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Planning Health Services for Children

A **NAWCH** CONFERENCE

at the KING'S FUND CENTRE on 14 FEBRUARY 1985

CHAIRMAN: Professor David Hull
Department of Child Health, University of Nottingham

Contributors:

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KING'S FUND CONFERENCE

These papers were given at the first NAWCH Conference on planning children's services. Increasingly we have become aware of the need for NAWCH to concentrate on the planning cycle if we are to improve conditions for sick children both in and out of hospital. The publication of draft Regional strategic plans and requests for advice from NAWCH members on health authorities prompted an approach to the King's Fund Centre. The Centre's staff were very supportive and provided extra rooms with CCTV for all the health authorities' members and staff eager to hear about and discuss the planning of services for children and their families.

Speakers covered Regional and District planning of all services for children, as well as two particular aspects which cause us concern: accident and emergency services and the pressure to increase the throughput which can result in more day care in hospital without any increase in community support for families.

Professor Hull indicated in his preface to the day's proceedings that planners have to face a series of dilemmas and choices involving the centralisation or widespread distribution of services, the balance of specialist and generalist, the training needs of professionals and the welfare of families. In the balancing of different interests and the discussion of these issues NAWCH is concerned to try to represent the best interests of the child and we hope these papers make a contribution in that debate.

Lady Jean Lovell-Davis
Director, NAWCH

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PLANNING HEALTH SERVICES FOR CHILDREN

CHAIRMAN: Prfessor David Hull, Department of Child Health, University of Nottingham

C O N T E N T S

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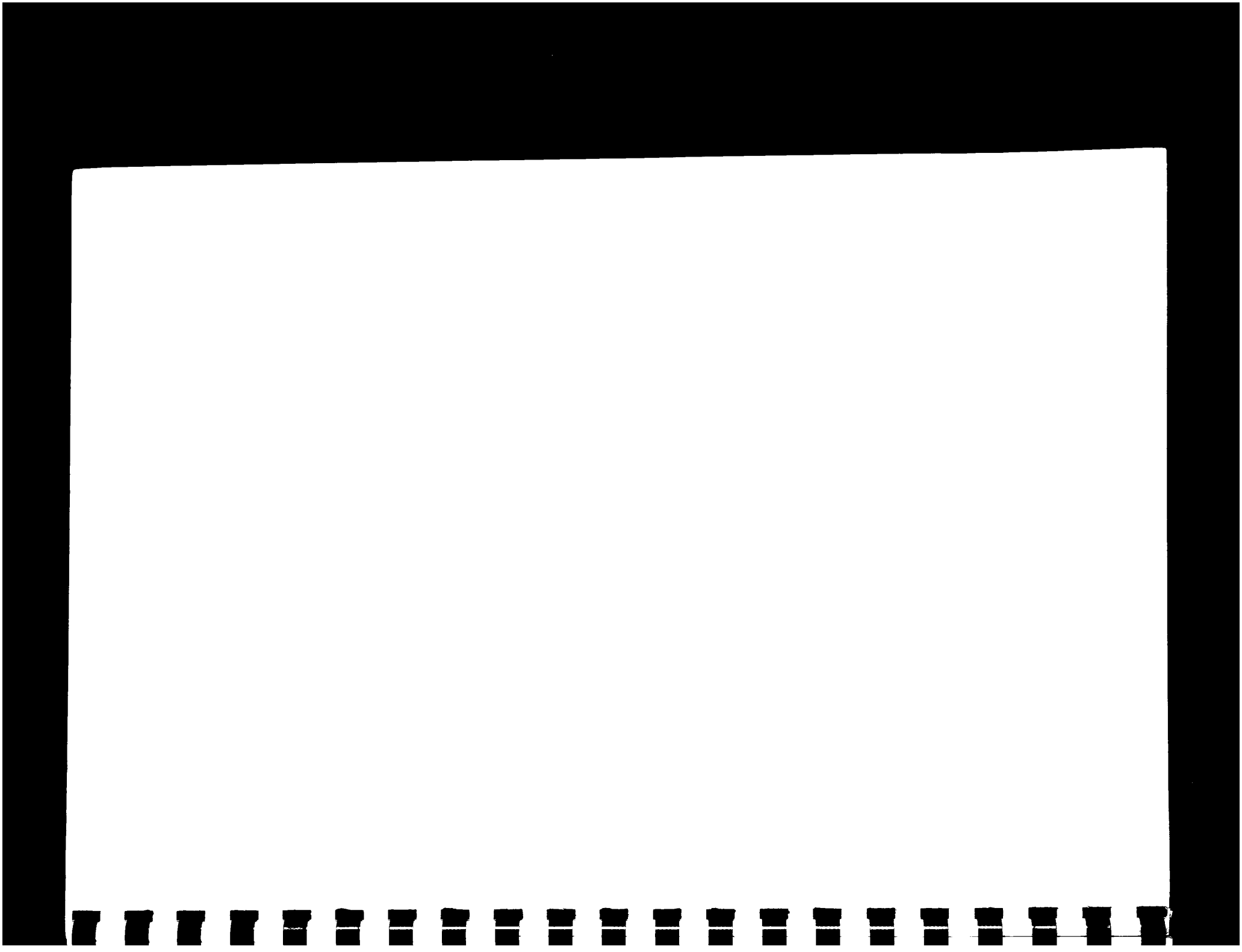

WHY A STRATEGY FOR SERVICES FOR CHILDREN - **Miss P. Hudson, Regional Nursing Officer, North West Thames Regional Health Authority**

1. Planning for Children

In developing a strategy we are only too aware that the gap between good strategies, good plans and good practice can be disturbingly wide. As a priority group, it is very important that we plan for children without delay. My purpose therefore is to tell you how we developed our plans at NWT not as tablets of stone but to encourage discussion on how this can be done and hopefully to help us all to move towards a situation where services for children are designed with the needs of children in mind. All too often children are regarded as small adults and are in consequence made to fit into small adult provisions.

The NWT Region have identified Services for Children as a high priority. Some parts of the Region contain extremely deprived areas, there are a considerable number of centres of population where ethnic minority groups are dominant.

It is estimated that the size of the 0-14 population will increase by 12.5% in the strategic period. In addition NWT, with other Thames Regions, continues to address the problem of very restricted resources in both capital and revenue.

The Region must shift large amounts of revenue from acute to priority services if the basic needs of the population are to be met. This shift of resources includes moving revenue from the Inner City to the shires for the concept of equality of access to even start to be addressed.

Both children and the elderly are likely to make heavily increased demands on the Regional Resources in the Planning Period.

Sick children need the same components as sick adults.

However, there are two major and important differences in providing care for children.

1.1 The acceptance that children are children before they are patients and children before they are adults and that their health care must be provided within an appropriate environment and in a suitable style.

1.2 The twin processes of growth and development may be affected by ill health and/or environment so that a substantial proportion of the resources for child health must be used to ensure by regular checks, that growth and development are occuring normally.

1.1 Regional Policy

With these constraints in mind the Region have accepted the need for:

1.1.1 Integration of services between community, primary care and hospital care including interchange of staff between hospital and community, development of specialist services for the handicapped in each district, the appointment of consultant community paediatricians.

