The Scottish Government
Riaghaltas na h-Alba

Dr Zoe Dunhill

Developing a Community Child Health Service for the 21st Century

A Report for the Children and Young People's Health Support Group

Acknowledgements

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Abstract

Keywords: Community child health; vulnerable children; sustainability

Concerns have been expressed about the future of the Community Child Health Service in Scotland but little has been known about the state of the service and how the NHSiS should respond to raised public expectations, changes in morbidity and workforce challenges. The project has charted the current service and reviewed future options and suitable outcome measures by which the service can be evaluated and improved. Recommendations have been made to enable the necessary changes.

The CCH service focuses on children in their own communities and especially on children who are vulnerable by virtue of disability, chronic illness or disadvantage. Threats to the service will compromise the identification and care of these children.

A review of current models and what works, a survey of Health Boards and analysis of workforce issues has revealed an urgent need to adopt a strategic redesign of the service to ensure sustainability and best care for children. Suggested solutions include actions by NES, clinical redesign and establishing regional speciality networks.

Key findings are:

- The majority model for paediatrics in Scotland is of a combined service, with acute and community paediatrics co-managed as a single service. This is the preferred model.
- There are currently 2.8WTE trained CCH doctors per 100,000 population in Scotland (2.4WTE in England).
- 77% of the current CCH workforce are SASG doctors and 72% of these doctors are over 50 years of age. There is a 10% vacancy rate amongst these posts.
- There is no workforce plan to replace these doctors or their work.
- There has been a 16% fall in the number of consultant paediatricians working in the community since 2007 with a 6% vacancy rate whilst there has been a 47% increase in specialist paediatricians in the acute sector over this period.
- Adopting a generic model of paediatrician in DGH settings, ie working across the acute/community interface, should help the challenges in CCH and covering acute services.
- In some areas of Scotland children have to wait more than 6 months for an appointment with a community paediatrician.

- In nearly half of Scotland's health board areas, failure to attend CCH clinics (DNA rate) is either not known or greater than 26% (HEAT Target 2010 9.3% for first appointment).
- In two large health board areas the 18-week referral to treatment guarantee is not applied to CCH clinic attendances.

Executive summary

In 2009 the expert Ministerial advisory group, the Children and Young People's Health Support Group, commissioned a piece of work to look at the provision of Community Child Health (CCH) services in Scotland to ensure such services are sustainable and fit for purpose. The emphasis of the project has been on paediatricians working in the community and the teams they are associated with in delivering care. Co-dependencies with other professions including nurses and allied health professionals have been examined.

Across the UK, and in similar health systems, it is generally agreed that the main focus of this service should be the care and support of vulnerable children and young people and children with developmental disorders and chronic illness in the community and as close to home as possible. It is anticipated that in the future, services will be delivered by consultants leading a team of trained doctors working in multi-disciplinary and skill-mixed teams.

The CCH21 Health Board survey (November 2010) has shown that a combined model of care (acute and community services delivered by a co-managed clinical team) has been adopted in 73% of mainland health boards with strong links to Child and Adolescent Mental Health Services (currently co-managed in 55% health boards in Scotland) and to local authority and third sector providers.

A robust community child health service is essential to meet the needs of our children, but there are a number of challenges facing Health Boards in delivering the service.

Pressures in delivering acute paediatric care relating to changes in the way junior doctors are trained and the application of European Working Time Regulations have required an increase in numbers of trained doctors to provide 24/7 cover in hospital. This increase has sometimes been at the expense of Community Child Health. Vacancy rates for Community Child Health medical staff are rising and unfortunately few paediatric trainees (circa 11%) seem to be attracted to the speciality. The prospect of Child Protection clinical duties also has limited support amongst trainees.

New models of care are developing involving greater skill mix with multi-disciplinary teams working to GIRFEC principles, but there has been limited central policy direction to assist Health Boards in delivering this – with a high level of variation in local CCH services and very restricted collection of outcome data for CCH such as waiting times and DNAs and limited availability of guidelines for referrers. The health board survey revealed that 4 health boards have waiting times for a CCH consultation in excess of 18 weeks. Distinct from other paediatric specialities, there are no networks across health board boundaries aside from child protection and exceptional healthcare needs. To ensure a skilled trained doctor workforce in CCH , with appropriate leadership and competencies to support SG priorities for care and deliver the quality agenda, the adoption of a generic model of paediatrician is recommended as per the RCPCH Modelling the Future reports. Through team job planning, both acute and community responsibilities can be factored in.

However, a recent survey suggests most trainees have less than 6-9 months' training in Community – inadequate to tackle the complex issues which face the community paediatrician on a day-to-day basis. In addition, local teams will need access to paediatricians with higher level skills in neurodisability and complex needs, child protection and vulnerability and special senses impairment. Such paediatricians could work on a regional basis linked to the four tertiary centres or through joint appointments between Boards.

Workforce data shows that the current community child health workforce in Scotland is primarily female and mainly in older age groups. Current NES Deanery feedback indicates that few current trainees are specialising in Community Child Health. A "bulge" of trained paediatricians will emerge in the period 2011-16 and it will be important, before that, to have a clear vision of how we should shape the workforce to respond to the needs of children in the community, especially in the new landscape of "Better Health, Better Care", "Equally Well", the "Early Years Framework" and "Getting it Right for Every Child (GIRFEC)". In this context, paediatricians and others practising in the community will have a key role in advocacy for children, in advising on strategy and delivering a responsive clinical service which supports parents and is integrated into the local Children's Plan.

Project Methodology

The terms of reference posed the following questions for the project**:**

- How is the service being delivered at present?
- What models are successful?
- What should a Community Child Health Service be offering in Scotland according to the evidence?
- How does this fit with overall SG/COSLA policies?
- How would the quality of the service be measured? By what outcomes?
- What workforce do we need to deliver this model of care?
- What are the implications for training and recruitment of the workforce?
- What changes do we need to make to ensure the service is responsive and sustainable?

A project consultant was appointed in January 2010 and the Royal College of Paediatrics and Child Health (RCPCH) Scottish Officer, Dr Jim Beattie, agreed to Chair the Steering Group. Representation[1] on the Steering Group from SACCH, AHPs, Community Nursing, the voluntary sector, ADSW and relevant Scottish Government departments was secured. The Steering Group had 3 meetings between March 2010 and November 2010.

[1] See Annexe 1

The project team employed a number of consultation methods to garner and include the views of Health Professionals and NHS Health Boards. Two electronic questionnaires were designed, one for all 14Health Boards and another one for all paediatric Specialist Trainees to provide an overview of the current community paediatric services available and ascertain the current training and future training requirements and aspirations of Specialist Doctors.

With the aid of the Scottish Government Analytical Service Division (ASD) and NHS Education Scotland (NES) the project has compiled and analysed the results of the questionnaires and they have provided a valuable picture of current community child health services and future workforce focus.

The Project team has also consulted with a range of stakeholder groups during its formulation by visiting all 3 Scottish Regional Planning Groups, contacting the Royal College of General Practitioners (RCGP) and seeking the views of the Child Health Commissioners. The Scottish Association for Community Child Health, RCPCH and BACCH have also been involved as well as a number of key contacts elsewhere in the UK. Academic CCH paediatricians and those teaching community paediatrics have also been included. Data has been received from the Workforce Division of the SGHD and the RCPCH annual census.

A draft workforce model has been derived by updating the original 1999 BACCH workforce scheme and this has been tested on a Scottish population model using a combined or generic paediatrician job plan.

Service specification (see Annexe 6)
The project has produced a draft Service Specification (based on the work of Dr Fawzia Rahman and the "Derby Model") with the support of an informal consultation group which was presented to the Children and Young People's Health Support Group on 13 December 2010.

The Service Specification aims are to:

Provide a consultant-led locality-based paediatric service for children and young people who are vulnerable due to disease, disability and/or disadvantage aged 0-18.

- To access traditionally 'hard to reach' groups of children and young people to ensure that they are able to receive the health input required;
- To improve the outcomes for children as identified in national and local strategies.

It is believed that the application of the Service Specification will ensure a Community Child Health Service for Scotland which will aim to meet the relevant overarching outcomes identified nationally and locally and included in local Children and Young People's Plans. Introduction of more robust monitoring of the service should deliver reduced waiting times, early diagnosis and intervention and reduce late/more intense treatment of conditions as far as possible. The emotional needs of children are to be supported in partnership with local CAMHS Services; Co-ordination and sharing of information relating to specific children will be facilitated by

the use of information technology such as the national Support Needs System; appropriate attendance at multidisciplinary and multi-agency team meetings according to agreed guidelines, and ensuring clear processes by the provision of lead or designated doctors for child protection according to RCPCH guidance.

Adoption of the Specification should support integrated working with other services to provide an holistic care approach to vulnerable children and is facilitated by appropriate attendance at planning meetings with interagency partners. The emphasis is on reduction of health inequalities, improved access and service for deprived areas and population groups. This will be underpinned by all future training being delivered and evaluated at a high level.

Findings in Relation to the Original Project Questions

Q.: What models are successful?

Across Scotland the most common model is a CCH service combined with acute services for children, co-managed either in a directly managed unit or a community health partnership. This model is that recommended by RCPCH. It would seem to offer most flexibility in terms of use of the medical workforce and also enable continuity of care for children and young people. Co-management of these services with community children's nursing, paediatric AHPs and CAMHS (55% of services) services are also seen. The HB questionnaire showed there is some best practice in terms of collaborative working with CAMHS, but in a number of areas this could be improved. Across the UK better results are seen if there is an effective IT and administrative infrastructure enabling efficient clinical administration.[2]

Q.: What should a Community Child Health Service be offering in Scotland according to the evidence?

The European model of paediatric care includes community paediatricians in 14 of 34 countries and the UK is commended for its provision. The professional bodies have laid down the elements of the service concerning the care of children with long-term conditions and disability, the care of vulnerable children (often termed *social paediatrics*) and the oversight of a population's needs and the policy and operational response to those needs in conjunction with colleagues in public health.

The accepted UK model for CCH is that of a locality-based team comprising paediatricians, Allied Health Professionals (AHPs) skilled in working with children and specialist children's community nurses working closely with colleagues in primary care and local authorities.

Community-based paediatricians are ideally placed to intervene at an early stage for young children referred with a range of developmental morbidities[3] and can gain the trust of parents when interventions are being planned. These benefits can only be realised if the CCH service has appropriate staffing and infrastructure and waiting

[2] Rahman,F. http://www.bacch.org.uk/index.php
[3] Horridge K. ADC 2011Educ Pract Ed 2011;96:9-20

times are acceptable according to standards set for other groups in society (eg 18-week RTT). As has been said, a month is a long time in the life of a baby or toddler, especially for one where disadvantage prevails.

In the course of preparing the CCH21 report, it is apparent that a model whereby at least some paediatricians in a locality team work genericall, ie in both acute and community paediatrics, is a way of smoothing the patient journey and also enabling adequate acute cover at trained doctor level. However, the limited training for general paediatricians in CCH (may be 6 months only) may mean that further work should be done to equip such consultants of the future with more skills in community paediatrics.

Q.: How does this fit with overall SG/COSLA policies?

In terms of current policy and guidance, the Scottish Government has had a welcome emphasis on the wellbeing and care of children in all sectors and early intervention for those most at risk of poor health outcomes. The recent NDP programme has seen investment in the workforce, but mainly in the acute specialist sector (47% increase in specialist consultants in 2007/9).

Despite this welcome investment in the specialist consultant workforce, the CCH medical workforce has fallen progressively both in Scotland and across the UK. CCH doctors are the frontline clinicians in the diagnosis and management of young children with developmental and socially-mediated disorders such as speech impairment alongside local multi-disciplinary teams. They can develop essential networks in the community with partners in the local authority and the third sector and are the current acknowledged paediatric experts in child protection. They can have an overview of population child health and advise strategic decisions to enhance it.

Therefore ensuring a sustainable CCH service will be necessary to fully implement the principles of “Equally Well” and the “Early Years Framework” and the Scottish Government’s child protection guidance[4].

Q.: How would the quality of the service be measured? By what outcomes?

The NHSScotland Healthcare Quality Strategy in 2010 emphasised the importance of “… making measurable improvement in the aspects of quality of care that patients, their families and carers and those providing healthcare services see as really important.”

Scottish Government Level

Looking at the Scottish Government’s HEAT standards for DNA management and RTT, there are significant challenges for CCH services in some areas to meet these.

[4] Scottish Government. Consultation on revised guidance on child protection, to replace the 1998 guidance Protecting Children – A Shared Responsibility: Guidance on Inter-Agency Co-operation. 2010

It would be appropriate to audit present CCH services against these Scottish Government standards and others such as BACCH[5].

Regional Planning Group Level

Close monitoring of relevant MCN quality standards (child protection,children with exceptional needs and epilepsy) should drive up the quality of care delivered by regional CCH services.

Health Board/CHP Level

A CCH service specification, if accepted, can provide a framework for measuring a range of outcomes agreed between the health board and CCH service. The lack of consultation of parents and carers reported by health boards in the survey (only 4 of 14 boards consult parents) does not indicate there is a consumer responsiveness or focus in most services. The "Participation Toolkit"[6] recently launched by the Scottish Patient Experience Programme could be of assistance in progressing a better partnership with parents and indeed children and young people to improve CCH services as suggested in the "Quality Strategy".

Looking at published standards and guidelines relevant to CCH practice endorsed by RCPCH[7] there are a number of measures which could be adopted in relation to specific diseases and conditions such as autism.

Q.: What workforce do we need to deliver this model of care?

In a combined paediatric workforce model there will still be a need for the provision of CCH trained doctors at a minimum of 2.8WTE per 100,000 population alongside the requirement to factor in a minimum of 10 WTE trained doctors to cover an acute paediatric rota.

Detailed predictive workforce modelling has been outside the scope of this report. However, the demographics of the current CCH medical workforce, the future career paths of our trainees, the limited training in CCH for most trainees and the demands of the acute sector for trained doctors to provide cover, will result in few consultants trained in the specialist skills required for CCH practice, and a likelihood of virtually no service in 10 years without focused and sustained remedial action. The effects on the management of Scotland's most vulnerable children are likely to worsen health, educational and social outcomes.

The revised workforce model (see Section 12 and Annexe 7) suggests maintaining the current Scottish CCH workforce numbers (circa 160 WTE trained doctors) would be the absolute minimum required, equivalent to 2.8 WTE CCH trained doctors per 100,000 population. However, this figure omits particular demands such as a correction for local deprivation or rurality or supra-regional specialisms such as aspects of child protection (eg child sexual abuse management).

[5] See Annexes 2 and 12
[6] http://www.bettertogetherscotland.com/bettertogetherscotland/682.html
[7] Annexe 5

Q.: What are the implications for training and recruitment of the workforce?

In terms of the supply of doctors to carry out the specialist CCH clinical work defined above, it is clear there will not be a reliable supply of adequately trained potential appointees at consultant level. Even if there are "generic" general paediatricians working across the acute/community interface there will still be a need for specialist CCH consultants.

The picture for specialty and associate specialist doctors in CCH is worse, with a 10% vacancy rate and great uncertainty regarding recruitment. Assumptions that the forthcoming possible bulge (2013/14) of paediatric doctors with CCT[8] would take up specialty (SASG) doctor posts (starting salary £36.8k vs £74.5k as a consultant) in the absence of opportunities at consultant level in Scotland seem optimistic and not based on evidence. Home Office regulations do not permit non-EU doctors to enter the country for these posts. Few EU doctors will be skilled in the UK model of CCH practice without additional training.

In addition, if there is no decoupling of the run-through scheme in paediatrics at ST3/4 there will be fewer doctors to recruit to SASG posts other than those who drop out of training. Some SASG recruits may come from the GP sector, but salary differentials are very marked in favour of general practice. Reported attrition rates from paediatric training across the UK are as much as 25% in years ST1-3. If decoupling were allowed, it is possible that the supply of doctors to the SASG would increase. To date the RCPCH seems to have resisted the idea of decoupling, although other specialty schemes have done so (eg Emergency Medicine).

If decoupling were agreed, It has been suggested that a more valid salary comparison for recruitment might be that between an ST3/4 salary (£37k) and that of a speciality doctor at the bottom of the scale (circa £37k), taking into account the more family-friendly terms and conditions.

Redesign and skill mix opportunities using novel combinations of staff including advanced practitioners and clinical specialist nurses and AHPs may mitigate the shortage of SASG doctors.

[8] This bulge may be less than predicted because of out-of- programme experience, maternity leave and interdeanery transfers.

Key issues for training and recruitment

- Scotland's children and young people need and deserve a CCH service, but radical action requires to be taken to ensure a sustainable CCH workforce in the light of the decline in numbers of CCH consultants (16% in 2007/9) and the ageing SASG workforce (72% over age 50) who comprise 77% of the trained doctors in CCH.
- The appointment of generic paediatricians with competencies across general paediatrics and CCH is accepted but assuring more advanced CCH competencies for general paediatricians would improve their confidence and enhance their ability to deliver high quality care which is not just "hospital outreach"[9].
- Boosting the CCH experience of a larger number of ST4-8 paediatricians already in the system could improve the supply of paediatricians with an interest in CCH. To do this both trainees and Deaneries would require to accept this notion.
- Clinical leadership needs to ensure close relationships between all paediatricians in a local system by closely intertwined CPD, inspired mentoring for younger consultants (Post-CCT) and shared duties to improve the service to children.
- Increasing the skill-mix in teams by redesign of some CCH SASG posts to substitute other clinical disciplines such as nurses and AHPs. The supply of such alternative clinicians relies on appropriate investment in nursing and AHPs and in their training opportunities which is a significant challenge for the NHS in Scotland.

Q.: What changes do we need to make to ensure the service is responsive and sustainable?

See a full list of recommendations below and in Section 14.

Recommendations

1. Model of care

1.1. All paediatric specialist services adopt a combined (co-managed acute and community services) model whether in a directly managed unit or a CH(C)P or other configuration.

1.2. CCH services should renew their focus on the care of vulnerable children in the context of "Equally Well" and other Scottish Government policies.

1.3. Services managers to review CCH co-working with CAMHS and ensure management arrangements facilitate delivery of best practice for children and young people with emotional and behavioural disorders.

[9] Note: 60% of Paediatricians responding to the SACCH survey who did c25% CCH work had under 6 months' training in CCH and 30% of them had no training at all.

2. Infrastructure

2.1. Review IM and T systems in use across combined paediatric services including general and CCH to ensure efficient and effective management for a nationally agreed set of conditions, eg: CEN Pathway of Cep, SIGN evidence for ASD, SIGN evidence for ADHD.

2.2. Ensure the availability of appropriate clinical guidelines and pathways for common childhood presentations including shared pathways for "overlap" conditions with CAMHS.

3. Standards, performance and outcome measures

3.1. By applying the priorities of the "Healthcare Quality Strategy for NHS Scotland" (May 2010) to CCH services, ensure children, young people and their families receive the best care as close to home as possible.

3.2. The specification for CCH services should be consulted upon, and used to standardise the access to CCH services across Scotland.

3.3. With a set of outcome and performance measures for the incorporation of national indicators such as those developed for EYF and HEAT work.

4 Workforce

4.1 SGHD/RCPCH/NHS Education Scotland and NHS Boards to undertake paediatric workforce modelling and a requirements analysis to enable delivery of the appropriate model of CCH across Scotland as part of a combined service and including consideration of regional MCNs for tertiary level CCH problems.

4.2 Address the predicted shortfall of CCH doctors by innovative workforce redesign.

4.3 Consider multidisciplinary health professional team and skill mix, development of expanded roles including enhanced skills for nurses and Allied Health Professionals in the care of vulnerable children, children with complex conditions and children with disabilities.

5 Training/CME

5.1 RCPCH to consider adopting a 'generic' model of paediatrician with competencies across traditional community and acute general paediatrics, whilst retaining the required number of trained paediatricians with specialist competencies such as paediatric neurodisability according to population needs.

5.2 RCPCH to review CCH competencies required for paediatricians aiming for CCT in general paediatrics.

Section1: Introduction

In 2009 the expert Ministerial advisory group, the Children and Young People's Health Support Group, commissioned a project to look at the provision of Community Child Health (CCH) services in Scotland to ensure such services are sustainable and fit for purpose. The emphasis of the project has been on the role of paediatricians working in the community and the teams they are associated with in delivering care to Scotland's children and young people. Co-dependencies with other agencies and professions including nurses and AHPs have been examined, together with infrastructure and workforce issues.

Dr Zoe Dunhill, a recently retired paediatrician and former Clinical Director of the Royal Hospital for Sick Children and its associated services, was appointed as the project consultant in March 2010.

Terms of reference

The following questions were posed at the beginning of the project:

- How is the service being delivered at present?
- What models are successful?
- What should a Community Child Health Service be offering in Scotland according to the evidence?
- How does this fit with overall SG/COSLA policies?
- How would the quality of the service be measured? By what outcomes?
- What workforce do we need to deliver this model of care?
- What are the implications for training and recruitment of the workforce?
- What changes do we need to make to ensure the service is responsive and sustainable?

Project deliverables

The following were listed at the outset:

a. Engagement of stakeholders

b. A questionnaire to establish the status quo of CCH services for all Health Boards in Scotland

c. A questionnaire for all paediatric trainees in Scotland

d. A report for the Children and Young People's Health Support Group summarising the results of the above and recommending a way forward.

Methodology

A variety of stakeholders and colleagues were consulted during the course of the project. A literature search was conducted using search terms: community child health; community paediatrics; paediatric models of care and related topics. Publications by RCPCH (especially census material), GMC, BACCH, Scottish Government, Department of Health England and ISD Scotland were consulted amongst many others. Relevant professional meetings and conferences were attended. Information was obtained from NES Deaneries and the Scottish Government Workforce Division about doctors in training.

Two questionnaires were designed and circulated using electronic methodology – one to all 14 health boards in Scotland and the other to paediatric trainees in Scotland. RCPCH and SACCH also devised a questionnaire for paediatricians undertaking CCH work across Scotland.

The questionnaire results were subject to further analysis using Excel.

A revised draft specification for CCH services was drawn up with the help of an informal consultation group of paediatricians, building on work by Dr Fawzia Rahman and published on the BACCH website[10]. A revised workforce scheme was also developed from an original document also published by BACCH in 1999. This scheme was tested on some indicator Scottish populations.

Sponsors and stakeholders

The project was sponsored by the Child and Maternal Health Division of the Scottish Government Health Directorate under the aegis of the Children and Young People's Health Support Group, Chaired by Malcolm Wright.

A Steering Group[11] was convened in early 2010 and Chaired by Dr Jim Beattie, RCPCH College Officer for Scotland (to January 2011) and Clinical Director at RHSC Yorkhill. The group met on 4 occasions during 2010 to approve the terms of reference for the project and oversee progress.

Dr Helen Gibson of the Scottish Association for Community Child Health (SACCH) acted as liaison with that organisation and undertook a survey of paediatricians in Scotland regarding community child health work which she shared with the Steering Group[12].

Links were made with academic community paediatricians in Scotland and England; AHPs working with children across Scotland and Child Health Commissioners. Visits

[10] Rahman,F http://www.bacch.org.uk/index.php
[11] See Annexe 1 for list of members of the steering group
[12] See Annexe 7

were made to the three regional planning child health groups across Scotland to appraise them of the project and hear their comments.

There was also close liaison with the NHS Education Scotland (NES) Obstetrics and Gynaecology and Paediatrics Speciality Training Committee.

The Lead GP for Paediatrics, Dr Chris Boardman of the RCGP, was contacted. Through him there was sight of the RCGP's Child Health Strategy (2010).

Dr Kathy Leighton, Royal College of Psychiatrists CAMHS Lead for Scotland, was invited to join the steering group.

Dr Sue Bloomfield, Director of the School of Community Paediatrics in Edinburgh, gave a presentation on the new GP Paediatric scholarship scheme.

Contact was also made with the Chairs of the RCPCH College Specialty Advisory Committees in Community Child Health and Neurodisability, Martin McColgan, the College Workforce Officer and Dr David Shortland, RCPCH Vice President for Health Services.

Contact was made with Clinical Directors in Nottingham and Derby as well as with many colleagues in the Community Child Health Service across Scotland too numerous to be named. Relevant colleagues within Scottish Government departments were also involved.

Section 2: Context of child health in Scotland

Wellbeing of Children in Scotland

The poor comparative wellbeing and health of children in Scotland and in the UK as a whole have been highlighted by UNICEF[13] and the OECD[14]. The precursors of these findings are well documented and discussed and the Scottish Government has sought to address the problems in a variety of ways. Beginning with "Better Health, Better Care" in 2007, "Equally Well" in 2009 and the "Early Years Framework" in 2009[15], early intervention has been prioritised and effective ways of supporting children and families signposted through the "Getting it Right for Every Child" (GIRFEC) initiative beginning in 2008[16].

Figure 1. Showing OECD Wellbeing ranking for 23 member countries in 2000

Health Inequalities in Childhood in Scotland

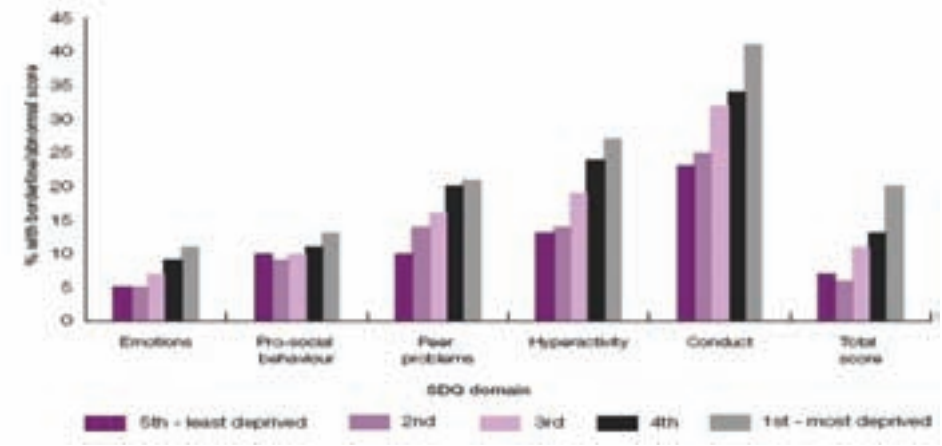
In addition to poor comparisons with other developed nations in terms of child wellbeing, there are substantial inequalities across society in Scotland, with persisting differences in the outcomes of pregnancy, child death rates[17], accident rates and in the health morbidity experienced between the least deprived and the most deprived SIMD quintiles. Around 25% of Scottish children are living in poverty today.

The "Growing up in Scotland Study" (GUS) is following 13,000 children across Scotland longitudinally and is a useful barometer of the status quo of child wellbeing across a range of domains. The authors have highlighted a number of health outcomes and associated risk factors which are known to impact on the future health

[13] UNICEF (2007), Child Poverty in Perspective: An Overview of Child Well-being in Rich Countries, Innocenti Report Card 7
[14] *ibid*
[15] Scottish Government. Early Years Framework 2009
[16] GIRFEC http://www.scotland.gov.uk/Topics/People/Young-People/gettingitright
[17] Source ISD Scotland 2007

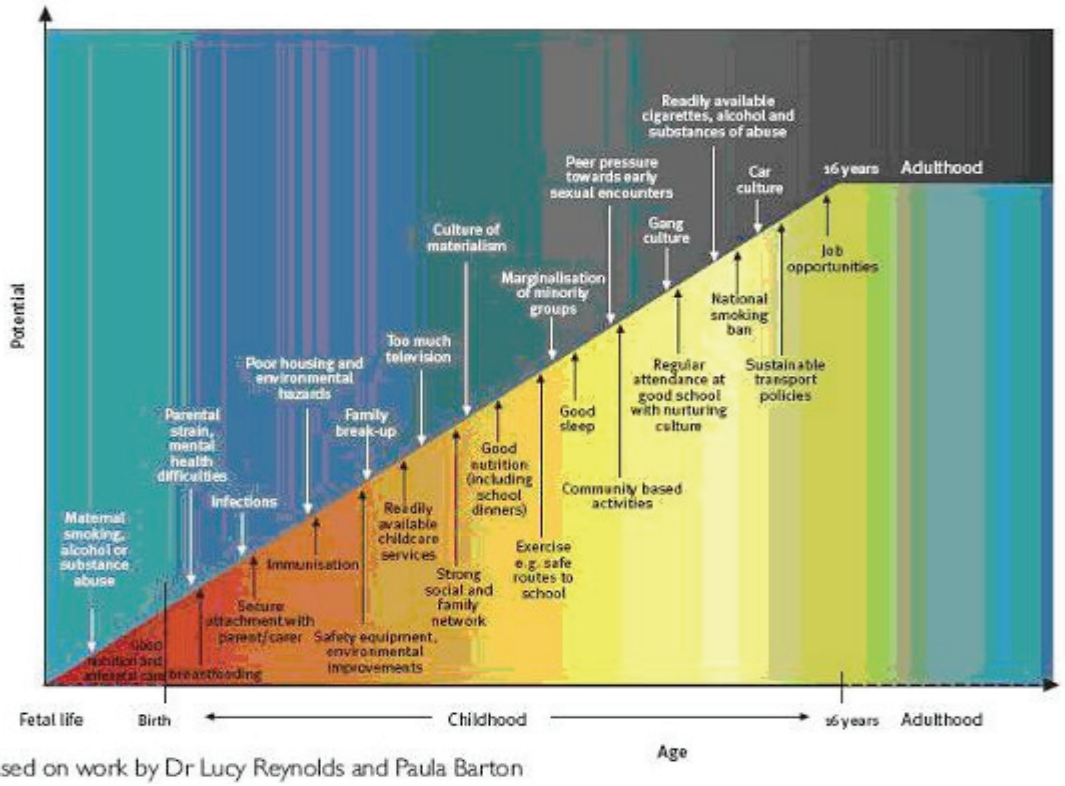
of a child both pre-birth and during the early years, and documented the social gradient of morbidity across a number of domains for example, symptoms of behavioural disorder as elicited by the Strengths and Difficulties Questionnaire (SDQ) administered to parents of 46-month-old children. The graph illustrates the worsening symptoms of disorder from the least to the most deprived youngsters.

Figure 2: SDQ individual domain scores, by SIMD quintile (46 months) (GUS Study 2009)



The welcome improvements in acute hospital performance measures such as waiting times seem not to have impacted significantly on the global wellbeing of children and young people. More fundamental societal measures such as parenting capacity which may be influenced by circumstances (including substance misuse), physical or mental health issues for parents, family composition, access to play and education, housing etc. are factors which affect mental health, attachment, educational attainment etc. Increased awareness of the protective influence of resilience factors in children and their families has guided the GIRFEC initiative in its quest to improve children's life outcomes. Figure 3 shows the complex interaction of positive and negative factors which may prevail in a child's life.

