

Child public health in 21st-century practice: Examples of collaborative working with the paediatrician

Public health is central to health visitors' work, and a key element of effective health promotion is joint working with other professionals. Paediatrician Professor Mitch Blair discusses the health visitor's crucial role in primary prevention, and shares examples from his own practice of working with health visitors in child public health.

Health visiting originated with a public health orientation and a distinct focus on providing a truly universal health service. It can be argued that this requirement is even more necessary in a 21st-century context and practice. This article provides some examples of joint working with a paediatrician in addressing injury, nutrition and infant mortality in North London, and calls for the strengthening of such multidisciplinary child public health partnerships in future.

Early public health origins and focus

The birth of health visiting in the 19th century arose from the need to respond to the public health challenges of the time. These included high infant mortality rates from diarrhoeal illnesses due to poor sanitation, infectious disease related to overcrowding, and nutritional deficiencies related to sub-optimal feeding practices and poor-quality dietary intake. Several reviews have already highlighted the early historical success of the service and have demonstrated the importance of

a public health approach working in partnership with others, so this article will not review this area.

A public health approach remains at the forefront of 21st-century health visiting practice. The Government's current health visiting strategy for England has highlighted four ways of working for modern health visitors (Department of Health, 2011):

- ♦ Community development
- ♦ Leadership of the Healthy Child Programme
- ♦ Provision of targeted services for those with additional needs
- ♦ Working in partnership with specialist services with those with the highest needs.

The *National Health Visitor Plan: Progress to date* (Department of Health et al, 2013) and the new *National Health Visitor Service Specification* (NHS England, 2014) further emphasise the importance of a proportionate or progressive universalist approach to practice. However, in many places, health visitors are spending much of their time with the highest-risk families

in terms of child protection issues and the prevention of neglect and abuse. They often find themselves having to juggle negotiating thresholds for supportive care with their social care colleagues, who are particularly stretched as the local economic climate affects councils. This is not a new phenomenon; the duality and overlap of roles over the years has been well reviewed recently by Baldwin (2012). For many teams around the country, the still relatively small numbers of health visitors and their teams have meant that this focus on child protection has been at the expense of wider community development activities. There is some evidence from the *Health Visitor Implementation Plan* early implementer sites around the country of positive changes in more recent months, as teams focus on developing these aspects.

Prevention during times of stress

As health visiting moves under the control of local authorities, it is imperative that these aspects of the work are not subsumed and overtaken by the tyranny of the urgent and a poor understanding by colleagues of the value of true primary prevention (as opposed to secondary prevention, sometimes termed 'early intervention' by social care and education colleagues).

In the early 1990s, the cardiologist



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and epidemiologist Geoffrey Rose made a strong case for the importance of retaining universal preventive services as the bedrock for the primary prevention of disease. He used the example of two approaches of dealing with hypertension in the population: screening and treatment of those small numbers with a high risk of blood pressure, or lowering the salt content of the diet with a view to reducing the risk for the population as a whole. Common diseases have their roots in lifestyle, social factors and the environment, and successful health promotion depends on a population-based strategy of prevention (Rose et al, 1992). Marmot has also emphasised that if we are going to be effective at improving the life chances of children, we need to ensure an effective preventive strategy which reaches all members of the community (Marmot, 2010). The move of public health back into local authority organisation could potentially be seen as threatening to many, but is also an opportunity for some health visitors to return to working with more of a focus on child public health with the community as a whole.

New scientific insights and the health visitor as 'knowledge broker'

Health visitors will have become familiar with the huge impact that neurobiological scientific insights have had on our understanding of human infant development and the exquisitely sensitive relationship between the environment and brain development (Shonkoff and Phillips, 2000). It is not only the socio-emotional environment but also the physical environment that is changing at such a fast pace, with the production of thousands of new chemicals every year that find their way into air, food and water.

The insights that we have now on epigenetics have also led us to a far greater understanding of the mechanisms of how social determinants play their part in the programming of many different body systems in development. Health visitors

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are in a unique position in helping to act as 'knowledge brokers' in this field. The implementation of evidence-based practice requires that there is a common understanding of causality; how social determinants interact, how resilience can be built and community assets strengthened to ultimately influence the outcomes observed (Blair, 2014). Practitioners are able to explain to those around them why it is so critical to have high-quality childcare, healthy attachment, a smoke-free environment, adequate nutrition and a safe environment—and the effects of all these factors on the rapidly developing infant and child.

