CURRENT TOPIC

Ambulatory paediatrics: stepping out in a new direction?

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Background

In 1976 the Court report recommended the rationalisation of child health services in England and Wales,[1] and although it has taken longer than hoped and the terminology has changed along the way,[2] there has been real progress towards the achievement of 'combined' and 'integrated' children's services, with 'seamless' care at the point of delivery of care.

Recently, the Audit Commission published its report on hospital services,[3] highlighting a number of problems in this important area which, however, forms only one part of health services for children. This paper discusses some of the difficulties currently confronting children's health services and suggests a development already in place in other countries that could provide a solution to some of them.

While childhood mortality, the risk of serious illness, and lengths of hospital stay for children have all diminished there is little difference in the rate of admission to hospital between the children of those enrolled 43 years ago into the National Survey of Health and Development and their parents.[4] The reasons for this may be related to altering demographic and social circumstances. For example, there are fewer 'nuclear' and increased numbers of 'lone parent' families, leaving children and their carers sometimes with little support in times of crisis; the postponement for some of childbearing to accommodate careers contrasts with the continued high rates of teenage pregnancy. Patterns of disease have altered, with the emergence of the 'new morbidity' of children's behavioural and learning problems and family stress.[5 6] Improved medical technology has led to the increased survival of children of low and very low birth weight as well as others with previously untreatable conditions, so while advances in treatment might have been expected to lead to fewer admissions, this promise has not been fulfilled.

Demographic and technological changes are not the only factors involved in this apparent failure. There are structural factors which should also be considered. The many reorganisations in the NHS during the period since the Court report, culminating with the attempt to introduce an internal market, have meant uncertainties for child health services, particularly recently in London,[7] but also in other areas, for example where the formation of separate hospital and community trusts has hindered the process of combining and integrating services. While the change to a consultant led secondary community service has been a positive step there have been problems in recruiting suitably trained staff. This problem is not confined to community services but now affects hospital services at consultant, senior registrar, and registrar level.

The move towards a reduction of junior doctors' hours and away from exploitative clinical apprenticeships is long overdue but sometimes difficult to reconcile with the provision of adequate junior and middle grade cover. Many consultant paediatricians still work without the benefit of an intermediate tier of medical staff, carrying onerous on-call responsibilities with relatively inexperienced juniors, often doctors in six month jobs as part of vocational training. These doctors, as future general practitioners, receive a distorted picture of the major problems of childhood they are likely to encounter when they enter primary care. Consultants meanwhile spend increasing time on management; there are growing demands from the altered pattern of morbidity, leading to new requirements such as child protection work and fulfilling the role of a member of the multidisciplinary team. Demands on their time are only likely to increase, with further strain on them and their families.

A new model

The development of an ambulatory paediatric model[8] may be one way in which we can address some of these issues. Ambulatory paediatrics has its roots in the United States in the sixties when the increasing superspecialisation of paediatricians with the major focus on inpatient care led to concerns that there was no generalist available to take an overall view of the child and their family, and little emphasis on the needs of the child who did not require admission to hospital. Recently the Ambulatory Pediatric Association voted narrowly against a motion to change its name to the General Pediatric Association, illustrating perhaps some unease with what is to some a rather cumbersome title but also indicating what its philosophy is all about.

What is ambulatory paediatrics? Basically,

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everything that does not require the child to be admitted to hospital. It includes primary care paediatrics, community paediatrics, accident and emergency consultations, outpatients, day care paediatrics, hospital at home schemes, and community nursing services for children. Training in ambulatory paediatrics covers much of the work of the community paediatrician, including special needs, social paediatrics and public health paediatrics, but also emphasises the management of the common conditions seen in the community whether they be asthma and diabetes or behavioural problems. Given that primary care paediatrics is the undisputed responsibility of general practitioners and the primary health care team, what does ambulatory paediatrics have to offer of particular relevance today?

Two million children are seen in accident and emergency departments in England and Wales annually; 15–20% have medical conditions.[9] Generally, consultant paediatricians are not closely involved with accident and emergency departments. Junior staff often have no previous experience in paediatrics and rely heavily on middle grade paediatric opinion, if available. Where it is not available they may be assessing and managing children with the full range of paediatric conditions, including acute illness as well as non-accidental injury, in which they may have received very limited training.

The ambulatory paediatrician is in a position to provide support to emergency departments by dint of their training and experience, which includes dealing with the common acute paediatric conditions. They can introduce strategies to reduce hospital admissions[10] and quality assurance programmes to ensure adequate and consistent care.[11] In inner city areas, where primary care services sometimes struggle to meet the greater demands of that setting, emergency departments are often used as a source of primary medical opinion but may also be used as a secondary service, providing paediatric consultations for cases referred by general practice or community health. Some departments recognise this by running emergency paediatric clinics. Again, the ambulatory paediatrician is ideally placed to be involved with such clinics and to liaise between the accident department and the community.

Finally, an important task that has emerged in recent years as one of the public health responsibilities of the paediatrician and confirmed by the publication of *The Health of The Nation*[12] has been accident prevention. A presence in the emergency department gives the ambulatory paediatrician an appropriate and perhaps underexploited base from which to work, both in information collection, for example through accident surveillance systems[13] and as a launching pad for preventive campaigns.