Figure 3: Interaction of positive and negative factors in a child's life



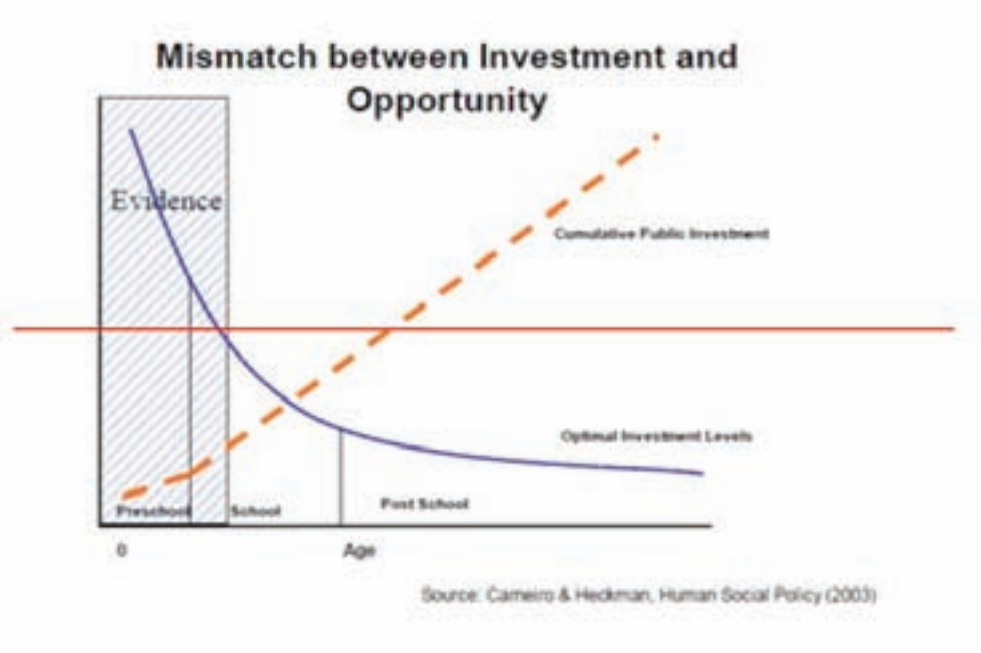
Source: Based on work by Dr Lucy Reynolds and Paula Barton

Economic Arguments for Early Intervention

In terms of economic gain for the country, it has been estimated by James Heckman[18] that there can be a 12-16% gain per annum for every £1 invested in very young children who are in disadvantaged households and a 5 times benefit for each such child reaching adulthood after appropriate interventions. This emphasises the necessity for long-term planning to produce sustained investment and effort over many years. The high tariff spend for young people who may have been looked after by the state; become involved in the criminal justice system, suffer from mental illness etc. cannot easily be disinvested and diverted to early intervention. This dilemma is highlighted in the diagram below.

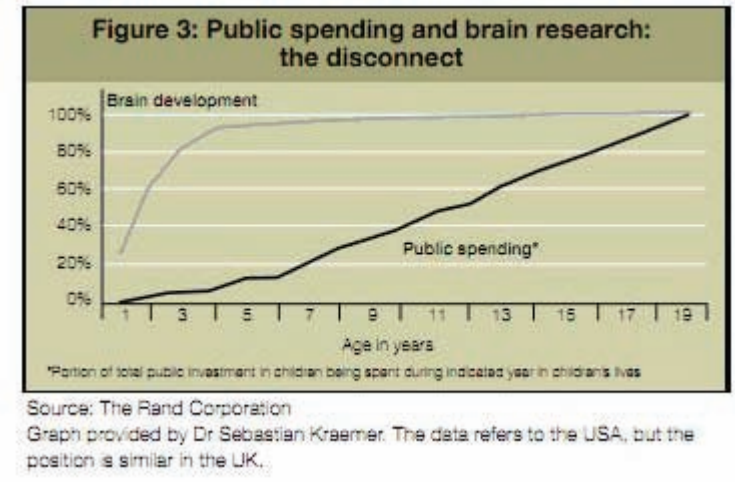
[18] Heckman,J.,2010 "Investment in birth to five early education for disadvantaged children helps prevent the achievement gap, reduce the need for special education, increase the likelihood of healthier lifestyles, lower the crime rate and reduce overall social costs. In fact, every dollar invested in early childhood education produces a 10% per annum return on investment. Equitable early childhood education resources produce greater social and economic equity."

Figure 4



Such efforts require attention to the intervention mechanisms and structures supporting children and families and to the workforce (capacity and numbers). Sir Ian Kennedy also showed this mismatch graphically in data from the USA in terms of investment during the critical period of brain development in his recent report for the DoH[19].

Figure 5: Public spending and brain development



Source: The Rand Corporation
Graph provided by Dr Sebastian Kraemer. The data refers to the USA, but the position is similar in the UK.

[19] DoH (2010) Getting it Right for Children and Young People. Kennedy, I

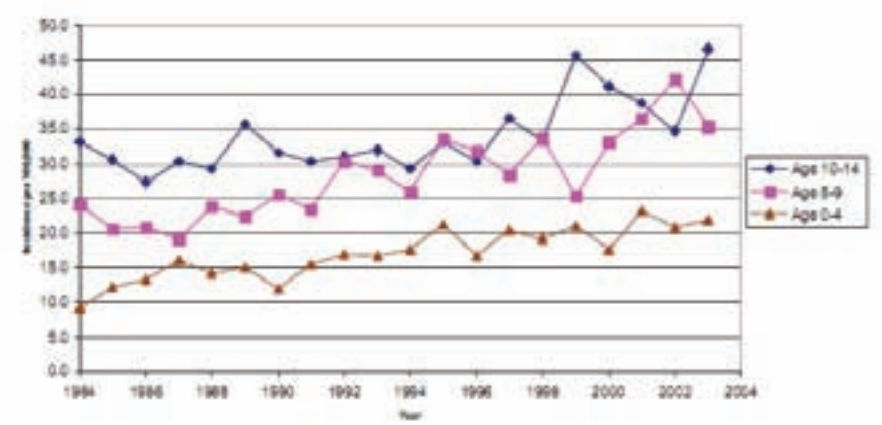
Getting it Right for Every Child (GIRFEC)

The Scottish policy Getting it Right for Every Child (GIRFEC)[20] emphasises the collaborative nature of working with parents and their children, both between agencies at a strategic level and between those working directly with families. It sets out a comprehensive methodology for redesign of services focused on the child and their family and sets out to avoid duplication, to provide clear pathways of care and support and to produce a Child's Plan where additional input is needed. There are numerous examples of good practice in this domain, but significant case reviews of specific harm events to individual children have shown families may not be getting optimum support from one or several agencies because of ineffective use of resources or personnel, or poor communication or all three. Adoption of the GIRFEC principles in the context of the NHSScotland Quality Strategy[21] should enable best care for every child and young person.

Epidemiological Trends: 21st century Morbidity

A change in the pattern of morbidity is also placing increased pressure on local and specialist services for children and young people. An increase has been observed in obesity amongst children, with 20% of all primary school entrants in Scotland having an overweight BMI and 8% measured as obese[22]. There has also been an increase in Type 1 diabetes with the fastest relative increase in under 5s and with Scotland having one of the highest incidence rates in the world.

Figure 6: Incidence of Type 1 Diabetes in Children in Scotland by Age at Diagnosis[23]



Asthma also has a high prevalence causing 23% of all emergency hospital admissions of 15 years and under children in 2005/6[24] in Scotland. Mental health disorders amongst children and young people are worryingly prevalent at 8.5% of all

[20] GIRFEC website http://www.scotland.gov.uk/Topics/People/Young-People/gettingitright
[21] Healthcare Quality Strategy for NHS Scotland. May 2010
[22] ISD Child Health Newsletter 2010
[23] Short Life Working Group on Type 1 Diabetes Report 2009
http://www.diabetesinscotland.org.uk/Publications/Final%20report%20of%20the%20Type%201%20Diabetes%20Short%20Life%20Working%20Group.pdf
[24] ISD Child Health Newsletter 2007

children[25]. Children with complex needs, often consequent upon very low birth weight, are surviving longer, often into adult life and their care needs may be very intense. The UK Epicure study has shown 45% of children born before 26 weeks gestation exhibit severe functional disability at 11 years of age (Johnson, S et al 2009)[26].

Children affected by a range of previously untreatable conditions are able to live longer due to advances in medical technologies, but they may require very demanding multi-agency packages of support at home and at school to enable them to be fully included. These packages can be enormously challenging for parents and the agencies who are striving to deliver them and require the highest standard of interagency working to devise and maintain[27], and awe-inspiring dedication by their parents and carers.

Family supports are less strong than in former times and parents may be juggling with pressures of employment or seeking work, their own health and the needs of the other children in the family. UK public sector spending is now under pressure with both central government and local systems examining services closely in terms of effectiveness and efficiency. NHSiS is not exempt from this.

Responding to a Child and Family's Needs: Clear Pathways and Good Co-ordination

In order to respond to child and family needs in a timely and appropriate fashion, the health services for children need to be responsive and highly attuned to the needs of all and especially vulnerable families. Universal contacts in antenatal and postnatal settings need to be enabling of parents; adopt a strength-based approach such as has been demonstrated in the Family Nurse Partnership methodology (Olds)[28] and be able to respond to their concerns and enable quick referrals through defined pathways of care for children whose social, emotional or physical development causes concern.

All early years practitioners in health, social work and education and the third sector need to know how to access diagnostic, therapeutic and supportive services for children. The local multi-disciplinary team around the child should be cohesive and mutually supportive. The Scottish GIRFEC model of integrated working and the English equivalent "Every Child Matters" signpost evidence-based successful methodologies for the team around the child. However, firm evidence in terms of improved outcomes for individual children and families across the UK is limited[29] but a recent evaluation of the Highland GIRFEC pathfinder site[30] has shown significant improvements for both parents and professionals.

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[25] Meltzer H, Gatward R, Goodman R, Ford T. The mental health of children and adolescents in Great Britain. Report of a survey carried out in 1999 by Social Survey Division of the Office for National Statistics . Stationary Office 2004

[26] Johnson S. et al Pediatrics 2009;124: e249–e257

[27] Local Government Association England (2009) In it together: achieving quality outcomes for young people with complex needs

[28] http://www.scotland.gov.uk/Topics/People/Young-People/Early-Years-and-Family/family-nurse-partnership

[29] Oliver C, Mooney A with Statham, J. Integrated Working: A Review of the Evidence. Thomas Coram Research Unit, Institute of Education, University of London, July 2010

[30] Scottish Government. An evaluation report of the development and early implementation phases of Getting it Right for Every Child in Highland(2009).

The care-co-ordination model which has recently been reviewed by Riddell et al[31] and GIRFEC principles also can assist in more effective working with the family by provision of a trained key worker, particularly at the various transition stages of a child's life.

The Key Role of Primary Care in Community Child Health

GPs, Paediatricians, nurses and therapists working in the community need to be both well-positioned in terms of their partners in the acute and specialist healthcare sector, but also firmly embedded and orientated in relation to local community services from both a case management and a planning perspective.

For a service encompassing the whole spectrum of care for children and young people to function effectively, all concerned have to share a vision for children and be confident in each other's skills and contributions, so that children who present through the screening process, or opportunistically to a variety of practitioners, can be referred and seen quickly by the appropriate clinician. Conversely, children presenting to acute settings with developmental or social problems can be seen and assessed by the paediatrician who can initiate investigations and refer the child to other colleagues within the multi-disciplinary team in the community such as early years workers, AHPs, social workers, educational or clinical psychologists, specialist peripatetic teachers etc. and keep the child under review to ensure ongoing support is given to the child and their family.

General Practitioners are an essential part of these mechanisms and contribute their knowledge of the whole family as it impinges on any particular child with problems. If mutual confidence does not exist then children may fall through the net and parents are left to negotiate their way through thickets of inter-professional rivalries, suspicions and unnecessary delays may be incurred.

In relation to paediatric expertise in primary care, concern was expressed by Professor Steve Field (outgoing Chair of RCGP) in 2010, about the lack of training of GPs in paediatrics (only 40% currently have had specific training)[32], and initiatives are afoot to correct this. The recent RCGP "Child Health Strategy"[33] document has emphasised the need for additional training in paediatrics although this is mainly in the sphere of "the sick child". It also points out that currently less than 3% of the UK "Quality Outcome Framework" (QOF) indicators for primary care relate to children and young people. The RCPCH "Facing the Future" report also draws attention to the need to enhance GP competencies in paediatrics. Wolfe et al (2011) recently reviewed outcomes for children across Europe and expressed concern about the primary to secondary care interface and a range of outcomes in comparison to other European systems of care for children[34].

[31] Purves R, Riddell S, Weedon E. The development of care co-ordination services in Scotland: a report to Care Co-ordination Network UK. Centre for Research in Education Inclusion and Diversity, University of Edinburgh (2008)

[32] http://www.telegraph.co.uk/health/healthnews/8146460/GPs-lack-training-in-treating-children-report.html

[33] RCGP Child Health Strategy 2010

[34] *BMJ* 2011; 342:d1277 doi: 10.1136/bmj.d1277 (Published 8 March 2011)

In his 2010 report for the Department of Health in England "Getting it right for children and young people", Sir Ian Kennedy recommended that "both initial training and revalidation (of GPs) should include the ***comprehensive care*** (author's font) of children and young people, as should the Quality and Outcomes Framework" because of the gaps he found in his enquiry.

Hopefully, GPs can gain more experience in paediatrics through extended training programmes and initiatives such as the NES GP paediatric scholarship scheme[35] and through access to improved CME. They have a vital role as navigators through the health system for parents and children with difficulties and disorders and will often take over the lead role after a young person with additional support needs leaves school.

[35] NES/School of Community Paediatrics Edinburgh (see Annexe 8 for programme)

Section 3: Background and Development of the Community Child Health Service in the UK

History of CCH

Today's community child health service had its roots in the early part of the 20th century and was considered a branch of the public health service. Community paediatricians were employed by local authorities as part of the public health workforce. These doctors came from a variety of clinical backgrounds but often without formal paediatric training. They tended to focus on screening examinations, child development and examining children "in need of special educational treatment" as defined in the Education Act (Scotland) 1946. Essentially these medical examinations of children and young people continued without question until the publication of Health for All Children in 1989.

In 1973 the Scottish Home and Health department published "Towards an Integrated Child Health Service" which laid the foundations for the present service with the emphasis on joined-up working between clinicians and other statutory bodies. In England one of the main recommendations of the Donald Court Report – "Fit for the Future" – published in 1976[36] was that consultants should be appointed in the community. The first consultants "with an interest in community child health" were appointed in the 1980s across the UK.

Individual clinicians with particular specialisms or interests tended to develop services serendipitously according to those interests. Service planners were often constrained by the availability of trained doctors rather than meeting the needs of a population, especially in more remote areas. Some doctors specialised in physical disability, others in mental health issues and others in learning disability and sensory problems.

There was a large cadre of less experienced doctors (later called staff grade doctors) who learned on the job and were promoted by virtue of their experience and contribution to the service. Formal training opportunities for these doctors were extremely limited. Often they worked on a part-time basis because of domestic commitments. There was no implementation of integrated hospital and community children's health services until the early 1990s. Subsequently, the need for formal training programmes was acknowledged and competency frameworks have been developed by RCPCH.

Public Health Nursing: CCH Partners

The origins of health visiting in the UK lay in the mid 19th century. The Women's Sanitary Inspector's Association was founded in 1896. The role became associated with infant welfare clinics from 1900-1948 whereafter HVs were incorporated into the NHS.

Public health nursing for children was based on a cadre of highly skilled health visitors and school nurses. Community paediatricians had a close relationship with their health visitor colleagues through a network of child welfare clinics, and with

[36] Court S D M. Fit for the Future. Report of the Committee on Child Health Services, HMSO 1976

school nurses through school-based clinics. School nursing did not really fulfil its potential until 2001 when a more dynamic 'public health' role for the school nurse was defined to promote the health of school-aged children[37] to develop health promotion programmes for populations. Research has shown a poor justification for routine screening medical examinations[38] of school children although many areas in Scotland continued to undertake these especially at school entry until the late 1990s.

Attention continues to be focused on redesign of public health nursing with the recent formation of the Modernising Community Nursing Board by the Chief Nursing officer in Scotland[39]. As new models of care for children emerge, the vital role of community children's nurses and public health nurses may become even more important. If nurses and their AHP partners are to play a greater role, then there will be a need for more training in this area.

The Modern CCH Service

Throughout the 1990s there was increasing demand for services for vulnerable children and young people in need of protection. Challenges such as enhanced responsibility for child protection were absorbed by the community child health service, which became consultant-led in most areas of the UK including Scotland. Some of these consultants were senior doctors who took advantage of a regrading scheme in the mid-90s. Quite a number of these doctors are now approaching retirement and it seems timely to review the development of the service across Scotland.

In 1990 the doctors' training body, the Joint Committee on Higher Medical Training, published the requirements for Higher Specialist Training for doctors aiming for accreditation in 'Paediatrics with a special interest in Community Child Health'. These recommendations resulted in the designing of specific senior registrar training programmes in many paediatric teaching centres, and encouraged a new generation of paediatricians to enter what had by now become known as the speciality of Community Paediatrics.

In 2002 RCPCH published "Strengthening the Care of Children in the Community" following a review by Professor Alan Craft. He outlined the following principles

- The service will be provided by a fully trained workforce
- There must be a flexible and adaptable workforce working in a multidisciplinary environment
- No paediatrician should work in isolation
- Parents and children must have ready access to a knowledgeable paediatrician
- The service must be provided as close to the child's home as feasible
- The service must include a comprehensive locally-based community child health service aiming to promote child health as well as treating disease
- When necessary, there must be a clear pathway from the local paediatrician to a tertiary specialist through managed networks

[37] Scottish Government. Nursing for Health 2001
[38] Barlow J, Stewart Brown S, Fletcher J. ADC 1998;78:301–311

[39] Scottish Government. Modernising Nursing in the Community. Joint statement November 2009

- Each local area must ensure that it has a full range of skills available to deal with all aspects of paediatrics and child health, which are appropriate to be delivered locally.

In addition, in 2001 the RCPCH published "The Next Ten Years" which suggested a future paediatrician would need to be flexible and skilled in both the practice of paediatrics in a hospital setting and in the community. It also foresaw that the boundary between acute hospital and community-based work would become more permeable.

However, despite the attempts to build sustainable training and produce adequate numbers of CCH consultants, the number of consultants has always been fewer than required and in 2004 Dr Mary Mather's leader "Community Paediatrics in Crisis" in the Archives of Disease in Childhood[40] stimulated a robust debate, resulting in the publication in 2005 of "Community Child Health: the Future"[41] by BACCH which outlined the scope of services which should be available for children in the community from primary care through to tertiary services (see Annexe 2). This service outline from 2005 remains the specialty guideline for what should be in place across the UK. The CCH21 Project has sought to compare what is in place with this specification.

[40] Mather M. ADC 2004; 89: 697-699
[41] BACCH 2005

Section 4: Models of care in other countries

USA

Paediatricians in the USA work in a very different healthcare delivery paradigm. However the American Academy of Paediatrics has been forthright in its insistence of the importance of Community Paediatrics (CP) and defined it in a policy statement in 2005 (reaffirmed in 2010) which emphasises the advocacy role of paediatricians in this aspect of practice as follows (US spelling retained):

"The American Academy of Pediatrics (AAP) offers a definition of community pediatrics to remind all pediatricians, generalists and specialists alike, of the profound importance of the community dimension in pediatric practice.

Community pediatrics is all of the following:

- A perspective that enlarges the pediatrician's focus from one child to all children in the community;

- A recognition that family, educational, social, cultural, spiritual, economic, environmental, and political forces act favorably or unfavorably, but always significantly, on the health and functioning of children;

- A synthesis of clinical practice and public health principles directed toward providing health care to a given child and promoting the health of all children within the context of the family, school, and community;

- A commitment to use a community's resources in collaboration with other professionals, agencies, and parents to achieve optimal accessibility, appropriateness, and quality of services for all children and to advocate especially for those who lack access to care because of social, cultural, geographic, or economic conditions or special health care needs; and

- An integral part of the professional role and duty of the paediatrician."

So, in summary, the AAP model emphasises the duty of all paediatricians to consider community aspects of a child's life in a holistic way whether they are generalists or specialists and also highlights the advocacy role of a paediatrician. However, the practice of office-based paediatricians is not directly comparable to our UK set-up.

Canada

In 2009 Ukpeh[42] described Canadian community paediatrics as two complementary concepts – the community-based paediatrician and the community paediatrician. He

[42] Ukpeh H. Paediatr. Child Health 2009; 14(5):299–302

said: “The community-based paediatrician, as the name implies, is a paediatrician based in the community, usually outside a tertiary centre, whose practice is focused on those who visit the clinic, including support for patients accessing needed services within the community. The community paediatrician, on the other hand, sees the community as the patient“”. These two groups of clinicians therefore appear to combine a clinical practice model with a public health approach.

New Zealand

In New Zealand in 2006 the Paediatric Society of New Zealand issued a paper, “Community Paediatric Service: Notes for Purchasers“. They laid out the goals of a community paediatric service with the emphasis on health promotion and improvement as follows:

To develop and/or implement within a defined population for all children:

- a detailed assessment of the health and development needs
- effective health promotion and health protection programs
- a comprehensive co-ordinated system of quality child health services that meet identified needs
- systems for identification, support and reintegration programs for children with "special needs"
- an integrated framework of services linking health and non-health sectors to achieve maximum support and health gain for children and families
- systems for monitoring and evaluation of the efficacy, efficiency and community value of child health programs, and of the service as a whole
- information systems that use evidence to tailor child health services to meet the changing needs and health outcomes of a community
- participation in, and often leading the Child and Youth Mortality Review system.

Europe

In European countries care of children outside hospital is divided between GPs, Primary Care Paediatricians (PCPs) and community paediatricians (CPs). In a review of the European approach to paediatric care, Katz et al (2002)[43] defined a CP as “a paediatrician who devotes to the comprehensive recognition and understanding, prevention, and treatment of community-related health problems such as child protection, children in need, behaviour problems, teenager approach, growth and developmental assessment, school medicine, etc.”

[43] Katz M, Rubino A, Collier J, Rosen J, Jochen H, Ehrich H. Pediatrics 2002;109:788–796.

Katz and colleagues issued questionnaires to 34 country paediatric associations concernng their country's paediatric care and training of paediatricians. They found that 14 out of 34 countries had community paediatricians practising according to their definition above. The UK is praised for its system of community paediatricians, but the point is made that this is an "expensive option". However, there is no economic analysis of the cost of not having CPs.

In 2001 Crouchman et al[44] had observed European patterns of community and social paediatric care as showing "wide disparity in overall structure of services, as well as variation in interpretation of what is meant by social/community paediatrics. A comprehensive community paediatric service exists in the UK and Sweden (where 25% of paediatricians work outside hospitals), but elsewhere in Europe secondary paediatric and disability services are still very much hospital based. The concept of child development centres is spreading slowly, and there are isolated initiatives, for example, in Greece and Portugal".

From these references one can gather that the UK has been regarded globally as a leader in providing community and social paediatrics. The absence of primary care paediatricians in the UK (although concept had been successfully piloted, eg in West Lothian during the 1990s), means that a possible gap has developed between primary care and community paediatrics. The future role of GPs in the care of children may need to be re-examined.

[44] Crouchman M, Pechevis M, Sandler B. *ADC* 2001;84:299–301.

Section 5: The modernisation agenda for paediatrics in the UK

Modelling the Future

To provide some guidance for services and to meet the challenges in delivery of paediatric services the RCPCH "Modelling the Future" (MTF)[45] reports described a variety of models of paediatric care depending on local circumstances and in the context of changing training arrangements and EU working time regulations (EWTR) which limit working hours.

Figure 7 Modelling the Future: Vision of Care across Acute and Community Settings (RCPCH 2008)

Modelling the Future envisages teams of paediatricians delivering "urgent" and "planned" care with a portfolio of skills within a team of other professionals across hospital and community settings. The career of a consultant paediatrician would include very demanding acute work with a great deal of out-of-hours cover in the early consultant years to a greater emphasis on planned care in their later years. Innovative approaches to job planning for clinicians and good continuing professional development will obviously contribute to implementing such "portfolio" careers

Changes in Training of Junior Doctors

In 2005 the Modernising Medical Careers (MMC) programme marked a major reform in postgraduate medical education across all specialities. Following graduation all doctors spend 2 years in foundation programmes which lead doctors through a holistic programme of training and education. Subsequently they will enter an 8 year specialty ((ST1-ST8) or GP orientated "run-through" training programme leading to a certificate of completion of training (CCT) at the end.

In order to match the number of trainees to consultant posts, the number of trainees is strictly controlled. However, once enrolled in a training programme, with a "number", the trainee can take time out or work flexibly and still be guaranteed a place to re-enter training. This issue creates difficulties when combined with EWTR requirements maintaining middle grade (ST3-6) rotas.

This need for consultant cover for acute rotas has resulted in consultant appointments which are reconfigured with solely acute duties or with a more generic

[45] RCPCH Modelling the Future 1-3 2008–2009

role combining community and acute duties as Professor Craft envisaged in the RCPCH report "Strengthening the care of Children in the Community" (2002).

The Basket of Competencies for CCH

The MMC changes resulted in a positive move to provide every trainee with an assured set of assessed competencies, including a minimum of 6 months in Community Paediatrics[46] as part of their core training. However, the author finds there is a considerable overlap between the competency framework for level 3 General Paediatrics and those for Community Paediatricians so perhaps in the future these programmes could be better integrated.

The essential competency domains for CCH in the Higher Specialist programme for CCH (ST4-ST8) require skills in the following areas of practice:

- Vulnerable children/social paediatrics
- Neurodisability and chronic disease management
- General Paediatrics component
- Behavioural Paediatrics
- Public Health and Epidemiology

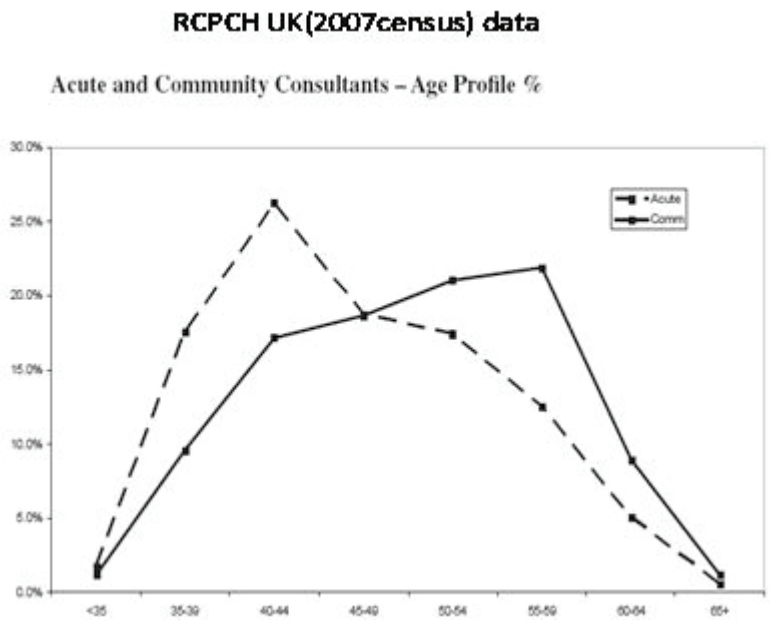
Note: If a model is adopted whereby a generic breed of paediatrician is appointed who undertakes duties both in the acute setting and in the community, then they require training at the ST5-8 stage to assure appropriate competencies in the care of children in the community.

Workforce Challenges

Because of workforce challenges, over the next few years it is anticipated that services will be delivered by trained doctors in consultant-led teams working in multi-disciplinary and skill-mixed teams. Workforce data shows that the current CCH workforce in Scotland is primarily female and a significant proportion of these are near retirement.

[46] RCPCH Community Child Health Competency Framework 2010

Figure 8: Age of Acute and Community Consultants (RCPCH 2008)



Challenges for the Present Service in Scotland

During the course of visits, by personal communication and from discussion with key stakeholders such as RCPCH and SACCH, it appeared that a variety of models of care are prevailing across Scotland. Informal networks exist but are not formally constituted with the exception of Child Protection and Complex Needs (Managed Clinical Network for children with exceptional healthcare needs (CEN)).

Children may receive one service or assessment in one area and not in another. Relationships with local authorities are variable, with some very successful partnerships with unitary authorities. However, where there are several authorities corresponding to a health board unit, complexities can arise when, for example, education and social work policies and structures vary across boundaries. Public health challenges such as obesity and improving the wellbeing of children and young people may have slipped in terms of priority because of the pressures on face-to-face clinical services. Strategic planning, which needs to be done in partnership with commissioners, local authority officers and communities, may also have suffered in this respect. The Health Board questionnaire has given an overview of how services are being delivered in 2010.

Section 6: Existing standards, performance and outcome measures relevant to CCH services

Scottish Government

The Scottish Government has published performance measures since 1997 when the Clinical Resource and Audit Group produced a range of indicators for acute hospitals. Davies (2005)[47] produced a report for NHSQIS in which he recommended the development of "comparable clinical indicators" but cautioned regarding the production of robust and interpretable data and highlighted the need to create (IT) systems that encourage "data usage in programmes of quality improvement at service level".

As noted in CCH services, paper recording systems are widely used which present challenges in monitoring quality. More recently the NHSiS Quality Strategy[48] has been published with a range of parameters for improving services.

- **HEAT Targets**

HEAT[49] targets were introduced in the "Better Health, Better Care" report in 2007. Those for 2008-9 covered three areas specifically relating to children: dental registration of 3-5 years; children defined as overweight completing healthy weight intervention programmes and new-born children exclusively breastfed at 6-8 weeks.

These could be used as an indicator of effectiveness of primary care and community services but not specifically for community paediatrics.

The new out-patient Did Not Attend (DNA) HEAT target sought to achieve a reduction of the DNA rate to 9.2% in the year ending March 2010. Overall, the rate was 10.5% in 2010, making the fact that three health boards are reporting DNA rates for CCH clinics at over 26%, very far from what is deemed acceptable for the whole Scottish population and represents lost opportunity and waste which can be ill afforded.

- **18-week Referral to Treatment (RTT) Initiative**

NHSScotland says that 18-week RTT sets "a whole-journey standard for almost all patient pathways - from GP to hospital". As noted from the HB questionnaire results, 2 large health boards do not apply 18-week RTT to their CCH clinics and do not intend to. It is not clear why CCH clinics (who see some of the most deprived children in Scotland and present the opportunity of mobilising early intervention for such children) should be exempt from 18-week RTT.

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[47] Davies H. NHS QIS 2005 Measuring and reporting the quality of health care: issues and evidence from the international research literature.
[48] Scottish Government. Quality Strategy 2010
[49] Scottish Government. Better Health, Better Care (2007) Health Improvement, Efficiency, Access and Treatment

RCPCH Standards

RCPCH has published a whole series of standards and College-endorsed guidelines[50] relevant to CCH practice on its website.

The "Charter for Paediatricians" (2004)[51] is a comprehensive document intended to improve working practice and promote best care for children. Helpfully it outlines the facilities a paediatrician should have to enable them to carry out their duties. Requirements particularly pertinent to CCH are marked * on the list.

"All paediatricians should expect to have the following:

- Satisfactory bed allocation in a suitable environment staffed by nurses with appropriate paediatric qualifications
- Access to short stay, day case and emergency beds*
- Dedicated paediatric outpatient departments*
- Children's services should not be disseminated too widely among too many centres*
- Support from appropriate multidisciplinary team*
- Full investigative facilities for children readily available*
- Access to modern information technology in clinical areas*
- Adequate facilities for education of undergraduates and post graduates*
- Appropriate secretarial support with cover arrangements for absence*
- Appropriate additional clerical and administrative support to undertake filing, photocopying, finding medical records, etc.*
- Consultant letters sent out preferably within 5 days and at a maximum within 10 days of dictation*
- Appropriate office facilities must be provided. There must be easily and readily available access to facilities for private work and confidential meetings, conversations and telephone calls, recognising the sensitive nature of much of the work which paediatricians are required to carry out, and the right to confidentiality of children and their families*

[50] See Annexe 5
[51] RCPCH A Charter for Paediatricians 2004

- The office must have access to appropriate IT facilities including access to e-mail and the internet for appropriate levels of CME/CPD commensurate with requirements for revalidation*

- Adequate arrangements to provide continuity of care."*

BACCH Standards

BACCH has published a number of helpful documents regarding monitoring and measurement of quality in CCH.