1.1.2 A district managed child health service including a district wide information base.

1.1.3 In-patient and out-patient facilities designed exclusively for the use of children, including specialist services - other than in highly exceptional circumstances.

1.1.4 Continuous monitoring of these policies and evaluation of their outcome.

2. Developing the Strategy

NWT have adopted a method of strategic planning which involves a number of phases.

2.1 Agreeing an information base

This is done through a process of research and consultation. Research and analysis of the information available nationally and local epidemiological trends etc. Having taken account of population projection, use of facilities etc a framework of information within which both the strategy and the subsequent operational plans are formulated. This framework is then the subject of formal consultation from the RHA.

Information is a very big problem in the NHS -

- The collection and interpretation of statistics.
- The inadequate data when it is collected.
- The uncertainties of OPCS etc. particularly the more recent problem in predicting birthrate.

2.2 Towards a Strategy

2.2.1 Each care group is analysed. The present position outlined and existing facilities listing District by District. Small working groups of RHQ staff with selected professionals and planners meeting to examine the background to the speciality. National policy, relevant reports, projected changes, and within the agreed resources and the information base an outline policy for each speciality is formulated.

2.2.2 In services for children, particular attention was paid to; Special Education Needs - Maternity Care in Action - Welfare of Children in Hospital - The Black Report - to mention but a few.

At the same time links were formed with groups working with other strategies - acute services, primary care, (of which children are major users), maternity and neonatal, mental handicap, mental illness, as well as Supra District and Regional Services. Services for children inevitably overlap and cross referencing has been a major issue.

2.2.3 Particular emphasis was made of the role of parents in developing services for children from the clinics, school medicals etc. To the the availability of access and support at all times when in-patient care is unavoidable.

2.2.4 Costing the strategy has been of high priority - most strategies describe a level of service, but do not identify how it is to be funded.

2.2.5 There is strong commitment at RHQ to developing potentially greater roles for the voluntary sector in the care of children. Collaberative schemes including the use of joint finance, support for joint groups to be established and in suitable circumstances actually funding voluntary societies to provide care - a good example of this is Autism in which voluntary and charitable societies have made substantial advances in provision where generally the NHS is not renowned for its innovative approach. (1)

2.2.6 Strategic Principles

In the course of these deliberations and developing the Regions' policy there has developed for consultation, the following strategic principles:-

1. Planning and provision of health services must take account of the varying needs within different parts of Districts. Staff must be sensitive to the importance of class and cultural factors in the attitudes to and use of preventive services in particular.

2. Good links with Health Authority are essential not only for those children with a health problem but also to ensure the normal development of healthy children.

   - School Health, Environmental Health, Social Work Services, Prevention of Abuse etc.

3. Children should only be admitted to hospital when there are clear clinical indications otherwise care should be provided within primary care at home or as an out or day patient.

   - Development of home care with skilled nurses

   - full support for families.

4. All care for children should be provided in a child centred environment, with maximum involvement of parents, and with play and educational facilities.

- More nurses with skills - banishment of visiting times, teaching parents to treat.

5. The number of in-patients beds for children will not be increased although units for children may have more beds as specialities are reorganised.

   - Absolute ban on children in adult units.

6. The childrens unit and the maternity unit must establish close links so that 24 hour paediatric medical cover is provided for maternity and SCBU.

   - Importance of location and size of maternity unit.

7. Each DHA must identify policies, objectives, goals and priorities for community child health services.

   - Involvement of FPC etc.

8. The two main areas of activity within community child health services - immunisation and surveillance, and the management of handicap - should be considered as separate services, with different approaches to care, being planned and implementated.

   - Clear policies on family support.

9. Better information is required to monitor and evaluate the whole range of child health services.

   - Körner.(2)

   - Child health computer systems, Vaccination/Immunistion policies.

10. Districts should review their medical staffing within hospital and community services. Greater integration of training posts inside and outside hospital should be ensured.

    - Consultant of clinics in community. Training circuits for medical students.

11. Links with services for the mentally handicapped should be strengthened so as to provide the best possible caring services for children.

    - Admitting children banned to hospital except for medical care.

12. Child health should be organised on a District basis with tertiary referred to more specialised units.

    - Provide as much as possible locally.
    - Do not attempt highly specialised so that skills and resources can be used more effectively.

Within these strategic principles issues such as the quality and quantity of staff particularly medical and nursing, the availability of adequate training programmes of all kinds, the development of computer and screening programmes must be addressed. Much closer links with the school health services must be planned.

2.3 The Regional Strategy

2.3.1 Having consulted on the strategic principles a statement of general direction is now within the consultation process.

2.3.2 The next stage will be the collection of comments and drawing together a plan which will identify the priorities which the DHA will be expected to address in their planning and the resources which are likely to be available to implement their plans.

2.3.3 Stage 3 will be matching the strategy to the operational plans which annually arise from DHA through the planning system.

3. Reality

- Resources are limited. We do however have what is called our Strategic Development Fund. This is an amount of money which is used to pump prime developments which are critical to the Regional strategy being implemented. Some very obvious things are already being funded - increase in neonatal ITU, additional HV & DNs - these areas are beyond consultation. The needs are obvious.

- The strands of child health are often very frayed. There are artificial divisions between primary care, hospital care and School health.

- It is never possible to please everyone all the time, but our aim has been to begin to bring together all the needs of children into one Planning System. This must be an evolving process and standards will be trimmed and tidied for many years to come.

- Hopefully this helps to answer the question "Why a Regional Strategy for Children".

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1. National Society for Autistic Children. 276, Willesden Lane, London NW2

2. Körner Reports. Steering Group on Health Services Information. Available through HMSO.

Strategic Principles 1984-1994

- The planning and provision of health services for children must take account of the varying needs within different parts of the District. Staff must be sensitive to the importance of class and cultural factors in the attitudes to and use of preventive services in particular.
- Good links with local authorities are essential, not only for those children with a health problem, but also to ensure the normal development of healthy children.
- Children should only be admitted to hospital when there are clear clinical indications. Otherwise care should be provided within primary care, at home or as an outpatient or day patient.
- All hospital care for children must be provided within a child-centred environment, with maximum involvement of parents and with play and educational facilities.
- No increase in the number of paediatric beds is anticipated, although, by a reorganisation of the beds used by surgical specialties, there may be a large number of beds within each District's children's unit.
- Paediatric beds must link closely to maternity units, so that 24 hour paediatric medical cover is provided for maternity and special care baby units.
- Districts must identify policies, objectives, goals and priorities for community child health services.
- The two main areas of activity with community child health services – immunisation and surveillance, and the management of handicap – should be considered as separate services, with different approaches to care being planned and implemented.
- Better information is required to monitor and evaluate the whole range of child health services.
- Districts should review their medical staffing both within hospitals and within the community; greater integration of training posts inside and outside hospital should be ensured.
- Links with other services, especially mental handicap, should be strengthened to provide the best possible care for children.
- Child health services should be organised on a District-wide basis, with tertiary referral to more specialised units.

