Community Child Health and the Future
a BACCH discussion paper

February 2005
The background to this paper is the on-going discussion in the RCPCH and BACCH on the future configuration of, and training for, community-based paediatric and child health services. It builds on recent College documents, *Strengthening the care of children in the community* and *The Next 10 years: educating paediatricians for new roles in the 21st century*. The paper is also influenced by the changing profile of paediatric care with increasing focus on care of children, even those with complex conditions, outside hospital settings and the decreasing role of the purely hospital-based general paediatrician.

The recent publication of the White Paper ‘*Every Child Matters*’ and the full NSF for Children are likely to have a profound effect on paediatric practice. The advent of Children’s Trusts and the renewed focus on child protection and multi-agency working highlight the importance of ensuring high quality primary and local secondary child health care services working closely with other statutory and voluntary agencies to promote the health of all children.

The objectives are:
1. to lay out a simple framework for community-based child health services including staffing and training requirements
2. to contribute a BACCH perspective on training for future paediatricians and the role and function of community paediatricians
3. to highlight the need to strengthen the academic base of community child health
4. to promote discussion on the future of community child health. To this end, we have appended a list of questions for readers in order to encourage feedback on the document and on-going debate (Appendix).

High quality child health services delivered as close to children’s homes as possible

This paper starts from the needs of children for accessible, acceptable, flexible, high quality child health services delivered when possible close to their homes. While recognising that many child health services are provided by GPs, nurses and other health care professionals, the paper focuses on paediatricians and their role in service provision and their training and academic needs but refers to other professionals when outlining the skill mix necessary for the provision of comprehensive community-based child health services. The majority of children use only primary or secondary child health services with a small minority requiring tertiary expertise. For this reason, the paper stresses the importance of high quality primary and local secondary child health care services capable of dealing with the majority of child health problems and of identifying those rare occasions on which tertiary care is needed. Future child health services should be built on the firm basis of high quality primary and secondary child health...
health care with training programmes appropriate to this aim. The figure shows the services that a PCT would be expected to offer depicting the overlapping of services for some child health problems. The table below extends the community element of the services depicted in the figure summarising the contribution that community child health services can make to primary and secondary child health care, the staff groups most likely to be required to provide the service and training programmes to ensure service quality. Children covered by each PCT should have ready access to each of these services but they do not all need to be provided by every single PCT.

Table: Community-based services that should be available to all children

<table>
<thead>
<tr>
<th>Service</th>
<th>Staffing</th>
<th>Training</th>
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<tbody>
<tr>
<td><strong>Primary care of common child health problems and child health promotion/surveillance</strong></td>
<td>GPs/A&amp;E doctors, Health visitors, Practice nurses/A&amp;E nurses, Supported by paediatricians and child health nurses</td>
<td>Adequate levels of knowledge of primary level paediatrics in general practice – one practitioner with interest in child health, Paediatric skills in liaison and working with primary care</td>
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<tr>
<td><strong>Child Public Health:</strong> a) overseeing health protection/promotion and prevention (eg: Sure Start initiatives, profiling local community, injury prevention)**</td>
<td>Paediatrician* with an interest &amp;/or public health nurses &amp;/or Public Health physician with an interest in child health</td>
<td>Basic training for all paediatricians &amp; child health nurses in population paediatrics and more detailed training for those with a special interest, Basic child health skills for PH physicians</td>
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<tr>
<td><strong>b) vaccination and immunisation</strong></td>
<td>Paediatrician with an interest supported by nurses &amp; public health physicians</td>
<td>Training in vaccination and immunisation sufficient to act as an adviser and resource to immunisation programme providers</td>
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<tr>
<td><strong>c) Child Health Surveillance/ Promotion Coordinator</strong></td>
<td>Paediatrician with an interest to liaise with primary care professionals undertaking CHS/P</td>
<td>Training and experience in child health surveillance/ promotion sufficient to act as advisor and resource to providers</td>
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<td><strong>Education liaison &amp; SEN</strong></td>
<td>Nurses should provide the main support to schools with clear referral pathways to appropriate secondary child health services, Paediatric input to support the nurses and provide medical advice to the LEA.</td>
<td>Enhanced training for nurses to undertake the increased responsibilities of this role, Training for paediatricians related to educational needs of children and the SEN process</td>
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<td>Vulnerable children including looked after children, children in need, refugee and asylum seeking children and child protection</td>
<td>Paediatrician with special interest in child protection and vulnerable children, supported by highly trained nurses</td>
<td>Adequate general level of awareness with additional training for nurses and paediatricians with a special interest</td>
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<td>Behavioural paediatrics including services for enuresis and encopresis</td>
<td>Child health practitioners (particularly HVs and nursery nurses in primary care) Nurses in schools and community services Paediatricians in close liaison with CAMHS</td>
<td>Special training for Paediatricians and nurses with an interest in this area Improved levels of training for primary care practitioners in the management of behavioural problems in childhood Specialist level training for Paediatricians and nurses with an interest</td>
</tr>
<tr>
<td>Audiology</td>
<td>Trained neonatal screeners 3 possible combinations: 1. Paediatrician trained in audiology 2. Audiology consultant working closely with paediatrician 3. Paediatrician with an interest working with paediatric audiology technician</td>
<td>Specific training in screening MSc in Audiology desirable Paediatrician should have a good grounding in audiology As above</td>
</tr>
<tr>
<td>Neurodisability</td>
<td>Primary care practitioners with sufficient expertise to distinguish normal from abnormal development Paediatrician with special interest and nurses and PAMs</td>
<td>Adequate level of training in child development for key primary care child health practitioners Specialist training for those offering a secondary service</td>
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<tr>
<td>Children with longstanding illness including those with complex needs</td>
<td>Paediatrician with special interest and nurses and PAMs</td>
<td>Specialist training including palliative care for those offering a secondary service</td>
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<tr>
<td>Adolescent &amp; transition services</td>
<td>Paediatrician, nurses and PAMs</td>
<td>Specialist training for those offering service (there may be a need for all practitioners to receive enhanced training in the management of adolescent problems and particularly transition issues)</td>
</tr>
</tbody>
</table>

