork	AMO not always able to be present for 9 month developmental so 2 PHNs in these situations.
Sligo/Leitrim	2 PHNs in clinic setting.
Cork South Lee	PHNs or PHN and AMO not now applicable.

18 to 24 Months Health Check	
Galway	Child health screening carried out by health care staff as recommended in line with BHFCR, but in the absence of training – as such not complete.
3.25 to 3.5 Years Health Check	
Galway	Child health screening carried out by health care staff as recommended in line with BHFCR, but in the absence of training – as such not complete.
School Entry Health Check	
Donegal	Dedicated School PHN sometimes assisted by PHN.
Dublin North Central	No designated school nursing service.
Dublin South City	Do not have a dedicated School Nurse. PHN does vision and hearing screening in schools.
Dublin West	PHN
Dun Laoghaire	In schools where school screening was done it was as per BHFCR.
Galway	Child health screening carried out by health care staff as recommended in line with BHFCR, but in the absence of training – as such not complete.
Sligo/Leitrim	Dedicated school PHN.
Wicklow	Senior Infants are screened in LHO Wicklow.
Donegal	Dedicated School PHN sometimes assisted by PHN.
School Leaving Health Check	
Donegal	Dedicated School PHN sometimes assisted by PHN.
Dublin North Central	No designated school nursing service.
Dublin South City	Do not employ a School Nurse. PHN does screening.
Dublin West	PHN
Dun Laoghaire	In schools where school screening was done it was as per BHFCR.
Galway	Child health screening carried out by health care staff as recommended in line with BHFCR, but in the absence of training – as such not complete.
Sligo/Leitrim	Dedicated school PHN.
Wicklow	Senior Infants are screened in LHO Wicklow.

3.3. Resources

In Section 2 (2.5 to 2.9) of the questionnaire respondents were asked to specify the resources in place which enabled adherence to the health check standards as recommended in *BHFCR* (2005). The data returned indicate that child health services are actively working to comply with the use of resources as recommended in the standards. However, many comments also provide insights into continuing constraints, challenges and areas for improvement. This section summarises the responses under the following headings:

- equipment and facilities
- staffing and training
- documentation
- information systems
- other.

In the analysis of the qualitative data returned, it was possible to provide a quantitative analysis for the responses in relation to equipment and training. Appendices IV and V summarise the information received on these resources and also include explanatory notes on the categorisations used in the analysis.

3.3.1 Equipment and Facilities

Equipment

Over half the country's LHO areas (18) reported complete, or near complete, use of the recommended equipment as defined in *BHFCR* (2005). A further 11 LHO areas reported the recommended equipment as partially available or that the adherence process was still incomplete. The remaining two of the reporting 31 LHO areas did not report details. Emerging issues affecting partial adherence to the standards of equipment include:

- moving premises (Dublin South East)
- limited quantities of particular equipment (Dublin South City and Wexford and Wicklow – only some items from the developmental pack)

Broader issues which emerged were the absence of national agreement on developmental assessment kit content (Dublin North Central) and the lack of an agreed screening tool for developmental assessment (Wicklow).

Facilities

Inadequate clinical facilities were specifically reported from eight LHO areas (Cork South Lee, Dublin North West, Dublin South City, Dublin South West, Galway, Longford/Westmeath, Mayo and Wicklow) and were linked to difficulties in adhering to some standards, particularly for hearing tests: "Poor facilities make hearing tests often unreliable or not even possible" (Dublin South City); "facilities are reasonable but hard to obtain sound proofing of clinical rooms" (Cork South Lee). These issues often relate to the physical state of the buildings used: "Some of the buildings are very old and are not always suitable for child development clinics" (Dublin South West). Galway LHO area also included: "infection control risks where the child health assessment room and the clinical room is a shared facility... health and safety issues for children, their families and staff..., inadequate parking."

3.3.2 Staffing and Training

Staffing

Staff “with significant experience and wisdom” (Dublin North Central) were identified as a contributor to adherence to *BHFCR* (2005) standards.

Level of Staffing

Staffing deficits and vacancies were identified as a factor in non-adherence to the standards. Ten LHO areas mentioned levels of staffing specifically, in either the relevant section or in responses found in the additional comments section of the questionnaire.

Clinical Staff

Galway LHO reported “targets unmet in child health screening for a number of years until three posts were provided under PCTs”, while Sligo/Leitrim identified the need for an additional eight PHNs to deliver BHFC “to date this has not happened, thus the difficulties in adhering to required timescales.” Three LHO areas (Dublin South City, Dublin South West and Dublin West) highlighted issues related to clinical staffing deficits as an issue in non-adherence to the health checks’ standards, reporting a shortage of PHNs “staffing level only 62%”, and “a total collapse of all medical services due to a decrease of doctors from ten to two doctors (1.4 WTE) on 1/2/07” (Dublin South West). “No approval to fill the 50% medical staffing deficit in DW has been received.” (Dublin West). “Only 2.6 of a complement of 4.8 WTE doctors in place. As a result, a backlog developed with some 600 babies waiting for their 9 month medical check up.” (Dublin South City). A direct link between the level of medical staffing available and the inability to attend *BHFCR* (2005) training was referred to by Dublin South City.

Administrative Staff

The importance of administrative support was noted as an element in adherence to standards by one LHO area (Dublin North West) where dedicated clerical support staff facilitate organisation of clinic appointments for screenings by PHNs in local health centres. The absence of administrative support was identified as a barrier to compliance by two LHO areas (Mayo and Wicklow).

Training

Two thirds (21) of reporting LHO areas have completely provided the necessary training to adhere to the *BHFCR* (2005) standards, or are in the process of nearing completion. Seven LHO areas report a partial roll out of standardised training. A further two LHO areas have not offered any training to staff and another made no reference to training in section 2.6. The Child Emotional and Mental Health Training module was in pilot phase in 2007, so seven LHO areas mentioned its non-delivery. Two LHO areas (Donegal and Longford/Westmeath) specifically refer to regional training committees and representation of the nursing department on the committee as a resource in adherence to *BHFCR* (2005) standards. The need for refresher training for staff already trained was identified by Dublin North Central, Dublin North West and Wicklow and initial training for new staff by Dublin North Central and Dublin North West. The absence of TDOs and CAHDOs is cited by two LHO areas (Longford/Westmeath and Mayo) as a factor in non-adherence to the *BHFCR* (2005) standards.

3.3.3 Documentation

The PHR and CHISP (Child Health Information Services Project) resources were specifically reported on as enabling adherence to standards. Six LHO areas (Clare, Donegal, Limerick, Louth, Sligo/Leitrim and Tipperary North/East Limerick) reported use of the PHR documentation as recommended by *BHFCR* (2005). The remaining 23 LHO areas reported using the standard manually-recorded HSE records. Four LHO areas (Dublin North West, Dublin West, Galway and Wicklow) highlighted inadequacies in the documentation and recording systems describing them as “very laborious”, “inaccurate”, “not good practice”. The need for standardisation of

records to be agreed nationally was highlighted “to meet service needs in line with statistics, performance indicators and transferral to school health service, immunisations, and transfer of children to other areas” (Galway). A further two LHO areas (Longford/Westmeath and Wexford) reported that their current child health record and local policy and procedures were being reviewed in 2007. Four LHO areas (Galway, Longford/Westmeath, Mayo and Wicklow) made specific recommendations about introducing the PHR: “the PHR is essential ... and would really support screening” (Wicklow).

CHISP resources were reported as routinely available for parents in eight LHO areas (Donegal, Dublin North West, Dublin West, Limerick, Louth, Roscommon, Sligo/Leitrim and South Tipperary) but Donegal Sligo/Leitrim and South Tipperary also reported that supplies were either no longer available, or were running low: “currently awaiting national procurement, updating in order to continue” (South Tipperary). Donegal reports running off photocopies as “not satisfactory.” Four LHO areas (Dublin South City, Dublin South West, Dublin West and Kildare/West Wicklow) reported that they did not receive CHISP materials in 2007.

Other documentation reported on as enabling adherence to *BHFCR* (2005) standards was:

- Health promotion leaflets (Clare, Cork North Lee Donegal, Dublin North West, Dublin South East, Limerick, Louth, Sligo/Leitrim and Tipperary North/Limerick East, and South Tipperary)
- ‘Can Your Baby Hear You?’ tools (Dublin North West and South Tipperary)
- Speech and language screening tools (Dublin North West)
- Edinburgh Post Natal Depression Assessment Tool (Dublin North West)
- Parenting support booklets developed in conjunction with *Marte Meo* (Dublin West).

Two LHO areas, Cavan/Monaghan and Dublin North, did not respond in this section.

