King's Fund
Management College

# INTEGRATED APPROACHES TO CHILD HEALTH CARE:

# A SUBMISSION TO THE HEALTH SELECT COMMITTEE

### The Results of a Seminar held at the King's Fund, hosted by the Royal Victoria Infirmary NHS Trust, facilitated by the King's Fund Management College

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# *Contents*

# INTEGRATED APPROACHES TO CHILD HEALTH CARE

## Notes of a Seminar Held on Friday 30 August 1996
## at the Kings Fund Management College

## SUMMARY

1. This report is the result of a seminar bringing together providers, experts in paediatrics, health service managers, purchasers and clinicians. The purpose of the seminar was to explore integrated child health care, its benefits, problems and to pull together a submission for the Select Committee to inform their report.

2. The process of the day[1] was to create dialogue by bringing together:

- health care providers working with integrated child health services;
- experts in the field of child health care from academia, voluntary sector, Audit Commission, and the Royal College of Nursing; and
- managers, civil servants and clinicians who had a general interest in child health as part of their roles, but who were not specialists or experts, and as such had a broader perspective to offer.

3. The main issues arising from the day were:

- The Children's Contract
- Achieving integration within a market system and across the territorial boundaries between disciplines and services
- Health Authorities' capability to purchase children's services
- Policy focus for children
- The lack of expertise in primary care

4. *The Children's Contract*

4.1 Is at one and the same time to be a contract <u>for</u> children (i.e. a new deal for children) and a service specification. It should be all embracing, covering all dimensions of children's health care and should ideally provide for the management of ECRs.

4.2 The strength of the contract is that it can be driven by the needs of the child, and not the needs (or wishes) of professionals.

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[1] The programme for the day is at Appendix 1

## 5. *Integration*

5.1 Is there a way of preserving the ownership of services, within a particular institutional framework, whilst managing the boundaries such that the clinical service itself is integrated?

5.2 If this integration process is led from within, by committed individuals, then it was believed that ways would be found around the structural obstacles that have prevented some integration attempts.

5.3 Above all, however, it was clear that successful integration had been driven by "the people who know the business", and at this time those people reside in provider organisations. There was a strong view that purchasers should be partners in securing integrated child health but at the moment they do not have the knowledge base to participate.

5.4 An outstanding feature of the presentations was the clear management focus on children. Both professional morale and standards of care were enhanced as a result of such focus and conversely poor care was given by units without such a focus

## 6. *Health Authorities capability to purchase children's services*

6.1 The common concern was 'how to help purchasers purchase?' One suggestion was that purchasers might devolve their responsibility for children's services to an "expert" provider, rather than try to develop the expertise themselves.

6.2 An alternative proposal suggested that with a more mature relationship between purchasers and providers and services developed and provided through dialogue rather than confrontation, would achieve good results. This might be termed a customer/supplier model.

## 7. *Policy focus for children*

7.1 Policy and policy making should focus on children as a whole. At the moment the process is fragmented. Thus there is a need for a mechanism to pull the strands together and this requires action not least at Department of Health level.

## 8. *The lack of expertise in primary care*

8.1 In particular it was felt that the emphasis needed to move away from general practice to the broader concept of primary care and specialist practice in a primary care setting.

8.2 The discussion concluded that there were a number of inherent features which need to change before primary care could properly form part of an integrated

children's service. In particular it was felt that the emphasis needed to move away from general practice to the broader concept of primary care and specialist practice in a primary care setting.

## 9. *Key Messages*

9.1 Key messages which the seminar participants believed the Health Select Committee and the Department of Health needed to address.

i) There needs to be a children's focus to commissioning healthcare, from the Department of Health down to local operational level.

ii) Every DHA should be required to appoint a children's services commissioner, who would be given authority to set the child health specification, and the budget to make this happen. The individual would need to have appropriate levels of knowledge and expertise, and would have to be accountable to the Chief Executive.

iii) Every Health Authority should be required to produce a plan for child health services.

iv) An appropriate contract currency needs to be found for specialist services, which should also encourage providers to keep children out of hospital.

v) Health Authorities need to develop their own knowledge of child health services. This will be best achieved through the development of mature relationships with providers.

vi) Policies need to be introduced which encourage paediatric expertise at the primary care level.

vii) Paediatrics should be a core component of primary care training, with continuing education.

viii) There is a shortage of paediatric skills in all areas. There has been a pleasing increase of children's nurses since project 2000. Recruitment and retention of all types of staff in child health is difficult and measures need to be taken to address this. There is an overwhelming shortage of doctors and therapists.

ix) Outcome measures, against which quality in children's services could be monitored, should be developed.

x) The "knee-jerk" response to critical incidents should be abandoned: long term plans should instead be developed to secure the health of children .

xi) Central initiatives are needed to enable integration : guidelines tend to be ignored, as witnessed by the disparity in standards around the country ; therefore it needs to be mandatory for Health Authorities and providers to make progress on this issue.

xii) Children are different: they require a holistic approach to care, and this in turn requires a unitary framework for the planning and provision of services.

## 10. *Key Ingredients for Success*

10.1 Reflecting on the content of the day, participants identified the following key ingredients for success:

- Personal commitment to integration is what makes it work: mandatory guidance comes later
- A "passion for paediatrics" is an absolute requirement
- Risk takers are successful: the Department of Health needs to recognise this
- A common goal and a common voice for children are important. A successfully integrated service will be child and family focused.

10.2 Above all, however, it was clear that successful integration had been driven by "the people who know the business", and at this time those people reside in provider organisations.

# QUOTATIONS FROM THE DAY

*"The service ends up all right, but managerially and contractually it is a hotch potch. Where it breaks down is over who will buy an electric wheelchair ... and that is where the child suffers".* Paediatrician

*"There is an enormous lack of knowledge about children"* Observer

*"We don't have a strategic overview"* Purchaser

*"We want to know a few years down the line that policies and strategies make a difference"* Purchaser

*"Before integration we couldn't get a feeding pump from the ward, into the community - that was the ward's property"* Paediatrician

*"We wanted to walk before we could run. In fact we've done a lot of stumbling"* Paediatrician

*"The focus is very very short term"* Provider, of a Purchaser

*"Look at Health of the Nation - looking for a reference to children and you are looking in vain"* Paediatrician

## 1. PURPOSE & PROCESS

1.1 The purpose of this seminar was to gather together a group of people who could explore integrated child health care, its benefits, and problems and to then make an informed submission to the Health Select Committee based on the dialogue generated at the seminar. The seminar was initiated by Barrie Dowdeswell, Chief Executive of the Royal Victoria Infirmary NHS Trust, Newcastle, and was hosted and facilitated by the King's Fund Management College. The Secretary to the Select Committee, Tom Healey, attended the day to listen and note the main strands of the submission as it was created.

1.2. The process of the day[2] was to create dialogue by bringing together:

- health care providers working with integrated child health services;
- experts in the field of child health care from academia, voluntary sector, audit commission, and the Royal College of Nursing; and
- managers, civil servants and clinicians who had a general interest in child health as part of their roles, but who were not specialists or experts, and as such had a broader perspective to offer.

1.3 Four presentations were made by NHS which had made progress locally in integrating child health care services. A team of paediatricians, nurses and managers represented each Trust. The Trusts had been invited to also bring a GP along as part of the team, none of the Trusts had found this possible in the timescale. There was one GP present as an observer. The role of GPs and other primary care staff in integrated child health services figured largely in the discussion, and the lack of GPs present was an issue, although many of the Trust's team had experience in primary care.

1.4 The experts were: Sue Burr of the Royal College of Nursing; Dr Ian Smith of the Nuffield Institute for Health; Anne Rivett of Action for Sick Children; Claire Blackman, Audit Commission. ( For a full list of participants see Appendix 2).[3]

## 2. INTRODUCTION

2.1 In his opening comments Barry Dowdeswell drew attention to the importance of the purchasing process to the pursuit of integrated child health care services; in his analysis there were significant weaknesses at present. He drew attention to the boundaries between those engaged in the provision of child health services and the challenge of managing those boundaries.

2.2 The group of Trusts invited to this seminar had been chosen because of the progress that they had made at some of these boundaries. One of the aims of

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[2] The programme for the day is at Appendix 1

[3] The King's Fund would like to acknowledge gratefully the contribution made by all those came, at the expense of their own organisations.

the day would be to find "ingredient X", which was common to successful integration. He added that whilst there are obvious difficulties in integrating child health services, there are also very clear benefits; both need to be highlighted.

