PAEDIATRICS 2020

Back to the future?

Hilary Cass
Four Questions re the Current Model

- Is the current UK model of children’s healthcare:
  - Delivering best quality care?
  - Well matched to patient need?
  - Sustainable?
  - Affordable?
- How radical are we being re changes to the model?
- Can our current workforce model survive?
Links between service quality and outcomes
Some case studies

Case 1: OT

Case 2: BB
Health & social outcomes

Case 1: OT
Expert input from paediatric team
Results......

Had correct BMI

Took plenty of exercise

Showed early leadership skills

Had good vocational training
Health & social outcomes

Case 2: BB
Had an untreated early eating disorder

Suffered from social exclusion

Left public school with no qualifications
In absence of formal qualifications, was forced to take a senior policy development post in the NHS
Improving child health services in the UK: insights from Europe and their implications for the NHS reforms

Ingrid Wolfe, Hilary Cass, Matthew J Thompson, Alan Craft, Ed Peile, Pieter A Wiegersma, Staffan Janson, T L Chambers, Martin McKee

BMJ 2011;342:doi:10.1136/bmj.d1277 (Published 8 March 2011)
UK deficits of care
UK has a higher all-cause childhood mortality rate compared with Sweden, France, Italy, Germany and Netherlands.

Death rates for illnesses that rely heavily on first-access services (e.g. asthma, meningococcal disease, pneumonia) are higher in the UK than these other European countries.
All cause mortality in children aged 0-14
Causes of deaths in children 1-14 years, in 1948 and 2006

Wolfe BMJ 2011
26% of deaths - “identifiable failure in the child’s direct care”

43% of deaths – “potentially avoidable factors”

Errors by staff with inadequate paediatric training or supervision especially common
First access care

- 50% children with meningococcal disease sent home at first primary care consultation
- £20 million legal settlements

Thompson Lancet 2006
First access care

- > 1/3 short stay admissions in infants are for minor illnesses
- Cost: over £100 million pa
First access care

- 75% asthma admissions preventable with better primary care
- Cost: over £7 million pa
ED attendances

- Steep rise in ED attendances since 2004
- 1:3 children under 1 year old admitted to hospital
- 67% are short-stay admissions <1 day
- 39% of these are for minor illnesses
Planned care is fitted around acute care models

- Only 3% of children with asthma have written plans to prevent and manage leading to:
  - Many preventable asthma admissions
  - Mortality from asthma which is higher in the UK than in comparable European countries.
- A national audit found that only 4% of children with diabetes received care consistent with guidelines:
  - 82% had HbA1c concentrations above target levels
  - Nearly 9% had at least one episode of ketoacidosis in the preceding year
- The Healthcare Commission reported that 46% of acute trusts are weak in paediatric outpatient care, with services designed around acute illness rather than chronic disease.
Between $\frac{1}{3}$ and $\frac{1}{2}$ of referrals to paediatricians are potentially avoidable.
Outpatients seen in wrong place by wrong staff

- 50% of children attending paediatric outpatients could have been seen in a community setting
- Changing epidemiology of OP presentations
- Paediatric trainees poorly trained and equipped to manage social and behavioural paediatrics
Why do we have a poorly designed service model?
Not through lack of policy!!

- Children’s NSF
- Every Child Matters
- ‘Improving the Life Chances of Disabled People’
- ‘Choosing Health’ White Paper
- Laming report
- Children Act 2004
- ‘Our Health, Our Care, Our Say’ White Paper
- HM Treasury Children & Young People Review 2006
- Children’s Plan
So what causes the problems?

Primary care

- Inconsistent expertise and diagnostic resources

The primary-secondary care gap

Hospitals

- Overwhelmed with acute & minor illness, services for LTC fitting around acute care
Children’s Healthcare Needs

<table>
<thead>
<tr>
<th>SHORT-TERM CONDITIONS</th>
<th>LONG-TERM CONDITIONS</th>
<th>ACUTE ILLNESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minor</td>
<td>Day-to-day</td>
<td>Minor</td>
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<tr>
<td></td>
<td>Minor</td>
<td></td>
</tr>
<tr>
<td>Serious</td>
<td>Strategic</td>
<td>Serious</td>
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PRIMARY CARE

SECONDARY CARE
| PRIMARY CARE |  |
|--------------|  |
| Minor        | Day-to-day | Minor |
|              |            |       |
| SHORT-TERM CONDITIONS | LONG-TERM CONDITIONS | ACUTE ILLNESS |
| Serious      | Strategic   | Serious |

Incomplete fill by Secondary Care
Incomplete fill by Secondary Care

GAP SET TO WIDEN – SECONDARY CARE MODEL NOT SUSTAINABLE!
Out-of-Hospital Services

PRIMARY CARE

Minor | Day-to-day | Minor

OUT-OF-HOSPITAL PAEDIATRICS

SHORT-TERM CONDITIONS | LONG-TERM CONDITIONS | ACUTE ILLNESS

Serious | Strategic | Serious

HOSPITAL CARE
Primary Care

Out-of-hospital services

School health

LAC

CDT

CAMHS

BUT!!!