3.3.4 Information Systems

LHO areas were asked to report on the information systems used to enable adherence to the *BHFCR* (2005) standards. Responses highlighted the following:

- PHR utilised in six HSE areas (Clare, Donegal, Limerick, Louth, Sligo/Leitrim and Tipperary North/East Limerick)
- Child Health Information System (CHIS) in Dublin areas (Dublin North West, Dublin West, with Wicklow and Dublin North Central reporting limited use)
- Mobile computing palmtop manual monthly activity return form used by school PHNs and three area PHNs (Donegal)
- Database Monthly Returns
- Performance Indicators
- Immunisation Database.

Constraints in functioning information systems were identified in many LHO areas, primarily a lack of Information Technology (IT) equipment and a lack of clerical support for IT activities (Dublin West and Dublin South West, Sligo/Leitrim and Donegal). A lack of internet connectivity was identified in Carlow/Kilkenny, Dublin South West, Kerry and Wexford “[there is] IT equipment in only about 20% of all health centres (Carlow/Kilkenny); “no IT system (Kerry); “no IT support” (Wexford).

Difficulties in information collection relating to child health were identified in eight LHO areas (Dublin North Central, Dublin South City, Dublin South West, Dublin West, Donegal Dun Laoghaire, Galway and Kildare/West Wicklow,) due to:

- the lack of computerised information systems
- inconsistency in access to computerised information systems

- the absence of a National Minimum Data Set (NMDS)

Galway LHO area also linked deficiencies in information systems to equity issues for socially excluded groups: “Problems exist with transfer of records and tracing of families with regard to travellers, non-Irish nationals, asylum seekers, and other transient care groups. No child health information systems, Information Communication Technology (ICT) systems, or child health office – this poses great challenges [in delivering] the child health service. Inequity in this area needs to be addressed.”

3.3.5 Other

Other resources mentioned in enabling adherence to the standards in *BHFCR* (2005) were:

- Information given by PHN to parents at local antenatal classes, through family resource centres and mother and toddler groups (North Cork)
- Breast feeding clinics (North Cork)
- Second tier referral for all core health checks (South Tipperary)
- Access to referral to early intervention team (South Tipperary)
- Direct referral to specialist services (South Tipperary)
- Common assessment tool for children (Dublin South East).

4. Results - Birth Health Check and 6 to 8 Weeks Health Check

There were wide ranging responses to the open-ended questions asked about the formal notification process to the child health services of the recommended health checks at birth (Question 3.1) and at 6 to 8 weeks (Question 3.2). More details by LHO area can be found in Appendix V1 (for birth health check) and Appendix V11 (for 6 to 8 weeks health check).

4.1 Birth Health Check

Out of the 31 LHO areas responding, 24 areas cited the maternity hospital as a source of formal notification of the birth health check to the child health services. A quarter of those (six LHO areas) commented on the limitations and inconsistencies in this process. For example, a particular problem about transferring from hospital to community was highlighted by Dublin North City:

“We would receive liaison information regarding sick children but would not generally receive any formal information regarding routine health or development checks. There is an early transfer home scheme in place from the Rotunda Hospital. This was reviewed recently and we are working at making more formal handover and discharge pathways from hospital to community for mothers and infants in this scheme. Up to now, handover arrangements were informal and not satisfactory.”

Inter-LHO birth health check formal notification is problematic for some LHO areas. For example, Longford/Westmeath reported: “very good communication with local maternity hospitals in the Midlands. [but] there is frequently a delay in receipt of birth notifications from the Dublin hospitals.”

Most of the LHO areas in the greater Dublin region highlighted that: “there is no integrated child health service at the LHO level” (Dublin South City). This LHO area went on to recommend: “putting one in place, and supporting it with a comprehensive database system and a sufficient number of dedicated (‘ear-marked’) well-trained clerical staff.”

Out of the 31 LHO areas responding, a third (10 LHO areas) specifically cited the community midwife as a formal notification source of home birth health checks to the child health services. This is consistent with the low numbers of home births. Three LHO areas specifically cited the General Practitioner (GP). Five LHO areas (Dublin North City, Dublin North West, Dublin West, Limerick and Wicklow) also commented that, even though the birth notification is reaching the child health services, the quality of information it contains needs to be improved, particularly in relation to the birth health checks.

Three LHO areas did not specify the source of formal notification as hospital, GP or community midwife. In the absence of specific information, these LHO areas have been included in the ‘Limited, no notification’ categorisation for all three sources in Appendix VI.

4.2 6 to 8 Weeks Health Check

Two LHO areas (Clare and Cork South Lee) reported effective implementation of formal notification of the 6 to 8 weeks health check from GPs via the PHR or the Child Health Record.

Responses from a further four LHO areas revealed that although a formal notification process existed, it was hampered by limitations and inconsistencies, for example: “6/52 health checks from GPs [are notified] for about 33% of births (Limerick); “doctor/nurse usually fills in date of baby check and sometimes weight [via MIS]” (Longford/Westmeath).

A sizeable majority of responses from 21 LHO areas specified a lack of any formal notification for this health check, for example: “no formal arrangement in place – most GPs do not complete this section [of PHR]” (Donegal); “no information received in regard to the 6/8 week check; equally we do not send GP the results of development screenings carried out by the PHN service” (Wicklow); “[the] 6 week check [is] not recorded on PHR IT system” (Louth).

Four LHO areas did not give specific information regarding the notification process, however, one, Dublin North, made the following comment: “PHR is not available in this area but this is essential if we are to move forward.” .

Four LHO areas (Dublin South City, Dublin South West, Dublin West and Kildare/West Wicklow) in the Greater Dublin region returned the following identical comment: “What is required is a “birth to 18 year” integrated child health and vaccination record to be used by all health professionals who are in contact with the child/adolescent, that follows that child/adolescent around from service to service and from place to place. This could be an electronic record (if all doctors and nurses had a laptop) or a paper record following the Dutch standards. As an alternative, a comprised and practical personal child health/vaccination record (0-18 years) could be used, to be kept by the parents and maintained by all service providers. However, all parties must rely on this as the only available record (otherwise the professionals will not keep it up to date).”

5. Results – Additional Comments

In Section 4.1 of the questionnaire, each LHO area was asked to make any additional comments relevant to the CHSS health checks in their area. This was an open-ended section without any specific question prompts or pre-existing categorisation. Responses were received from 27 out of 31 reporting LHO areas. These responses are summarised in this section and incorporate direct quotes from respondents, edited grammatically, when appropriate, but not for content. Overall, this section mirrors the results in other sections and indicates that substantial progressive efforts are being made by child health services to ensure compliance with the *BHFCR (2005)* standards. However the respondents identify ongoing challenges and constraints in relation to seven issues as follows:

- service delivery
- risk management
- support for parents
- funding
- data systems
- staffing
- training.

Questions on these last two issues were specifically asked in Section 2 of the questionnaire (and the responses are reported on in Section 3.3 of this document). It is worth noting that the respondents recorded additional comments in this open-ended section.

5.1 Service Delivery

Twenty LHO areas made comments relating to service delivery. Child health services are seen as an integral part of the role of the PHN but deficits within the current provision of the core child health service are identified: “given the competing priorities with all of the other needs” (Dublin North Central). Particular reference was made to:

- service organisation and coverage
- waiting lists
- integration and coordination with early intervention, second tier clinics and hospital services
- lack of service coverage.

Varying organizational arrangements and service coverage are indicated. One LHO area (Kildare/West Wicklow) states that “clinics are a mix of 9 month screening and nurse referral clinics.” In Dublin North Central “seven out of the nine health centres in the area offer appointments ...two health centres do not offer a formal appointment”. Laois/Offaly reports on a “very experienced community health doctor (who) carries out the medical assessment of the children referred (in Offaly). There is no such input in Laois. ..PHNs are referring any babies about whom they have concerns to general practitioners. This has resulted in most parents having to pay their GP for a service that they are statutorily entitled to free of charge.”

Continued AMO/PHN developmental/screening services are reported in five areas (Dublin South West, Carlow/Kilkenny, Clare, Limerick and Tipperary North/ East Limerick). Dublin South West reported it as an “important and much appreciated medical service.” Clare, Limerick, Tipperary North/East Limerick reported it as “ best practice that the routine child health check at age 7 to 9 month should be performed by a Public Health Nurse and Medical Officer” and recommend its continuation.

School health checks practices vary from *BHFCR (2005)* recommendations as some areas screen other cohorts e.g. hearing in senior infants. In some instances this reflects a phased introduction of *BHFCR (2005)* standards.

One LHO Area (Dublin North Central) mentions difficulties in accessing some primary schools and securing adequate facilities i.e. room for hearing and vision screening programmes due to: increased school populations and extra school personnel requiring accommodation i.e. Personal Assistant (PA) and Resource Teachers. Deficits in relation to the school child health screening service were identified as “due in the main to the lack of designated school nurses” (Dublin North Central), “No school medical screening service offered” (Carlow/Kilkenny).

Continuation of PHN/AMO school health checks was recommended by three LHO areas (Clare, Limerick and Tipperary North/East Limerick) identifying it as “best practice”.