2.3 The main aim of the seminar was, however, to inform the Health Select Committee Inquiry into Services for Children. He hoped that the report which would follow the inquiry, would be important in setting the agenda for the development of children's services over the next few years.

## 3. PARTICIPANT'S EXPECTATIONS

3.1 The seminar began with an exercise to clarify the expectations of those who had given their time to come along and these were as follows:

i) To define what an integrated service is and to identify the outcomes/ benefits of an integrated service.

ii) To identify the obstacles to achieving an integrated service.

iii) To find out how to integrate; how to square vision and reality; how to integrate beyond health; how to include the Department of Health in the process.

iv) To collect, analyse and disseminate different ideas and experiences from Trusts which have been successful in integrating, to inform others.

v) To explore a means of overcoming the challenges and operational difficulties faced in integrating services.

vi) To put forward a clear message to the Select Committee : a Statement <u>for</u> Children.

vii) To give a clear customer focus to this piece of work: the voices of children and families must be acknowledged.

## 4. TRUST PRESENTATIONS

4.1 The Trusts each made a presentation, and were frank and open about their achievements and the difficulties that they encountered. A range of approaches and models were presented, which produced very rich pictures of their services. In some instances Trusts described the care of an individual client, how they worked with parents and the child, and how decisions were reached. The Trusts presentations are at Appendix 3.

## 5. MAPPING THE PICTURE

5.1 Following the four presentations and the debate which ensued after each, the King's Fund team began to put together a map of the key issues and themes, with all participants subsequently working to enrich and expand it. The resultant map is shown at figure 3. For each key themes addressed by the presentations or in the discussion a number of points was recorded which participants believed had policy implications.

**Please see attached Figure One**

### 5.1.1 Purchasing

- A need for a long term view
- DHAs' poor knowledge of children resulting in a lack of vision
- Fragile contracting process
- Getting the right advice
- The GP dimension in commissioning - where does this come in?
- The fragmented requirements of GP fundholders
- Children's contract versus customer/supplier model (for an example of a children's contract see Appendix 5)

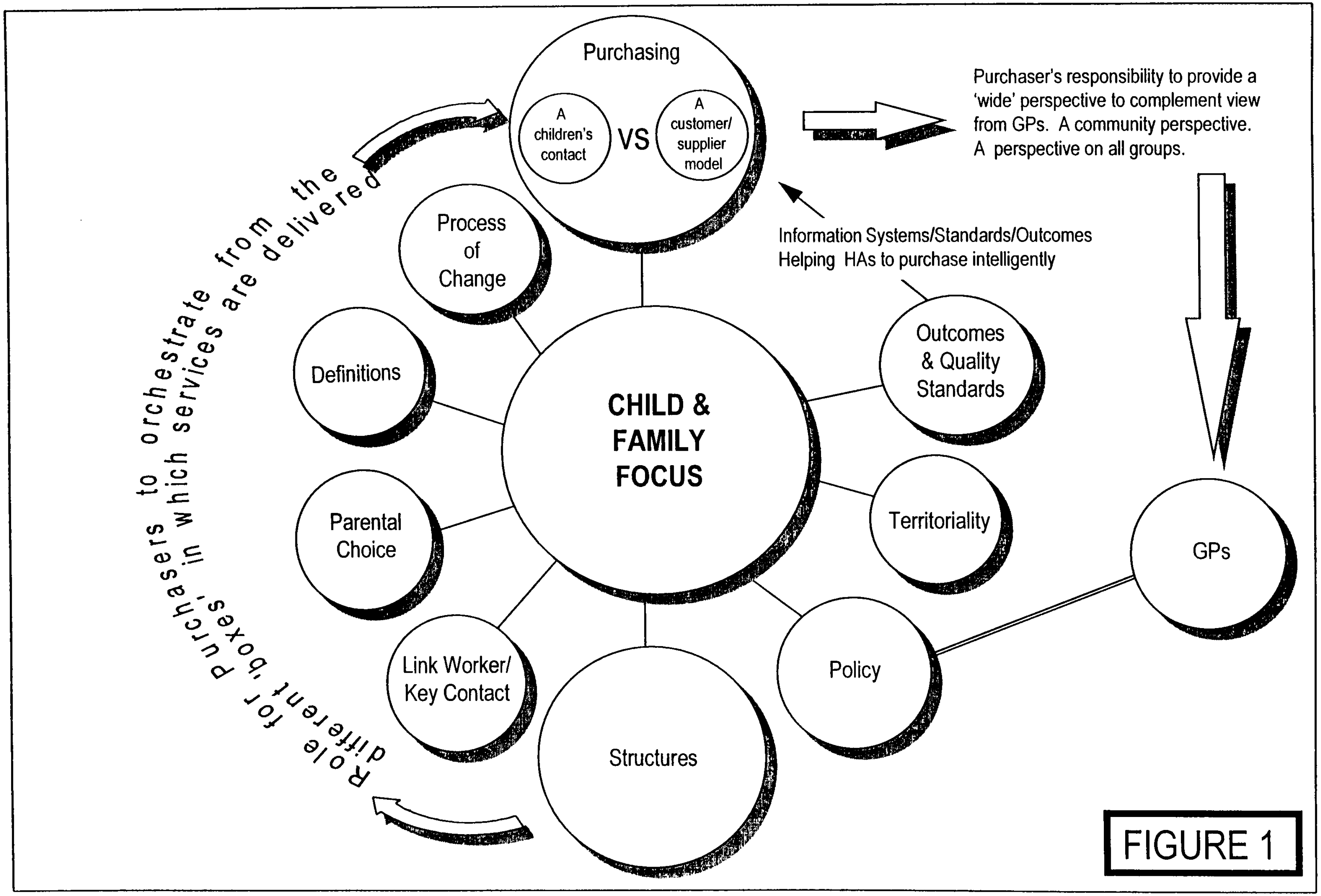
### 5.1.2 Territoriality

Between:

- Agencies
- Disciplines
- Trusts
- GPs and Paediatricians
- Community/well child and hospital/sick child

### 5.1.3 Outcomes and Quality Standards

- Why integrate unless outcomes can be shown to be improved ?
- Standards need to be set that can be monitored
- Information systems are needed to help DHAs to purchase
- Quality versus access, a trade off



Purchaser's responsibility to provide a 'wide' perspective to complement view from GPs. A community perspective. A perspective on all groups.

Information Systems/Standards/Outcomes Helping HAs to purchase intelligently

Role for Purchasers to orchestrate from the different 'boxes', in which services are delivered

FIGURE 1

### 5.1.4 GPs

- To what extent do GPs understand or are skilled in caring for children?
- Immediate access to the correct level of expertise is required
- A GP's knowledge of the family and its environment is precious

### 5.1.5 Policy

- Where are children in Health of the Nation and other national initiatives?
- A focus on children in whole, not in parts
- Financial investment doesn't recognise the value we place, or say we place, on children in society

### 5.1.6 Structures

- Post-reform fragmentation
- Community/acute resource competition
- Staffing supply problems and the future of small units
- How big is an integrated system?
- An integrated focus on children will result in increased morale

### 5.1.7 Link/Key Worker

- Someone to make the system work for the child
- Investment in liaising/staff time
- Knock-on effect through the system

### 5.1.8 Parental Choice

- The responsible citizen: parents and professionals
- Good liaison facilitates choice
- Parental loyalty to units where services aren't of the best standard, but are local
- Exercise of choice can be uncomfortable for professionals

### 5.1.9 Definitions

- Integration versus combined
- Does a combined child health service include GPs?
- The different needs of those children with long term needs, compared to those with short term needs - how does this affect our definition of a combined child health service ?

### 5.1.10 Process of Change

- Investing in relationships
- Increased morale from the team focus on children and a coherent structure
- Doing things well gives a sense of achievement and also increases morale
- The lobby: "those bloody children's nurses again"

5.2 The map prompted a full discussion and observers, experts and presenters began to focus on key issues with policy ramifications.

### 5.2.1 Management Focus and Society's View

An outstanding feature of the presentations was the clear management focus on children. Both professional morale and standards of care were enhanced as a result of such focus and conversely poor care was given by units without such a focus.

Essential in this picture is the question of the value which is placed upon child health services within the whole NHS. A comparison was drawn between the values of society, in which the phrase "women and children first" is used, and the health sector where this type of value judgement is not exercised. Indeed, various comments on the day indicated that the reverse was taking place with those championing children's services often being criticised for their zeal by colleagues within the health sector. This was compounded by the lack of understanding and ignorance amongst Health Authorities of children's services.

