Strengthening the Care of Children in the Community

A Review of Community Child Health in 2001

February 2002
Foreword

Public health and children’s preventive health care have a long and honourable tradition in the UK. In the last fifty years, we have seen the disappearance of many infectious and nutritional diseases, the survival of low birth weight babies has increased dramatically, the quality of care for disabled children and their families has improved and we have learned to recognise – though not to prevent – the neglect and abuse of children. Now that the focus of so much medical research is on technological miracles such as magnetic resonance imaging and organ transplantation, it is easy to forget what has been achieved, and what remains to be done, in the less glamorous areas of child health.

For historical reasons, UK paediatrics has been both blessed and cursed by the perpetuation of two very distinct divisions of paediatrics, generally known as “hospital paediatrics” and “community child health” respectively. Hospital paediatricians climbed the traditional ladder through the training grades en route to consultant status but for many years there was little or no formal training in community paediatrics. In 1976 the Court Report, “Fit for the Future”, made a number of recommendations about the structure of paediatrics and child health, including a gradual elimination of the perceived boundaries and barriers between hospital and community. Many of these have been implemented at least in part, but some were not deemed acceptable or achievable in 1976.

A quarter of a century later, it seems more obvious than ever that such distinctions are unhelpful, yet they still persist in our training, our thinking and our service planning. In the spring of 2000, I invited Professor Alan Craft, vice president for education and training, to lead a small working group to review the current state of community child health in the UK and make suggestions as to the changes needed. It was intended that this should be a wide-ranging review, including the interface with, and implications for, the whole range of services for children. Professor Craft was assisted by Dr Neil McLellan, consultant general paediatrician at Birmingham Children’s Hospital and the College adviser on NHS Direct; and Professor Jo Sibert, professor of community child health at the University of Cardiff and (from 1999 till 2001) president of the British Association of Community Child Health.

They have produced this visionary report after wide consultation and discussion. The group’s work has proceeded in parallel with that of the Health Services Committee, which has developed a strategic paper to be published simultaneously with this one, entitled “The next ten years”.

The tasks that traditionally make up community child health are clearly set out in this report and it will be obvious that they make up a significant and growing proportion of the health care of children. But there are many ways of providing this care. We must now consider new approaches that will offer children and their families the genuinely seamless service that is often spoken about but rarely delivered.

The College owes a debt of gratitude to Professor Craft and his group for an important contribution to the evolution of paediatrics and child health in the UK. Like the Court Report, it marks a milestone in our history.

David Hall, President.
07.01.02.
STRENGTHENING THE CARE OF CHILDREN IN THE COMMUNITY

A REVIEW OF COMMUNITY CHILD HEALTH IN 2001

Introduction

In 1972 Lord Cohen of Birkenhead wrote in the preface to *Paediatrics in the Seventies* (1):

“The health of British children has notably improved in the past twenty-five years. Their average height and weight have increased, and many diseases, which maimed or killed, for example, diphtheria, poliomyelitis and tuberculous meningitis, have virtually disappeared.

“The British Paediatric Association is rightly anxious not only to maintain, but to improve on this past record. To this end, it has produced a blueprint to guide its members (and doubtless to influence the Government’s decisions) during the next decade.”

*Paediatrics in the Seventies* outlined how the health needs of children might be catered for in the 1970’s and this led to the government commissioning their own review chaired by Donald Court. *Fit for the Future*, set out a government blueprint for the care of children. One of its main recommendations was the establishment of Consultant Community Paediatricians (CCPs) to run the community child health services (CCHS). (2)

Now in 2001 we can re-visit the thoughts of Lord Cohen. Although health improvements continue we face new challenges.

- The health of the whole population of children continues to improve.
- More can be done for infants and children who are very sick.
- There are more chronically disabled children, their disabilities are more severe, they are surviving longer and their parents have higher expectations.
- Emotional and behavioural problems are on the increase.
- Many of our children still live in poverty or are disadvantaged.
- Many children now receive much of their care at home or out of hospital.
- Paediatricians play their part in multidisciplinary teams working with the local authority dealing with child protection, disability and school health.

There have been great changes in paediatric practice over the last three decades and there will undoubtedly be more in the years to come. The time is right for us to suggest what these changes might be and to determine how we should be training paediatricians who will be caring for children for the next 25 years.

**Background to this review**

In 2000 the Council of RCPCH recognised the need to take a fresh look at the sort of service which children will need now and in the future. The President, Professor David Hall, has been taking an overall view of the future and his document *The Next 10 years: Educating Paediatricians for New Roles in the 21st Century*, should be read in conjunction with this present report. As part of the overall process, and as a response to perceived problems around Community Child Health, a separate review has been undertaken led by Professor Alan Craft, (Vice President RCPCH) along with Professor Jo Sibert (Chairman of BACCH) and Dr. Neil McLellan (Consultant Paediatrician...
and College Adviser in NHS Direct.) In 2000 we did not know what impact the College could make on Government policy but hoped to influence DH thinking on paediatric services, and to persuade Ministers that there should be a National Service Framework for children. Without a clear policy on how we thought children’s services should develop we would not be able to have much impact on policy and planning. The “new morbidity” and the Government emphasis on vulnerable children had to be addressed and seems likely to assume importance in any attempt to modernise children’s services. These are of course central issues in community child health. The question was certainly not whether CCHS were relevant or important but rather how these services ought to be provided in the future and what the training implications are for any changes that might be recommended.

At the end of 2001 there is now both a DH Task Force for Children and a National Service framework. Whilst the focus of this report is on what has, for the past 25 years, been considered as community child health, excessive emphasis on the place where a service is delivered is less relevant than the nature and quality of service that children receive. It also tends to create artificial boundaries that obscure and dislocate the continuum of healthcare for children. Relationships with hospital based general and specialist paediatric services are an essential part of the overall equation.