Working together in child public health

Health visitors are clearly not alone in influencing the health of children at a community level. There are a few paediatricians across the country who are able to take this population-based approach in a sustained way in their current consultant contracts. This has been encouraged through the development of a textbook on the subject (Blair et al, 2010) and the Child Public Health Special Interest Group in the mid-1990s—later relaunched as the British Association for Child and Adolescent Public Health—which is open to all those interested in promoting the health of children and young people, with a core membership of paediatricians and public health specialists.

Personal reflections

As a paediatrician who has worked both in the community and in acute settings, I am only too aware of the value and satisfaction of treating individual children, but in the last 20 years of my practice, I have always retained at least half to one

day per week to work on the wider determinants that affect a much larger population of children as a whole.

In this endeavour, I have been fortunate to work with a number of like-minded health visitors, who have not only had the passion but have found the time within their busy schedules to dedicate to this population-based approach. The following examples outline some of the initiatives that we have carried out together around injury prevention, infant mortality reduction, breastfeeding promotion and improving uptake of vitamin D. Each of these was prompted by an identified need in the community from excessive deaths or morbidity in each case and as measured against neighbouring boroughs.

Injury prevention

I worked with the liaison health visitor in my hospital, who had an outstanding passion to try to improve injury prevention in the local area. Between us, we were able to set up a small committee locally that included members of the fire brigade, police and housing departments, along with Age Concern (now Age UK). Age Concern had been fitting elderly people's homes with safety equipment and had some spare capacity to do the same for children living in disadvantaged circumstances. Over a period of three years, we managed to set up a system of hazard surveillance in the home linked to the supply of safety equipment to help prevent injury in children under 5 years old. The focus was on burns and scalds prevention in a multi-ethnic population (Blair et al, 2008). In the period 2008–11, more than 100 families received equipment.

The key to the effectiveness of the project was in raising public awareness

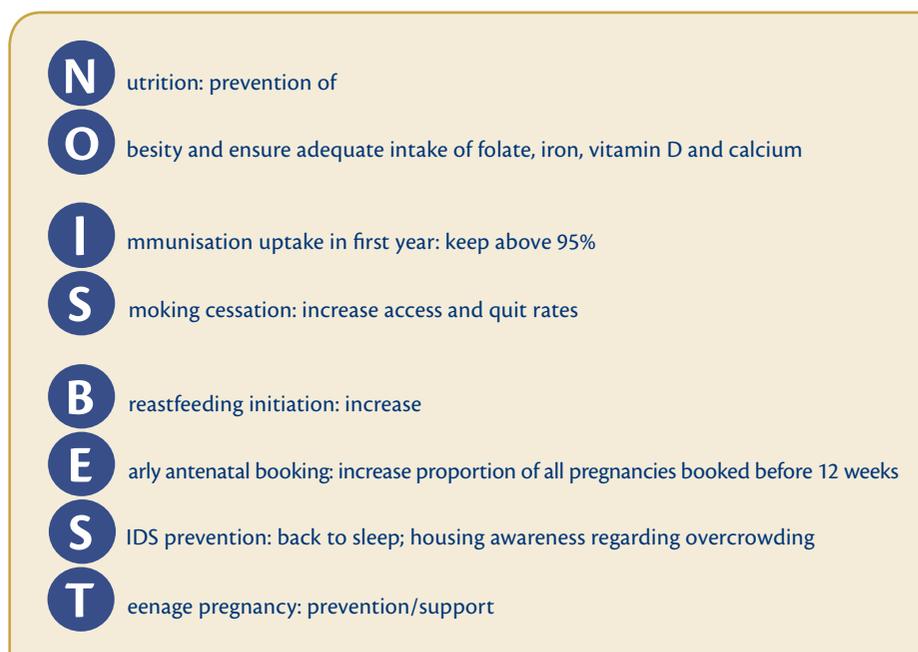


Figure 1. NO (Death) IS BEST campaign has led to a reduction in infant mortality in the local area

of the issues, making time to connect with other voluntary agencies that could support our work, and meeting with managers of different services to highlight the importance of injury prevention and the cost of injury to society in both financial and emotional terms. Unfortunately, when my health visitor colleague left, the scheme was abandoned because of the lack of sustainability in the system.