PLANNING AN INTEGRATED SERVICE - PROBLEMS & POSSIBLE SOLUTION

Dr. Pat Troop, Specialist in Community Medicine, Cambridge Health Authority

In Cambridge we have established, with the local authority, Joint Development Teams for all services including children's services. These teams are multi-agency and multi-disciplinary and are set up on a care-group basis, thus providing a broad based representation.

The children's service Joint Development Team has been established for about two years. There have been peaks and troughs in development. The team is full of very strong minded people and at times the discussions have been extremely 'lively' but the overall picture is of positive progress. The main benefits for the group as a group have been:-

1. Educational.

   Bringing the group together on a regular basis has been extremely helpful to all those involved. The agencies are made aware of the different perspectives and of some of the problems faced by the other sectors.

2. Cross Agency links.

   a) There has been a marked improvement in the relationship between the health authority and the local authority educational services department. Prior to the JDT links between health and education had not been strong at the planning level. There were good field links, however between for example, clinical medical officers and educational psychologists, but now there is much more input at the planning level. A good example of this is liaison over two new units for physically handicapped children that the local educational authority are opening, these will be attached to mainstream schools. The JDT have been very involved with the planning of the units in areas such as operational policies, occupational therapists on the planning team etc.

   b) Social Services. Initially the links with social services were not as good as those with the educational services. This was in part because the social services delegates were not at an appropriately senior level. More recently there has been a senior management delegate and this has improved the link enormously. There has been a re-organisation of the social services department recently and the JDT has been drawn upon in shaping this plan.

Setting up the team

Some of the problems.

1. The team should not be too large as this would make in unworkable but it must be representative of a wide range of services.

2. The level of representation can be a problem and it is vital that you get this element of the team right as how the team works and how effectively it works is dependent on the right representation. In the experience of the Cambridge JDT there should be senior level management on the main team to ensure effective policy making but often senior management have

JOINT DEVELOPMENT TEAM FOR CHILDREN'S SERVICES

S.C.M.

Planning Administrator

Consultant Paidiatrician

Nursing Officer -Paediatric Wards

Principal Clinical Medical Officer

Nursing Officer - Health Visiting

Child Psychiatrist

Principal Clinical Psychologist

General Practitioner

Social Services Divisional Director

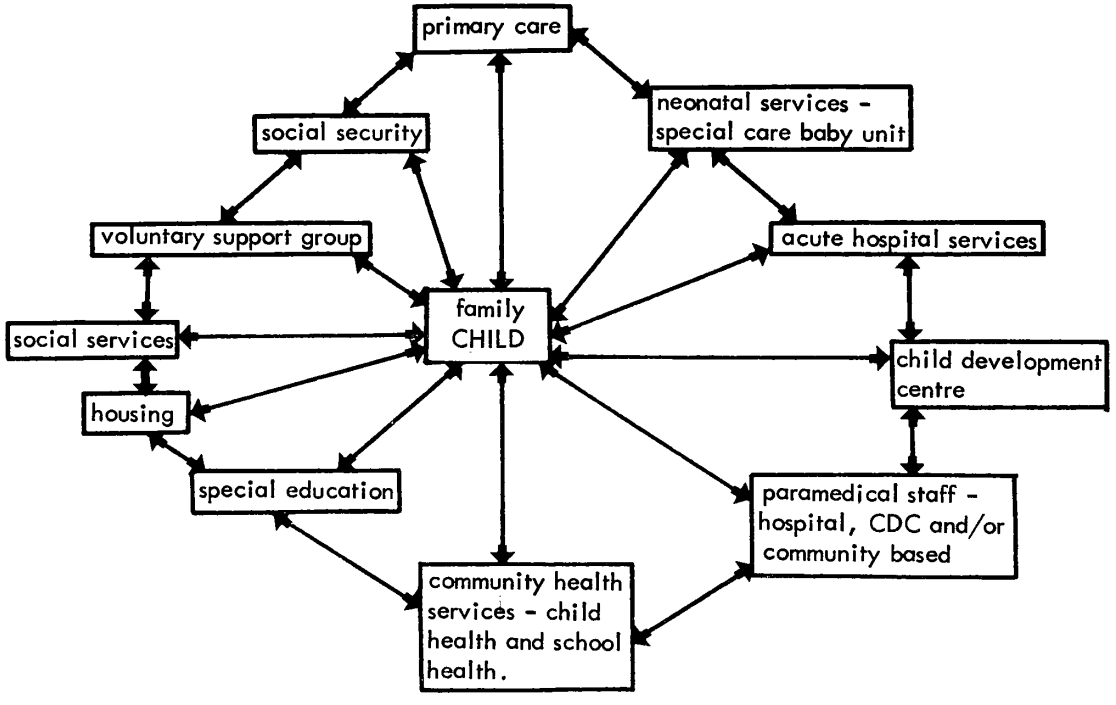
Area Education Officer

Voluntary representatives - N.A.W.C.H.

- Save the Children Fund

- one vacancy

THE CHILD WITH MULTIPLE HANDICAPS



lost touch with the field and it is useful to balance this by drawing widely on field workers for the sub-groups. The JDT uses many field workers in its sub-groups and again these are multi agency and multi disciplinary. The team has the power to co-opt widely throughout the services it represents.

3. Consumer representation. On all JDTs in Cambridge, including children's Service there is input from the voluntary sector but it is recognised that this does not represent the consumer directly.

Overcoming problems

1. An example of overcoming the size of the group problem can be demonstrated by the team working on a co-ordinated community service for handicapped children which brought together all those working in the field. Similarly the mental health programme brought together health, education and social services on a number of projects promoting positive development. For example, adolescent with behaviour problems the team consisted of child psychiatrist, schools service, educational psychologist, teachers and social worker.

   In all there is currently a pool of about 50 people working on projects and reporting back to the main group.

   Some of the organisational problems are common to all Joint Development Teams not just the children's service team. Cambridge have set up a Joint Co-Ordinating Group which includes planning officers from the health authority and the local authority. This small group has a brief to promote joint planning and improve the system. Improvements so far that have come out of this team are:

   1. Joint briefing for teams and a recognition of the team across the authorities.

   2. Common timetable for planning. This is vital to enable the teams to work together. Statutory obligation means that the timetables cannot be totally modified but there has been a change in the timetable for joint finance to enable cross authority proposals to go into medium term plans as well as into the health service plans.

   By bringing together a team, working as a team and tackling some of the organisational problems, the Cambridge JDT have produced a broad based strategy for the next ten years.

Implementation

Producing the plan is one thing but getting it implemented is something else entirely. If we are paying close attention to planning an integrated service we must pay as much attention to implementing that plan. This is an area to which insufficient attention has been paid in the past.

The children's Joint Development Team set up a priorities list for financial targets. These priorities are set against the other JDT priorities lists. In arguing their case, the team has had variable success, and these financial decisions immediately begin to distort the teams' priorities, e.g. More

proposals were accepted by the mental handicap team than by the mental health team. So, at the first hurdle of financial targets some of the proposals fall.