**Historical perspective**

Before 1974, the care of children outside of hospital was either undertaken by GPs or by the Community Health Services, which were part of the local authority as opposed to the health authority. In 1969, Court and Jackson in their book *Paediatrics in the Seventies* suggested that there should be a new type of paediatrician who would take on the roles previously undertaken by Senior Clinical Medical Officers and Specialists in Community Medicine (child health). These were to be Consultant Community Paediatricians (CCPs). (1)

The reforms in 1973 (the NHS Reorganisation Act) brought together most of the child health services under a ‘health’ umbrella and left the way clear for Court to further develop the ideas for a consultant-led community child health service and this was one of the main recommendations of the Court Report – *Fit for the Future* – published in 1976. (2) They were to be responsible for all non-GP aspects of the care of children outside of hospital with particular regard to preventative paediatrics. Court wrote

‘The Consultant Community Paediatrician will have special skills in developmental, social and educational paediatrics and have a special responsibility for supporting GPPs in these aspects of their work’.

‘We want to make it clear, however, that we see him also engaging in selective aspects of traditional, consultant paediatric work, in the wards and outpatient departments of hospitals – just as we anticipate that other consultant paediatricians will in the future spend more of their time in the community’.

Court also suggested that there would be GPs who would specialise in paediatrics, the general practitioner paediatrician or GPP, and that they would take on much of the preventative work. However, there was much opposition to the GPP concept but in 1990, the new contract for GPs gave them the opportunity, if they were appropriately trained, to take on a major part of the surveillance and preventative work which had been in the remit of the community child health services. A paper recently published by RCGP and RCP re-visits the question of specialisation in general practice. (3) In the years since Court, there have been many appointments to the post of Consultant
Paediatrician (Community Child Health). The money for these posts has mainly been found through retirements of Senior Clinical and Clinical Medical Officers. The role of doctors working in the community has also changed with much of the routine work in immunisation, child health surveillance, school health and looked after children being taken over by nurses in primary care.

The new consultants in community child health and their staff have been engaged in bringing leadership and consultant skills to vital fields for the health of children. These include specialist work in disability, child protection, school health, improving the public health of children, audiology and looked after children. An essential part of the function is working in a multidisciplinary environment with children’s nurses, therapists, teachers and social workers.

In the last 15 years there has been a very critical look at the evidence-base for work in Child Health Surveillance and Hall’s book *Health for all Children* (4), will soon be in its fourth edition. There is now a clear definition of the preventive health services which are of value to children.

Over the last 30 years “hospital” paediatrics too has seen dramatic changes with subspecialisation especially in larger centres. The needs of children with chronic illness and handicap are now more clearly understood and there is a growing trend for work across traditional boundaries. Care of children in the community has never been the exclusive province of the community paediatrician and increasingly hospital based paediatricians are looking after the community aspects of their patient’s care.

A broader perspective of child health and the doctors who deliver it has emerged as a legacy of the Court Report. This provides a conceptual and practical foundation from which to respond to the new challenges and expectations that confront paediatrics, an opportunity to reflect on aspects that have remained neglected, and a mechanism through which to incorporate innovations and new insights into future practice.

**The Review - Methodology**

The review team studied previous reports and papers on community child health from UK and overseas. We invited paediatricians to submit views, evidence and opinions. We received submissions from both community paediatricians and other, more hospital-based, specialists. The team also attended the BACCH Annual Meeting in Chester in September 2000 and received much useful comment. The BACCH and RCPCH executive committees had an opportunity to see an early draft of this report and much helpful and constructive comment was received. The final draft was approved by Council of the RCPCH and endorsed by the BACCH Executive.

In undertaking this review we have attempted to describe the changing needs more fully, assess the concerns about community child health and put these in the context of the medico-political scene.

**The concept of Community Child Health**

One great strength of the NHS is its ability to think in terms of whole communities. The combination of the GP list system and the community child health focus on a whole locality or district facilitates the delivery of health care to those who need it as well as those who demand it. There has been an increasing focus in modern general practice on the health of all those on the practice list, and it will be important not only to maintain this as PCTs take over much of the funding and control, but also to remember the duty of the PCT to provide care for the whole community including those not on the list of any primary health care team for whatever reason.
In 1994, Robert Haggerty from Boston identified the unique contribution and focus of Community Paediatrics (5):

‘Community paediatrics has sought to provide a far more realistic and complete clinical picture by taking responsibility for all children in a community, providing preventative and curative services, and understanding the determinants and consequences of child health and illness, as well as the effectiveness of services provided. Thus, the unique feature of community paediatrics is its concern for all of the population – those who remain well but need preventative services, those who have symptoms but do not receive effective care, and those who do seek medical care either in a physician’s office or in a hospital’.

In 1999, the American Academy of Pediatrics produced a definition of community paediatrics (6):

‘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 favourably or unfavourably, 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 the 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 or economic conditions or their special health care needs
- An integral part of the professional role and duty of the pediatrician.’

The RCPCH Duties of a Paediatrician(7) also cover the majority of these principles and this emphasises that there is significant common ground amongst all paediatricians. Whilst the range of skills and knowledge of community and general paediatricians is different, there is a shared commitment - to a philosophy of holistic care of the child and family, and to the imperatives of effective communication between professionals, improving the co-ordination of children’s care, co-operating in management and, increasingly, in multidisciplinary service planning. This convergence of perspective needs to be combined with a convergence in practice so that the full complement of expertise can be brought together in the interests of the child population.

What do community paediatricians do in 2001?

Today the Community Child Health service provides a wide variety of services for children including:

- assessment and care of the child with a disability (most of which are neurological disabilities);
- audiological services (screening, middle tier and diagnostic tertiary);
- a child protection service including the statutory functions of designated doctor and membership
of the ACPC;
• support for education including the duties of the designated doctor for educational liaison;
• medical care for children looked after;
• medical support for the local adoption panels;
• some child mental health services and in particular ADHD;
• the role of immunisation co-ordinator;
• planning and management of statistical data; policy development,
• teaching and training for primary health care staff regarding preventive child health programmes;
• overview of localities and districts in respect of health needs and services; liaison and inter-agency working to develop and implement new initiatives such as Health Action Zones, Behaviour Support Plans, injury prevention programmes etc.

The changes in community child health have been mirrored in changes within the professional organisation representing community paediatricians. The old Community Paediatric Group of the British Paediatric Association has evolved into the British Association for Community Child Health. BACCH now has over 1200 members and is run from an office within the Royal College of Paediatrics and Child Health.