- **Standards for Outpatients (Annexe 12)**

These standards provide a comprehensive framework to enable services to provide a "flexible child friendly service appropriate to needs of the client and profession for all children and young people" relating to structure process and outcome parameters. This document can assist in monitoring quality in local CCH clinics, but it is apparent from the HB questionnaire that some services in Scotland are not meeting some of the parameters (for example appointment waiting times).
It is recommended that local services perform an audit of their CCH clinics to determine whether they are meeting these standards.

- **Service specification for Community Paediatrics (Annexe 9)**

Dr Fawzia Rahman and colleagues in Derby City PCT have produced a comprehensive service specification for CCH Medical Services and the author has received much support and help from DR Rahman regarding her methodology and results. Derby City is a small PCT and there is a small local CCH workforce. Further work was deemed necessary to adjust the specification for broader application in the Scottish context and taking account of different terminology and legislation. An informal consultation was carried out with a group of paediatricians working in the community and amendments were made. Further formal consultation may be needed before widespread application of this service specification.

The specification seeks to do the following:

- Define the evidence base

- Describe the service

- Specify the mode of service delivery

- Outline the Access criteria

- Define the discharge criteria

- Specify information and support for parents carers and children

- Lists the quality and performance standards

- **Standards for Child Development Services**[52]

This guide for commissioners and providers was published in 2000. It lays out the requirements for a comprehensive child development service, and why what is needed is needed. In particular it lists the client groups of children.

- **Job Planning Guidance for Consultant Community Paediatricians**[53]

This guide outlines best practice in job planning for CCH consultants.

[52] BACCH 2000
[53] BACCH 2005

Section 7: The Health Board (HB) Questionnaire Methodology

A questionnaire[54] was devised to elicit a range of information about how local Health Boards organise their community child health services. The questionnaire was approved by the Steering Committee. It was formatted in Questback (proprietary questionnaire software) to enable online completion with the help of colleagues from the Scottish Government Analysis and Statistics Division and in the hope that analysis of the information gathered would be easier.

Health boards were also sent a Word version of the document to enable data gathering before final completion of the questionnaire. It was expected that the Child Health Commissioner in each Board area would lead the task with input from key colleagues such as clinical and nurse directors from within clinical services. In some cases it proved difficult for data to be entered online and some Boards made paper returns which then required to be entered manually by members of the Child and Maternal Health Division administration. In a few cases, it was difficult to find an individual to gather the data, and the whole process from issuing the questionnaire to receipt of the final data took in excess of 3 months, far longer than was originally envisaged. Clarification of some responses was sought if they seemed unlikely or contradictory.

Questionnaire Response Handling

The data was received as a large Excel spreadsheet which was then subject to further analysis by the project consultant. A number of key themes emerged which related to structures, processes and outcomes in local CCH systems. Limited workforce data was also gathered but it was agreed that ISD and RCPCH census data would provide more detailed and robust information.

Summary of Health Board Questionnaire Findings

(For full report on findings see Annexe 4)

Management Configuration and CCH Clinic Arrangements

- More than half of HBs report they have a combined CCH and Acute Paediatrics Service which may be managed either in a directly managed unit or a CHP. However, 45% of CAMHS services are managed separately from either CCH or acute children's services.

- The number of senior managers responsible for CCH services varies widely and does not correlate with the HB population.

- The number of staffed office bases for CCH varies from 4-10 and does not correlate with the HB population.

- All HBs report they have local CCH clinics available for 0-16 year olds.

[54] See Annexe 2 for full questionnaire details

- 71% of HBs deliver general paediatric care in CCH clinics.

- Most CCH services across Scotland use a variety of premises in the community but a minority use child and family centres, forensic medical facilities and respite venues.

- In 5 HBs less than a quarter of clinics have reception and booking staff on site.

- 4 HBs report <50% of CCH clinics have adequate space to enable appropriate supervision of trainee paediatricians.

IT and Process Issues

- More than half of HBs use paper-based patient administration systems (PAS) for CCH clinics.

- 11 of 14 HBs use the national Support Needs System to monitor children with additional support needs.

- Half of HBs have online referral guidelines for CCH; 14% have paper guidelines only. One-third have none.

- One-third of HBs do not have shared patient pathways between CCH and CAMHS services for overlap conditions.

- However, more than two-thirds of HBs have clinical consultation sessions between CCH and CAMHS for problematic cases.

- In a few HBs CCH clinicians do not have any access to comprehensive clinical investigations or to online results.

Specialty CCH Provision

- All HBs except 2 island HBs have a lead (Tier 3) consultant in paediatric neurodisability.

- All HBs bar one have a senior community paediatrician leading for children with visual impairment.

- All HBs except two have a lead senior community paediatrician for children with hearing impairment.

- All HBs have a lead paediatrician for child protection.

- All HBs save 2 island boards have a one-door entry system for child protection referrals.

- In all HBs save 2 island boards CCH doctors participate in interagency initial referral discussions (IRDs).

- In the majority of HBs CCH clinicians have access to child protection peer review sessions.

Performance and Outcome Measures for CCH

- All HBs bar two large HBs operate 18-week referral to treatment (RTT) for CCH clinics.

- These two HBs do not intend to introduce 18-week RTT for CCH clinics.

- Waiting times for a CCH clinic appointment vary from a maximum of 4 weeks to 6 months.

- 3 HBs have more than 26% did not attend (DNA) rates in CCH clinics. Not all these HBs had a high proportion of deprived wards.

- 3 HBs did not know their DNA rates in CCH clinics.

- In terms of new to return patient ratios in CCH clinics, 7 HBs did not know their ratios for CCH clinics.

- Where known CCH N/R ratios varied from 1:1.5 to 1:9.

- 4 HBs did not consult parents/carers about their CCH clinics.

Participation in Networks and Planning Processes

- 8/14 HBs reported involvement in both national and regional networks by CCH clinicians.

- Only 4 HBs reported CCH involvement in local networks.

- However, the majority of HBs (71%) state there is CCH involvement in planning of children's health services at HB regional and national level.

Section 8: CCH workforce briefing

This examination of the medical workforce issues affecting CCH would not have been possible without the support of the Workforce Officer of the RCPCH and colleagues in NHS Education Scotland and the Scottish Government.

The current "trained doctor" workforce in paediatrics comprises consultants and specialist doctors who were formerly known as staff and associate specialist grade doctors (SASG). For convenience the latter designation is used.

When enumerating trained doctors in paediatric services the RCPCH census describes them in four categories:

- **Specialist** – working in tertiary centres with subspecialty interests and accreditation
- **General** – Working as general paediatricians
- **Combined** - contributing to both acute and community paediatric services and
- **Community** – Working most of the time in community settings

Figure 9: Present Configuration of the Paediatric Workforce in Scotland

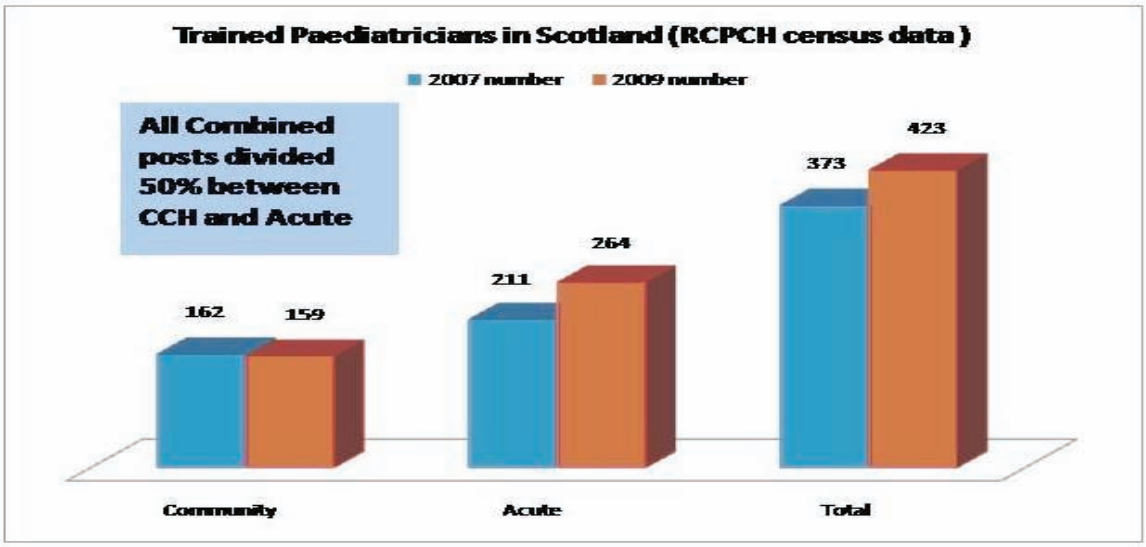
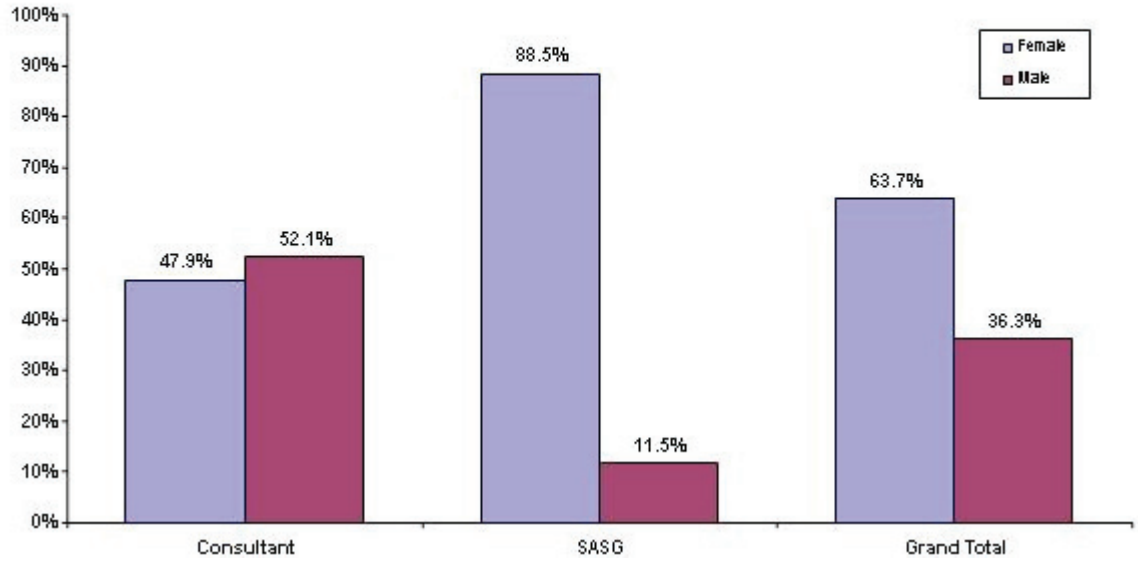
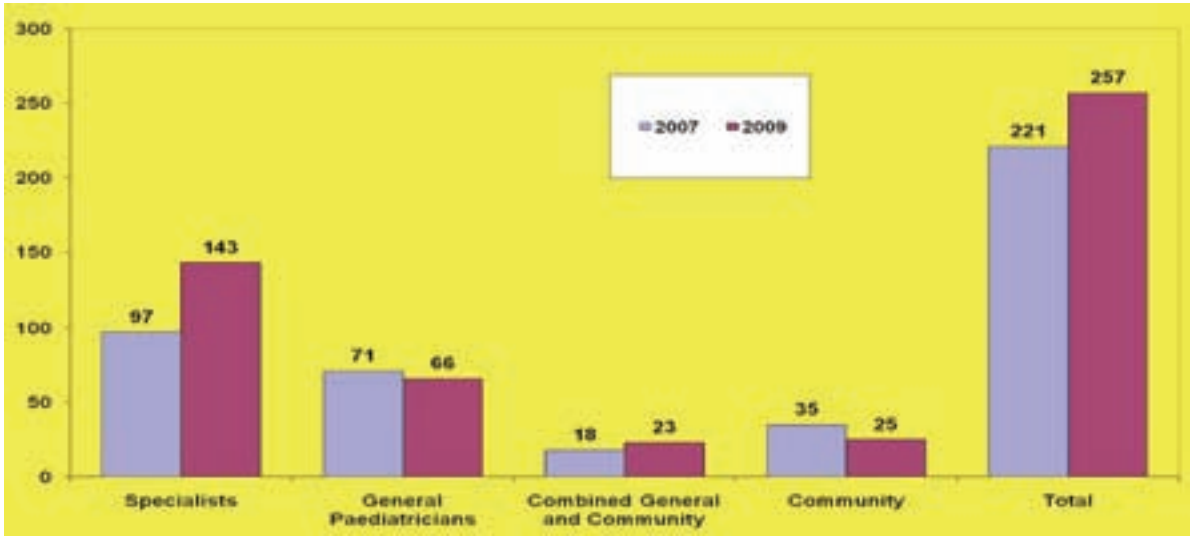


Figure 10: All Career Grade Paediatricians by Gender 2009 (RCPCH Census)



The proportion of trained paediatricians (consultants plus SASG), working in the community has fallen in Scotland from 43% in 2007 to 38% in 2009 and there has been a 16% fall in the number of community consultants in Scotland since 2007 even if "combined" posts are included pro-rata (see Figure 11). Simultaneously there has been a 47% increase in acute paediatric subspecialty consultants including neonatology.

Figure 11: Consultant Paediatricians in Scotland 2007-9 (RCPCH Census 2009)

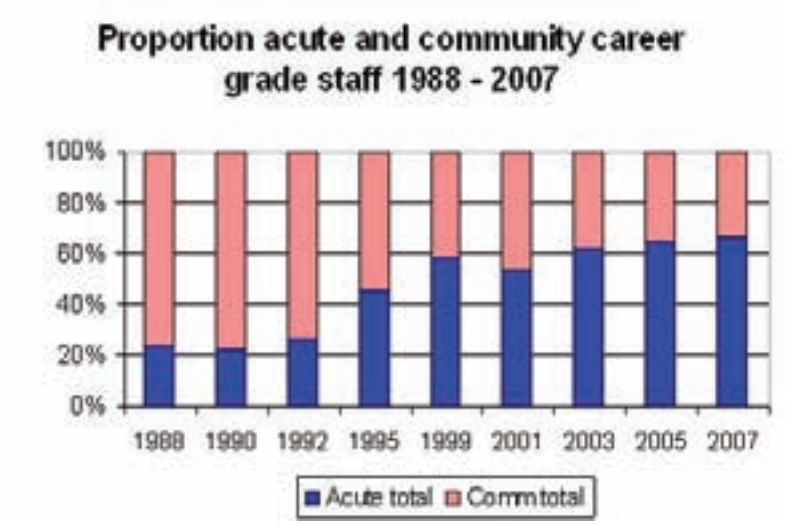


This mirrors the trend over the past 20 years experienced across the UK. In data provided by Dr Cliona Ni Bhrolchain[55] (Figure 12), it is easy to see that the proportion

[55] Ni Bhrolchain C. Chair RCPCH CSAC Community Child Health. Personal Communication. 2009

of trained paediatricians in the UK working in CCH has decreased markedly in relation to those working in acute paediatrics over the past 20+ years. Across the UK in 2007 about 38% of all trained paediatricians worked in community having been around 78% in 1988.

Figure 12: Proportion of trained Paediatricians in CCH/Acute (C.Ni Brolchain 2008)



Why Have CCH Numbers Lagged Behind Acute Paediatrics?

Despite clinical pressures on CCH services, there has not been investment in the medical workforce akin to that in the acute sector. Unfortunately, CCH activity has been ill-defined across the UK apart from a few beacon sites such as Derby[56], and the persistence of paper records (see Health Board survey results) in many services across Scotland has meant that arguing for workforce increases has been difficult to justify with good data.

Where excessive CCH clinic waiting times are recorded, scrutiny would suggest that staffing pressures may be contributing to excessive waits. Often, pressures from the acute sector have taken precedence over CCH when resources are tight and posts may be redesignated as acute posts. Short-sightedly, it has been said that " no child dies if CH services are cut". Unfortunately, there is no cost-benefit analysis available for the CCH service to the author's knowledge.

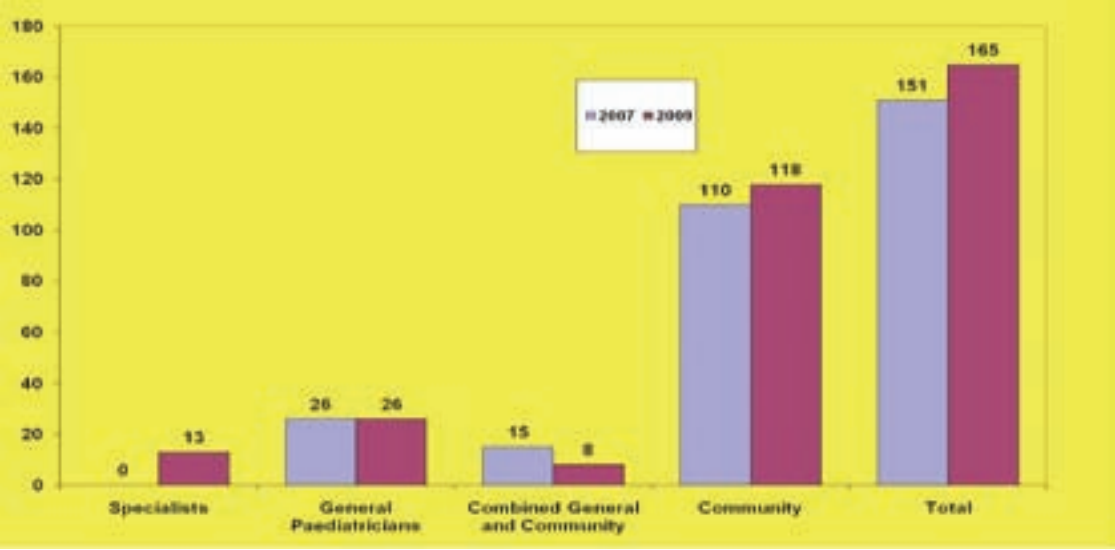
In recent times in Scotland, consultants have been appointed to combined posts (ie with both an acute and CCH role) but these numbers appear to be small (18 in 2007, 23 in 2009) although the SACCH questionnaire revealed that quite a few general paediatricians undertake CCH duties without being recognised as such. The RCPCH has been encouraging development of such posts in the Modelling the Future documents[57], especially in the DGH setting.

[56] Rhaman F. Derby PCT. http://www.bacch.org.uk/index.php
[57] RCPCH Modelling the Future (MTF) 2008–2009

The Role of Specialty and Associate Specialist Grade (previously SASG) Doctors

Although it is recommended that there should be consultant-led CCH services, CCH still relies on a substantial cadre of experienced SASG or specialist doctors (the new term for trained paediatricians below consultant grade) who deliver a large proportion of the current clinical CCH service with some SASG doctors also contributing to the acute and specialist care of children.

Figure 13: SASG Doctors in Paediatrics in Scotland 2007-9 (RCPCH Census 2009)



Over the past 10 years or so the proportion of SASG doctors in all paediatric specialities in Scotland has reduced from 50% in 1999 to 39% in 2009. In 2009, SASG doctors made up 39% of the total trained paediatric workforce in Scotland[58].

However there has been little change in CCH where SASG make up 77% of the total CCH workforce, which means that any future workforce plan needs to factor in their considerable contribution.

Age Demographics

The age profile of paediatricians varies between those practising acute and community paediatrics and between consultants and SASG doctors with CCH and SASG doctors being in general older.

Currently 64% of all consultant paediatricians in Scotland are over 50 years of age versus 72% of SASG[59] doctors. Although retiral at 65 will not be compulsory, present patterns indicate the majority of doctors will be retired by age 65, therefore there will

[58] RCPCH Census Report November 2010
[59] Source ISD Scotland 2010

be a need to replace the retirees and/or redesign work presently done by these doctors over the next 10+ years.

Figure 14: Acute and Community Consultants UK – Age Profile % (RCPCH Census 2009)

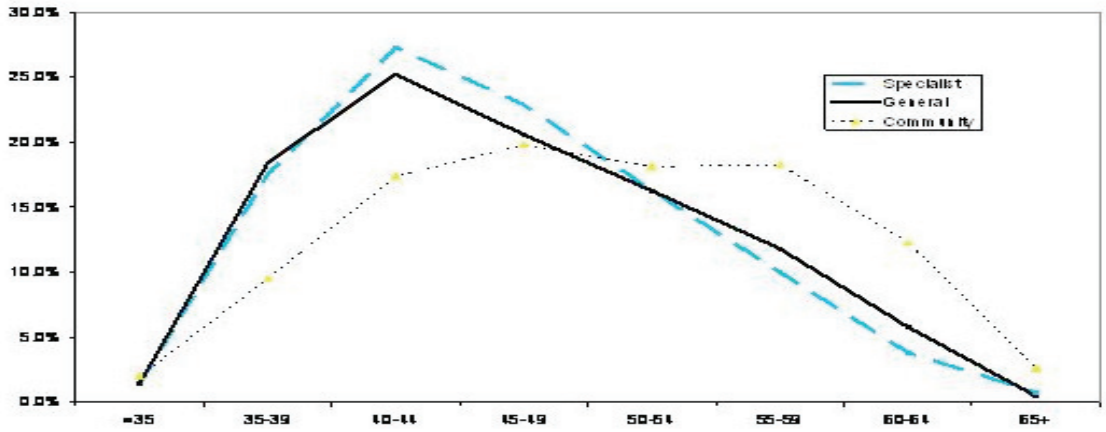


Figure 15: Age of Paediatricians by Grade in Scotland (2010) (ISD Scotland 2010)

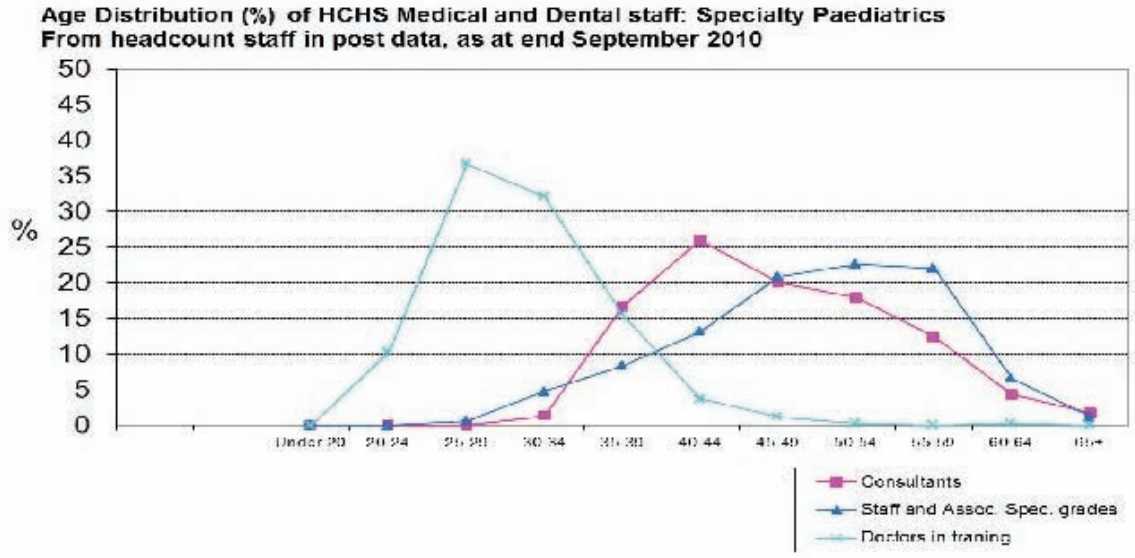


Figure 16: Proportion of UK Paediatric Consultants Under and Over 50 by Specialty (RCPCH Census 2009)

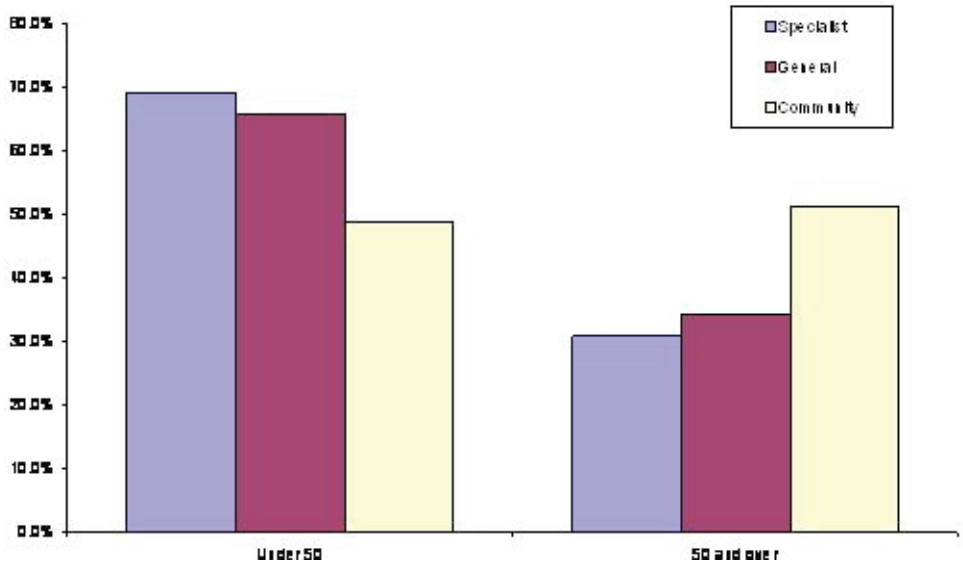
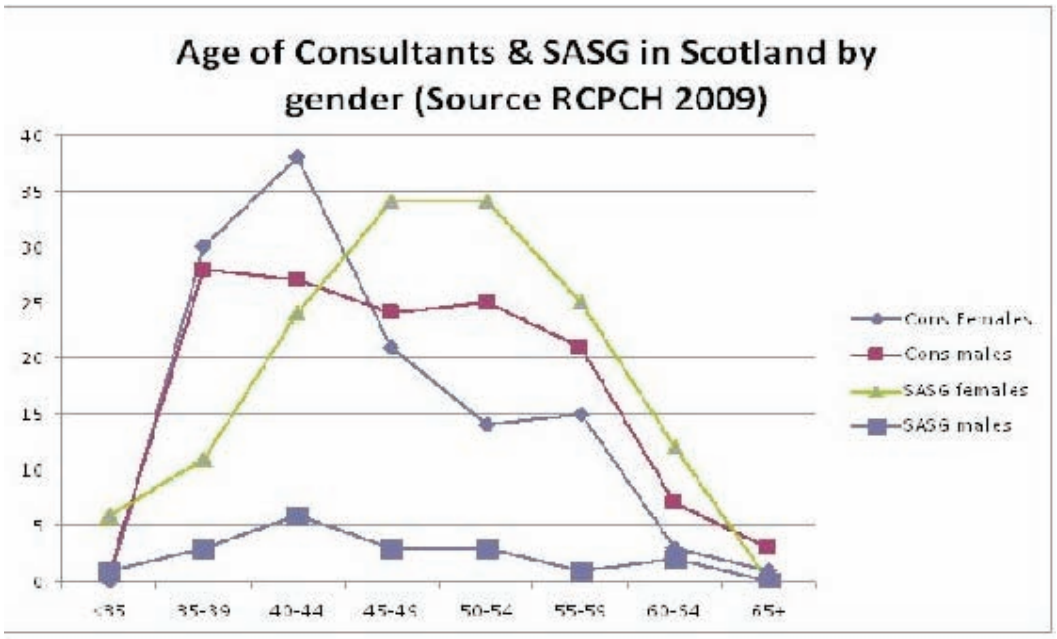


Figure 16 above shows a clear division between the under and over 50s, with more younger consultants in general and specialist paediatrics and more CCH consultants in the older age group. This confirms the trend towards acute specialties over the past 20 years.

In the Scottish profile below (Figure 17), there is a clear bulge in the number of over 45 SASG female paediatricians (of whom we know about three-quarters work in CCH), but also a peak of female consultant paediatricians of 40 and under.

The implication of these age facts is that currently demand for replacements is exceeding supply, and that younger paediatricians are tending to go into acute and specialist posts.

Figure 17: Consultants and SASG Paediatricians by age in Scotland (RCPCH Census 2009)



Section 9: Scottish Association of Community Child Health/Royal College of Paediatrics and Child Health questionnaire 2010: summary of results

At the first meeting of the CCH21 Steering Group, Dr Helen Gibson, the SACCH representative, offered to undertake a questionnaire of all consultant paediatricians working in CCH in Scotland to ascertain their work patterns. With the permission of SACCH, the results of the survey are summarised here.

Methods

The RCPCH Scottish Office kindly circulated the survey to all consultant paediatricians in Scotland. Colleagues were asked to respond if they undertook one or more clinical sessions per week in traditional community paediatric disciplines. Prior to the survey SACCH estimated there to be about 40 consultant paediatricians working in CCH. The estimate was based on membership lists and the knowledge of committee members.

Results

There were 48 replies with 44 meeting the inclusion criteria. Only 32% of the group had a specific reference to "community" in their job title. Responders came from 10 of the 14 Health Boards in Scotland with 25.6% from Greater Glasgow and Clyde Health Board (GGC) and 60.5% from GGC, Lothian and Grampian Health Boards.

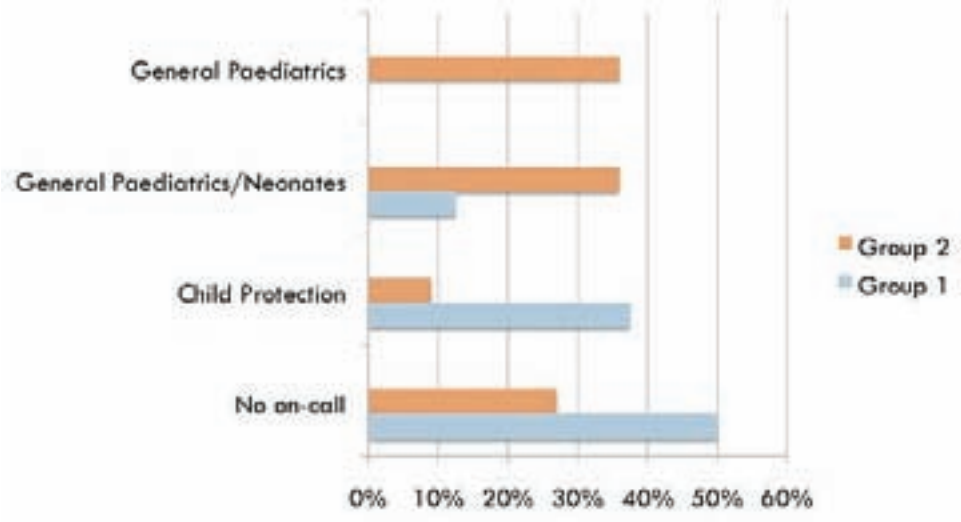
Because of a noticeable diversity of answers it was decided to analyse the responses by the amount of CCH work undertaken. Responders divided into two groups:

- ***Group 1 - More than 75% of job plan in CCH (n=16)***
- ***Group 2 - Less than 50% of job plan in CCH (n=11)***

Although the sample was small the findings are useful. The groups differed substantially in their characteristics in relation to on-call, main place of work and patterns of work and between the type of service in which they worked. In GGC, Lothian and Grampian 90% of survey Consultants work more than 50% of the time in CCH roles compared with 21% in other Health Boards. 82% had intended to work in CCH specialties, 82% had over 6 months training in CCH, suggesting that better trained and motivated paediatricians are attracted to the major teaching centres' CCH services.