One comment was that "the British do not like children" with this factor pervading policy decisions, including those involving health. The paradox in this is that if the public are asked where their money should be spent, they will always say 'on children'.

### 5.2.2 GPs

The second major issue focused around the role of Gps. The group felt the absence of GPs in the room on the day and although several managers present had good knowledge of primary care they recognised the advantages of having clinicians present. The Department of Health had a policy of pursuing a 'primary-care led NHS,' where by implication GPs would have significant influence on the type of health care provided. GP fundholders are already taking powerful decisions on the range and type of services. Experience in a number of centres has shown that fundholders want different things, or at least are perceived to have different health priorities, and it is very difficult to square this diversity of opinion with coherent policies for children.

Compounding this was a concern about the way that GPs work with children. Comments included the following: that GPs do not have training in child health care and they are not experts in it; that GPs are "afraid of children",

even though they see a lot of them; GP's need a framework of expertise around them with regard to children. These comments did not draw unanimous agreement.

One view put was that all of the integration that had been talked about was only of specialist services and that GPs had an important role within a combined child health service. This was because GPs had a unique overview of all of the factors involved in the child's health requirements (for example social, economic). This view was challenged, with the argument made that many of the specialists involved also worked so closely with children and their families that they know a great deal about the background and circumstances of any individual.

A final point on this theme was that "parents will vote with their feet, and are doing so" in that they are moving away from GPs who they perceive not to have the expertise required to care for their child. Instead, they are seeking alternative providers.

### 5.2.3 Purchasing

The common concern was 'how to help purchasers purchase?' A number of the presenters had commented that purchasers are not listening to those working in children's services with a consequence that their knowledge base was not improving quickly enough. Fragmentation of services was a phenomenon that recurred throughout the day. Even where there is effective integration within the health sector, a danger of fragmentation remained, it was argued, if we looked at the whole child within the context of family and wider environment. So it becomes crucial that Health Authorities have enough knowledge to understand what is provided in each "box", and how to purchase in this context.

The Health Authority perspective was also ably put by purchaser participants. They argued that child health is just one of a whole range of 'priorities' which purchasers have to deal with. Within each of these there is always a range of professional opinion to be balanced and this is part of the process of determining the order of priorities in any Health Authority. One comment ran:

"Providing an integrated service response for children is not a Health Authority responsibility. This is an area where providers have the expertise, and this expertise should be used."

Returning to the issues in primary care, purchasers expressed the view that they have responsibility for providing an overall framework for services; GPs who work within the system are not "corporate animals". This results in a real tension, which may be a creative one.

One suggestion was that purchasers might devolve their responsibility for children's services to an "expert" provider, rather than try to develop the expertise themselves. To do this they would make a block allocation of funds for children's services to the expert provider, who would then sub-contract if necessary with other local providers of child health care. Such a block allocation could include all ECR funding, to make the administrative process much simpler.

An alternative proposal suggested that with a more mature relationship between purchasers and providers and services developed and provided through dialogue rather than confrontation, would achieve good results. This might be termed a customer/supplier model.

### 5.2.4 Responsible Citizen

The phrase "responsible citizen" recurred through the day and attracted much discussion. The implication underlying this, that there comes a point at which citizens became irresponsible, was challenged. How could this 'irresponsibility' be defined, given that recent policy trends sought to increase citizen/patient autonomy over their own health care. An added danger was that professionals might define 'responsible' as 'agreeing with the established view'.

One example used was the issue of consent to treatment where a 16 year old is believed to be competent to give consent, if s/he agrees with the doctor, and is viewed as not competent if s/he chooses an alternative option.

The group also considered the different perceptions of service quality - the popular versus the professional view of services. Quite often local people will see their local service as perfect, without really understanding or rating the problems that are perceived by the professionals in terms of the quality of services available. Who is right?

Reference was made to experiences in the United States, where the prevailing attitude of parents appears to be that they want an ambulatory paediatric service (a general paediatric service) provided locally, but that they are prepared to travel large distances for highly specialised services. Participants echoed this in their experience of UK health care ; a key consideration being whether the 'distant' referral is suggested by a figure the parents trust.

A final issue raised was one of territoriality, with the focus on the way that services were provided for the sick and the well child. This division in the way children are seen was thought to reflect the different ways in which acute and community child health services were provided, with subsequent problems for the chronically ill or disabled child. These children tended to fall through the net because their care needed to be provided in the community, which otherwise concentrated on the well child. This problem was compounded by

the fact that 50% of districts were believed to have no community paediatric nursing service at all.

## 6 Key Issue

6.1 From the preceding discussion four key issues were selected for further, more detailed consideration in small groups. These were :

### 6.2 CHILDREN'S CONTRACT[4]

6.2.1 This subgroup was asked to explore the proposal of a block allocation of funds to one provider who would then manage children's services on behalf of their Health Authority ("the Children's Contract").

6.2.2 The Children's Contract is at one and the same time to be a contract <u>for</u> children (i.e. a new deal for children) and a service specification. It should be all embracing, covering all dimensions of children's health care and should ideally provide for the management of ECRs.

6.2.3 One potential problem would be in identification of the total resource for child care services, and this could be an area of conflict between providers.

6.2.4 Essentially, providers would be invited to bid for 'lead provider' status, and the successful bidder would then act on behalf of the purchaser, as a commissioner for child health care, within the framework of the contract. The lead provider would be expected to achieve the targets enshrined in the contract (however the issue of non-compliance and how this might be managed was not considered).

6.2.5 The group considering this concept were unanimous in their support for it. They felt that purchasers in their own localities did not have the requisite experience to devise a plan for children's services. It was believed that a proper piloting of this option in one or two areas would be beneficial. The group looked at how this notion would sit for example with the Newcastle Child Health Board and concluded it would sit well within that particular framework, in this case with the contract being between the Health Authority and the Child Health Board, which would then subcontract to each of the main providers.

6.2.6 Two problems were highlighted: one in managing the interface with GPs; and the other the complexity of defining effective boundaries to the service because of issues of co terminosity.

6.2.7 The strength of the contract was that it could be driven by the needs of the child, and not the needs (or wishes) of professionals.

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[4] For an example please see appendix 5 submitted from the Nuffield Institute

6.2.8 It was evident from earlier discussions that the commitment of clinicians to the process would be far greater if they themselves were involved in shaping the contract specification with the resultant feelings of ownership. For the same reason it would be the ideal vehicle for the promotion of evidence-based clinical practice in that in both its formation and implementation it would be clinician led.

## 6.3 INTEGRATION POST-REFORMS

6.3.1 A number of references were made during the seminar to the fragmentation which some perceived to have resulted since the 1990 reforms. Policy directives from the Department of Health had conflicted. In the early days the Department's view seemed to be that mixed Trusts, i.e. those which provided both acute and community services, should not be created because of the risk to funding for non-acute services. This line had softened such that many Trusts came to be formed along whatever lines best suited local needs. However, there remained difficulties about Trust "ownership" or identification with services.

6.3.2 Is there a way of preserving the ownership of services, within a particular institutional framework, whilst managing the boundaries such that the clinical service itself is integrated?

6.3.3 It was noted that most often, it has been clinicians, not managers who have driven integration of child health services. The question to ask is therefore "Where are the committed people?" and once they are found, they need to be encouraged to lead the way. If this integration process is led from within, by committed individuals, then the group believed ways would be found around the structural obstacles that have prevented some integration attempts.

6.3.4 It might also be possible for child health care providers (the clinicians, together with perhaps their local managers) to force integration on the respective Trust Boards, by forming strong links directly with the purchasing organisation. Under such a scenario although the Trust Boards might have separate negotiations with the purchaser, there would also be a dialogue between the Health Authority and the integrated child health structure "created from within". In some ways, this is ultimately the Newcastle model, although as yet in Newcastle there is no executive authority with the Child Health Board.

6.3.5 Integration over a wide area is also required, in order to plan strategically for children's health services. In some instances the only way that improvements will be made to community services is to close small hospital departments and create links with larger hospital departments and the local community provider(s). Where smaller hospitals are closed successfully, the local community service has to be enhanced, and appropriate locally-driven day care provided. An integrated child health service across district boundaries would

be useful in such an instance, but in the post-reform era would be even more difficult still, in that it would involve more than one purchaser and a larger number of Trusts.

6.3.6 The idea of following the spirit of the reforms, by using the sub-contract model, was considered. The most difficult questions in such circumstances would be the choice of provider with which to place the main contract. It was felt that this could be a threatening process to small units and also that much of the discussion would centre around who held the contract, rather than the detailed specification or measurement of outcomes.