As work in community child health becomes more complex, there has been the development of specialisation within the subject. This has been particularly in disability, child protection and public health. These subjects form the three speciality groups within BAACH. There is also specialisation within the fields of audiology and looked after children with BACDA and the medical group of BAAF representing those who specialise.

Academic Community Child Health

The changes in Community Child Health have resulted in changes in the Academic basis of Paediatrics and Child Health. They have resulted in a number of academic appointments in community child health throughout the country. However, there are some medical schools without a single post. This is partly due to the low priority given to Community Child Health by the medical schools but also the difficulty in finding suitably qualified applicants.

When appointed academics in Community Child Health are able to make real contributions to undergraduate teaching, particularly in fields of child protection and disability. They are able to make major contributions to the new more community based undergraduate curricula. Some run M.Sc Courses in CCH which have been successful.

Maintaining research programmes has been difficult for many academics in Community Child Health. This is partly because of the difficulty in maintaining a critical mass of research staff. It is also because the subjects studied have not been of a high priority for Grant funding organisations although this may well be changing.

The wider context of this review

There are many reasons why we felt it was important to review community child health. These can be divided into three groups: issues of changing health care needs; concerns related to the current delivery of community child health services and the changing medico-political scene with respect to patient expectations and the delivery of care.
The Changing Scene - Changing needs of children in the developed world

The last ten years have seen a huge shift in the delivery of care across the whole field of medicine. Hospital Day care and home care are now given higher priority. More recent changes have included GP Co-operatives and NHS Direct. GPs are under ever-increasing pressure, because of shortage of doctors, shrinking consultation times, and, in particular, patient demands – these often translate into rising workload at secondary care level.

Children have never been physically healthier and yet hospital admission rates have continued to rise whilst length of stay has declined. Parents are no less anxious or concerned, however, and worry about failing to recognise a serious problem. This has resulted in a continuing increase in general paediatric workload. Most of the attenders are not seriously ill; a report from Nottingham recently illustrated the large number of children attending an inner city A and E unit with essentially minor illnesses, of which a substantial majority were dealt with by SHOs and, by implication, could have been managed in a primary care setting (8).

A study in a regional paediatric centre in Australia, in which almost 15,000 consecutive consultations were documented, found that most time was spent with “chronic illness, chronic physical or intellectual disability, learning and behavioural disorders” (9).

In Australia, the USA and much of Europe, the need for trainees to support the service demands of hospital based acute units inevitably takes precedence over non-acute problems. Yet in terms of the volume of work that can be anticipated in the next few decades, it is clear that the pattern described in Australia is likely to be the same in the UK.

Changes in the workforce and the Working Time Directive, resulting in growing concerns about the need to centralise acute services, will also have an impact.

A solution is required to the management of emotional and behavioural problems that are now so widespread, and to the emerging threat of obesity and avoidable ill-health. New initiatives are required to empower parents, to provide more appropriate means of assessment and support, and to create alternatives to the traditional, hospital centred model of care. Equality of access for equal needs has been an elusive objective but must be attained.

Community child health cannot be considered in isolation and the review has to some extent had to consider the whole of the future delivery of services to children at a primary/secondary level. Tertiary services have also to be considered where these impact on community services. However, the wider view is the subject of The Next 10 Years: Educating Paediatricians for New Roles in the 21st Century.

Concerns about current Community Child Health services

There are many excellent examples around the UK of effective integrated paediatric care programmes. Nevertheless, the following concerns have also been noted:

- poor recruitment of SpRs into some community training posts, a vicious circle that sometimes results in these posts being lost or absorbed into another rotation.
- a lack of applicants for many advertised consultant community paediatrician posts – some consultant community paediatrician appointments remain unfilled and there is reason to think that some trusts have deferred advertising because of the perceived shortages of high calibre applicants.
A number of trainees have expressed unhappiness about their training in community child health. There are major gaps in the training of some paediatricians in “community” type issues, such as child protection, outreach, communication with the education service etc.

Some of these concerns can be attributed to the short history of these services being consultant lead within the NHS, and insufficient priority given to developing these services, despite general acknowledgement that secondary care for children should be delivered where possible in a community setting.

The Changing Medico-political Scene: Professionals’, Children’s and Parents’ Expectations

Doctors and other professionals

The Secretary of State has made it clear that he aims to move towards a consultant-delivered service. There will therefore need to be a considerable consultant expansion and once a ‘steady state’ has been reached, there will be a very substantial reduction in the number of registrars. There is also likely to be a major reduction in the number of SHOs who will be in much more structured and time limited programmes. The EU working time directive is also going to have a major effect on the pattern of consultant work with on-average only 48 hours of weekly working allowed, with compulsory rest periods. Paediatrics has a particularly large proportion of women trainees and consultants and it will be important to ensure that job structures facilitate part time and flexible working.

The pressures on doctors are steadily increasing. It is essential for all doctors to keep up to date with CPD/CME and professional isolation will become increasingly dangerous and unacceptable. All doctors, including those in paediatrics and child health, need to collaborate with colleagues, both those who work at the same level in adjacent areas and those who have a narrower specialisation, perhaps at regional level.

Similar comments apply to other disciplines such as nursing, psychology and the various branches of therapy. Working with colleagues as a team, with the doctor often but not invariably the team leader, is a skill that will be expected of every trainee whether hospital or community based.

All these realities must be anticipated and incorporated into proposals for the future of paediatric services. Equally, new roles for specialist nurses, including nurse practitioners and nurse consultants, will allow services to be delivered and managed in new and potentially innovative ways.

Changes in General Practice

Radical changes are taking place in general practice and it is difficult to foresee the consequences in the long term. The majority of acutely ill children throughout the 24 hours are seen and managed in general practice. Relevant training in paediatrics and child health is extremely important for GP vocational trainees. GPs must be backed by paediatric liaison and consultation services to avoid unnecessary hospital admission for children. This applies as much to acute and subacute medical conditions as it does to the range of non-acute problems of childhood and adolescence. PCTs are well placed to ensure that all the children in their locality, irrespective of allegiance to any one primary care team, have access to appropriate primary care.

