British paediatrics

Integration of child health services: an introduction

This paper outlines the recent history of the child health services, explains the policy of the British Paediatric Association (BPA) for the integration of these services and makes proposals for the mechanism of change.

History

After the reorganisation of the National Health Service (NHS) in 1974, school health and community services for preschool children were brought together under the supervision of the Area Specialist in Community Medicine (Child Health) but the tripartite division of medical care for children remained. Primary care was shared by the general practitioner, providing mainly a therapeutic service, and the community medical staff, providing almost exclusively a preventive service. Secondary care was provided by consultant paediatricians working in hospitals.

The move towards a bipartite child health service

Since the publication of the Court report in 1976 the integration of the child health services, preventive and therapeutic as well as hospital and community, has been an agreed objective. It is the policy of the BPA to work towards achieving this objective. Changes are already taking place. An increasing number of general practitioners are providing comprehensive primary care for children, there is a growing involvement of clinical medical officers in the work of general practitioners, and many consultant paediatricians are providing secondary care outside of hospitals.

The view of the BPA is that secondary care for children in the community should be consultant led and that the medical staff of the community health service should have a career structure similar to that of hospital paediatricians. The Central Committee for Hospital Medical Services (CCHMS) and the Department of Health and Social Security (DHSS) have agreed that at least one consultant paediatrician with a special interest in community child health (CPCCH) should be appointed in each health district. The pattern of work for these consultants will vary; some will have access to hospital beds as well as to diagnostic facilities. In those districts where hospital based consultant paediatricians are already providing services outside the hospital this is likely to continue after the appointment of a CPCCH.

The responsibilities of the CPCCH would include the assessment and care of handicapped children, educational medicine, research and advice to the education authority and the social service department. Some may have administrative responsibility, delegated by the District Medical Officer, for the overall administration of the community child health service.

The mechanism of change

The BPA recommends that each district should now consider introducing a consultant led service in community child health. Since it will be difficult at present to fund new consultant posts, the posts of retiring senior clinical medical officers (SCMO) should be converted to consultant posts (CPCCH). In addition, the expertise and consultant work of many existing SCMOs should be recognised by their appointment ad personam to the consultant grade. For this purpose criteria should be agreed between the profession and the DHSS for regrading those SCMOs who have appropriate training and experience and are clearly undertaking consultant work. This procedure might be conducted over a period of some three years but would be a ‘once for all’ exercise.

All current SCMOs who were not eligible for regrading under these arrangements would have security of tenure until they resigned or retired but no new SCMO posts would be created after the publication of a DHSS circular setting out the agreed arrangements.

Advertised new CPCCH posts will continue, as at present, to be subject to the consultant advisory appointments committee regulations.
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