CURRENT TOPIC

Building a combined child health service

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The fragmentation of health services for children has been recognised as unsatisfactory for at least 15 years.¹ Children cannot themselves complain about this and those of us working for them have been slow to tackle the problems that had to be surmounted in order to achieve integration. This paper outlines the need for this integration and suggests how to achieve it, based on the experience of West Dorset.

Why integrate?
It is logical. The existing fragmentation into at least two and often three units or trusts in any district creates boundaries that are not designed to be cohesive and inevitably create gaps and overlaps in any service which has to cross them. Figure 1 is the management structure in West Dorset before and, figure 2, after integration.

This illustrates the complexity of child health services whatever system of management operates, and the simplification which integration allowed.

Children require a whole service
The gaps, overlaps, and fragmentation can never provide a whole service for the whole child. Every district has its own examples of working together with the best of intentions but often in opposite directions. Examples of such situations are given and referred to under subsequent headings. All of them apply under this particular heading.

Other carers and agencies require it
There are frequent complaints of ‘buck passing’

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Figure 1 Management of children’s services before integration; SCBU= special care baby unit.

Figure 2 Management of children’s services after integration; SCBU= special care baby unit.

and inaccessibility of the service from general practice, social services and education, and parents are completely bewildered by the divisions and splits which prevent their children receiving an effective service (see example 3 particularly).

Policy making requires it

The majority of policies or good practice guidelines that relate to the health of children involve contributions to the overall service from several units or agencies (see example 4).

Policies and protocols are only effective if they are then 'owned' by all the members of the groups involved, from management level to field workers and clerks. This can happen if there is clear accountability for creating a policy and then putting it into operation.

Purchaser/provider split requires it

The division from the old health authority units into a purchasing health authority and provider trusts or directly managed units threatens to increase the feeling of fragmentation for workers within the service. Priorities for contracts and funding may be quite different from one trust to another (see example 5).

Recruitment requires it

There are certain professional groups, such as speech therapists, clinical psychologists and, in some areas, health visitors, which are in short supply. Applicants can choose from the many districts with vacancies, who then find themselves competing to attract new staff. A well organised integrated department that has clear standards and policies is far more attractive to these applicants and quite soon generates a confidence which gives the district a good reputation. It is not long then before advertisements start to produce a choice of field, which in turn enhances the quality of the department as a whole. West Dorset found this particularly true in the speech therapy department, and the prolonged vacancies that used to be a frequent feature now seem to be a thing of the past.

Examples

EXAMPLE 1

A young child with profound disability discharged from hospital, with the assurance to his parents that there will be prompt visits from their health visitor and respite care arrangements made. These arrangements were mentioned in the discharge summary from ward sister to health visitor and ward doctors to general practitioner (GP) but nobody actually referred the child to the respite panel, nor checked that there was a health visitor in post at the time. Under the integrated system the ward sister telephones the senior health visitor or liaison health visitor directly and requests both a visit to the family and a referral to the respite care panel. This does not depend on the ward sister's good memory, as it is part of a written policy and the procedure is known to the consultant paediatrician, ward sister, senior health visitor, etc.

EXAMPLE 2

A child with enuresis referred to the outpatient department by his GP. The acute paediatrician recommends an

enuresis alarm and suitable follow up, writes to whichever agency he believes supplies this service but finds when he sees the child three months later that the alarm has never been supplied. This is because the alarms are held under the incontinence budget of the community unit which is overspent and every request has to be assessed and vetted by the continence adviser who has a very long waiting list. Under the new system an overall policy for the management of enuresis is agreed, the consultant paediatrician knows that he refers direct to the school nurse for that child's school, who keeps her own stock of alarms and, if she has a waiting list, can alert her senior nurse who must monitor that the general waiting list standards for the whole department are met—that is, assessment must be within six weeks of referral and treatment initiated within 12 weeks. In neither situation does the child actually get the alarm any sooner but in the second, everybody knows exactly what is happening and the family do not feel ignored.

EXAMPLE 3

A child with cerebral palsy requiring specialised seating in order to be in a position where he can carry out school work. The health service has supplied seating at home for mealtimes; the education department considers that it has no budget for such specialised seating in school and social services will not contribute to meet the child's needs within school. The education department's links are with the consultant paediatrician who is unaware of the complexity of this problem so writes angrily to the district physiotherapist in the community unit who has no links with the other agencies. Under the integrated service the department of child health's management group can tackle the whole problem by delegating one person, for example, the community paediatrician, to get the relevant agency staff together. Recommendations from these staff should lead to an effective, united interagency bid, for example, to joint finance, to cover any specialised seating requirements within schools. Such bids carry weight because they have a clear policy and recommendations behind them and the united voice of relevant departments and agencies expressing them.