The role of PCTs in commissioning children’s services is beginning to take shape but if paediatric
and child health services are already fragmented in a locality, the priority given to children may be
diluted and we are concerned that CCPs could be very isolated. The College has always argued
that although managerial arrangements do not necessarily either support or prevent close integration
between hospital and community staff, deliberately placing staff in different trusts is hardly the best
way to encourage a fully integrated and seamless service.

**Demand and Clinical Management Systems**

The introduction of NHS Direct (NHS 24 in Scotland) represents the first step in a process inten-
tended to ensure that patient’s needs are identified and met in a consistent and effective way, wherever they live. Computerised decision support and clinical management systems will be increasingly
deployed throughout the NHS and the electronic patient record will provide continuity of informa-
tion. Such developments are intended to require highly integrated networks of care and will have a
significant impact on future medical practice and will need to be anticipated and exploited in design-
ing future services for children.

**Parents and children**

Parents have higher expectations, are more knowledgeable and more demanding. They want:

- Ease and speed of access to relevant services (whether in their neighbourhoods or more
distantly)
- The right treatment and the best outcome
- Excellent communication, with timely and understandable information
- Reassurance and support
- Continuity and co-ordination of care for chronic disorders

Children need:

- Acute assessment and care of the sick and injured
- Basic neonatal care
- Outpatient consultation for common problems
- Community-based care for those with long-term problems
- A child protection service
- Adoption and fostering advice
- The particular health care needs of looked-after and other vulnerable children
- A programme of immunisation, health promotion, screening and surveillance for pre-school
  and school age children (school health)
- Access to child mental health expertise (both CAMHS and other options)
- Easy access to specialist and tertiary level expertise where needed, with some care provided
  locally through managed networks
- An overview of health care needs and provision (public health, statistics, strategy develop-
  ment) and links with other agencies

**Patient Centred Care**

In planning the provision and disposition of services, the approach of considering the patient’s jour-
ney through the NHS, from the point of first access to whatever the final destination is increasingly
used as a yardstick. How can needs be identified at the outset of the journey? How can the patient
be directed to the most appropriate service and receive consistent and satisfactory treatment with
the best outcome? Designing and developing paediatric services in the future will rightly, in our view, demand this type of analysis and this is likely to prove a significant stimulus to organise services around the needs of the child rather than the preferred location of the doctor.

Community Child Health and changing needs

A concern that arose out of our review was the wide range of skills expected of a community paediatrician. Some consultants specialised very much in one topic whereas others were offering a generic service that encompassed all the aspects of the specialty. The demands created by the pace of medical developments in this field are illustrated by considering how the situation has changed over the last 30 years.

1. Most disability services used to focus on conditions such as classic diplegic cerebral palsy, autism and Down’s syndrome. Rare syndromes were recognised but little was known about them and less could be done. It was possible to provide a service for these children that was more or less independent of acute services. Now, both diagnosis and intervention are vastly more sophisticated. Children with very severe disabilities and complex mixtures of multi-system problems are surviving longer and they and their parents rightly have higher expectations. Many need a range of specialist services both for the planning of long term medical care and for acute events such as infections or seizures. The management of nutrition has become a very important part of the care of such children.

2. Audiology services incorporate screening, diagnosis and management. Screening is moving from the clinical method of distraction testing to newborn screening methods which involve an investment in technology and technical skills; diagnosis similarly involves a number of advanced technical investigations and procedures; intervention may include cochlear implants; and in addition the importance of genetic diagnosis is growing rapidly.

3. The diagnostic and process issues in child protection are becoming more complex for the paediatrician. This now includes the complex areas of physical, sexual, emotional abuse and neglect, and factitious illness. The expectations of precise diagnosis, sympathetic management and high quality evidence in Court are now very high with the price of error being correspondingly high. An example is the management of subdural haematoma in childhood where the skills of the paediatric neurologist, neurosurgeon, neuroradiologist, ophthalmologist, radiologist and social worker are needed with the paediatrician in a co-ordinating role. The expectations and demands on services have been further extended with the recent reviews of adoption and of children looked after.

4. Understanding of child mental health has steadily become more sophisticated and new research findings are being disseminated. Models of care are taking on a wider remit for community based mental health services. Paediatricians have rightly been drawn into these, and many now provide some support for conditions such as ADHD. Close collaboration with psychologists and therapists in managing psychosomatic problems and complex disorders like chronic fatigue syndrome has become commonplace but by no means universal. On the other hand, there are also many paediatricians, working both in hospital and in community settings, who have little training in behavioural or emotional disorders and their management yet are called upon to deal with such issues.

5. Child public health is also becoming more time consuming – for example, there are increasing
demands for quality and excellence on those who manage screening and immunisation programmes. Major catch-up campaigns and new programmes e.g. meningococcal C vaccine are a major test of the managerial skills of staff.

6. For many children with chronic disorders e.g. diabetes, asthma and arthritis the majority of care is given in the community. Most of these children are managed by doctors whose main base is the hospital but they require exactly the same multidisciplinary team management as children with neurological handicap.

7. Physical health has improved in conjunction with better living standards over the last 50 years. Against expectation, psychosocial disorders (crime, suicide, suicide behaviours, depression, eating disorders, alcohol and drug abuse) have become significantly more prevalent. Teenage pregnancy rates in the UK are amongst the highest in Europe. Adolescent services cannot continue to languish. Paediatricians will need to develop their skills in adolescent health and advocate the recognition and understanding of the social, psychological, and biological forces that are particularly impinging on young people and threatening to spoil young lives. A greater appreciation of the continuity from childhood through adolescence to young adult life is essential, with a greater emphasis on anticipation and proactive interventions. Improvements are equally necessary in the arrangements for those with long term health needs so that they can make a successful transition to adulthood.

**Should there be subspecialisation with Community Child Health?**

There are strong arguments and proponents both for and against the development of separate subspecialties with Community Child Health. Possible candidates for such would be:

- Disability
- Social Paediatrics – including child protection, adoption and fostering and looked after/vulnerable children.
- Child Mental Health – which might include educational medicine.
- Public Health paediatrics.