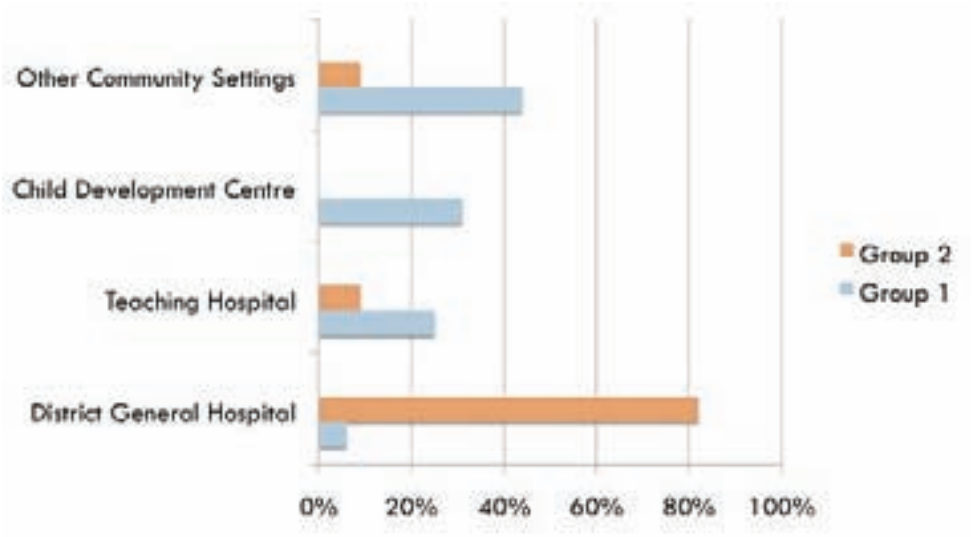
On-call Commitment by Group

There are significant differences between the two groups in terms of on-call commitments, with Group 1 (CCH duties dominant) doing child protection on-call, and Group 2 (integrated model) doing more general (acute) on-call and less child protection on-call. The newer consultants' job plans (delivering CCH in an integrated fashion) provide general acute paediatrics on-call. The future sustainability of separate child protection on-call rotas is doubtful.



Main Place of Work by Group

Overwhelmingly Group 2 were based in DGHs. Group 1 were in various community settings. Responders in Group 1 were drawn mainly from large urban centres (Lothian, GGC and Aberdeen) versus Group 2 consultants whose job plans may have been created to sustain acute rotas in DGHs.



Pattern of Work

Examining the CCH component of responders' work, 93.8% of the Group 1 consultants understand neuro-developmental work and 43.8% worked in four or more CCH areas of work (eg adoption and fostering, sensory impairment, child protection, behavioural paediatrics etc.).

Amongst the integrated consultants (Group 2), 55.6% undertook eurodevelopmental work but 27.3% stated they had no dedicated sessions in CCH. It has to be assumed that these consultants are undertaking CCH duties as part of their general paediatric

commitment and the skills and competencies are not considered to be specific to CCH.

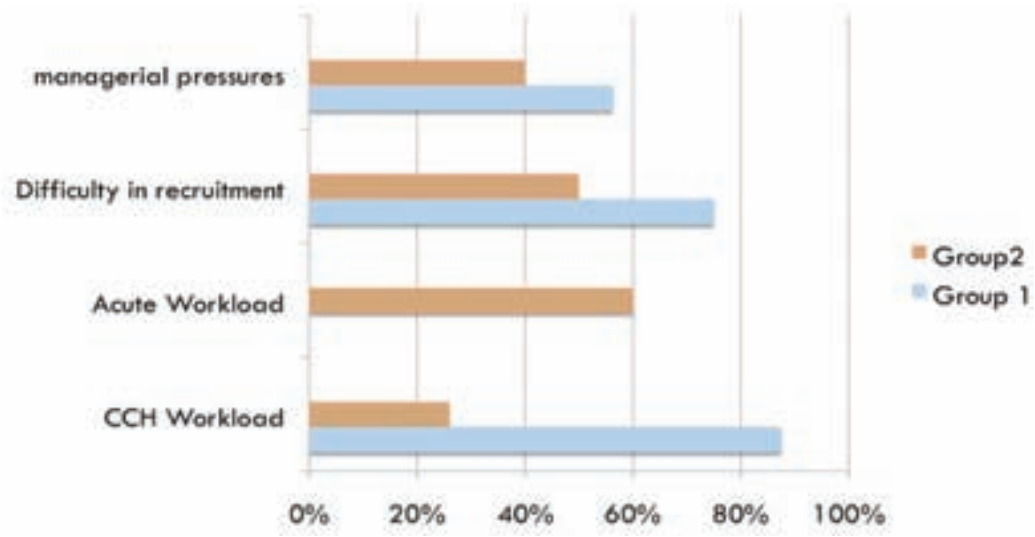
Dr Gibson highlights the following comments from three Group 2 (Integrated) consultants:

“I … see many children with problems traditionally CCH (mainly neurodevelopmental and elimination disorders), referred directly to the General Outpatient service.”

“CCH work was and is an automatic part of general paediatrician’s duties.”

“I do not think of my child protection duties as CCH.”

When asked about pressures on their CCH practice the consultants responded as follows:



Comment on CCH Pressures

“I am employed for 8 sessions, but regularly work 12-14. My referrals have increased 5-fold and the complexity has increased significantly. I could not possibly take on acute commitment in addition.”

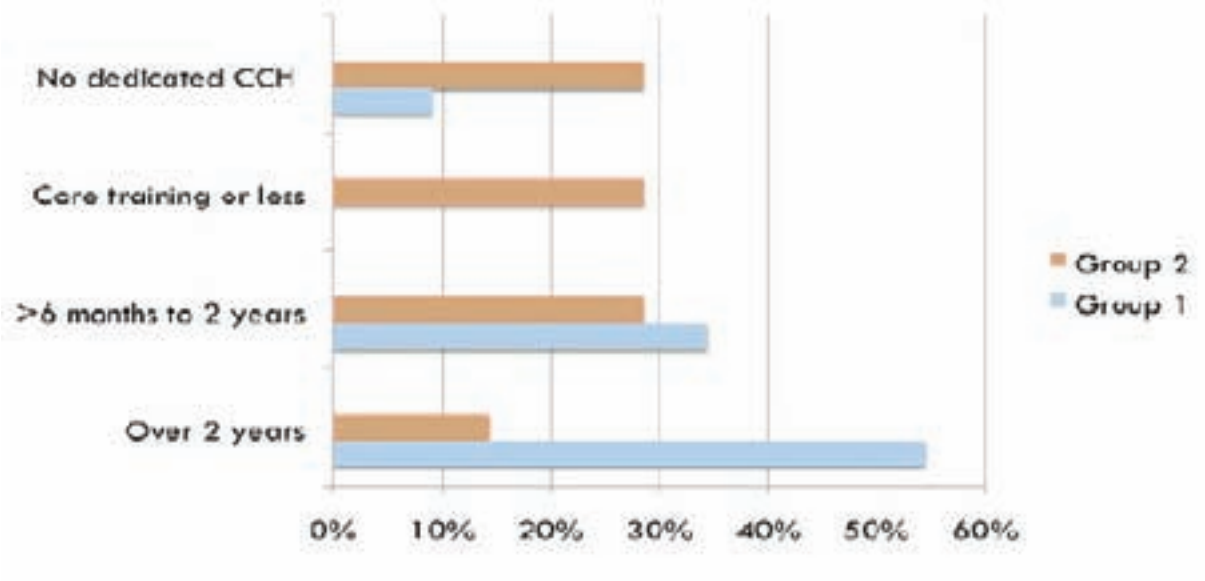
In terms of the consultants’ original career intentions:

- 73.3% of the whole group had intended to work in CCH as a consultant
- 100% of group 1 had intended to work in CCH as a consultant
- 14.3% of group 2 had intended to work in CCH as a consultant
- 20.5% of the survey had previously worked as Non-Consultant Career Grade Paediatricians

These replies indicate that a number of the consultants in Group 2 (integrated model) find themselves undertaking CCH duties even although they never intended to do so.

Previous Training in CCH

Responses about previous training in CCH showed about ***30% of Group 2 had had only core training in CCH and 30% no training at all***. Of Group 1, 55% had had more than 2 years. This finding concurs with the findings of the ST survey.[60]



Summary of Survey Findings

Dr Gibson showed two predominant models of Consultant work in CCH in Scotland – the Group 1 the ”traditional” model – working predominantly in CCH in community settings, covering a number of CCH specialties and the Group 2 an “integrated” model – with the majority of their workload in general paediatrics.

The integrated model (Group 2) was mainly based in DGHs where consultants had less specific CCH training and original intention to work in CCH. Consultants describe acute paediatric workload stresses and problems in recruitment of doctors with community expertise as their main pressures.

The traditional model (Group 1) consultants emphasise their greater training and expertise in CCH. Their work was community-based with a tradition of multi-agency and multidisciplinary team working. However, significant pressures in CCH workload have arisen from increased referrals and greater complexity.

[60] ST survey results, see Annexe 6

Author's Comment on SACCH Findings

This study confirms that workforce challenges are driving the consultant model in DGH settings towards combining general paediatric and CCH duties. There remain concerns about the competency and skills in CCH of these general paediatricians, especially in leadership and advocacy for the smaller subspecialties of CCH such as the care of Looked After and Accommodated Children and Young People.

Section 10: Academic CCH

Professor Alan Edmond wrote a paper for BACCH about the future of academic community child health in 2005. He outlined the threats and opportunities. Citing imminent retirals of a tranche of academics across the UK and difficulties in finding suitable candidates for the replacement posts. The RCPCH census for 2009 noted a small increase (+13 WTE) overall in academic paediatricians across the UK. But there as no specific data about CCH academics.

The CCH21 Steering Group consulted Professor Anne O'Hare (University of Edinburgh) and Professor Charlotte Wright (University of Glasgow)[61] to garner opinion about the future of academic CCH. The following is a summary of their remarks:

"The academic standing of Community Child Health is reflected in the number of professors in CCH in Scotland. This academic leadership reflects the main areas of work in Community Child ie generic and important paediatric implications such as growth and failure to thrive; neurodisabiliy and child protection. These areas have a resonance for research and academic endeavour and postgraduate training across all the paediatric specialties but with Community Child Health giving leadership.

Community Child Health is particularly well placed for research and supporting of postgraduates because of its child health information systems, eg the Support Needs System and also the Community Child Health Child Protection Database held in Lothian which holds information on all children who come forward for an inter-referral discussion through the child protection referral pathways. The RCPCH Scottish Surveillance BPSU is presently gathering information on the child protection issue of straddle injuries.

The workforce can benefit from research for example by developing appropriate skills for selection of children using clear eligibility criteria to go into research programmes that might involve basic science such as the molecular genetics, translational research and randomised controlled trials.

There are very strong links between Community Child and AHPs, professionals in education and social work and in the voluntary sector which has led to a number of consultants have supervising MDs and PhDs, both with medical staff and also with allied professionals.

A number of consultants in Community Child Health are tutors with the neurodisability diploma in the University of Sheffield and a number of neurodisability trainees have completed this diploma. Postgraduate trainees have presented widely at a range of national and international meetings and Community Child Health regularly supports postgraduates and undergraduates in activities such as audit and special study modules.

Community Child Health has contributed to the evidence base across a range of areas including that of treatments for language impairment and has been able to

[61] Personal references have been edited in this contribution

build on the privileged position that it holds in working across with other professionals and agencies.

Community Child Health is also well placed to conduct research into conditions that have mental health implications and we collaborate with colleagues in child psychiatry and psychology, eg around developing an understanding of attachment disorder in the face of child emotional abuse and its differentiation from empathy disorders such as autism spectrum disorder.

Summary

Community Child Health is well poised to progress the academic agenda and training into the 21st century and can build on the strengths of achievements to date, the scope from child health systems and the multiprofessional, multidisciplinary working that characterises the specialty of Community Child Health. Whilst a number of individuals work in collaboration with basic scientists, this specialty is also very well placed to develop the understanding of outcome tools.

Academic Community Child Health is a separate specialty and along with public health can work closely with the NHS, the Scottish Government and other bodies and play a useful dissemination role as well as undertaking research of direct clinical relevance and much postgraduate teaching and training.

Section 11: 2010 NES Specialist Paediatric Trainee Questionnaire

Methodology

The questionnaire was sponsored jointly by NES and the SGHD workforce division and RCPCH Scotland. The design of the questionnaire was agreed by the Steering Group and reference was made to a questionnaire issued to trainees in 2000 by Dr Linda Ross and colleagues[62]. The questionnaire covered a range of topics including demographics; future career intentions; training experience; hospital work and study/research facilities.

The BMA also helped by circulating to their trainee representatives. It was formatted using Questback proprietary software to enable online completion and was issued via local directors of training in the Deaneries across Scotland. All 220 Specialist Trainees currently undertaking paediatric training in Scotland were sent links to the online questionnaire by e-mail. There was a 25% response rate (55/220) despite multiple reminders to the trainees and the high-level sponsorship.

For fuller account of results see **Annexe 6.**

Summary of Results

Although only 55 out of 220 trainees replied it is not known whether the respondents were more or less likely to be interested in CCH than the non-responders to the questionnaire. Only 11% of the respondents expressed a wish to work as full-time CCH paediatricians versus 62% acute general paediatrics. About two-thirds expected to have had 6-9 months training in CCH (presumed core training) before they attain their CCT. Only 11% would have spent two or more years in CCH. In general, training experience in CCH was rated better than 5 out of 10 by the majority of responders.

[62] Ross LM. ADC 2003; **88**:97–98

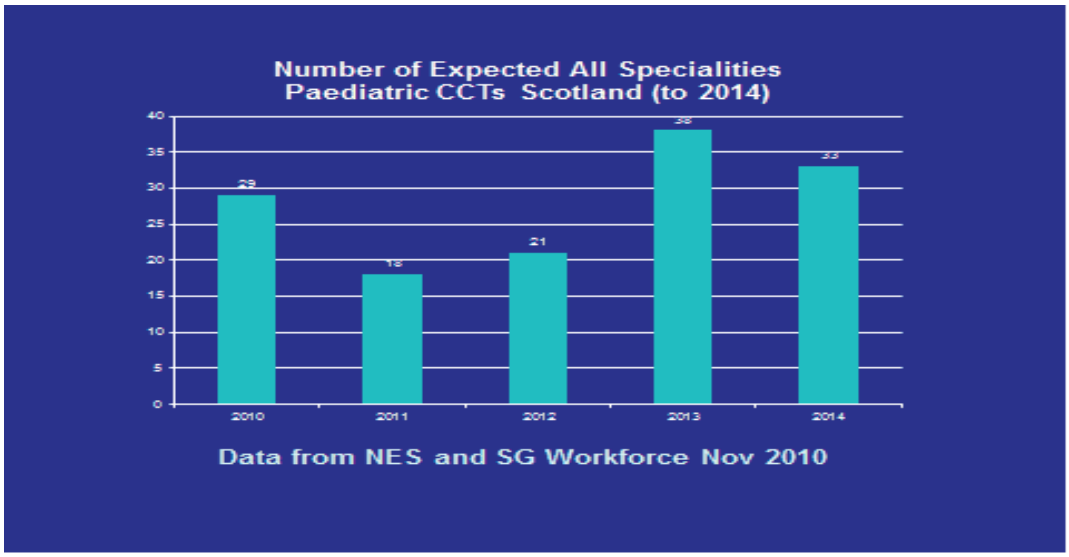
Section 12: Paediatric trainee demographics in Scotland

In 2005 the start of Modernising Medical Careers (MMC) established 'run-through' training for doctors, whereby doctors enter a training scheme at ST1 after two foundation years (FY1&2) and emerge after ST7 with a certificate of completion of training (CCT).

The number of doctors entering paediatrics at ST1 has been directly linked to consultant requirements and over the years has been reduced to bring the number entering training and those completing training into balance with the number of expected vacant consultant posts. There has been a gradual absorption of doctors already in training since the scheme started with the expectation that a bulge of trainees will emerge in 2013-14 with a CCT (see graph below).

However there is some uncertainty in these predictions as trainees may be on flexible programmes or take out of programme experience (eg overseas or to do research). There is an attrition (loss of trainees from the scheme) rate of 2-5% and currently a 10% vacancy rate amongst all ST posts in Scotland. The trainee numbers have not taken into account CCH vacancies, probably because the majority of these vacancies were in the SASG as opposed to the consultant grade.

Figure 18: Expected Paediatric CCTs to 2014



Current CCH Trainee Numbers

A recent poll of the NES Deaneries in Scotland was not encouraging in terms of current trainees undertaking higher training in CCH or neurodisability.

Note: Neurodisability is a subspecialty within CCH. Doctors trained in this area may take on some generic duties in CCH and may contribute to a regional paediatric neurology service depending on local need and the skills of the individual. Paediatric Neurodisability (PND) subspecialty training is allocated as part of a National Grid Scheme in the UK. The Chair of the PND College Specialty Advisory Committee

(CSAC), Dr Karen Horridge, provided the following information regarding PND training in Scotland:

> 2009 Grid entry: One NE Scotland; Two West Scotland (slot sharing)
>
> 2010 Grid entry: One SE Scotland (0.5)
>
> 2011 Grid entry: One West of Scotland

PND grid slots will be allocated "according to perceived need" and may result in fewer non-specialist CCH trainees in a Deanery because of the pressure on slots from other paediatric subspecialty grid schemes.

Deaneries in Scotland have reported there are no CCH trainees in the East, South-east or North Deaneries (See Table 1). The postgraduate advisor in the West Deanery has advised that around one trainee "with some CCH interest" will achieve their CCT each year. NES colleagues have advised that the calculation of ST numbers to date has not taken account of workforce requirements in CCH, so there has been limited central direction regarding numbers of trainees with enhanced experience in CCH/PND. Although there will be substantial numbers of trained paediatricians emerging in the next few years (2013-2014), most of them will have limited experience in CCH. After that numbers will reduce gradually. In the current year ST1 numbers are still being debated but between 16-24 are anticipated.

Table 1: Deanery Responses regarding CCH Specialist Trainees

Deanery	West	East	South-East	North
Current Numbers:	CCT within 1-2 Y: Neurodisability grid (SpR 0.6) 1 wholely CCH training (SpR 0.8) 1 (SpR 1.0 on mat leave) CCH plus general training	East currently does not have any higher specialist trainees in CCH	No trainees doing sole CCH, one 0.5 doing neurodisability which involves CCH	No higher trainees specialising in CCH
Future Numbers:	CCT in 2-4 years: 2 (ST6 1.0) 1 combining CCH and general training. 2 applying for Neurodisability grid 1 (SpR 0.6) current Neurodisability grid trainee.	May have a LTFT trainee in 2011	No information	No information

Summary

Given the age profile of the CCH medical workforce, it appears that the current number of trainees in the system are insufficient to replace expected retirals of trained doctors in CCH. Even if a model of paediatrician who undertake duties in both community and acute sectors is adopted, further training in CCH, including enhanced CPD opportunities will be required. The SACCH questionnaire revealed that over half of consultant paediatricians who are undertaking some duties in CCH have had under 6 months training. Over a quarter had had no training at all. Given the complexity and challenges of CCH work, there needs to be a review of the paediatric training strategy to ensure sustainability of the workforce.

Section 13: Future workforce requirements

In terms of model of care advice from RCPCH[63], in the small to medium DGH, it is thought that "combined" or "generic" paediatricians with a broad range of competencies could work across planned and acute care, in hospital and community settings, enabling a 24/7 consultant-led service with sufficient doctors in a team (assuming minimal middle grade cover) to comply with EWTR[64]. It is envisaged that with team job planning and the advent of "portfolio careers", consultants may opt to change the balance of planned and acute care during their working lifetime. Opportunities for retraining may be needed for consultants with no previous CCH experience. Any review of the paediatric workforce therefore needs to incorporate mechanisms to enable retraining in order to maintain maximum flexibility in a team of consultants.

The job plans of these "combined" paediatricians should allow a balance of time spent between CCH and hospital settings. In addition, acute on-call organised around "hot weeks" would be required. However, adequate time spent in community to build up networks and undertake interagency work in multi-disciplinary teams will also be needed. The challenge for these acute combined paediatricians is maintaining competencies where neonatal cover is also required. It is doubtful whether this model of consultant could be competent across all three domains of neonatology, general and community paediatrics.

Subspecialisms in Community Child Health

The issue of sub-specialties in CCH (paediatric neurodisability, child protection, looked after children and YP, behavioural paediatrics etc.) may require additional training to meet local needs, particularly in large urban populations. In Scotland, paediatricians with enhanced skills may be part of a regional or national managed network (eg child protection), ensuring delivery of the whole range of expertise across Scotland. Maintenance of these skills using peer review and telemedicine is already established through the existing managed networks. Managed networks could be considered for vision and hearing impairment services. Succession planning for such specialists needs to happen well before retiral to avoid a gap in service as they are very few in number.

Future of the Specialty Doctor in CCH

The future of specialty doctors (previously SASG) in CCH must be considered actively because of their age profile; the high level of contribution to CCH in Scotland; the vacancy rate of 10% amongst SASG doctors, and with many centres reporting difficulty in recruitment of suitably trained individuals.

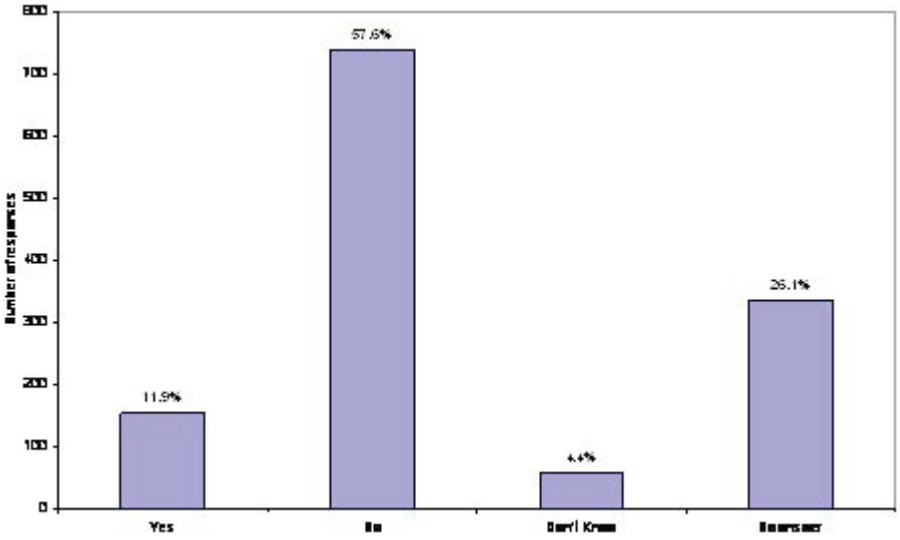
High attrition rates in the first few years of paediatric training have not resulted in good recruitment to the SD cadre in CCH. The reasons for this are not clear, but may

[63] MTF *ibid*
[64] Cook A. Reshaping the Medical Workforce in Scotland Update to NDPIG – July 2010

relate to a perceived unattractiveness of SD posts *per se* or CCH itself, or (more likely) of the increased attractiveness of general practice as a career in terms of satisfaction, family friendliness and remuneration.

The RCPCH 2009 UK census document included the following question and responses (referring to all SASG doctors in paediatrics): if a SASG post became vacant would it be replaced by a Consultant post? A response was received in respect of 950 of the 1285 SASG doctors (73.9%). Figure 18 shows that for 57.6% of posts, there would not be conversion, for 11.9% there would be, leaving 4.4% who were not sure and 26% non-responders. There is a significant number of non-responding services, but this suggests only a minority of services were contemplating conversion of SASG vacancies to consultants in 2009 . In view of the difficulty of recruitment, further examination of this problem would appear necessary.

Figure 19: If a SASG post became vacant would it be replaced by a Consultant post? (RCPCH Census 2009)



There are a number of options in terms of the way ahead and these may be applied in various combinations according to local circumstances:

1. Status quo: ie seek to fill SD/AS vacancies as they arise:

   If there are excess CCT holders over the next few years due to the ST "bulge" would some of these accept jobs at a lower grade? To work in the CCH service, additional "on the job" training may be required to enable such appointees to develop enhanced skills as required in CCH. To enable ST's entering the Specialist Doctor grade at the bottom to progress and have a satisfying career, excellent continuing professional development programmes need to be in place to allow competence and skills to be developed to meet local need.

   An alternative route to filling SD posts is from existing paediatric trainees wishing a career break from an ST training programme without acute duties. Presently this route does not favour re-entry to a programme at a later date.

Another alternative would be to "decouple" run-through training at ST3/4 stage so that trainees could take up an SD post and possibly be able to re-enter training through competitive appointments if desired.

Note: There has been no "decoupling" of posts after ST3/4 stage in Paediatric ST programmes across the UK unlike some other specialties such as emergency medicine, therefore doctors who might seek an alternative post at this stage will not be available unless they drop out of "run-through", which seems undesirable in terms of rational workforce planning.

2. Skill mix:
   Adopt a policy whereby vacant SDAS posts are reviewed and considered for re-allocation to either SD or consultant grade posts (accepting they may change to generic or CCH consultants as described above) as part of a pre- planned workforce plan.

3. Redesign: Review vacant SASG posts and reallocate to advanced AHP or nursing or both specialist/practitioner posts in the particular local clinical area of need according to requirements[65].

How Do We Know What CCH Workforce We Need?

In 1999 the British Association for Community Child Health (BACCH) published a workforce guide[66] which remains as the only guide of its type. The methodology of the guide is on the BACCH website[67]. However, because of service changes since the guide was published there has been a reworking of the guide taking into account the following factors:

- The original sessions were designated in 3.5 hour slots. These have been adjusted to 4-hour slots to fit the unit of programmed activity (PA) of the new SASG and consultant contracts.

- A number of tasks of CCH doctors have changed including:

  - Cessation of child health screening activity by CCH doctors
  - Contribution by doctors in training has diminished
  - Greatly increased survival of young people with complex needs
  - Greater recognition of disorders such as ADHD and Autism

- General paediatric duties were excluded

- Child protection work has become more demanding

The consultant contract initiated across the NHS in 2000 provides a balance between Direct Clinical Care activity (DCC) and Supporting Professional Activity

[65] NES has put in place a Paediatric Advanced Practice Network together with other training initiatives to encourage the building of expertise at this level across professions
[66] See Annexe 7
[67] http://www.bacch.org.uk/index.php

(SPA) measured in units of 4-hour programmed activities. When the consultant contract was changed in 2000 a ratio of 7.5 PAs to 2.5PAs was negotiated. More recently the expectation has been a ratio of 8.5DCCs:1.5SPAs and the onus has been on consultants themselves to argue for any additional SPAs on the basis of their responsibilities during the job planning process. For SASG doctors, in their new contract in 2008, 1SPA was agreed, ie a ratio of 9:1.

Deriving the total DCC PAs from the revised workforce guide (Annexe for a total population of 300,000 the table below shows workforce requirements.)

Table 2: Revised Workforce Guide: Estimated DCC PAs

	total DCC Pas			
Clinical Activity	**consultants**	**Assoc spec**	**Spec docs**	**total**
ASN/disability/gen paediatrics	10	7	8	25
Sub-specialties	6.5	16	8.8	31.3
Vulnerable children/YP	14.255	2	7.38	23.635
Public Health	1.75			1.75
total DCC PAs required	32.505	25	24.18	81.685

Making a range of assumptions about the number of SPAs in a job plan ranging from one (SASG and some consultants) to 2.5, the required establishment based on the assumptions in the revised workforce guide would be as follows:

Table 3: Estimated Required CCH Establishment for Population of 300,000

For 300K total population CCH establishment would be:			
Consultant	**AS**	**Spec Doc**	**Total**
WTE With 1 SPA			
3.57	**2.8**	**2.7**	**9.07**
WTE with 1.5 SPA			
3.8	**2.8**	**2.7**	**9.3**
WTE with 2 SPA			
4.1	**2.8**	**2.7**	**9.6**
WTE with 2.5 SPA			
4.3	**2.8**	**2.7**	**9.8**

To see exemplars of this model some defined populations in Scotland see Annexe 10.

The Whole of Scotland Model

Applying the model to the whole of Scotland (Population 5.194 million)[68], the total establishment of trained CCH paediatricians derived is very similar to the current workforce numbers which implies that the current trained doctor CCH workforce numbers are adequate, although the balance of SASG versus consultants has not been examined at national level and the distribution of those trained CCH doctors across the country needs to be benchmarked against the workforce model for local populations.

In addition, no weightings or corrections for rurality, deprivation or number of part-time staff have been applied to the anticipated numbers of staff, and these would need to be agreed to a consistent formula (perhaps akin to the Arbuthnott formula for funding of health boards[69]). As already stated, there are currently 2.8 WTE trained CCH doctors in Scotland/100,000 population versus 2.4/100,000 in England and Wales, although the Chair of the RCPCH CCH CSAG suggests the aspiration is 4.5 per 100,00 population.

There is also no allowance for CCH subspecialties at Regional level. In relation to PND for example, the Chair of the CSAC suggests that the recommendation is 1 per 100,000 population, equivalent to a total of 52 for Scotland, although this level has not been reached across the UK. Encouragingly, all Scottish Health Boards bar two reported a lead consultant for paediatric neurodisability in the HB survey.

[68] GRO 2008
[69] Scottish Government. Fair Shares for All Final Report 2000

Table 4: Estimated Whole of Scotland CCH Workforce Requirements

Scotland population 2008	5,194,000		
Est no of CCH trained doctors WTE per 300,000 population			
9.3 (1.5 SPAs for consultants)			
9.1 (1.0 SPA for consultants)			
Est. total no of CCH trained paeds needed		161	
RCPCH Current CCH establishment (2009)			
	Combined General and Community CCH WTE (est50%)	Community	Total
Cons	23(12)	25	37
SASG	8 (4)	118	122
Other	0	1	1
total		144	160

Summary of Workforce Findings

There are insufficient expected CCTs in the pipeline to fill the expected number of CCH posts (SASG and consultant) likely to become vacant over the next 10 years. There is already a 10% vacancy rate amongst SASGs and a 6% vacancy rate amongst Consultant posts. Most current trainees have only core training in CCH, although this needs to be confirmed. There is a vacuum in terms of plans for filling the CCH SASG posts despite their age profile and large proportion of CCH work which they carry out.

Replacement consultant posts are now more likely to be "combined" paediatricians who have skills across acute and community, but support and further training will be needed for young consultants who are expected to carry out CCH duties with limited training.

Section 14: Findings of the report in relation to the original questions

Q.: What models are successful?

Across Scotland the most common model is a CCH service combined with acute services for children, co-managed either in a directly managed unit or a community health partnership. This model is that recommended by RCPCH. It would seem to offer most flexibility in terms of use of the medical workforce and also enable continuity of care for children and young people. Co-management of these services with community children's nursing, paediatric AHPs and CAMHS (55% of services) services are also seen. The HB questionnaire showed there is some best practice in terms of collaborative working with CAMHS, but in a number of areas this could be improved. Across the UK better results are seen if there is an effective IT and administrative infrastructure enabling efficient clinical administration.[70]

Q.: What should a Community Child Health Service be offering in Scotland according to the evidence?

