ARCHIVES OF DISEASE IN CHILDHOOD

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Annotations

Children First – the Audit Commission study of hospital services

The Audit Commission's study *Children First*[1] is a critical appraisal of hospital services in England and Wales that draws extensively on the recommendations of numerous earlier reports from Platt and Court, through the National Association for the Welfare of Children in Hospital (NAWCH) Charter, to the Department of Health's *Welfare of Children and Young People in Hospital.* Why yet another report? Why should it be effective when its predecessors have been so sluggishly implemented? The answer is that the Audit Commission report marks the beginning of a series of detailed local audits of hospital services for children in all districts in England and Wales, each of which should enable changes to be made to improve local services. In a year or so, at the end of this process, the Audit Commission plans to collate the results and publish a follow up report.

An earlier Audit Commission study in the NHS, *A Short Cut to Better Services,* on day surgery,[2] indicates how effective this approach can be. The report, published in 1990, estimated that 214 000 patients could be transferred to day surgery. The Audit Commission's follow up report based on the local audit studies *All in a Day's Work*[3] was published in parallel with the Royal College of Surgeons revision of its guidelines for day surgery[4] and has been followed by significant developments in day surgery services.

If the audit of hospital services for children is equally effective, we have an opportunity to make a great improvement in the quality of care offered to sick children.

The Audit Commission

The Audit Commission is an independent self financing statutory body whose responsibilities were extended in 1990 from auditing local authority services to include the NHS in England and Wales. In addition to auditing the financial accounts of all health service bodies, it is required to examine the economy, efficiency, and effectiveness with which resources are used. National studies are undertaken by a small study team that includes relevant professionals and is supported by a larger advisory group consisting of individuals with a close interest in the subject. The audits are done locally by professional auditors of whom about a third are from private audit firms and the remainder from the Audit Commission.

QUALITY VERSUS EFFICIENCY

It was with considerable misgivings that I joined the study team two years ago. My own view of clinical audit, as a means of achieving excellence in care through critical appraisal, appeared to conflict with the stated aims of the Audit Commission to achieve economy, efficiency, and effectiveness. However it soon became clear that quality was to be a key issue in the study and this was secured with the appointment of Jo Rodin, a coauthor of the NAWCH Quality Review, to the study team.

METHOD

The study team's work extended over 18 months with two main products expected: a national report and an audit guide. In practice the two productions developed together but each had its own function, the report to stimulate action by the Department of Health and by professionals and managers involved in the service; the guide to inform and instruct the commission's auditors. The auditors, who may have had very little experience of the health services for children, have attended national training workshops run by the Audit Commission project team and based upon the report, the guide, and the experience of those auditing sites chosen for pilot audit.

The study team undertook a detailed examination of eight study sites spread across England and Wales, including teaching and non-teaching centres, large urban and small rural districts, each chosen because of reputed excellence in a particular field. This work, together with a review of published research and an analysis of national data, formed the basis for the report. In addition the commission funded a six month personal interview study of 48 families of children with asthma, diabetes, or cystic fibrosis to investigate their needs and perceptions of services. This part of the study was carried out by Rosemary Thornes who is well known for her work as project officer with the consortium Caring for Children in the Health Service.

Children First

The report highlights six important principles. The first three directly address quality issues, child and family centred care, specially skilled staff, and separate facilities. The remaining three principles – effective treatments,

appropriate hospitalisation, and strategic commissioning – are concerned more with the efficacy and effectiveness of the service. These principles will receive the general support of paediatricians who have been actively striving to achieve their implementation for many years.

The problems identified and the solutions recommended are generally not contentious, although there will be resistance to the further centralisation of some tertiary care and to national monitoring of the outcomes of intensive care of very low birthweight babies, issues I will refer to later. Inevitably in a short report such as this there are many issues that have not been addressed. Some will form part of future studies, others were omitted because they were considered of lesser importance. A general principle of Audit Commission work has been to pick the largest apples from the lowest branches!

THE REPORT'S LIMITATIONS

The omission that has caused the most concern and against which the advisory group fought hard and long is that of community paediatrics. The long awaited concept of an integrated child health service and the recent recognition by the Department of Health of the need to contract for a combined (secondary) child health service appeared to be cut in half by this decision. However, *Children First* makes clear recommendations concerning the coordination of child health services and especially the important role which purchasing (commissioning) teams should play. The Audit Commission's second study of services for children, established early in 1992, will focus on health promotion, disease prevention, and child protection including the roles of both health services and local authorities. It is likely that the complex issues surrounding management of children with special needs will also be addressed. A new report from Caring for Children In the Health Services *Bridging the Gaps*[5] on the interface between primary and secondary care complements both Audit Commission reports.