We are clear that all paediatricians must have foundation level skills in all of these subjects. Some will take one or more to a higher level of expertise. With the increasing sophistication of medicine there will be a much greater understanding of these areas of paediatrics. The time is here when we are fulfilling Donald Court’s wish expressed in his 1970 Charles West lecture (10):

“We must continue to strengthen the foundations of paediatrics in the biology of development, extend our studies of the social determinants of health and disease in child and family, especially by the use of well planned local records; seek with psychology and psychiatry for a better understanding of the development of personality in the hope that we may find ways of diminishing maladjustment, excessive anxiety and destructive aggression in our children and parents: treat our patients with increasing skill and consideration and try to as honestly as we can overcome the dichotomy of treatment and prevention: establish these principles in the education of doctors and others professionally involved in the care of children.”

“Without continuing enquiry there is no progression. My plea is that we should apply the same critical energy to the study of social as we do to cellular behaviour.”
There is an inevitability that subspecialisation will occur and this needs to be actively managed. The RCPCH is already piloting a disability training course and plans are advanced for mental health and child protection.

We do not think it wise that paediatricians should devote the whole of their time to very stressful and vulnerable areas of work e.g. child protection but they undoubtedly will develop special expertise with which to support other colleagues.

**Is the distinction between hospital and community becoming increasingly artificial?**

Many disabled children are first identified as having problems in NICU or after a neurological insult, or because of a syndrome diagnosis that needs further investigation and management. Of those who present later with disabling conditions, for example severe epilepsy, autistic spectrum disorder or Duchenne dystrophy, the majority will need some hospital investigation and a substantial proportion will need hospitalisation from time to time for acute events such as fits or gastrostomy problems.

Conversely, there are many children with “medical” rather than neurological disorder who will nevertheless turn out to have some degree of disability and will need community services. Examples include congenital heart disease with residual disability due to incomplete correction or intra-operative problems, inherited metabolic disorders presenting with encephalopathy and leaving some permanent impairment, severe dermatological disorders, diabetes, juvenile idiopathic arthritis, the long term effects of treating malignant disease.

Much of the care of these children needs can be provided at home or at school with a network of community care and their conditions have various implications for their education which must be spelled out to the school staff. In the modern era these children will all need to be managed by a team but they might reasonably expect one paediatrician to be their key clinician who would be available to co-ordinate their care whether in hospital or in the community.

In the case of child protection, all paediatricians need to have basic skills in recognition and early management of abuse. The preparation of evidence for case conference or for legal proceedings is an increasingly complex business undertaken increasingly by community paediatricians. However, in many cases this can not be done without help from colleagues in the hospital.

In the case of less severe developmental problems such as communication disorders (which are often identified in pre-school settings), and emotional and behavioural problems (many of which originate from the school health service), there is a large and growing overlap between CCHS and CAMHS. This is partly due to the fact that undifferentiated behavioural difficulties have always been likely to present to paediatricians before being identified as basically psychiatric problems; partly due to parental preference for seeing a paediatrician rather than a psychiatrist; partly due to the overload and under resourcing of CAMHS for many years. Many children presenting to a paediatrician with apparently organic complaints have at least an element of psychosomatic disorder as well. In addition to obvious examples like chronic fatigue syndrome, there are many less differentiated complaints where a knowledge of psychosomatic medicine will be helpful.

Paediatricians feel that they can and should contribute to children’s health care in this field, but there are implications both for workforce numbers and for training – if paediatricians are going to practice child psychology and psychiatry they need to be trained for the task and to work closely with their CAMHS colleagues.
We are led to the conclusion that the distinction between hospital and community paediatricians has become increasingly artificial and should be phased out.

**What are the current concerns of community paediatricians?**

It is very difficult to give a simple or single answer to the question. However, the concerns can perhaps be categorised into three groups – personal anxieties and discontent; issues to do with structures and management arrangements; and worries about training.

**Personal Issues**

There are many different models of practice around the UK with examples of innovative practice and enthusiastic community paediatricians and trainees. However, there are other individuals and areas for which the situation is not so satisfactory. Some of the major problems identified at an individual level were:

- For some, perhaps for many, there is perceived low status in the professional hierarchy of paediatricians. This can create and perpetuate feelings of low self-esteem which are particularly distressing when there is poor communication with, or difficult access to, hospital colleagues - whether at secondary or tertiary level. This can conspire with the complexity of current workloads to produce a real feeling of isolation that hampers professional development, service delivery, and the opportunities for doctors in training. There are concerns about a lack of mentoring and support for new consultants and a very real feeling of isolation and therefore vulnerability in dealing with child protection cases and other difficult issues.

- These perceptions are heightened by the knowledge that activity within the community service is not always recognised in official statistics, or understood for its real complexity and contribution. Furthermore, acute medical services are almost always prioritised ahead of community services when there is competition for funding. There are also feelings of dislocation from important clinical information because of the lack of access to hospital records in community clinics.

- There is widespread concern that inappropriate demands might be made in the future to take on acute on-call work, with or without further training. Specifically, it is seen as being neither wise nor realistic to expect those with no recent experience to have responsibilities for neonatal emergencies or for high dependency acute paediatric care. Some feel that their role and outlook excludes, and should continue to exclude, the acquisition or renewal of such skills. On the other hand, contributions to the on-call child protection rota would present less difficulty.

- The transition from hospital to community practice can be unsettling for trainees, most of whom will have backgrounds influenced exclusively by a biomedical view of health, and clinical experience limited to acute medical conditions. A more balanced perspective of child health needs to be part of the curriculum in medical schools. Trainees should be introduced to community services at a time when they have sufficient experience to appreciate its complexities. They then need to spend long enough within the discipline to acquire real understanding, knowledge, and skill.

- Academic paediatrics is seen as being much too heavily focussed on organ and system diseases and insufficiently interested in the major child health issues of the UK population. The former is as important to technical scientific progress as the latter is to the welfare of the generality of children, and both must be properly represented in academic departments of paediatrics and child health. Paediatric public health issues, questions of rehabilitation and disability, analysis of the “new
morbidities”, health services planning - are some of the subjects that could be developed.

**Training in Community Child Health**

When we examined training in Community Child Health, we found that the picture was varied. Those Districts with inadequately staffed services presented a less favourable picture. Regions with modernised community child health services, significant academic presence in Community Child Health (often with M.Sc courses) did much better. In Wales, where these three criteria apply, approaching a half of the trainees want to do Community Child Health as a career.