The European model of paediatric care includes community paediatricians in 14 of 34 countries and the UK is commended for its provision. The professional bodies have laid down the elements of the service concerning the care of children with long-term conditions and disability, the care of vulnerable children (often termed *social paediatrics*) and the oversight of a population's needs and the policy & operational response to those needs in conjunction with colleagues in public health.

The accepted UK model for CCH is that of a locality-based team comprising paediatricians, allied health professionals skilled in working with children and specialist children's community nurses working closely with colleagues in primary care and local authorities.

Community-based paediatricians are ideally placed to intervene at an early stage for young children referred with a range of developmental morbidities[71] and can gain the trust of parents when interventions are being planned. These benefits can only be realised if the CCH service has appropriate staffing and infrastructure and waiting times are acceptable according to standards set for other groups in society (eg 18-week RTT). As has been said, a month is a long time in the life of a baby or toddler, especially for one where disadvantage prevails.

In the course of preparing the CCH21 report, it is apparent that a model whereby at least some paediatricians in a locality team work generically, ie in both acute and community paediatrics, is a way of smoothing the patient journey and also enabling adequate acute cover at trained doctor level. However, the limited training for general paediatricians in CCH (may be 6 months only) may mean that further work should be done to equip such consultants of the future with more skills in community paediatrics.

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[70] Rahman,F. http://www.bacch.org.uk/index.php

[71] Horridge K. ADC 2011Educ Pract Ed 2011;96:9-20

Q.: How does this fit with overall SG/COSLA policies?

In terms of current policy and guidance, the Scottish Government has had a welcome emphasis on the wellbeing and care of children in all sectors and early intervention for those most at risk of poor health outcomes. The recent NDP programme has seen investment in the workforce, but mainly in the acute specialist sector (47% increase in specialist consultants in 2007/9).

Despite this welcome investment of the consultant workforce, the CCH medical workforce has fallen progressively both in Scotland and across the UK. CCH doctors are the frontline clinicians in the diagnosis and management of young children with developmental and socially mediated disorders such as speech impairment alongside local multi-disciplinary teams. They can develop essential networks in the community with partners in the local authority and the third sector and are the current acknowledged paediatric experts in child protection.

Therefore ensuring a sustainable CCH service will be necessary to fully implement the principles of "Equally Well" and the "Early Years Framework" and the Scottish Government's child protection guidance[72].

Q.: How would the quality of the service be measured? By what outcomes?

The NHSScotland Healthcare Quality Strategy in 2010 emphasised the importance of "making measurable improvement in the aspects of quality of care that patients, their families and carers and those providing healthcare services see as really important".

Looking at the Scottish Government's HEAT standards for DNA management and RTT, there are significant challenges for CCH services in some areas to meet these. It would be appropriate to audit present CCH services against these Scottish Government standards and others such as BACCH[73].

A CCH service specification, if accepted, can provide a framework for measuring a range of outcomes agreed between the health board and CCH service. The lack of consultation of parents and carers reported by health boards in the survey (only 4 of 14 boards consult parents) does not indicate there is a consumer responsiveness or focus in most services. The "Participation Toolkit"[74] recently launched by the Scottish Patient Experience Programme could be of assistance in progressing a better partnership with parents and indeed children and young people to improve CCH services as suggested in the Quality Strategy.

[72] Scottish Government revised guidance on child protection, to replace the 1998 guidance Protecting Children – A Shared Responsibility: Guidance on Inter-Agency Co-operation.2010 http://www.scotland.gov.uk/Publications/2012/12/9727

[73] See Annexes 2 and 12

[74] http://www.bettertogetherscotland.com/bettertogetherscotland/682.html

Looking at published standards and guidelines relevant to CCH practice endorsed by RCPCH[75] there are a number of measures which could be adopted in relation to specific diseases and conditions such as autism.

Q.: What workforce do we need to deliver this model of care?

Detailed predictive workforce modelling has been outside the scope of this report. However, the demographics of the current CCH medical workforce, the future career paths of our trainees, the limited training in CCH for most trainees and the demands of the acute sector for trained doctors to provide cover, will result in few consultants trained in the specialist skills required for CCH practice, and no service in 10 years. The effects on the management of Scotland's most vulnerable children are likely to worsen health, educational and social outcomes.

The revised workforce model (Section 13; Annexe 10) suggests maintaining the current Scottish CCH workforce numbers (circa 160 WTE trained doctors) would be the absolute minimum required, equivalent to 2.8 WTE CCH trained doctors per 100,000 population. However, this figure omits particular demands such as correction for deprivation or rurality or supra-regional specialisms such as aspects of child protection (eg child sexual abuse management).

Q.: What are the implications for training and recruitment of the workforce?

In terms of the supply of doctors to carry out the clinical work defined above, it is clear there will not be a reliable supply of adequately trained potential appointees at consultant level given the large number of retirals expected over the next 5-10 years and the current 6% vacancy rate. The picture for SASG doctors in CCH is worse, with a 10% vacancy rate and great uncertainty regarding recruitment. Assumptions that the forthcoming bulge (2013/14) of paediatric doctors with CCT would take up specialty (SASG) doctor posts (starting salary £36.8k vs £74.5k as a consultant) in the absence of opportunities at consultant level in Scotland seem optimistic and not based on evidence. Home Office regulations do not permit non-EU doctors to enter the country for these posts. Few EU doctors will be skilled in the UK model of CCH practice.

In addition, if there is no decoupling of the run-through scheme in paediatrics at ST3/4 there will be fewer doctors for SASG posts which cuts out any recruitment at that level.

Some SASG recruits may come from the GP sector, but salary differentials are very marked. If decoupling were allowed, it is possible that the supply of doctors to the SASG would increase. To date the RCPCH seems to have resisted the idea of decoupling, although other specialty schemes have done so (Emergency Medicine and Obstestrics & Gynaecology).

[75] Annexe 5

Summary

Therefore, if it is accepted that Scotland's children and young people need and deserve a CCH service as specified in this report, fairly radical action requires to be taken to ensure a sustainable CCH workforce. The appointment of generic paediatricians with competencies across general paediatrics and CCH has already started in a limited way. Assuring more advanced CCH competencies for general paediatricians would improve their confidence and enhance their ability to deliver high quality care which is not just "hospital outreach"[76].

Boosting the CCH experience of a larger number of ST4-8 paediatricians already in the system could improve the supply of paediatricians with an interest in CCH. Both trainees and Deaneries would require to accept this notion and perhaps different approaches to CCH training need to be considered. Fostering closer relationships between all paediatricians in a local system by closely intertwined CPD, inspired mentoring and shared duties must be the way to improve the service to children.

Increasing the skill-mix in teams by redesign of some CCH SASG posts to substitute other clinical disciplines such as nurses and AHPs should be possible, although additional training of such individuals would be needed. The supply of such alternative clinicians relies on appropriate investment in nursing and AHPs and in their training opportunities which is a significant challenge for the NHS in Scotland.

Q.: What changes do we need to make to ensure the service is responsive and sustainable?

There is a full list of recommendations in Section 15.

[76] Note: 60% of Paediatricians responding to the SACCH survey who did c25% CCH work had under 6 months' training in CCH and 30% of them had no training at all.

Section 15: Recommendations

The report has been presented to the Children and Young People's Health Support Group. Next steps will be decided by the Scottish Government.

Recommendations

1. Model of care

1.1. All services adopt a combined (co-managed acute and community services) model whether in a directly managed unit or a CH(C)P or other configuration. CCH services should renew their focus on the care of vulnerable children in the context of Equally Well and other Scottish Government policies.

1.2. Services to review CCH co-working with CAMHS and ensure management arrangements facilitate delivery of best practice for children and young people with emotional and behavioural disorders.

2. Infrastructure

2.1. Review IM and T systems in use across combined paediatric services to:

2.1.1. Ensure all paediatricians in that system can access patient information readily both in CCH and the acute sector

2.1.2. Phase out paper systems eg for call/recall

2.1.3. Enable electronic access to clinical investigative facilities and access to online results for all CCH paediatricians

2.1.4. Ensure a standardised method of monitoring children and young people with disability such as the National Support Needs System

2.2. Make available online to all practitioners appropriate clinical guidelines and pathways for common childhood presentations including shared pathways for "overlap" conditions with CAMHS.

3. Standards, performance and outcome measures

3.1. By applying the priorities of the Healthcare Quality Strategy for NHSScotland (May 2010) to CCH services, ensure children, young people and their families receive the best care possible.

3.2. As part of the implementation plan, the specification for CCH services should be consulted upon and adopted as the benchmark for CCH services across Scotland with a related set of required outcome and performance measures for CCH including:

3.2.1. Adopting the 18 week RTT should be in place for all CCH clinics
3.2.2. Auditing CCH outpatient clinic facilities in relation to the BACCH standards

(Annexe 12) and make improvements if necessary

3.2.3. Monitoring and reporting of DNAs in CCH clinics with measures in place to minimize DNAs especially for hard to reach families

3.2.4. Introduction of measures of parent/child/carer satisfaction as a routine.

4. Workforce

4.1. SGHD/RCPCH/NHS Education Scotland and NHS Boards to undertake paediatric workforce modelling and a requirements analysis to enable delivery of the appropriate model of CCH across Scotland as part of a combined service and including consideration of regional MCNs for tertiary level CCH problems.

4.2. Address the predicted likely shortfall of CCH trained doctors by innovative workforce redesign including enhanced skills for nurses and allied health professionals in the care of vulnerable children, children with complex conditions and children with disabilities.

5. Training

5.1. RCPCH to consider adopting a 'generic' model of paediatrician with competencies across traditional community and acute general paediatrics, whilst retaining the required number of trained paediatricians with specialist competencies such as paediatric neurodisability according to population needs.

5.2. RCPCH to review CCH competencies required for paediatricians aiming for CCT in general paediatrics.

Annexe 1: List of Steering Group members

Alison Ritchie (Barnardo's, Scotland)

Dr Catherine Calderwood (Senior Medical Officer, Maternal and Child Health)

Kerry Chalmers (Scottish Government, Workforce)

Dr Alastair Cook (Scottish Government, Workforce)

Donna Hunter (NHS Greater Glasgow & Clyde, Community Paediatric Nursing Manager

Dr Helen Gibson (SACCH)

Fiona McManus (HMIe)

Gillian Garvie (Scottish Government, Maternal and Child Health)

Dr Jim Beattie (Chair, RCPCH)

Dr Katherine McKay (National Clinical Lead for Children and Young People's Health in Scotland)

Shirley Laing (Deputy Director for Early Years and Social Services Workforce)

Mary Boyle (NES)

Dr Deirdre McCormick (Scottish Government, Chief Nursing Officer Directorate)

Prof. Anne O'Hare (University of Edinburgh)

Dr Rachael Wood (Information Services Division)

Nicola Robinson (Scottish Government, Allied Health Professions Officer)

Saffa Baxter (ADSW)

Simon Watson (Barnardo's Scotland)

Jonathan Wright (Scottish Government, ASD)

Dr Zoë Dunhill (Project Consultant)

Annexe 2 BACCH list of recommended CCH services (2005)

Service	Staffing	Training
Primary care of common child health problems and child health promotion/surveillance Child Public Health:	GPs/A&E doctors Health visitors Practice nurses/A&E nurses Supported by paediatricians and child health nurses	Adequate levels of knowledge of primary level paediatrics in general practice – one practitioner with interest in child health Paediatric skills in liaison and working with primary care
a) overseeing health protection/promotion and prevention (eg: Sure Start initiatives, profiling local community, injury prevention)	Paediatrician* with an interest &/or public health nurses &/or Public Health physician with an interest in child health Paediatrician with an interest supported by nurses & public health physicians	Basic training for all paediatricians & child health nurses in population paediatrics and more detailed training for those with a special interest Basic child health skills for PH physicians
b) vaccination and immunisation		Training in vaccination and immunisation sufficient to act as an adviser and resource to immunisation programme providers Training and experience in child health surveillance/ promotion sufficient to act as advisor and resource to providers

c) Child Health Surveillance/ Promotion Coordinator	Paediatrician with an interest to liaise with primary care professionals undertaking CHS/P	Enhanced training for nurses to undertake the increased responsibilities of this role
Education liaison & SEN	Nurses should provide the main support to schools with clear referral pathways to appropriate secondary child health services, Paediatric input to support the nurses and provide medical advice to the LEA	Training for paediatricians related to educational needs of children and the SEN process
Vulnerable children including looked after children, children in need, refugee and asylum seeking children and child protection	Paediatrician with special interest in child protection and vulnerable children, supported by highly trained nurses Child health practitioners (particularly HVs and nursery nurses in primary care)	Adequate general level of awareness with additional training for nurses and paediatricians with a special interest

Behavioural paediatrics including services for enuresis and encopresis	Nurses in schools and community services Paediatricians in close liaison with CAMHS	Special training for Paediatricians and nurses with an interest in this area Improved levels of training for primary care practitioners in the management of behavioural problems in childhood
Audiology	Trained neonatal screeners 3 possible combinations: 1. Paediatrician trained in audiology 2. Audiology consultant working closely with paediatrician 3. Paediatrician with an interest working with paediatric audiology technician	Specialist level training for Paediatricians and nurses with an interest Specific training in screening MSc in Audiology desirable Paediatrician should have a good grounding in audiology As above
Neurodisability	Primary care practitioners with sufficient expertise to distinguish normal from abnormal development Paediatrician with special interest and nurses and PAMs	Adequate level of training in child development for key primary care child health practitioners Specialist training for those offering a secondary service

Children with longstanding illness including those with complex needs Adolescent & transition services	Paediatrician with special interest and nurses and PAMs Paediatrician, nurses and PAMs	Specialist training including palliative care for those offering a secondary service Specialist training for those offering service (there may be a need for all practitioners to receive enhanced training in the management of adolescent problems and particularly transition issues)

Annexe 3: The Health Board Electronic Questionnaire

Developing a 21st Century Community Child Health Service

The expert Ministerial advisory group; the Children and Young People's Health Support Group, has undertaken to carry out a piece of work to review the provision of Community Child Health Services. This questionnaire will provide information to the advisory group on the provision of services in your Health Board area which will help inform the review.

If you have any questions regarding the work of the advisory group or regarding completing the questionnaire please contact Stewart Squire on 0131 244 2704.

About you

*** What health board are you from?**

- ☐ Ayrshire and Arran
- ☐ Borders
- ☐ Dumfries and Galloway
- ☐ Fife
- ☐ Forth Valley
- ☐ Grampian
- ☐ Greater Glasgow and Clyde Highland

- [ ] Lanarkshire
- [ ] Lothian
- [ ] Orkney
- [ ] Shetland
- [ ] Tayside
- [ ] Western Isles

Service leadership and accountability

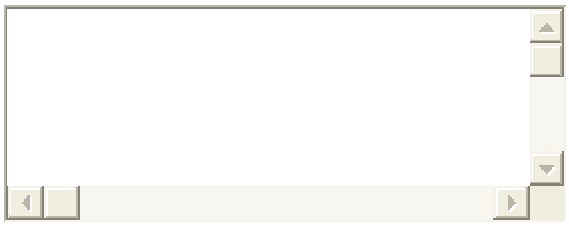
How would you describe your Health Board's Community Child Health Service? Please tick all that apply.

- [ ] Standalone in Directly Managed Unit
- [ ] Standalone in Community Health and Care Partnerships (CHCPs)
- [ ] Combined with acute service hosted in Community Health Partnerships (CHPs)
- [ ] Combined with Acute service in Directly Managed Unit
- [ ] Other, please specify

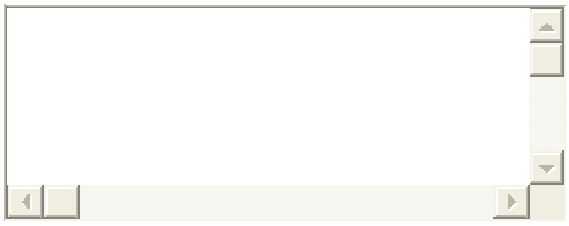
How many accountable senior managers does your Health Board have for budget and day to day running of your Community Child Health Service?

- [ ] One
- [ ] Two
- [ ] Three
- [ ] Four
- [ ] More than four
- [ ] Other, please specify

What is the span of responsibility of your accountable senior manager(s) for budget and day to day running of the CCH service?



What is the job title of your accountable senior manager(s) for budget and day to day running of the CCH service?



How would you describe the Community Child Health Services medical leadership for your Health Board area? Please tick all that apply.

- [ ] Dedicated lead clinician or clinical director for Child Health
- [ ] Dedicated lead clinician/ clinical director for Combined Service
- [ ] Other, please specify

Is the community child health service in your Health Board area co-managed with any of the following disciplines? Please tick all that apply.

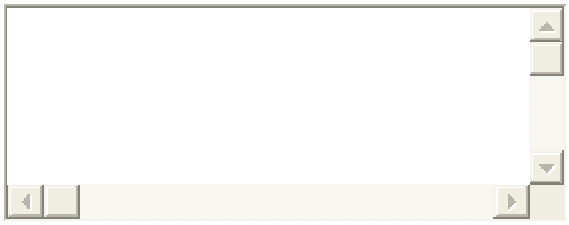
- [ ] Community nursing
- [ ] Allied Health Professionals (AHPs)
- [ ] Child and adolescent mental health services (CAMHS)
- [ ] Other, please specify

Has there been a significant management change in your Health Board area in the last 5 years affecting the Community Child Health Service (CCH)?

- [ ] Yes

- [ ] No
- [ ] Don't know

Please briefly describe this significant management change.

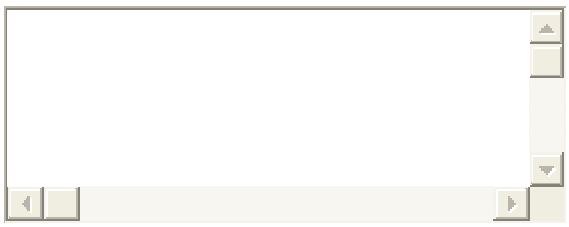


Infrastructure and support

How many staffed Community Child Health (CCH) office bases are there in your Health Board area?

- [ ] One
- [ ] Two
- [ ] Three
- [ ] Four
- [ ] Five
- [ ] Six to Ten
- [ ] More than Ten
- [ ] Don't know

What are the postcodes of each office base? Please list all Child Health staffed office base postcodes in your Health Board area.



What percentage of Child Health clinical staff in your Health Board area have access to PCs (intranet/web/email) on a daily basis?

- 100%
- 75 - 99%
- 50 - 74%
- 25 - 49%
- 1 - 24%
- 0%
- Don't know

Which of the following patient administration systems (PAS) are used for Community Child Health clinics in your Health Board area? Please tick all that apply.

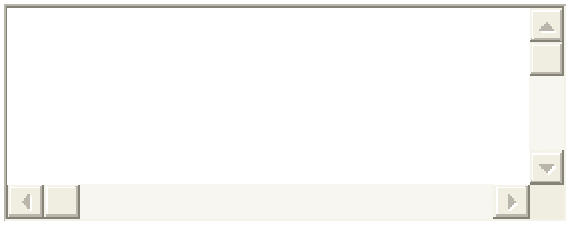
- Paper
- Locally devised database (eg EXCEL)
- Primary care system
- Proprietary software not shared with acute paediatric service
- Shared with acute service eg Medtrack
- Not shared but Community Child Health (CCH) can access Acute system to see appointment/admissions status
- Other, please specify
- Don't know

Is the 'National Child Health Systems' Support Needs System in use in your Health Board's Community Child Health Service?

- Yes
- No

- [ ] Don't know

Is another system in place to monitor children with disability? Please describe briefly.



What percentage of Children and Young People in your Health Board area are on SNS or other disability register as of 1/4/10?

- [ ] 0 - 05%
- [ ] 0.6 - 1%
- [ ] 1.1% - 1.5%
- [ ] 1.6% - 2%
- [ ] More than 2%
- [ ] Don't know

How would you describe your NHS Board's Community Child Health case notes?

- [ ] Unique to Community Paediatric Staff
- [ ] Shared with other disciplines in Community
- [ ] Shared with Acute sector notes
- [ ] Hospital notes available on demand
- [ ] Health Visitor records available on demand
- [ ] Other, please specify
- [ ] Don't know

Do Community Paediatricians in your Health Board area have direct access to any of the following imaging facilities? Please tick all that apply.

- [ ] X-ray
- [ ] Ultrasound
- [ ] CT
- [ ] MRI
- [ ] Nuclear medicine eg renal scans
- [ ] Don't know

Do Community Paediatricians in your Health Board area have access to any of the following laboratory facilities? Please tick all that apply.

- [ ] Clinical chemistry
- [ ] Genetics
- [ ] Pathology
- [ ] Microbiology
- [ ] Don't know

Do Community Paediatricians in your Health Board area have access to Neurophysiological investigations? Please tick all that apply.

- [ ] EEG
- [ ] Sleep EEG
- [ ] Evoked response potentials
- [ ] Don't know

Does your Health Board's Community Child Health Service have online access to the following results? Please tick all that apply.

- [ ] Imaging

- [ ] Lab
- [ ] Other, please specify
- [ ] Don't know

Clinic Facilities

What age range do clinics in the Community Health Service for your Health Board area cover?

- [ ] 0-16
- [ ] 0-18
- [ ] Other, please specify
- [ ] Don't know

Do all under 16's in your Health Board area have access to the following? Tick all that apply.

- [ ] Local Community Child Health clinic/s
- [ ] Child development centre/s (CHC)
- [ ] School-based clinics
- [ ] Other, please specify
- [ ] Don't know

What premises are used by Community Child Health staff for clinics in your Health Board area? Please tick all that apply.

- [ ] Local primary care clinic in a health centre
- [ ] Local GP surgery
- [ ] Rural general hospital
- [ ] Community Hospital

- [ ] Schools (mainstream)
- [ ] Schools (special)
- [ ] Respite facility
- [ ] Secure Unit
- [ ] Local District General Hospital Out Patients
- [ ] Children's hospital Out Patients
- [ ] Child and family centre
- [ ] Forensic medical facility
- [ ] Private school facilities eg Royal Blind School.
- [ ] Other, please specify
- [ ] Don't know

What percentage of your Health Boards Community Child Health clinics have reception/booking facilities on site?

- [ ] 0-24%
- [ ] 25-49%
- [ ] 50-74%
- [ ] 75-99%
- [ ] 100%
- [ ] Don't know

What percentage of your Health Board's Community Child Health clinics have two clinic rooms available simultaneously to allow clinical supervision of Speciality Trainee doctors by a senior clinician?

- [ ] 0-24%

- [ ] 25-49%
- [ ] 50-74%
- [ ] 75-99%
- [ ] 100%
- [ ] Don't know

Management of referrals

Is 18 week Referral to Treatment (RTT) in place across the Community Child Health service in your Health Board area?

- [ ] Yes
- [ ] No
- [ ] Don't know

Are there plans to introduce 18 weeks Referral to Treatment (RTT) across the Community Child Health service in your Health Board?

- [ ] Yes
- [ ] No
- [ ] Don't know

What referral guidelines available for the Community Child Health service in your Health Board area? Please tick all that apply.

- [ ] Online
- [ ] On paper
- [ ] For a few conditions
- [ ] Not at all

☐ Other, please specify

☐ Don't know

Are agreed pathways of care in place in your Health Board's Community Child Health service, including Girfec?

☐ Yes

☐ Not yet being implimented

☐ No

☐ Other, please specify

☐ Don't know

Is there direct access for referrers to the following in the community for children and young people? Please tick all that apply.

☐ OT

☐ PT

☐ SALT

☐ Don't know

In terms of triage of referrals (according to agreed guidelines) to the Community Child Health service in your Health Board area, which of the following are in place?

☐ By an individual

☐ By a multi-disciplinary group

☐ Across certain localities

☐ Across whole Health Board area

☐ Planned to introduce

☐ Not in place

☐ Other, please specify

☐ Don't know

Is a protocol in place with the Community Child Health service in your Health Board area for the management of Did Not Attend (DNA) patients?

☐ Yes

☐ No

☐ Don't know

How are vulnerable children who DNA managed within your Health Board's Community Child Health service?

What is the average rate of Did Not Attend (DNA) in Child Heath Clinics in your Health Board area as a percentage?

☐ 0 - 5%

☐ 6 - 10%

☐ 11 - 15%

☐ 16 - 20%

☐ 21 - 25%

☐ 26 - 30%

☐ 31 - 35%

☐ 36 - 40%

☐ 41 - 45%

☐ 46 - 50%

☐ 50 +

☐ Don't know

Range and scope of services Note: Tier 1 Primary care/universal services Tier 2 Secondary Paediatric services – Consultant-ledTier 3 Specialist paediatric services – Accepting consultant referralsTier 4 Supra-regional services

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Does your Health Board area provide Generic Community Paediatric Service Clinics (Tier 2)?

☐ Yes

☐ No

☐ Don't know

Does your Health Board provide General paediatrics OP delivered by Community Paediatricians (Tier2)?

☐ Yes

☐ No

☐ Don't know

Does your Health Board provide General paediatrics OP delivered as outreach by Hospital-based paediatricians (Tier 2)?

☐ Yes

☐ No

☐ Don't know

Does your Health Board have a neurodisability (Tier 3) lead consultant?

☐ Yes

☐ No

☐ Don't know

In your Health Board area where is neurodisability care is delivered? Please tick all that apply.

☐ School clinics

☐ CDC

☐ CCH Clinic

☐ Inreach to Hospital

☐ Other, please specify

☐ Don't know

Does your Health Board's Community Child Health service provide services for care of children with chronic illness/ long term conditions?

☐ Yes

☐ No

☐ Don't know

Where does your Health Board's Community Child Health service deliver services for care of children with chronic illness/ Long Term Conditions? Please tick all that apply.

☐ School

☐ CDC

☐ CCH Clinic

☐ Other Clinic

☐ Inreach to Hospital

☐ Other, please specify

☐ Don't know

Does your Health Board area have a visual impairment lead consultant?

- [ ] Yes
- [ ] No
- [ ] Don't know

Does your Health Board area have a visual impairment lead associate specialist?

- [ ] Yes
- [ ] No
- [ ] Don't know

Where does your Health Board area deliver services for visual impairment? Please tick all that apply.

- [ ] School
- [ ] CDC
- [ ] CCH Clinic
- [ ] Other Clinic
- [ ] Inreach to Hospital
- [ ] Other, please specify
- [ ] Don't know

Does your Health Board area have a hearing impairment lead consultant?

- [ ] Yes
- [ ] No
- [ ] Don't know

Does your Health Board area have a hearing impairment lead associate specialist?

- ☐ Yes
- ☐ No
- ☐ Don't know

Where does your Health Board area deliver services for hearing impairment? Pleaee tick all that apply.

- ☐ School
- ☐ CDC
- ☐ CCH Clinic
- ☐ Other Clinic
- ☐ Inreach to Hospital
- ☐ Other, please specify
- ☐ Don't know

Overlapping Conditions

Does your Health Board provide services for care of children and young people with "overlap conditions" such as ADHD/ASD/ etc between Community Child Heath and CAMHS?

- ☐ Yes
- ☐ No
- ☐ Don't know

What are the main services for childen and young people with "overlapping conditions"? Please tick all that apply.

	No service	Acute only	Community Child Heath only	CAMHS only	Shared	Don't know
ADHD	☐	☐	☐	☐	☐	☐

ASD	☐	☐	☐	☐	☐	☐
Somatising disorders	☐	☐	☐	☐	☐	☐
Learning disability	☐	☐	☐	☐	☐	☐
Emotional and behavioural disorders presenting in school	☐	☐	☐	☐	☐	☐
Complex neuropsychiatric conditions	☐	☐	☐	☐	☐	☐

Are shared pathways in place between CAMHS and Community Child Health for children and young people with "overlapping conditions"?

☐ Yes

☐ No

☐ Don't know

Which shared pathways are place for children and young people with "overlapping conditions"? Please briefly describe.

Are "Consultation" sessions for discussion in place for children and young people with "overlapping conditions"?

☐ Yes

☐ No

☐ Don't know

Child Protection and vulnerable Children

Does your Health Board have any of the following services for vulnerable children in place? Tick all that apply.

- [ ] LAACYP /Medical Advice to Adoption and Fostering service
- [ ] Comprehensive medical assessment of children deemed at risk
- [ ] Child protection (Including NAI, Child Sexual Abuse (CSA), Neglect, Emotional abuse)
- [ ] Don't know

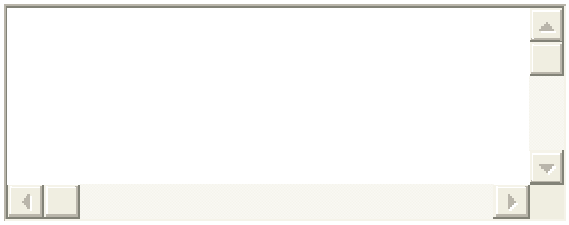
Is a one-door entry system for Child Protection referrals in place in your Health Board area?

- [ ] Yes
- [ ] No
- [ ] Don't know

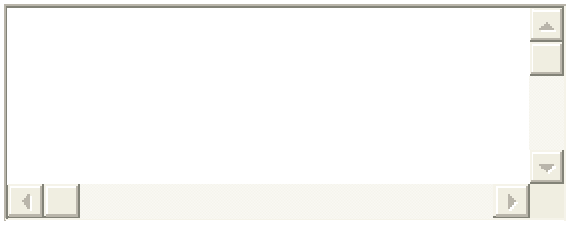
Do Community Child Health Doctors participate in Interagency initial referral discussions (IRDs) in your Health Board area?

- [ ] Yes
- [ ] No
- [ ] Don't know

Who within your Health Board area undertakes Forensic or other Medical Examinations for NAI?



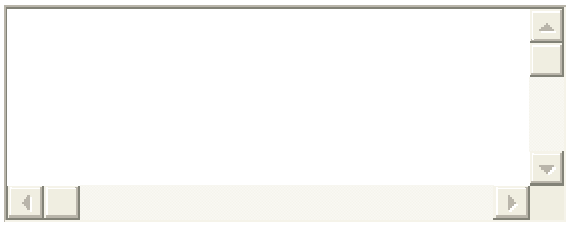
Who within your Health Board area undertakes Forensic or other Medical Examinations for CSA?



Are regular staff peer review sessions accessible in your Health Board area around child protection?

- [ ] Yes
- [ ] No
- [ ] Don't know

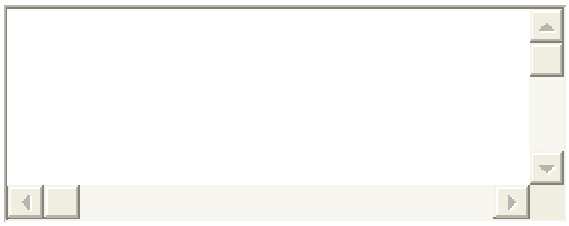
For children/Young People with Acquired Head Injury who provides Child Protection input in your Health Board? Please specify.



Does Court work (Witness to fact/expert witness) impinge on the Community Child Health service in your Health Board?

- [ ] Yes
- [ ] No
- [ ] Don't know

How does Court work (Witness to fact/ expert witness) impinge on the Community Child Health service in your Health Board? Please briefly describe.



Interface of the service

How would you describe your Community Child Health service's managed network involvement in your Health Board area?