Waiting lists or backlogs were specifically referred to in six LHO areas (Cavan/Monaghan, Dublin South West, Galway, Kildare/West Wicklow, Laois/Offaly and Longford/Westmeath). However, two of those areas also report proactive approaches to manage these issues. Kildare/West Wicklow reports on “5000 children up to 4 years of age (who) never had a medical developmental check up but from Jan '09 all developmentals will be re-instated... the backlog of older children (1- 4 years) will be called up in mass clinics during school holidays.” In Dublin South West, Community Health Doctors provide a service which has “60-80% uptake of this service. Some 200 two-year old children could be taken off the 2007 waiting list this way.”

Integration and coordination of child health services, particularly with early intervention needs assessments, second tier clinics and hospitals, were other issues highlighted in the “Additional Comments” section. Second tier service by AMOs was commented on by three LHO areas (Kerry, Longford/Westmeath and Wexford), reporting it as “a worthwhile development, appreciated by parents, who find the process supportive and informative” (Wexford). The usefulness of coordination with hospital services was referred to by three LHO areas. One area identified the value of a discharge notification system where: “the local pediatric [sic] hospital ...assists in informing the community child health professional and provides continuity in terms of information” (South Tipperary). North Cork indicates a desire by PHNs to be “better informed of policies and procedures within the maternity hospital, thus ensuring standardisation of practice within the community setting.” Dublin West and Kildare/West Wicklow referred to the need for increased staff cover to facilitate better coordination of hospital and community services.

Lack of service, particularly for neonatal hearing screening and difficulties in administering the distraction hearing test, was identified by five LHO areas (Carlow/Kilkenny, Galway, North Cork, South Tipperary and Wexford). The lack of a child health services at weekends and bank holidays was referred to by four LHO areas (Dublin North Central, Dublin North West and Kildare/West Wicklow) as it “mitigates against achieving the required performance outcome” (Dublin North West). The lack of an age-appropriate dental chart or dental risk assessment form was also commented on by North Cork.

5.2 Risk Management

Nine LHO areas (Carlow/Kilkenny, Dublin South City, Dublin South West, Galway, Laois/Offaly, Louth, Tipperary North/East Limerick, South Tipperary and Wicklow) commented on risk management issues. Galway LHO area identified these risks as:

- waiting lists for audiology, ophthalmology, speech and language therapy services, and 7 to 9 month developmental clinics
- late diagnosis of dislocated hips
- late diagnosis of hearing losses
- late diagnosis of visual problems
- late diagnosis of behavioural problems
- lack of training in standardised practice
- ICT systems and administrative staff not adequate/sufficient to support immunization programmes.

Inappropriate and/or inadequate accommodation is also identified “with exposure to infection risks” (Galway); “no soundproof room is available for hearing checks” (North Cork).

Inadequate staffing and administrative support for IT are also linked to risk management: “The only [recorded] CHSS checks are for the 7/9 month developmental carried out by the AMO/PHN, no other checks are noted or supported” (Wicklow).

5.3 Supports for Parents

The importance of health promotion and the link between child health and family wellbeing were identified by seven LHO areas (Dublin North Central, Dublin North West, Dublin West, North Cork South Tipperary and Wexford). “PHN visit includes the whole family’s health, not just appropriate screening, as these can impact on the child’s health” (Dublin West). Specific health promotion services identified as important are:

- one-to-one health promotion interventions with parents and their children.
- breast feeding support groups and mother and toddler groups run and managed by PHNs.

However health promotion work is not reflected at present in data collection systems. “The performance indicators and CHIS is purely focused on child screening outcomes, however ... PHN visits and contacts are inclusive of whole family health and this also needs to be captured as family wellbeing impacts strongly on child health” (Dublin North West).

The lack of information for parents, particularly in the unavailability of CHISP resources, is commented on by four LHO areas. “CHISP information booklet and DVD has been in use. Currently out of print and awaiting national procurement and updating” (South Tipperary).

The importance of financial support especially for parents whose child suffers from a disability is identified as “paramount” (Wexford).

5.4 Funding

Lack of targeted dedicated non-pay funding for child health services was highlighted by two LHO areas (Dublin North West and Roscommon). This was reported as impacting on:

- availability of CHISP booklets
- roll out of *BHFCR* the training programme to current PHNs and student PHNS
- IT structure development
- PHR
- new immunisation programmes for primary school children.

5.5 Data System Issues

Comments on data system issues related to:

- inadequate IT infrastructure
- PHR
- CHIS
- birth notification form
- performance indicators
- data collection.

The inadequate IT infrastructure for child health services was commented on by six LHO areas (Dublin South West, Dublin North West, Dublin West, Longford/Westmeath, Roscommon and South Tipperary) as making it difficult or impossible to provide statistics for the survey.

The necessity of introducing an adequate ICT and PHR system for child health was identified by five LHO areas (Cavan/Monaghan, Cork South Lee, Donegal, Dublin South City and Galway). "The Introduction of the Personal Health Record will ensure best practice provision of quality service". (Cavan/Monaghan) "The whole (PHR)system would benefit from national direction/leadership" (Donegal). Donegal also reported on the value of the PHR system where it is in place and of its being: "very well supported by local managers and the PHNs."

The limits on the usefulness of the CHIS system was referred to by two LHO areas (Dublin North and Dublin North West) as it is "unable to provide timely notification" (Dublin North West), "Currently CHIS is set-up to accommodate appointments for 9 month (+) old babies and will not accept this Area's target group - 7mth olds; therefore neither appointments nor relevant reports can be generated." (Dublin North). However, "PHN linkages to the CHIS could facilitate improvement in the 1st visit within 48 hours" (Dublin North).

Limitations of the present birth notification form was commented on by two LHO areas, reporting it as: "totally inadequate...to accommodate the initial home visitation by the PHN" (Dublin North) and recommending "a national standardised birth notification form"(Roscommon).

Data collection issues were commented on by three LHO areas (Dublin North, Longford/Westmeath and South Tipperary). Issues raised were the lack of data collection for non-PI health checks and the lack of clear definitions of PIs nationally in relation to each health check. But "this could readily be agreed and put in place based on criteria agreed in areas where the PHR system is in operation" (South Tipperary). The usefulness of the Population Health Information Tool (PHIT) was identified as generating "more accurate data on Family Health including the Core Visiting Programme within *BHFC (2005)*" (Dublin North Central).

The difficulty of accessing manual records to make returns for the survey was noted by Dublin South City ("for this kind of data set to be collected accurately, I would need a comprehensive date based system"), Longford/Westmeath ("as there is no IT system in place I am totally reliant on the monthly returns for info. on child health activity"), Louth ("would require additional time") and by Roscommon (the statistics...requested... would involve each PHN and AMO having to extract all records for the outlined cohorts...and collate them manually").

5.6 Staffing

Staffing issues were identified by over half (16) of the LHO areas, in particular highlighting that "nursing and doctor shortages have greatly impacted on the service delivery" (Dublin South West) and that "child health services compete with service delivery in other care groups". More positively it was also reported that "increases in the number of PHNs allows for an increased focus on delivery of the core Child Health Visits" (Dublin North Central).

The impact of medical manpower gaps was commented on by two LHO areas (Cavan/Monaghan and Louth) referring to the withdrawal of the AMO service from the 7 to 9 months check and follow up, resulting in: "large waiting lists for the audiology and ophthalmology referrals from the 7-9 month developmental examination" (Cavan/Monaghan and Louth).

Inadequate administration support for frontline staff was identified as an issue by Galway and Dublin West, with "40% of PHN time spent on administration work and line managers have inadequate clerical support to support their role" (Galway).

5.7 Training

There is widespread support in the LHO areas for an evidence-based service and the need for on-going education in all aspects of child health to ensure best practice. “We are aware that *BHFC* is being revisited, and would like to be appraised of developments. *BHFC* is an excellent evidence based document to support service delivery” (Mayo). Eight LHO areas (Cork North Lee, Donegal, Galway, Laois/Offaly, Mayo, Roscommon Sligo/Leitrim and South Tipperary) commented on training, referring to the standardised programme as “very well organised” (Cork North Lee) and ‘excellent’ (Mayo), “staff and management embraced the *BHFC* recommendations and the associated training” (Donegal). The successful integration of the *BHFC* (2005) training programme into the postgraduate diploma course at St Angela's College in Sligo was reported by Donegal and Sligo/Leitrim.

Limits on training implementation were referred to by six LHO Areas. Issues identified were:

- absence of a training officer (Roscommon)
- absence of PAC (standardised) training (Galway)
- non-replacement of staff organising training in 2008 (Cork North Lee)
- the need for training be rolled out on a three-year rotation (Mayo)
- funding to keep staff up-dated in evidence-based-practice (Donegal)
- cover for staff whilst on training (Sligo/Leitrim).