At the operational level of implementing particular policies problems occur because of the wide range of services. When talking about re-deployment and re-organisation there are more problems. Much of the planning of services for children is about co-ordinating services so that they are more child orientated. Each of the management group is being asked to take on the proposals made by the team and implement them within their own unit but the different units of management have different priorities so that each project has to be argued through with many different groups. Cambridge are currently trying to establish a unit of management for children's services. This is in line with a proposal which came from the health authority who decided in 1982 to change all the units of management to a care group base. This proposal is being actively planned and a blueprint for management structure with a unit for children is contained within the plans. We hope that the services working directly with children will be managed by this unit:- community services, child and family psychiatrists, child assessment units, section of mental handicap services and part of the acute service. The unit will not be able to manage every service for children as some professionals work across age groups and client groups, where this happens part will come under the child management unit and arrangements will be made with other units covering other parts of the service. The main point of the children's units is that they will be charged with the responsibility for children's services and ensure that a co-ordinated, integrated service is being provided. At the moment no one is charged with that responsibility except at central and district management level. If there is one group clearly identified as being responsible for children's services, that will monitor services for children in other units and develop links with other units, this will provide an integrated service and provide a focal point for other agencies such as social services and education to have direct access to health service planning.

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ACCIDENT AND EMERGENCY SERVICES: **Dr. J. Sibert, Consultant Paediatrician, South Glamorgan Health Authority**

Cardiff Royal Infirmary is sited in a poor inner city area of Cardiff. The hospital serves a wide area but there are marked differences in the numbers of children that present at the A. & E. department from the various areas served by the hospital. In an area 4 miles from the hospital about 7% of the child population present over the year whereas up to 25% of children living in the electoral ward in which the hospital is sited present within the same period. Although this is in part convenience it is also that G.P. services are perhaps not as good in inner city areas as they are in the suburbs. Indeed, there is evidence that in large cities the A. & E. departments of hospitals in inner city areas are used in the same way as G.P. surgeries.

An important role to be played by the A. & E. department of any hospital is that of detection of non-accidental injury and of prevention of accidents. Hospital staff should always check for signs of non-accidental injury and signs of physical abuse, for example bruising behind the ears. Staff should always watch for signs of neglect. In many cases neglected babies may present at an A. & E. department rather than to a G.P. or Health Visitor.

The British Paediatric Association has an accident committee which recently looked at what is happening in A. & E. departments around the country. From their survey they obtained 189 replies from 250 hospitals.

Of the 189 replies one third had paediatric in patient facilities in a different hospital from the main A. & E. department. 23 hospitals had no in patient facilities for children at all.

Some hospitals did not keep accurate records of child attendances. Record keeping is vitally important and computerisation would be of great benefit for:

a) Collecting epidemological information which may be useful for accident prevention.

b) Highlighting children on the 'at risk' register.

c) Simplifying work for follow up from Health Visitors.

The CAER project at Leeds, which is sponsored by the DHSS, is producing software for use in A. & E. departments in the U.K. Currently only 3 or 4 A. & E. departments have successful computerised systems.

Medical Staffing

105 of 183 departments had a full time consultant in A. & E. medicine. Only 13 hospitals had a regular sessional commitment from paediatricians. Nearly half the hospitals that replied had a liaison health visitor doing follow-ups. Only 15% had an RSCN on the staff.

Distances between A. & E. and main paediatric department

31 hospitals they were 2-4 miles distant
5 " " " 5-9 " "
9 " " " 10 or more miles

Separate Waiting Room

25% of hospitals that replied had a separate childrens waiting room.
26% " " " " had a separate treatment area.

This is important, particularly at night, when there may be drunk and undesirable characters and children can become very frightened.

ACCIDENT AND EMERGENCY SERVICES: **Mrs. Davies, Nursing Officer at Cardiff Royal Infirmary**

Cardiff Royal Infirmary is a General Hospital with the only Accident and Emergency department in South Glamorgan. As well as dealing with casualties it is a receiving unit for any speciality on intake and all these patients are examined in the A & E department before being warded. In 1984 89,500 patients were seen and treated in the A & E department; of these 9,554 were children under the age of 10.

The nursing establishment for the day duty is 4 sisters, 15 staff nurses, 4 enrolled nurses, and 1 auxillary nurse part-time. The night staffing is 5 trained nurses on every night. There are two consultants, one with a surgical and orthopaedic bias, and one with a medical bias. One senior registrar 13 house officers and four senior house officers give cover between 9 a.m. and midnight and one between midnight and 9 a.m. Both consultants are in by 8 a.m. and there is excellent doctor cover.

A Children's A & E Unit - Where and How Much?

For many years the department had talked about a separate area for children but it had been impossible to find the space. Cardiff Royal is an old hospital and the A & E department is housed in what was the first ward to be built there in 1882. We did however put all children with minor injuries under the age of six to the front of the queue; of course very sick children or adults would be dealt with immediately.

In 1981 there was a change in bed allocation which meant that emergency surgery and the number of days on which we accepted emergency surgery was reduced, so that within our department there was a large secluded area which was definitely under used. Situated within the area was a dental suite (25% of the emergency work done in the suite was for children) and a night plaster room that was used after 5 p.m. and at weekends - the main fracture and orthopaedic dept being sited too far from the A & E to be used at these times.

About a year went by with a lot of discussion about having a special children's area but for every new positive idea there would be objections and difficulties put forward. The director, who was in favour of the new unit, left the hospital and the plans were left on ice. At this point pressure was put on the senior nursing staff and the administrative staff by Jo Sibert and a new A & E consultant, Dr. Roger Evans. A meeting was held in May 1983 and the Nursing Officer was asked what the minimum amount of work and alteration would be to change the function of the area. We were to be allowed to increase the nursing establishment by one enrolled nurse.

The only structural alteration needed was to divide the night plaster room in half to make a clinic room. The half allocated as the children area already had piped oxygen and suction. The area of the new room would measure 9' x 14'. The walls of the area needed to be emulsion painted and the finance allocated to the project was £2,000. The following work was carried out:-

1. A partition wall was erected.

2. The unit was painted.

3. New curtains for the clinic area and for a large examination room.

4. A large blackboard for the play area.

5. Transfers for the walls.

This was done by the hospital work force and the cost of £2,000 included labour charges. The hospital amenity fund was asked for, and gave, £200 for toys. Among other things the £200 bought eight small red chairs and two child size tables, a play mat and cars to use on the mat, a baby bouncer and a rocking seat.

Operational Policy

On the 14th July 1983 a meeting was called between all interested parties, namely Dr. Sibert, Paediatrician, Mr. Newham and Dr. Evans, casualty consultants, the Hospital Administrator, Sisters of the A & E department, the Senior Staff Nurse (an RSCN) and the Assistant Director of Nursing. The purpose of the meeting was to write an operational policy.

It was decided to have few rules and only those that would be kept. These rules were:-

1. All children under the age of 10 should be seen and treated in the new dept.

2. There would be a senior house officer allocated to be present in the dept. between the hours of 9 a.m. and 9 p.m. (The times during which the unit would be open).

3. All injuries to children, apart from those that need resusitation, would be seen and treated in the unit. This would include a dressing clinic and parents would be given an appointment for dressings at a time convenient to them and not, as in the past, at a time convenient to the A & E department.