- throughout the table the term paediatrician is used and includes Consultants, Staff and Associate Specialist Grades whether community or hospital based
Should Community Paediatrics further sub-divide into sub-specialties?

David Hall’s paper (*Neurodisability and Community Child Health – where do we go from here?)* focuses on the issue of specialisms. Neurodisability has been accepted as a new sub-specialty and has its own CSAC. David’s paper questions whether other areas of community child health work, such as Child Protection (Forensic paediatrics) and Behavioural paediatrics, should be considered for sub-specialty status. The issue of sub-specialty status is important and does need to be debated but it should not become the main focus of our plans for the future configuration of high quality community child health services. The main task is to ensure that all children have access to the services outlined in the table above with skill mix necessary to offer high quality services to families and children. An essential underpinning of the service areas identified in the table is general practitioners and primary care nurses with an interest in child health and general community paediatricians with the skill to identify and manage common paediatric problems or refer on children with more complex problems.

Figure showing universal PCT services for children

![Diagram of universal PCT services](image)

Source: *Community Paediatric Workforce Requirements to meet the needs of children in the 21st century.*
Training paediatricians for the 21st century

The ‘Looking ahead’ Document suggested that all paediatricians would be trained in all aspects of the sub-specialty. They would provide a generic service across acute, non-acute and preventive paediatrics. Maintaining competence in all areas: NICU, acute general paediatrics, non-acute physical illness, developmental difficulties and preventive paediatrics at a level safe enough to practise independently will become increasingly difficult to sustain. We already find that paediatricians working across acute and non-acute settings find their posts difficult to sustain.

The more recent thoughts on a phased consultant career structure open up other opportunities. There will always be a need for generic paediatricians and a broad-based integrated training in acute, non-acute, developmental and preventive paediatrics is to be welcomed. They are likely to work in acute units, providing on-call for acute paediatric emergencies on a 24/7 rota and to contribute to the other aspects of the service in day time hours. Their special expertise will be in diagnosing and managing undifferentiated illness and is likely to include neonatal care, A&E including resuscitation skills and urgent child abuse referrals.

Other, perhaps more experienced, paediatricians will provide predominantly non-acute services: long-term management of chronic conditions with a physical component such as diabetes or cystic fibrosis, detailed assessment and management of developmental and neurodisability, consultancy to the local authority on the health aspects of social care and education or managing health protection programmes with public health colleagues. It is likely that ‘interface’ paediatricians will be needed to manage the interfaces between primary and secondary care, and hospital and community care. These paediatricians will need competencies in both areas to function effectively. As indicated in the table, these paediatricians will need support from other medical grades, nurses, therapists, managers and administrators. The emphasis will be on delegation and teamwork, using scarce and expensive skills where they are most needed.