There are other important issues that although referred to in the report could usefully have been developed further. These include the viability of small paediatric departments, accreditation of services, and reducing admission rates.

VIABILITY OF SMALL UNITS

It is clear from the Audit Commission preliminary studies that there are shortfalls both of trained nursing and experience medical staff, findings that confirm Royal College of Nursing and British Paediatric Association (BPA) studies.[6]

While improvements can be achieved by ensuring children are only admitted to children's wards, by reducing split site working, and by making full use of paediatric medical manpower, it is very likely that there are insufficient experienced junior medical staff to provide the level of cover required in all paediatric departments in England and Wales. (In this context an experienced junior doctor is one with at least 12 months' paediatric experience.) The situation will become more difficult as junior doctors' hours of work are reduced and amalgamation of some paediatric departments appears to be inevitable. The BPA is currently addressing this difficult issue through a group of small working parties concerned with the future staffing of smaller units, paediatric staffing requirements in maternity departments, and the development of extended day care (ambulatory) services.

ACCREDITATION OF SPECIALIST SERVICES

The issue of accreditation of specialist services received considerable attention within the study team but it is not addressed in *Children First*. It was discussed particularly in relation to neonatal intensive care services but also to paediatric intensive care, oncology, and cystic fibrosis. National data indicated, and visits to the study sites confirmed, that much specialist care is provided locally and that insufficient use is made of tertiary level services. The fault does not lie solely with the district paediatrician; many centres fail to provide the outreach services that would encourage tertiary referral, for example in the form of specialist clinics held jointly with the local paediatrician, enabling proper shared care to be provided. Too often there did not appear to be a close working relationship between the district paediatricians and those providing tertiary services. The Audit Commission believes that accreditation is an issue which the profession should address; certainly if this is to happen there will need to be nationally agreed criteria, and the Clinical Standards Advisory Group on the access and availability of neonatal intensive care has discussed recommendations for appraisal of neonatal intensive care units that the profession must consider urgently.

REDUCING HOSPITAL ADMISSIONS

The issue of appropriate hospitalisation is one of the six principles in *Children First* and several mechanisms are proposed to reduce unnecessary admissions including providing experienced paediatric cover to accident and emergency and admissions departments and monitoring bed availability and demand. It is suggested that admission rates to special care baby units are often too high and could be reduced nationally by about one third if a target were achieved of 7·3% or less of all newborns being admitted to special care baby units. No similar target was suggested for infant and child admissions partly because of the wide variations in case-mix, levels of care, and social circumstances. Admission rates in paediatrics are increasing dramatically, perhaps as a result of increased availability of beds following a reduction in length of stay.

In a study of paediatric admissions in the Oxford region, Hill found a rise in total admissions of 80% from 7523 in 1975 to 13 043 in 1985.[7] Upper respiratory tract infections, bronchitis/bronchiolitis, and pneumonia rose from 1073 to 2516, a 135% increase; asthma rose from 356 to 1705, a 379% increase; and head injury rose from 57 to 356, a 525% increase.

The Audit Commission found evidence of a wide variation in bed use even when allowance was made for differences in the conditions treated. This is a topic which should be included in the local clinical audit process. Targets could also be set by commissioning authorities.

Controversial issues

There were several issues which nurses, doctors, and managers will find controversial, of which the most important are the development of guidelines and policies, monitoring outcomes in very low birthweight babies, and the apparent incompatibility of improving quality without increasing costs.

POLICIES AND GUIDELINES

The report recommends that a clear management focus is needed to develop written policies of child and family centred care including indicators for monitoring the quality of care of children on wards. In addition the development of written guidelines for management of specific con-

ditions, agreed by all involved staff including general practitioners, is recommended to improve the management of inpatient admissions. Both policies (managerial) and guidelines (clinical) arouse anxiety and concern among many paediatricians who fear they may stifle service developments, discourage innovation, make the service inflexible, and encourage litigation. They were strongly criticised by some responding to the draft report including the British Medical Association. However, without management policies the haphazard provision of good services evident in so many units will persist, with good practice found on one ward but sadly lacking in an adjacent ward. The management team should ensure that policies are implemented and subjected to regular critical review.