4. All minor suturing would be performed in the clinic room.

5. All children would be received by a qualified nurse who would decide on the order in which they would be seen. Dr. Sibert also suggested a separate filing system for the children's unit and different coloured cards but this has not yet happened. The possibility of a paediatric nursing profile was also discussed but this was decided against as a new profile had just been established for the department as a whole and it was felt that too many new forms would be confusing.

Opening the Unit

The new unit was opened, very quietly, on 1st August 1983. After the first week we realised that it was going to be a success. Parents could not have been more complimentary; we had far fewer upset children. In fact, the problem was getting them to leave the play area and go home.

We see in the department between 30-50 patients daily. Those needing admission are examined in the department and sent from there directly to a ward or occasionally to one of the other Cardiff hospitals. When this occurs the nurse dealing with the child will go with him/her to the new hospital. Nursing staff are allocated on a shift basis - one trained and one student nurse or helper on each shift. There is one RSCN who has special responsibility for the area. She takes charge whenever on duty and is consulted on any decisions to be made. There are two voluntary workers - a young enrolled nurse with a school-aged child who helps during term time for two mornings a week, and the other a Spanish trained nurse whose husband is working with the Professor of Surgery for six months. She works 9 a.m. - 3 p.m. Monday to Friday.

The unit can offer facilities to feed and change babies. There are also lavatories within the area. Unfortunately, there are no facilities for tea and coffee although there is always squash and milk on hand for the children and feeds for babies. The non-accidental injury file is kept in the unit and a check is made by the nursing staff on every child that is seen. If there is any doubt about the nature of the accident the Paediatric Registrar is called in to see the child.

The unit has now been in use 18 months and it is widely thought to be one of the best schemes carried out in the A & E department. Everyone has benefitted - child, parent, doctor and nurse. Last October an Accident and Emergency Nurses Forum was held at Cardiff Royal Infirmary. Sixty nurses from South Wales and the West attended. All were very impressed by the unit and what it could offer. None of the hospials represented by these nurses could offer special facilities for children and at all of them children had to wait their turn with adults for sutures to be put in.

In Cardiff we have a marvellous oral safety department and oral surgeons on call 24 hours a day. They do all facial lascerations and for lascerations over a certain size the child will often be admitted for a general anaesthetic.

We do need an endless supply of small toys; they get taken home with alarming regularity. We have just had to ask for £100 from hospital amenity money to replace them. We also hope to buy some seersucker material to make tabards for the nurses to wear over their uniforms. Last year the nursing staff decided we needed a proper rocking horse and worked very hard to fund raise the £400 needed. We ran jumble sales, sold home-made marmalade, had coffee mornings and some of the staff made parachute jumps! The rocking horse is called CRISP which stands for Cardiff Royal Infirmary Special Pony.

Statistics on Use

Number of children using the unit during the first year:

Month	No. Children	Month	No. Children
August 1983	1,183	January 1984	480
September	880	February	410
October	690	March	348
November	568	April	921
December	520	May	1,160
		June	1,246
		July	1,141

Summary

For a small cost Cardiff Royal Infirmary have made a conversion immensely beneficial to children. Finally, it is important that A & E departments always remember that they can have a role in accident prevention - if there is a preventable factor in cases, try to eliminate that factor.

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DAY CARE SERVICES FOR CHILDREN - THE PRACTICALITIES OF IMPLEMENTATION:

Miss S. Day, Nurse Planning Officer,
South West Thames Regional Health Authority

I have been asked to talk this afternoon about day care for children - the implementation of a service or the expansion of an existing one. This remit is, as most of you will readily recognise, a mine field, but I hope to reach the far side in safety and not to tread on too many toes in the process.

I do not have any particular expertise in setting up day care services for children and if you are looking for schemes in existence I can do no better than refer you to Southampton(1). I do however have some knowledge of children in hospital since I am a Registered Sick Children's Nurse, and of planning since my present job includes elements of service, manpower and capital planning.

As a preliminary investigation for this conference Jean Lovell-Davis wrote to all the Regional Health Authorities in England asking what figures they are using to determine the quantity of day care provision they propose. She has had a 57% response. Of that 57% the majority expressed an interest in the problem, but declined to give figures relating to children(2). Some have figures for Paediatric Services, others have overall figures for specialties within the Acute Services and one is undertaking a survey. The responses could be said to state strategic aims in line with the Court Report(3) in very broad terms - with District Health Authorities being responsible for implementing strategic plans to meet these aims. All very right and proper, but, we do need to know how Regional Health Authorities intend to monitor District Health Authorities and ensure that the Regional Strategic Plans for child care are being implemented in line with the recommendations of Platt(4) and Court.

We are talking about planning day care within the Acute Services sector and, as with planning any sort of service, there is a need to know from what basis one is planning, that is to say "where are we now?" Having satisfactorily answered that question the next one we face is "where do we wish to be?" The final question is "how do we get there?" or alternatively, "how do we achieve the development required?" I should like to look at these three elements individually in relation to day care services for children.

1. Where are we now?

In most Districts it will probably be necessary to start from basic principles to determine what provisions for care are presently available and what level of care is presently undertaken. This will probably not be easy! It is perhaps relevant, at this point, for me to remind you that on SH3 Returns paediatrics refers to medical paediatrics and does not include any children admitted or treated in any of the surgical specialties. The first task therefore, of establishing how many children are treated as day patients is not likely to be a simple one. The secondary task of determining in what category these children are treated should be easier once the total numbers are agreed.

At the same time as determining how many children are being treated in hospitals as day patients, it is necessary to determine what effects child day care has on community provision. It is important to know how any immediate follow up help is obtained by parents. Is it by telephone? Is there a service on which they may rely? How is the longer term follow-up

THE UNIT MANAGEMENT TEAM.

achieved? Is it by District Nurses in the course of their general duties or, are you fortunate enough to have a Paediatric District Nursing Service? For those childen who have had surgery, who takes out the sutures and where is it done? (Unless of course all surgeons now use absorbable sub-cuticular sutures for skin closure). If these children are being brought back to the hospital to have their sutures removed, are they coming to Out Patients or Accident and Emergency Departments or the ward?

Day care services for children. What does this mean? Are we talking about day care surgery, day care investigations, investigations and treatments undertaken in Out Patients Departments or consultations which take place on the ward (the "just come up to the ward any time you are worried" syndrome) or, what?

It is also necessary to know how children are selected for day care. Who assesses the home environment, and how is it done? Who talks to the parents so that they are aware of the advantages and disadvantages of day care?

Whilst one group of people are beavering away endeavouring to determine the current situation, it is entirely appropriate for another group to begin looking at where you wish or are required to be. I expect most Health Authorities will be responding to the Department's request that day care should account for an increased percentage of patients being treated in the Acute Services sector.

We must remember that Children's services are a relatively small part of the acute services in any Health District. Paediatric nurses and their medical colleagues must be alert to the possibility of being required to increase the level of day care work with children disproportionately to adults in all specialties within the acute services, since traditionally children are seen to be ideal consumers for a day care service.