6. Staffing

6.1 Whole Time Equivalent

This section presents information on the PHN and MO staffing for each LHO area. Respondents were asked to provide information in response to the following question:

- *Please provide numerical information on the PHN and MO staff complement (WTE) which delivered the broader child health service (including CHSS) in your LHO area for 2007, by filling in the appropriate boxes.*

Respondents were asked to record the total WTE for all services, the percentage WTE used to deliver the child health service, and the percentage allocated to the child health service that was unfilled on 01/01/07.

Table 6.1(a) presents the numerical information on the PHN and MO WTE for each LHO area. The combined number of children eligible for the postnatal/primary visit; 3 months; 7 to 9 months; 18 to 24 months; and 3.25 to 3.5 years health checks are included in the table.

Table 6.1 Staffing PHN and MO

In Table 6.1 the WTE information provided by LHO, in relation to Section 8 of the questionnaire, is presented along with their combined total of children eligible for five of the health checks.

Table 6.1

Information on the PHN & MO staff complement (WTE) which delivered the broader child health service (including CHSS) for 2007							
LHO Area		Public Health Nurse (PHN)			Medical Officers (MO)		
	Combined number of children eligible for postnatal/ primary, 3 months, 7 to 9 months, 18 to 24 months and 3.25 to 3.5 years health checks as from 01/01/07	Total WTE (for all services) as of 01/01/07	Percentage WTE used to deliver child health service as of 01/01/07	Percentage WTE allocated to the child health service that was unfilled as of 01/01/07	Total WTE (for all services) as of 01/01/07	Percentage WTE used to deliver child health service as of 01/01/07	Percentage WTE allocated to the child health service that was unfilled as of 01/01/07
Carlow/Kilkenny	10,002	50.20	33%	3%	4.40	64%	25%
Cavan/Monaghan	8,337	57.00	65%	0%	1.50	95%	40%
Clare	8,413	47.06	35%	0%	5.00	65%	0%
Cork North Lee	12,120	NR	NR	NR	NR	NR	NR
Cork South Lee	13,148	67.75	100%	1%	3.00	25%	3%
Donegal	10,797	102.61	55%	NR	5.80	70%	0%
Dublin North	20,622	47.32	100%	NR	4.74	25%	NR
Dublin North Central	8,243	67.73	65%	NR	NR	NR	NR
Dublin North West	19,251	58.50	66%	33%	4.40	55%	8%
Dublin South City	8,454	85.00	32%	16%	4.80	90%	50%
Dublin South East	7,214	26.50	84%	14%	3.30	70%	33%
Dublin South West	12,489	58.50	67%	33%	5.40	80%	80%
Dublin West	13,945	40.50	70%	20%	5.40	50%	20%
Dun Laoghaire	8,596	63.75	66%	16%	NR	NR	NR
Galway	17,852	145.00	NR	10%	NR	NR	NR
Kerry	9,409	48.83	68%	0%	7.10	24%	3%
Kildare/West Wicklow	16,161 (figures for 3.25 to 3.5 years health check not avail.)	40.30	80%	16%	10.00	80%	0%
Laois/Offaly	10,053 (figures for 3.25 to 3.5 years health check not avail.)	55.00	63%	16%	8.00	25%	70%
Limerick	8,980	49.20	39%	0%	7.00	80%	1%
Longford/Westmeath	3,395 (figures for 3 months, 18 to 24 months and 3.25 to 3.5 years health checks not avail.)	100.00	40%	1%	5.30	25%	65%
Louth	6,433 (figures for 18 to 24 months and 3.25 to 3.5 years health checks not avail.)	50.30	43%	0%	2.80	93%	54%
Mayo	9,323	54.00	52%	0%	5.60	62%	0%
North Cork	6,987	34.97	80%	0%	NR	NR	NR
Roscommon	5,542	25.00	96%	0%	5.00	60%	0%
Sligo/Leitrim	4,756	65.30	18%	3%	4.20	52%	31%
South Tipperary	6,246	62.34	28%	0%	NR	NR	NR
Tipperary North/East Limerick	8,313	48.00	50%	0%	5.75	60%	9%
Waterford	9,687	32.00	100%	25%	NR	NR	NR
West Cork	3,704	39.50	50%	10%	2.50	50%	NR
Wexford	10,641	38.08	92%	0%	2.30	65%	49%
Wicklow	8,870	59.50	22%	10%	4.40	41%	62%

* NR – No Response

7. Conclusions and Recommendations

7.1 Overview

This report collates the findings from the audit of the CHSS programme which was carried out to survey the extent of *BHFCR (2005)* implementation. At the beginning of the report, its structure is explained and the project is contextualised. The process that was followed and the decisions made regarding the design of the questionnaire are outlined in Section 1.4.

As a result of a consultation process, it became apparent that very few LHO areas were in a position to report on all aspects of the questionnaire. It appears that information on the health checks may not be recorded or may be only recorded manually, making retrieval of this information difficult and time consuming. In some cases, it may be that information is not recorded because health checks are not being carried out. A decision was made by the Project Team to give the option to respondents of recording 'not available' when information was not known. On initial dissemination of the questionnaire, concerns regarding this issue were again expressed to the Project Team and it was decided to issue a memo to reassure respondents on this and other points of clarity requested. While it may have been desirable to request the specific reasons the information was not available, it was decided that it was more appropriate at this stage to focus on the information that is available. More in-depth information gathering would require a follow-up study.

Of the 32 LHO areas nationally, 31 returned questionnaires although many of these returns were received a couple of months after the original deadline. In addition, many LHO areas were contacted to clarify information that they provided. One LHO area, Meath, contacted the Project Team in January 2009 explaining that they were not in a position to make returns due to insufficient staff available to complete the questionnaire.

The questionnaire's numerical returns on child cohorts were analysed manually using Excel spreadsheets to collate the results and to generate the figures that are presented in Section 2 of this report. The qualitative information presented in Sections 3, 4 and 5 was analysed manually to identify key themes and was then organised under those headings. The numerical information provided by respondents on staffing is presented in Section 6 in table form. This table also presents the numerical information received on the eligible cohorts for each health check.

The following subsections of 7.1 follow the main section headings of the report and are provided as a summary and discussion of each section.

7.1.1 Recommended Timing of Health Checks

Section 2 of this report presents the responses on adherence to the recommended time frame for the health checks.

Twenty nine LHO areas report for the postnatal/primary visit that 77% of the eligible cohort received this health check on time. The main reasons recorded for receiving this health check later than the time specified by the standard are: five rather than seven day service provided by the PHN staff; birth notification received too late; service not available; and incorrect details given on the birth notification form. This health check, however, had the highest rate of returns for all information requested. A possible explanation for the relatively high rate of returns is that information on this health check is gathered for PIs. An efficient system to support the standardisation and communication of the birth notification form is required to address the birth notification issues. The current five day nature of the PHN service needs to be explored in terms of capacity to achieve the required time standard.

Twenty two LHO areas reported that 86% of eligible children received the 3 months health check on time. Fifteen LHO areas reported that a further 8% received the health check later than the time specified by the standard. Twenty five LHO areas reported that 70% of the eligible cohort received the 7 to 9 months health check on time. Nineteen LHO areas reported that 16% received the health check later than the time specified by the standard. In the 22 reporting LHO areas, 82% of the eligible cohort received the 18 to 24 months health check on time. Eleven per cent of the eligible cohort in 15 LHO areas received it late. Twenty LHO areas reported that 77% of the eligible cohort received the 3.25 to 3.5 years health check on time. Thirteen LHO areas reported that 17% of the eligible cohort received the health check later than the time specified by the standard.

The number of LHO areas reporting on the health checks decreases for the older cohorts. In these LHO areas there is still evidence of a high rate of service delivery, albeit that a significant percentage are received late. The lack of data provided by many LHO areas on either some or all aspects of the health checks makes it difficult to get a complete picture of the levels of delivery.

The most comprehensive reporting from the LHO areas was on the size of the cohort of children that are eligible for the health checks. A striking divergence between cohorts is evident from this data between different parts of the country. Dublin North and Kildare/ West Wicklow consistently report the highest cohorts with figures of over 4,000 children reported for most checks. In contrast West Cork and Roscommon report figures below 1,000. This information is important in assessing how to plan a standardised approach to service delivery that ensures that there is flexibility and capacity to meet the different cohort needs throughout the country.

7.1.2 Recommended Content, Staffing and Resources

Responses on adherence to the recommended standards for the examination; health promotion activities; staffing; and resources are collated in Section 3. The responses received to this section are critical to the overall purpose of the audit: "To collect information on the extent of implementation of the CHSS Programme as per *BHFCR* (2005) standards" (see *Survey Purpose* in Appendix I).