A recent survey conducted by Rosemary Thornes for the College\(^{(1)}\) has illustrated in detail the wide variability in the perceived quantity and quality of training in the various facets of community child health. For example, some trainees had as little as six months part time exposure to disability training and considered that they spent far too much time in pure service provision – others at the opposite extreme described model programmes and were very enthusiastic about their work.

**Managerial arrangements**

These can be a source of concern to community paediatricians. There are two main models of current working:

1. Where the community and hospital teams are clinically, and often managerially distinct with infrequent direct contact
2. More integrated models where there are better established lines of communication both clinically and managerially

Quite frequently, however, in both types of model, communication between hospital and community sectors remains uneasy or unpredictable. Where this is the case the reasons are diverse and can include heavy individual clinical workloads, poorly resourced and inadequately staffed services, unsympathetic management structures, or a failure fully to appreciate the complexity of each others contribution to the needs of the community served. The effect of commissioning services through PCTs could make matters worse, particularly where current services are poorly integrated.

The review team acknowledges these concerns and recognises their significance. It is equally aware of the future challenges that face the acute medical services, at least as they are presently configured. **All these considerations add urgency to the need to find a unifying solution.**

**Providing a comprehensive paediatric and child health service in the future**

*The following principles are suggested by this review:*  

- The service will be provided by a fully trained workforce (DH policy)  
- 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
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.

Balancing ease of local access with the need for a comprehensive range of expertise

Children must have ease of access to the best possible care. This might be provided by local clinics and day care facilities. It could be provided by scheduling clinics at other locations at more convenient times for families and improving transport links. As the demand management function of organisations such as NHS Direct become more extensive and familiar, access to a range of secondary level services may be facilitated. However, proximity of care to home is not the only determinant to providers and only one aspect of opportunity cost to the users, and in any case will clearly differ between urban and rural populations. Parents might prefer to attend a neighbourhood clinic but they may be willing to travel if the end result is worth it. Travelling for inpatient care is inevitable and journeys might increase in the longer term if, as seems likely, some smaller units become non-viable and inpatient care is relocated to units with the critical mass to function to the highest standards at all times.

Other than core hospital functions required for inpatient management, care should be decentralised wherever possible. In the past, control and most activity has been retained at the centre whilst community care has been seen as outreach. Community paediatricians have become adept at local networking. The future need is to co-ordinate and resource existing networks more intensively and add to these as services are increasingly devolved from hospitals. These **Managed Networks** will require careful management and we believe that this should be the fundamental mechanism through which child health services are delivered in the future.

It is vital that these changes bringing everyday care of children closer to where they live does not reduce the capacity to deliver the key aspects of community child health to the population.

The principle should be that all of these services are provided by a team of paediatricians, and other health care professionals, probably working in a locality. Their clinical base may be in a hospital or in a community setting. Pathways of care need to be established for different circumstances so that the child receives the right assessment and care, at the right time, and in the right place.

**What type of paediatricians would be needed to serve these needs?**

The key principle is to centre the service around the needs of the child and family. We believe that the distinction between hospital or acute care and community care is becoming less relevant as patterns of morbidity and care change. It therefore makes sense to stop defining doctors according to where they do most of their work. A paediatrician should be first and foremost a doctor with generic training in paediatrics and child health. Their training should equip them to be comfortable with basic care of the main acute and chronic problems of newborn infants and children. No one paediatrician can have all the skills needed for a modern service, but a team can. There are certain foundation skills which all members must have but also many areas where a varying degree of specialisation will be needed.
A Locality Team – an example

Skills

<table>
<thead>
<tr>
<th>Paed</th>
<th>Foundation +</th>
<th>Child Protection</th>
<th>Diabetes</th>
<th>Respiratory</th>
<th>Disability</th>
<th>Vulnerable Children</th>
<th>Adoption/ Fostering</th>
<th>Etc....</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>√</td>
<td>√*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>√</td>
<td></td>
<td></td>
<td></td>
<td>√</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>√</td>
<td></td>
<td></td>
<td></td>
<td>√*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>√</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>√</td>
<td></td>
<td></td>
<td></td>
<td>√*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>√</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>√</td>
<td></td>
<td></td>
<td></td>
<td>√*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>√</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

+Foundation skills: Generic training to be able to cope with the “local” needs of children in acute and chronic paediatrics and Child Health

*Lead Clinician: The person within the locality team who takes foundation skills to a higher level, acts as resource to locality colleagues and is the link to higher levels of expertise through a managed network.

What might this mean in practice?

Training in relation to delivery of care – general considerations Comprehensive pathways of care need to be created for different circumstances so that the child receives the necessary assessment and care, at the right time, and in the most appropriate place. We believe that the aim should be to ensure that there are suitable numbers of doctors available with generic skills to handle a range of common problems on the majority of pathways, and with special skills to offer specific expertise on a few, rather than to have large numbers of selectively trained individuals without the necessary flexibility (and perhaps commitment) to contribute as needed.

The acquisition of generic skills by all paediatricians is a way of ensuring that they are equipped with sufficiently broad a training in child health to apply their expertise across the range, whilst understanding the implications of their interventions to the whole child and to other parts of the paediatric healthcare network. It deliberately acts as a counterweight to the reductionism of modern medical science and the tendency to lose sight of the child as a social being and member of a family. Furthermore, it is likely to lead to a paediatric workforce with the ability to adapt as the mix of services and children’s needs alters in response to epidemiological trends, new technologies (including digital communications), to the expectations of the public and government, and to British and European legislation affecting working practices.

The generic skills will include competencies to recognise and manage acute illness in children of all ages but equal weight must be given to the assessment and management of the child in the worlds they inhabit - worlds of the family, school, and neighbourhood, and as members of the wider child population of modern society. Paediatricians should be comfortable seeing children not just in hospital, or in a child development centre, but at any location.