Perhaps we should look briefly at why there has been a request to increase day care services. I would suggest that it is to try to reduce the number of beds and cots required, thereby reducing the costs of in-patient beds although that premise is questionable. It is also to try to increase the through-put in the beds available and be more efficient by making more effective use of resources. What resources are we considering? I believe they are staff, equipment and buildings, probably in that order of importance.

I believe that all management teams looking at the question of increasing day care provision should be very clear in their own minds that it is a cost effective way of increasing the through-put of patients. There are other ways of achieving increased efficiency especially in areas where social structures are not best able to cope with the demands which day care as opposed to in-patient provision puts upon them. In that situation the use of an appropriately staffed five-day ward should be given due consideration. Many of the anxieties which parents have when their child has undergone surgery may be allayed by that child remaining in hospital with one of his parents for one night post operatively. This is also achievable in areas of high social deprivation.

2. Where do we want to be?

The difference between the current and projected positions in any District is likely to be dependent on local social conditions as well as planning and policy decisions. In every District it is essential to identify the gap.

Once the gap in services is identified, we have to look at how the service can be developed in order to achieve the target. The first element which needs to be decided is the definition of day care in a particular District. Does it include surgery and dressings, removal of sutures, application of plasters, investigations such as biopsies and fibre optic endoscopies,, does it include treatments, for instance the administration of drugs to oncology patients? Once again there is no one answer to this, but in each District it is important to have a definition which everybody understands.

3. How do we get there?

Having arrived at a definition, the real problem starts, and that is how to achieve the required goal.

Since the required goal should be seen in terms of providing the best service possible for the patients for whom we are caring, it again becomes necessary to look beyond day care for the solution. However, this afternoon we are interested in day care provision. I would suggest that the first thing to be done is look at existing facilities and see if there is any available resource not yet taken up.

Each Region will have determined how it has identified the costs of running day care services and whether or not the beds regarded as being used for day care patients are part of the proposed in-patients bed numbers or not. In my Region these calculations have been done in such a way that costs are identified for assumed percentages of day care in any one specialty but the in-patient bed numbers calculated per specialty exclude the provision for day care patients. This assumes that day patients will not use in-patient beds. Perhaps this is the point to reiterate that designated paediatric beds are for paediatric medicine and in children's wards one will aslo require a proportion of non-paediatric children's beds to accommodate children undergoing surgery. The same criteria apply to day care in as much as a proportion of each specialty will be regarded as being appropriate for day care and children will be a percentage of that proportion.

The better use of existing resources - since a large number of Districts are going to be in the situation of having to reduce the total number of beds within their acute sector, it follows that the numbers of staffed beds in children's wards are likely to reduce.

I would suggest that all children's day care should be based on the children's ward but should not under any circumstances involve the practice of using in-patient beds for day patients. It will, of course, also become necessary to provide facilities for the parents of children receiving day care especially if those children are undergoing surgery since the parents may expect to stay with their child until he or she is anaethetised and be on hand immediately the child returns to the ward.

THE DROP-IN SYNDROME —

WHAT STATISTIC —
OUT PATIENT ?
DAY PATIENT ?
CASUALTY PATIENT ?

Once the hospital side of day care for children is planned, before any implementation can take place, there must be consultation and liaison with community nursing staff and general practitioners. Whilst one hopes that the selection of children for day care surgery and procedures is such that it is essentially the well child having an investigation or operation, the parents of these children are going to require support for at least the first post operative night. I do not necessarily see a requirement for every child who has had day care surgery to be visited at home although that would be ideal. It is however, necessary to provide a service whereby parents may obtain assistance if they feel they require it. As we all know, if there is an availability of assistance we generally feel less need to use it.

It has also to be said that studies around the country have indicated that with appropriate selection for day care procedures there is relatively little need to increase community nursing services. However with the added pressure being put upon Health Authorities to increase the volume of day care work, it may be that the criteria for selection will be less stringent, in which case Authorities should look to the necessity of increasing their District Nursing services in the evening and at night in order to cover the problems of post operative patients. As far as children are concerned, this should include the provision of District Nurses, who are trained in the care of children, being available around the clock.

Community follow-up for child day care patients has ever been a problem. In some areas it may not be practical to have sufficient Registered Sick Childrens nurses in the Community where they can provide a 24 hour service over a wide area. In these situations consideration should be given to setting up a hospital based service caring for children in the community. This type of service as many of you will know, is not always easy to set up because of the legal implications involved in hospital staff going into patient's homes.

There is also the consideration of liaison with the community nursing service, since those nurses may well feel that their collective noses are being put out of joint by such a scheme. If a hospital based children's community nursing service is set up it will be necessary to monitor it very carefully in order to ascertain its cost effectiveness. By this I do not mean that if it is costly it should not be done, merely that if it is costly then the benefits received from it should be great, and quantifiable.

Such a service could also be used to follow up in-patients who have been discharged early and children with chronic disease - perhaps thereby reducing their needs for hospital admission.

It occurs to me that what I have been saying for the last few minutes could very easily be summarised in one sentence - an option appraisal needs to be undertaken. Since the steps I have set out will have enabled the setting of service objectives, the appraisal of various options for providing a service, assessment of the benefits that each of those options will provide and then selection of that option which provides the best benefits, perhaps I have not done too badly. The only element, dare I say it, which remains is that of pounds, shillings and pence - or at least the pounds and pence. In order to ascertain the most cost effective option,

Happiness
is
sleeping
in
your
own bed.

it is advisable to draw the Treasurer into discussions at an early opportunity in order that he may do his exercises of cost discounting and cost/benefit analysis.

To conclude, an increase in the throughput of patients in the Acute services is required by the Minister, within the Strategic Planning period. This will have an impact on all Acute Services specialties, particularly child care, since children are seen to be excellent consumers of a day care service.

But - a note of warning -

It is totally inappropriate for children receiving day care to receive it in the same ward as adult patients. In the mid 1980's it is indefensible to plan services in such a way that they contravene the recommendations of the Platt( ) report of 1959 and the Court Report of 1976. To digress momentarily, it has to be said that not all District Health Authorities have been as diligent as they might have been in working towards the goal of having Registered Sick Children's Nurses taking charge of all Children's wards and all children nursed in wards catering for their special needs as recommended by the Platt report and reiterated by the Court report, and, recently, the Mitchell report from the Scottish Home and Health Department. As planners we must look forward and not reproduce examples of existing poor practice.

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DOES THE VOLUNTARY SECTOR HAVE A ROLE IN PLANNING?

Mrs. S. Gatiss, NAWCH Representative on Joint Team Child Health

What I am going to say to you this afternoon at the conclusion of a stimulating day is on my experience as a paediatric nurse with a Diploma in Health Education, and with a twenty year plus experience as a mother of three children during which time I have done various things, but the contact thread has been as an active member of National Association for the Welfare of Children in Hospital.

For those of you who are not familiar with NAWCH, it is perhaps sufficient to say that we are a voluntary body of 25 years standing, made up of parents and professionals concerned to promote the welfare of sick and handicapped children and their families and in particular to highlight the parental role. The basic framework for our work for an appropriate hospital provision for sick children is set out in the Government report "Welfare of Children in Hospital", commonly known Platt Report, and subsequent circular notably H.M.(71)22. But today I am here to answer the question

"does the voluntary sector have a role to play in planning"

In answering this question, I shall, of course, be concentrating on our NAWCH perspective of the question, and, of course, child health, but arguments I believe could be applied to other voluntary groups working with and for other client groups.