## 6.4 ADVISING PURCHASERS

6.4.1 Commissioning (and indeed providing) has to be child-focused, was the starting point for this group. In order to secure this scenario, clear direction from the Department of Health was needed. The group returned to a theme that had featured already in the discussions: is guidance really effective in securing minimum standards of service or is mandatory determination required? This group believe the time had come for mandatory changes thus:

- For strategic commissioning of child health services, and
- For each Health Authority to appoint a lead commissioner to oversee the commissioning of all health care (including mental health) for children and young people

6.4.2 The lead commissioner would be the key individual in ensuring that child health strategies were implemented. S/he would need a significant level of knowledge and expertise to ensure that the purchasing process encouraged the provision of high quality services for children. The lead commissioner would also need to be the budget holder for child health services within the Health Authority and would need a degree of influence over GP fundholders.

6.4.3 It was felt that regular meetings between the lead commissioner, fundholders, and the local Children's Services Directorate(s) would enable dialogue to develop, out of which a partnership between purchasers and providers would ensue.

6.4.4 To develop the child health strategy, a Health Authority-wide children's strategy committee was suggested. Someone reminded the group that it is sometimes difficult to "be strategic" when your contracting discussions begin with: "there has to be a 2% cut".

## 6.5 IS THERE A ROLE FOR PRIMARY CARE WITHIN THE INTEGRATED CHILD HEALTH SERVICE?

6.5.1 The discussion here centred around the importance of primary care, but concluded that there were a number of inherent features which need to change

before primary care could properly form part of an integrated children's service. In particular it was felt that the emphasis needed to move away from general practice to the broader concept of primary care and specialist practice in a primary care setting.

6.5.2 Primary care needs to cater for a very broad spectrum of children in the community ranging from the health to those needing emergency treatment; from children with occasional everyday ailments to those with continuing illness requiring long term care and to vulnerable children who might also be ill or disabled, perhaps with complex health care needs. In other words there are ideally differing needs to be met of fairly large groupings of children including the well child and the healthy environment. However in this group's view, GPs did not generally see children as in need of specialist care, partly because of the way that they are trained (GPs are not seeking paediatric experience) and partly because of isolation from areas of expertise and knowledge elsewhere in the healthcare system and often also within the primary care team.

6.5.3 Health visiting was discussed in the context of a primary care involvement in an integrated service. the bulk of their work is child related and it was felt that the increasing concentration and specialisation of health visiting on specific care areas including children, rather than a more general population approach would be essential in the future. Beyond this was the proposal for specialist nurse practitioners (community paediatric nurses and nurse practitioners who would support and enable GPs to expand their responsibilities to the children in their care.

6.5.4 The group made reference to the Court Report and the notion of a primary care paediatrician. It was felt that primary health teams often had a sketchy knowledge of paediatrics and that the development of primary care paediatrics was inevitable and essential. It was acknowledged that this was difficult to envisage under the present practice arrangements where that development of a degree of expertise could take away from, and be seen to diminish, the work of other practitioners. However, it was also acknowledged that general practice in this present form was unlikely to survive. Already the NHS reforms were leading to larger GP groupings, multi-funds and total purchasing groups and the remuneration system was under review in a way which was likely to promote an increasing range of services being provided in a primary care setting. Thus it was envisaged by the group that general practice would have increasing specialisation with affiliations and groupings working in improved community facilities, polyclinics, and other settings.

6.5.5 It was suggested that junior doctor training should include paediatrics and that emphasis should be given to continuing education to skill or reskill practitioners. The notion of care paediatric training to define the quality of general practice as a gatekeeper was regarded as an attractive proposition. It was also felt that there was a good deal that specialist children's services could do to support and develop primary care including:

- The use of rapid access clinics to create an important safety net where a GP faced with a problem wanted an opinion quickly, but did not necessarily want to admit.
- Involving GPs in the work of the hospitals through clinics etc. Encouraging them, to take a wider view and exposing them to the work of their agencies and specialists in developing a holistic approach.
- Providing support and back up systems in poor deprived areas by plugging the gaps in primary care with the expertise of health visitors and specialist nurses and back up from a specialist team.
- Working out the perversities of the contracting and activity performance measures of the current system which militate against specialist staff and expertise supporting and developing primary care practitioners.

6.5.6 Generally it was felt that the aim should be to encourage flexibility and achieve higher quality child health and awareness at primary care level. If necessary, it was felt this might be achieved through some form of accreditation process linked to training, standards, and clinical practice. This group acknowledged, as did other participants, that it would have welcomed GP involvement in the discussion.

## 7 WHAT WOULD YOU SAY TO STEPHEN DORRELL?

7.1 At this stage in the proceedings participants were invited to imagine they had an opportunity to shape Department of Health policy directly and they were asked in small groups to settle on a number of key messages which they believed the Health Select Committee and the Department of Health needed to address. These were the main points :

i) There needs to be a children's focus to commissioning healthcare, from the Department of Health down to local operational level.

ii) Every DHA should be required to appoint a children's services commissioner, who would be given authority to set the child health specification, and the budget to make this happen. The individual would need to have appropriate levels of knowledge and expertise, and would have to be accountable to the Chief Executive.

iii) Every Health Authority should be required to produce a plan for child health services.

iv) An appropriate contract currency needs to be found for specialist services, which should also encourage providers to keep children out of hospital.

v) Health Authorities need to develop their own knowledge of child health services. This will be best achieved through the development of mature relationships with providers.

vi) Policies need to be introduced which encourage paediatric expertise at the primary care level.

vii) Paediatrics should be a core component of primary care training, with continuing education.

viii) There is a shortage of paediatric skills in all areas. there has been a pleasing increase of children's nurses since project 2000. Recruitment and retention of all types of staff in child health is difficult and measures need to be taken to address this. There is an overwhelming shortage of doctors and therapists.

ix) Outcome measures, against which quality in children's services could be monitored, should be developed.

x) The "knee-jerk" response to critical incidents should be abandoned: long term plans should instead be developed to secure the health of children .

xi) Central initiatives are needed to enable integration : guidelines tend to be ignored, as witnessed by the disparity in standards around the country ; therefore it needs to be mandatory for Health Authorities and providers to make progress on this issue.

xii) Children are different: they require a holistic approach to care, and this in turn requires a unitary planning and provider structure.

## 8 FACTOR X : WHAT MAKES FOR EFFECTIVE INTEGRATION?

8.1 At the very beginning of the seminar Barrie Dowdeswell asked the question - Is there a "Factor X", an ingredient common to all successfully integrated child health services? Reflecting on the content of the day, participants identified the following possible candidates for “Factor X”:

- Personal commitment to integration is what makes it work: mandatory guidance comes later

- A "passion for paediatrics" is an absolute requirement

- Risk takers are successful: the Department of Health needs to recognise this

- A common goal and a common voice for children are important. A successfully integrated service will be child and family focused.

8.2 Above all, however, it was clear that successful integration had been driven by "the people who know the business", and at this time those people reside in provider organisations. There was a strong view that purchasers should be partners in securing integrated child health but at the moment they do not have the knowledge base to participate.

APPENDIX 1

## Seminar on Integrated Approaches to Child Health

## King's Fund Management College with Royal Victoria Infirmary, Newcastle

## Friday, 30 August 1996

**The purpose of this seminar is to:**

- Develop our thinking in order to put in a submission to the Select Committee
- Provide opportunities for us all to learn different approaches to integrating services for paediatrics
- explore our priorities for developments across our whole services.

### Roles

There are the following roles on the day:

- **The Select Committee** - will either be themselves if they can make it, or Sue Burr from the RCN will play into the role and 'rove' around the groups commenting.

- **The Trusts** will present their work as the 'backbone' of the day. They will be the group who instigate the dialogue. Each Trust will bring an Executive officer, a paediatrician, a nurse and a GP (if possible).

- **The Experts** will listen and also present their own view on the present and future, contributing to the dialogue. Our experts are Ian Smith (the Nuffield Institute for Health), Roddy MacFaul (Consultant Paediatrician and Vice President of the Paediatric Association) Anne Rivett - Director, Action for Sick Children, London and Claire Blackman - Senior Manager, Audit Commission.

- **The Observers** are there to also contribute to the dialogue but from the perspective of the generalist with competing priorities and demands for attention. These observers are drawn from the King's Fund Purchasing Dilemmas Network and from within the Fund itself (including in the afternoon Robert Maxwell).