Infant mortality

The 'NO (Death) IS BEST' campaign was a supreme example of how health visitors, midwives and paediatricians could come together and work closely with commissioners to develop a whole programme of activity to reduce the risk factors for infant mortality. This is a good example of a social marketing exercise, which was shared with all early years and health staff through educational meetings and interdisciplinary workshops and supported by a total commitment from the Director of Children's Services. Each Children's Centre manager had to report to the local Children and Young People's Strategic Partnership Board on a quarterly basis on progress made against key indicators, often using innovative posters and displays in each

centre, improving access to services such as community midwifery. The Head of Midwifery, the Chief Executive of our acute Trust and I were also asked to meet with the council scrutiny committee to demonstrate that we had achieved some changes over the 2-year period of the campaign. Regular meetings with public health and local GPs ensured immunisation rates were kept high and coverage of smoking cessation services was comprehensive. School nurses increased their activity around improving adolescent access to sexual health services.

Figure 1 shows the main components of the sustained campaign over a period of time, which has led to the reduction of infant mortality in the local area (Allen et al, 2013).

Breastfeeding promotion

Our area in North London is particularly fortunate in having a single individual who has been there for a long time and has developed links with community leaders and families to help promote breastfeeding. Specifically, a lot of work was done with young mothers in the Somali community, where our breastfeeding coordinator worked to develop a strong peer-support network and a great deal

of involvement with fathers around appropriate help for their partners. This was achieved through education and discussion, which aimed to stress the benefits of breastfeeding and normalise its adoption as the first choice of infant feeding. Indeed, that same network has been invaluable for developing health education messages relevant for that community around Vitamin D deficiency (see below).

In the past year, the Breastfeeding in Harrow programme has been awarded UNICEF Baby Friendly accreditation level 3, both in the hospital and in the community. I have supplied a number of registrars over the years to carry out projects with our specialist health visitor to help support the audit of activities and the measurement of success. Again, this is an example of a partnership between paediatrician, health visitor and midwife.

Vitamin D

I have worked closely with a senior midwife in addressing vitamin D deficiency in our community. We carried out research which indicated that at least one third of women at antenatal booking had levels below 25 nmol/l and, therefore, were at significant risk of bone disease—both in themselves and their unborn infants (McAree et al, 2013). Subsequent work with the Somali community has indicated that the messages about vitamin D are not getting through and that there is a need to do a great deal more to tailor them for high-risk groups (Chandaria et al, 2011).

Health visitors have helped develop local community champions of breastfeeding in this particular community, who have been able to help us take forward a campaign with appropriate local TV and radio coverage. This is a community that relies very much on an oral tradition of transmitting health messages, and the health visitor is well placed to influence such messaging. As Fieldgrass (1992) stated, a small injection of professional skills can reach a long way when combined with a network close to the community.

Such community perspective can make a professional message far more powerful and accurately targeted.

Conclusions

There continues to be a need to build and retain a child public health approach at a local level to prevent disease, and promote and protect the health of the population. That can only be achieved if we have a strong, fully staffed team led by the health visitor and supported by paediatricians and local public health specialists who can engage the wider workforce. This includes early years professionals who, in my experience, are only too hungry to be involved alongside health experts in coordinated, sustained activities to improve the health and development of children and their families. **JHV**

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Key points

- ◆ Health visitors are key players in supporting the local child public health agenda in 21st-century practice
- ◆ Health visitors' training, skills and unique access to family homes gives them the opportunity to assess and highlight needs in situ and at population level
- ◆ Successful joint action along with other senior clinicians and public health specialists can help to validate this important role

Further reading and resources

Websites

Breastfeeding in Harrow: www.breastfeedinginharrow.org

British Association for Child and Adolescent Public Health: www.bacaph.org.uk

Archived documents

Department of Health (2001) Health Visitor Practice Development Resource Pack (available from <http://tinyurl.com/najt7qq>)

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