In general a very high adherence to the recommended content standards is recorded for the postnatal/primary visit; 3 months; 18 to 24 months and 3.25 to 3.5 years with figures of over 90% adherence. The 7 to 9 months visit is lower at 83% and the comments reported indicate that this results from differences regarding the delivery of the distraction hearing test combined with a lack of training in a number of LHO areas. The school entry and school leaving health checks report an adherence with the content standards of 59% and 62% respectively. The reasons reported indicate that some LHO areas are in a process of transition, moving from senior infants to junior infants for the health checks, with other areas reporting a lack of training or resources.

An adherence rate of above 80% is reported for the delivery of the health checks by the recommended staff. The reasons given for not achieving complete adherence are similar to those recorded for the content standards and focus primarily on either a lack of training or capacity of existing staffing arrangements.

Respondents specified the resources in place that enabled them to adhere to the health check standards under the following headings: equipment and facilities; staffing and training; documentation and other materials; information systems; and other. Some LHO areas raised issues about having limited equipment available and limited clinical facilities particularly for hearing screening. Ten LHO areas reported difficulties with staffing deficits and unfilled vacancies in clinical and administration posts. While two thirds of respondents report having completed or nearly completed the national training, eight areas report only partial delivery and two report no training received. Eight areas comment on the value of the CHISP in assisting their delivery of the health checks to the required standards but a number also mention that they no longer have

supplies of this resource available. The PHR documentation and information system is active in six LHO areas and receives widespread support from these, and other LHO areas, for its efficiency in enabling adherence to the recommended standards.

7.1.3 Birth and 6 to 8 Weeks Health Check Information

Information provided to the child health service on the birth health check and the 6 to 8 weeks health check is summarised in Section 4.

Twenty four LHO areas report that the maternity hospital is the main source of formal notification. A quarter of respondents commented on limitations and inconsistencies including informal arrangements; lack of standardisation and a delay in birth notifications particularly from the Dublin hospitals. A third of respondents also mentioned that the community mid-wife is a source of formal notification with a few also mentioning the GP. Overall there was concern expressed that the quality of information that is provided needs to be improved.

Twenty one areas reported a lack of formal notification between general practice and the community child health services regarding the outcomes from this health check. Only two areas reported that the co-ordination of information between general practice and the child health community services was effective with four other LHO areas commenting on difficulties in receiving this information.

Standardisation is clearly lacking in the quality of information or method of communication used to provide information to the community child health services about the birth health check and the 6 to 8 weeks health check. The integration of community/primary care and hospital services in the HSE reforms process may create an opportunity to strengthen the hospital and community information systems. Within primary health care the co-ordination of child health information between general practice and the community child health services needs to be standardised in terms of timeliness and content.

7.1.4 Additional Comments

The additional comments provided by respondents in Section 5 are collated under six themes that emerged from the data: service delivery; risk management issues; support for parents; funding; staffing; and training.

Twenty respondents commented on issues arising from service delivery. Competing priorities with other care group needs and an unavailability of service coverage for the PHN service was reported as impacting on the capacity of the service to deliver according to the standards. Comments were also made indicating varying practices and organisational arrangements throughout LHO areas. Four LHO areas highlighted that they use MO staff in addition to the required PHN staff to deliver the 7 to 9 months health check. Varying practice including a phased introduction of the standards was commented on in the delivery of the school health checks.

Nine LHO areas report that there are risk management issues arising in relation to waiting lists and resulting late diagnoses. A number also mention inadequate facilities. Seven LHO areas specifically mention the broader role of the PHNs in supporting parents as important. It is acknowledged that the current system of collecting information about performance through the collection of the PIs does not provide scope for reporting on this activity. Funding concerns were raised about the non-pay available to the service to purchase resources such as CHISP.

Strong support for the PHR is consistently expressed by respondents in this and other parts of the questionnaire returns. In particular, the PHR is identified as the major solution to the currently inadequate electronic information systems because of its standardised collection of information based on adherence to the standards. Sixteen LHO areas comment on difficulties with clinical and

administration staffing capacity in enabling them to adhere to the standards. There is widespread support for the value of the national training that has been delivered over the last five years. Eight LHO areas make particular comments on its importance in adhering to the standards.

A number of themes that have emerged under previous questionnaire headings are reiterated in this section. There is overwhelming support for standardised resources to enable the LHO areas to meet the required standards. The most frequently commented on are the need for standardised information data collection systems, the CHISP resource; and the ongoing and comprehensive rollout of the national training. In addition there are frequent concerns raised about the capacity of the existing staffing arrangements to meet the increasing numbers in cohorts, particularly in the Greater Dublin region.

Despite the many challenges that staff are experiencing in adhering to the standards it is commendable that there appears to still be a high level of quality delivery operating in the majority of areas. Nonetheless, it is a major concern that some areas are not delivering to the required standards and that a lot of information is unknown about many aspects of the delivery. A further, more in-depth audit, focusing on a sample of LHO areas, would be useful in adding to the information gathered through this survey. In addition serious consideration needs to be given to supporting the development of robust information systems, particularly electronic information systems.

7.1.5 Staffing

PHN and MO staffing is outlined in Section 6. The information received from respondents on their PHN and MO staffing is presented with the returns for the eligible cohorts for the health checks. There are major differences between LHO areas regarding their use of clinical staff. A more in-depth study to ascertain local reasons for the management decisions, behind these differences, will need to be undertaken before reaching conclusions.

Section 7.2 summarises the key conclusions that can be drawn from the report. The key themes which emerged from the qualitative data are used to present the information to provide consistency with the reports findings. A set of recommendations arising from the findings are presented for future action by the HSE.

7.2 General Conclusions

7.2.1 Service Delivery

- There is widespread delivery of the health checks throughout most LHO areas. This is particularly true of the postnatal/primary visit, the 3 months health check and the 7 to 9 months health check.
- A number of LHO areas have not returned information about the delivery of some of the health checks, particularly those that coincide with the older age groups, but the reasons for this are not always clear. In many instances, it may be that information about the delivery of the health check is not recorded even though the health check has been carried out; it may also be that some areas are not complying with the standards for these health checks. Further work is needed on this to ensure that all children are provided with equity of access to the CHSS Programme.
- There are difficulties in some LHO areas in delivering on all aspects of the health checks within the times specified by the standards. Three of the reasons recorded are: insufficient staffing capacity to deal with increasingly large cohorts of children; the five day nature of the PHN service in some LHO areas; and the lack of co-ordination of information between hospitals and community.
- There are difficulties in a few areas, with large cohorts in delivering specific health checks. This is particularly true of the school health checks.

- The health checks that coincide with the older age groups, and particularly the school health checks, do not appear to be delivered in as comprehensive a manner as the initial three checks.
- There are differences between LHO areas regarding the standardised delivery of the programme.
- There are differences between LHO areas regarding the number of staff that is allocated to deliver the programme relative to the population served.
- There are competing priorities, with the CHSS programme, for the PHN WTE allocation in some LHO areas.
- The unavailability of PHN child health service provision at weekends and public holidays in some LHO areas militates against delivering the CHSS programme within the time frames specified in the standards.

7.2.2 Standards

- There is a high level of compliance with the *BHFCR* (2005) standards in the delivery of the health checks.
- There is strong support expressed for the *BHFCR* (2005) standards.
- There is strong support expressed for the CHISP resource as a support for delivering the standards. There is a concern, however, that this resource is no longer available in many LHO areas.
- There is support expressed for universal neo-natal hearing screening to be implemented.
- There is some concern raised about maintaining the MO's role in the delivery of the 7 to 9 months and school health checks. The current standards recommend that these checks can also be carried out by PHNs alone.
- The second- tier referral services delivered by MOs support compliance with standards and best practice.

7.2.3 Training

- There is strong support for the national CHSS training programme that has been delivered on a regional basis.
- A number of concerns are raised about the CHSS training: some LHO areas have not received training; some LHO areas have received some of the modules but not all; and some LHO areas, that have received training, have new staff members that have not received the training.
- The unavailability of training support staff in many LHO areas is a barrier to implementation. The training infrastructure that is in place is not standardised across regions.

7.2.4 Child Health Information Systems

- The lack of electronic child health information systems to collect and collate the data on the health checks is of great concern to many LHO areas.
- Areas that have the PHR system in place were able to provide comprehensive information on the delivery of their service in response to the questionnaire. It is interesting to note that these LHO areas recorded a high level of adherence to the delivery of the health checks within the time frame specified.
- LHO areas in Dublin that are using the CHIS identify difficulties in accessing the system.
- The systems used to communicate the birth notification details are not standardised or effective in ensuring that the details are received on time by the community child health service.
- The hospital maternity and community midwifery information systems as well as the community child health service systems used to communicate the birth health check information are not standardised, effective or robust in some areas.
- The general practice and the community child health service systems used to communicate the 6 to 8 weeks health check information are not standardised, effective or robust in some areas.