- **The Royal Victoria Infirmary staff** will be acting as scribes for the day, as well as hosts and participants.

- **The King's Fund facilitators** are Becky Malby and Gina Shakespeare, who designed the process and will make the day flow.

## PROGRAMME

| | |
|---|---|
| 0930 | **Coffee on Arrival** |
| 1000 - 1010 | **Introduction** - Barrie Dowdeswell, Chief Executive, Royal Victoria Infirmary |
| 1010 - 1030 | **Why am I here?** - King's Fund |
| 1030 - 1200 | **Presentations and questioning** - Invited Trusts to make their brief presentations and take questions of clarification from the observers and experts. |
| 1200 - 1300 | **Lunch** |
| 1300 - 1315 | **Mapping the Picture** - working together on the issues that have come up from the morning which will have been pulled together by the King's Fund facilitators over Lunch |
| 1315 - 1400 | **Experts and Observers Dialogue** - the Experts and Observers contribute their views and observations and add to the 'map'. |
| 1400 - 1500 | **What helps us and what hinders us** - mixed groups to take themes and work through their implications. |
| 1500 - 1515 | **Tea** |
| 1515 - 1545 | **What would you say to Stephen Dorrell?** Thinking about what would be an important contribution to policy makers understanding and policy making. |
| 1545 -1600 | **Final Comments** |

APPENDIX 2

## SEMINAR: INTEGRATED APPROACHES TO CHILD HEALTH CARE

FRIDAY, 30 AUGUST 1996

ROOMS: 5, 6 7 & 8

## LIST OF PARTICIPANTS

### SELECT COMMITTEE

Mr Tom Healey, Clerk to the Health Committee

### EXPERTS

Claire Blackman, Audit Commission

Sue Burr, Royal College of Nursing

Anne Rivett, Action for Sick Children

Iain Smith, Nuffield Institute for Health

### OBSERVERS

Dr Carol Beattie, Consultant in Public Health Medicine, Eastern Health and Social Services Board

Sean Boyle, London Commission, King's Fund (afternoon only)

Melvin Ellis, Chief Executive, Herefordshire Health Authority

Philip Hewitson, NHS Executive

Eric McCulloch, Chief Executive, Eastern Multifund Belfast

Robert Maxwell, Chief Executive, King's Fund (afternoon only)

Terry Mullins, European Philanthropy Committee, Johnson & Johnson

## TRUSTS

**Newcastle City Health NHS Trust**

Jeff Dean

**Northampton General Hospital**

Dr Nick Griffin

Mrs Vee Hales

Mr Philip Webster

**Loddon NHS Trust**

Mrs Fiona Corkhill

Mrs Alison Day

Mrs Helen Mehaffey

Dr Andrew Mitchell

**Hinchingbrooke Trust**

Mrs Janet Dullaghan

Mr Stephen Hunt

Dr Angela Owen-Smith

## ROYAL VICTORIA INFIRMARY, NEWCASTLE

Nigel Coomber

Rachel Coyne

Barrie Dowdeswell

Martin Ward-Platt

## KING'S FUND COLLEGE

Becky Malby

Gina Shakespeare

## TRUST PRESENTATIONS

### NEWCASTLE, ROYAL VICTORIA INFIRMARY AND CITY HEALTH TRUST

Newcastle does not have an integrated child health service at present. The idea to have one has emerged from a number of discussions involving clinicians from across Tyneside and the options put forward had included a separate Children's Trust; and integrating all the children's services within one of the existing Trusts. Neither of these options was accepted, largely for political reasons. Thus a service which had always tried to work in an integrated way found itself, after a total re-organisation of all health services in the city, split up in two large Trusts, one acute (the RVI), and one Community/Mental Health (Newcastle City Health Trust).

The compromise which emerged to fill the vacuum left by the re-organisation of the city's health services, is the Newcastle Child Health Board. Establishing the Board took a long time. It was a year from conception to actually meeting. The aim of this board is to encourage the partner Trusts to find ways of integrating clinical services for the benefit of children in Newcastle. Both Trusts also serve the population of Northumberland and other districts within the north of England, providing specialised regional services, as well as local DGH/Community services.

The structure of child health services in Newcastle ( shown in Figure x) allows for separate contracts to be held between the Health Authority and the partner Trusts, while the Child Health Board's role in relation to the Health Authority is primarily to produce the specification which informs those contracts. Other bodies (Local Authority, Community Health Council, etc) are represented on the joint Advisory Group, which also has a relationship with the Child Health Board, albeit a quite limited one.

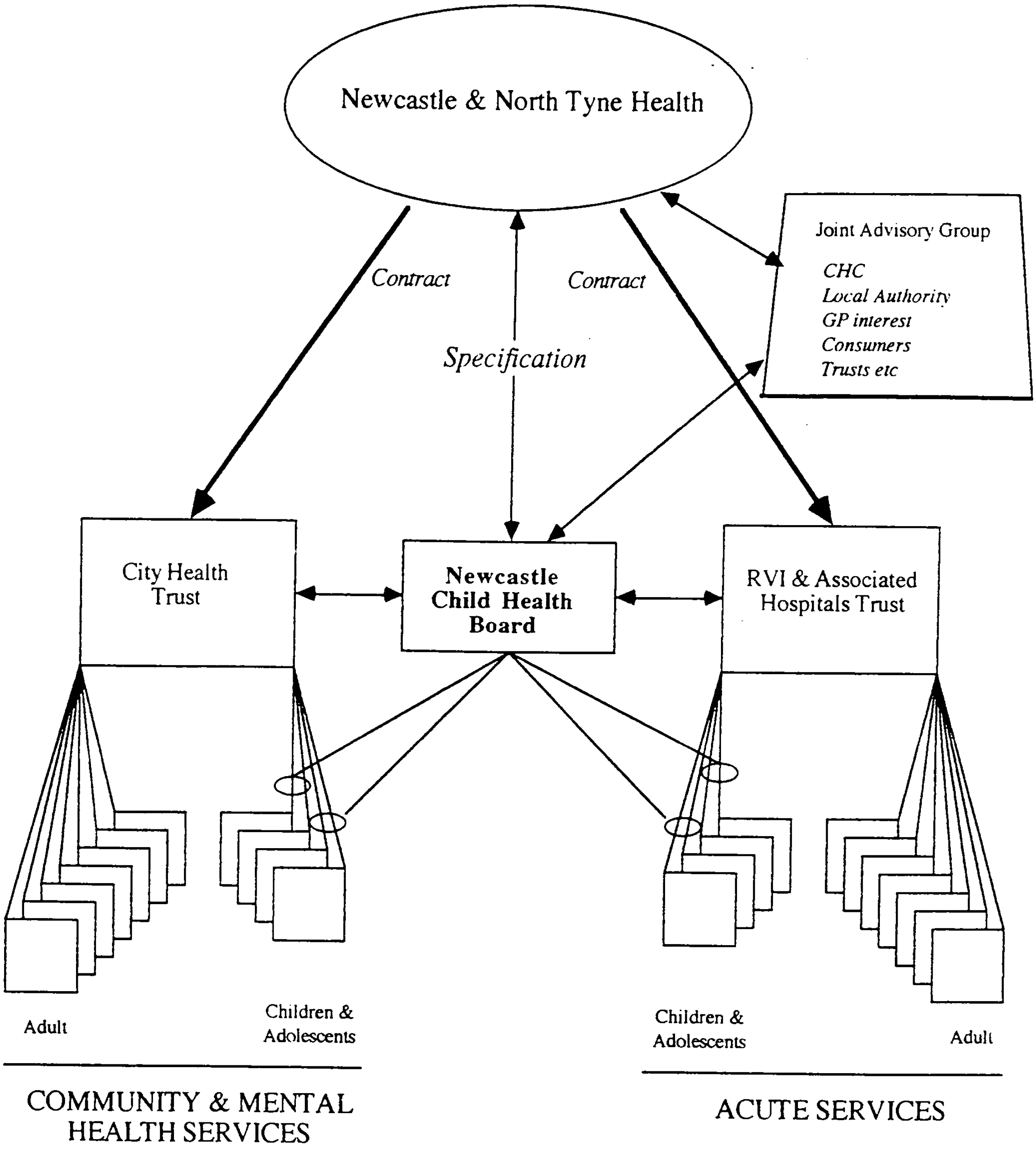
**Please see attached Figure One.**

The status of the Board is that it makes recommendations to the Trusts for the implementation of integrated child health strategies. As such, its membership includes the chief executive, two senior doctors, a senior nurse and a senior manager from each Trust, in addition to a public health doctor nominated by the Health Authority, a general practitioner and the professor of child health.

