Child care in general practice

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Introduction

THE Court Report (Committee on Child Health Services, 1976) and the Scottish Home and Health Department's (1971) report have made recommendations for the organization of primary care for children in the UK, and a recent document from the Royal College of General Practitioners (1978) has outlined College policy for the care of children. A recent meeting of some members of the Developmental Paediatric Research Group, a working party consisting in the main of general practitioners working as general practitioner paediatricians, discussed the above reports and, in particular, considered the general statement of College policy.

The general policy of the Royal College of General Practitioners is: "that a comprehensive integrated child and family-centred service should be based upon general practice, and the College's aim is that every child shall receive a comprehensive, curative and preventive service, including health surveillance through general practice." The College policy document does not spell out in detail what "a comprehensive child care service" should be. However, if those in general practice do not evolve a more effective philosophy and practice in child care, there is a real danger that substantial parts of the primary care of children will be taken over permanently by hospital departments and the community paediatric services. In many areas it is already accepted practice for general practice to be bypassed in the provision of acute and preventive care for children, and this is especially true in big cities.

It seems reasonable, before implementing any service in general practice, to attempt to define the requirements for "a comprehensive child care service". The following are our suggestions and are put forward as a starting point for discussion by training practices.

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Organization

Effective management of the child care services in general practice depends not only on the skill of the individual doctor but on the way he runs his practice sensitive to the needs of families with children. Availability is essential, requiring 24 hours per day accessibility for children and their families to the general practitioner or general practitioners in the practice, with an easy *one-step* method of obtaining a deputy.

Appointment systems should be the method of choice for orderly organization of the daily workload. They should be sufficiently flexible to allow children with acute problems of recent onset to be seen at short notice when necessary. For example, some group practices set aside a specific time in the working day when children with acute problems of recent onset can be seen without appointments.

The child care team in general practice includes the general practitioners, trainee(s), attached health visitors, practice nurse(s), practice midwive(s), receptionist(s)/secretaries and psychologists. Regular team meetings should be organized on the basis of the practice and local needs, and their organization should be the responsibility of the doctor or doctors in the practice responsible for the overall care of children. These doctors (or one doctor in a single-handed practice) should be responsible for:

1. Calling team meetings.
2. Maintaining links with other agencies concerned with child care (for example, district handicap teams, consultant paediatricians).
3. Organizing and maintaining child health records in the practice.

In a teaching practice the last task listed should include checking and updating immunization records, maintaining a practice register of children with handicapping and disabling conditions, and with health visitors' co-operation, ensuring that the general practitioner records

provide adequate information on 'at risk' children/families who require careful follow-up. Where developmental surveillance is part of the service provided within a practice, it is necessary to have regular scrutiny of attendance rates, a common method of routine examination, and an effective system of recording developmental progress.

The responsibilities outlined above would be largely administrative and could be shared on a rotational basis depending on practice policies. In single-handed practice this degree of delegation is obviously not necessary, but even single-handed practices should be encouraged to have regular team meetings to review child care in the practice. Large training practices should have policies and regular review of services. In their absence the service is bound to be less efficient and perhaps insensitive to local needs of families and children. There is also a real danger that the organization of preventive services and continuing care of chronically ill children will be taken away from general practice altogether if these services are not properly organized.

Preventive services in teaching practices

Antenatal and immediate postnatal care

Child care cannot be divorced from antenatal care and an antenatal service should be provided by the practice for all mothers. Where possible this service should be provided at regular antenatal clinics where general practitioner and midwife are both present to ensure effective co-operation. Health visitors should be fully involved in antenatal care including positive health education, the organization of relaxation and mothercraft classes and keeping the mother informed of services for children in the first five years of life.

Where babies are born in hospital and discharged within one week, there are statutory requirements for midwife and subsequent health visitor attendance in the home. There is a tendency in many practices for the general practitioner not to visit mother and baby at this juncture unless specifically asked to do so by midwife or health visitor. Training practices should encourage general practitioner attendance in the home during the first few days after discharge from hospital, for this is an ideal opportunity to observe initial parent/child interaction, and to demonstrate an interest in the mother and her baby. This often influences the family's positive perceptions of the doctor's interest in their new baby.

