

State of Child Health



Short Report Series:
Community paediatrics workforce

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Background

Community Child Health (CCH) is the largest paediatric sub-specialty focussing on the care of vulnerable children and families, children with long-term conditions and child public health. This includes children with

- developmental disorders and disabilities,
- complex health needs (including end of life care),
- behavioural presentations of neurodevelopmental disorders (e.g. Autism, ADHD)
- safeguarding concerns, who are “Looked After” or being adopted.

Community paediatricians usually work in multidisciplinary teams and across agencies with therapists, nurses and colleagues from schools, social services, the voluntary sector and local authorities. They have a vital role in planning and implementing local strategies to improve the health of all children in their area including safeguarding policy, universal and targeted lifestyle programmes and tackling local social determinants of health. A number of statutory roles are also usually provided by community paediatricians relating to child protection and child deaths, looked after children and those with special educational needs and disability (SEND). These roles vary slightly across the four nations of the UK in terms of nomenclature and function.

The nature and relative volumes of childhood illness have changed in recent decades with more mental health and neurodevelopmental disorders such as autism and ADHD being diagnosed, greater reporting and awareness of safeguarding issues and more emphasis on children in public care. These, together with additional statutory duties in recent years have added to the volume and complexity of community paediatric roles. Generally community paediatricians no longer

provide primary care services such as immunisations and child health surveillance which are now provided through general practice and community nursing services.

The scope and provision of community paediatrics is complex and varied across the UK. It can be delivered across a range of locations which may include clinics, homes, nurseries, schools and social care settings. The many layered nature of community paediatric work makes services difficult to measure and the voices of children, young people, parents and carers hard to hear. CCH often falls 'below the radar' of NHS Trusts, Health Boards, commissioners and public attention, but failings in these services can affect the longer term health and wellbeing of children and families throughout their lives. For example, delays in autism diagnosis can have major effects on family life¹ and inadequate child protection expertise, peer review and support can have fatal consequences². It is therefore essential that service planners and commissioners (in England) work closely with clinical staff and service users to design systems that work for the long term health of children and young people.

Changes in the demands on community paediatricians alongside changes in commissioning arrangements and the structures in the NHS have led to a lack of clarity on the role of community paediatrics. A greater understanding of the role of CCH is needed to help service planners, paediatric teams and associated clinicians to talk together and plan how their service will meet demand going forward.

To support this planning, an evidence-based toolkit has been produced by the RCPCH and the British Association for Community Child Health (BACCH) for designing modern, efficient CCH services including

- Survey findings and benchmarking data on the current state of community paediatric provision.
- A planning framework with details of the components of a community paediatric service, linked to guidance, literature and practice examples.
- A workforce calculator for providers and planners to determine their paediatric workforce requirements.
- Examples of innovative practice to inspire services to improve.

Principal findings

UK Service Provision

- In 2015, there were 169 distinctly managed CCH services in the UK.

- On average (mean), a CCH service covers a 0-19 years population of 89,527 (range 31,520 - 250,360).
- Each CCH service provides an average (mean) of 11 different types of clinics and services with a mid spread (inter quartile range) between 9 and 14 services.
- Some are core services e.g. 99% of CCH services provide an autism spectrum disorder assessment clinic and over 90% provide special school clinics and undertake looked after children assessments. However other services are less common: only 4% reported conducting child health promotion clinics and 11% offer clinics for constipation/encopresis.

The community paediatric workforce

- Over 20% of paediatric consultants and 65% of paediatric Staff and Associate Specialist (SAS) doctors work in CCH.
- 8.5% of community paediatric consultant posts were vacant in 2015, compared to a 3.8% vacancy rate for all paediatric consultants.
- There are currently just two career grade paediatricians for every 100,000 total population. Using an evidence-based calculator, we estimate that to meet demand 2.4 paediatricians are required, an increase of approximately 25%.