Hospital still ‘happening place’ to be
Accessibility v Expertise
Epidemiology v Expectations
European models
How does Europe differ?

First-access model
Training for doctors
Organisations and mechanisms
## Cause-specific mortality


<table>
<thead>
<tr>
<th>First access model</th>
<th>General practice</th>
<th>Combined GP and paediatrician</th>
<th>Paediatrician</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>UK</td>
<td>Nether-lands</td>
<td></td>
</tr>
<tr>
<td>Meningococcal disease</td>
<td>0.47 6</td>
<td>0.24 4</td>
<td>0.14 3</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>0.65 6</td>
<td>0.47 5</td>
<td>0.17 1</td>
</tr>
<tr>
<td>Asthma</td>
<td>0.27 6</td>
<td>0.07 5</td>
<td>0.06 4</td>
</tr>
</tbody>
</table>
More doctors per capita (GP and paediatric) looking after children
Most countries – mandatory & specific post-graduate training in paediatrics for GPs
Co-location of primary and secondary care practitioners
No perverse financial incentives between primary and secondary care
Choice of first-access professional
**UK training model**

- **GPs:**
  - 3 years
  - no required dedicated paediatric training

- **Paediatricians:**
  - 5 years
  - no required dedicated primary care training

**European training model**

- Common training 2 yrs
- Primary care paediatrician 3 yrs
- Hospital general paediatrics 3 yrs
- Subspecialist paediatrics 3 yrs
Examples from Europe

- Sweden: GPs, who are trained in paediatrics, work closely with paediatricians, nurses, and other primary care professionals in community health centres to deliver acute and planned care for children and their families.

- Netherlands: Transmural system - co-location in jointly managed service with direct incentives to cooperate.
Comparison of child health in Britain c.f. rest of Europe

- “In the last 15-20 years we have slipped down the league table of infant and perinatal mortality”

Child health services have been fragmented and often inadequate.

- Treatment of sick children has been divided between general practitioners and the hospitals
- Prevention and surveillance have been left to the community services
- Often contacts between the two have been minimal

Parents should be able to expect "a considerably greater level of paediatric competence among doctors and nurses ...than exists at present"
1976: Court report published
- 1978: First test tube baby
- 1980: Post-it notes
- 1988: Fax machine
- 1990: World wide web
- 1994: Digital camera

2011: Problems identified in Court report re child health in UK unresolved
RCPCH modelling and proposals
10 new College standards released
Cannot deliver care to these standards in all current inpatient units – 218 total
- Not enough middle grade staff
- Ratio of trainees to consultants too high for sustainability
RCPCH proposals

- Decrease number of inpatient units (48-76 sites)
- Increase number of nurse led SSPAUs
- Increase number of consultants - 3,084 to 4,600-4,900 (i.e. 50% - 60% dependent on 1.)
- Decrease number of trainees
- Increase number of GPs trainees in Tier 1 rotas
- Consultants resident for variable length of time, dependent on speciality

N.B. 5-10 year plan and could not work unless all parts dovetailed. Consultant numbers must increase before trainee numbers decrease
Most important challenges

- Economic viability of 50% increase in consultants
- Political viability of 25% reduction in inpatient units
Other options and risks

- Consultant resident rotas
  - Detail under discussion
  - Impact on recruitment into speciality?
  - Sustainability?
- ANNP and APNP roles
  - Possible recruitment challenges
- Primary care paediatricians
  - Not popular with RCPCH or RCGP
  - Not an appropriate overall policy!
NHS advisers tell Lansley to shut down Chase Farm departments

Kiran Randhawa, Health and Social Affairs Correspondent
18 Aug 2011

Under threat: Health Secretary Andrew Lansley risks a storm if he agrees to close Chase Farm's A&E and maternity unit
The public are uninformed purchasers of health care
- “Kidderminster’s a brand new hospital: Why close it”
- “It’s all cuts”: Any change must be for financial reasons and for the worst
  - No understanding of relative risk or clinical specialties
The public judge on external appearance, locality, friendliness and waiting times, not on clinical outcomes (which they don’t trust anyway)
- Antipathy to “experts” and “outsiders”
In a consumer, rights based society, you have to take the public with you if you change public services.

The NHS has to decide whose job it is to explain the need for change to the public:

- Only medics can do it
- Preferably local medics
- How do Royal Colleges bring local medics on board?
- Why should they be brave?

Local politicians are important and should be taken into confidences and treated seriously but afraid of the “Kidderminster effect”.