The conventional view is that young doctors need to acquire clinical and diagnostic skills, knowl-
edge, and confidence before moving into the more complex arena of child health. In other words they require a level of experience before they are in a position fully to understand and absorb the wider perspective and make sense of the ways in which they will need to function for the rest of their professional lives. This reality is not necessarily immutable. It could be changed by a more thoughtful balance between biomedical and biosocial models of health within the curricula of medical schools, so that future graduates are less constrained by a focus on physical illness as the exclusive determinant of health. We believe that it can also be accommodated by introducing a more widely based postgraduate training programme that progressively introduces exposure to all the key elements of paediatrics and child health, and to which added value is generated by experience in a specialised field towards the end of the general training period.

Doctors in training need to realise where that training is leading them - not to a state in which they do more of the same, with greater responsibility for the individual child and with higher professional status, but to a position that is a springboard for further development as an effective paediatrician. Continuing professional development will become progressively less ad hoc an arrangement, and increasingly essential as a way of tuning the skills and knowledge of the individual consultant to meet the needs of the child population. It will also prepare the way for the evolution of responsibilities with time, in which acute on-call commitments are replaced by equivalent contributions in ways that can be physically sustained without exhaustion by those over the age of 55 years.

**HOW WILL WE TRAIN SUCH PAEDIATRICIANS?**

A change of emphasis in training is the first step to bring about these changes. The following observations are equally relevant whatever changes might be made in the duration or structure of training.

- Acute and neonatal paediatric problems accumulate in larger centres and provide essential opportunities to gain a breadth of experience more quickly than will ever be possible if the trainee eventually becomes a consultant in a smaller unit, so their importance must never be underestimated.

- Nevertheless, trainees need to be equally diligent in acquiring competence in the fields of child protection and basic developmental and behavioural paediatrics, and in learning to apply public health concepts to medical care both in hospital and in community settings. These aspects of paediatric care will need to be given more priority in the SHO programme and in the first two years of SpR training.

- Different trainees will have different aspirations once they move on from their first two years SpR (“core”) training.

- For those whose aspirations are in what are traditionally the more “community” oriented areas, opportunities to specialise must continue and expand.

- There is an issue as to whether the RCPCH should move towards “dividing up” the current components of CCH into sub-specialties. This has of course already happened to a considerable extent with regard to paediatric audiology. Areas for sub-specialty recognition might include disability, behavioural, educational and social paediatrics, child protection and child public health. The disadvantage of doing this at present is that, with the exception of child public health, these subjects have a considerable degree of overlap. Much time would be consumed in establishing precise new guidelines for each new sub-specialty to be agreed with the STA, without any knowledge of how many doctors would take up these alternatives or how many consultant job descriptions would call
At present we would suggest the following:

- All SHO training should incorporate a basic introduction to disability, child protection, child mental health and public health principles. These should be tested in the examinations set by the College.
- All SHOs and core SpRs should have experience of paediatric practice in primary care settings and in A and E departments, in order to be familiar with, and expert in the assessment of, acute undifferentiated illness.
- All SpR training should similarly incorporate such topics but taken to a level appropriate to the foundation skills concept of the generic paediatrician – this will involve demonstration of competencies as well as knowledge.
- Those who wish to focus on “community” topics for their years 3, 4 and 5 training should take these skills to a higher level, with definition of the minimum standard expected in each.
- There should be an option to focus on one or two areas of skill such as disability and develop these to a more advanced level – disability would probably be the most popular option but most trainees will also want to ensure that they are competent in child protection work.
- Throughout training foundation skills acquired in the early years must be maintained by regular acute on call commitments.
- Specific areas of expertise such as disability or child protection would often be the main part of a consultant job description but the extent of specialisation sought will vary according to the nature and size of the district.
- There should be a structured training programme and package for each of these areas of expertise and these should also be available to established consultants and NCCCG doctors. Their programmes might follow the models being developed for disability and child mental health.
- Masters’ programmes may well add value to training where they exist but should not be mandatory.
- The RCPCH should continue to develop its various distance-learning packages of which the Sheffield Distance Learning course in child disability is an example. There is a clear need for structured approaches to learning particularly in those areas traditionally regarded as community paediatrics, where the opportunities for teaching and learning in the hospital setting are highly variable within and between trusts.
- The option of formally seeking recognition of sub-specialties such as disability should remain on the agenda but there is no urgency so long as the above progressive plan of action is being implemented.
- The approach to definition of competencies and skills should be based on what is needed at district level, but it must be recognised that few trainees will have completed every item of training and experience that could be specified for each sub-specialty. What is more important is that each consultant appointment should include in its job description both the requirement and the opportunities to participate in continuing professional development by being a member of a managed network.

Implementing Change

We are not in a position to anticipate the outcome of the NSF for children’s services or to predict how the NHS care might change over the next five to ten years. Nevertheless we would hope and expect to see a broad coherence of view with the one expressed in the present report. This is important because it translates into a corresponding perspective for PCTs as commissioning authorities (in England only), who are projected to be in control of 75% of the health budget by 2004. When
reinforced with support from paediatricians across the UK, the pressure for change will be compelling.

It is against this background that both training and local activity can be made immediately purposeful. Established paediatricians are not expected to develop new skills overnight or to take on responsibilities for which they have no training. Rather, their experience and knowledge needs to be invested in creating closer integration and mutual collaboration with existing colleagues, improved team working across the range of child health problems, and sharing of responsibilities across the many areas of common ground.

The development of combined pathways of care in and between each locality will be a practical way of bringing these issues into focus. It will reveal areas in which realignment of old roles and relationships are possible, identifying priorities for development, and suggesting ways in which the coordination of activity can be improved so that a child’s journey along each pathway is a matter of careful design.

The training opportunities offered to specialist registrars will require re-evaluation, reflecting the future roles they will play as consultant paediatricians. Consolidation of new patterns of working will progressively occur as new consultant appointments are made and a consultant delivered service emerges as the rule rather than as the exception. We envisage that all paediatricians, even if they are going to be tertiary specialists, should be trained first and foremost as generic paediatricians who would have the necessary knowledge and skills to be able to function as a locality paediatrician. They might then go on to further training as a sub specialist and this could be immediately, or after a period, working as a ‘locality’ paediatrician.

This evolutionary process will not gain direction without careful, consistent, and proactive management. Suitably responsive arrangements will need to be introduced in each district and locality.

We do not underestimate the obstacles that will have to be overcome but we believe that paediatricians have the commitment, resourcefulness and imagination to implement change when they share a vision of the future.