- [ ] No involvement
- [ ] Local (eg Autism spectrum disorder)

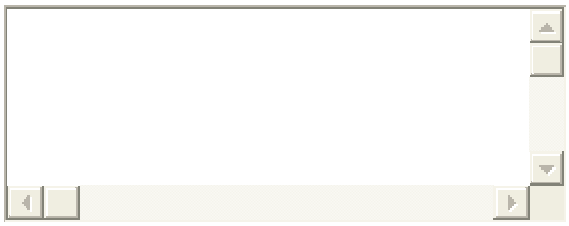
☐ Regional (associated with RPG eg CSA)

☐ National (eg CEN, Epilepsy)

☐ Other, please specify

☐ Don't know

Please give more details of this involvement?



Is any of the following interagency planning in place with your Community child Health Service in your Health Board area? Please tick all that apply

☐ Direct engagement with Children's Services Planning at Locality CHP level

☐ Direct engagement with Children's Services Planning at Board level

☐ Direct engagement with Children's Services Planning at RPG level

☐ Don't know

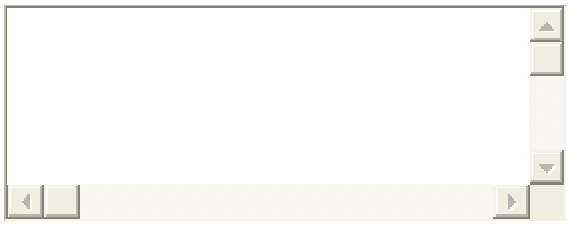
Is there as paediatrician on each Child Protection Committee in your Health Board area?

☐ Yes

☐ No

☐ Don't know

As there is not a paediatrician on each Child Protection Committee in your Health Board area how is Child Protection Committee business disseminated to Community Child Health (e.g. result of serious case review)?



Performance monitoring

In terms of activity what are the new return ratios for general Community Child Health clinics in your Health Board area?

What percentage of Children and Young People in your Health Board area are on SNS or other disability register as of 1/4/10?

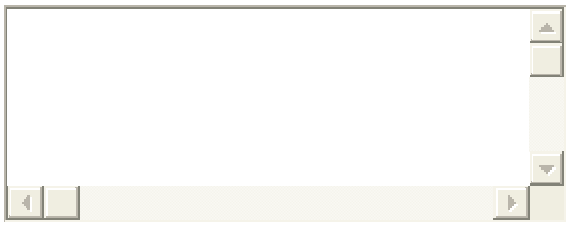
- 0 - 05%
- 0.6 - 1%
- 1.1% - 1.5%
- 1.6% - 2%
- More than 2%
- Don't know

What are the waiting times for Community Child Health new patient clinics in your Health Board area?

- Up to a week
- Up to two weeks
- Up to four weeks
- Up to six weeks
- Up to eight weeks
- Up to 10 weeks

- [ ] Up to 12 weeks
- [ ] Up to 14 weeks
- [ ] Up to 16 weeks
- [ ] Up to 18 weeks
- [ ] Up to six months
- [ ] Up to seven months
- [ ] Up to eight months
- [ ] Up to nine months
- [ ] Up to ten months
- [ ] Up to eleven months
- [ ] Up to a year
- [ ] Over a year
- [ ] Don't know

How is inequality of access to Community Child Health clinics addressed in your Health Board area?



What outcomes are measured around Community Child Health Clinics in your Health Board area? Please tick all that apply.

- [ ] Attendance rates
- [ ] Referrals

- [ ] Investigations
- [ ] Actions such as report for DLA/SCRA
- [ ] Parent/carer satisfaction – if measured how
- [ ] Other, please specify
- [ ] Don't know

100 % completed

Test Quest

Annexe 4: Health Board Questionnaire Findings

Notes:

- Where graphs are shown, the Health Boards are displayed on the X axis in order of population from the left.
- Comments follow as appropriate for each finding or group of findings
- The RCPCH terminology refers to a ***combined and integrated child health service***, ie with acute and community services co-managed and working closely with partners in local authorities, criminal justice and the police and the third sector.

Structure and Infrastructure Issues for CCH services

- **Management Configuration of CCH**

8/14 (57%) of HBs report CCH is combined with acute paediatrics which rises to 8/11 (73%) if Island Boards are omitted. One large HB currently has a standalone CCH in various community health partnerships (CHPs) with an overarching manager. 35.7% of Boards have a combined service with acute paediatrics in a directly managed unit. 21.4% are combined with acute in a CHP. 7 HBs co-manage community paediatrics, community children's nursing, paediatric AHPs and CAMHS services. 11 HBs (79%) report significant management change affecting the CCH services within the past 5 years.

- **Co-management of CAMHS**

In 45% of HB CAMHS in Scotland are not co-managed with CCH.

Comment: The majority of services are organised as a combined service with acute and community co-managed. Sometimes CCH is co-managed with CAMHS or CAMHS may be separate from other children's services with adult MHS. The shared interests of Paediatric Services and CAMHS require there is close co-ordination of service delivery and strategy.

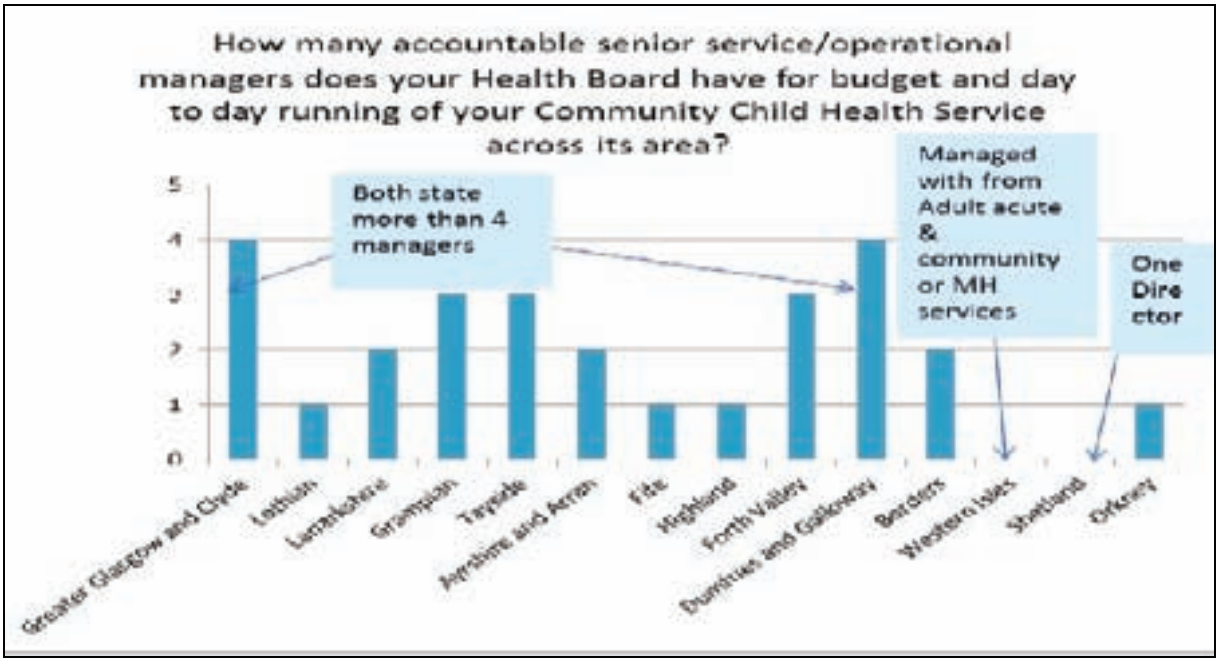
- **Clinical leadership models**

64% HBs have a dedicated clinical director for their combined service. Other boards have adopted similar lead clinician models. One HB reported a Head of Service.

- **Accountable senior/operational managers**

The number of managers for CCH vary from 1 to more than 4 (mean 2.25 managers reported).

Comment: There was no clear correlation with the size of the health board population. There might also have been a lack of clarity in the question eliciting vague answers.



- **Pattern of delivery of CCH and General Paediatric clinics**

In 10 (71%) HBs CCH staff provide general paediatric outpatient clinics (MTF model).

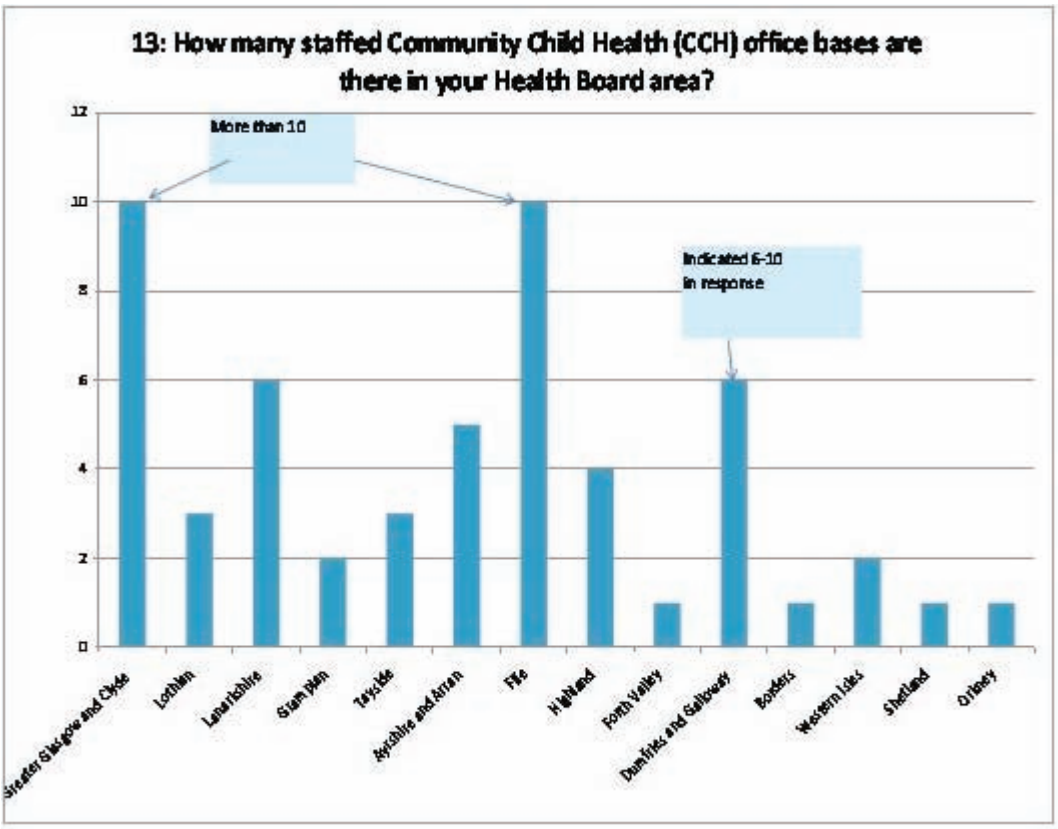
In 93% of HBs general paediatric OP clinics are provided by outreach from Hospital with 10 (71%) HBs using a combination of CCH and outreach from hospital (91% without island boards).

Comment: Perhaps some further discussion is needed about how general paediatric OP should be delivered by a combined service most efficiently.

- **Staffed CCH office bases**

The average number of CCH staffed office bases is reported as 4 with a range of 1-10.

Comment: Numbers of bases are not obviously related to population size of the HB but obviously rurality may be a factor here.



- **Patient administration systems (PAS) used in CCH**

57% of HBs are using paper-based PAS systems

29% use a locally devised database such as Excel

36% use a proprietary system shared with acute services such as Medtrack etc –

14% of services do not share their system with acute services but can access acute patient information by agreement.

Comment: Analysis of patient flows and DNAs is more difficult and time-consuming without adequate IT for patient administration and can lead to poorer attendance rates eg because text reminders cannot be sent easily. Some databases eg using excel do not adequate security.

- **Use of National Support Needs System (SNS) to monitor children with additional support needs**

11 HBs (64%) reported using the national SNS or similar database to monitor children and young people with additional support needs (ASN). One HB mentioned its local authority has an LD register. 4 HBs had no means of monitoring youngsters with ASN. The percentage of Children and YP on these databases varied from 0.6%-

5%. 5 boards did not answer this question. Across the UK, a figure of 2% of children and YP with ASN is evidenced.[77]

Comment: Carefully monitoring the number of children and young people with ASN is the way in which their needs can be best ascertained and planned for.

- **Premises used by CCH staff to see children and young people**

HBs were asked where CCH consultations took place from a range of venues: local primary care clinic in a health centre; local GP surgery; rural general hospital; community hospital; schools (mainstream); schools (special); respite facility; secure unit; local DGH out-patients; children's hospital out-patients; child and family centre; forensic medical facility; private school facilities, eg Royal Blind School.

Only one 1 HB uses 10 of the possible 12 venues described.

6 (43%) HBs indicate CCH clinicians are using rural general hospitals for consultations.

6 (43%) HBs report that CCH staff are using community hospitals.

8 (57%) are using mainstream schools and special schools.

5(36%) consult in a children's respite facility.

In only one HB do clinicians visit a secure unit[78].

64% HBs indicated CCH staff use local DGH outpatient facilities

43% HBs state CCH staff use children's hospital outpatient facilities

29% of HBs report CCH staff visit child and family centres.

In 29% of HBs CCH staff use a forensic medical facility (FMF).

Comment: A wide range of premises are used but a minority of CCH services use child and family centres, forensic medical facilities and respite facilities for consultations.

Process Issues

- **Availability of referral guidelines for CCH**

50% of HBs have online referral guidelines for CCH.

[77] ISD Summary of SNS statistics 2008

[78] Secure units are residential homes that cater for children at risk and offenders under the age of 16. There are around seven homes in Scotland providing 124 beds which are due to be reduced.

64% HBs use paper guidelines (2 use only paper guidelines). Paper guidelines may be difficult to access and become outdated rapidly.

29% of HBs have referral guidelines "for a few conditions" only.

Comment: Guidelines should be available online as well as on paper in all HBs. They can assist referrers in making the correct referral and avoid delays (see BACCH OP Clinic standards Annexe 9).

- **Shared pathways between CAMHS and CCH for "overlapping conditions" such as ASD, ADHD, somatising disorders etc.**

8(57%) HBs do have shared pathways and 5 (36%) HBs do not have shared pathways.

Comment: A lack of shared pathways could lead to duplication or delays in accessing diagnosis and treatment.

- **Availability of consultation sessions between CAMHS and CCH**

10 (71%) HBs have consultation sessions available but 2 HBs do not
2 HBs don't know if they have consultation sessions.

Comment: Consultation sessions enable communication between CAMHS and CCH clinicians to ensure effective referrals and appropriate patient management in the case of doubt. They are an accepted part of service in most HBs and perhaps should be regarded as essential.

- **Access to laboratory, neurophysiological and imaging investigations by Community Paediatricians**

  - **Imaging**

9 (64%) of HBs indicated community paediatricians have access to all of CT, MRI, ultrasound and ordinary X-ray facilities.

2 HBs indicated no access at all (one mainland and one island).

5 HBs indicated no access to nuclear scans.

  - **Labs**

In 7 HBs CCH doctors can access all of clinical chemistry, pathology, genetics, and microbiology.

3 mainland boards indicated no access to lab investigations and one did not know.

Comment: As community paediatricians are diagnosing and investigating children access to all these facilities is essential.

- **Neurophysiological investigations (EEG, Sleep EEG and evoked potentials)**

7 HBs have all three but 2 had none. These investigations are used with children suspected of epilepsy, language disorders and vision problems.

- **Online access to imaging and laboratory results by Community Paediatricians**

In 9 HBs (64%) access to both lab and imaging results online is available to CCH doctors.

79% have access to lab results only.2 HBs (one mainland) indicated no access at all.

> **Comment:** Online access to results allows clinicians to act in a timely and evidence-based way and can speed up diagnosis and communication with parents and avoid delays in appropriate treatment.

- **CCH clinic facilities**

- **Local clinic venues**
  All HBs have local CCH clinics accessible to under 16s.

  4 HBs do not operate clinics in schools (2 island and 2 mainland).

  10 boards have Child Development Centre (CDC) clinics accessible to under 16s. Others may restrict CDCs to younger children but this information was not elicited.

- **Clinic reception and booking capacity**

7 HBs reported >75% of their CCH clinics had these facilities.

5 HBs reported less than 25% of their clinics had reception and booking available on site.

> **Comment**: BACCH clinic standards[79] suggest a named clerk for each clinic. Not having reception or booking facilities may make life difficult for parents and can waste valuable clinic time if the flow of patients is not managed. Parents of vulnerable children who may miss appointments can be contacted in advance of a clinic by reception staff to improve their chances of attending.

[79] See Annexe 9

- **Capacity to accommodate paediatric trainees with consultant supervision (dual-consulting) in CCH clinics**

3 (21%) HBs report they have 100% of their clinics available for dual-consulting

4 (29%) HBs have >75% of their clinics available for dual-consulting.

4 (29%) HBs have <50% of their clinics available for dual-consulting.

> **Comment**: RCPCH recommends that CCH trainees be taught access to a consultant or other senior colleague during clinics. There needs to be two adjacent consulting rooms available in any clinic where trainees practise.

- **Availability of specialist community paediatricians in HB areas**

  - **Neurodisability**

All but 2 island HBs have a lead (Tier 3) neurodisability consultant.

5 of these 12 consultants work in school clinics

8 in child development centres

7 in CCH clinics

7 undertake inreach to hospital

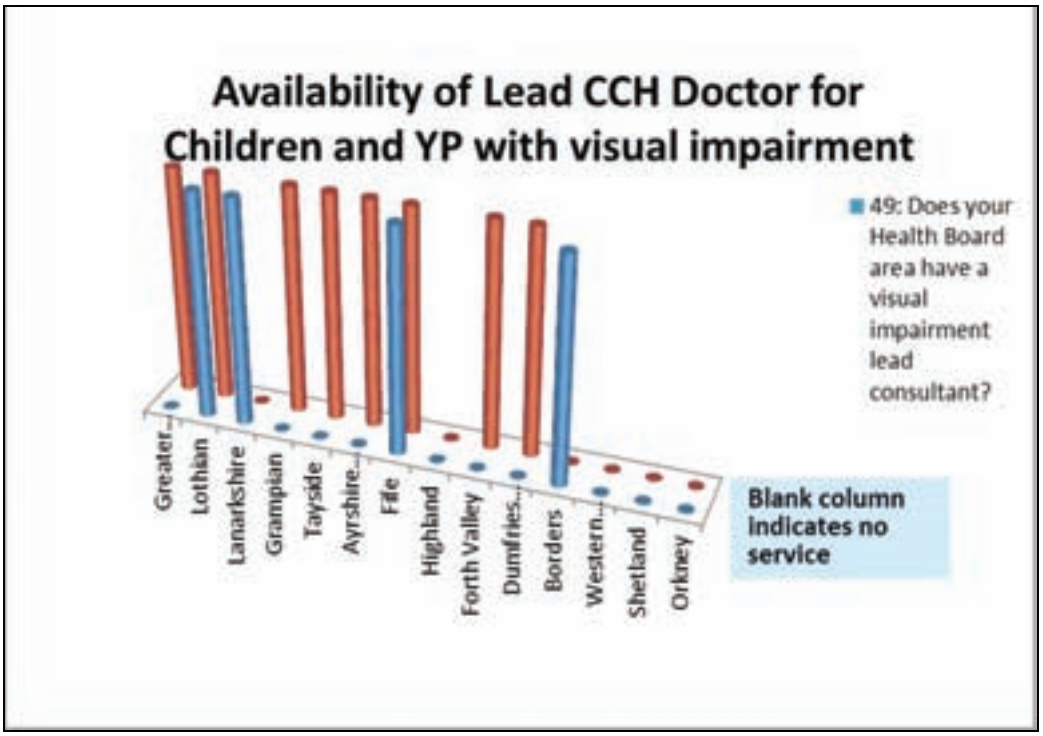
> **Comment**: The Chair of the CSAG for the neurodisability grid[80] indicates that their workforce model recommends one paediatric neurodisability consultant for a total population of 100,000. This would amount to 52 for Scotland and 13 for Greater Glasgow & Clyde. Exact numbers of PND consultants in Scotland are not available to the author.

  - **Long-term illness**

In relation to children with chronic illness and long-term conditions, care is delivered via school clinics in all but 3 HBs. These children and YP also receive care in CCH clinics in 12 HBs (86%) and by inreach to hospital clinics in 9 HBs (64%).

[80] Horridge K, Chair RCPCH CSAC Neurodisability Personal communication 2011

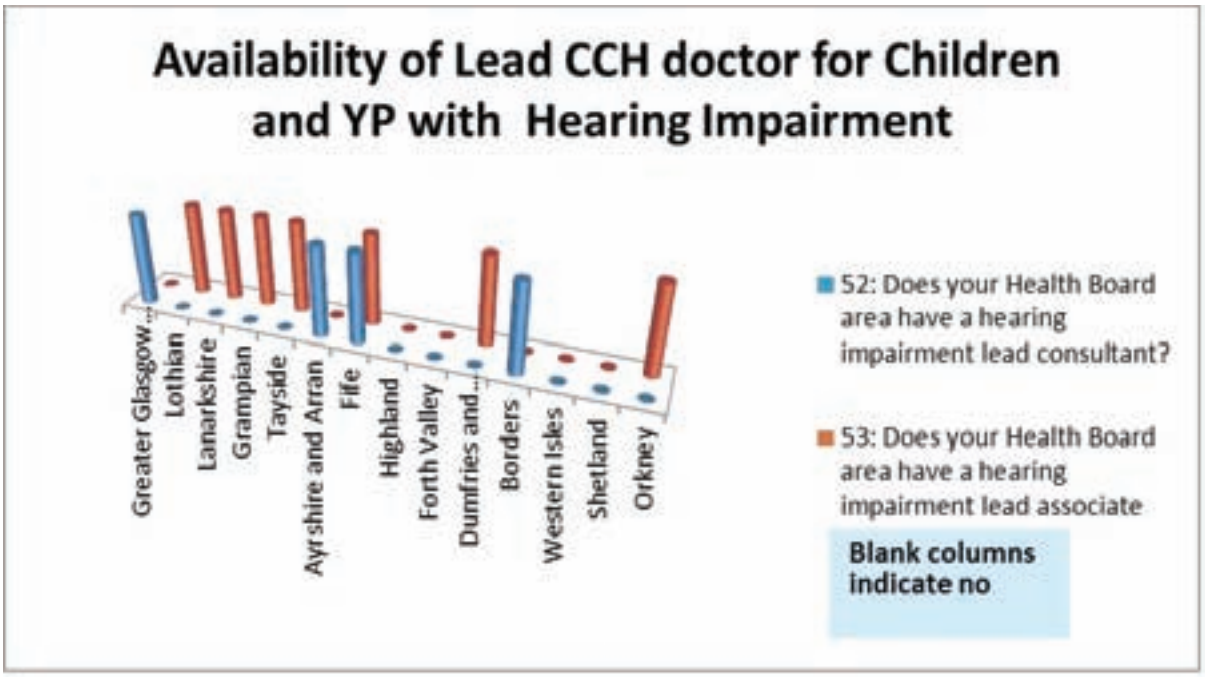
- **Special Senses**
  - **Visual Impairment**



4 HBs report a lead consultant (blue columns in diagram) for visual impairment and 8 an associate specialist (red columns in diagram). One HB has both. One mainland board has neither.

Comment: As part of the Scottish Vision Strategy (SVS) Implementation Plan (May 2009) NES was to "examine future workforce needs to meet skills and competencies and to consider service redesign". It is not clear if this recommendation applied to CCH services. At present there are no standards for the provision of visual impairment services for children and young people although there are opportunities in the formation of networks as recommended by the SVS.

- **Hearing impairment**



HBs were asked if they have a lead CCH doctor (Consultant or Associate Specialist) for children with a hearing impairment. The graph shows what is in place.

4 HBs have a lead consultant for children with hearing impairment.

6 HBs have an associate specialist lead.

One HB (not a tertiary centre) has both.

2 mainland HBs reported having neither.

Comment: Many children with significant sensorineural hearing loss will be detected by neonatal screening but their ongoing care needs to carry throughout their childhood and adolescent years, with a need for continuing team support, especially in the education setting. Children will develop also significant hearing loss during their later childhood. Doctors in paediatric audiology work as part of multi-disciplinary teams with close links to ENT and audiometricians.

- **CCH Services for vulnerable children and young people**

All 14 boards indicated that they provide comprehensive services for vulnerable children in respect of adoption and fostering.

13 boards also provide comprehensive medical assessment (CME) of vulnerable children and also child protection services including assessment of children

suspected of being abused (non-accidental injury; child sexual abuse; neglect and emotional abuse).

One HB indicated they did not provide CME or Child Protection services.

The question was asked “Is a one door entry in place for child protection referrals?” All save 2 island boards replied it was.

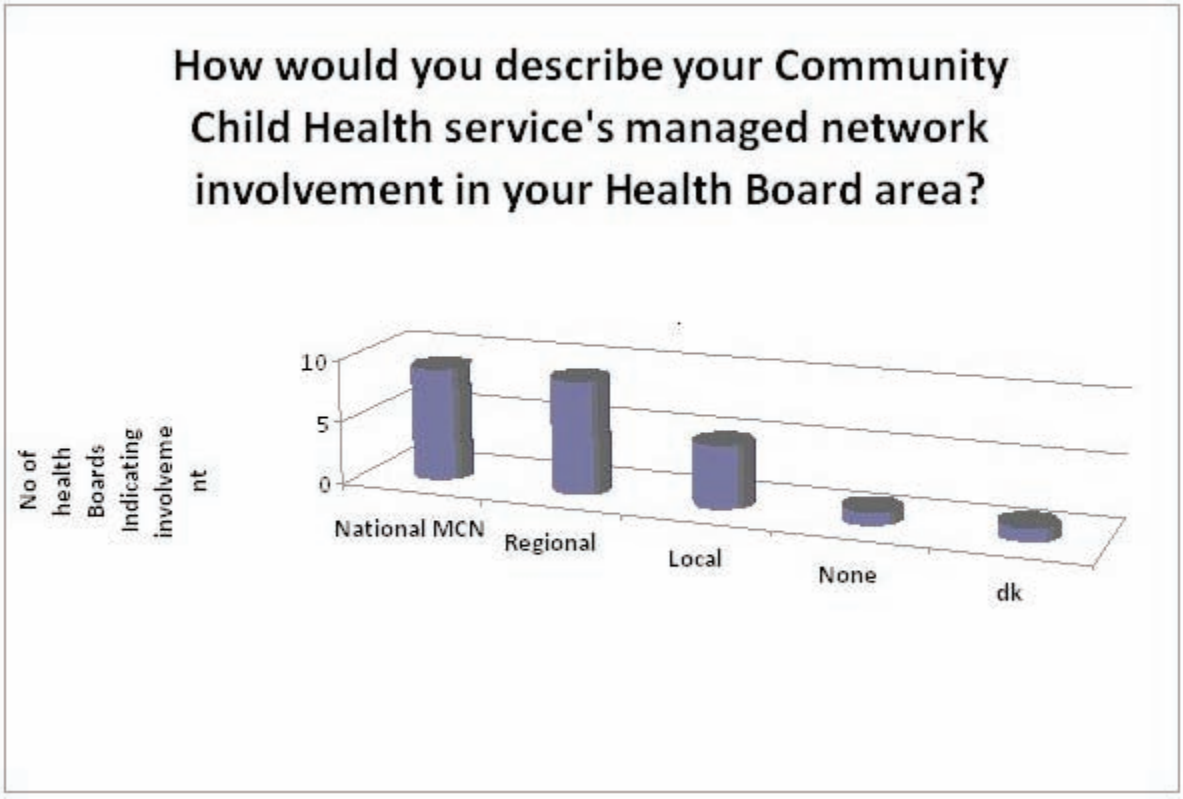
CCH staff are involved in interagency referral discussions (IRDs) except 2 island boards.

The majority of boards undertake peer review sessions for staff involved in child protection.

Comment: The RCPCH recommends that paediatricians participate in peer review sessions. HMIe recommends that IRDs are held when dealing with suspected abuse. HMIe has undertaken an inspection process of child protection processes in all local authority areas and further information can be obtained from their reports.

Planning activity

Health boards were asked about the participation of community child health staff in local regional and national networks.



8/14 HBs reported involvement in both national and regional health networks.

One HB reported no network involvement and one did not know.

Only 4 (29%) reported CCH involvement in local networks (eg local authority/CHP etc.).

Comment: The local network response indicates that CCH is still working in isolation from other agencies and acute services and there has been little inter-Board or inter-regional network activity compared to acute services for children, which have benefited from investment in regional networks.

However, when the question was asked about CCH engagement in children's services planning at locality/CHP, board and regional planning group level a slightly different picture emerged,

- **CCH engagement in children's services planning**

11 boards indicated CCH staff engagement at locality level, 11 at board level and 10 at regional level. 2 mainland boards had no engagement in planning at Board level. One mainland Board stated they did not know of engagement at any level.

Comment: It is encouraging the CCH is involved in children's services planning in a majority of HBs at all levels (79%). The answer to this question conflicts with that of the previous one.

CCH service performance and outcome measures

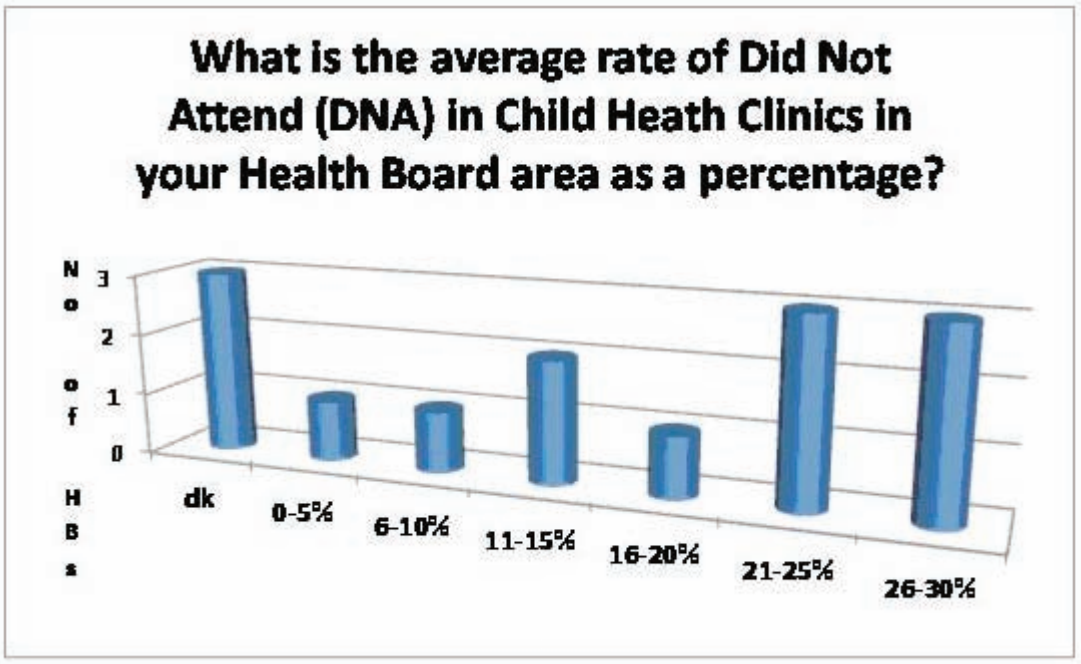
- **HBs were asked "Is 18-week Referral to Treatment (RTT) in place for CCH clinics?"**

12 of the 14 (86%) HBs have 18 week RTT in place for CCH and two mainland boards do not. Two HBs covering large urban populations stated they did not intend to introduce 18 week RTT for CCH clinics.