EXAMPLE 4

Creating a policy for management of the dying child requires first of all a decision that this is necessary and then delegation of a convenor to draw up a working party and make recommendations. Under a fragmented system the working party recommendations may only be taken up in part by one unit so that the management of such a child within hospital may become excellent but with none of the recommendations met when he goes back home, or vice versa. Under an integrated system the recommendations can be discussed and converted into policy which is then effective because it is clearly owned by the whole department. It also makes it possible to promote and publicise the policy among the wide range of professionals involved in this sort of situation.

EXAMPLE 5

A child with severe learning disability who has reached adulthood must transfer from all the services who have supported him and his family throughout childhood to, not only new services and service givers, but a whole new trust or unit. Under the fragmented system this could work in some cases where the child was well known to a community team who dealt with children and adults but may not work at all where a child has been predominantly hospitalised or away at residential school and therefore not known to the community team. In an integrated department the two trusts or units can already have been asked to draw up a contract which includes effective overlap of services so that hand-over is planned during the last two or three years of childhood, wherever the child is, so that the adult services have a clear picture of that particular young person's needs before they take on full responsibility for meeting them.

Who and what to include?

It is essential to start off with the inclusion of obvious main groups of child health services: the paediatric ward(s), special care baby unit, paediatric intensive care, community paediatrics, school health, and paediatric therapists. There are other important departments that must be included at an early stage, no matter what the difficulties in doing so: child and family guidance, health visiting, mental handicap services, and clinical psychology.

In West Dorset the groups that required more discussion and compromise than others were the special care baby unit, health visiting, clinical psychology, and speech therapy. *The special care baby unit* had been run as part of the maternity unit and its nurse management line was not the same as that for nurses in the children's ward. It was agreed that the nurse manager for midwifery would relate to the director of child health over all matters in the special care baby unit but the budget stayed with the acute unit manager and was not separated out to child health. Once it was found that the new department worked, it became uncontentious to hand over the budget for the unit and this experience eased the way for the eventual inclusion of midwifery/obstetrics into the same department when, two years later, it became the department of maternal and child health.

Health visitors were invited to meet the director of child health very soon after his appointment. He put forward his management philosophy (see later) and asked if health visitors agreed that these ideas were fundamental to them and if so, he invited them to join him in the department of child health. There were of course many anxieties expressed and felt over the early weeks and months, particularly relating to the generic work of health visitors but they joined the department by consent, not coercion.

A similar agreement was made with *speech therapists*, again making clear, in all documents as well as verbally, their continuing generic role.

Clinical psychology was embryonic, being only a recognition by the district clinical psychologist that some behaviour modification advice was necessary for children with learning disabilities! It has since been possible to appoint a full time clinical psychologist within the department of child health and this is an area for further development in the near future.

It is logical to include *obstetrics, genetics, and all antenatal services* within the integrated department. Each of these may be quite a big step to take and may be achieved more easily once the department of child health is seen to be up and running with an identifiable management. In West Dorset the maternity and gynaecology services were integrated after the department had been running for two years and a system of clinical directorates was introduced for all specialties.

Paediatric surgery—general, ear, nose, and throat (ENT), eyes, other specialties—should also eventually be included but will certainly take time to achieve. The most important step initially is to assist surgeons to see children as a

separate group and not as 'mini' adults and a group whose needs are already well defined in the recent guidelines published by the National Association for the Welfare of Children in Hospital.²

Tertiary services—paediatric cardiology, oncology, neurology, and urology, etc, should be formally linked to the department of child health even though they will usually be in another unit or trust or district altogether. Informal discussions that eventually lead to formal contracts between each of these specialties and the department of child health is one way of achieving this.

All administrative staff relating to all the included departments, should be brought within the department of child health under an overall business manager. This requires some negotiation where staff have divided posts, for example in community clinics where they may cover a range of jobs. By including them from the beginning their loyalty to child health itself can grow because they feel part of a whole service.

Where will the main problems lie?

ORGANISATIONAL BOUNDARIES

Initially these will be in the breaking down of previous fixed structures or professional allegiances—for example, children's wards in acute services, school health and health visiting in community services, the special care baby unit in midwifery services, ENT patients in ENT wards, etc. Professional bodies such as the Health Visitors' Association and other therapists' associations may intervene and require individual discussion and reassurance in order to gain their support for the changed management of their members.