Clinical Leadership

- 81% of services have a community paediatrician as clinical lead. This role is pivotal in developing the service, liaising with the range of health and non-health agencies and ensuring that the medical team is working effectively to meet the required standards of care and maintaining professional competencies.
- Fewer than half (40/83) have one programmed activity (PA) allocated in their job plan for the lead role and 35% have less than 1 PA. On average clinical leads spend nearly twice the allocated time on their leadership duties.

Activity and Performance

- There are an estimated 1940 referrals per 100,000 children aged 0-19 per annum to community paediatrics (509 referrals per 100,000 total population).
- The average waiting time for first appointment is 14.6 weeks (range 6-33 weeks) and the Was Not Brought/Did Not Attend (DNA) rates for new and follow up appointments are 10.8% and 12.8% respectively.
- For Autism Spectrum Disorder 42.5% of services have a waiting time over 18 weeks for a first appointment, and a referral to treatment (RTT) time of 35.5 weeks, breaching the 18 week RTT rule in countries where it applies.

- The average waiting time from referral to diagnosis of ADHD is 29.9 weeks also breaching the 18 week RTT rule.
- For ADHD services only 11.4% of services can always see patients when follow up is due and 60% can do so no more than half the time, raising issues of medication safety if the recommended monitoring programme cannot be completed on time.
- Fewer than half (43%) of services can see 90% or more of newly looked after children (children in care) within the required 4 weeks, risking children failing to receive the care they need swiftly at an intensely traumatic time in their lives. and breaching statutory requirements³.

Statutory Roles

- Across all UK services we found too few staff with too little time to meet statutory roles which protect children's health and wellbeing.
- Designated doctors for safeguarding are responsible for ensuring all medical services in an area meet recognised standards for child protection services. They were allocated 2.8 PAs for this role on average against 4.5 -5 PA recommended in Intercollegiate guidance⁴.
- Designated medical officers for Special Educational Needs and Disability (SEND) ensure that children with special needs are properly assessed and their condition is managed to enable them to get the best from education. BACCH and the British Academy of Childhood Disability (BACD) guidance states 2 PAs are required for this role for a child population of 70,000. The RCPCH census has found that on average only 1.1 PA was allocated per service covering over 89,000. Nearly a quarter of services reported being unable to attend SEND panels when requested to discuss the health needs of CYP being assessed.

Administrative and IT arrangements

- Many respondents could not collect basic data about their service activity and performance -
- Almost three quarters of clinical leads whose services were allocated less than 1 PA per clinic for clinical administration and case management felt there was insufficient time in clinicians' job plans to properly follow through after clinics and ongoing case management
- The availability of IT and access to electronic records to community paediatricians is poor - 37% cannot access it whilst in clinic.
- In over half of services doctors were doing inappropriate tasks which is reducing their availability for seeing children

Conclusions

Workforce

The rising demand for services, long waits reported in our survey and a high level of vacancies indicate a service where there is a serious workforce shortfall. We estimate that an increase in the order of 25% in the size of career grade paediatric workforce is required to meet that demand. A decline in the SAS doctor workforce in the UK of 12.5% between 2013 and 2015 combined with a workforce older, on average, than general paediatrics and other paediatric specialties exacerbate these problems. The Royal College of Paediatrics and Child Health (RCPCH) is concerned that increasing needs, higher expectations, long waits, vacancies and the risk of 'burnout' amongst skilled professionals mean services may not be safe for these vulnerable children and families.

Access, activity and performance

An average wait of 14 weeks for their first appointment (not diagnosis) is far too long for families and children. As full diagnosis often takes more than one appointment, a full picture of the child's difficulties may take even longer to achieve. For example 42% of ASD referrals breach the 18 week wait even to be seen and the average wait for a full diagnosis (in effect when 'treatment' could start) was estimated to be 35.5 weeks (double the 18-week standard where it applies). The waiting time from referral to diagnosis for ADHD is also over 6 months. For children with complex neurodevelopmental conditions attending general development clinics, fewer than half can be seen when follow up is due. These delays are unacceptable for a family desperate to understand how to manage their child's behaviour and access support. The further impact on schools, peers, and the children themselves, including delays in their learning, development and self-esteem is difficult to estimate but can be significant and life-long. Delays in monitoring appointments for ADHD can put children and young people at risk of drug side effects and breaches NICE recommendations. Statutory roles are under-resourced and therefore cannot be delivered to the standards expected.

