Developments in child health surveillance programmes

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The promotion of good health and well-being for children is essential to improve adult health. Child health surveillance has been crucial in attempting to achieve this goal. The National Service Framework for Children promotes a new child health programme. If it is to be successful, nurses involved in primary care must play a central role.

Historically, child health surveillance and screening have been central to monitoring children’s health and development (Robertson, 1991; Luker and Orr 1996; Hall and Elliman, 2004). There is no doubt that health throughout life is influenced by the experiences in early years of childhood.

Recent government policy has highlighted the importance of health professionals working with families and children to improve their health outcomes (Acheson, 1998; DoH, 1999; DoH, 2004a). Although the health of children is predominantly a parental responsibility, society has a vested interest in ensuring that parents are supported to improve the health and well-being of their children. This will help to ensure the needs and rights of our children are respected.

Background

The best-known historical recordings of childhood surveillance are probably those of Charles Darwin, who observed his eldest son in the 19th century. These records, together with the increase in childhood mortality at this time, provided a catalyst for increased interest in determining how children’s health could be improved.

More recently, the first edition of Health For All Children (Hall, 1989), produced by the Joint Working Party on Child Health Surveillance, provided the building blocks for shaping future surveillance. The report’s main purpose was to review the tests and procedures carried out by health care professionals on children in the first few years of life.

In the next decade, the working party agreed that preventive health care should involve more than simply identifying health problems; there should also be a focus on primary prevention. From this, child health promotion evolved as the main theme, delivering the message that preventive health services for children needed to be extended beyond the remit of child health surveillance. Positive efforts to prevent illness and promote good health were now required. A clear focus on early years and preschool children was suggested, with the health visitor in the community setting having a key role (Hall, 1996).

The reports became fundamental to the development of child health services. They required health professionals and families to form relationships of ‘partnership rather than supervision’, in which parents could be empowered to make use of services and expertise according to their needs. The fourth edition of Health For All Children (Hall, 2003), commonly known as Hall 4, included recommendations for a streamlined surveillance programme, with even greater emphasis on health promotion and primary prevention.

Early years screening

Health professionals now recognise child health surveillance as an activity relating to secondary prevention. The term ‘surveillance’ has often been used in conjunction with ‘screening’ and over the years their advantages and disadvantages have been hotly debated (Elliman et al, 2004).

Traditionally, the role of the health visitor has been seen as being involved in the developmental screening and immunisation of children (DoH, 1995). Their visits have often been the first point of contact with parents/carers, providing valuable opportunities to share concerns and detect variations from normal childhood development.

Each week Nursing Times publishes a guided learning article with reflection points to help you with your CPD. After reading the article you should be able to:

- Understand the developments that led to childhood screening programmes;
- Recognise the role of screening in a national health promotion strategy;
- Explain the new early years developmental assessment;
- Identify the role of nurses and health visitors in screening interventions.
At present, health visitors (alongside their increasing public health role) continue to undertake a range of health assessments in children up to preschool age. These are performed in conjunction with the GP at various stages (Table 1).

In the past, numerous schedules or tools have been used to assist in this process. The Denver Developmental Screening Tool and the NFER-Nelson Schedule of Growing Skills are the most common, the latter based on work by Sheridan (2000) on normal developmental patterns. This approach was further assisted by the introduction of the parent-held child health record in 1990, which encouraged parents to be aware of their child’s development and become more actively involved in observing and monitoring progress.

For contacts to be effective, it was vital that information provided to parents was clear and easy to understand. Health promotion advice had to be tailored to individual needs but to include issues such as breastfeeding, weaning, safety, sleep and play.

Some health visitors believe that not all children and families need such comprehensive routine health surveillance (Clarke et al, 2004). Hall 4 suggested a more holistic approach that would involve the assessment of children and families according to need, rather than routinely offering rigorous surveillance to all. This was to provide the evi-
REFERENCES


Implications of NSF for children

The children’s NSF (DoH, 2004a) incorporates a 10-year strategy to improve the lives and health of children and young people. Its overall aim is to provide high-quality health care from pregnancy to adulthood. The NSF contains 11 standards, which require a fundamental change in the culture of service provision, so that services can become more child and family-centred. The first five standards apply to all children while the rest focus more on specific groups (such as children with disabilities and those in hospital, and maternity services).

In an attempt to limit health inequalities, the NSF proposes a succinct child health promotion programme focusing on prevention and early intervention, based on recommendations in Hall 4. Although similar to the traditional early years surveillance programme, this will enable professionals to offer a more targeted approach, supplemented with additional or intensive support depending on individual family needs. Although there will be fewer routine contacts, the programme will continue to offer a comprehensive overview of individual children’s health, with greater emphasis on offering parents continued support and advice along with improved access to services. Children are to be seen as important users of services and key to this will be improved consultations and advice for parents. It is therefore important that child health promotion takes a multi-agency approach incorporating social, political and educational interfaces.

Focus for primary health care

There is no doubt that the vision of the NSF is vast (Lachman and Vickers, 2004) and will require leadership and commitment from NHS trusts. It is likely to have substantial implications – especially for those who plan and deliver services for children. Its impact and success will depend on the quality of local implementation, and it will undoubtedly mean that extra resources and training are required, especially for community-based services.

Primary health care will be pivotal to the delivery of the NSF, as most services for children need to be provided in the community. Its aims will therefore only be achieved if NHS services are able to develop partnerships with other agencies working with children, such as education, social services and the voluntary sector (DoH, 2004b).

Coordinated service provision is essential, especially in light of reports such as Laming (2003) on the Victoria Climbié inquiry. This emphasised the need for greater collaboration through a multi-agency approach to ensure that at-risk children are identified and protected.

In order to improve the long-term health of children, and to reduce health inequalities, identification of health need is central to child health promotion programmes, and to ensure parents understand what constitutes good health in a child and how they can promote this in their children. All agencies must have the same priorities, working with not only individuals but also the wider community.

In addition, it is vital for agencies to recognise that some children and families come up against barriers that make it difficult for them to access services. These include people seeking asylum, people who do not speak English, travellers, people with disabilities, homeless people and many other disadvantaged groups.

Ensuring that disadvantaged groups have access to the same high-quality, holistic and family-centred services as other users will be a real challenge for service providers. However, it is crucial that they meet this challenge as it is likely that a large proportion of the children and families for whom additional support is necessary will come from these vulnerable groups.

Conclusion

All members of the primary health care team, including midwives, practice nurses, health visitors and school nurses, have key roles in achieving the aims of Hall 4 and meeting the standards set out in the NSF.

These professionals will continue to be involved in early intervention measures, involving the promotion of physical, mental and emotional well-being of children. If these measures are taken, services have the opportunity to transform the health and well-being of many of our most vulnerable children and families.

Guided reflection

Use the following points to write a reflection for your PREP portfolio:

- Write about your area of practice and why this article is relevant for you;
- Outline the main points that the article makes;
- Identify any new piece of information you have learnt;
- Consider how you will use this information to develop your practice;
- Explain how you will follow up what you have learnt from this article.