7.3 Recommendations

7.3.1 Service Delivery

- Staffing levels for the CHSS Programme should be reviewed across the LHO areas to ensure a more equitable provision of staff to population cohorts, to enable them to deliver the required programme. In relation to risk management, priority should be given to LHO areas that are currently not delivering specific health checks.
- Staffing allocations should be standardised throughout LHO areas based on models of best practice and equity of access to the local child health population. These staffing arrangements should be configured as part of the primary and social care networks and primary care teams.
- An in-depth audit focusing on a sample of LHO areas should be carried out to complement the information that has been gathered by this survey. In particular, information is required on the capacity of LHO areas to deliver the required programme based on existing resources. The information gathered should be used to develop standardised models of best practice.
- The delivery of a 7 day PHN service to meet the required standard for the postnatal/primary visit should be introduced across the country.
- The standards for delivery of the school health checks should be standardised as in *BHFCR* (2005) and supported at LHO area level.

7.3.2 Standards

- A national expert group should be put in place to oversee that child health standards are updated in line with evidence and best practice.
- This national expert group should provide clarity regarding staffing for the 7 to 9 months health checks and school health checks.
- The universal neo-natal hearing screening programme should be implemented.
- The revised hard copy CHSP resources should be made available to support the standardised delivery of the CHSS Programme according to best practice.

7.3.3 Training

- The national CHSS training programme should be implemented in all LHO areas that have not received this training to date. A rolling programme to provide catch-up for other areas and individuals should be made available, as well as ensuring those already trained are updated with best practice.
- The national standardised CHSS training should be integrated into pre-registration PHN courses.

7.3.4 Child Health Information Systems

- A standardised electronic child health information system should be implemented. The PHR offers a model of best practice for a comprehensive child health system as evidenced by the returns from the areas where this is active.
- An electronic, comprehensive system used to communicate the birth notification form should be standardised and implemented.
- An electronic, comprehensive system used to communicate the birth health check information should be standardised and implemented.
- An electronic, comprehensive system used to communicate the 6 to 8 weeks health check information should be standardised and implemented.

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Introduction

Thank you for undertaking the completion of this survey on behalf of your Local Health Office (LHO) area. The survey is being carried out to meet the HSE National Service Plan deliverable: *an “Audit of HSE performance against standards as outlined in ‘Best Health for Children’ should be undertaken” (NSP, 2008:37).*

A national Project Team has been established by Dr. Sean Denyer, Director of Public Health, Children and Young People’s Team, Population Health (PH), Mr. Hugh Kane, Assistant National Director (responsibility for Children and Family Services), Primary, Community and Continuing Care (PCCC) and Mr. Seamus Mannion, Assistant National Director, Children Services, Office of the CEO (OCEO). The OCEO will lead on the project management of the audit under the auspices of the HSE Expert Advisory Group (EAG), Children. Information collected on the postnatal/primary visit will be shared with a HSE national group established to review this performance indicator (Q1.6 and Q1.7).

Project Team

The following Project Team are responsible for the Audit of the Child Health Screening & Surveillance Programme.

Project Sponsor:	HSE Expert Advisory Group, Children
Project Chairperson:	Dr. Sean Denyer, Director Public Health, Children & Young People’s Team, PH
Project Manager:	Ms. Caroline Cullen, Specialist (National Policy), Children Services, OCEO
Project Team:	Ms. Helen Barry, Business Processes Manager, Children Services, OCEO Ms. Carmel Cummins, National Training & Development Officer, Children Services, OCEO Ms. Finola Downes, Clerical Officer, Children Services, OCEO Ms. Tina Gallagher, Child Health Development Officer, PCCC Ms. Karen Kennedy, Clerical Officer, Children Services, OCEO Ms. Mary Liston, Director Public Health Nursing, PCCC Dr. Clare O’Sullivan, Principal Medical Officer, PCCC

Survey Purpose

To collect information on the extent of implementation of the Child Health Screening and Surveillance (CHSS) Programme as per *Best Health for Children Revisited (2005) (BHFCR) standards*. BHFCR (2005) is available at: http://www.hse.ie/eng/Publications/Children_and_Young_People/

This information is being collected to meet the HSE National Service Plan deliverable: an “*Audit of HSE performance against standards as outlined in ‘Best Health for Children’ should be undertaken*” (NSP, 2008:37). The focus of the audit is on the core CHSS Programme, with the exception of Section 5 (p. 9), and does not require information about the broader child health service.

Use of Survey Data

The information collected through this survey will be collated and reported to the EAG, Children. It will also be made available to: Dr. Sean Denyer, Director of Public Health, Children and Young People’s Team, (PH); Mr. Hugh Kane, Assistant National Director (responsibility for Children and Family Services), (PCCC); Mr. Seamus Mannion, Assistant National Director, Children Services, OCEO.

Completion Details

The information required to complete this survey **should be drawn and collated from your entire LHO area** for the period from the **01/01/07 to the 31/12/07**.

Only **one completed and collated survey** for your LHO area should be returned (**preferably by email**) to **Karen Kennedy by: 19/11/08**

E-mail: Karen.Kennedy3@hse.ie Fax: 061-310612

Instructions for Completion

Please complete all sections of the survey. If information is currently unavailable for a particular section, indicate this on the form by stating ‘not available’. It is noted that some requested information may not be readily available in all areas, however, this should be recorded as ‘not available’ as it will provide useful information for data collection. Please use the period from 01/01/07 to 31/12/07 in answering the questions which refer to the health checks before school entry. Please use the school year 2006 to 2007 to answer the school health check questions.

The following terms used in the survey are defined as follows:

- **cohort** number of children in your area that were in the age band relevant to each health check during 2007.
- **health checks** examination and health promotion activities as outlined in *BHF CR (2005)*.
- **standards** recommendations for the health checks as per *BHF CR (2005)*. **These do not include follow up or second tier referrals.**

(A summary of the health checks as recommended in *BHF CR (2005)* can be found in Appendix 1).

To complete the survey electronically, save it to a folder e.g. “My Documents” prior to working on the document. Use the cursor or arrow keys to the right of your keyboard to navigate the survey in sequence.

Further Information

If you require further information on this survey please contact Caroline Cullen, Project Manager, CHSS Audit Project.

E-mail: Caroline.Cullen@hse.ie Tel no: 061-310437

SECTION 1

Please fill in a numerical answer in each box in Section 1 under the heading for the relevant health check. 'Not available' should be inserted when the numerical information is not known.

	Information Required	Health Checks (01/01/07 to the 31/12/07)					School Health Checks (School Year 2006/2007)	
		Postnatal/ Primary Visit <i>Up to 48hrs after discharge</i> (Children born 2007)	3 months (Children born 01/09/06- 31/08/07)	7 to 9 months (Children born 01/03/06- 28/02/07)	18 to 24 months (Children born 01/11/04- 31/10/05)	3.25 to 3.5 years (Children born 01/01/03- 31/12/03)	School Entry (School year 2006/2007)	School Leaving (School year 2006/2007)
1.1	What was the total cohort (number) of children of eligible age for this health check in 2007?							
1.2	How many of this cohort were offered this health check in the time specified by the standard?							
1.3	How many of this cohort received this health check in the time specified by the standard?							
1.4	How many of this cohort were offered this health check later than the time specified by the standard?							
1.5	How many of this cohort received this health check later than the time specified by the standard?							

SECTION 1 (continued)

For questions 1.6 & 1.7 please indicate your answer(s) by placing a check in the relevant column(s). For electronic use, place the cursor in the box and click to automatically insert a check. If your answer is "Other" please specify the reason(s) in the space provided.

		Health Checks (01/01/07 to the 31/12/07)				
Information Required		Postnatal/Primary Visit Up to 48hrs after discharge (Children born 2007)				
1.6	With reference to 1.4 indicate the reason(s) this cohort were offered this health check later than the time specified by the standard.	PHN received birth notification later than 48 hours following discharge <input type="checkbox"/>	Lack of PHN service coverage <input type="checkbox"/>	5 day (Mon-Fri) postnatal service only <input type="checkbox"/>	Incorrect details on notification form (including change of address) <input type="checkbox"/>	Illegible details on notification form (faxed copies, carbon copies etc.) <input type="checkbox"/>
		Other: <i>Please specify reason(s)</i>				
1.7	With reference to 1.5 indicate the reason(s) this cohort received this health check later than the time specified by the standard.	PHN received birth notification later than 48 hours following discharge <input type="checkbox"/>	Lack of PHN service coverage <input type="checkbox"/>	5 day (Mon-Fri) postnatal service only <input type="checkbox"/>	Incorrect details on notification form (including change of address) <input type="checkbox"/>	Illegible details on notification form (faxed copies, carbon copies etc.) <input type="checkbox"/>
		Other: <i>Please specify reason(s)</i>				

SECTION 2

*For 2.1 indicate your answer by placing a check in the box opposite “completely”, or “partially”, or “not at all”. For electronic use, place the cursor in the box and click to automatically insert a check (please ensure only **one** box in each column is checked).*

		Health Checks						
	Information Required	Postnatal/ Primary Visit	3 months	7 to 9 months	18 to 24 months	3.25 to 3.5 years	School Entry	School Leaving
2.1	Was this health check carried out according to the recommended examination and health promotion activities as outlined in <i>BHFCR (2005)</i> ?	<input type="checkbox"/> completely <input type="checkbox"/> partially <input type="checkbox"/> not at all	<input type="checkbox"/> completely <input type="checkbox"/> partially <input type="checkbox"/> not at all	<input type="checkbox"/> completely <input type="checkbox"/> partially <input type="checkbox"/> not at all	<input type="checkbox"/> completely <input type="checkbox"/> partially <input type="checkbox"/> not at all	<input type="checkbox"/> completely <input type="checkbox"/> partially <input type="checkbox"/> not at all	<input type="checkbox"/> completely <input type="checkbox"/> partially <input type="checkbox"/> not at all	<input type="checkbox"/> completely <input type="checkbox"/> partially <input type="checkbox"/> not at all
2.2	If your answer to 2.1 is either “partially” or “not at all” please specify the reasons for non-adherence to health check standards as recommended in <i>BHFCR (2005)</i> .							