Similarly clinical guidelines can improve practice, prevent unnecessary admissions, and ensure effective treatment. Clinicians who fear they may disagree with guidelines or that guidelines may encourage litigation must appreciate that their purpose is to promote good practice by guiding care not by setting fixed rules. Multiprofessional clinical audit meetings, involving general practitioners when relevant, provide an ideal opportunity for evaluating the use of guidelines, encouraging their revision and development where necessary.

MONITORING OUTCOMES IN VERY LOW BIRTHWEIGHT BABIES

The recommendation that a national data collection exercise is needed with all neonatal units collecting data in a nationally agreed format has aroused serious concern among some neonatalogists, developmental paediatricians, and community paediatricians. Neonatologists fear the data will encourage unfair comparison between units that may be caring for babies with very different illness severity and that adverse outcome may be assumed to be due to poor care. Developmental paediatricians, many of whom have produced excellent detailed follow up data in research studies on survivors of neonatal care, fear the proposed measures are too simplistic and will not detect the common, important, but more subtle developmental problems often found at school age. Community paediatricians believe the information should be obtained from the district's child health data set – it should but the Audit Commission found no evidence that it could, and even if it were available it would be unlikely to be comparable at present with data from other units, districts, or regions.

The Audit Commission view is that a service costing in excess of £100 million per year must monitor its outcomes in a standardised way. The proposed measures are a minimum core data set indicating severe problems such as cerebral palsy and developmental delay of which both parents and professionals need to be aware. Although it may be argued that they are not true outcome measures as they do not necessarily result from interventions in the neonatal period, they are outcomes of the management process of which neonatal care is a part. Each unit should therefore undertake an individual case audit for each adverse outcome in the same way as perinatal deaths are audited.

The morbidity outcome measure is then the starting point of the audit process within a unit. Comparisons between units will be difficult to interpret until better measures of initial illness severity are available when the audit can be extended from a district to a regional and national basis.

QUALITY VERSUS COST

Difficulty has been encountered by auditors at some of the pilot sites in 'selling' the audit to trust executives or unit managers whose expectation was that the audit should save money. Most, however, have welcomed the opportunity of improving the quality of children's hospital care at little or no additional cost. Many of the improvements needed, and supported by the Audit Commission report, such as increasing levels of registered sick children's nurses and ensuring experienced junior doctor cover, can be offset against savings achieved by more effective care – for example, reducing operative intervention for glue ear and avoiding unnecessary admissions.

Other suggested methods of improving quality at little or no cost include caring for all children and adolescents in age appropriate wards and making full use of children's facilities for both inpatients and outpatients, involving parents in care, formal discharge planning, and increasing the use of paediatric community nurses.

The simplest and most easily achieved quality measure would be to get all children and adolescents off adult wards and into age appropriate facilities. Trust executives should be persuaded to grasp this opportunity to provide a high quality child centred service to display in their shop window.

Conclusion

Thirty two years separate the publication of the reports of the Platt Committee, *Welfare of Children in Hospital* (1959) that defined the problems, and the Department of Health's similarly titled *Welfare of Children and Young People in Hospital* (1991) that set standards to remedy them. We now have a mechanism to ensure that these standards are achieved through the Audit Commission report and the local audits that will follow. The Audit Commission work on hospital services, though broad, is not fully comprehensive, but points the way for change in areas of most importance to children and their families.

To quote a commentator on the first draft of the report 'it may be brief but it certainly packs a punch'. It is now our responsibility to make sure the punch finds its target. Paediatricians are therefore urged to study the report carefully, to prepare for the audit in the context of their local services, and to work with the auditors to effect the major improvements in hospital care which our children deserve.

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1 The Audit Commission for England and Wales. *Children first: a study of hospital services*. London: HMSO, 1993.
2 The Audit Commission for England and Wales. *A short cut to better services: day surgery in England and Wales*. London: HMSO, 1990.
3 The Audit Commission for England and Wales. *All in a day's work: an audit of day surgery in England and Wales*. London: HMSO, 1992.
4 Royal College of Surgeons. *Guidelines for day surgery*. London: Royal College of Surgeons, 1992.
5 Rosemary Thornes on behalf of Caring for Children in the Health Services. *Bridging the gaps. An exploratory study of the interfaces between primary and specialist care for children within the health services*. London: Action for Sick Children, 1993.
6 British Paediatric Association. *BPA census data*. London: BPA, 1990, 1992.
7 Hill AM. Trends in paediatric medical admissions. *BMJ* 1989; **298:** 1479–83.