The local media are crucial – and have a different agenda

Never underestimate the opposition but never be afraid to expose their motives – “there’s always an election looming”
Is no change an option?
WE’VE BEEN HEARING FOR YEARS THAT THE STATUS QUO CAN’T CONTINUE….

…BUT IT STILL DOES

Does one look bothered?
Beckhard’s Change Equation
Perceived Pain of Change $<$ Perceived Pain of Current Situation $\times$ Perceived Power of Vision $\times$ Perceived Feasibility of First Steps

Beckhard R & Harris RT. Organisational Transitions: Managing Complex Change 1997
Whose perspective? The stakeholders

- Patients
- Clinicians
- Providers
- Commissioners
- Media
Patients – pain of change

- May not recognise need for change
- Pain of current situation low
- Communication with public often ‘paternalistic’ and immature
- Reluctance to be honest about current risks
- Failure to address risk perceptions
Risk perception is influenced by different life experiences.

Mellissa Williamson, 35, a Bullitt Avenue resident, worries about the effect on her unborn child from the sound of jackhammers.
Clinicians – pain of change

- Recognise need for change
- Pain of current situation high

- BUT organisational loyalty
- Local politics > greater good
- Fine if you don’t close my inpatient unit?
- Loss of own team?
- Loss of autonomy?
- Geographical considerations
Commissioning perspective

At the end of the money,
I always have some month left.
Is incremental change enough?
Next steps from RCPCH proposals

- A fundamentally different relationship between primary and secondary care?

- Defocus from the hospital as the ‘happening place to be’?

- Comprehensive integrated teams in primary care settings?
Vertical integration of children’s healthcare: A possible solution??

SOME IDEAS – NOT RCPCH POLICY!
A new concept?

Hospital

Children’s Integrated Healthcare Centre

SERVICES
- Urgent care – evenings, weekend days?
- Health promotion, immunisation etc.
- Long-term condition management including children with disabilities, diabetes, eczema etc.
- Other non-urgent care - e.g. skin lesions, constipation, ‘tummy aches’ etc.

SHARED STAFF
- Paediatricians
- Children’s nurses
- GPs / GPVTS
- CAMHS staff
- AHPs

Group Practice A
Group Practice B
Group Practice C
Other essentials

OPERATIONAL
- Shared notes
- Shared governance
- Removal of perverse financial incentives

CULTURAL
- Public health support
- Public engagement

TRAINING
- Joint training initiatives
- Shared competency framework
- Shared guideline development

Hospital

Children’s Integrated Healthcare Centre

Group Practice A

Group Practice B

Group Practice C
What is **not** proposed

- For work currently done by the majority of GPs to move into the proposed centres
- For paediatricians and secondary care practitioners to take over existing primary care practice
Hospital site needed for conditions that are....

- Serious
- Rare
- Need high tech equipment
- Need inpatient care

Hospital site not needed for conditions that are...

- Minor
- Common
- Do not need technical equipment
- Need local access
How many and where?
Would this threaten community paediatrics as we know it?

- Great potential to strengthen community paediatrics
- Existing roles will remain essential
- Positive impact on recruitment
- Reduced risk of isolation within small provider
- Co-location / co-managed with larger critical mass of paediatricians and other healthcare providers
- Greater impact on practice of acute paediatricians
Potential advantages of vertical integration
Advantages for children

- Better continuity of care
- Right care in right place
- Services closer to home
Urgent care

- Preventing unnecessary referrals and admissions
- Improved detection of serious illness
- Rapid on-site access to 2nd opinion
- Better patient experience
- One hit rather than two
- Lower cost
Planned care

- Chronic disease
  - Convenient high quality planned multidisciplinary care for children with chronic disease and long-term conditions
  - Parenting advice and support

- Public health
  - Health promotion
  - Disease prevention
  - Health education
Advantages for training

- Shared learning environment

- Better environment for all GP trainees to gain basic paediatric experience ....and for some GPs to gain more specialist paediatric skills

- Opportunity for supporting advanced nurse practitioners and other professionals to gain relevant skills (e.g. non-medical prescribing)
Advantages for workforce sustainability

- Makes increase in number of consultants more economically viable – opportunity costs of reducing hospital attendance & supporting primary care
- Some hospitals become more sustainable
- Becomes more feasible to close some inpatient units
- Allows career development, with possible move from more to less acute roles
Really works for children and families!!

Delivers the planned health outcomes

Has workforce advantage

Stacks up financially

Gets professional buy-in and support

Makes sense in terms of activity

Can adapt commissioning mechanisms to support model
In summary

- Transformational change is needed to achieve safe sustainable services
- We need proper feasibility modelling of alternative proposals – activity, workforce and financial
- We need to consider our approach to gaining support:
  - We need a more mature relationship with the public in making the right choices
  - We need to lever third sector support
  - We need better cohesion between healthcare professionals
  - We need to break down traditional professional silos
  - We need professional networks to act as change leaders
Thank you for listening