(Return key can be used if additional space is required)

SECTION 2 (continued)

*For 2.3 indicate your answer by placing a check in the box opposite “completely”, or “partially”, or “not at all”. For electronic use, place the cursor in the box and click to automatically insert a check (please ensure only **one** box in each column is checked).*

		Recommended Health Care Staff for Health Checks						
	Information Required	PHN	PHN	PHN(s) or PHN & AMO	PHN	PHN	PHN/School Nurse	PHN/School Nurse
2.3	Was this health check carried out by the health care staff as recommended in <i>BHFCR (2005)</i> ?	<input type="checkbox"/> completely <input type="checkbox"/> partially <input type="checkbox"/> not at all	<input type="checkbox"/> completely <input type="checkbox"/> partially <input type="checkbox"/> not at all	<input type="checkbox"/> completely <input type="checkbox"/> partially <input type="checkbox"/> not at all	<input type="checkbox"/> completely <input type="checkbox"/> partially <input type="checkbox"/> not at all	<input type="checkbox"/> completely <input type="checkbox"/> partially <input type="checkbox"/> not at all	<input type="checkbox"/> completely <input type="checkbox"/> partially <input type="checkbox"/> not at all	<input type="checkbox"/> completely <input type="checkbox"/> partially <input type="checkbox"/> not at all
2.4	If your answer to 2.3 is either “partially” or “not at all” please specify the reasons for non-adherence to the use of health care staff as recommended in <i>BHFCR (2005)</i> .							

(Return key can be used if additional space is required)

SECTION 2 (continued)

Please specify the resources in place which enabled adherence to health check standards as recommended in BHFCR (2005).

Resources for Health Checks

2.5 *Equipment & facilities	2.6 Staffing & training	2.7 Documentation & other materials	2.8 Information systems	2.9 Other

(Return key can be used if additional space is required)

* See Appendix II for recommended list of equipment

SECTION 3

3.1 What formal information (e.g. Birth Notification Form, Discharge Notification Form or other) does your child health service receive, regarding birth health checks, carried out by a paediatrician, community midwife or general practitioner?

(Return key can be used if additional space is required)

3.2 What formal information does your child health service receive from the Maternity Infant Scheme, Personal Health Record or other, regarding the 6-8 week health check, carried out by a general practitioner or practice nurse?

(Return key can be used if additional space is required)

SECTION 4

Please use this section to record any additional comments that you would like to make.

4.1 Additional comments relevant to CHSS health checks in your LHO area.

(Return key can be used if additional space is required)

SECTION 5

Please provide numerical information on the PHN and MO staff complement (w.t.e) which delivered the broader child health service (including CHSS) in your LHO area for 2007, by filling in the appropriate boxes.

Staffing

Public Health Nurse (PHN)		Medical Officers (MO)	
5.1	Total w.t.e. (for all services) as of 01/01/07	5.4	Total w.t.e. (for all services) as of 01/01/07
5.2	Percentage w.t.e. used to deliver child health service as of 01/01/07	5.5	Percentage w.t.e. used to deliver child health service as of 01/01/07
5.3	Percentage w.t.e. allocated to the child health service that was unfilled as of 01/01/07	5.6	Percentage w.t.e. allocated to the child health service that was unfilled as of 01/01/07

SECTION 6

Please give contact details for the Local Health Manager (LHM), Director of Public Health Nursing (DPHN) and Principal Medical Officer (PMO) in your LHO area.

LHO Area					
LHM Name & Address		DPHN Name & Address		PMO Name & Address	
LHM Tel No		DPHN Tel No		PMO Tel No	
LHM E-mail		DPHN E-mail		PMO E-mail	

Please give details for a contact person in relation to the information provided.

Contact Name & Address	Contact Tel No	Contact E-mail
	Date Completed	

Please return survey to Karen Kennedy by 19/11/08

E-mail: Karen.Kennedy3@hse.ie

Fax: 061-310612

Appendix II - Standards

Timing	History	Examination	Health Promotion	Recommended Health Care Staff
Birth	Antenatal, birth and family history; Parental concerns;	Physical examination, including eyes, ears, skin, mouth, cardiovascular system for CHD, hips for DDH and genitalia for UDT in boys; Developmental examination; Growth;	Parental health and well-being Prevention of SIDS Transport in cars Feeding practice Sibling management Parent–infant interactions Child development Accident prevention Information about local support networks and contacts for additional advice and support when needed Identification of parents who may be in need of additional supports	Hospital Paediatrician or Community Midwife or General Practitioner
Postnatal visit	As above	Physical examination; Developmental examination; <i>Growth</i> ; “Can your baby hear you?”; <i>Guthrie test if not already taken</i> ;	As above	Public Health Nurse
6 to 8 weeks	As above	Physical examination as for neonatal age; Developmental examination; Growth; “Can your baby hear you?”	As above Family planning	General Practitioner and Practice Nurse
3 months	As above	Physical examination; Developmental assessment; <i>Growth</i> ; “Can your baby hear you?”	As above Oral health promotion Age appropriate play Return to work Child care Family planning	Public Health Nurse
7 to 9 months	As above	Examination for DDH; Developmental assessment; <i>Growth</i> ; “Can your baby hear you?”; Distraction Hearing Test	As above	Public Health Nurses or Public Health Nurse and Area Medical Officer
18 to 24 months	As above	Observation of gait; Developmental assessment; <i>Growth</i> ;	As above Management of challenging behaviour Toilet training	Public Health Nurses
3.25 to 3.5 years	As above	Developmental assessment; <i>Growth</i> ;	As above	Public Health Nurse
School entry	As above School entry questionnaire	Visual acuity testing; Pure tone audiometry hearing screening; Growth;	As per SPHE programme Advisory and supporting role to teacher in SPHE	School Nurse
School leaving	As above	Visual acuity testing; <i>Colour vision screening</i> ;	As above	School Nurse



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Children Services,
Office of the CEO
Health Service Executive,
First Floor,
1 Upper Hartstonge Street,
Limerick.
☎ (061) 310437
📠 (061) 310612

5th November
2008

Memo to: Principal Medical Officers & Directors of Public Health Nursing

Re: Audit of Child Health Screening & Surveillance (CHSS) Programme

Dear Colleague,

I am writing to you in response to issues raised by PMO's and DPHN's in relation to the survey for the CHSS Audit. I am taking this opportunity to respond collectively as clarification may be of benefit to all on these issues. I am particularly responding to issues brought to the Project Team by two of its members, Ms. Mary Liston, Director of Public Health Nursing and Dr. Clare O'Sullivan, Principal Medical Officer.

Issue 1: How do LHO areas that will have problems accessing sufficient information complete *Section 1*?

Response: It is fully appreciated that many areas, particularly those areas that do not have an electronic Child Health Information System will be unable to complete *Section 1* for 3 months check, 18-24 months checks and 3.25-3.5 months check. Please be assured that whatever information you have is of value and that it is useful to know that nationally it is not possible for areas to access all information.

Issue 2: Is information on individual staff performance required in *Section 2*?

Response: In *Section 2*, *Question 2.1 and 2.3* do not relate to the individual performance of staff but instead should be based on clinical guidelines that are agreed for your area. For example in a particular LHO area growth monitoring may not be covered as per the *Best Health for Children Revisited (2005)* guidelines in the School Entry Health Check and therefore the answer is "partially" with an explanation of this provided in *Question 2.2*. It is the general policy that is practised by the LHO area that should be the reference point.

Issue 3: Who should be included in *Section 5* for w.t.e. under PHN?

Response: RGN's should be included in addition to PHN's for the w.t.e. calculations.

Issue 4: What is covered in *Section 5* by the broader child health service?

Response: The broader child health service includes all activities carried out for child health (e.g. Immunisations, Domiciliary Care Allowance Assessments).