WORK WITH OTHER AGE GROUPS

There may be concern that generic services such as health visiting and speech therapy will be prevented from continuing their work with age groups other than children. Again, discussion and reassurance are required and written recognition of their responsibilities to other age groups should be made in every document.

INDIVIDUAL AND COLLECTIVE ANXIETIES

Supporting people during change is a management skill that is particularly required in the NHS. All must have an opportunity to ask questions and air concerns and positive, truthful answers are essential. Repetition of the department's philosophies, coupled with assurances that professional advisory links will be maintained, can reassure most staff. There are a few whose fears will cause them to rage and rebel against the new structure and they too must be heard and answered but they have an agenda of their own and cannot be allowed to prevent the whole movement from going forward.

MANAGERS

The director must be appointed at a very early stage once a policy of integration has been

agreed. It should be a clinician if clinical directorates generally are the district's intention and in most places it is likely to be one of the paediatric consultants; (s)he has to learn fast how to be a manager. The department's model must not be a medical one, nor yet a nursing one, but a new model for children and its philosophy must, in reality not just in lip service, be to meet children's needs and not necessarily those of the staff.

Obtaining a service manager of a high enough grade and experience to make the early stages of the integrated department work smoothly is essential in order to achieve the inevitable changes and make them tolerable for all concerned. A policy of 'slotting in' existing senior staff is unlikely to answer children's needs. There is a real danger of writing a job description to fit the person, rather than the post and this can only be resisted if it is clear from the beginning that the post will go to open advertisement. Some senior staff may well be encouraged to apply but others—those who are negative, those who need their halo to shine, those who are nice but with little management experience—should be told honestly from the beginning that they are unlikely to be suitable for the post.

An administrative or business manager is also needed in order to integrate the running of such a widespread department—from the hotel services of a children's ward to the administrative jigsaw of the school health service. Again, this post is most likely to be satisfactorily filled if it is advertised on an open market.

DEFINITION OF A BUDGET

Drawing up a realistic budget from the dispersed structure of children's services that spans several units or trusts requires cooperation from each of the relevant finance departments and the perseverance of the department's service manager. There may be much negotiation involved to get the budgets set high enough for at least the possibility of being within budget at the end of the first financial year.

DEPARTMENTAL HEADQUARTERS

The siting of the new integrated department in one or other unit or trust is a fairly arbitrary placement, though it is likely to cause much discussion and concern among those who actually have to move from one unit to another. When West Dorset planned its integration the idea of contracting for services between units was a new one but that is now common practice so poses no problem. In fact West Dorset started off in the community and priority services unit but when trust status was introduced, moved into the general hospital trust.

How to start

There must be a 'critical mass' of senior staff willing to integrate in order to take the initial steps. It is not necessary for all of these to be from one discipline but it is likely to be difficult to achieve if there is not a majority of consultant paediatricians who are in agreement. The initial discussions must lead to a strategy document addressing issues such as those outlined above and showing how integration will proceed.

The department's philosophy must be defined and stated at the start of the strategy document. To be convincing and create an effective service, these philosophies must be along the following lines:

- To meet the health service needs of all children living in the district;
- To meet these needs within the context of the family;
- To view childhood as a time of growth and development and not as 'mini' adulthood;
- To view prevention as a principal theme of the services offered.

The framework for the department, and its siting within the district's management system, must be worked out with unit/trust managers. At the same time the job description and salary grading for the new post of service manager must be agreed so that there is as little delay as possible before this important post is filled. Devolvement and definition of budget can then proceed and at the same time the director and service manager must consult with each group of staff being brought into the integrated department, outlining their philosophy, plans, timescale, and managerial structure and honestly addressing the anxieties which will be raised. It is important not to prolong this stage any further than is absolutely necessary because of the escalation of anxiety which occurs during periods of uncertainty and change.

Creation of an action plan with realistic deadlines is an essential early step within the new department. It makes a constructive focus and conveys the message that this is a department of progress which is willing to tackle the gaps and inefficiencies of the past. By formally reviewing this action plan at frequent intervals (for example, every six months at first) this positive feeling can be maintained and the ownership of the whole child health service can be felt by all its parts. This builds confidence and morale which is in turn conveyed to those for whom the department was created—the children and their families.

1 Committee on Child Health Services. *Fit for the future*. London: HMSO, 1976. (Court report.) (Cmnd 6680.)

2 Hogg C, Rodin J. *National Association for the Welfare of Children in Hospital Quality Review. Setting standards for children in health care*. London: NAWCH, 1989.