I want to take you back to the seventies when two specific things happened at that re-organisation of the N.H.S. Both aspects were covered in the Grey Book.

The first is the concept of consumer representation as a statutory part of the service.

The second was the introduction of Health Care Planning Teams.

Sir Keith Joseph, with whom I do not usually agree, thought through and was adamant that there was a need for a separate body which could find out consumers' views of the service and represent them to those managing the service - Community Health Councils came into existence in 1974. The previous year NAWCH spent a considerable time digesting the contents of the Grey Book and then at its A.G.M. in Cambridge discussed what role we should take. We decided to make an effort to put forward candidates to represent the child's needs and many of us started on a new career. As I look around the room I can pick out individuals from all over the country who have served on C.H.C.s and I am sure would say with me - we've learnt a great deal in the last ten years!

The second new aspect spelt out in the Grey Book was the Health Care Planning Teams and at this point I should like to remind you of what was said.

"The DMT will be responsible for identifying gaps in its services in relation to needs and for developing ways of improving its services to use existing resources better. For example, it will examine ways of changing existing patterns of care, by alterations in operational policies and procedures and priorities between services. This team activity will relate both to the operational health-care services and to the related supporting services. In

order to carry out the planning of the operational health-care services, the DMT will establish a number of multi-disciplinary health-care planning teams to concentrate on planning services to meet particular groups of needs."(1)

Later in the section, the four kinds of activity likely to be undertaken by Health Care Planning Teams are described as follows:

"(a) Continuously reviewing needs of particular groups and the services being provided to meet these needs. The purpose will be to identify gaps in service provision and the opportunities for improvement.

"(b) Contributing to policy recommendations and to development of the annual District plan. The teams will advise the DMT on the policy recommendations to make to the AHA. They will, for example, examine the relevance of new national policy guidance to the local situation. They will also develop the relevant part of the annual planning proposals for the District.

"(c) Carrying out special studies to establish ways of bringing about beneficial change. They will develop plans and programmes of action to implement identified improvement opportunities. The DMT will examine their proposals and decide on priorities.

"(d) Assisting the DMT to monitor and co-ordinate the implementation of projects and assess results. All members of teams will be responsible for assisting with the proposed changes. They will do this as a service to the DMT. After implementatin they will assess the effects of the change."(2)

Well of course, since then, we have seen another reorganisation in 1982 and although the planning process has been simplified we still have H.C.P.T/J.D.T.s of a similar ilk.

N.A.W.C.H. participated immediately in 1974 in C.H.C.s. The role and concept of working was familiar and we felt at home. But, as we entered further into the morass of bureaucracy that tends to work from top down, we were cautious about other processes and in particular planning. This was seen as a management function and it was felt necessary to distance ourselves from that responsibility but develop a dialogue with those managing the service.

Since then we have matured as an organisation. We have acquired a body of knowledge - from participating in C.H.C.s; public debate at local and national level; by observing managers at work and by comparing the effectiveness of services in different districts. We have undertaken surveys, initiated research, and highlighted good practice at our conferences. We have submitted evidence to the Royal Commission on the health service, to the Court Committee(3), Warnock Committee and Select Committees, but at the same time have kept feet on the ground by listening to parents and their experiences - this is done by our membership throughout the country and through Head Office here in London.

Now, as I said earlier, we have matured and so I believe we must and indeed have already taken on responsibility and have become part of the management structure. Many of our members are Health Authority members involved in taking policy decisions and ordering priorities, others are on J.C.C. and a few of us are on planning teams:

- child health
- maternity
- health promotion.

We have a similar agenda to those other members of the planning teams but our priorities are in a different order. We all have children and their parents at the core of our objectives, but nurse managers are looking to reviewing in context, their role, responsibilities and resources needed to carry them out effectively. Doctors, psychologists, para-medical staff, educationalists and local authorities representatives work within a similar framework with shrinking resources and rising expectations and the need to implement new legislation without extra resources.

We are there reflecting the concern of the users pressing for a responsive service which treats the child as a whole, taking into account both emotional and physical needs; that takes account of parental needs so that parents can carry out their important role in preparation for undergoing painful unpleasant procedures; supporting and comforting both at the point of crisis but also in the following weeks and months. Parents are the continuity for the child - the link with normal life, whilst the child experiences a strange environment, but are also the people who will experience the acting out of the child's feelings on return home.

You may say that the nurse or a doctor could argue from this perspective on such a planning team. My experience is that to some extent they do, but a multi-disciplinary team does need a wide spectrum of skills and know-how. A voluntary organisation such as NAWCH has acquired a body of knowledge, has defined its priorities based on 25 years discussion with the organisations and with professional and lay bodies, and the criteria for services in each district we feel should meet the criteria set out in our Charter - and after all it is Government policy of longstanding.

You will have found a copy of the NAWCH Charter on your seats. We are encouraged that already it has been endorsed by many bodies, including the A.C.H.C.E.W; B.P.A; R.C.N; B.M.A., R.C.G.P., and the C.A. who will carry an article on the subject in the April edition of "Which". So I should like to conclude by asking you to go back to your district with the Charter as a check list and see if in planning together we can realise these objectives.

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NAWCH CHARTER

FOR CHILDREN IN HOSPITAL

1

Children shall be admitted to hospital only if the care they require cannot be equally well provided at home or on a day basis.

2

Children in hospital shall have the right to have their parents with them at all times provided this is in the best interest of the child. Accommodation should therefore be offered to all parents, and they should be helped and encouraged to stay. In order to share in the care of their child, parents should be fully informed about ward routine and their active participation encouraged.

3

Children and/or their parents shall have the right to information appropriate to age and understanding.

4

Children and/or their parents shall have the right to informed participation in all decisions involving their health care. Every child shall be protected from unnecessary medical treatment and steps taken to mitigate physical or emotional distress.

5

Children shall be treated with tact and understanding and at all times their privacy shall be respected.

6

Children shall enjoy the care of appropriately trained staff, fully aware of the physical and emotional needs of each age group.

7

Children shall be able to wear their own clothes and have their own personal possessions.

8

Children shall be cared for with other children of the same age group.

9

Children shall be in an environment furnished and equipped to meet their requirements, and which conforms to recognised standards of safety and supervision.

10

Children shall have full opportunity for play, recreation and education suited to their age and condition.

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QUESTIONS FROM THE FLOOR TO MS. HUDSON AND DR. TROOP

To Ms. Hudson

Q. Why can there not be a standardization of definitions for Health Visitor staffing levels? Why is it not possible to obtain the numbers of children, other than paediatric, being nursed in other units?

A. On Health Visitor staffing levels the work load seems to be directed to population rather than work load.

Comment from the chair - Health Visitors in Inner City areas with high work loads are often the thinest on the ground. But, it is very difficult to make a proper assessment of work load.

To Ms. Hudson

Q. What about 14-18 age group? This is a problem area, there should be a stronger interest in this age group.

A. The problem of 14-21 is an area that needs thought and planning.(1) At present we do not have a strategy for adolescents but we are addressing the problem and we hope that we will be getting help at district level.