The purpose of the Board can be described thus:

- Integrate the activities of Newcastle City Health Trust and the RVI (consideration of the paediatric activities at the Freeman Hospital is not included at this stage)
- Ensure that the Child Health Specification is fulfilled by the Partner Trusts.
- Provide authoritative professional advice and strategic vision for the Partner Trusts.
- Refine the Child Health Service Specification, together with Newcastle and North Tyne Health.

FIGURE 1


Newcastle & North Tyne Health
Contract
Specification
Contract
Joint Advisory Group
CHC
Local Authority
GP interest
Consumers
Trusts etc
City Health Trust
Newcastle Child Health Board
RVI & Associated Hospitals Trust
Adult
Children & Adolescents
Children & Adolescents
Adult
COMMUNITY & MENTAL HEALTH SERVICES
ACUTE SERVICES

Its roles are as follows:

- To make recommendations to the Partner Trusts regarding the allocation and deployment of resources to meet the Child Health Specification.
- To identify better ways of delivering the services managed by the Partner Trusts.
- To make recommendations regarding the development of support systems (e.g. information systems).
- To establish sub-groups to consider specific issues.
- To propose and prioritise new service developments.

Getting the status and purpose right was the key to getting the Trusts to accept the Board. Previously they had feared that it might usurp their own authority.

The Board had already achieved a lot in terms of creating a partnership between the 2 Trusts, but further development was required. The benefits of the Board in its present configuration were that:

a) It preserved the tertiary/secondary integration that was already evident within one of the Trusts.

b) It secured the income for the Community element of child health services from any encroachment by the acute Trust.

c) It provided a strategic focus away from any of the operational management issues which either Trust might encounter.

However, it was quite clear that the Board had not actually integrated child health services in Newcastle, that it did not have any executive authority and that it only really addressed selected issues. It had already dealt with the health aspects of child protection, in that a proposal had now been made to integrate Child Protection Services. It was also tackling such issues as ambulatory child health care, respite facilities and children's services plans.

a) The next stage of development of the Board would probably look like this:

b) Its influence would be broadened to include other providers and Health Authorities north of the Tyne.

c) It would establish success criteria, against which to measure future projects.

d) Development of a long term plan for children's services, contrasting with the short termism of the Health Authority.

e) Strengthening the mandate from each of the Partner Trust Boards.

f) Separating the strategic from the operational roles of the Board.

The issue of the purchasers lack of vision was particularly highlighted, and was echoed by other Trusts present. There is no clear purchaser vision for children in Newcastle, and their focus is very much driven by the short term agenda, rather than long term requirements.

## NORTHAMPTON GENERAL HOSPITAL NHS TRUST

Northampton General Hospital serves a total population of around 300,000, in a semi-rural area. In 1992, the integrated Child Health Directorate was formed. It was notable that this has happened before the Trust had been created, and the view of the Northampton Child Health team, was that it would have been very difficult to integrate the services after the creation of Trusts. Indeed, one of the main factors which delayed the setting up of the Trust, was the fact that an integrated child health structure had not yet been established.

The outcome of the integration process was necessarily a compromise. There was now a unified budget and structure for child health, which is accountable to the Trust Board of the acute unit. This included the following services:

- Paediatric Outpatients & Inpatients
- Neonatal Unit
- Community Paediatric Nursing
- Child Development Centre
- School Nurse/Health Visitor Liaison
- School Nursing
- Child & Family Consultation Service
- Child Clinical Psychology
- Management and Administration
- Learning Disability

However, the following services remain outside the integrated Directorate:

a) **Surgical Specialities:** the size of the Trust does not justify paediatric specialists in many of the surgical disciplines, and therefore although the children may be admitted to the paediatric ward, in all other respects these lie within the adult surgical directorate.

b) **Adolescents:** the definition of adolescents had caused a problem, and it had not been possible to include them.

c) **Accident and Emergency:** again the numbers of children requiring emergency care were not sufficient to justify a separate department, and therefore a separate area within the main Accident & Emergency Department had been provided, but it was not managed by the Children's Directorate.

d) **Health visiting:** the integrated Directorate had a Health Visitor liaison, but otherwise health visiting had opted to stay within the Community Trust.

e) **Learning Disability Team:** this caused real problems as the team lack any kind of children's focus, and therefore would have difficulties in terms of liaison with education, for example, however specific expertise is sometimes requested.

f) **PAMS:** with the exception of Physiotherapy, these departments felt that they were already small enough and would not benefit from further fragmentation.

The problems associated with the Directorate included: increased management time required of clinicians of all disciplines; the acute shortage of specialist staff; and pressures on junior medical staffing, including the new deal and the speciality registrar programme.

Purchasers also faced problems, particularly in relation to quality standards. There are in existence a lot of quality standards, enshrined in government guidance, and other influential national reports. What actually matters, however, is providing a good quality service to the children who require it, and purchasers do not have the knowledge to be able to quantify these standards, it was suggested.

It was also clear to the team that purchasers, even if they can set quality standards, find it difficult to monitor them, and do not know where to seek specialist advice, as centrally (D.o.H.) produced documents lack a children's focus. Indeed, it was noted that if the Department of Health were really serious about integrating child health services, then they themselves must integrate child health planning, and not undertake this in separate departments.

Contract design was also highlighted as being crucially important. It needed to reflect the clinical services provided. This included all activity, not just finished consultant episodes. Such contracts have not been achieved as yet.

In summary, Northampton felt that the benefit of an integrated Child Health Directorate had been huge, although there were problems. They echoed the Newcastle experience of an absence of purchaser initiatives in terms of child health provision. Nevertheless, the Trust had been able to make some of its own decisions about such issues, for example taking money away from acute wards and putting this into community nursing.

## LODDON NHS TRUST, BASINGSTOKE

Loddon NHS Trust is a Community Trust which serves a population of 250,000, including 60,000 children, in a mixed urban/rural area. The Trust's Child Health Directorate is based on the top floor of the North Hampshire Hospital, Basingstoke. The Trust is responsible for the provision of a full range of children's services both in the hospital and the community. Integration was achieved by the assimilation of all children's services within a priority services unit prior to the establishment of the two Trusts in Basingstoke, and like Northampton they are not sure that integration could have been achieved after the establishment of the two Trusts.

The story of a 10 year old girl, with a learning disability and behavioural problems, was chosen to highlight the way in which child health services are integrated in Basingstoke. This particular child is from a middle class family, who are well aware of all of the relevant guidance, charters, and other information available about their daughter's health care requirements.

This child receives input from a full range of staff including a consultant paediatrician, a community nurse (the community paediatric nursing service in Basingstoke is available 7 days a week, 24 hours a day), a physiotherapist and occupational therapist (both of whom the child has access to in school, at home, and in the hospital), a psychologist, and respite care. All of these individuals/services are available as part of the "core team" within the Directorate.

Two years ago the parents moved their daughter to a different school which fell outside of the Loddon Trust's normal boundary and this involved number of Loddon Trust staff training those who provided the service in the new school.

The "core team" also have very strong links to a number of other agencies: the GP, who in this case is very involved in the child's care ; Social Services; and the school nurse. Problems are, however, encountered with mobility aids, because the family often look to other providers outside the Trust (they have the money and ability to do so), and this sometimes conflicts with the advice available from within the Trust. There have also been issues about the co-ordination of therapy care and appliance provision between home and school which require staff to take a flexible view of the 'boundary'.

An important individual in providing this integration to the child's health care, is the "key worker". For this girl, the key worker is a community paediatric nurse, and this particular role has been essential in this case.

For example, a planning meeting was recently held in order to discuss the girl's imminent elective orthopaedic operation. A total of 28 professionals attended the meeting, and they all needed to be there - no one was superfluous. Fortunately, the fact that all of the child health services are based geographically in one place, makes liaison of this kind far easier.

The case raised a number of issues which are pertinent when considering integrating child health services:

a) **Parental choice:** this was exercised when the child was sent to a different school. It clearly caused a number of difficulties.

b) **Inter-Agency communication:** there are quite clearly opportunities for one organisation to be played off against another, by the parents.

c) **Resources:** not all of the options for the care of this girl were matched by funding.

d) **Cross-boundary care:** this occurred both within and out side the Trust.

The benefits of integration were equally clear:

a) **Effective and efficient team communication:** this is much easier where services are integrated and there are also benefits in improved communication with parents and also GPs.

b) **Named Key Worker:** one person to take an overview of the child's care.

c) **Access to specialist services:** as and when required.

d) **Care follows the child:** and not the opposite, where the child would move around the system.