There are increasing numbers of children in the community with special needs. Ambulatory paediatrics does not limit its remit to particular conditions, but is concerned with all children. Doctors trained in ambulatory paediatrics can provide care not only to children with complex disability but also to those children with conditions such as asthma, diabetes, epilepsy, and cystic fibrosis for example which doctors currently working in the community have hitherto felt uncomfortable in assessing and managing. Ironically, some community doctors are less than confident as a result of deficiencies in their training in dealing with the conditions that comprise the emerging new morbidity.[14] Training in ambulatory paediatrics provides the doctor with skills in developmental and behavioural paediatrics which allows him or her to manage many behavioural problems using simple structural interventions based on behavioural techniques.

Consultant clinics held in general practice premises have been shown to be an effective teaching device and means of further strengthening liaison between primary and secondary care[15]; with a broad background in general and community paediatrics, the ambulatory paediatrician is in a strong position to conduct such clinics. Of course the ambulatory paediatrician cannot pretend to have expertise in rarer diseases but can deal with many aspects of such conditions outside the hospital with the support of specialist colleagues. Moving between the hospital and community, the ambulatory paediatrician is able to facilitate the development of integration between primary and secondary care.

Nurses are a professional group with rising aspirations and are taking on duties, as nurse practitioners, that were once the province of medical staff. Project 2000 aims to provide a more integrated pattern of care, moving away from the rigid divide between hospital and community and the distinction of treatment and prevention. A number of paediatric community nursing schemes treat children in their homes who would otherwise be admitted to hospital.[16] This is another area in which the ambulatory paediatrician can usefully contribute by providing medical support and advice.

A compelling reason for the development of ambulatory paediatrics, however, is the need to consider structural change in the organisation of children's services, arising from the crisis facing children's units in some parts of the country. This is principally as a result of problems in medical staff recruitment in what is perceived as a very hard working specialty, but also because of resource constraints and the tensions introduced as a result of the provider/purchaser split and other changes in management arrangements. The problems of providing adequate junior cover have already been alluded to. Where consultant community paediatricians have joined their hospital colleagues in on-call and other acute duties to alleviate some of their burden there is anxiety that the time they have for community duties can quickly become eroded.

One solution parallels that advocated by groups reviewing specialty services in London who have suggested the 'hub and spoke' model,[17] where fewer, bigger tertiary

units allow adequate staff cover and the development of specialist expertise together with research and teaching. The example of paediatric intensive care shows how centralisation of some services can be beneficial to children.[18] This model need not be confined to London and tertiary services but can be extended to paediatric care generally. One proposal is for the introduction of day care facilities for children (B Taylor, personal communication), run on a five day a week, nine to five basis and providing facilities for investigations, day case surgery, treatment of conditions like leukaemia in conjunction with tertiary centres and initial management at least of most 'hospital' care. Children needing admission would be transferred to a central unit providing comprehensive children's services. Such a system would suit some localities particularly well, for example where two geographically close paediatric units are currently operating independently or where a unit presently operates in the shadow of a large children's unit in a metropolitan centre. In both situations there would be a comprehensive children's unit on one site which would provide care for children who need admission and neonatal intensive care with an obstetric unit for high risk deliveries, together with one or more children's day centres. Such centres would be staffed by paediatricians able to offer all the services required by children up to the point of admission to hospital and the ambulatory paediatrician is again the obvious person to head such a unit.

Such a change would allow the redeployment of staff which could in turn lead to reductions of juniors' hours and freeing of consultant time. Staff could rotate between the comprehensive secondary centre and the children's day centre and thus receive a more balanced training. General practice trainees in particular would receive experience much more in line with their needs and might spend the whole of their paediatric post attached to the children's day care centre. Staff from the secondary unit could rotate to the peripheral centre for training in ambulatory paediatrics. Dealing with the commoner complaints of families, the children's day centre would also be an appropriate setting in which doctors currently practising exclusively in the community might usefully work for some of their time, at associate specialist or staff grade level.

Some families would have to travel further if a child needed admission but to counterbalance this the use of senior staff in the peripheral unit should ensure fewer children need admission and the care they receive if they do require it would be of a higher standard. A vital part of the functioning of such a system would be close professional liaison between the centre and periphery both to ensure continuity of care and to avoid the professional isolation that has in the past sometimes marred aspects of work in the community. It would be important that doctors in the satellite unit be proficient in the initial care of children with life threatening conditions and regular training such as the advanced paediatric life support course would be especially valuable.

Paediatricians have long held that the place for the child is in the home. In the light of continued high rates of admission of children to hospital it seems right to look at an alternative that considers the needs of children who may not need hospital admission. Such an alternative is ambulatory paediatrics. Its introduction should not be seen as yet another step in the proliferation of paediatric specialties. It should be seen rather as a drawing back from specialisation and a return, for some paediatricians at least, to a more generalist approach with a practitioner able to see the bigger picture and more in touch with the hospital and the community, a moving together of community and general paediatrics and thus another way of furthering the combination of hospital and community services. Ambulatory paediatrics could provide answers to some of the more pressing problems facing paediatrics today.

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Commentary

Dr Heller's paper expands upon some of the important themes outlined in the BPA's discussion document 'Flexible Options for Paediatric Care'. The aims of this discussion document were to avoid unnecessary admission to hospital, to offer high quality consultant based care accessible to the local population,