To Dr. Troop

Q. What does Dr. Troop feel the impact of the new FPC's due to begin in April will be. Will they revolutionize primary care for children?

A. Most people in Community Medicine and Planning don't have a child health background. I find 'revolutionary' a difficult word to apply to FPC's; I see them rather as a retrograde step. It would be a shame if the G.P. service became more cut off as a result of FPC's.

To Ms. Hudson

Q. Would you like to comment on the importance of respite care for families in keeping children out of hospital permanently?

A. One of the highest priorities is to ensure that families will get, and know that they can get, help with relief services. If there is to be community care there must be respite care. Beds in acute hospitals are not suitable for respite care. Lack of respite care is one of the most regrettable failures of the Health Service and Social services today.(2)

To Dr. Troop

Q. When you talk about lack of resources on the Joint Development Team you do not mention G.P.'s. Are there plans to use G.P.'s as a resource?

A. Primary care is an essential part of child services. We are trying to bring G.P.'s in as part of our resource bank on the Joint Development Team. We have to use all our resources, but until we are talking to FPC's we cannot judge how best we can use them. There is a lack of information in trying to identify children most at disadvantage and gaps in the service.

Q.
To Dr. Troop

A. Initially they did feel that this was their role but now, two years on, there is a close commitment to joint planning at senior management levels. The core group of convenors is fairly closely balanced between health, social services and education so there is close accountability between the local authority and the DHA. There has been some very close work done together in implementing the 1982 Education Act.

P.M. Session

Questions to Dr. Sibert A & E

Q. In the survey that you used during your talk, you said that 63:189 hospitals had a paediatric ward on a different site to the A & E department. This is a major problem for Harrogate where we have the commitment but no money. How can we achieve good practice in these circumstances?

A. One solution may be to have a small A & E department on the site at which the paediatric wards are run by paediatric staff. This doesn't solve the problem completely and we do need to give this issue a high priority.

Comment from Chair It is important that, for example, orthopaedic surgeons recognise a fracture may be the end result of a complex set of circumstances; it is important that we take into account the complete welfare of the child and the family. Transfer of a child from one site to another can be worked out as in the case of neo-natal care although we should recognise that there may be less flexibility in less populated areas.

Q. How does the A & E department follow up cases and how do you identify non-accidental injury?

A. All 'under fives' are followed up by a visit from the health visitor who will discuss preventative measures if appropriate, e.g. point out danger areas such as steep stairs that need a stair gate, unguarded fires, low

level or unlocked cupboards storing poisonous materials. Staff should be trained to look out for danger signs of abuse such as bruising behind the ears, areas of neglect.

Reply to answer. In the experience of the questioner the amount of time used in follow up is not very effective.

A. This certainly can be the case. We may not be putting Health Visitors where they are most needed.

Q. What links are there between the A & E department and community with reference to immunisation programmes?

A. Specialised A & E departments are often geared up to child immunisation programmes often giving triple rather than just tetanus.

Questions to Sally Day

Q. There has been a great enthusiasm for day care on emotional grounds and there is now enthusiasm for it on financial grounds. How much can we move nursing staff around between the various disciples? How can nurses such as health visitors, district nurses, ward nurses be used in a flexible way to take up and form an option appraisal within the resources that we have already got?

A. Within any caring service we must be more flexible in our ideas. By blurring the edges and welding together groups we have one way of doing this. If there are nurses based within the children's department of a hospital or within a children's hospital then we must look on this as a centre of expertise which may not be used to its maximum ability. To allow people to go out from that central situation to care for others in the community has to be one way forward. Liaison and unit management teams in care groups is very important.

Q. Day care is usually meant as day care surgery but you have broadened it to include activities of medical investigation. Do planners include these in their considerations.

A. The problem is where there are so many definitions of day care every one has a different definition. Within our region (SW Thames) day care is to be increased across all acute services specialities.

Q. What about facilities for parents and children who are coming in for day care. Some of them will not be 'ill', what is provided for these children and for their siblings? I am interested in play provision in hospital and I hope that day care facilities will properly use play provision for parents and children.

A. I feel about day care that children should always be nursed in children's units whether long or short stay. In terms of district general hospitals, as opposed to children's hospitals we should be thinking of using beds in children's wards that are not being taken up by in-patients. Within this

planners should make sure that facilities include parents and that day care children should be separate from those ill in bed. So that, in one area, there may be two playrooms.

Q. I am worried about prejudicing the safety of children by using certain day care procedures. We must make sure that children are fit to go to theatre, and after surgery are they fit to go home? It may not be appropriate to discharge them if they have a long night journey or if it is especially cold. Yes, day care is desirable for children but at times it could jeopardise their safety.

A. I see a compromise in using 5 day wards. If facilities were planned so that a parent or parent substitute could stay with the child there is no harm in keeping the child in overnight.

Comment from the Chair

We must be careful before we embrace day care. Not all parents may be ready for their child to be whisked in and out. There should be more parent counselling about the advisability of day care. It is important to recognise that home quality is variable; some homes may be suitable to day care whereas others may not.

Q. I have recently moved to a new appointment in a different health authority and find it very difficult to influence decisions. Who should I aim to influence and what can they do?

A. The people at the top need to be aware of problems experienced 'on the shop floor'. The RHA are producing strategic plans and the DHA provide aims and objectives for care groups that they are planning for.

Questions to Sheila Gatiss

Q. The organisations name, NAWCH, suggests that your interest rests with the child in hospital. To what extent does NAWCH intend to be involved in the needs of the child in the community and in their own homes?

A. This has caused a good deal of discussion within the organisation. Some feel there is still so much to do with the hospital and others take a wider view of child health. We would all press for the child to be at home whenever this is appropriate.

Comment - Jean Lovell-Davis, Director of NAWCH

Our first priority was for children in hospital. Children should have access to their parents when in hospital. There are still something like 160 wards where there are restrictions on parents going in - mostly on the day of operation. We also want to see accommodation for parents whose child is in hospital and on this we still have a long way to go.

We would like to see more nurses trained to look after sick children. What we have found is that patterns of child health and treatment have changed. The average stay for a child in hospital is now only three days so the child is probably needing more care at home. NAWCH interests are moving into A & E departments and out-patient departments and liaison with community services.

We have limited resources and it is hard at times to know where we should direct our main focus. Our main interest is still hospital and how the community services relate to hospital. If we had more money we could take on more of child health.

This is the first conference where we have focused on planning - if we don't look at planning and get involved in looking ahead then we won't get far with our work.

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King Edward's Hospital Fund for London is an independent charity founded in 1897 and incorporated by Act of Parliament. It seeks to encourage good practice and innovation in health care through research, experiment, education and direct grants.

The King's Fund Centre was established in 1963 to provide an information service and a forum for discussion of hospital problems and for the advancement of inquiry, experiment and the formation of new ideas. The Centre now has a broader interest in problems of health and related social care and its permanent accommodation in Camden Town has excellent facilities for conferences and meetings. Allied to the Centre's work is the Fund's Project Committee which sponsors work of an experimental nature.