Issue 5: In *Section 6* if a Senior Medical Officer completes the form should their details be given instead of PMO's?

Response: PMO details should always be included. SMO details can be given additionally in *Section 6*.

I hope the above helps to clarify outstanding issues. Please do not hesitate to contact any of the following should you require further information or clarification.

1. Ms. Caroline Cullen - 061 310437
2. Ms. Mary Liston - 061 483735/3718/3716
3. Dr. Clare O'Sullivan - 056 7784100

Yours sincerely,

Caroline Cullen,
Project Manager.

Appendix IV - Extent of equipment in place to enable adherence to the child health check standards as recommended in *BHFCR* (2005)

Resource level: equipment	n / 31	LHO area
Complete, nearing completion	18	Clare, Donegal, Limerick, Sligo/Leitrim, Tipperary North/East Limerick, Cavan/Monaghan, Louth, Dublin West, Dun Laoghaire, Kildare/West Wicklow, North Cork, Cork North Lee, Cork South Lee, South Tipperary, Waterford, West Cork, Dublin South East and Longford/Westmeath
Partially	11	Galway, Mayo, Roscommon, Dublin North, Dublin North Central, Dublin North West, Dublin South City, Dublin South West, Laois/Offaly, Wicklow and Wexford
Not at all	0	
No response	2	Carlow/Kilkenny and Kerry

In categorising the responses from each LHO area, the category “Complete, nearing completion” was applied to responses, relating to equipment only (not facilities), which reported, “Equipment as documented in Appendix I”, “As per recommended list of equipment” or where a LHO area provided an equipment list which was substantially in line with *BHFCR* (2005) recommendations.

The category “Partially” was applied where LHO areas indicated constraints on use of recommended equipment e.g. “Equipment provided where possible”, “doctors do not have all necessary equipment” “there are deficits in equipment” (which are then listed) or where the response referred to one resource only e.g. “Developmental Assessment Pack available”.

Appendix V - Extent of training implemented to enable adherence to the child health check standards as recommended in *BHFCR (2005)*

Resource level: training	n / 31	LHO area
Complete, nearing completion	21	Clare, Limerick, Donegal, Sligo/Leitrim, Dublin North Central, Dublin North, Dublin North West, Louth, Dublin West, Dun Laoghaire, Carlow Kilkenny, Kildare/West Wicklow, Longford/Westmeath, Kerry, North Cork, Cork North Lee, Cork South Lee, South Tipperary, Waterford, West Cork and Wexford
Partially	7	Mayo, Tipperary North/East Limerick, Dublin South City, Dublin South East , Laois/Offaly, Wicklow and Dublin South West
Not at all	2	Galway and Roscommon
No response	1	Cavan/Monaghan

In categorising the responses from each LHO area, the category “Complete, nearing completion” was applied to responses which indicated, for example, “RCHSSP training modules offered to all staff”, “all relevant training received by all staff “, “training as per BHFCR “or where training in progress was indicated “same to be completed early 2009” or where the LHO area listed five or more of the nine training modules as delivered.

The category “Partially” was applied where LHO areas indicated constraints on training implementation, “training as recommended has not been completely rolled out, no training officer in this geographical area”, where limits on staff being trained are indicated, “37 PHNs receive training on vision, 37 received training on hearing, no community health doctors could participate” or where less than five training modules are reported as delivered.

Appendix VI - Extent of formal notification of the birth health check to the child health service

Notification Level	From	n / 31	LHO area
Formal notification in place, no problems specified	Hospital	18	Clare, Donegal, Galway, Mayo, Roscommon, Sligo/Leitrim, Dublin North, Louth, Dublin South East, Laois/Offaly, Longford/Westmeath, Kerry, North Cork, Cork South Lee, South Tipperary, Waterford, West Cork and Wexford
	GP	2	Louth and North Cork
	Community Midwife	10	Mayo, Roscommon, Donegal, Sligo/Leitrim, Louth, Dublin South West, Carlow/Kilkenny, Kerry, North Cork and South Tipperary
	Source is unidentified	3	Tipperary North/East Limerick, Limerick and Cavan/Monaghan
Formal notification in place, with limitations specified by respondents	Hospital	6	Dublin North Central, Dublin North West, Dublin South City, Dublin West, Dublin South West and Wicklow
	GP	1	Dublin South West
Limited, no notification	Hospital	7	Kildare/West Wicklow, Dun Laoghaire, Carlow/Kilkenny, Cork North Lee, Tipperary North/East Limerick, Limerick and Cavan/Monaghan
	GP	28	Clare, Donegal, Galway, Mayo, Roscommon, Sligo/Leitrim, Limerick, Tipperary North/East Limerick, Cavan/Monaghan, Dublin North, Dublin North City, Dublin North West, Dublin South City, Dublin South East, Dublin West, Kildare/West Wicklow, Dun Laoghaire, Laois/Offaly, Longford/Westmeath, Wicklow, Carlow/Kilkenny, Kerry, Cork North Lee, South Tipperary, Waterford, West Cork, Wexford, and Cork South Lee
	Community Midwife	21	Clare, Galway, Limerick, Tipperary North/East Limerick, Cavan/Monaghan, Dublin North, Dublin North Central, Dublin North/West, Dublin South City, Dublin South East, Dublin West, Kildare/West Wicklow, Dun Laoghaire, Laois/Offaly, Longford/Westmeath, Wicklow, Cork North Lee, Cork South Lee, Waterford, West Cork and Wexford.

Appendix VII - Extent of formal notification of the 6 to 8 weeks health check to the child health service

Notification Level	n / 31	LHO Area
Formal notification process in place, no limitations reported in responses	2	Clare and Cork South Lee
Formal notification process in place but limitations or inconsistencies reported in responses	4	Limerick, Tipperary North/East Limerick, Laois/Offaly and Longford/Westmeath,
“No formal notification process” or “None” reported in responses	21	Donegal, Galway, Mayo, Roscommon, Sligo/Leitrim, Cavan/Monaghan, Dublin North Central, Dublin North West, Louth, Dublin South City, Dublin South East, , Dublin West, Dun Laoghaire, Kildare/West Wicklow, Carlow/Kilkenny, Kerry, North Cork, Cork North Lee, South Tipperary, Wexford and Wicklow
No response to this question	4	Dublin North , Dublin South West, West Cork and Waterford

9. Glossary

Cohort - Group of subjects from a given population defined by experiencing an event (typically birth) in a particular time span.

Early Intervention Team - If there is a diagnosis of a disability, the child is referred to the Early Intervention Team for the LHO area. Early Intervention is the term used to describe the process of diagnosing the extent of a child's intellectual disability at the earliest possible stage, after a disability has been identified, so that a programme of preventative and remedial care can be put in place to ensure that the disabling effects of any difficulties are minimized.

Guthries - Newborn Metabolic Screening Tests, sometimes referred to as 'heel prick' tests, carried out in maternity hospitals or in the community.

Key Charts – Charts used in vision screening at school entry level, using crowded pictures which have been shown to correlate with letters for accuracy whilst being more appropriate and easier for the age group.

Marte Meo - The Marte Meo programme is a developmental support programme, which can be used in daily interaction moments. The central focus of Marte Meo is to encourage people to use "*their own strength*" to advance and stimulate developmental processes on the part of children, parents, professional caregivers and supervisors, and thus learn to utilise their capacities to the optimum.

National Minimum Data Set (NMDS) - A national minimum data set (NMDS) is a minimum set of data elements agreed for the mandatory collection and reporting of a common set of relevant and evidence-based health and performance indicators that clearly and accurately report child health status across the country and enables international comparisons. It may include data elements that are also included in other national minimum data sets e.g. birth weight. A NMDS is contingent upon a national agreement to collect uniform data and to supply it as part of the national collection, but does not preclude agencies and service providers from collecting additional data to meet their own specific needs.

Neo-natal Hearing Screening - Newborn hearing screening programmes (NHSP) or universal neonatal hearing screening (UNHS) takes place 24 to 48 hours after birth, usually in maternity hospitals. The commonest screening tool, or instrument, is known as otoacoustic emissions (abbreviated as OAE, TEOAE or DPOAE) which measures sound emitted from the cochlea in response to other sounds. It is fast, accurate, non-invasive and cost-effective

Notification Visit - The postnatal/primary visit is sometimes referred to as the notification visit.

Sonsken Silver - Type of vision test used for age group 3:5 years and upwards.

Warbler – Audiological stimulus used in the distraction hearing test to produce high and low frequency sounds.

10. References

Denyer S, Pelly H, Thornton L (1999) Best Health for Children – Developing a Partnership with Families. A Progress Report. Dublin. www.hse.ie

Hall D, Elliman D eds Health for all children 4th edition. Oxford: Oxford University Press, 2003.

Health Service Executive (October 2005) Best Health for Children Revisited – Report from the National Core Child Health Programme Review Group. Dublin www.hse.ie