Comment: These 2 boards have the highest proportion of Scotland's most deprived children. There may be further worsening of health inequalities as these children and young people may have to wait the longest for a CCH consultation.

- **Did Not Attend (DNA) rates**

The average Did Not Attend (DNA) rate in CCH clinics varied from 0-5% to 26-30%. Three HBs did not know their CCH clinic DNA rate[81]. Six HBs had a CCH clinic DNA rate of between 21 and 30%.



Three HBs had >26% DNA rate but not all these HBs had a high deprivation factor (SIMD).

One had only 1.4% of the total most deprived wards for health; one had13.7% of the total most deprived wards for health and the third HB had 50% of the total most deprived wards for health.

Comment: There is a documented association between deprivation and DNA rates, but some centres in the UK[82] have managed to reduce these rates below 20% for disadvantaged families by the judicious use of texting prior to appointments and HV follow-up and a determined focus on the most vulnerable families.
Of note, 3 HBs indicated don't know responses. DNAs can lead to a serious delay in diagnosis and intervention for our most needy children. Highly mobile families, children of asylum-seekers and families where there is parental substance misuse or chronic ill-health may be in this high risk group, increasing their health inequalities and measures are required to be applied to increase access for such children.

- **New to return (N/R) patient ratios for CCH clinics**

Boards were asked to give their "new to return (N/R) patient ratios for CCH clinics". This question seemed problematic as there was a high number of no replies and

[81] See page 40 about PAS systems in place in CCH
[82] Derby PCT CCH service

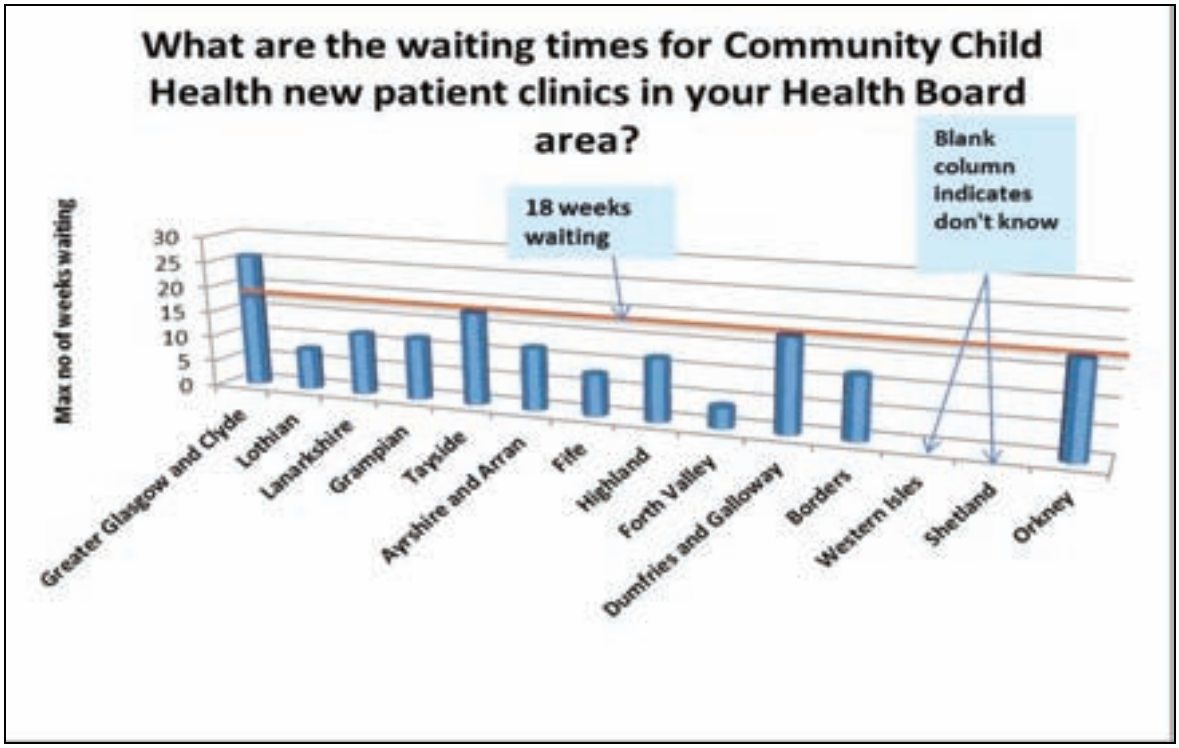
don't knows (7/14 HBs) 50%. Across the 7 boards which replied, the average N/R ratio was 1:3, similar to acute general paediatrics (anecdotal evidence), but there was a wide range of 1:1.5 to 1:9.

Comment: Further work may be needed in this area as this measure is standard in medical paediatrics out-patient clinics.

- **Waiting times for CCH clinics**

In the question about waiting times for new referrals to CCH clinics there was a wide range of waits from a maximum of 4 weeks to a maximum of 6 months. The largest, most deprived HB declared the longest waiting times (a maximum of 6 months) and 3 HBs have waiting times up to 18 weeks (One larger; one small; one island). 2 island HBs indicated don't know for waiting times.

Comment: It appears that in the largest health board with 50% of the most deprived wards in Scotland, children have to wait the longest to see a paediatrician in community settings.



- **Quality assurance processes for CCH activities**

12 (86%) HBs monitor attendance rates at CCH clinics. 10 (71%) HBs monitor referrals to CCH clinics. 2 HBs monitor investigations, 4(29%) HBs monitor parent/carer satisfaction and it is not clear if this monitoring is part of generic surveys

rather than direct feedback with parents at the time of clinical contact. No HBs monitor actions such as DLA or interagency reports etc.

Comment: Clinic effectiveness can be measured by monitoring attendance, referral patterns, pattern of investigations and patient (parent/carer) satisfaction. There is a low level of measurement of parent/carer satisfaction with CCH services and no monitoring of CCH activities such as report writing which can be very time-consuming.

Annexe 5

NHS SCOTLAND PAEDIATRIC TRAINEE QUESTIONNAIRE 2010

SECTION I. PERSONAL DETAILS

1. Age:…

1. Gender: M/F

2. Year of graduation from Medical School

3. Where trained:

5. Deanery:_____

1. ST / SpR (circle)

2. Current year of rotation:_____

3. Less than / Full-time (circle) If LTFT a) no. of hours/week_____

b) are you a flexible trainee? Y / N

4. CCT Date: ____/____/____

SECTION II. YOUR FUTURE

1. What type of post are you hoping to fill at the end of your training? (please circle)

a) Consultant general paediatrician (acute duties only)

b) Consultant general paediatrician (acute and neonatology duties)

c) Consultant General Paediatrician some duties in Community Child Health & some acute.

d) Consultant General Paediatrician with an interest in Community Child Health

e) Consultant Paediatrician in Community Child Health only (Large district)

Special Interest _____

f) Tertiary Specialty please specify

Speciality _____

g) Speciality Community Consultant, e.g. Neurodisability

Speciality _____

h) Other_____

2. How many programmed activities per week are you hoping to work as a consultant? _____

(I P A = 4 hours)

3. Do you intend to do out-of-hours work as a consultant? Y / N (circle)

If Yes please tick all which apply:

For acute medical cover ( )

For acute medical and neonatal cover ( )

For Child protection ( )

4. Certain feature make some jobs more desirable than others. Please tick the relevant boxes.....

Aspect of job …	**Essential**	**Desirable**	**Neutral**	**Not wanted**	**Not acceptable**
Disability – neurological handicap, developmental disorders, assessment of complex multiple disability, behavioural problems, at *tertiary or supra-district level*					
Disability – neurological handicap, developmental disorders, behavioural problems, school health and special needs *at secondary or district level*					
"Social" paediatrics – child protection, adoption and fostering, children looked after etc.					
Interagency working, public health, local epidemiology, management and planning.					
General medical paediatrics – outreach, ambulatory, non-acute, outpatients					
General medical paediatrics – acute, on-call, some in-patient care					

Neonatal unit cover					
Other (specify):					

SECTION III. YOUR OWN PERSONAL TRAINING

1. By the end of your rotation (CCT Date)...

a) How long will you have spent training in Community Child Health? (Yrs / Mths)?_____

b) Do you feel this is adequate taking into account your preferred career choice?

2. Areas of training covered:

Subspecialty	Have you trained in these areas (tick box if yes)	Do you feel your training was successful at meeting your learning objectives (tick if yes)
Population paediatrics		
Screening + surveillance		
Immunisation+ Communicable disease control		
Health protection / promotion		
Epidemiology		
Public health needs assessment		

Social Paediatrics		
The Disadvantaged Child		
Child Protection		
Adoption and Fostering		
Developmental + Disability Paediatrics		
Learning Difficulties		
Motor Difficulties		
Vision problems		
Hearing Problems		
Communication Problems		
Behavioural Paediatrics		
Accidents + Injuries		

Comments_____

Section III. YOUR OWN PERSONAL TRAINING Contd.

3. Do you have an initial induction programme in Community Child Health? Y / N

If Yes was this useful Y/N if No please comment……..

4. Were you provided with a resource pack in Community Child Health? Y / N

5. Do you have an allocated educational supervisor? Y / N

If Yes a. How often do you meet to discuss progress?_____

b. How long do you meet for?_____

6. Are educational objectives agreed prior to commencing training in the above subspecialties? Y / N

7. At your formal reviews of training.

Are there community paediatricians on the panel? Y / N

Has this been helpful to your training? Y / N

Comments…….

8. Which guidelines are being used to guide your training in Community Child Health?

a) BACCH Y / N

b) RCPCH Y / N

c) Both Y / N

d) None aware of Y / N

9. Have you completed an e-portfolio of training? Y / N

Or another portfolio? (SpRs) Y / N

If yes, please describe

_____

Section IV. HOSPITAL WORK

1. Are you involved in hospital based general paediatric work at the same time as your attachment to community?

Yes / No (circle) If no, go to q.2

If Yes, is this on-call only? ( )

daytime cover only ( )

day and night cover( ) please tick which applies

I. If doing hospital daytime work, how many hours per week?_____

Were these sessions a) compulsory?

b) optional?

II. If doing acute on-call, is it a) on the same rota as hospital based trainees?

b) a fixed night/week?

c) Other? - please specify_____

Was acute on-call a) compulsory?

b) optional?

III. Do you feel general hospital-based work is helpful to your training? Y / N

2. Do you do on-call for child protection ? Y / N

Is this a) as an observer only

b) providing full cover

Section V. STUDY / RESEARCH

1. How much time per week are you given as allocated study time for audit / research? (hrs)

_____

2. Study Leave (SL)

a) Do you feel you have appropriate time allowed? Y / N

Comments_____

b) Has SL ever been refused for
Budgetary reasons? ( )

Lack of cover? ( )

3. Available facilities:

Do you have access to

Adequate library with relevant CCH books? Y / N

Journals ? Y / N

Circulars ? Y / N

Your own desk? Y / N

Your own PC? At work Y / N

At home Y / N

Both Y / N

The internet? at work Y / N

at home Y / N

both Y / N

Appropriate clinical training facilities?

Community? Y / N

If No please comment…….

Hospital? Y / N

If No please comment

Designated secretarial support? Y / N

4. Are you intending to do an MSc? Y / N

MD? Y / N

PhD? Y / N

Sheffield Diploma in Neurodisability? Y / N

Other certificate/diploma? Y / N

Please specify _____

5. Do you have support for doing a higher degree a) From senior paediatricians? Y / N

b) financially Y / N

If Yes, where from?_____

Section V. STUDY / RESEARCH Contd.

6. If you had more support, would you be interested in doing a further degree? Y / N

7. Do you have Community Child Health peer review sessions? Y / N

If Yes, Are these structured / informal? (circle)

How often? _____

How long is each session? (hrs) _____

Who attends? _____

8. What other educative meetings do you regularly attend in your area?

e.g. relevant Royal College of Physicians meetings, local Postgraduate Department of Medicine meetings, e.g. Management sessions

Section VI. TRAINING SATISFACTION

1. How would you rate the quality of your training in each subspecialty

v. poor 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 excellent

Subspecialty	Rating
Screening + surveillance	
Immunisation / Communicable disease control	
Health protection / promotion	
Epidemiology	
Public health	
Disadvantaged child	
Child protection	
Adoption + fostering	
Learning difficulties	
Motor difficulties	
Vision problems	
Hearing problems	
Communication problems	
Behavioural paediatrics	
Accidents and Injuries	
Research	
Teaching	

Section VI. TRAINING Contd.

2. Do you feel your training is centred around

You 1- 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 Service commitments

3. Why, if rating poorly, do you feel your training is deficient?
_____

4. How would you improve your training?
_____

5. **Lastly**, do you have any other comments regarding your Community Child Health training you feel haven't been covered?
_____

Annexe 6

Results of the Paediatric Trainee Questionnaire

1. Background of trainees

Of the 55 who replied:

- 67% of responders were female (current ST1 entry across the UK is 76% female)
- 24% were flexible trainees
- 84% were aged between 25 and 35 (16% 36 and over)
- 73% attended medical schools in Scotland; 18% outside the UK and 9% trained in England.

2. Training

- Duration and overall satisfaction

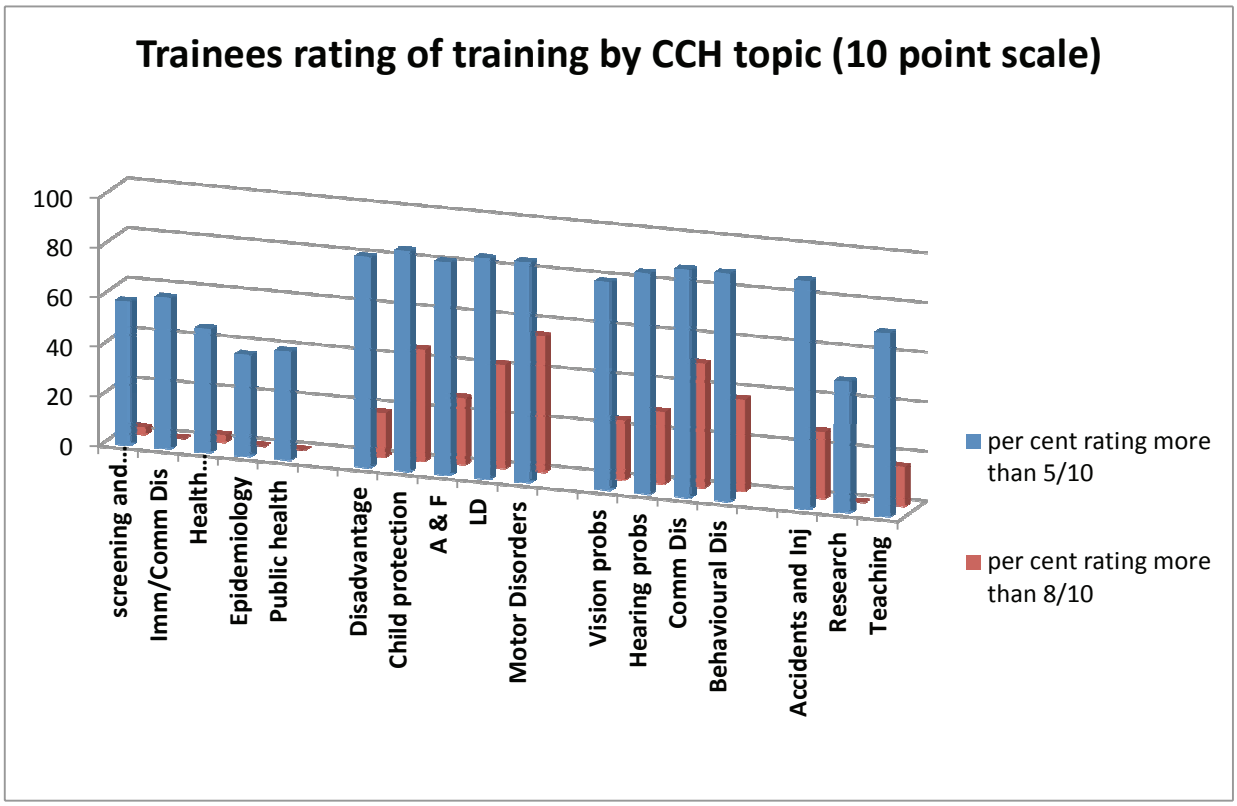
The majority have spent (or expect to spend) 6-9 months in CCH. (11% expected to or had spent 2 or more years in CCH). Responders were almost equally divided across training years 1-7 giving a good spread across the training period. 75% felt that their training was adequate given their choice of career but 24% said no or were uncertain. 7 responders (13%) had either not done any training or were not sure how long they had trained in CCH .

- Rating of elements of training

In terms of the elements of CCH training there was a high level of satisfaction with some elements of training. Trainees rated their experience highly in child protection; learning disability; motor disorders and communication disorders with more than 40% responders scoring these topics 8 or more on a 10-point scale . Public health topics and research training scored poorly with very few good/excellent ratings. Overall, 80% of trainees rated 10 out of 17 CCH topics listed at >5/10.

Author's Note: Availability of Supervision in CCH Clinics

RCPCH guidance suggests dual consulting (simultaneous presence of consultant at trainee clinic) is available for supervision of trainees. In the Health Board survey 21% (3) HBs in Scotland indicated that all their clinics allow this but 29% (4) indicate less than 50% of their clinics allow dual-consulting. This finding may mean that trainees are not supervised adequately in some areas.



3. Current Duties of Trainees

The vast majority of participants are combining daytime community placement with acute hospital work (82%) and 84% felt this was helpful for their training.

71% are working night "on-call" cover and a further 27% are working both "day and night cover". For those undertaking acute on call, 74% respondents are on the same rota as hospital based trainees. 5% respondents report they are on fixed night work.

20% of participants were undertaking child protection on call but 65% were not.

11% were providing "full cover" and 15% were acting as an "observer only".

Comment: If trainees are actually undertaking " full" child protection cover, then questions need to be asked about their supervision in this very difficult area of work.

4. Study and research

The majority of participants (95%) have access to a PC and the internet at home and at work (96%). 84% felt there were appropriate clinical training facilities in hospitals versus 62% satisfied with training facilities in the community. 84% believed there

were adequate library facilities with relevant books and journals but only 62% believed there were adequate library facilities with relevant CCH books.

5. Future career choices

Most trainees (62%) were looking for a consultant post in acute general paediatrics with acute on-call. Several noted other sub-speciality roles eg paediatric emergency medicine; respiratory paediatrics; academic paediatrics; paediatrics with an interest in Diabetes/Endocrinology and paediatric intensive care. When asked if they wished to undertake out of hours/on–call duties as a consultant, 87% answered yes but only 9% of these wished to undertake child protection on call. 40% thought that “social paediatrics” would be an essential ingredient of a future job. 65% thought interagency working/public health/management and planning as essential or desirable in a future job.

Significant numbers rated neonatal on call duties as “undesirable” in a future post with18% stating they wished a job as a general paediatrician with acute and neonatal on-call. 16% wanted a general paediatric post which included child protection on call. 11% wanted to be a community paediatrician with acute on call. 9% wanted to be a community paediatrician with child protection on-call. A majority wished a special interest clinic.

Annexe 7

Scottish Association of Community Child Health Survey of Paediatric Consultants Working in Community Child Health in Scotland 2010 (Dr Helen Gibson)

Summary

In May 2010, SACCH conducted a survey of Consultant Paediatricians in Scotland, who worked at least one session per week in a traditional Community Child Health (CCH) specialty.

48 responses were received and 44 met the criteria for analysis. 10 out of 14 Health Board areas were represented. There was a great deal of diversity in response and after initial analysis, it proved more useful to compare those Consultants working more than 75% of the time in CCH specialties (Group 1, n=16) with those working less than 50% of the time in CCH (Group 2, n=11).

Results:

Consultants in Group 1 were more likely to be female (75% cf. 54.5%), less likely to work full-time (62.5% cf. 90.9%) and more likely to work in community settings, such as Child Development Centres (CDCs) (68.75% cf. 9.1%). 82% of those in Group 2 worked in District General Hospitals (DGHs).

Group 1 were less likely to work a 'out of hours' rota (50% cf. 72.7%). They predominantly covered specialist Child Protection rotas (75%). 100% of Group 2, who worked out of hours, covered general paediatrics and 50% of this group also did neonatology.

In both groups the main area of work is neuro-development/ neuro-disability. 93.8% of Group 1 worked in this area compared to 55.6% in Group 2. Traditionally, the Community Paediatrician has worked in several inter-related areas. 43.8% of Group 1 worked in four or more CCH specialties (cf. 12.5% in Group 2), whilst 36.4% of Group 2 work in a single specialty (cf. 12.5% in Group 1).

For Group 1, the main pressures on CCH practice were CCH workload (87.5%) and difficulty in recruiting CCH doctors (75%). For Group 2, the main pressures were acute/general Paediatric workload (60%) and difficulty in recruiting CCH doctors (50%).

More of Group 2 were within 5 years of appointment (45.5% cf. 25.1%) but more had been appointed in Group 1 than 2 in the past 2 years (18.8% cf. 0%). Percentages for those working longer than 10 years were similar (36.4% cf. 37.5%) but were lower for those working in DGHs (25%).

100% of Group 1 had intended to work in CCH specialties as a consultant, compared to 14.3% of those in Group 2. 90.9% of Group 1 had received more than 6 months training in CCH prior to appointment compared to 42.9% of Group 2. 20.5% of the survey had previously worked as Non-Consultant Career Grade Paediatricians before appointment to Consultant posts.

When asked if they had adequate time and support to increase CCH skills in post, 62.5% of Group 2 said yes compared to 43.8% of Group 1. Only 37.5% of previous Non-Consultant Grade doctors answered yes. For all groups, the main barriers to further training were overwhelmingly time (91.3%) and workload (82.6%).

In terms of training and support, clinical guidelines were universally used and the majority of Consultants used conferences and seminars and local educational meetings. Group 1 had high usage of Special Interest groups (87.5%) and peer review (81.3%) compared to 37.5% each for Group 2. Group 2, however, cited peer mentoring/buddy system at 62.5% compared to 12.5% of Group 1.

60.5% of responses were from three Health Board areas (Greater Glasgow and Clyde, Lothian and Grampian). SACCH had previously identified 40 consultants thought to be working predominantly as "Community Paediatricians" and 87.5% were based in the three Health Board areas. Analysing survey responses from these Health Boards, 90.1% worked over 50% of the time in CCH specialties compared to 21.4% in other Health Boards. 82.2% had intended to work in CCH specialties compared to 33.3% and 82.2% had over 6 months training in CCG compared to 37.5% in other Health Boards.

Discussion

From the survey results, there appear to be two predominant models of CCH provision for Consultants in Scotland. The majority of responding Consultants working in the traditional CCH role are based around three teaching hospitals. These consultants are more likely to be based in community settings, work for most of the time in CCH and cover a number of CCH specialties. They intended to work in CCH and have more training. Outside of the teaching hospital Health Boards, Consultants working in CCH are most likely to be based in District General Hospitals, have integrated posts with general paediatrics and to cover fewer or a single CCH specialty. Many did not intend to work in CCH specialties and they have less training. The implications for this is that outside the three centres, Consultant practice in CCH is moving out of the community and becoming a hospital-based outpatient specialty. Even with the greater awareness of multidisciplinary and multiagency working, this tends to encourage shorter appointments and a more problem-orientated approach.

The core issue of the definition of CCH was present throughout the survey. Is CCH an integrated, holistic approach to working in a number of inter-related specialties in community settings or is it currently a loose amalgamation of specialties, which are increasingly fragmenting into independent special interests? Despite the criteria for the survey, which was to do at least one session in a CCH specialty, 27.3% of Group 2 said they had no sessions in CCH. They may have entered the survey in error, but comments suggested that these Consultants did not consider, for example, their child protection work as CCH or they considered the CCH specialties as part of General Paediatrics.

The increasingly integrated approach to General and Community Paediatrics was overwhelmingly welcomed with two provisos. Both those working in integrated posts and those in wholly community posts were concerned that acute workload impacted negatively on CCH practice. There were also concerns about maintaining adequate

skills to work in diverse areas of Paediatrics. Some of those working predominantly in CCH were concerned that acute colleagues perceived it as less important.

The prevalence of the traditional CCH working model in teaching hospital Health Boards may reflect the nature of tertiary Paediatrics. In DGHs, Consultant care is based around the individual child, whilst in teaching hospitals, Consultants work predominantly in individual specialties. A child with Complex needs is likely to have several specialists and so there is a need for someone (traditionally the Community Paediatrician) to take a holistic view. In this survey, however, those taking the traditional Community Paediatric role cite increasing workload pressures with longer waiting lists and an increasingly complexity. This, in particular, also applies to Specialty and Associate Specialty Grade (SASG) doctors, who work a similar model and are crucial to the delivery of CCH services in most areas. There needs to be careful consideration of whether the current model is sustainable, what the core CCH services are and how they are provided in future.

There have been suggestions that as Consultants become more senior, they move from acute to CCH work. In this survey, only one Consultant had taken on CCH duties after appointment. This was for service development and was seen as a positive move. This does not suggest that currently this model is happening to any great extent and pressures on acute services put this into some doubt.

All Paediatric trainees now undertake core training of 6 months in CCH, but this is under pressure from acute paediatric rotas. For the same reason, it is becoming harder to obtain significant training in CCH outside of Grid posts, suggesting that those qualifying are less experienced than their predecessors. At the moment, those with most expertise are being retained around teaching hospitals, although the needs of children are the same throughout the country.

With the difficulty in recruitment of Consultants and SASG doctors into CCH posts, the role of the specialist nurse is becoming increasingly important. It is increasingly recognised that the holistic and flexible approach of nursing services may be more appropriate in some circumstances; however, there remains an important wider leadership and advocacy role for doctors beyond the role of diagnostician. This is particularly important in specialties such as the Looked After and Accommodated Children's service, where there are increasing problems in recruiting doctors, but a multiagency, multidisciplinary approach is vital.

Annexe 8

List of CCH related RCPCH-endorsed guidelines

Community Child Health

- NICE: Alcohol Use Disorders
- SIGN/BTS: Management of Asthma
- SIGN: Attention deficit and hyperkinetic disorders in children and young people
- NICE: Attention deficit hyperactivity disorder (ADHD)
- SIGN: Autism spectrum disorders
- RCPCH: Chronic fatique syndrome (RCPCH)
- NICE: Chronic fatique syndrome / Myalgic encephalomyelitis
- BTS: Community acquired pneumonia in childhood
- SIGN: Management of Diabetes (2010)
- NICE: Drug misuse: opoid detoxification
- NICE: Drug misuse: psychosocial interventions
- NICE: Head Injury
- SIGN: Early management of Patients with a Head injury
- SIGN: Management of sore throat and indications for tonsillectomy
- SIGN: Management of sore throat and indications for tonsillectomy (2010)
- RCPCH: Physical signs of child sexual abuse
- SIGN: Preventing dental caries in children at high risk
- NICE: Nocturnal Enuresis
- NICE: Prevention, identification, assessment and management of overweight and obesity in adults and children
- SIGN: Management of Obesity
- RCPCH: Standards for services for children with disorders of sleep physiology
- Royal College of Physicians: Stroke in childhood
- SIGN: Diagnosis and management of childhood otitis media in primary care
- NICE: Surgical management of children with otitis media with effusion
- BTS: Use of home oxygen in children
- NICE: When to suspect child maltreatment

Annexe 9

DRAFT SERVICE SPECIFICATION (Reference Dr Fawzia Rahman)

Service	**Community Child Health and General Paediatrics in the Community**
Commissioner Lead	
Provider Lead	
Period	

1. Purpose

1.1 Aims

- To provide a consultant led locality based paediatric service for children and young people aged 0-18, who are vulnerable due to disease, disability and/or disadvantage including common childhood conditions
- To access traditionally 'hard to reach' groups of children and young people to ensure that they are able to receive the health input required
- To improve the outcomes for children as identified in national and local strategies.

1.2 Evidence Base

Policy Guidance

- National Delivery Plan for Children and Young People's Specialist Services in Scotland
- Getting it Right for Every Child
- Health for All Children 4 : Guidance on Implementation in Scotland
- Equally Well
- Early Years Framework
- Better Health Better Care

Activity

The following data should be collected as standard

- % DNAs for new and return appointments by SIMD postcode quintile
- Analysis of demographic data for opt-in booking systems by SIMD quintile
- Number of referrals by SIMD postcode quintile
- Sources of referral
- 18 week referral to treatment achievement for initial routine paediatric referrals
- % of children (0-16) with significant additional support needs (SNS or similar)
- Number and rate of Child Protection referrals by SIMD quintile

- Number of Forensic Medical Examinations
- Number of health assessments for looked-after children
- Number of children with disability on SNS database or comparable IT system

Service Benefits

- Supports targeted approach to children in most deprived quintiles
- Clinical leadership encompassing the most vulnerable groups with the objective of reducing health inequalities
- Broad range of specialisms provided within the Service to ensure that complex health needs can be met
- Strong, positive multiagency and multidisciplinary planning and working relationships according to GIRFEC principles that ensure effective delivery of health services to vulnerable and disadvantaged children and young people.

1.3 General Overview

The Service will provide appropriate paediatric assessment, diagnosis and management of children and young people within the Service boundary according to agreed guidelines in collaboration with other members of the Team around the Child including:

- Public Health Nurses, Health Visitors and School Nurses
- Community Children's Nurses
- AHPs
- CAMHS teams
- and others in partner agencies as required

1.4 Objectives

- To work as part of a broad children's services network as a combined and integrated paediatric service to provide high quality specialist child centred care
- To improve equity and accessibility of service to the most vulnerable and hard to reach children;
- Provide appropriate support to increase the knowledge and skills of staff in other services who are responsible for providing health, social care and education to vulnerable children
- To provide clinical designated expert paediatric leadership for child protection, looked after and accommodated children and young people and children and young people with additional support needs as appropriate
- To provide a specialist paediatric child development and neurodisability service to children, young people and their families.
- To work through Health Boards to ensure high quality, effective and value for money services are delivered

1.5 Expected Outcomes

- The Service will aim to meet the relevant overarching outcomes identified nationally and locally and included in the local Children and Young People's Plans.
- Early diagnosis and intervention are prioritised therefore reducing late/more intense

treatment of conditions
- The emotional needs of children are supported in partnership with local CAMHS Services
- Co-ordination and sharing of information relating to specific children is facilitated by appropriate attendance at multidisciplinary and multi-agency team meetings
- Ensure clear processes by the provision of lead or designated doctors for child protection according to RCPCH guidance
- Integrated working with other services to provide an holistic care approach to vulnerable children is facilitated by appropriate attendance at planning meetings with interagency partners
- Reduce health inequalities and improve access and service for deprived areas and population groups
- All training delivered is evaluated and of high quality.

2. Scope

2.1 Service Description

The Service will provide:
- General and community paediatric assessment and diagnosis of children referred according to agreed guidelines.
- Urgent and planned assessment, diagnosis and follow up of children in need of protection looked after by the local authority; with additional support needs; with complex needs and chronic illness in collaboration with Primary Care services and local authority teams.
- Medical advice to planning processes and assessment and management of children with emotional and behavioural difficulties in collaboration with colleagues in CAHMS
- Assessment, counselling and support for children from marginalised groups such as travellers, asylum seekers, refugees – in collaboration with colleagues in nursing, public health, general practitioners and CAMHS
- Detailed paediatric assessment reports to other agencies, including Children's Hearings and criminal justice processes
- Public health advice on health concerns related to adoption and fostering (LA adoption panels), childhood accident prevention and other health promotion initiatives
- Co-ordination of disability services in the community by leadership, service and care coordination; joint working with Acute Services (Inpatient, Orthopaedic, Neurology, etc) plus support to other agencies and liaison with Adult services
- Provision of Designated/Lead doctors for child protection
- Medical advice to planning processes and provision of clinics for vulnerable adolescents – in collaboration with colleagues in GUM

2.2 Accessibility/Acceptability

The Service will make provision to address any issues that are within its power to resolve to ensure that it is accessible to all families, children and young people for appropriate targeted support.