Infant welfare clinics and immunization

'Well baby' clinics are held in many practices and are sometimes thought to be a health visitor responsibility. This is not so. Training practices should ensure that a doctor is always present in such clinics. His presence and influence strengthen the effectiveness of the clinic and show visibly a degree of co-operation with health visitors that mothers can witness, seeing clearly the close co-operation between the two.

It is the responsibility of the practice to maintain an immunization register and constantly update practice records of immunization to ensure maximum acceptance rates. Ideally, immunization should always be provided by teaching practices, but local circumstances vary. Whatever system exists, teaching practices should have a system of providing rapid information about immunization status of young children in the practice and should ensure the highest possible levels of immunity. Lack of medical leadership is, in part, the cause of the present poor figures.

Developmental surveillance

It is not the purpose of this paper to debate the advantages and disadvantages of routine developmental surveillance. It is sufficient to say that overall developmental surveillance should be the responsibility of the doctor in primary care. Surveillance in the setting of primary care can be carried out either:

1. Within a practice *or*
2. In co-operation with community medical officers who visit the practice *or*
3. Within health authority clinics.

Where general practitioners organize their own surveillance programmes within a practice, the following schedule for examination is often recommended:

1. At six weeks—often combined with postnatal visit
2. At seven to 10 months
3. At around $2\frac{1}{2}$ years and
4. At around $4\frac{1}{2}$ years (pre-school).

The objects of such a programme are to make early diagnosis of physical abnormalities and to look for visual, hearing, and language disorders and the early signs of mental handicap. As far as the parents are concerned, the confirmation of normality (in 85 per cent of children routinely attending) is the most important aspect of this service, followed by realistic, effective, and sympathetic help for the remaining 15 per cent with suspected handicap. The actual arrangements and methods of examination will be determined by local policies but the recall procedure requires regular review by one doctor taking responsibility for administrative arrangements for child care. Health visitor involvement in surveillance will also be determined by local policies. Surveillance should be offered to all children—that is, it should also include regular review of children who may be attending specialist departments. Where general practitioners provide surveillance services for pre-school children, this should be an item of payment by health boards/health authorities and there are ample precedents for this. Certainly sessional payments should become standardized at the clinical medical officer rate for doctors currently carrying out such work in general practice.

Teaching practices with health centre premises, or

purpose-built premises with sufficient room but without a surveillance programme, should be urgently encouraged to invite community medical officers into the practice to provide routine screening of the pre-school child population. Ideally, the results of examination should be incorporated in the general practice records. Such a system allows for ease of communication and 'on the spot' opportunity for trainees to participate in preventive medicine.

Where surveillance for pre-school children is still being carried out in health authority clinics, teaching practices must ensure that all pre-school children in the practice get every opportunity to receive high quality developmental guidance. Practice organization should include a method of identifying non-attenders (about 60 per cent over two years old nationally) and not assume that the health authority will automatically follow up these children.

Training

Where general practitioners are carrying out the services mentioned above, there is ample opportunity for trainees to learn techniques of measuring physical and sensory development in children and to become attuned and sensitive to the special needs of children. If the above services are not available in training practices, it is essential that local arrangements are made to ensure that *all* trainees have received appropriate training in child development and child care in the setting of general practice. It would be quite wrong to assume that this aspect of training is automatically covered during paediatric rotations in vocational training.

The object of providing training opportunities is not just to encourage trainees to organize surveillance programmes in their future practices, but to enlarge their range of skills in the day-to-day management of children. Their future activities will depend on the effectiveness of their involvement in the child health care system of the training practices to which they are attached.

Summary

These recommendations are merely a starting point for discussion by all those involved in vocational training. Their main thrust is towards defining guidelines for the maintenance of continuing care for young children in training practices. This will go a long way towards ensuring that every trainee has been exposed to comprehensive child care.

The emphasis has been on the pre-school child as this is the period when the greatest demand occurs and where services tend to be most fragmented. More information is still required from practices which have had experience of providing preventive services for pre-school and school children.

All teaching practices should aim at setting a standard of services and care which should be available to all young children in every general practice.

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