# HINCHINGBROOKE HEALTHCARE NHS TRUST, HUNTINGDON

Hinchingbrooke Healthcare NHS Trust serves a population of 150,000 (30,000 children), and has an income for children's services of £4 million. Its integrated Children's Services Directorate was formed in 1993, when the district's single combined Trust was formed.

Hinchingbrooke have identified certain key processes of integration, including the following:

- Setting clear targets
- Getting the structure right - this included the meeting structure as well as the management structure
- Building a team
- Discovery tours - this included staff taking on a clinical role in another service area, as well as clearly seeing how another area worked
- Tight financial management
- Working together on the same tasks - for example business plan

It was also necessary to set clear objectives of the integration process. In Huntingdon these included:

- Bringing together services for children under one management division of the Trust

- Producing tangible clinical benefits over and above the status quo

- Ensuring that Community-based services were enhanced by the process, not asset stripped

- Ensuring that the views and wishes of the parents and children were considered as part of the process

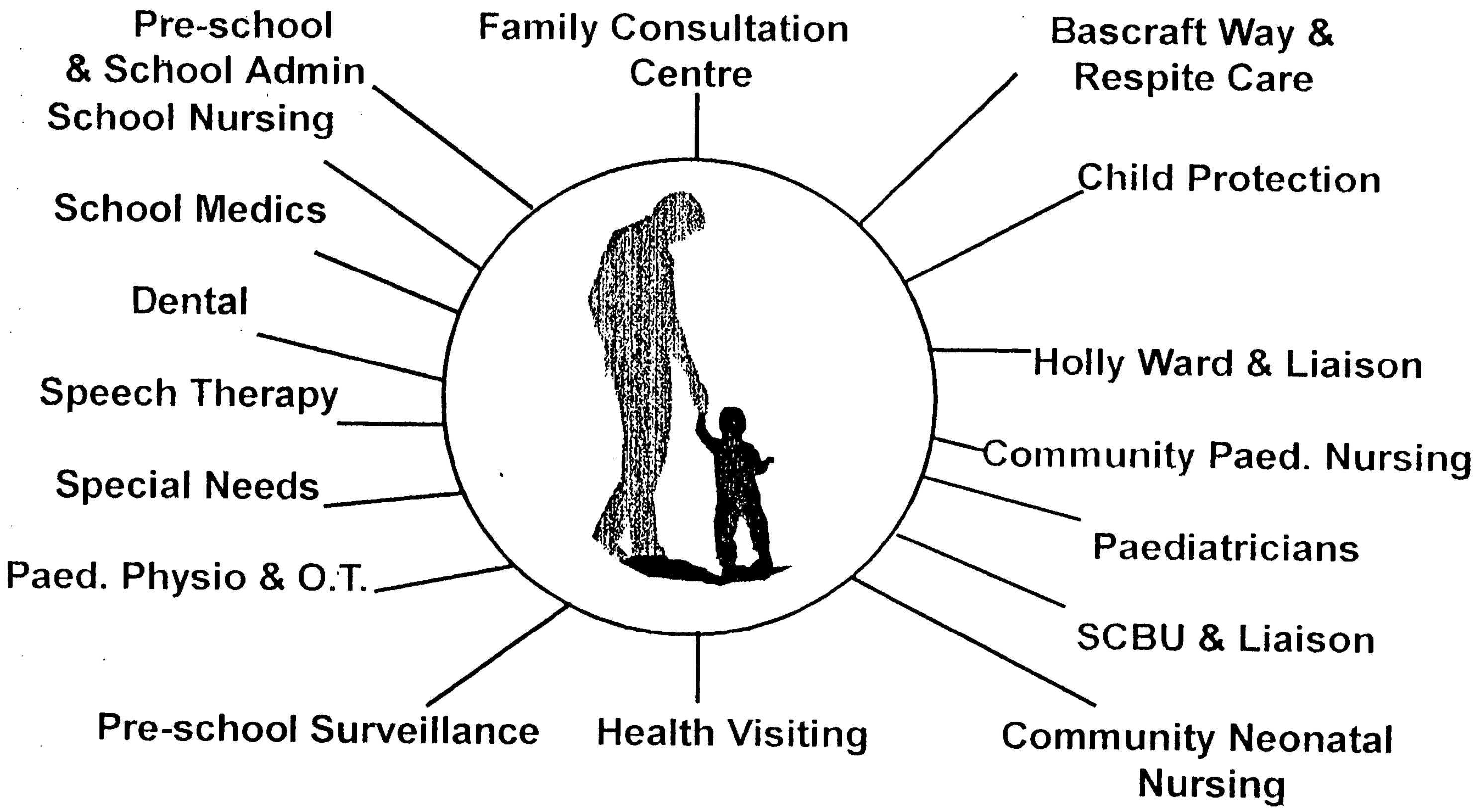
Having integrated the service and set objectives for the process, objectives were also set for the services themselves. Most important amongst these, was the aim of delivering health care "with minimal disruption to normal development, education, family and social life".

The precise way that the integrated children's services worked in Huntingdon is diagrammatically shown in Figure 2. From the Trust's point of view, this diagram is very similar to a combination lock where it is the outer circle of services which rotates around the child and family in order to fulfil their needs, rather than the family moving around the services.

**Please see attached Figure Two**

HINCHINGBROOKE health care

# Integrated Childrens Services.



Pre-school & School Admin

School Nursing

School Medics

Dental

Speech Therapy

Special Needs

Paed. Physio & O.T.

Pre-school Surveillance

Family Consultation Centre

Health Visiting

Bascraft Way & Respite Care

Child Protection

Holly Ward & Liaison

Community Paed. Nursing

Paediatricians

SCBU & Liaison

Community Neonatal Nursing

FIGURE 2

Initially there was considerable debate about where the boundaries lay between services within the directorate. One example was of health visiting, which originally formed part of the community services directorate, but after 14 months moved into the children's services team.

The way in which the directorate was structured seemed to be important, not only in terms of organisation, but in terms of staff morale and working relationships. The structure is extremely flat. Within the Hinchingbrooke model, all heads of service were fully involved in the management process, and there were clear links and lines of accountability between the actual deliverers of the service and the Trust board. These lines of accountability worked in both directions. Such a structure led to better communication, and a sense of identity.

Benefits of the integrated approach have been identified to both clients and staff. For clients, these included:

a) greater continuity of care between home, school and health care workers;

b) the fact that one service could inform clients about another, with some degree of accuracy;

c) That there was a greater continuity of faces for the client to deal with;

d) The service was more sensitive to clients' needs.

For staff, GPs and the Trust, the benefits include the following:

a) Being part of a respected and successful team.

b) Breaking down barriers, and reducing professional jealousies.

c) Seeing things more clearly from a client perspective.

d) Improved communication with the primary health care team.

e) Providing a single voice for children and their health care.

f) Protecting more vulnerable services (notably Community services).

g) Helping purchasers define good quality health care.

The key messages of the Hinchingbrooke experience were:

a) That children should be a priority and that they are unique in terms of their health care needs. They are not small adults.

b) The full range of children's services must always be considered.

c) Children's services should be resourced correctly. This was especially true following clear policy guidance from the centre (the example of the Clothier Report was presented, where two RSCNs are now required on each ward at all times, but when no additional funding was identified).

d) There are currently contractual disincentives for integrating children's health care. This included the cost of keeping children out of hospital.

e) Territoriality should be reduced.

f) Joint commissioning, between Health and Social Services for example, is important.

g) Children and their parents/carers should be listened to, and their views must be acted upon.

h) Good quality care must be defined, and measures of this fully agreed.

**Summary of Evaluations**

The feedback from the participants after the event was:

*What would you have like more of in the day?*

Three thought that the day would have benefited from a large Integrated Child Heath service (There were some invited but they chose not to attend).
Two of the group would have liked slightly more time to discuss practical implications for service delivery, although one recognised that this probably meant we would have needed another day.
One of the group thought the day would have benefited from inclusion of social service and other agencies.

*What would you have liked less of in the day?*

90% said "nothing". One comment was that they would have liked less round the table brainstorming. Another found the workshops difficult, but commented that it still worked well.

*What did you find particularly useful?*

Sharing approaches, experiences
Small group discussions
The mixture of disciplines
"An excellent day - well organised and stimulating"
"The format for the day and the skills used in managing it."