There will also be a need to train all paediatricians in the principles of multi-disciplinary working and continuity of care in order to fulfil the roles outlined above.

What is a community paediatrician?

Community paediatricians are paediatricians first, with the skills, knowledge and attitudes required by all paediatricians. Within the sub-specialty, they may further
specialise in neuro-disability (now recognised as an independent sub-specialty), social paediatrics and child protection, child public health and behavioural paediatrics, but most retain skills across this spectrum. They are skilled in the assessment of child development; physical, intellectual, social and emotional, and in considering the impact of any difficulties on the family and on the ability of the child to access education and daily activities. They are committed to a policy of advocacy for a healthy lifestyle in children and young people and for the protection of their rights. They are often major contributors to child public health programmes such as immunisation and injury prevention. Increasingly they work in partnership between agencies, both in service delivery and strategic development.

Much of the day-to-day work of a community paediatrician is undertaken in multi-disciplinary teams, with colleagues from a wide range of professional groups and with other agencies. Parents and children are included in the planning of care programmes that aim to ensure that services are co-ordinated and appropriate for the individual child and their family. Community paediatricians also have a number of statutory duties including their role in adoption and fostering, child protection and the notification and assessment of children with special educational needs.

As with all paediatricians, those working in the community endeavour to promote evidence-based practice wherever possible and to update their knowledge and skills. They may not be based in a centre with paediatric colleagues, necessitating the development of new approaches to learning, teaching and strengthening the research base. They are committed to the highest standards of care and of ethical and professional behaviour within their sub-speciality. Central to their work is the principle that all decisions should be made in the best interests of the child or young person in their care.

**Academic community child health**

More than 30 years ago, Donald Court made a plea ‘that we should apply the same critical energy to the study of social as we do to cellular behaviour’. However, as acknowledged in ‘Strengthening the care of children in the community’, academic community child health, an essential requirement for realising Donald Court’s vision, remains weak. The combined effects of Treasury/Department of Trade and Industry work on research funding and the Research Assessment Exercise (RAE) have led to a crisis in academic clinical medicine. Even those academic paediatric departments dominated by a biomedical and cellular focus (the majority) are struggling with these changes. The chances of developing a stronger academic base for community child health in this climate are slim despite the need for such a base if we are to ensure a
sound evidence-base for primary and secondary child health services and suitably trained paediatricians to undertake the training of future paediatricians and doctors. The suggestion that the RAE rules may be changed so that research with a practical impact is rated more highly offers an opportunity to influence the paediatric academic base towards more community-based research. BACCH urges the College to work with us with a view to achieving the following:

1. Produce a plan to ensure the future of academic child health (including community child health) in the face of the current threats
2. Lobby for changes in the rules governing the RAE judgement of research quality to ensure that this has a real impact on assessments
3. A critical mass of multi-disciplinary community child health researchers in 4 or 5 UK departments with the remit of addressing the key research questions for the health of child populations and for child health service delivery
4. Standardising and further developing the existing University-accredited MSc programmes with a view to incorporating them into the training of specialist registrars as has been done in Leeds.
5. Academic departments of paediatrics and child health with a skill mix enabling them to provide comprehensive undergraduate medical education including population paediatrics and the practical and theoretical aspects of primary and secondary care paediatrics.
6. Establishment of further research training fellowships possibly with joint accreditation in epidemiology and paediatrics
7. Extend the remit of the research network for children to look at childhood disability given the volume of service demand and the paucity of good research.

Professor Nick Spencer,
Chair of BACCH on behalf of BACCH Executive Committee
January 2005
Appendix

Suggested issues for discussion:
1. Does the table list all the services that you think community child health services should be offering?
2. Are there listed services that you don’t think community child health services should be providing?
3. Do you agree with our thoughts on skill mix and workforce development?
4. Do you think we have adequately captured the role of the community paediatrician?
5. Do you agree that academic community child health should be developed in a few centres rather than in all medical schools?
6. Do you have any ideas for taking this debate forward?

Please send e-mail responses to:
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or
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