Possible configurations of service delivery

The NHS is changing and the next five years may determine whether the present structure can survive. There are a number of alternative models of care – for instance, the local polyclinic concept, or even the notion of “chambers” of staff (consultants and other professionals) who hire their expertise back to the NHS. New patterns of care are beyond the scope of this present report but are considered in The Next Ten Years. Whatever model emerges paediatricians must be flexible enough to adapt to such changes. The principles of basing a service on the needs of the children in a locality and delivering it with a team of paediatricians with complementary skills will ensure children are well served.

It is impossible to be prescriptive about the best configuration of services for each area and arrangements that work well in one area may be unsuitable in others. There will clearly be a major difference between urban and rural areas. Flexibility is essential and it is our intention to suggest a configuration that could evolve and develop over future years rather than to provide a template that could or should be used as an immediate substitute for arrangements that already exist. The principles are:

- Each locality (total population 125 - 150,000) would relate to a DGH serving a district.
- A typical district might have 3-5 localities and have districtwide staff of consultant paediatr-
• The function of the DGH would be to concentrate inpatient resources (including high depend-
ency provision and level 2 neonatal care); provide specialist investigation facilities such as radi-
ology; act as a focus for all it’s localities paediatricians for education, CPD, and support.

• Each locality will have a team of paediatricians who have generic competencies but with addi-
tional special interests, and who between them hold the necessary skills to provide the portfolio of services needed by that population. They will work from shared locations and all will have access to inpatient beds.

• The locality paediatricians could take their place on the daytime locality rota for child protection and acute assessment and on the DGH rota for acute in patient on-call work where appropriate. Large DGHs will need two on-call rotas, one for neonates and one for general paediatric medi-
cine.

• In some situations it will be appropriate for certain skills to be made available to all or a number of localities rather than providing such expertise individually in each. Audiology, for example, may be better organised as a district wide service with contributions from one or more locality paediatricians who possess the necessary training and background.

• Regional centres will have an additional responsibility to provide for their own locality and may in addition subserve the DGH function.

Managed network of care

The basic health care needs of a population should in future be provided by a team of locally based paediatricians all of whom have the basic foundation skills to enable them to be part of a locally delivered service. However, we envisage that all paediatricians will develop a special interest and that for their particular expertise they will link both “horizontally” and “vertically”.

• **Local integration** - We envisage a team of paediatricians serving a locality each will have foundation skills and also at least one special interest. For that particular area of interest they will take the lead in their locality ensuring the best possible local service. They will also be responsible for supporting their local colleagues in their particular area.

• **Wider integration** – For every subspecialty area there will be a managed network of care linking local, district and regional paediatricians. The local paediatrician is likely to spend regular ses-
sions at the district or regional centre and similarly there may well be visits from the regional specialists to the locality.
CONCLUSIONS AND RECOMMENDATIONS

1. There is a need to strengthen the care of children in the community. The concept of Community Child Health is important and should be retained. The designation of paediatricians according to where they have their base is outmoded. We suggest that the consultant community paediatrician label should be replaced with Consultant Paediatrician.

2. We need to work towards a different model of care with “locality” paediatricians providing for the majority of the population needs of their children.

3. The basic training of paediatricians needs to be re-orientated to ensure that all SpRs at the end of their core training have the necessary foundation skills to provide a locality service. We must ensure that there are sufficient good training opportunities in dynamic well integrated departments.

4. We should encourage the development of managed networks of care for all subspecialties of paediatrics.

5. We should work with general practice to ensure that all GPs have adequate training in the care of children both for their work with ill children and in prevention/surveillance. We should also encourage paediatric trainees to spend time in general practice.

6. It is important to foster the development of academic work in Community Child Health and its subspecialties.

7. Subspecialisation in CCH should be allowed to evolve whilst ensuring that all paediatricians retain foundation skills.

8. We should promote and support the development of advanced nursing roles.

Conspectus

Paediatrics is at a crossroads. The RCPCH can and should have a real influence on the pattern and delivery of care to children over the next 15 years or more. This review of community child health is one contribution to a much wider debate. There is a great deal of work to be done to develop these and other ideas and to draw on the many examples of innovative practice which already exist.

A W. Craft
N. McLellan
J. R. Sibert

15th December 2001
References

1) Court D, Jackson A
   *Paediatrics in the Seventies*
   Nuffield Provincial Hospitals Trust 1972.

2) Court S.D. M,
   *Fit for the Future*
   Report of the Committee on Child Health Services, HMSO 1976

3) Royal College of General Practitioners and Royal College of Physicians of London, Inter-Collegiate Working Group.

   (www.health-for-all-children.co.uk)

5) Haggerty R, 1994
   “Community Pediatrics, past and present”
   Pediatrs.Ann. 23: 657

   Pediatrics 1999:103:1304-1306

7) *The Duties of a Paediatrician*, Royal College of Paediatrics and Child Health, 2000

8) Arnon K et al.
   “One year’s paediatric medical attendances at Nottingham A&E Dept.”

9) Hewon PH et al
   “A 12 month profile of community paediatric consultations in the Barwon region.”
   J.Paediatrics Child Health 1999: 35: 16-22

10) Court SDM
    “Child Health in a Changing Community”
    BMJ; 1971, ii, 125-131

11) Thornes R,
    *Training Needs in Community Paediatrics*
    Royal College of Paediatrics and Child Health, 2001
Abbreviations

A&E  Accident and Emergency
ACPC  Area Child Protection Committee
ADHD  Attention Deficit Hyperactivity Disorder
BACCH  British Association Community Child Health
CAMHS  Child & Adolescent Mental Health Services
CCHS  Community Child Health Services
CCP  Consultant Community Paediatrician
CME  Continuing Medical Education
CPD  Continuing Professional Development
DH  Department of Health
GP  General Practitioner
GPP  General Practitioner Paediatrician
NHS  National Health Service
PCT  Primary Care Trust
RCGP  Royal College of General Practitioners
RCP  Royal College of Physicians
RCPCH  Royal College of Paediatrics and Child Health
SHO  Senior House Officer
SpR  Specialist Registrar
STA  Specialist Training Authority