Management and leadership

Clinical leaders were often allocated insufficient time for their leadership role and in nearly 20% of services the clinical lead was not a community paediatrician.

Management is made more difficult because many organisations do not appear to have good data collection systems or they were not being used.

Service planning and commissioning

There is marked variability across the UK in terms of the planning, organisation and commissioning of community child health services. The Health and Social Care Act 2012⁵ in England has been associated with fragmentation of the commissioning of care pathways across health and local authorities and the financial pressures for local authorities have impacted particularly on community health services. In addition, clinical staff working within a team may be employed by many different organisations with different targets and priorities and in some areas there is a lack of support for and understanding of the role of the community paediatrician.

Most services which responded to the survey were funded by block contract. As a result, increased activity is not matched by an increase in funding, putting additional pressure on identifying monies for service development and investment to improve. This is compounded by the absence of a clear service specification in many areas and limited clinical involvement in strategic planning and commissioning⁶.

Recommendations

1. The number of career grade community paediatricians needs to rise to 2.4 whole time equivalents (WTE) per 100,000 total population to meet the current and anticipated demand for community paediatric medical services. Across the UK this requires an increase of 25%, or 320 WTE on the current workforce over the next 3-5 years
2. CCGs in England should commission community paediatric services against a clear service specification aligned with service specifications for other relevant services e.g. local child and adolescent mental health services (CAMHS), allied health professionals and nursing teams so that clinical pathways are clear and gaps avoided. These should recognise specific and unique requirements including multidisciplinary and multi-agency work and should include adequate funding for statutory roles to meet national recommendations. The service needs to be sufficiently resourced to adhere to statutory timeframes without consequent adverse impact on other referrals where there may be higher clinical need, or on timely follow up.
3. Agreed performance indicators must be embedded in the service specification and reflect statutory and NHS requirements. NHS Improvement and NHS Digital in England, service planners and providers should use the opportunity of the Community Services Data Set to strengthen data collection systems to become equivalent to those for tariffed services, easily recording pertinent and statutory statistics in all clinical settings. This would promote monitoring of demand, activity, clinical and financial performance, and benchmarking

against other community paediatric services. This information should be made available routinely to community paediatricians and their management team.

4. Children, young people and families should be actively involved in the planning and decision making around their care and also in the design (co-production) of services as a whole.
5. Community paediatric teams should have a clinical lead who understands fully the detail of day to day work, strategic issues, population needs and workforce requirements and who can lead and represent the service effectively. This will usually be a community paediatrician. The clinical lead should have a minimum of 1 PA allocated for the lead role and included in the job plan. More time may be required for larger or more scattered services. .
6. Community paediatricians should be supported to make best use of their skills and expertise, focussing their time on what only the community paediatrician can do; there should be clarity on roles and responsibilities within the team and with professionals from other health services and agencies. Paediatricians should have adequate time allocated to assess children and young people appropriately and to complete administrative and case management tasks resulting from their face to face work. The average requirements for most services appear from our survey to be at least 1 hour to assess a new patient, at least 30 mins for a review and an equal amount of administrative/case management time to follow up the consultation and manage cases.
7. Clinical settings should be accessible and equipped and staffed appropriately with nursing, play and administrative support. This is of particular importance as many of the children seen will have physical disabilities and/or challenging behaviour. Relevant standards are set out in 'You're Welcome'⁷ and the Paediatricians' Handbook⁸. For children with severe disabilities, they will often be best seen in a familiar environment where possible e.g. school.
8. Community paediatricians should have secure, rapid, real time access to full clinical records and corporate systems which facilitate appropriate information sharing between disciplines and across organisations. Record handling should comply with the organisation's information management policies. Wherever possible full data access and secure communication should be available at all clinic locations.
9. There should be a sustained plan to improve staffing including early exposure of trainees to community child health, recruitment drives, use of contract flexibility to retain staff, increase skill mix and support staff to develop and extend into other professional roles.

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