*What will you be doing next as a result of the day?*

1. Delivery of a paper on integrated services a the NAHAT conference where I hope to incorporate some of the issues highlighted.
2. Review outcomes in small groups and present proposals for development to the health board.
3. Try and enlarge our approach including health visitors and PAMs
4. Arranging local multidisciplinary meeting with a panel including education / health and primary care to discus issues
5. Have shared the experience with GP colleagues
6. Discussions continue with a large Regional provider on better integration and the day provided a further impetus for this.
7. Try to negotiate integrated child health contract through lead provider concept.
8. Engage with Barry Dowdeswell who is chairing the Action for Sick Children Conference on 4th October - to take forward the sentiments contained in the statements at the end of the day.

# A CHILDREN'S CONTRACT:
## A novel solution to the purchasing of children's services.

## 1.0 PRINCIPLES

1.1. Needs Based: Places the needs of children at the centre of the contracting process

1.2. Organisations suit patients: Ensures that services are configured to the needs of children and their parents and not to the staff of the organisation.

1.3. Effective professional advice: Confirms that local clinical expertise is utilised effectively in configuring local services.

1.4. Equitable resource allocation: By allocating local resource decisions to local providers ensures that local equity is maintained.

1.5. Enhances professional and children's autonomy: Encourages local clinical providers to "own" local services.

## 2.0 DESCRIPTION

The key management style is neither an abdication of contractual and financial responsibility for small separately negotiated contracts, nor is it a block contract and a "provider issue". The approach is that of the **enhanced preferred provider**. Enhanced by using clinical expertise (not readily possessed by purchaser) to manage issues which require a patient centred approach e.g. ECRs.

The process involved is:

2.1. Local purchaser confirms the range of services within a local contract with key provider(s).

2.2 Using local needs analysis the purchaser confirms the health care needs of local children. This is a "rapid and robust" analysis linked to annual public health report, regional/national guidelines and local knowledge. This includes consultation with the LMC, CHCs, ASC, local charitable groups and older children.

2.3 By using an approach which requires open, realistic and sensible discussions with the key provider(s) agree the content, volume of work, access, quality standards (kept simple and relevant), developments and financial planning and control. Review the contract with the preferred provider at, say, 6 monthly intervals.

2.4 If there is more than one preferred provider, use a bidding system for the contract.

## 3.0 KEY ADVANTAGES

3.1 Keeps the purchaser on the high moral ground - child centred approach, not organisationally based.

3.2 Encourages all professionals to work closely together e.g. GPs and paediatricians.

3.3 Allows clinicians to develop innovative packages of care with local internal funding - encourages disinvestment strategies which are locally desired.

3.4 A single contract has only a single set of management overheads. This encourages an effective use of scarce resources (high moral ground). A single management structure allows for clarity of communication.

3.5 Shift operational issues away from strategic organisation e.g. ECRs and child protection discretionary funding.

3.6 Encourages effective clinical audit across organisational boundaries e.g. child health surveillance in primary care.

3.7 Enhances professional commitment to quality services - ownership.

3.8 Encourages the development of a truly integrated child health service i.e. client led across organisations not confined by organisations. The analogy is the airline and the airport, where the children's contract is the airline using a variety of airports (NHS organisations) to develop an integrated service.

## 4.0 RESOURCE IMPLICATIONS

4.1 Child centred financial resources require identification and quantification from both the purchaser and all providers. This will give a split of costs and, therefore, the total contract price.

4.2 Areas for cost improvement e.g areas of unnecessary duplication, can be identified, agreed and used for innovations (disinvestment leading to reinvestment).

4.3 It will allow staff recruitment, development etc to be agreed (talented staff recruitment and retention are a key purchaser issue).

4.4 Once agreed, the contract can be monitored at appropriate intervals and at year end. This will free the small strategic purchaser to do more important things. This devolved management style is now used by a number of large organisations such as RTZ and Shell. They operate a hub and satellite system of small business units with the small strategic headquarters being the hub.

## 5.0 POTENTIAL DEVELOPMENTS

5.1 Purchasers could look to preferred provider to produce, for example:

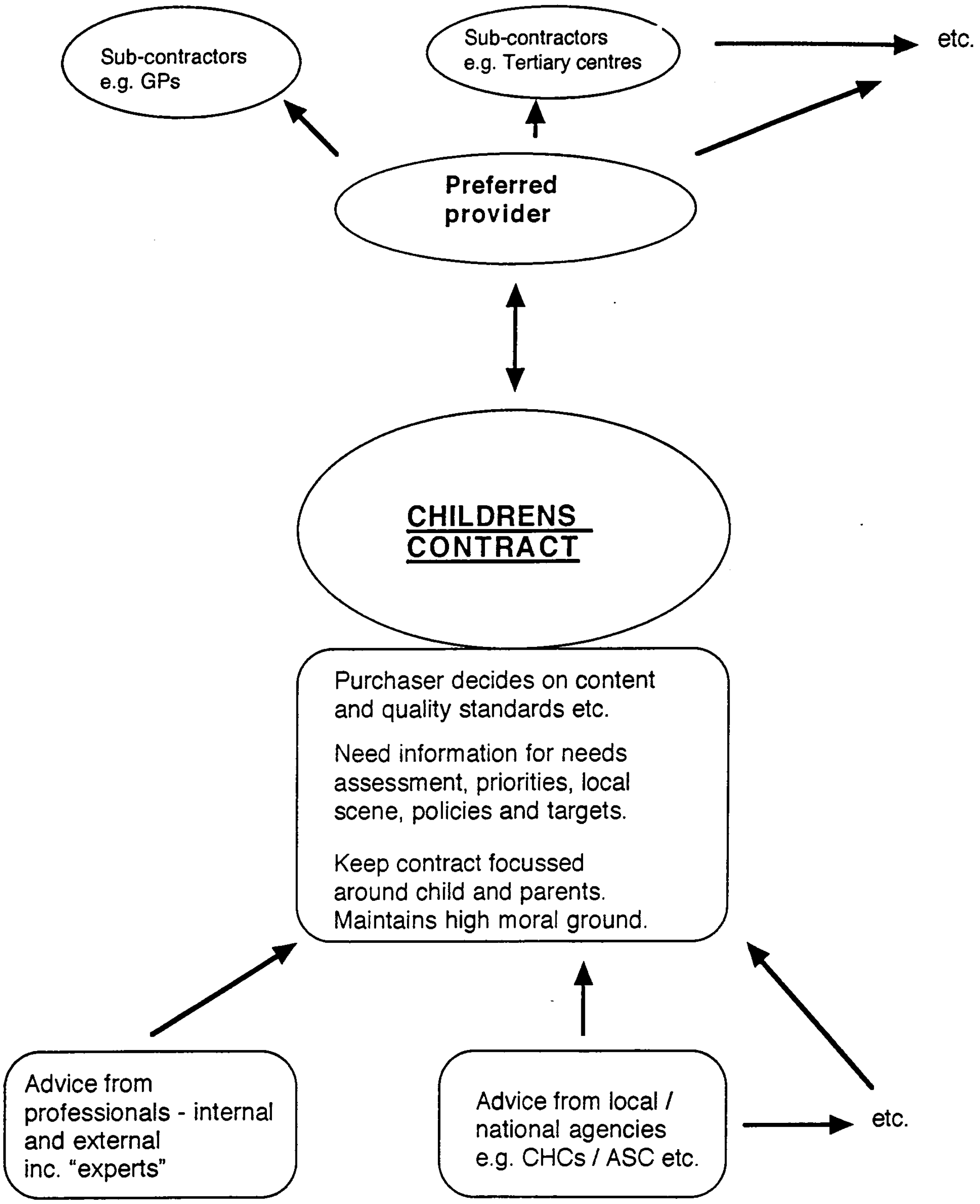
Hospital at home service
Nurse skill-mixes on wards
All children on childrens wards
Enhanced information systems e.g. linking the child health computer and the FHSA computer
Complete introduction of parent held records

5.2 Additional "imposed" improvements might include:

Reduction in inappropriateness of admissions
Reduction in inappropriate ECRs
Reduction in management costs as a consequence of ownership.

Iain Smith
Nick Nicholson
September 1996

**Figure 1: Processes involved in developing and setting the Children's Contract**



Purchaser decides on content and quality standards etc.

Need information for needs assessment, priorities, local scene, policies and targets.

Keep contract focussed around child and parents. Maintains high moral ground.

Advice from professionals - internal and external inc. "experts"

Advice from local / national agencies e.g. CHCs / ASC etc.

Figure 2: Content of children's contract