Service will be provided according to agreed priorities

- Statutory procedures (must do, response time dictated by circumstances (eg child protection vs permanency medicals
- High need to do as soon as possible (including urgent medical referrals)
- Medium Priority need to do within waiting time standards

The service will work to its agreed waiting time standards (18 week RTT) where applicable.

2.3 Co-dependencies

Stakeholders and co-dependencies will include:

- Parents/carers and children and YP
- Midwifery, neonatal and obstetric services
- Health Visitors/public health nurses
- School Nurses
- *Allied Health Professionals*
- Health clinic facilities and staff
- Child and Family Centre facilities and staff
- GPs
- Hospital based paediatric care
- NHS Adult providers of care to young people
- CAMHS
- Local authority children and young people services
- Voluntary providers of children's services
- Reporter to the Children's Panel

2.4 Relevant Networks

The service is expected to be involved in a wide range of multidisciplinary and multiagency networks based around its key network planning groups and professional leadership areas.

- Additional Support Needs
- Vulnerable *children and* adolescents
- Emotional & behavioural problems in terms of their medical and developmental co-morbidities in collaboration with CAMHS
- Population paediatrics in collaboration with the Child Health Commissioner and Public Health colleagues with a particular focus on inequalities and patterns of morbidity.
- National Managed Services and Clinical Networks across Scotland and Regional Children's Service Planning Groups

2.5. Training, Continuing Professional Development, Research and Audit

In order to promote and maintain high professional standards and ensure RCPCH specialist competencies, the service will undertake a range of training and development activities including:

- Undergraduate teaching including other disciplines such as nursing and AHPs where appropriate
- Postgraduate medical training at core and higher specialist trainee level
- Continuing professional development including promoting peer review and participating in accredited CPD programmes
- Research and audit will be promoted and encouraged
- Contribition to the curriculum design and content of In-service teaching materials for other partner agencies where appropriate and by agreement

3. Service Delivery

3.1 Service Model

The Service will be delivered generically by consultant-led locality teams of paediatricians *working* in the community.

Specialist consultant clinical leadership will be provided for each of the network planning areas identified with a focus on equity of provision and access across Scotland, allowing for different workforce models to suit prevailing need both in terms of population requirements and geographical issues of, for example, remoteness.

The service will specifically target vulnerable and disadvantaged children and those with complex health needs and will work closely with public health colleagues and managers to plan appropriate services.

A lead consultant will take a lead role for ensuring that overall professional standards are set

and maintained, that a cost effective in-service training programme is provided and that the service collects robust and effective activity information.

There will be adequate support from the IT, administration and clerical services to meet Royal College guidelines and to support and assist the specialist functions described above.

3.2 Care Pathways

Pathways may have been specified by SIGN or NICE or have been accepted by local consensus or have been drawn up by MCNs.

Clinical care pathways that are likely to be followed in this Service include

- Developmental disorders and disablity
- Vulnerable Child pathway and GIRFEC
- Response to child protection concerns including children and young people affected by substance misuse
- Specialist Health assessments for children looked after and accommodated
- Sensory impairment pathways
- Down's syndrome
- Epilepsy
- ADHD – shared or split with CAMHS
- ASD
- And other specific conditions eg cerebral palsy, degenerative muscular disorders, bony dysplasias etc. which may apply

4. Referral, Access and Acceptance Criteria

4.1 Geographic coverage/boundaries

The Service will be available to all families, children and young people who are registered within the health Board area or sub-division of this area.

4.2 Location(s) of Service Delivery

The Service is locality and community focussed and therefore should be delivered from appropriate locations and within suitable settings that will ensure an effective service to assess children and young people and their families.

4.3 Days/Hours of operation

The Service will operate flexibly within normal working hours (as defined in national medical contracts) for the majority of its services. Rapid response services will be provided outside normal working hours for child protection medical advice and urgent assessment of children who may have been abused or neglected, and will be covered by an on-call consultant

service for agreed hours as part of the overall out of hours service for children and young people on a safe and sustainable basis.

4.4 Referral inclusion criteria and sources

The service will see all children from birth up to their sixteenth birthday (or while still at school).

For children in certain categories (those in special schools or involved in child protection processes) care will be provided until their eighteenth birthday.

The General and Community Paediatric Service will prioritise referrals as follows:

Statutory / dictated by Procedures (eg child protection procedures)

- "Acute" child protection work (rotas/on call)
- Transition planning (as appropriate)
- Adoption medical examinations
- Child in Need (Social Services referrals/requests designated as CiN)

High Priority

- Children presenting at pre-school and school age with serious areas of concern including growth/social/developmental/behavioural problems
- Children and young people with onset common medical conditions when agreed with service commissioners as part of community based general paediatric service
- Child/young person at risk of significant harm
- Specialist clinical work for long-term and complex conditions including sensory impairment

Medium Priority

- Children with common chronic medical conditions and those conditions where there is acute hospital OP FU but need assessment and liaison with school over impact on function, e.g. epilepsy, oncological sequelae
- Multi-disciplinary Review Patient Clinics
- Reviews of children in Special Educational provision where medically indicated
- Reviews of children with disability or developmental disorders
- Interagency respite care planning
- Medical and interagency role in transition of vulnerable young people to adult services
- Attendance at GIRFEC multi-agency assessments and planning meetings where child or young person has a medical condition requiring Community Paediatric input

4.5 Referral route

Referrals will be through a number of avenues including:

- Health professionals
- Education services
- Children's Social Work Services
- Reporter to Children's Panel
- Police
- Voluntary agencies
- Self referral

4.6 Response time & detail and prioritisation

The Service will meet the following response times:

- Acknowledgement and appropriate follow-up of formal child protection referral within 24 hours;
- Looked After Children specialist medical assessments where needed – within 4 weeks of referral;
- Statutory assessment for Additional Support for Learning – within 6 weeks of referral;
- Other referrals – within 12 weeks;
- Referral to treatment – by 18 weeks.

4.7 Equity Issues (EIRA)

It is the responsibility of the Provider to actively meet the requirements of the Equality Duties (Race, Disability and Gender).

These include:

- Eliminating discrimination
- Promoting equality of access to services and of employment opportunity
- Ensuring effective data capturing and analysis of service provision
- Conducting Equality Impact Risk Assessments (EIRAs) on policies, procedures and services

Equality Impact Risk Assessment (EIRA) must be undertaken and documented as part of any service review process or if any change is made to the provision of the service which could impact on those in receipt of the service.

All staff employed by this Service will recognise and respect the religious, cultural and social backgrounds of service users in accordance with legislation and local and national good practice.

The Service will ensure that it has access to appropriate translation services/resources to enable equity of access and understanding.

5. Discharge Criteria & Planning

- When health issue has been resolved or an appropriate shared or self-care programme has been fully implemented
- The service will monitor repeat attenders and review care plans to ensure children are safely discharged
- DNAs will be monitored and action taken with health and interagency partners to ensure vulnerable children and young people receive the diagnostic and treatment service they require in a timely fashion with particular attention to efficacy of opt –in booking systems

- Discharge from CCH to relevant Adult Services when of an appropriate age (16 – 18 years)

6. Self-Care and Patient and Carer Information

The service will support parents/carers in developing their capacity to reduce the health consequences of long term vulnerability in their children. This will include the appropriate provision of written materials and signposting to other support services.

Quality Performance Indicator	*Threshold*	*Method of measurement*	*Consequence of breach*
Infection Control	100% Meets the required standards within NICE guidance	% of staff trained at appropriate level No. of recorded incidents Infection Prevention & Control audit	**Improvement Plan required**
Service User Experience	At least 50% return for surveys issued All dealt with under Provider complaints procedure	User Survey Self reported User Experience Compliments No. of complaints received and resolved	Alternative ways of obtaining service user experience Exception Report

Improving Service Users & Carers Experience	All actions to be met by deadline	User/Carer Survey report highlighting areas for improvement and where experience has improved Time scaled Action Plan to address areas for improvement	Exception Report	
Reducing Inequalities	Baseline to be identified	• % contact rate per deprivation quintile • DNA rate per deprivation quintile		
Reducing Barriers	Baseline to be identified	• Contacts per diversity group • % of contacts requiring an interpreter • Improvement Plan		
Improving Productivity	Baseline to be identified	• Reduce 0verall DNA rate to 15%		

Access	90%	% of first appointments made within 12 weeks of referral receipt Profile of caseload – no. of: • Children looked after • Disabled • BME • Immigrant/migrant traveller/ refugee • Other 'hard to reach' groups • Remainder By Locality Area (do not count any child twice but illustrate any multiples if a child can be categorized into two or more of the above)	**Exception Report**	
Care Management	**Baseline to be identified**	• **New referrals compared with discharges** • **Agreed clinical audit programme**		
Indicators to evidence Outcomes	Baseline to be identified	• Child Protection: no. of peer reviews; attendance by discipline • Downs Syndrome Monitoring: adherence to pathway • ADHD audit – adherence to pathway		
Activity Performance Indicators	*Threshold*	*Method of measurement*	*Consequence of breach*	
Referrals	Baseline to be identified	No of referrals received for following groups of children:		

		• Children with special needs; • Children at risk of harm; • Designated children in need; • Children Looked After; • Travellers, asylum seekers and refugees; • Young offenders; • Young perpetrators of abuse; • Families where language is a barrier.		
Initial Assessments	Baseline to be identified	• No. of assessments completed by area • No. of Did Not Attend by area (for above groups of children) • Number of DNA by referral source • Waiting times by vulnerable category and priority level • Referral to treatment time • Activity data analysed by deprivation For each of the elements under 4.4 (Referral criteria & resources) above for Statutory, High and Medium Priority levels		
Follow up appointments	Baseline to be identified	• No. of follow ups completed by area • No. of Did Not Attend by area (for above groups of children) • No. of follow ups seen within 12 weeks of planned date		

Children/young people discharged from/left service		No. of children/young people who were discharged/left the Service (by reason/by area)	

Annexe 10

CCH workforce guides

BACCH Workforce Guide 1999

	Consultant	Ass Specialist	Staff Grade	Total
Disability and Special Needs	0.65	2	2	4.65
Clinical Specialisms	0.45	1.05	0.5	2.0
Children in Need/ Child Protection	1.3	1.0	0.8	3.1
Public Health etc*	0.5	-	0.7	1.2
Service Management	0.6	-	-	0.6
Training	0.15	-	-	0.15
Involvement in general paediatrics not included				
Total	**3.65**	**4.05**	**4.0**	**11.7**
Total Allocations				
Service needs	3.65	4.05	4.0	
+ 10% CME/audit	0.4	0.4	0.4	
+ 33% for part time CME**	0.15	0.15	0.15	
+ 10% for Committee Work	0.4	-	-	
Total	**4.6**	**4.6**	**4.55**	**13.75**

* The estimates for preschool CHS is 10% coverage by CCH; school entrant medicals 30% coverage. This will vary significantly according to need and demand.

**Because of the large numbers of part time doctors in Community Paediatrics, we have added 33% to the CME allocation for all grades.

Trainees may provide 50% service. Core SpRs will be considered equivalent to Staff Grades and HSpRs to Associate Specialists. SHOs are unlikely to provide more than 25% service unless a large amount of CHS still exists.

The table reflects the current staffing structure in most CCH services, with a high population of non-consultant career grade paediatricians. Workforce estimates show a rapid decline in the numbers of doctors in such posts. As they decline, the service will move increasingly to a consultant-delivered service. This will have significant cost implications and should be included as a factor in workforce planning estimates.

Revised CCH21 Workforce Guide

Notes on the Revised Workforce Guide

1. A Programmed Activity (PA) is 4 hours of a clinician's time
2. Supporting Professional Activities (SPAs) in blue
3. White cells are Direct Clinical Care (DCC PAs))
4. Totals represent number of PAs required for a particular activity for a population of 300,000 people
5. Yellow cells represent total PAs for each area of activitiy
6. Total represents number of PAs for that area of work, eg disability, for each grade of doctor with an overall total for all grades for that activity

Staffing for locality/district of 300,000 population (est 60,000 children)				
	4 hour PAs			
	Consultant	Assoc Spec	Spec doctor	Total PAs
ASN/disability				
Outpatient clinics	2.6			2.6
ASN assessments	4	4	5	13
SNS reviews	2	2	3	7
Complex needs reviews	1.5	1		2.5
Service planning/audit/SNS	1.75			1.75
CPD Training/in-service	0.875	0.5		1.375
Total Disability	**12.725**	**7.5**	**8**	**25.625**

Sub-specialties				
Hearing Imp	1.75	7	4.4	13.15
Visual imp	1.75	7	4.4	13.15
Neurodevelopment	1.5	1		2.5
Behavioural paeds/CAMHS Link	1.5	1		2.5
total sub spec	**6.5**	**16**	**8.8**	**31.3**
Vulnerable Children				
Lead for Child Protection	2.63			2.63
Clinical CP work including SCAN	8.75			8.75
Case conferences/interagency meetings	1	1	3.25	5.25
A and F(panels/training/medicals)	1	1	1.5	3.5
Support to SWD (Child centres etc)			2.63	2.63
Service management/planning/interagency	0.875			0.875
Total vulnerable children & YP	14.255	2	7.38	23.635
Public Health				
Liaison re surveillance/SNS/locality issues	1.75			1.75
total Public Health	1.75			1.75
Service management				
HR/recruitment/appraisal/etc	1			1
Audit/Quality assurance	0.875			0.875
Cross Children's services issues	1.75			1.75

total management	3.625			3.625
Teaching and training				
Undergraduates	0.5	0.5		1
Post-grads (assume 0.5 per trainee)	1.5			1.5
total teaching	2	0.5		2.5

Exemplar CHPs				
Area	**South Lanarkshire Community Health Partnership**		**South East Glasgow Community Health & Care Partnership**	
	Population	**CCH Medical Establishment**	**Population**	**CCH Med Establishment.**
0-14	**53,088**		**16,078**	
15-64	**206,369**		**72,793**	
All Ages	**310,090**	**circa 9.3WTE**	**101,897**	**3.1WTE**

Annexe 11
School of Community Paediatrics Scholarship Programme 2010/11
Modules and lecture topics
School of Community Paediatrics, RHSC, 18 Millerfield Place, Edinburgh EH9 1LW

Module 1 **27 & 28 September 2010 or 27 September and 23 November 2010**

Day 1 – Acute Paediatrics **27 September 2010**

Lecture Title

Introduction to Paediatric Scholarship Programme

Acute Surgical Emergencies

Acute Respiratory Emergencies

Acute and Life Threatening Illnesses

Basic Life Support

Child Protection **23 November 2010**

Setting the scene – Scottish context

What is Child Protection? – Making judgements

Recognition of Abuse

Problem Substance Use – Assessing risk: It's everybody's job

Protecting Children –Roles & Responsibilities

'Nil by Mouth' – Domestic Abuse

'The GP's Role in Safeguarding Children & Key Messages & Where do you go from here?

Audit findings of GP reports & attendances to CPCCs in East Lothian over past 2-3 yrs

Module 2 **24 & 25 November 2010**

Day 3 – Developmental Paediatrics 24 November 2010

Lecture Title

An Overview of Child Development

Practical Aspects of Child Development

Neonatal Examination

What to do if you have an abnormality?

Day 4 – Child Development 25 November 2010

Lecture Title

Visual Problems in Children

Vision

Hearing

Hips, Knees and Feet

Dietetics and Infant Feeding

Communication Disorders

Module 3 **10 & 11 February 2011**

Day 5 – General Paediatrics 10 February 2011

Lecture Title

Endocrinology (normal puberty, small and large stature)

Diabetes

Child with Cancer

Paediatric Palliative Care in Scotland

Preconception, Genetics and Antenatal Health

Skin: Eczema, Psoriasis and Acne

Common Infections and Allergies, Wheezy Bronchitis and Asthma

Day 6 - General Paediatrics 11 February 2011

Lecture Title

Common gastroenterology problems encountered in childhood

Haematuria /Proteinuria, and Childhood UTI

Cystic Fibrosis

Congenital heart disease/ murmurs, fits, faints and 'funny turns'

Convulsions and Epilepsy

Juvenile idiopathic arthritis and paediatric musculoskeletal examination

Module 4 **30 & 31 May or 31 May & 1 June 2011**

Day 7 – Community Paediatrics **31 May 2011**

Lecture Title

Public Health and the Early Years

Immunisations

Consent and Confidentiality

Faltering Growth

Skin Rashes and Pyrexial/Infective Presentations (from a GP perspective)

Care of the Child with Motor Disorder

Day 8 – Mental Health **1 June 2011**

Lecture Title

ADHD

Autistic Spectrum Disorders

Depression, Suicide and Self-Harm

Adolescence and emotional well-being

Drugs, Alcohol and Solvent Abuse

'Looked After' Children and Transition to Independence

Annexe 12

BACCH Standards for CCH out-patient clinics

STANDARD	**SERVICE/DEPT.**	**ACTIVITY**
Community Health clinic	Child Health/School Nursing Health Visiting/Administration	Community Children and Young Person's Health Clinic

CARE GROUP Children from birth to school age and their carers

STANDARD STATEMENT

All children and young person's clinics will provide a flexible child friendly service appropriate to needs of the client and profession

STRUCTURE	**PROCESS**	**OUTCOME**
1. The child/young person will receive an appointment to see a community paediatrician at the health centre.	▪ Written information about the clinics will be available to potential referrers. ▪ Referrals may be made either to the named clinic doctor or to the community paediatric patch team leader: i) in writing, by letter or standard referral form, for routine appointments. ii) by telephone followed up in writing for urgent appointments ▪ The doctor after receiving the referral will indicate level of urgency when appointment is to be made to a named appointment clerk. ▪ All appointments will	▪ Referrers will be aware of the role and purpose of the clinic ▪ Professionals involved with children will be able to access and request an assessment by a community paediatrician at a local clinic ▪ Routine appointments will be within eight weeks of a referral being received by the Trust. i) The doctor will have the individuals records for the clinic ii) Families will receive notification of an appointment

	be within eight weeks of receipt of referral. ▪ The named clerk will be responsible for; i) Obtaining the records for each clinic session and returning them at the end of the session. ii) Ensuring that follow-up outcomes and appointments as indicated on clinic outcomes sheet are made and appointment letter sent to family at least two weeks before appointment is due.	within a minimum of two weeks notice of the appointment date

STANDARD NO.	SERVICE/DEPT. Child Health/School Nursing Health Visiting/Administration	ACTIVITY Community Paediatric Referral Clinics

STRUCTURE	PROCESS	OUTCOME
2. Provision of safe and stimulating child friendly environment during clinic experience.	▪ Each clinic has a designated, named health care assistant or person. ▪ On arrival to the clinic a health care assistant or designated person will greet and direct them through the clinic experience. ▪ The health care assistant will be responsible for: i) Setting up the clinic with suitable clean and safe toys etc. ii) All toys to conform to British safety standards iii) Soft toys have potential cause infection control risks therefore should not be used within the clinic environment. iv) Damaged or broken toys should be removed from clinic environment v) Opportunities for colouring or painting (if practical) should be encouraged and if necessary aprons should be provided vi) Children's artwork if	▪ Families will have an identified clinic support staff ▪ Family receives a pleasant clinic and supportive experience. At the clinic clients will be made to feel welcome and will be able to wait in a comfortable, relaxed atmosphere i) Provision of a safe stimulating environment for child and their family ii) Health and safety addressed iii) Infection control issues addressed iv) Hazardous toys removed from clinic environment v) Children's own artwork produced to take home or donate

	donated could provide wall decoration within clinic areas	

STANDARD NO.	SERVICE/DEPT.	ACTIVITY
Community Health Clinics	Child Health/School Nursing Health Visiting/Administration	Children and Young People's Health Clinics

STRUCTURE	PROCESS	OUTCOME
3. Each Child and Young Person's health clinic will have a named and designated clinic support worker with clinic duties.	▪ Named clinic support worker (HCA) will be identifiable to individual families when attending clinic by introduction and badge identification ▪ Responsibilities will include: i) ensuring that each session is properly set up with working equipment, records and stationery in clinic rooms ii) undertakes measurements of height, weight and head circumference (when necessary) of the child iii) assists the doctor and supports the child undergoing blood or urine specimen taking iv) supports and looks after child in the waiting area when parents are being seen separately with the doctor v) ensures that equipment required by the doctor ie. Blood taking equipment (needles,	▪ Effective and smooth running clinic ▪ Doctor receives up-to-date information ▪ Child and family feels supported through difficult and invasive procedure ▪ Child is safe during consultation between parent and doctor ▪ Equipment is available and safe to use ▪ Medicines can be safely used by the doctor or HCA when prescribed

	syringes blood bottles) is in date and well stocked and is easily accessible vi) basic medicines, i.e. Paracetomol, Emla or Ametop cream is in stock and in date	

Annexe 13

Bibliography

A Framework for the Developing of Integrated Multi-agency Care Pathways for Children with Life-Threatening and Life-Limiting Conditions. Elston S .ACT Promoting Palliative Care for Children (2004)

A Guide to Support Delivery of Healthy Lives, Brighter Futures: The Strategy for Children and Young People's Health Department of Health (2009)

A Template for Child Health Services. Child Health Support Group Scottish Executive Health Department (2001)

Aspiring to Excellence. Findings of the Independent Inquiry into Modernising Medical Careers. Tooke J (2007)

Better Health Better Care: Update on the National Delivery Plan for Children and Young People's Services for Scotland (2009)

BMA Survey of workload and remuneration of medical managers 2007/8. Health Policy and Economic Research Unit BMA. (2009)

Child Health Inequalities (Presentation). Chalmers J, Information Services Devision, NHS National Services Scotland(2009)

Children's Community Nursing: Promoting Effective Team Working for Children and their Families. Royal College of Nursing (2005)

Commissioning Safe and Sustainable Specialised Paediatric Services, A Framework of Critical Inter-Dependencies. Department of Health (2008)

Community Health Partnerships and Integrated Child Health Services: Additional Guidance Note. Child Health Advice Scottish Executive (2004)

Delivering for Remote and Rural Healthcare, The Final Report of the Remote and Rural Workstream. NHS Scotland Remote and Rural Steering Group (2007)

Evaluating Models of Care Closer to Home for Children & Young People who are Ill. Parker G et al. Department of Health Sciences University of York (2009)

Fit for the Future: Report of the Committee on Child Health Services HMSO (1976)

Framework for Obligate Networks. Feeley D and & Gibbins R. Healthcare Policy and Strategy Directorate, Remote and Rural Implementation Group (2009)

Healthcare Quality Strategy for Scotland

How Many Consultants Would it Take to Provide a Resident Service? Jenkins J. RCPCH (2003)

Long Term Models for Paediatric Services. Report by Short Life Working Group. Health Workforce Directorate. Scottish Government (2009)

Making It Better. Delivering Safe Services: Consultant Delivered Care. Children

Young People and Families NHS Network Greater Manchester (2008)

Modelling the Future- Sub Group Emergency Care and Acute Paediatrics (Medical and Surgical) RCPCH (2006)

Modelling Children's Services for the Future – Behavioural Disorders Encompassing Neurodevelopmental and Child Mental Health Disorders RCPCH (2000)

Modelling the Future – Commissioning of Specialised Children's Services RCPCH (2006)

Modelling the Future II: Reconfiguration and Workforce Estimates RCPCH (2008)

National Framework for Assessing Children's Continuing Care Needs. Consultation document. Department of Health (2008)

Non Consultant Career Grade Doctors – An Important Part of the Paediatric Workforce. RCPCH (2006)

Personal Perspectives on the Future of Remote and Rural Medicine in Scotland. RCPE (2005)

Preparing Nurses to Care for Children at Home and Community Settings. Royal College of Nursing (2008)

Publications Policy and Guidance: Children's Community Teams. Department of Health (2007)

RCPCH Advice on WTD and Consultants Working Patterns (2009)

RCPCH report "Facing the Future" in press (2011)

RCPCH Guidance on the role of the consultant paediatrician in providing acute care in the hospital (2009)

RCPCH Medical Workforce Census 2009

RCPCH MMC Cohort Study 2008/2009 Briefing (2009)

RCPCH Workforce Briefing, Paediatric Workforce and the Acute Sector-hospital on-call (2009)

Remote and Rural Paediatric Project Oates B. RARARI Paediatric Fellow, Children and Young People's Health Support Group Scottish Executive (2005)

Reshaping the Medical Workforce. Guidance on Projecting Future Medical Requirements within Clinical Workforce 2009-14. CEL 28 (2009) Scottish Government (2009)

Scottish Paediatric Telemedicine Project. Scottish Executive Health Department (2006)

Securing better health for children and young people through world class commissioning. The Strategy for Children and Young People"s Health. Department of Health (2009)

Show Me the Way to Stay Home: A Discussion Paper on the Development of Out-of-hospital Care for Children, Young People and their Families (2006).

SIGN guidelines relevant to children in the Community:

#	Guideline Title	Publication Date
112	Management of attention deficit and hyperkinetic disorders in children and young people	October 2009
98	Assessment, diagnosis and clinical interventions for children and young people with autism spectrum disorders	July 2007
83	Prevention and management of dental decay in the pre-school child	November 2005
81	Diagnosis and management of epilepsies in children and young people	March 2005

Skills Maximisation Toolkit. NHS Education for Scotland (2007)

Supporting Paediatric Reconfiguration: A Framework for Standards. Royal College of Paediatrics and Child Health (2008)

Thinking Differently. Maher L et al. NHS Institute for Innovation and Improvement (2007)

Towards an Integrated Child Health Service. Scottish Home and Health Department (1993)

Understanding the 2004 Health Indicators Report – A Focus on Children. NHS Quality Improvement Scotland (2004)

Annexe 14: List of figures and tables

Annexe 15: Glossary of Terms and Abbreviations

AAP: American Association of Paediatrics

ADHD: Attention Deficit Hyperactivity Disorder

ADSW: Association of Directors of Social Work

AHP: Allied health professional (Professions allied to medicine such as physiotherapy, occupational therapy, speech and language therapy, dietetics, podiatry)

AS: Ass Specialist: Associate specialist grade doctor - This was a more senior grade than the staff grade and intended for those doctors performing more specialised work. A window of opportunity was given to SASG s who wanted to apply to it, as there were differences in the terms and conditions. This grade is now closed to newcomers, as the window of opportunity to re-grade to AS closed on 31st March 2009.

ASD: Autistic Spectrum Disorder

ASN: Additional support for learning needs (legal term used in Scotland to describe the educational needs of children and young people with conditions compromising their learning ability)

BACCH: British Association for Community Child Health –UK organisation for community paediatricians

BME: Black Minority Ethnic

CAMHS: Child and adolescent mental health service – encompassing the whole specialist clinical team supporting the mental health of children and young people.

CCH: Community child health

CCT: Certificate of completion of training awarded to doctors when they have completed their higher specialist training in medicine and are eligible to apply for a consultant post.

CDC: Child Development Centre

CEN: Children with exceptional healthcare needs requiring intense multi-disciplinary support packages.

CH(C)P: Community health (and care) partnership – Unit of management in the NHS set up in Scotland to manage community and primary care services and sometimes also encompassing social care in conjunction with the local authority.

CHS: Child Health Service

CMA: Comprehensive medical assessment undertaken by a paediatrician for children suspected of being neglected or abused.

CME: Continuing professional education for medical staff

COSLA: Convention of Scottish Local Authorities – the consortium body which represents the collective views of Scottish local authorities.

CP: Child Protection

CPD: Continuing professional development for staff in the NHS

CSA: Child Sexual Abuse

CSAG: College Specialty Advisory Group, a body which advises on subspecialty training and devises the curriculum and arrangements for Higher Specialist Training (q.v.) in Medicine

DCC: Direct clinical care –Used to describe the patient care commitments [programmed activity or PA (q.v.) slots] of consultants and speciality doctors as part of their job plans.

DLA: Disability Living Allowance

DNA: Did not attend. Term used to describe patients who do not keep their appointments.

EWTR: European Working Time Regulations. These were introduced in the UK in 1998 after the passing of the Working Time directive by the European Union. Critically, the average maximum working week has been set at 48 hours from 2009, impinging on the way service is delivered in the NHS..

GIRFEC: *Getting it Right for Every Child*. The Scottish Government policy and guidance for the interagency approach to children.

GMC: General Medical Council – The body which oversees the training and probity of doctors in the UK

GUS: Growing up in Scotland longitudinal study.

HB: Health board – Main unit of management of the NHS in a geographical or policy area of Scotland.

HEAT: Scottish Government health improvement targets (relating to health improvement, efficiency and governance, access to services, treatment appropriate to individuals).

IRD: Initial referral discussion regarding child protection concerns between members of agencies including the NHS, Police and Local Authority Social Work.

LAACYP: Looked After and Accommodated Children and Young People

LEA: Local Education Authority

LD: Learning Disability

MCN: Managed clinical network for a specific condition across a geographical area (local, regional, national)

MMC: Modernising Medical Careers was introduced in 2007 as a programme of radical change to drive up the quality of care for patients through reform and improvement in postgraduate medical education and training.

MTF: RCPCH's Modelling the Future reports(1-3) which analyse and describe the future for paediatrics in the UK.

NAI: Non Accidental Injury

NES: NHS Education for Scotland – A special health board in Scotland which oversees the training of a wide range of health professionals and support CPD.

NHSiS: NHS in Scotland

OECD: Organisation for Economic Co-operation and Development. This organisation publishes comparative reports on the performance of different countries.

OP: out-patient

OT: Occupational Therapy

PA: Programmed activity (4 hour unit of work in a trained doctor's job plan).

PCT: Primary care trust (England) – NHS Unit of management for approximately 300,000 people.

PND: Paediatric Neurodisability

RCGP: Royal College of General Practitioners – Professional body for GPs

RCPCH: Royal College of Paediatrics and Child Health – Professional body for paediatricians

RHSC: Royal Hospital for Sick Children

RTT: Referral to treatment time (refers to Scottish government 18 week target).

RPG: Regional Planning Group

SACCH: Scottish Association for Community Child Health – Professional association for community paediatricians in Scotland.

SALT: Speech and Language Therapy

SASG: Staff and associate specialist grade [predecessor term for specialty doctors (q.v.)].

SCRA: Scottish Children's Reporter Administration

SDQ: Strengths and Difficulties Questionnaire - a brief validated behavioural screening questionnaire for 3-16 year olds.

SGHD: Scottish Government Health Department

SPA: Supporting professional activity (referring to trained doctors' non- clinical work including their continuing professional development.)

SpD: 'Specialty doctor' is the new term for Specialty and Associated Specialty Grade (SASG) doctors. The specialty doctor post is not a training grade; it is a grade where a doctor has at least 4 years of postgraduate training, two of those being in a relevant specialty. As specialty doctors are not in training, their roles are usually much more focussed on meeting NHS service requirements, compared to consultant roles

ST: Specialist trainee in a recognised postgraduate medical training programme with annual slots – Usually over 8 years (ST 1-8).

SWD: Social Work Department

UNICEF: United Nations International Children's Emergency Fund

UTI: Urinary Tract Infection

WTE: Whole time equivalent unit of employees

YP: Young people

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