

Take it with a pillar of salt or “ambitious but achievable targets”

The document *Modernising health and social services—priority guidance* outlines the policy for health and social services to 2002.¹ It is divided into four sections entitled “Where are we heading?”, “How we get there”, “What needs to be done”, and “How will it work?” It is hard to disagree with a wish list to reduce inequalities in health, especially where it is backed by £17.7bn extra for the NHS.

However, several important questions must be asked:

- To what extent can health inequalities be influenced by health or social service interventions?
- To what extent are the effects of disadvantage reversible by creating a more favourable climate in health and social services?
- Are the timescales realistic in terms of generating necessary changes in training and local programmes?
- Are generations rather than years the timescale to achieve fully some of the targets?
- Will the inertia both in the services and in the behaviour of individual citizens prove too great a challenge?

The officers of the Sodom and Gomorrah² Health Authority may also have been given targets and however lofty their intentions, they were not achieved. Are we being set up for a similar fate? Should we plead for more time as in Sodom and Gomorrah?

The circular covers the whole range of services for all age groups. In this commentary, I will confine discussion to those targets that relate to children.

Where are we heading?

A key objective is “to maximise the social development of children within stable family settings”. While desirable, how can the State in the short term achieve this? Support can be achieved through health visiting and through innovative programmes such as Surestart,³ but the stability of families as a whole might be beyond the reach of the proposed interventions, at least as short and medium term objectives. Such policies were recommended in the Acheson Report.⁴

“Breaking down barriers between services” recognises that barriers do exist and work against the interests of patients and the efficient use of services. The barriers, however, are not just structural, but also reflect a lack of understanding of other professions, and this needs to be addressed through education as well as organisational structures. Confidentiality can provide an additional set of barriers that will require both parental consent and professional agreement to provide the envisaged joined up service. Partnerships will, in theory, be developed by initiatives such as health action zones,⁵ but we will have to wait to see how many of the individual programmes work across agencies and how many are confined within traditional boundaries. We also need an exit strategy for each local health action zone programme to determine how, after the short term funding for the programme is finished, the lessons from those programmes with positive or at least promising outcomes are translated into long term, mainstream services.

Higher quality services will be achieved through investment, and recognition and application of good practice, as will faster and more convenient services. They also require attention to training, professional support, and the avoidance of burnout among clinicians.

How we get there

The circular cites the Green Paper *Our healthier nation*,⁶ the White Paper *The new NHS, modern, dependable*,⁷ and the consultation document *A first class service: quality in the NHS*⁸ as the policy framework. It rightly identifies the importance of modern buildings and equipment providing better facilities for patients and better working conditions that attract and retain staff. It lists the extra funding available to the NHS and Personal Social Services to achieve these ends: 4.7% real growth for the NHS and 2.8% for Personal Social Services. Children in need, especially looked after children are identified as a priority group.

Do problems + extra resources = success in the target areas chosen?

Expenditure on looked after children is already very high.⁹ What is needed is much earlier intervention with the aim to avoid children developing major social, educational, and behavioural problems, combined with innovative, skilled, and consistent care for those where early intervention has not been available or successful.

Improving the working conditions of staff will improve morale and hopefully also performance, but the extra resources available to reach an optimal professional standard,¹⁰ might be insufficient to make an impact.

What needs to be done

This section starts with some relatively low lying fruit such as “continuing and effective protection of the public’s health with particular regard to the prevention and control of communicable disease”. It goes on to some more difficult, though equally worthy proposals. “Reducing the number of moves of looked after children so that no more than 16% of children have three or more placements in a year”, may be regarded as a proxy for simply reducing moves or for providing high quality care that copes therapeutically with crises. The former might be achieved, though with only small benefit to the young person; the latter has huge implications for the training and support needs of carers. This is an important target, but there must be a realistic appreciation of the scale of the task. Targets of 50%, rising to 75% of looked after children obtaining GCSEs or GNVQ may not be attainable as up to a third of this population have learning difficulties that might preclude them obtaining these qualifications in the very best of social circumstances. Improvements in the employment levels of care leavers to at least 60% of the level of other young people of the same age will require not just educational achievement and employment opportunities, but also effective management of behavioural difficulties, housing, and continuing support. The gap between no services for the 16+ care leavers and this high level of well coordinated services may be difficult to achieve; however, how might the rest of the population fare if they did not have a slow transition from 16 to 21+ towards independent living and self support? The socially excluded with long histories of services that have not met hopes, promises, or expectations might require rather more persuasion than the professionals that things will be different.

New interagency programmes through youth offending teams¹¹ will overlap with the programmes of care for looked after children and the needs of children excluded from school. There will need to be excellent liaison between the

police, probation, social service, education, and health components of the youth offender teams with their generic services.

Programmes such as Surestart³ which provide preventive services and better developmental care for children under the age of 4, may in the longer term provide better outcomes than complex services for children who have already been severely damaged by their previous experiences. We cannot ignore this group of children and their needs, but the prospects for improvement may not be as good as envisaged by the targets set. The evidence for the effectiveness of early intervention programmes for pre-school children is stronger. The numbers of children who would be eligible for an early intervention from Surestart would be much larger than the numbers of looked after children. The biological effects of disadvantage, such as low birth weight and its sequelae¹² might not be as easily reversible.

Other areas such as reduction in unwanted teenage pregnancies have been described as “ambitious, but probably achievable”.¹³ We also need to improve the outcomes of teenage pregnancies for mothers and their children. The service implications in terms of new services and reorientation of existing services are huge.

Objectives for child and adolescent mental health services to “improve provision of appropriate, high quality care and treatment for children and young people by building up locally based child and adolescent mental health services” are clearly very much needed. Demand is high from health, education, and social services, but recruitment to fill these gaps might prove difficult without first creating more trainees in clinical psychology and child and adolescent psychiatry. Again, should the focus be on prevention and early intervention or management of established problems?

How will it work?

Much emphasis is placed on the importance of local health improvement plans. Clearly a great deal of effort and resources needs to go into this process. “Performance

improvement” is the last section. The problem is how high is the mountain that we have to climb? I am in strong agreement with the chosen targets, but the difficulty of meeting them presents challenges for services in those areas that we can control such as training, resources, and interagency cooperation; there are also areas that might require generations of change to achieve results. Innovation overload is a real threat even for those of us who think we thrive on change. The signposts are pointing in the right direction, and, as such, should be supported by the child health professionals, but the speed of travel anticipated might not be attainable and we might be making excuses about “the wrong type of snow”.

LEON POLNAY

*Division of Child Health, School of Human Development,
Floor E, East Block, Queens Medical Centre,
Nottingham NG7 2UH, UK
email: leon.polnay@nottingham.ac.uk*

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